Primary Health Care Opioid Response Initiative

Year 2 Summary Evaluation Report

March 25, 2020

Primary Care Networks | Alberta Health Services | Alberta College of Family Physicians | Alberta Medical Association | PEER Patients Experience Evidence Research | Alberta

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Limitation of Liability

Use and Disclosure of Presented Information

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Contents

List of Acronyms & Abbreviations

ACFP	Alberta College of Family Physicians
ACTT	Accelerating Change Transformation Team
AH	Alberta Health
AHS	Alberta Health Services
AMA	Alberta Medical Association
AMH	AHS Addiction and Mental Health
ARES	Applied Research and Evaluation Services
CEA	Collaborative Evaluation Approach
CMN	Collaborative Mentorship Network for Chronic Pain and Addiction
EAC	Evaluation Advisory Committee
EMR	Electronic medical records
IF	Improvement Facilitators
IWLE	Individuals with lived experience
MOERC	(Alberta) Health Minister's Opioid Emergency Response Commission
OAT	Opioid Agonist Therapy
ODP	Opioid Dependency Program
ODT	Opioid Dependency Treatment
ORC	Opioid Response Coordinator
OUD	Opioid Use Disorder
PACES	Provincial Addiction Curricula & Experiential Skills Training
PCN	Primary Care Network
PEER	Patients, Experience, Evidence, Research team
PF	Practice Facilitator
PHC	Primary Health Care
PHC ORI	Primary Health Care Opioid Response Initiative
PMH	Patient Medical Home
Suboxone™	Buprenorphine/Naloxone
VODP	Virtual Opioid Dependency Program

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Primary Health Care Opioid Response Initiative

Year 2 Summary Evaluation Report

Executive Summary

Introduction & Background

This evaluation report presents year two of the evaluation findings completed for the Primary Health Care Opioid Response Initiative (PHC ORI). This is the executive summary of the *Year 2 Summary Evaluation Report*; is an evaluation of activities that have occurred, from January to December 2019, and their advancement towards the stated PHC ORI goals and objectives. In May 2019 an *Interim Evaluation Report* was produced summarizing findings from a mid-term process evaluation covering the majority of activities what took place from grant initiation to January 2019.

The PHC ORI work began with a collective understanding that tackling the opioid crisis in Alberta would require new and innovative approaches, including an immediate response of the entire health system to change the trajectory of the crisis. The engagement and response of primary care physicians, teams, and Primary Care Networks (PCNs) in Alberta was deemed essential in defining appropriate primary health care approaches that would address the systemic issues contributing to the crisis, and optimize the ability of primary care partners to respond quickly and effectively.

The resulting PHC ORI was a multi-stakeholder project funded by Alberta Health through a grant agreement with the Alberta College of Family Physicians (ACFP). The ACFP (including the Patients, Experience, Evidence, and Research (PEER) team), the Alberta Medical Association (AMA), Alberta Health Services (AHS), and zone Primary Care Networks (PCNs) Committees collaborated to lead this essential work in the primary care context that continued through March 2020.

PHC ORI Goals

The goals provided the common vision and strategic priorities for the initiative.

Evaluation Approach & Methods

The PHC ORI was a complex intervention, involving provincial partnerships, new planning based on zone-level considerations, and practice-level change. Correspondingly, it required an evaluation approach that could capture how the work unfolded, what was learned, what changed, what did not change and why. A collaborative evaluation approach[1] underpinned this evaluation. The PHC ORI evaluation team worked with project stakeholders to collaboratively design, develop, and implement the evaluation, based on their information needs and interests. To enable this approach, an Evaluation Advisory Committee was formed with representatives from each of the provincial partner organizations, zones, and a family physician.

The summative evaluation plan used several data collection strategies comprising both quantitative and qualitative methods between January and February 2020. These are listed briefly here, and further detail can be found in the technical report.

Table 1: Data Collection Strategies

Primary Data Collection Methods	
Focus Groups with Zone Working Groups	Collaboration Forum Survey
Focus Group with Provincial Operations Team	Key Informant Interviews
Focus Groups with Practice Facilitators	Primary Care Provider Survey
Focus Groups with ORCs	Case Studies
Opioid Response Coordinator Survey	Practice Facilitator Survey
Secondary Data Sources	
Program Data	Administrative Data

Evaluation Questions

1. What were the key activities that occurred in Year 2 of the grant?
2. What practice level changes occurred as a result of the PHC ORI grant?
3. What difference has this made for people at risk of /with Opioid Use Disorder (OUD) in the primary care context?
4. What were the facilitators and barriers (or strengths and challenges) of the PHC ORI grant?
5. What parts of the work built capacity for sustainability?
6. What elements of the PHC ORI can be scaled or leveraged for other health issues in Alberta, in Canada?
7. What lessons can be applied to rapidly respond to future health crisis needs?

[1]Cousins et al. (2015). *Principles to guide collaborative approaches to evaluation.* Retrieved from https://evaluationcanada.ca/sites/default/files/20170131_caebrochure_en.pdf

At-A-Glance

What follows is “a glance” at the core themes revealed through evaluation data analysis. These themes are those which had the greatest triangulation of data sources and thus represent the most substantiated findings from the evaluation.

Growth of Relationships/ Partnerships

Evidence indicates many activities fostered the growth of relationships and partnership at the provincial, zonal, community, and clinic-level. Collaboration was advanced across these relationships, with the Opioid Response Coordinators, Practice Facilitators, and Collaboration Forums being identified as a key mechanisms.

Education, Training & Knowledge Translation was Foundational

The evaluation captured the extent of the education and training activities that occurred as a result of the grant, as well as the numerous tools and resources developed for primary care. Results indicate these activities were informative, highly accessible and easy to use. Further, collectively, they were found to provide knowledge and increase skills and awareness about opioids and Opioid Use Disorder (OUD).

Increased Awareness, Reduced Stigma about Opioids

The combined educational, training, and knowledge translation efforts of the PHC ORI grant have helped increase awareness about opioid use, the importance of the PHC ORI work, and reduce stigma in primary care. Harm reduction training was a critical factor in increasing awareness and reducing stigma.

Capacity Built Amongst Primary Care Providers & Teams

The evaluation found evidence of increased capacity in primary care. The educational and training activities as well as the role of the Opioid Response Coordinators/ Practice Facilitators were fundamental in advancing this finding. There is indication of a shift in practice occurring in primary care settings due to these efforts.

Increased Access to Services

Increasing awareness, reducing stigma, building primary care capacity and shifts in practice have all led to increased access to Opioid Agonist Therapy (OAT) services beyond a more specialist model of care by building on the familiar relationships that Albertans have with their primary care providers.

Sustainability & Scalability Opportunities

Data indicates there have been many activities to support the sustainability of the work and stakeholders remain committed. Key elements that will continue post-grant include established relationships and ongoing collaboration, awareness and skills about opioids, and access to foundational tools and resources.

Engaging Individuals with Lived Experience

When engaging Individuals with lived experience occurred, it was viewed as highly meaningful and impactful to the work. While some results indicated this engagement was challenging at times and in a few cases, unsuccessful, when it did happen, it helped to advance the work in important ways.

Elements that Facilitated the PHC ORI Work

The evaluation determined several elements that were critical to moving this work forward. The provincial governance structure was identified as an important facilitator of deliverables whereas the zonal governance structure enabled continued relationships and collaboration. Existing relationships were also key.

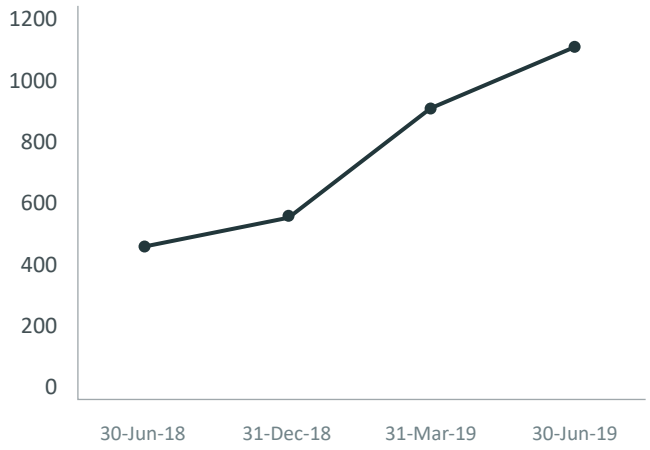
By the Numbers

One goal of the grant was accelerating access to Opioid Agonist Therapy (OAT) across the province. Throughout the initiative, the province demonstrated an increase in the number of Primary Care Network (PCN) providers trained on and prescribing OAT.

The number of PCN patients receiving OAT also increased over the course of this grant.

PCN Prescribing Providers Trained to Prescribe OAT

Figure 1: Total increase in the number of PCN Providers Trained to Prescribed OAT per Quarter, June 30, 2018-June 30, 2019



158%↑

increase in the reported number of PCN providers trained to prescribe OAT (June 2018-June 2019)

PCN Patients Receiving OAT

Table 2: Total number of PCN patients receiving OAT by zone, June 30, 2018-Dec 31, 2019

	June 30, 2018 (baseline)	Dec 31, 2019 (% ↑ from June 30/18)
South	686	917 (34%)
Calgary	1465	1665 (14%)
Central	790	796 (1%)
Edmonton	1827	2554 (40%)
North	386	550 (42%)
Total	**5154**	**6482 (26%)**

More Albertans are receiving OAT

PCN Physicians Prescribing OAT

891
Physicians prescribing OAT as of December 31, 2019

↑457
Additional 457 physicians in Alberta prescribing OAT

434
434 Physicians prescribing OAT as of June 30, 2018

Ways Forward

Maintain Relationships and Collaboration Efforts

Many gains have been made in building relationships and fostering collaboration at multiple levels in primary care. Trust has been foundational. Work should go into maintaining these efforts and building on these successes.

Maintain the provincial partnership. The PHC ORI grant represents the first time the Alberta College of Family Physicians (ACFP), Alberta Medical Association (AMA), and Alberta Health Services (AHS) have formally collaborated to address a shared health crisis. This partnership is now well positioned to collaborate on future issues.

Continue collaboration and intentionally sustain all levels of relationships. Relationship development was a key factor of much of the PHC ORI success. Further developing and strengthening these relationships will need to be intentional moving forward. Sustaining a virtual space, such as the Collaboration Forum, as a (webinar) platform to share activities and to advance a culture of organizational learning and quality improvement, will be essential.

Continue to explore collaboration between primary care and AHS Addiction and Mental Health. There are many opportunities available through greater collaborative efforts with AMH with the potential to further help individuals living with needs in a primary care setting. Barriers to treatment and stigma remain for those who are at risk of/living with Opioid Use Disorder (OUD) and increased linkages between primary health care and Addiction and Mental Health will support positive impacts for these patients.

Explore formal partnerships with the other stakeholders or healthcare partners involved or impacted by the work. Responding to the opioid crisis requires the entire health care system and multiple healthcare provider types.

Invest in Specific Activities to Continue and Broaden the Impact of PHC ORI

Aligning the work with other priorities is one important way to broaden this work. In addition, several activities were critical in forwarding the PHC ORI work. Continued investment in these activities are important to maintain momentum towards changing the trajectory of the opioid crisis.

Maintain and expand education modules, resources, and tools on-line, ensuring they remain centralized and easily accessible. Primary health care teams now have an accessible repository of a wealth of opioid-related information that were carefully created to serve their informational needs. This should be maintained. A mechanism to review, regularly update, and disseminate is important.

Continued efforts to reduce stigma and increase awareness about opioids, OUD, and addiction. While much work occurred in this regard, stigma still exists and continues to be a barrier for people at risk/with OUD. Continuing this discussion with a patient-centred care lens is critical.

Continue communication and information sharing on the indicators related to service planning work in the area of addiction and mental health. Provincial investment into ensuring zone and PCN teams stay connected to relevant planning information will be important to keep issues front and centre in the future. Sustaining the provincial reporting that began with this grant will contribute to more informed population health needs planning at multiple levels.

Maintain structures/mechanisms that allow primary care providers to build capacity in providing opioid related care. Many new structures, mechanisms, and roles were seen as building capacity for primary care providers and teams. The Collaborative Mentorship Network for Chronic Pain and Addiction (CMN), time spent building community partnerships and subject matter expertise, and advancement of demonstration projects allowed individuals to become, or have access to, experts in the domain of opioid related care.

Continue Knowledge Sharing Efforts

Efforts to continue provincial data reports is critical to build on the momentum created through this initiative. Reports moving forward should build on past reports that show mortality from opioid overdose by zone/attachment to PCN providers, emergency visits/hospitalizations linked to OUD, as well as prescribing data. Without continued reports summarizing provincial data, there is an increased risk that this work will no longer be prioritized, jeopardizing the success of the extensive work done to date on changing the trajectory of the opioid crisis in Alberta.

Collective impact. More could have been done to set up better coordination between the opioid response initiatives funded through Alberta Health. Strengthening evaluation efforts to allow for examination of the collective impact for system-level work would be ideal and allow for a path to extend the investment of any one initiative's work and learnings.

Align Work with Other Priorities

The PHC ORI goals and objectives should be aligned with future health priorities in order to sustain the work.

Look for opportunities to leverage the PCH ORI knowledge assets with advancing provincial work, such as the AB Surgical Initiative and the AB Pain Strategy. In addition, find opportunities to share findings from this work to ensure that evidence informed principles inform resource decisions moving forward in order to meet the needs of patients across the care continuum.

Find other opportunities to align this work. The best way forward for this work is to find sources of additional funding. In the absence of specific PHC ORI money, provincial stakeholders should look for other funding opportunities with which this work can align.

Zones & PCNs have a Key Role in Forwarding this Work

There is much that zones and PCNs can do to continue this work beyond the PHC ORI grant.

Integrate PHC ORI work with Patient Medical Home (PMH). Becoming a PMH requires that the family physician and health care team commit to changing the way the care is delivered in pursuit of continual improvement supported by appropriate funding and infrastructure. By integrating opioid related care into this process, this important work can be advanced through this broader vision.

Implement and test development pathways. This evaluation found that while many pathways have been developed, few stakeholders have had the chance to implement, test, and revise the pathways. Moving forward, these pathways must be tested and assessed, or there is the possibility that the investment in their development may result in wasted effort.

Continue to offer OAT and harm reduction practices to patients that require it. The PHC ORI established that these are effective ways of supporting patients at risk of/with OUD. Scientific evidence supports these practices and it aligns with health's core principle of patient-centred care. PCNs and clinics can continue to work in this manner and harm reduction can be integrated with recovery.

Zones and PCNs should continue to come together and collaborate. The PHC ORI grant work emphasized the power of collaboration and trusting relationships. Some zones already had this work underway and found the grant strengthened this for them. Continued efforts to share information and learnings across zones should continue.

Scaling Opportunities

There are several activities that can be scaled across the province, or the country.

Share training, education, resources, and tools nationally. Many effective training, education, resources, and tools were developed from this grant and can continue to be shared nationally.

Further scaling of opioid change package. The AMA Opioid Process Improvement Change Package was an effective mechanism that forwarded the PHC ORI work. This package ultimately helped transfer learnings into practice settings and should be considered as an essential tool/format to supporting change to guide improvement work.

Scale/adapt pathways across the province. While pathways are not fully transferable across contexts and require local adaptation, there is opportunity to examine how these can be shared through Plan Do Study Act cycles of "testing" to advance this work across the province.

Scale Opioid Response Coordinator (ORC) work with Alberta Works. ORCs in the North zone were successful in streamlining the approval process for individuals needing financial assistance for OUD treatment. Applications are now placed on high priority by Alberta Works and patients typically receive approval within one day. This is a significant change that should be examined in other regions to improve access to help for patients at risk/with OUD.

Increase Efforts at Engagement with Particular Populations

Increased efforts at engagement should occur across the province with individuals with lived experience (IWLE) as well as with Indigenous communities.

Increase efforts at engaging IWLE. Some significant success occurred working with IWLE in this grant, noting how powerful this engagement was for both practitioners and the IWLE. The evaluation also found that this was challenging for others and some zones were unsuccessful in their engagement with IWLE. Further and continued engagement with IWLE should occur, and additional supports for this work should be considered.

Increase Efforts Engaging with Indigenous Communities. It is well understood that opioids and OUD have a disproportionate effect on Indigenous peoples and their communities. Working with Indigenous communities was identified in the early conceptualization of the grant and was reconfirmed in the interim report. However, this evaluation revealed that little further work was conducted in Year 2 of the grant activities. Concerted efforts are needed to meaningfully engage with Indigenous communities to disrupt the impact of the opioid crisis.

Conclusion

The PHC ORI grant resulted in numerous successes while also uncovering important challenges. Looking back, the PHC ORI interim evaluation report (2019) readily acknowledged that momentum throughout primary care was going to take time to build; this summary evaluation report, written less than a year later, was able to triangulate multiple data sources and determine meaningful progress in the key thematic areas outlined in this report. While this report highlights the progress made against the goals and objectives put forth in the proposal, the work cannot stop. The opioid crisis continues to claim lives and devastate families. This will continue to be a challenge to our health system, reinforcing the importance of carrying on the work begun through the PHC ORI grant; it is our collective responsibility to improve the quality of life of those with OUD and save lives.

"In order to have a fully integrated health system that can respond effectively and efficiently to crisis will require us to continue to look for ways of working together, to share successes, to build trust and collaboration, and to drive policy and legislation that allows for resource reallocation and patient centred strategies. The people that joined forces to respond to the opioid crisis recognize the value of this integration, and we need a system that supports this ongoing way of working together. Thank you to all of you who had a role in the PHC ORI! We made a difference."

Terri Potter, PHC ORI Executive Lead, ACFP

Primary Health Care Opioid Response Initiative

Year 2 Summary Evaluation Report

Introduction

Introduction

This report presents Year 2 of the evaluation findings completed for the Primary Health Care Opioid Response Initiative (PHC ORI). The grant partners proactively included this summative evaluation report as a deliverable in the grant in order to assess effectiveness of the PHC ORI after two years of activities. This report is one of two produced for this evaluation. Referred to as the *Year 2 Summary Evaluation Report*, this work is an evaluation of activities that have occurred from January to December 2019, and their advancement towards the stated PHC ORI goals and objectives. It considers the short and mid-term outcome achievements, and whether any changes resulted from this work. Through consideration of the evaluation findings, including identified grant facilitators and challenges, this report also offers insight into how future service planning may unfold in primary health care. The second report, referred to as the *Year 2 Technical Report*, is a separate document outlining the details of the evaluation methodology and findings across all data collection streams.

This evaluation report will not cover PHC ORI key activities. This will be captured in the *Primary Health Care Opioid Response Initiative: Project in Review*; an interactive summary highlighting the achievements and teams of each of the partner organizations responsible for the success of the PHC ORI.

Background

The PHC ORI work began with a collective understanding that tackling the opioid crisis in Alberta would require new and innovative approaches, including an immediate response of the entire health system, to change the trajectory of the crisis.[3] The Minister's Opioid Emergency Response Commission (MOERC) was established in May 2017 to support the Government of Alberta's urgent response call to the opioid crisis. As part of its mandate, MOERC was responsible for making recommendations to the Minister and to oversee and implement urgent coordinated actions to address the opioid crisis. Its work focused on six strategic areas: harm-reduction initiatives, treatment, prevention, enforcement and supply control, collaboration, surveillance, and analytics.

In September 2017, MOERC recommended the Minister support a $9.5 million funding request from primary care partners to increase and accelerate the participation of primary care in the urgent opioid response. The engagement and response of primary care physicians, teams, and Primary Care Networks (PCNs) in Alberta was deemed essential in defining appropriate primary health care approaches that would address the systemic issues contributing to the crisis, and optimize the ability of primary care partners to respond quickly and effectively.

[3] The Minister's Opioid Emergency Response Commission's mandate was completed in 2018. Work on a mental health and addictions strategy is being continued by the Mental Health and Addictions Advisory Council.

The resulting PHC ORI was a multi-stakeholder project funded by MOERC through a grant agreement with the Alberta College of Family Physicians (ACFP). The ACFP (including the Patients, Experience, Evidence, and Research (PEER) team), the Alberta Medical Association (AMA), Alberta Health Services (AHS), and zone Primary Care Network (PCNs) Committees collaborated to lead this essential work in the primary care context that continued through March 2020.

In May 2019 an interim evaluation report was produced summarizing findings from a mid-term process evaluation covering the majority of activities what took place from grant initiation to January 2019. Following the presentation of the report findings to the PHC ORI Steering Committee in June 2019, the provincial and zonal partners were each asked to meet to review the recommendations provided (e.g., provincial or zonal recommendation), and develop a series of "go forward" strategies to advance the work in Year 2 considering the recommendations. These strategies were submitted to the project Secretariat in early fall, and were reviewed in follow-up meetings in fall 2019 to reinforce the importance of this work.

Goals and Objectives

Goals and objectives provided the common vision and strategic priorities for the initative.

GOAL

1

Access and Continuity

Improve access, continuity and care delivery within primary care settings for individuals at risk of/with Opioid Use Disorder (OUD).

Objectives

1.1 Albertans using opioids have access to a primary care provider and team that they know and trust.

1.2 Patients at risk of/with Opioid Use Disorder are offered to develop a plan of care with their primary care provider and team.

1.2 Expand and improve the capacity within PCNs to support member practices to implement practice changes related to opioid prescribing, monitoring of opioid use, pain anagement, patient self-management support, and Opioid Agonist Therapy (OAT).

1.4 AHS zone services and PCNs support primary care clinics to increase access to and distribution of Opioid Overdose Response (naloxone) Kits and OAT.

1.5 Primary care providers increase offers of OAT and/or other appropriate offers of care to patients with Opioid Use Disorder.

GOAL

2

Decision Support, Knowledge Translation and Education

Implement relevant and practical evidence informed decision supports and knowledge translation tools, including mentorship, to better equip and educate primary care providers and teams, including clinics and PCNs, to support patients with addiction, mental health and/or pain issues resulting in use of opioids and/or with Opioid Use Disorder.

Objectives

2.1 Within a harm reduction approach, develop and support implementation of provider and patient education, decision support tools, knowledge translation strategies, practice change tools and resources.

2.2 Develop and implement a capacity building plan and approach to support distribution and uptake of decision supports, tools, resources and education in zone, PCNs and primary care practices.

2.3 Develop and coordinate a mentorship collaborative network(s) within each zone related to opioid use.

GOAL

3

Enhanced Coordination of Care and System Integration

Enhance system integration and coordination of care between primary care practices and other service delivery partners for patients using opioids including those with Opioid Use Disorder.

Objectives

3.1 Primary care, specialty care and community teams work together to identify opportunities for improved coordination and continuity of care across or within service areas, such as primary care clinics, Primary Care Networks, specialists, AHS specialty care programs, hospitals, acute care services, community services, social services, and other community supports.

3.2 Primary care teams work together to develop comprehensive and accessible care pathways for patients using or at risk of using opioids, Opioid Use Disorder, addiction, mental health and pain between primary care, specialty programs, specialists and hospitals in each zone.

3.3 Utilizing a harm reduction approach, interdisciplinary teams of providers within primary care settings work collaboratively with patients and their families to develop and implement successful care planning processes.

3.4 Patients using opioids are collaboratively supported to transition between primary and specialty care as needed.

3.5 Integrated Care Partnerships are formed and/or enhanced within each zone and enable the opioid response with primary care, community, specialty care services areas, specialty care programs and acute care focused on opioid use.

GOAL

4

Population Health Planning

Using a population health based approach, develop and implement a service plan and urgent response for the integrated delivery of opioid related care.

Objectives

4.1 Based on identified population and community needs, Zone PCN Committees develop and implement a service plan focused on opioid related care, including urgent response activities.

4.2 Zone PCN Committees prioritize the development of comprehensive and accessible care pathways across the continuum.

Evaluation Approach

Funding for an in-depth evaluation was included as part of the MOERC grant funding for PHC ORI. The purpose of the measurement and evaluation activities was to both inform the development of the project activities, and to further knowledge about advancing an opioid response in primary health care. In December 2018, the PHC ORI Evaluation Framework was released to guide the evaluation activities.

The PHC ORI was a complex intervention involving provincial partnerships, new planning based on zone-level considerations, and practice-level change. Correspondingly, it required an evaluation approach that could capture how the work unfolded, what was learned, what changed, what did not change, and why. Based on the short timeline and the multi-layered approach to the grant, the evaluation focused on the macro (systems) and meso (zone/ PCN) levels. Front line provider and practice facilitator perspectives were also brought into this Year 2 evaluation when possible.

A collaborative approach to evaluation (CEA)[4] underpinned this evaluation. The PHC ORI evaluation team worked with project stakeholders to collaboratively design, develop, and implement the evaluation, based on their information needs and interests. To enable this approach, an Evaluation Advisory Committee (EAC) was formed with representatives from each of the provincial partner organizations, zones, and a family physician. The EAC was engaged in the development of the logic model, the evaluation questions and design, and implementation of the evaluation plan. Their perspectives also guided decisions made around data collection methods. Examples of CAE principles incorporated into this evaluation included: fostering meaningful relationships, developing a shared understanding of the program, promoting appropriate participatory processes, and monitoring evaluation progress and quality.[5]

This Year 2 evaluation report is a summative evaluation that focuses on the advancement of the PHC ORI goals and objectives, the short and mid-term outcome achievements, and examines whether any changes resulted from this work. While grant work will continue up until March 31, 2020, this report was designed to assess the outcomes of activities that were funded through this grant. Impact was assessed through a mixed method data collection approach from mid-December 2019 through early February 2020. The core themes presented in this report are drawn from the evaluation evidence gathered through several strategies outlined below. Only themes that appeared repeatedly in the data were collated for this report as the evaluation team looked for triangulation of findings across sources. The analysis for this report does not utilize data sources from outside of the evaluation. Participating partners at both the Zone and provincial levels on this grant have also conducted their own evaluation to serve their organizational learning needs that are beyond the scope of this evaluation.

A separate technical report is also available which includes the detailed evaluation methodology, detailed findings and instruments designed to capture the impact of this investment.

[4]Cousins et al. (2015). *Principles to guide collaborative approaches to evaluation.* Retrieved from https://evaluationcanada.ca/sites/default/files/20170131_caebrochure_en.pdf

[5]Ibid.

Evaluation Questions

1. What were the key activities that occurred in Year 2 of the grant?
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7. What lessons can be applied to rapidly respond to future health crisis needs?

Evaluation Methods in Brief

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Secondary Data Sources	
Program Data	Administrative Data

Triangulation of data requires the comparison of multiple perspectives, data sources, or methods to corroborate the analysis, and build credibility of research and evaluation.[6] This evaluation used two types of triangulation in the analysis: data methods and analyst. Data from several methods, including qualitative and quantitative, were triangulated to test for consistency, corroborate the analysis, and neutralize bias. Analyst triangulation was also used by engaging multiple analysts to review the evaluation findings.

[6]Patton, M. (2002). *Qualitative research & evaluation methods.* Thousand Oaks, CA: Sage.

Limitations

There are several limitations to note when reviewing the findings. These are described below:

- The most robust data about the new roles created through this grant funding (e.g., Opioid Response Coordinator (ORC)/project level Improvement Facilitator roles) was only collected from North zone ORCs and thus, their voices and contributions may be overrepresented in this report.[7]
- The intertwined and evolving roles of Practice Facilitators (PFs) and the additional supports provided through the ORC (most often set at a .1 or .2 of their full time improvement facilitator role) made it difficult to make attributions of benefit.
- The continuing challenge in administrating surveys in primary care to obtain generalizable perspectives at a system level. A central contact list does not exist to easily reach primary care physicians and teams, PCN funded staff, and AHS primary care staff.
- The accelerated timeline to complete the evaluation and write a report resulted in very limited time to host extended conversations regarding the mobilization of results prior to grant end.
- Work to host activities and finalize decision support products were being completed through the grant's end in March 31, 2020. Benefits that may be attributed to work produced in the last quarter of the grant are therefore not captured in this evaluation report.
- AMA Physician champions[8] were trained in late 2019 and thus, their contributions likely have not been captured through this evaluation.
- Clinic level demonstration projects, led by the AMA, started in late fall 2019 and thus, insights drawn from this project have not been captured in this report. Results will become available in fall 2020.
- AHS zone and PCN relationships, both formal and informal, vary across the province of Alberta. Therefore, trust and emerging structures to make zonal decisions emerged along different timelines.
- System-level work takes time to demonstrate longer term benefits, including improved patient/provider experience and sustained/ matured partnerships. However, this grant was still able to demonstrate impact on most medium-term outcomes laid out in the provincial logic model (finalized October 2018).

The authors do not believe that these limitations affect the value of the evidence provided in this summary evaluation report. This report has a rich array of information that will assist organizational learning and decision-making as primary health care continues forward to reach its provincial objectives.

[7] In an attempt to trial a "shared service model for evaluation", zone level evaluation support was written into the ARES evaluation contract for this work when the request aligned to the broader project goals and evaluation resources were available. In fall 2019, the North zone project team requested evaluation support to provide insight into the newly created ORC role to guide their PCN business plan renewals. The PHC ORI grant extension was declined in December 2019 precluding further evaluation work being replicated in the other zones employing a simlar ORC like role.)

[8] Alberta Health provided funding through a separate grant to support selected family physician leaders. Those supported will work with AMA staff, PCN physician leaders and Practice Facilitators to advancement the Opioid Change Package as well as other quality improvement initiatives.

Primary Health Care Opioid Response Initiative

Year 2 Summary Evaluation Report

Findings

This section presents the main findings from the Year 2 summative evaluation. Full details of the methods and data can be found in the separate technical report.

Related PHC ORI Goals

1 2 3 4

Relationships/ Partnerships

Growth of Relationships/Partnerships

The growth of relationships and partnerships as a result of the PHC ORI grant was the first major theme revealed through data analysis. Qualitative findings across focus groups and key informant interviews emphasized the development of relationships and collaboration as a critical focus and outcome of this work. Findings further revealed relationship activities and partnership advancement occurred at multiple levels and that each partner, zone, and relationship was at a different stage of development. These are discussed below.

The Provincial Level

At the provincial level, the PHC ORI represents the first time AHS, AMA, ACFP (including PEER), and PCNs have formally partnered to collectively address a provincial health crisis. Many evaluation participants found this extensive partnership to be one of the major successes of the initiative.

Partners reported an increased understanding of roles and responsibilities among various stakeholders, between direct service provider groups, and the programs that support them (e.g. AMA and AHS). Communication and information sharing have occurred regularly at this level (e.g. through status reports) which aided in collective understanding of the issue and initiative and drove momentum.

> *"The major success of the initiative is partnership: bringing partner organizations to work on a common focus. AMA, ACFP, AHS, with AH to advance the goals and objectives of this initiative." (Key informant interviewee)*

The Zone and Community Level

In much of Year 2 of the PHC ORI grant, zones reported focusing many activities on relationship building at the zone level. Some zones centred on establishing relationships in each PCN by engaging with PCN leadership in opioid planning and identifying a key PCN contact for the opioid work. One zone set up a community of practice where PCNs gathered to share and learn. New relationships with pharmacists, AHS Addiction and Mental Health (AMH), and in some cases individuals with lived experience (IWLE), were also noted in qualitative data. Another Zone created a clinical working group comprised of multiple stakeholders such as PCNs, representatives from the Opioid Dependency Program (ODP), Pharmacists, and an IWLE, demonstrating multi-stakeholder partnership at the zonal level. These new relationships were also reported in status reports.

Through the PHC ORI grant, and based on the initial needs assessments done by the zones in fall 2018, a designated Opioid Response Coordinator (ORC) was created in three Zones. The ORCs centred some of their work on building relationships in their respective Zones and communities. Respondents explained this position was pivotal in connecting with pharmacists and urgent care centres in rural communities and in some instances, with local reserve members. Relationships with the ODP, Virtual Opioid Dependency Program (VOPD), and other specialty services were also set up in several areas. In addition to ORCs, one zone added additional grant funded roles (e.g. grant-funded improvement facilitator and educator) that were designated to facilitate relationship building activities. Notwithstanding official delegated grant-funded positions/roles, relationship building activities could have fallen to other existing positions; for

example, existing facilitator- type roles involved in opioid-related work. These types of roles are often referred to as Improvement Facilitators (IFs) or Practice Facilitators (PFs) depending on the PCN. Overall, how best to organize the staffing for this grant was based on information collected through needs assessments. This nimbleness allowed the respondents to creatively try new ways of advancing the work.

The Clinic Level

The tailored training opportunities that were created, planned, and implemented through this initiative emphasized a team-based model, such as collaborative team-based approaches and multi-disciplinary teams, to advance care for those living with Opioid Use Disorder (OUD). Most PHC ORI training sessions invited family physicians, nurse practitioners, pharmacists,[9] registered nurses, licensed practical nurses, and improvement/practice facilitators.

In addition to zone and community level work, data indicated ORCs and PFs also worked with individual clinics in their areas and reported clinic-level relationships as a foundational element to advance PHC ORI activities. These staff described that having a prior relationship and familiarity within PCNs and clinics improved their chances to reach physicians, which can be challenging. Being a trusted and familiar face in the clinic setting and having previously established working relationships with physicians and clinic staff enabled those participating in the specialized training to know how to create knowledge sharing opportunities due to their familiarity with local clinic operations. While established relationships with physicians did not necessarily guarantee uptake, PCN and clinic staff (both PFs and those working in ORC roles) overall felt they had greater success providing offers of support where they could leverage pre-existing relationships with clinics and physicians.

> *"Through the grant structures [that] were established, we could collaborate across organizations both provincially and zonally…and through that collaboration we had a shared priority to a specific population need…because the grant was set up that way, we actually collaborated to work in provincial and local ways around a shared priority."*
> *(Key informant interviewee)*

Collaboration

The PHC ORI grant also promoted collaboration across partnerships. For some zones, this was a new way of working, while for others, zonal collaboration was already occurring, and this new emphasis accelerated their efforts:

"Prior to the grant, this zone *held lots of relationships already. The grant facilitated a more tactical, action-oriented form of collaboration. On the ground type of work."* (zone working group member)

Analysis also revealed the grant facilitated greater collaboration between partners both provincially and regionally due to the multitude of collaborative and multidisciplinary meetings, forums, and educational opportunities held regularly (i.e. Monthly Collaboration Forum, Continuing Medical Education Events and Opioid Agonist Therapy (OAT) training). These events were reported to be well attended with broad representation of stakeholders.

Qualitative evidence also suggests challenges with collaboration. For some interviewed, engaging those with lived experience and interorganizational collaboration proved to be challenging at times. For example, how to engage IWLE in a meaningful way without it feeling tokenistic was sometimes challenging.

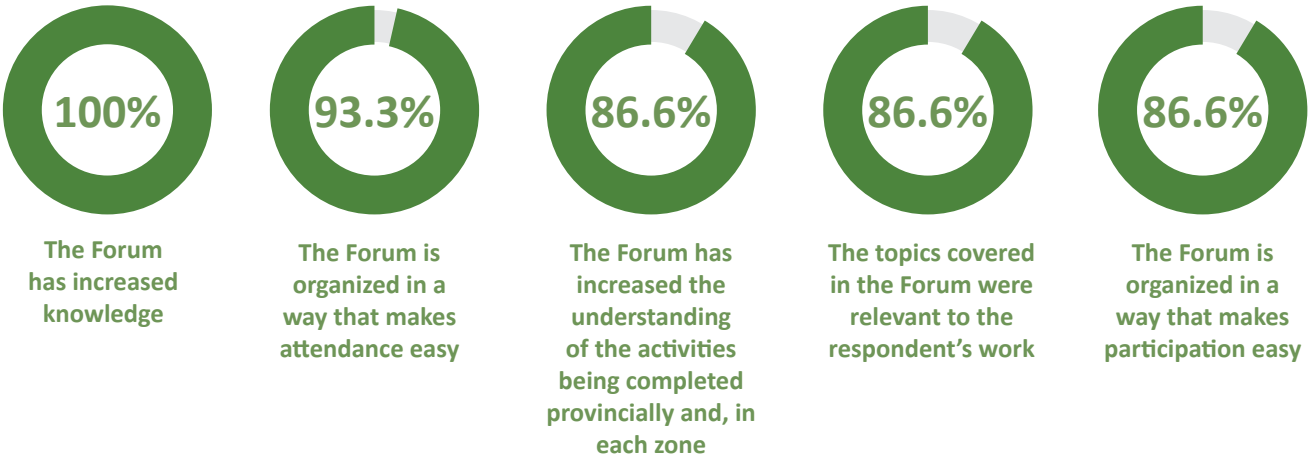
In addition, pathways that included transitions between programs and primary care were difficult to coordinate as attachment back to PMH was not always seen as key by all involved. Advancing this work proved difficult and speaks to the broader challenges that still exist within the health neighbourhood (e.g., specialty clinics, community pharmacies, and primary care).

[9]Some pharmacists were employees of PCNs while others were community pharmacists. Some PCNs chose to use this training as a way to advance partnerships between a PCN and their community providers like pharmacists.

Collaboration Forum

Interviewed participants explained that the monthly Collaboration Forum provided a platform where provincial and local information could be shared in order to advance their collaboration. Survey respondents echoed these findings as all respondents reported the Forum to be a successful platform used across the provincial zones. These respondents also found the Forum to be beneficial to fostering relationships, connections, sharing knowledge and resources, and collaboration across stakeholders. Overall, the Collaboration Forum was gauged to be a useful and an informative instrument of collaboration.

Of those who responded to the Collaboration Forum Survey (N=15), representing a response rate of 24%, the following agreed or strongly agreed that:



The survey also asked questions drawn from the Wilder Collaboration Factors Inventory,[10] which is a research based, validated questionnaire used to assess the strength of a collaboration. Scores on each of 5 collaboration factors are calculated with scores between 4.0 and 5.0 indicate areas of strength, scores between 3.0 and 3.9 are borderline areas that warrant discussion, and scores between 1.0 and 2.9 are areas of concern that should be addressed.

Scores for all the five collaboration factors were on the positive end of the Wilder scale, suggesting collaboration of the Forum was moderate to strong. The highest scores were Adaptability to Changing Conditions (4.3), Members See Collaboration as Being in their Self-Interest (4.2), and Appropriate Cross-Section of Members (4.2). These scores signify survey respondents believed the monthly Collaboration Forum adapted well to changing conditions, had representatives from a relevant segment of partners, and benefited participating organizations, zones and working teams.

Open and Frequent Communication (3.9) and Established Informal Relationships and Communication Links (3.8) received moderate scores. Survey respondents felt that members of the Forum interacted often, updated one another and discussed issues openly, and participating organizations, zones, and working teams connected informally, but there was room for improvement. Survey participants did not identify any factors that ranked as areas of concern to be addressed.

[10]Mattessich, P. W., & Johnson, K. M. (2018). *Wilder Collaboration Factors Inventory.* Accessed January 2019 from https://wilderresearch.org/tools/cfi-2018/start

Related PHC ORI Goals

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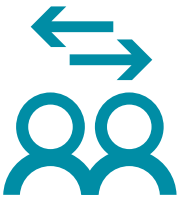


Education & Knowledge Translation

Education, Training & Knowledge Translation was Foundational

Education and training were important focal points of the PHC ORI grant. Almost all interviewees recognized education, decision support and knowledge translation opportunities the PHC ORI offered to primary care practitioners as one of the most significant achievements of the initiative, thus representing the second major finding.

Activities that forwarded education and knowledge translation aims were also common in Year 2 of the PHC ORI grant. Zone working groups and key informant interviews discussed the extensive educational initiatives available such as OAT training, and in-clinic naloxone presentations. Practice change, education, knowledge translation, and decision supports were developed by ACFP, PEER, AMA, and AHS, and were promoted in accordance with the PHC ORI Coordinated Dissemination Plan (a supplemental deliverable to the PHC ORI Communication Strategy). Working in conjunction with provincial community working groups, these supports were promoted to, and used by, the zones, PCNs, and individual providers. The following list provides a high-level overview of the education, knowledge translation, and decision support deliverables developed by the provincial partners as well as the zone PCN working groups:

- ACFP PEER Simplified Guideline: Managing Opioid Use Disorder in Primary Care
  - » PEER Opioid Use Disorder Primary Care Pathway
  - » Buprenorphine/Naloxone Induction Flow Diagram
- AMA Opioid Process Improvement Change Package
- Identifying and Treating OUD in Primary Care Workshops (Collaborative Mentorship Network for Chronic Pain and Addiction (CMN) and PEER)
- Primary Health Care Opioid Response Toolkit
- ACFP Collaborative Mentorship Network for Chronic Pain and Addiction
- AHS Harm Reduction and Recovery Module for Primary Care

Education and trainings were offered through various platforms including webinars, videos, websites, and other workshops not listed above. For example, participation in the Alberta ODT Virtual Training Program was a priority for the PHC ORI. The focus of this program was to provide healthcare providers with the necessary knowledge, skills, and attitudes when providing care to patients with OUD. This program was available through AHS Addiction and Mental Health's Provincial Addiction Curricula & Experiential Skills (PACES) training or through the University of Calgary Cumming School of Medicine continuing medical education. Participants in the focus groups and interviews also mentioned the monthly Collaboration Forum as a medium that increased access and uptake of education and training. Many interviewed were particularly appreciative of having the ability to financially compensate physicians for attendance at events and viewed such support as especially impactful to advance this work, as physician time is often in great demand.

Other education and trainings were delivered by ORCs or PFs (or similar local roles) within a zone and delivered in more familiar settings. For example, the grant-funded facilitators in the Calgary zone reached approximately 140 docs within the zone by coordinating and facilitating brief in-clinic meetings with PCN member clinics about the PHC ORI work and required changes in practice.

Interview participants highlighted the need moving forward for simplified pain management guidelines, since chronic pain wait-time is long at tertiary clinics, and patients living with chronic pain make up a sizable proportion of panels for family physicians.

Quantitative results show increases in training for all zones between December 2018 and June 2019. Urgent Response target A was to increase the number of primary care providers and teams trained to prescribe OAT in each zone by 20% per quarter. A proxy estimate used for the baseline number was the number of OAT primary care prescribers for each zone, obtained from AH administrative data reports. Information for tracking this target comes from zone reported numbers which may include Identifying and Treating OUD in Primary Care, AB Virtual ODT training, zone-specific education sessions, and others depending on what Zones included in their reporting. Targets were met in every zone for each quarter.

Table 2: #/% of PCN Providers Trained to Prescribe OAT by Zone, per quarter

	Baseline June 30/18	Dec 31/18 Actual (% ↑ from baseline)	March 31/19 Actual (% ↑ from baseline)	June 30/19 Actual (% ↑ from baseline)
South	36	59 (64%)	82 (128%)	104 (189%)
Calgary	63	104 (65%)	177 (181%)	217 (244%)
Central	50	66 (32%)	73 (46%)	124 (148%)
Edmonton	230	275 (20%)	487 (112%)	519 (126%)
North	55	66 (20%)	77 (40%)	156 (184%)
Sum (of all zones)	434	570 (31%)	896 (107%)	1120 (158%)

AMA Opioid Process Improvement Change Package

The Opioid Process Improvement Change Package was developed by the AMA, and is organized around the Sequence to Achieve Change which is a step-wise change management approach that incorporates the Institute for Healthcare Improvement Model for Improvement. During the creation of the package, input was sought from patients who have lived experience using opioids, and providers with experience treating patients who use opioids.

In support of advancing deeper discussions around implementation of the Change package, 11 Opioid IF Training Sessions, reaching 175 individuals, were hosted between April 2018 and to October 2019. Trainings were provided in an effort to increase understanding around using a step-wise process to advance PHC ORI related change with primary care clinics and PCNs in support of the Patient Medical Home advancement.

Tools and Resources

Numerous tools and resources were developed to support patient-centred care behaviours, better prescribing practices, and harm reduction considerations as a result of the grant. Key informants and focus group participants remarked there was "wide uptake" of the tools and resources created through this work suggesting that many primary care providers and quality improvement oriented staff utilized them. Of the 32 respondents in the Primary Care Provider Survey administered in one zone, 100% of respondents indicated either "Somewhat" or "Yes" that the PHC ORI tools and resources provided adequate support to implement changes in opioid related care, reinforcing the above qualitative findings.

Respondents appreciated that the tools and resources were highly accessible via the Accelerating Change Transformation Team (ACTT) website, which acted as a centralized repository. As one PF noted, one "true" sign of success (with regard to the usefulness of material created for grant) was when more posters[11] were requested through her. ORCs and PFs played an important role in connecting physicians to these resources and working through their use. In addition to the tools and resources developed for this grant, ORCs or other PCN funded staff in most zones also produced a community resource inventory to distribute amongst PCNs, clinics, and physicians.

Physicians were also provided with several forms of support during the grant including access to mentorship through the Collaborative Mentorship Network for Chronic Pain and Addiction (CMN) and Virtual Opioid Dependency Program (VODP) for example. ORCs and PFs were available in many cases to provide support with tool implementation.

"The overwhelming majority feel they are getting lots of support from their mentors and they are better able to care for their patients, with greater confidence." (Focus group participant)

[11] "Let's Talk about Opioids" posters were designed for clinic offices, to encourage patients to "start the conversation" with primary care providers and teams, were created as part of this grant.

Spotlight: Empowering Primary Care through Evidence:

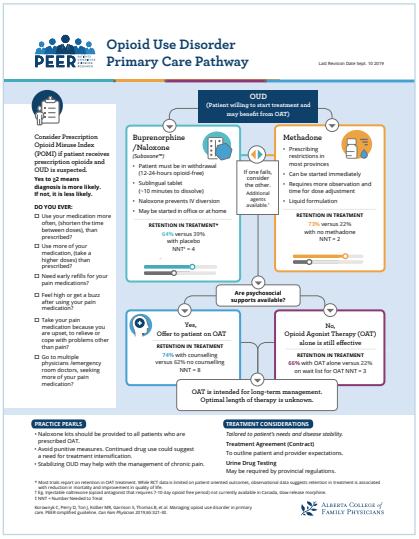
PEER's Expertise in Connecting Patients and Providers to Support Shared Decision-Making

Who is PEER and how have they contributed to the Primary Health Care Opioid Response Initiative (PHC ORI) work?

PEER (Patients, Experience, Evidence and Research) is a primary care led research team that includes family physicians, pharmacists and nurses based at the University of Alberta. PEER supports family physicians and primary care practitioners by generating evidence and decision-making tools.

PEER's main contributions in advancing the PHC ORI work included:

- Developing a simplified guideline for managing opioid use disorder (OUD) in primary care (published May 2019).
- Delivering education sessions on OUD delivered via a variety of media to almost 50,000 people.
- Completing a systematic review and tool for shared informed decision-making in chronic osteoarthritis pain (published March 2020).



What is PEER's impact as a partner on the PHC ORI grant?

Throughout the evaluation, practitioners and grant stakeholders regularly cited PEER's contribution to achieving the outcomes of the initiative. Members of the provincial steering committee, zone PCN leadership and implementation leads from Alberta College of Family Physicians, Alberta Health Services and Alberta Medical Association recognized the value of PEER's OUD guideline in providing capacity building and many expressed their excitement for the proposed guideline on management of chronic pain in primary care. Furthermore, all products can be regularly accessed past the end of the PHC ORI grant and are scalable beyond Alberta, promoting the longer term impact of the knowledge products created using the PHC ORI grant funds.

Statements about the impact of PEER products include:

"The first guideline was well received and made an impact in clinical decision making in primary care. And having the chronic pain management guideline is really needed."

"Guidelines and pathways PEER developed will be used and the use of them will be sustained."

"We have a mechanism to get the PEER guideline out to family physicians once it is available. That work will continue."

Spotlight: Empowering Primary Care through Evidence

As part of their work to support the advancement of the PHC ORI grant:

2,080

Presented to a total of 2,080 Primary Care Providers on Opioid Agonist Therapy or Opioid Use Disorder in Alberta

47,313

PEER's resources had 47,313 total online audience, including 10,755 views/downloads of the PEER Simplified Guidelines: Managing Opioid Use Disorder in Primary Care

Table 3. PEER Products Posted on Canadian Platforms and Number of Views/Downloads

Distribution Methods and Titles	Number of views/ downloads
Tools for Practice Location, Location, Location: Treating patients with opioid use disorder in primary care, Does this patient taking opioids have opioid use disorder, Buprenorphine-naloxone (Suboxone™) for pharmaceutical opioid use disorder, What is the incidence of iatrogenic opioid use disorder, Spread the word: widespread distribution of naloxone to decreased opioid-related deaths	26,306
Guideline publication PEER Simplified Guidelines: Managing Opioid Use Disorder in Primary Care	10,755
Systematic review on OUD Opioid Use Disorder in primary care: PEER umbrella systematic review of systematic reviews	4,221
Webinars Managing opioid use disorder in primary care, An office-based induction of buprenorphine/ naloxone using PEER guidelines	2,434
OUD Guideline-related Pathways Opioid Use Disorder Primary Care Pathway, Buprenorphine/Naloxone Induction Flow Diagram	2,108
Conferences	1,368
Pain Calculator website (http://pain-calculator.com/)	1,306
In-person/telehealth workshops	598
Small group educational outreach	114
Online video Opioid Use Disorder Guideline summary video	183
Educational Module developed with McMaster University and the Foundation for Medical Practice Education	Not available
Podcasts with the Best Science Medicine Podcasts Episodes 404, 405, 406, 417, 418, 419, 425	Not available
Systematic Review on managing chronic osteoarthritis pain	Published March 2020
Knowledge Translation tool for managing chronic osteoarthritis pain	Published March 2020
TOTAL:	**49,393***

As of December 2019. Note: The same individual may have accessed more than one product developed by PEER.

Family physicians reported the PEER OUD guidelines are valuable and have resulted in changes to their practice for patients with or at risk of OUD.

Thirty (30) family physicians attended a workshop on opioids use disorder at the 2019 Practical Evidence for Informed Practice (PEIP) Conference. Almost all (95%) of the family physicians (n=15) who responded to the six weeks post-workshop survey found PEER simplified guideline on OUD valuable, while **94% of the family physicians changed their practice for patients with or at risk of OUD.** Changes include initiating conversations about OUD with patients, a modified approach to identifying patients with OUD, initiating or referring more patients to OAT and accessing resources to help patients living with OUD. In addition, **38% prescribed buprenorphine/naloxone or methadone for the first time after attending the workshop.**

PEER's work aligned with PHC ORI's guiding principle to involve individuals with lived experience. PEER involved an individual with lived experience as an author of the OUD guideline and five more as reviewers. Two individuals with lived experience participated in the osteoarthritis Knowledge Translation Tool as reviewers.

What makes PEER decision support tools unique and impactful?

PEER has generated high quality and evidence-based resources for primary care providers for over ten years and has built a stellar reputation and credibility with family physicians. PEER's work is grassroots, led by primary care providers and researchers funded by various organizations focused on evidence-based practice, which eliminates financial conflict of interest and bias. As primary care providers, PEER's staff understand the demand for resources that are simple, precise, easy-to-use, rigorous and developed with end-users in mind.

What were the biggest challenges?

PEER has limited staff to meet the growing demand for their practical resources among primary care providers. Recruitment of qualified staff to advance PEER's work proves challenging as the grant funding only covers staffing costs for a short period of time. In addition, long-term funding sources are difficult to secure for work such as the much anticipated and needed guideline on management of chronic pain in primary care.

What does PEER's work mean for patients?

- Improved access to OUD services: PEER has shown patients with or at risk of OUD can be managed within the primary care setting and has built the capacity of primary care providers to do so through education and resources.
- Increased shared decision-making between patients and providers: PEER's guidelines promote conversations between healthcare providers and patients about opioid use.

For more information about PEER and their products, visit: https://peerevidence.ca

Related PHC ORI Goals

1 2 3 4

Increased Awareness/ Reduced Stigma

Increased Awareness, Reduced Stigma about Opioids

The combined educational, training and knowledge translation efforts, of the PHC ORI grant have helped increase awareness about opioid use, the importance of the PHC ORI work, and reduce stigma in primary care. Evaluation participants stated the harm reduction training was a critical factor in increasing awareness and reducing stigma. One focus group participant expressed harm reduction "brings back the humanity of patients."

All zone working groups reported that there has been an overall change in attitudes towards opioids. A few individuals described how previous needs assessments uncovered physician frustration with patients who use opioids, seeing these patients as "problematic," "time consuming," and in some cases refusing to work with them. Other physicians did not believe they had any OUD patients on their panels and therefore the opioid crisis was irrelevant to their practice. Respondents explained that "now both of these conversations have been changed dramatically."

"When they started this work, people thought Suboxone™ was just another drug for patients to become dependent on and that Naloxone supported street people. But starting to see that both those options are keeping people alive…" (Zone working group member)

The trainings were found to be pivotal in this change. Interviewees explained how these trainings promoted passion and care, created a safe culture where physicians could talk about their concerns, and provided important needed supports. Key informants indicated these activities increased their awareness about OUD, presented evidence that patients at/risk or with OUD can be supported in primary care, and supported practitioners to improve their ability to care for these patients.

"The workshops helped family physicians to realize we are all in the same boat. Allowed them a platform to talk about how they have been dealing with the problem in their own practice and it offered that interaction to realize there was help in various places including the network, RAAPID line and the discussion board. All the things made a difference." (Key informant interviewee)

Finally, the grant work raised awareness about opioids in general and the importance of addressing it within primary care. Interviewees stated that PCN leadership now understands the need for the PHC ORI activities as do the many physicians forwarding this work. Clinic staff, including the receptionist in some areas, are changing their response to OUD patients. The large physician turnout at educational events was highlighted as a true testament to the traction this initiative garnered.

"Physicians know there will be reluctance from patients (to advance conversations around long term use of opioids). Patients do not want to be labelled as an opioid user. There is a lot of stigma around opioid use and patients may feel they are viewed as a drug addict when physicians start to have these conversations with them. Some physicians have received pushback from some of their patients, while other patients are willing to talk about it. This initiative gave physicians "permission" to have these conversations with their patients." (Focus group participant)

Related PHC ORI Goals

1 2 3 4

Capacity Building Amongst Primary Care Providers

Capacity Building Amongst Primary Care Providers & Teams

Building capacity amongst primary care providers was another prominent theme revealed from data analysis. The World Health Organization (WHO) defines capacity building as the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion.[12]

Interviewees referred to capacity building as the "corner stone" of the grant as much of the work aimed to forward this goal. Evaluation participants stressed the combination of education, training, and knowledge translation activities (described above) have supported capacity growth in primary care. The tools specifically helped physicians feel "empowered" and better able to "navigate OUD."

Advancing the roles for PCN ORCs/PFs, the demonstration projects and CMN were also found to be capacity building accomplishments of the grant. These are discussed below.

AMA Opioid Process Improvement Change Package Training

Of the 22 PFs responding to a follow up survey after completing the AMA Opioid Change Package Training, 50% directly supported physicians in implementing opioid process improvement. Sharing of opioid management tools and resources, as well was as engaging in discussions with physicians and teams were reported as the primary activities to support these changes.

ORCs & PFs

One of the most common themes identified from across data sources was the capacity building role ORCs and PFs took on in the PHC ORI grant work. PFs are positions funded by PCNs that are armed with quality improvement methodology to build capacity at the practice level to advance the PMH. Qualitative data showed that during the PHC ORI, some PFs engaged in opioid training, and as such, their work in clinics naturally shifted to promoting opioid-related activities. The PFs leveraged their existing relationships and quality improvement background to forward this work.

The ORC role[13] was established in three zones, to specifically advance the PHC ORI grant activities. Leveraging their existing relationships within PCNs and clinics, ORCs were tasked with effectively disseminating the tools, resources, and providing offers of support to build the capacity of front-line providers and their teams. Sharing their knowledge and training with physicians, clinic teams, and community organizations that also support individuals with/at risk of OUD, created a common understanding of opioid related care. ORCs ensured physicians and clinic teams were aware of opportunities for OAT training, discussed opioid and harm reduction approaches, created inventories of community resources, and helped to clearly identify gaps in patients accessing care. These efforts helped enhance opioid and harm reduction awareness, supported access to OAT programs and opioid dependency services, and improved integration between primary care, health care partners and community agencies. The ORC role has been particularly helpful supporting newly trained physicians to locate and access the resources they need to build the knowledge and confidence in this area that they may have no experience in. Seasoned physicians found the ORC role equally valuable in connecting patients to the added supports and services in the community that are often needed to address issues related to the social determinants of health.

[12]Definition as cited on: https://www.publichealthontario.ca/en/about/blog/2018/capacity-building-interventions

[13]The opioid response coordinator (ORC) was a new role created and funded through this grant. Most often, these individuals were already working for the PCN, and through this role (often just .1 to .2 FTE of a full time position), the staff member was able to develop content expertise of opioids and OUD.

"She [ORC] is a wealth of knowledge…She knows which things she wants to use for the screening tools and where to find them. You know, definitely as a new doc…in our practice that is mostly younger docs…it's like "Where do I find that resource?" …"How do I actually get my patient from A to B?" … She has had the answers to those steps." (Physician)

Together, these positions have been instrumental in building capacity in the primary care setting. They have conducted numerous capacity building activities such as face-to-face training, shadowing and mentoring staff within PCNs, connecting with community resources, and compiling community resource inventories.

Offers of Care AMA Demonstration Project

The PHC ORI facilitated the development of the Offers of Care Demonstration Project. This work aimed to build physician/clinic capacity to utilize their electronic medical records (EMRs) to identify patients with/at risk of OUD and to track offers of care to these patients. Measuring "offers of care" could help teams determine 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. As of December 12, 2019, there were 64 physicians enrolled from 20 clinics, representing 11 PCNs in 4 zones participating in the project. Baseline data has been collected in late fall 2019, but process level data will not be available until later in Spring 2020.

Collaborative Mentorship Network for Chronic Pain and Addiction (CMN)

The PHC ORI funding initiated the launch of the CMN which is supported and facilitated through the ACFP in collaboration with PEER. One of the objectives of the network was to enhance the capacity of family physicians, their team, and community partners in providing complex care to patients with chronic pain and addiction. Physicians could become members of the network in any one of the following ways: becoming a mentor, requesting a mentor, using the discussion board, participating in the virtual collaboration forms, or attending various CMN educational events. Given that the full launch of the CMN was in spring/summer 2019, at time of writing there is limited data on the impact the CMN has had on members' practice.

As of January 15, 2020, there were over 85 physicians participating in the CMN.

Shift in Practice

There is some evidence of a shift in practice in some primary care settings, potentially due to capacity building efforts. Though in the absence of outcome data at the clinic-level, this finding should be interpreted with caution.

According to those interviewed, prior to the PHC ORI grant, there was resistance from many physicians regarding opioids and patients with OUD. One respondent explained:

"Previously there was some associated shame and a level of resistance with physicians and opioid prescribing. Physicians didn't think this was their problem (or wasn't a problem for their patients) and were ashamed to admit that if they prescribed opioids, they may not know how to have a plan to de-prescribe or have a plan for after initially prescribing. Some feared they had caused harm." (Focus group participant).

Following the grant activities, evaluation participants described how more physicians are now examining opioid seeking behaviour "with a different lens". Respondents also thought "more compassionate care" is being offered to patients and that physicians are more "open-minded" about OUD and how it fits within primary care, linking to the health neighbourhood.[14]

*"Overall there is more compassionate care being offered to patients and physicians are becoming more open-minded about the types of patients with OUD as they challenge their preconceptions about the "stereotypical opioid user." Physicians are seeing patients differently now." (*Zone working group member)

[14]The health neighborhood broadens the patient medical home and encompass community based supports as well including specialists, hospitals, laboratory, emergency medical services, home care, and continuing care.

Respondents emphasized there has been a change in language, from a narrative that was more punitive and dismissive to one that is more "relational," "collaborative" and "respectful," crediting the harm reduction training for this change. Others stated that physicians are more comfortable having conversations about opioids, risk and OUD with their patients. Moreover, harm reduction has led to greater patient-centred care as respondents explained that the new approach stresses meeting the patient where they are, and aligns with one of the core values of health care in the province:

"Harm reduction is an important tool because people who are living with addiction are all in a different place and in healthcare you need to meet people where they are at." (Zone working group member)

These findings are supported by results from Primary Care Provider Survey (N=32). While a relatively small sample responded to the survey, it gives some indication of care at the clinic level. Much like the qualitative interviews, survey results found that most providers were not providing care for patients at risk of/with OUD, and a quarter of respondents indicated they had very little experience treating this population. When asked if their experience providing opioid-related care had changed in the preceding 12-16 months, the majority of providers responded that it had 'significantly' or 'in some ways.' The three most common ways in which respondents reported their practice to have changed was by initiating conversations with patients about OUD and OAT, implementing a harm reduction approach, and involving patients in care planning.

Other trainings that were created to support the goals of this grant also advanced practice changes in clinics. For example, thirty family physicians attended a workshop on OUD at the 2019 Practical Evidence for Informed Practice (PEIP) conference facilitated by the PEER team. Sixteen participated on the 6-week post workshop survey and reported the following:

- 100% are more likely to consider initiating treatment for OUD
- 94% have changed their practice for patients with or at risk of OUD, these changes include:
  - 93% initiated patient conversation about OUD/OAT
  - 60% modified their approach to identify patients with OUD
  - 53% prescribed OAT (buprenorphine/naloxone or methadone)
- 88% are more likely to consider the diagnosis of OUD in their patients

Likewise, 219 family physicians who attended OAT workshops facilitated by the ACFP Collaborative Mentorship network from December 2018- May 2019 were later sent a follow up survey to assess if they have changed their practice for patients at risk of OUD. Fifty-seven (for a 26% response rate) responded to the question assessing whether their practice had changed:

- 75% indicated their practice for patients with, or at risk of, OUD has changed.

These changes include:

- 72% have changed their approach to identifying patients with OUD
- 61% have started prescribing OAT (e.g., buprenorphine/naloxone and methadone)
- 73% initiate patient conversations about OAT
- 51% have stopped/minimized the use of negative contingencies

Spotlight: Opioid Response Coordinators (ORCs)

Background

In Alberta, the engagement and response of primary care physicians, their teams and Primary Care Networks (PCNs) is essential to address the opioid crisis and the systemic issues contributing to the crisis. Three zones: North, Edmonton and Central, implemented a new Opioid Response Coordinator (ORC) role as a strategy to engage front line providers to advance PHC ORI grant activities and promote new approaches to opioid related care. In the North zone (NZ), the mode of delivering support for primary care was largely driven by local physicians. Interested PCNs were provided with a grant funded ORC. An in-depth evaluation of the ORC role was conducted in the NZ in December 2019. Nine ORCs participated in surveys and focus group discussions and two physicians were interviewed to identify successes of the ORC role, the elements contributing to their success and the challenges.

Where did ORCs experience the most success?

Physician engagement and dissemination of PHC ORI information to build clinic capacity: ORCs were able to effectively engage and connect with front line providers and their teams to disseminate PHC ORI information, share available tools and resources, communicate training and learning opportunities and provide offers of support to improve opioid related care. Sharing their knowledge and training with physicians, clinic teams and community organizations created a common understanding of opioid related care within communities. ORCs were the local capacity building enthusiasts, facilitating discussions about opioids and harm reduction approaches, encouraging physicians to enroll in OAT training, creating inventories of community resources, and helping to clearly identify gaps in services and challenges accessing care. The ORC role was extremely valuable to newly trained physicians who need support locating and accessing information and resources to build their knowledge, confidence, experience and expertise.

"She (ORC) is a wealth of knowledge…She knows which things she wants to use for the screening tools and where to find them." (Family physician)

Building connections and capacity in the community: ORCs engaged and built partnerships with front line providers in the community to further connect social and community agencies supporting individuals with/at risk of OUD with PHC ORI resources and primary care. Partnering with community organizations and engaging them in collaborative discussions helped to identify and address gaps in services and challenges accessing care. Seasoned physicians, familiar with prescribing OAT, found the ORC role equally valuable but focused more on the assistance ORCs could provide to connect patients to the added supports and services that are often needed to address additional issues related to the social determinants of health.

Increasing Access to Treatment: opening up opportunities for communication among primary care, pharmacies, social assistance programs, and other community agencies resulted in expediting the approval process for individuals seeking treatment to get them access to emergency funding for medication in a day rather than a week. In addition, conversations including pharmacists allowed physicians to become familiar with pharmacies willing to waive dispensing fees. Both these outcomes in the NZ are increasing access to treatment.

What elements enabled ORCs to be effective and successful?

Existing relationships: Most ORCs were working in other roles and had existing relationships with the PCN, physicians and clinic staff. Leveraging those established and trusted relationships allowed ORCs to get face time with physicians which can be difficult. While ORCs were not always successful at achieving buy-in from physicians, they were familiar faces armed with knowledge and were readily available for physicians, clinic staff and other health professionals to answer questions. ORCs noted greater success with clinics/physicians where they could leverage their relationships with quality improvement staff and family practice nurses that could further promote the initiative. Familiarity with community organizations also helped facilitate the flow of information as well as patients to and from primary care.

Training and opportunities to participate in collaborative engagement sessions: The numerous ORC training opportunities, provided at both provincial and zonal levels, increased their understanding of opioid related care and promoted their confidence to approach physicians. The interactive trainings and information sessions with physicians, harm reduction specialists, family practice nurses, and individuals with lived experience gave them an opportunity to prepare for difference scenarios. In addition, provincial meetings helped them situate and align their work with provincial objectives and goals.

Good working relationships with local physician champions: Guidance and advocacy from experienced physicians was a key to advancing the work in many communities. ORCs were able to lean on their physician champion for advice in their approach with physicians with challenging attitudes and in return physician champions were able to gain a better understanding through the ORCs of the challenges the local and surrounding communities were facing.

What challenges were faced by ORCs?

Limited FTEs and large geographic areas: ORCs and physicians both indicated that the small FTE's provided under this grant may have placed limitations on what was possible for advancing the work. Multi-tasking and prioritizing work in their other roles meant that, at times, the duties and progress of the opioid related work was delayed. In addition, successfully getting physicians to "buy-in" takes time and does not necessarily happen during the first encounter. In many cases, ORCs felt there was greater success in more accessible communities where they spend the majority of their time. Physicians working in clinics that are located hours away were difficult to get face-to-face time with and often ORCs were only able to connect with them once. Reaching out to physicians is even more challenging in remote communities where physicians may alternate with one another e.g. physicians working on a rotating monthly basis which lengthens the time needed to connect.

"You can't build any kind of relationship doing that kind of hit and miss." (ORC)

Overcoming stigma and stereotyping: Overcoming the stereotypical image of patients with/at risk of OUD was one of the ORCs greatest challenges. Many physicians declined offers of support because they simply did not feel they had patients on their panels that would need opioid related support or care. Others were not open to receiving support, feeling they do not have the time necessary to address the complex needs of patients with OUD.

Physicians lacked confidence to put education into practice: Next to stigma, ORCs felt that physicians lacked confidence to apply the education offered in their trainings into practice. Most ORCs indicated that there was a lot of focus on the clinical aspect of OUD but not enough support offered to deal with the human side of individuals with OUD. Initiating conversations seemed to be what physicians struggled with the most and often leaned on their ORCs, who had the credentials to provide patient care, to take on that part of the process.

Limitations on time for implementation: At the time of the evaluation, ORCs who had been in the role for 7-12 months indicated they were just starting to feel confident in their role and were starting to see the results of their work. The topic of opioids and opioid-related care is a complex, sensitive issue that is not always well received. The time needed to move this kind of work forward is an important consideration for setting realistic expectations of what can be achieved. Trust and relationship building takes time and the consensus among the ORCs was that without the existing relationships, advancing a physician response to opioid related care would have been much more difficult.

"It's a very valuable service…it still hasn't totally realized its potential." (Family physician)

Related PHC ORI Goals

1 2 3 4

Increased access to services

Increased Access to Services

Increasing awareness, reducing stigma, building primary care capacity, and shifts in practice had an impact on the service experience of the patient, including increasing service access. Pathway development, ORC activities, and prescription practices also had a role in increasing service access to patients at risk/with OUD.

Pathway Development

Interviews and focus groups revealed several pathways/frameworks were developed during the PHC ORI grant. These developed pathways/ frameworks were formalized as mechanisms guiding treatment, decision making, and care processes for particular groups of patients, they have contributed to increased service access for patients. The process to develop pathways, as well as the "type" of pathway developed, varied across the zones.

ORCs

Data from ORC focus groups conducted in the North zone revealed that ORCs had an essential role in increasing service access for patients. ORCs worked to identify barriers faced by patients once they left the clinic setting and were important advocates for change. In one example, ORCs were successful in streamlining the approval process for individuals needing financial assistance for OUD treatment. Upon learning that access to emergency funding for treatment could take up to a week through Alberta Works, thereby risking the urgent need of patients and potential treatment readiness, ORCs leveraged their relationships, sought support of leadership, and advocated to change how applications for emergency funding for treatment were prioritized. As a result of this work, applications are now placed on high priority by Alberta Works and patients typically receive approval within one day.

Prescribing Practices

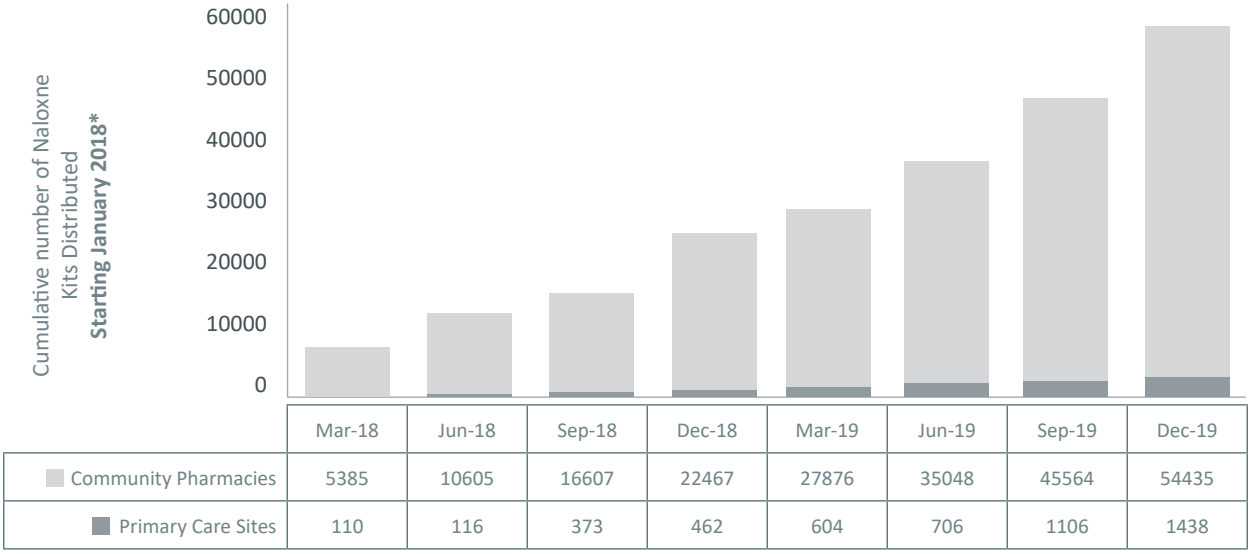
In August 2018, targets intended to accelerate access to OAT across the province were set by AH and zones were asked to focus on these targets as part of their urgent response plans. Prescribing data demonstrates changes in prescribing practices. Between April 1, 2018 and June 30, 2019, urgent response outcomes were tracked specifically around OAT training, prescriptions, and patients receiving OAT. During this time period, data reveals significant increases in the number of PCN physicians trained to prescribe OAT (Target A) and the number of PCN physicians prescribing OAT (Target B) (see Table 4 for Target definitions).

While Target C was not met with a 30% increase from baseline to June 30, 2019, it shows an increase (19% across the province) in the number of PCN patients receiving OAT. Furthermore, this data does not include the number of PCN patients who have been offered but declined OAT. Although process level data was not available at the time of writing this report, tracking offers of care to patients with /at risk of OUD was a key objective of the AMA's Demonstration project.

Table 4: Urgent Response Target Outcomes, September 2018 – June 2019

Urgent Response Target Outcomes (Sept 2018-June 2019)	Baseline N (Apr 1- June 30, 2018)	June 30, 2019 Target N (targeted %↑)	Provincial Total N (actual %↑)
Target A – Increase the number of PCN providers trained to prescribe OAT in each zone by 20% per quarter from September 1, 2018 to June 30, 2019	434	750 (60%)	**1120 (158%)**
Target B – Increase the number of PCN prescribers of OAT in each zone by 10% per quarter from September 1, 2018 to June 30, 2019	434	578 (30%)	**646 (49%)**
Target C - Increase the number of PCN patients receiving OAT in each zone by 10% per quarter from September 1, 2018 to June 30, 2019	5154	6860 (30%)	**6138 (19%)**

Data on distribution of naloxone kits is also available between March 2018 and Dec 2019. Findings indicate an increase in total number of naloxone kits distributed through PCN-associated clinics (13 times as many) and community pharmacies (10 times as many). Most kits are distributed through community pharmacies as there are proportionally more pharmacies than PCN-associated clinics in the province.



	Mar-18	Jun-18	Sep-18	Dec-18	Mar-19	Jun-19	Sep-19	Dec-19
Community Pharmacies	5385	10605	16607	22467	27876	35048	45564	54435
Primary Care Sites	110	116	373	462	604	706	1106	1438

Figure 1: Cumulative Count of Naloxone Kits Distributed Through Community Pharmacy and Primary Care Sites, by quarter, March 31, 2018 to December 31, 2019

*Naloxone kits were distributed prior to January 2018, however, the graph above only represents a starting point of January 1, 2018 and kits released through primary care and community pharmacy sites and as reported through the Community Based Naloxone (CBN) program.

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.[15] 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.

[15]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.[16] 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

[16] *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*

Related PHC ORI Goals

1 2 3 4

Sustainability and Scalability

Sustainability & Scalability Opportunities

Data indicates there have been many activities to support the sustainability of the work and people remain committed. Around scalability, much can be drawn from the PCH ORI work and applied to other health issues. Both themes are explored in greater depth below.

Sustainability

Sustainability of PHC ORI activities after project end is critical to ensuring the efforts imparted during the grant continue. Interview and focus group participants expressed hope and optimism that many activities will continue post-grant. Several zones indicated they plan to continue the work as best they can and seek new funding sources when opportunities emerge. Sustainability of the assets created through this work, at the zone level, formed a significant portion of January 2020 PHC ORI Steering Committee in an effort to ensure the investment of this initiative is carried forth. It is important to note that respondents expressed concern for sustainability of efforts due to lack of targeted continued funding. They explained that despite best efforts, without dedicated resources, staff and partners may not be able to carry out most of the activities necessary to sustain and advance the work in a meaningful way.

Interview and focus group participants identified four primary ways the PHC ORI work will be sustained through: established relationships and ongoing collaboration; opioids awareness, knowledge and skills; PFs and ORCs; and, pathways.

"We need to be very deliberate and purposeful about what sustainability looks like. If we just wind down and close out the project, I think we are going to miss an opportunity. As partners, we need to make sure we are having those conversations about what we are going to do within our mandate, so that it is not just an abrupt halt." (Key informant interviewee)

Established Relationships & Collaboration

Evaluation participants believed that established relationships and ongoing collaboration would continue post-grant. However, they stressed commitment and concerted efforts are needed in order to maintain and continue to grow these relationships. Mechanisms such as the Collaboration Forum were identified as possible tools that could support these relationships and the practice of collaboration.

Other participants indicated the sharing of information and data amongst partners will continue but again underscored the need for tools, such as the Collaboration Forum, in order to do this.

Opioids Awareness, Knowledge and Skills

Given the amount of educational and training efforts conducted over the last two years, participants believed that much of the awareness raising that has occurred, as well as new knowledge and skills acquired, will be sustained beyond the grant. Increased awareness about opioids, OUD, stigma/myths, prescription practices, and the role of primary care in pain management, addiction, and substance use will continue. Moreover, sustainability planning to continue support and mentorship in primary care is being discussed as project level work is wrapping up in March 2020. At time of writing, training is still underway and there are plans to make trainings available on-line for the future. For example, the AMA is transitioning their in-person change package training to a virtual format so that physicians and team members can continue to access content beyond the end of the grant.

In addition, access to the range of resources and tools will continue to be available and easily accessible on the ACTT website. In the zones, working groups have set up shared files or websites for their local stakeholders, and ORCs have established community resource inventories that will continue to be available after the grant. VODP will also continue.

ORCs & PFs

ORC and PF positions were considered sustainable by interview and focus group participants. In many cases, ORCs will continue to work at the clinic and PCN level in their previous roles, and in doing so, local settings will have ongoing access to ORC knowledge about opioids and OUD. In some zones, ORCs have committed to ongoing meetings and plan to disseminate opioid knowledge through their existing clinical/quality improvement roles in PCNs. Many PFs have received opioid training and are now recognized as an opioid resource in PCNs, and as non-grant funded positions will continue their role in PCNs.

Pathways

According to evaluation participants, pathways were developed with sustainability in mind. Representing formalized mechanisms that guide treatment, decision making, and care processes for particular groups of patients, respondents expect these will continue and new ones will be explored.

Scalability

Participants indicated several aspects of the PHC ORI initiative that could be scalable to other health issues provincially and/or federally.

Harm Reduction Approach: For some respondents, harm reduction is an approach that can be scaled to other issues because it is centred on "reducing the harm" associated with a disease or illness. Examples offered include using harm reduction with methamphetamines, alcohol use, smoking, Benzodiazepines, sleep medications, and "any other prescription with a potential for drug abuse." Other thoughts included harm reduction considerations with regard to obesity, pain management, mental illness, and diabetes treatment.

"There needs to be a shift in culture. The funding and collaboration for this work came because there was a health crisis, but this should happen for all projects. Partners and stakeholders coming together to work together, ensure the right people are at the right place at the right time, save lived, prevention and promotion, etc., should all be part of the normal culture. Feel things are moving in that direction rather than continuing to work in silos."
(Focus group participant)

"Harm reduction translates to other things such as alcohol and smoking; it's a shift in how you look at addiction and disease…"
(Zone working group member)

Tools & Resources: Scaling up the extensive tools and resources developed with this grant was another suggestion by respondents, such as the PEER Guideline and decision-support tools. Similar tool formats, access options, and usability can be used as a blueprint for future health issues, allowing for scaling up both for opioid resources and transferability to other health issues.

Education & Training: Some participants stated that the training programs and education modules created with the grant could be scaled nationwide and beyond, to reach a wider audience given that the opioid crisis affects many geographies both inside and outside of Canada. Some of these activities have already occurred through PEER, for example.

AMA Change Package: Many participants believed the Change Package could be translated for use with other conditions that require change management. The Change Package was found to be useful in supporting quality improvement process change at the clinic level supporting organized, evidence-based care.

Relationships & Partnerships: Several participants emphasized that relationships and partnerships advanced through the PHC ORI can be "leveraged for future work." Moreover, the partnerships and collaboration on a shared goal from the provincial and zonal partners can also be extended to other initiatives, and for some, should become a part of common practice.

Collaborative Mentorship Network for Chronic Pain and Addiction (CMN): The CMN could also be scaled across Alberta for other topics. The network is currently seeking funding to continue the CMN post-grant. Respondents noted that other provinces have a similar model.

Evaluation: Lessons learned from the PHC ORI can be utilized and applied in future work and other contexts. This has already begun with regard to work involving transitions in care. For example, given the complex nature and multi-stakeholder approach that will be required for implementing the provincial Home to Hospital to Home guidelines, collaboration at all levels, including any measurement and evaluation activities, will be required. In addition, a provincial shared service approach was trialed whereby zone level evaluation supports (e.g., creation of surveys, facilitation of focus groups) occurred through a centralized system to support better understanding of achievement of outcomes at multiple levels.

Related PHC ORI Goals

1 2 3 4

Engaging individuals with lived experience

Engaging Individuals with Lived Experience (IWLE)

The meaningful engagement of IWLE was recognized early on as an important way of working in the PHC ORI grant. AHS led the development of a deliverable framework for inclusion of IWLE into the project activities. Although some of the data indicates engaging those with lived experience was challenging at times, and some zones were unsuccessful in this work, when it did happen, it was highly successful and meaningful.

Those who worked with IWLE, explained how important it was to include the patient perspective and have it inform the work. Others offered that hearing these experiences firsthand connected the work to "real life":

"Being able to hear patient stories and having a patient rep on the steering committee allowed for grounding and connecting the initiative work to something really real. Connecting the initiative work the experiences of patients who have lived through addiction or an opioid crisis themselves allows you to link the work, which is generally pretty theoretical, to real life and it makes the work very real." (Zone working group member)

IWLE offered unique perspectives on their experiences accessing treatment and were able to identify significant barriers such as cost of medication, lack of transportation, and daily dispensing fees. In one zone, the IWLE shared with the zone working group that he felt empowered doing this work, giving him purpose and motivation. Respondents added that it "sparked changes in his personal life and career as well" suggesting that individual level change may have also occurred the IWLE. IWLE reported that they found the work fulfilling and providing them with purpose. The case study interviews noted that while the experiences of IWLE were overarchingly positive, it is important to be consistently mindful of their past experiences and needs. One IWLE explained he felt overwhelmed by a task that he was assigned, finding that kind of stress "triggering" to his substance use disorder. Creating a safe and secure relationship and environment that supports open communication is essential when working with IWLE, especially those with experiences of substance abuse.

It was also noted that importantly, IWLE are a link back to the community. Some IWLE work in addiction groups and have a presence in other community-related services and as such, are in a position to explain the changes in primary care to their communities, hand out information at groups and, share their experiences – both positive and negative - with accessing treatment. In some respects, this role could be viewed as an ambassador and may be a way for primary care to build trust in the addiction community, increasing access to treatment.

Spotlight: Meaningful Engagement of Individuals with Lived Experience

Background

The opioid crisis in Alberta is more widespread than people think with the effects not being unique to any one group of people. For those who have been directly impacted, by their own experiences of opioid use/misuse, their lives are often permanently changed. The added ripple effects leave a lasting impression on family, friends, care providers and entire communities. People in need of help, depend on primary care, hospital-based care, addiction and mental health services, and community and social services and yet individuals with opioid use disorder (OUD) are often not receiving the help they need. Experiences of being stigmatized and judged, a lack of appropriate, available and accessible services, and not knowing what services are available or how to access them are just a few of the challenges people fighting OUD face. In addition, the unrealistic expectation that people in a compromised state of health should be able to navigate a complex system, add to their challenges accessing the care.

Engaging Individuals with Lived Experience (IWLE) in a Meaningful Way

Valuing the insights, wisdom, and skills that can only be found in the lived experience is an important part of any practice. Research supports extending engagement of IWLE beyond "tokenism" and story-telling, towards deeper collaborative relationships; seeing them as true partners in the decision making stages of developing strategies to address the opioid crisis.[17,18]

As part of this work, the AHS Engagement and Patient Experience Program and the Primary Health Care Opioid Response Initiative (PHC ORI) Patient Engagement Working Group, developed and launched Engaging Individuals with Lived Experience: A Framework[19] in June 2018. The framework reflected a commitment to engaging IWLE in a proactive, patient-centered, and meaningful way; free of judgement and bias at various levels of the health care system throughout the 2-year PHC ORI project.

In order to better understand the experiences and value brought to the work through the meaningful engagement of IWLE, four individuals with lived experience who were involved in different levels of the project participated in a 1-hour individual interview. The team members who lead the engagement process were also interviewed.

[17]Dardess, P., Dokken, D. L., Abraham, M. R., Johnson, B. H., Hoy, L., & Hoy, S. (2018). *Partnering with patients and families to strengthen approaches to the opioid epidemic.* Bethesda, MD: Institute for Patient- and Family-Centered Care.

[18]International Association for Public Participation Canada. *Public Participation Spectrum.* Available from: http://c.ymcdn.com/sites/www.iap2.org/resource/resmgr/foundations_course/IAP2_P2_Spectrum_FINAL.pdf

[19]Engagement of Individuals with Lived Experience: A Framework. Available from: https://actt.albertadoctors.org/file/engaging-lived-experience-framework.pdf#search=Engagement%20of%20Individuals%20with%20lived%20experience%20framework

What was found?

While some teams struggled to find a way to meaningfully engage IWLE in their work without it seeming tokenistic, other teams at the provincial, zone and clinic level had very successful and significant experiences. At all levels of engagement, IWLE were responsible for ensuring the patient perspective and voice was represented to ensure activities reflected the true needs of individuals with OUD. The persons who were involved represented individuals with diverse circumstances that lead to their OUD and as such, were able to provide examples of how circumstances do not necessarily fall into a "one-size fits all" strategy to tackling opioids. Their stories put an everyday face to OUD and challenged the stereotypes normally associated with substance misuse. What all the IWLE did share, however, was a passionate commitment to influencing changes that would "prevent others from having to go through the same discomfort and tragedy."

The following are a few examples of meaningful engagement at different levels of the system that took place during this project. At higher levels of engagement, the major role of the IWLE was to ensure the work that was progressing was patient-centered, meaning the patient voice was represented and meeting the needs of patients remained a focal point of the decision-making process. In addition, at the provincial level one individual was involved in the development of training tools and resources. Notably, the individual was not just asked to share his story but also included in pilot testing the training which helped the team address tensions arising in response to some of the content. Having the IWLE present, not only validated their work but he was also able to offer the additional context around why the content was included, providing the presentation with the credibility needed to push controversial but necessary conversations. At the zone level, IWLE took on the role of educators and advocates, providing feedback and support in the creation of pathways and materials to enhance the understanding of the patient experience and perspective for health care professionals and their teams. At the clinic level, an IWLE was invited to work as a patient advisor to assist the clinic in making improvements to their practices and processes providing opioid related care. The insights shared from their lived experience informed several practice changes at the clinic level, such as the process involved with urine drug screening and clinic level stigma training.

"Even the stigma that [the IWLE] experienced in our own clinic, we might not have been fully aware or even at least to the degree that we are aware now, without her involvement." (Family physician)

The Immeasurable Impacts of Engaging IWLE in the PHC ORI Project

Finding Meaning and Purpose in Life's Challenges: IWLE and their teams had genuine feelings that the contributions of IWLE helped by offering a unique perspective. Contributing to this work allowed IWLE to turn their negative experiences into something positive, giving purpose and meaning to the challenges they faced. While speaking as a single individuals, IWLE were often sharing the voices and experiences of their peers. For an individual in active recovery, managing multiple health issues, coping with chronic pain issues and/or managing a complex history of trauma, engaging in this kind of work provided them with something to look forward to and focus on as part of her recovery.

"All those kind of experiences together, which I would have thought was those were my weak spots…but being in there talking about them and seeing others ask questions and dive into it more…my struggles are of value." (Working group member, zone level)

"No drug has ever given me a better high than being able to work with these doctors and work with [individuals I sponsor] and help everybody." (Patient advisor, clinic level)

Reduced Stigma and Discrimination: Stereotypical perceptions of individuals with OUD were challenged by engaging IWLE who have a diverse set of circumstances, skills, educational backgrounds and medical histories that do not fit the typical stereotypes. For those that grew familiar with IWLE working on their teams, the level of trust and communication that developed should reduce the incidences of stigma and discrimination among those physicians and team members, especially where training was paired with their work.

Renewed Hope in the System: Involving IWLE in the PHC ORI work provided them with an opportunity to see a different side of health care professionals and the health care system. Where some IWLE may have experienced stigma and judgement in the past, working alongside teams and seeing an authentic desire to make a difference for individuals with substance use issues inspired hope for that person where it may have been lost. In turn, all the IWLE that were engaged, are connected to a network in the community of organizations, programs and individuals with whom sharing what they learn about this project helps bring hope to others who may still be struggling to find some.

Personal and Professional Growth: Teams genuinely felt their experience working with IWLE was very rewarding, offering them opportunities to grow both personally and professionally, suggesting there is a mutual benefit to more purposeful engagement of IWLE. Representatives at the provincial level felt that with each success engaging IWLE, they are developing their professional capacity to engage IWLE in the planning of their work at earlier stages of each project. For IWLE, the confidence and experience they gained from learning how to voice their opinion and work as equals with health care professionals has led to further career related opportunities.

"It became a very honest and therapeutic relationship for both of us, as lived experience, that we had gone through together." (Family physician)

Practices That Created a Positive Engagement Experience

Although individuals engaging IWLE in their work were not familiar with the Engaging Individuals with Lived Experience: A Framework (2018), they were nonetheless implementing practices that supported positive experiences.

Building a safe and secure environment with good communication, mutual respect and consideration were foundational elements achieved through the following practices discussed by IWLE and their teams:

- Where possible, sharing back with IWLE how their contributions have informed the work or final products they have been involved in developing.
- Feeling that their opinions and perspectives were heard, valued and equitable to those of the healthcare professionals they worked with.
- Having a reliable and trusted point person to connect with to de-brief with after meetings, clarify things they do not understand, discuss their needs with and express their frustrations to
- IWLE seemed to be engaged in roles that suited their experience and background making the expectations, roles and responsibilities manageable and enjoyable.
- IWLE appreciated the genuine empathy and understanding and ability to work flexibly when personal circumstances would come up
- Being offered genuine and authentic, non-judgmental encouragement and kindness.

"We tried to really wrap him in a feeling of safeness and security and really support him more than, you know if we were [working with] someone else." (Working group member, provincial level)

Lessons Learned for Improving the Engagement of IWLE in Future Work

Discussing Roles and Responsibilities to Confirm it is a Good Fit: IWLE stated at times, expectations, roles and responsibilities were not always clearly laid out, leaving them to rely on their ability to navigate "the unknown" and speak up for themselves. Being provided with an adequate project background and training was something IWLE felt would have improved their experience. Even for IWLE who have a great deal of experience volunteering in different capacities, teams are best to remember, that these people are "visitors of the system"; one that is complex and daunting at times. Others who may be new to filling these kinds of roles may need more background and training to ensure they do not feel overwhelmed and to maximize their comfort to contribute in a meaningful way.

Focusing on the Positive Experiences with the Healthcare System: Teams sometimes struggled with balancing tensions between being true to the experience of the IWLE and needing to "soften" some of the stories to prevent "demonizing" primary care and sensationalizing the negative aspects of OUD. Looking for and focusing on the positive experiences that helped the IWLE out of their darkest place, helped teams locate the focal point of their work, and helped identify system strengths to build on.

Finding Opportunities to Work Differently at Higher Levels of the System: Working at lower levels of the system, it is easier for IWLE to see the impact of their involvement, but at higher levels of the system, IWLE can feel like decisions are already made and question the value of their involvement. For those who want to engage IWLE, the group may need to make a commitment to engage in discussions that respects and values all opinions. Engaging IWLE earlier on in the project will also help to support IWLE in being truly engaged in the planning and decision making process.

More inclusive and timely involvement of IWLE: One IWLE recognized that he was just one voice and recommended the inclusion of others who are more disproportionately affected by the opioid crisis. Teams also indicated that they had to go back and re-work some of the resources they developed because there were changes that needed to be made once the IWLE started working with them. Again, engaging IWLE early on in project planning phase can also increase project efficiency.

"I think it would be very important for somebody with a different perspective, especially a First Nations perspective, to be a part of these {PHC ORI activities} and offer that perspective." (Individual with lived experience)

Staying Mindful of the Ongoing and Daily Challenges of OUD: It is important to keep in mind when working with individuals with OUD that stress is a potential "trigger." Establishing open and honest communication will support both sides having realistic and reasonable expectations which, is important when addressing the challenges and complexities of system level change. Regular "check-ins" will also support manageable workloads that are respectful of IWLEs circumstances and time.

Related PHC ORI Goals

1 2 3 4

Facilitating Elements

Elements that Facilitated the PHC ORI Work

This last major theme focuses on the several elements that acted as important facilitators of the PHC ORI activities. These were governance structures, existing relationships, the Collaboration Forum, ORCs and dedicated resources.

Governance Structure

Both the provincial and PCN governance structures were notable facilitators of the PHC ORI work. The provincial structure, discussed in prior themes, was a formalized partnership among key health partners in the province. Interview and focus group respondents believed this was an effective governance structure able to support key deliverables and align the work across stakeholders.

"There has been a shift in thinking about the concept this opioid crisis is "not happening in my backyard" when it actually is. There has been a lot of awareness raising among physicians and staff using data to spread the message that this is a local problem everywhere. Data from the province was really important and valuable to show clinics and teams what was happening in their own geographic areas." (Zone working group member)

Operationally, the provincial deliverables created the foundation for zones to create regional-level change with one respondent describing the provincial work as a "catalyst." Provincial deliverables such as the AMA Change Package and ACFP educational tools (like the CMN) helped facilitate the zonal activities such as pathway development, connecting with community services, and identifying patients with OUD.

Furthermore, participants remarked that having ACFP as secretariat was a good opportunity and highly successful, as ACFP is well regarded by family physicians and has a record of being able to bring partners together. Participants recognized that although PHC ORI was a big undertaking for ACFP, the organization overcame the challenge by having a dedicated and effective project management team.

"The college [ACFP] as the grant custodian worked well. It was a big task for them, but they brought in additional supports and they were well positioned to do it." (Key informant interviewee)

Much like the provincial structure, almost all interview and focus group participants felt that the new Zone governance structure contributed to the success in the PHC ORI work. Those who were interviewed explained that the grant offered a unique opportunity for the Zone PCN committees, allowing them to focus on a single purpose and build structures that may be potentially used going forward. The PHC ORI grant also contributed to strengthening the new structure by providing increased funding and capacity for change management. It provided a platform for the committee to formally collaborate, regularly communicate, establish structures, and establish norms. The grant also fostered information flow in the zone and provided a layer of accountability.

"I would say that zone PCN governance structure is very effective. AHS and PCN were at the table along with AMA. Had the right people at the table to push the work forward" (Key informant interviewee).

Existing Relationships

The importance of leveraging existing relationships to move the work of the grant forward was a central theme shown in the data. For two of the zones, previous relationships and collaboration across the zone was already occurring prior to the grant. PCNs were also already in collaboration, and trust was present. Because of this, respondents felt they were able to move the work forward very quickly as they did not need to spend time building or creating new relationships and trust. Similarly, the PEER program is trusted and well recognized among family physicians, which promoted attendance of workshops and the uptake of the resources.

In addition, most ORCs were already embedded in a PCN prior to the grant and were supplementing other PCN related positions with ORC hours. Their existing roles as licensed practical nurses, registered nurses, social workers, pharmacists, and practice facilitators provided them with functional working relationships within the clinic and outside, with a broader community of organizations who delivered services to individuals at risk of/with OUD such as community pharmacies, wellness programs, and social assistance programs. ORCs detailed how these relationships were fundamental to forwarding the goals of the PHC ORI grant.

Collaboration Forum

The Collaboration Forum was identified as a "key tool" in supporting regional-level change. Evaluation findings indicate that participants found this platform largely beneficial in fostering relationships, connections, communication, and collaboration across stakeholders. While some provided suggestions around how the Forum could be improved (see challenges section), the intention and spirit of the tool was highly regarded.

"The collaboration forum was a key tool to bringing the zones together. Without it, there would not have been the same level of sharing of challenges, successes, and approaches. Prior to this initiative the zones would meet at a different level of the governance structure, but they would not meet at the level of the working groups, which was important. Would like to see this sustained by the zones moving forward." (Zone working group member)

ORCs

The founding of the ORC position, described in previous sections, was recognized by most as pivotal in forwarding the work of the grant. Through this evaluative process, evidence supports the findings that ORCs were a chief contributor to primary care capacity building, PHC ORI sustainability, and increasing service access for patients. Project partners appreciated the educational opportunities ORCs provided, for challenging stigma surrounding opioid use, leveraging their knowledge of local resources, and serving as go-to sources of information.

Dedicated Resources

A final facilitating element in the PHC ORI grant was the dedicated funding to advance the work. The monies made available through the grant allowed stakeholders to conduct careful planning with the support of skilled project management and support. It is important to note that not all funds were spent, demonstrating that significant work can be done in primary care when funding is provided.

"Important to note that not all funds have been expended. Even though only a portion of the funding has been used, there has been amazing results. This shows the ability of primary care to be able to make change and make a difference to improve care. Primary care is overall under-resourced, so extra funding allowed for lots of change." (Focus group participant)

Successes

Many successes have been achieved through the Primary Health Care Opioid Response Initiative (PHC ORI) grant. What follows are highlights (in no particular order) of the many accomplishments realized over the last two years.

- ✓ Primary Care demonstrated ability to mobilize and respond in a crisis
- ✓ Highlighted Primary Care's ability to manage Opioid Use Disorder within a Patient Medical Home
- ✓ The formalization of a provincial partnership amongst key provincial and zonal partners
- ✓ Building new relationships and strengthening already established ones
- ✓ Working collaboratively provincially, across and within regions
- ✓ Effective and impactful use of funds
- ✓ Establishing the Opioid Response Coordinator role to ensure dissemination (or communication) of PHC ORI information, resources, training and engagement opportunities reached front line providers
- ✓ Development and sharing of high quality, user-friendly and accessible tools and resources such as the PEER Simplified Guideline: Managing Opioid Use Disorder in Primary Care
- ✓ Reducing stigma and raising awareness regarding opioids and Opioid Use Disorder
- ✓ Developing pathways to support greater service access
- ✓ Launching the Collaborative Mentorship Network for Chronic Pain and Addiction for family physicians in Alberta
- ✓ Consistent increase from quarter to quarter in the number of Primary Care Network providers trained to prescribe Opiate Agonist Therapy in each zone (during the urgent response target reporting period)
- ✓ Net increase in the number of Primary Care Network providers prescribing Opiate Agonist Therapy, and the number of Primary Care Network patients receiving Opiate Agonist Therapy across all zones
- ✓ Appropriate choice of Secretariat or grant holder (Alberta College of Family Physicians)

Challenges

While there was much accomplished during the Primary Health Care Opioid Response Initiative (PHC ORI) grant, there were several challenges that occurred. Data analysis revealed the following challenge themes:

Timing

Almost all participants commented on the short timeline of the grant and emphasized the scope of the work required much longer than two years, given its goal of system-level change. Interview participants commended the successes achieved in the PHC ORI grant yet expressed their regret to "walk away, or at least significantly shift gears at this point." Many felt the initiative was ending at its peak, just when activities are gaining traction and partners have figured out how to collaborate and carry-out activities to achieve the ambitious grant goals. For some Zones and partners, creating the interest took a significant amount of time to gain momentum, and it is strongly believed additional time would have multiplied outcomes.

"Focus needs to be longer than just 4-year cycle [in reference to provincial government election cycle]. It needs to be a longer-term strategy. In this case, this particular work got caught in the current strategic political tension in the province." (Key informant interviewee)

Several participants stressed the time it took to understand the grant objectives and find alignment between AH and partner organizations. A significant amount of upfront work was required with multiple course adjustments made in order to meet AH requirements. Time to figure out partners' roles and responsibilities was also necessary, in addition to determining operationalizing the activities and outcomes. Finally, the release of funds was also stalled. For the above outlined reasons, there was a significant time delay at the outset of the grant, shrinking the timeline further.

"The maturity of the new governance structure hindered some of the work. If the opioid work was starting right now with the governance structure more evolved, some of the work might be easier. One the other hand, this initiative work did force the governance structure to evolve and mature and put the infrastructure in place to distribute funding, etc." (Focus group participant)

Change in Grant Objective & Alignment

Almost all interview and focus group participants found the reprioritization to the urgent response in July 2018, after the grant activities started, as one of the major challenges in implementation. Prior to the prioritization of the Urgent Response emphasis, an implementation plan was already underway when this change in focus was requested by Alberta Health (AH). Partners were asked to adjust quickly to determine how to pursue the new Urgent Response targets with several of the other grant goals were pushed back in order to work on these targets.

"The complexity of primary care in the healthcare system is probably one of the biggest barriers. How do we reach all these people in a consistent way making sure everyone has access to the same supports and resources?" (Key informant interviewee)

Several participants noted that they appreciated the concentrated effort of the urgent response to save lives, however they felt that prioritizing Opiate Agonist Therapy (OAT) prescribing had unintended consequences that hindered the long-term progress of the initiative. Further, OAT prescribing was prioritized prior to creating awareness about the scope and depth of the problem within the zones, which may have impacted engagement of primary care providers.

Although the urgent response accelerated the OAT work, some participants stated it was difficult to implement without formalized structures. Participants expressed their wish for the urgent response work to have come after some base progress with the grant work was achieved, as originally outlined in the grant proposal. For example, having the Patients, Experience, Evidence, Research group's (PEERs) Simplified Guideline for Managing Chronic Pain in Primary Care available before the Opioid Use Disorder (OUD) guideline. Participants emphasized their preference for starting with the chronic pain capacity building and then proceeding to urgent response goals.

"If we were to do it again, we would have done it how we proposed in the initial grant proposal and not have the Suboxone™ target forced on us at the beginning." (Key informant interviewee)

Healthcare System

Interview participants detailed several factors involving the healthcare system that acted as barriers to advancing PHC ORI:

- Some of the partners involved in this grant had not worked together in the past. As such, collaborating required additional effort, team building, and commitment.
- The size of the provincial partner organizations differed significantly, some are small and nimble, while others are large and need more time for decision making.
- Multiple organizations and projects received MOERC funding across the province beyond the PHC ORI. These initiatives were not well connected and did not build on each other's success.

- Primary care is dispersed across the province including in rural and remote areas. Family physicians are autonomous and sometimes sole medical practitioners, with some having minimal connection to Primary Care Networks (PCNs) and Alberta Health Services (AHS). Thus, identifying ways to consistently reach them and influence their practice is a difficult undertaking.
- There is an overall bias throughout the healthcare system against patients with chronic pain and addiction.
- The PHC ORI grant was limited in scope. Participants reported an inability to focus on preventative activities (prevent opioid addiction in the first place) needed to create system change and more comprehensively, manage the opioid crisis (i.e. more emphasis on treating trauma).

Misconception about OUD and PHC ORI

The PHC ORI faced a lot of misconceptions about individuals at risk/with Opioid Use Disorder (OUD) and the purpose of the grant initiative, which hindered its impact. In previous sections, respondents detailed how some physicians either refused to work with OUD patients or believed they did not have any on their patient panels. Further, some physicians feared that if they started providing OAT, demand would increase, and their patient panels would change, comprising of a high proportion of patients with/at risk of OUD. All zones reported a lack of interest among some in the PHC ORI grant activities and/or a slowness to generating momentum. This was unexpected and underscores the need for more time for large change projects.

When the initiative rolled out, many physicians thought it was specific to OAT. Participants suggested that informing primary care providers that the grant was more than OAT may have promoted faster buy-in and trust. Focus group participants reported believing that enduring stigma and potentially ineffectual messaging regarding the number of patients at risk/with OUD effected physician uptake. Framing the issue for physicians by aligning it with chronic pain may have been a better strategy since chronic pain suffers make up the largest demographic of opioid users and are more common on patient panels. With OUD stigma continuing to persist, some participants noted more work is needed to dismantle these wide misconceptions.

Competing Priorities & Administrative Burden

Interviewees described how primary care practitioners and their teams faced tremendous pressure as more requests and initiatives were, and continue to be, rolled out for various chronic diseases and public health issues. Some believed that the PHC ORI was not prioritized in some zones. Participants emphasized that aligning resources and prioritization were essential to ensure engagement and full commitment from primary care.

"The challenge with sustainability in primary care is that, there are no subjects that come to primary care that are not worthy of attention and effort. And once the extra dollar that allows for the extra personnel… disappears…we have enthusiasm, we have the knowledge, we just don't have the time on regular schedule to do the work the same way." (Key informant interviewee)

In addition to competing priorities, respondents explained that zones have different amounts of resources available to them. Zones with more limited resources struggled with the administrative burden of the PHC ORI. Those with limited resources suggested that while they appreciated the project management and accountability efforts, they found it difficult to balance operational and administrative responsibilities, and questioned the value of some deliverables.

"Because most of the zones have very limited capacity with people able to do the job on the ground, so if you are pulling people from ground to do planning work and continuously do reporting, then you are pulling them from operations." (Key informant interviewee)

Indigenous Perspectives

Concern for a lack of Indigenous perspectives or participation was a small, but important theme. One interviewee argued that given the prevalence of addiction and substance use disorders, including OUD, among Indigenous communities the initiative overlooked involving Indigenous perspectives in the planning and implementation effort. It was further reported that little work was done with reserves. Findings from the data analysis support this claim as little was uncovered through evaluation data sources. Finally, one respondent suggested that a focus on preventative activities by the PHC ORI would have had a greater impact if it also targeted root causes of addiction and social determinants of health such as poverty, unemployment and abuse; issues that are overrepresented in Indigenous communities.

Ambiguity

A level of ambiguity permeated the PHC ORI work, creating several challenges and barriers. Some participants shared that a lack of clarity around partner roles as well as provincial role versus zonal role was difficult and confusing. Recognizing that relationships and clarity take time to build, a few participants stated that there was miscommunication and lack of clear expectations, resulting in wasted time and resources in some instances.

Similar comments regarding the Opioid Response Coordinator (ORC) role were noted. This position initially lacked clarity and led to confusion about responsibilities. Many staff who were approached to take on the role of ORC were already embedded in the PCN and worked in another capacity. The absence of role clarity at the outset, compounded by ORCs "wearing multiple hats," resulted in role and boundary confusion. This effected ORC confidence in approaching physicians and left physicians uncertain about what they could ask of their ORC thereby delaying the effectiveness of the ORC position.

Finally, data suggests that the Collaboration Forum was somewhat limited in its ability for detailed sharing across zones. When asked in the Collaboration Forum Survey "What could be improved about the Collaboration Forum should this "virtual table" be organized for future provincial initiatives in PHC?" approximately one third of respondents said they would have liked to have seen more in-depth sharing of activities across zones and/or showcasing work going on in specific zones.

Some individuals in the focus groups admitted that they did not have a good understanding of what was occurring in other zones and that there was an overall lack of sharing to the extent that they felt isolated. While they recognized the purpose of the collaboration forum was to share across zones, they explained that the forum evolved to one that provided high-level overviews, rather than detailed sharing about activities. Furthermore, zonal project managers did not collaborate formally, as noted by one zone, which may have led to some missed opportunities of sharing and building on each other's work. Nevertheless, the Collaboration Forum was positively viewed as advancing the work of this grant, and with small tweaks it could be used as a platform to advance systems-level initiatives.

Primary Health Care Opioid Response Initiative

Year 2 Summary Evaluation Report

Ways Forward and Conclusion

Ways Forward

This Year 2 Summary Evaluation uncovered many successes as well as challenges of the Primary Health Care Opioid Response Initiative (PHC ORI) grant. From this work, several lessons and ways forward can be drawn.

Foremost, the evaluation revealed that indeed, dedicated funds enabled primary health care to respond to a health crisis. These dedicated funds provided the opportunities to engage with primary care providers, teams, and Primary Care Networks (PCNs) in Alberta to define appropriate primary health care approaches and address issues contributing to the crisis.

Second, and of chief importance, is the affirmation that system-level change takes time. Two years for such an endeavor was not enough to realize some of the system-level goals of the grant. More time would have likely revealed greater and measurable impacts at both the clinic- and system-level.

Third, the PHC ORI activities began at the same time as the provincial governance structures were being developed, roles defined, and processes identified. As discussed in the challenges section, this was very challenging and was often described as "flying a plane while building it." However, now that aspects have been solidified and experience gained, primary health care is even better positioned to collectively address both the opioid crisis and future health issues in the province.

In order to change the trajectory of the opioid crisis in Alberta, there needs to be continued primary health care efforts in tackling this crisis. However, there are several barriers that could jeopardize the work moving forward. The current primary health care landscape in Alberta is comprised of rapidly changing environments of competing priorities, existing and emerging initiatives, and political sensitivities that could impede advancing this work and pose serious challenges if not responded to appropriately.

"With this grant, funding was generous but time was insufficient. Culture change takes time. Takes a lot of time to develop…a lot of the Zones were just starting to gear up for this system-level change. And now the grant is expired. It takes a long time to build resources and change practice. Another 1-2 years would have offered much more results. Lost a lot of opportunity to make real change." (Key informant interviewee)

"Important to continue to set up regular working relationships and determine how to keep AHS, PEER, ACFP, etc., all connected and moving forward together, even if there is a lack of funding."
(Working group member)

Maintain Relationships and Collaboration Efforts

Many gains have been made in building relationships and fostering collaboration at multiple levels in primary care. Trust has been foundational. Work should go into maintaining these efforts and building on these successes.

Maintain the provincial partnership. The PHC ORI grant represents the first time the Alberta College of Family Physicians (ACFP), Alberta Medical Association (AMA), and Alberta Health Services (AHS) have formally collaborated to address a shared health crisis. A great deal of time and effort has gone into defining roles and building structures and processes integral to the work achieved in the grant. This group is now well positioned to collaborate on future issues.

Continue collaboration and intentionally sustain all levels of relationships. Relationship development was a key factor of much of the PHC ORI success. Further developing and strengthening these relationships will need to be intentional moving forward. Sustaining a virtual space, such as the Collaboration Forum, as a (webinar) platform to share activities and to advance a culture of organizational learning and quality improvement, will be essential.

Continue to explore collaboration between primary health care and AHS Addiction and Mental Health. There are many opportunities available through greater collaborative efforts with AMH with the potential to further help individuals living with needs in a primary care setting. Barriers to treatment and stigma remain for those who are at risk of/living with Opioid Use Disorder (OUD) and increased linkages between primary health care and AMH will support positive impacts for these patients.

Explore formal partnerships with other stakeholders or healthcare partners involved or impacted by the work. Responding to the opioid crisis requires the entire health care system and multiple healthcare provider types. For example, pharmacists play a big role in dispensing and managing medications and treatments associated with opioid use. While some work did occur at a zone level, ensuring there is a formal connection to pharmacists at a provincial, zonal and local level ensures that these important partners are represented as part of a collective response.

"If we're going to be out there pounding the pavement with physicians and teaching them about OAT… shouldn't we be prepared at the other end when that patient shows up at the pharmacy with that new prescription and make sure those providers are on the same page as the physician?" (ORC)

Invest in Specific Activities to Continue and Broaden the Impact of PHC ORI

Aligning the work with other priorities is one important way to broaden this work. In addition, several activities were critical in forwarding the PHC ORI work. Continued investment in these activities is important to maintain momentum towards changing the trajectory of the opioid crisis in Alberta.

Maintain and expand education modules, resources, and tools on-line ensuring they remain centralized and easily accessible. A large amount of investment and energy went into developing training and education resources and tools for the grant, and these were found to be critical in the work. Primary health care teams now have an accessible repository of opioid-related information that was carefully created to serve their informational needs. A mechanism to review and regularly update tools and resources is important. Additional planning and focus will be required around further dissemination of these tools and resources.

Continue efforts to reduce stigma and increase awareness about opioids, Opioid Use Disorder (OUD), and addiction. Increasing awareness and reducing stigma were aims that underpinned this work. The results of the evaluation suggest that shifts have been made in this regard largely due to the extensive educational and capacity building endeavors funded by the grant. However, stigma still exists and continues to be a barrier for people at risk/with OUD. Continuing this discussion with a patient centred care lens in mind is critical.

Continue communication and information sharing on the indicators related to service planning work in the area of Addictions and Mental Health. Provincial investment into ensuring zone and PCN teams stay connected to relevant planning information will be important to keep issues front and centre in the future. Sustaining the provincial reporting that began with this grant will contribute to more informed population health needs planning at multiple levels.

Maintain structures/mechanisms that allow primary care providers to build capacity in providing opioid related care. Through the PHC ORI, many new structures, mechanisms, and roles were seen as building capacity for primary care providers and teams. For example, the Collaborative Mentorship Network for Chronic Pain and Addiction (CMN), time spent building community partnerships and subject matter expertise, and advancement of demonstration projects allowed individuals to become, or have access to, experts in the domain of opioid related care.

Continue Knowledge Sharing Efforts

Efforts to continue provincial data reports is critical to build on the momentum created through this initiative. Reports moving forward should build on past reports that show mortality from opioid overdose by zone/attachment to PCN providers, emergency visits/hospitalizations linked to OUD, as well as prescribing data. Thinking proactively about ways to spark meaningful discussions with other sectors in health, it may be possible to have new data reports include indicators that might inform care transitions with other relevant programs supporting individuals living with OUD (e.g., VODP referrals), highlighting linkages from Primary Care and back to Primary Care; Emergency Departments starts of Suboxone™ with transition plans back to PCNs (as an example of a community site) and data reports that can help test the pathway work that has been advanced through this grant.

The evaluation showed how the initial secondary reports provided to the zones and PCNs, as well as their additional needs assessment work, advanced their activity planning. Without continued reports summarizing provincial data, there is an increased risk that this work will no longer be prioritized, jeopardizing the success of the extensive work done to date on changing the trajectory of the opiate crisis in Alberta.

Collective impact. More could have been done to set up better coordination between the initiatives funded through the MOERC. For example, this evaluation report could have been strengthened had this grant been aware of the logic models, performance measures, and outcomes created for the other funded initiatives. Strengthening evaluation efforts to allow for examination of the collective impact for system-level work would be ideal and allow for a path to extend the investment of any one initiative's work and learnings.

Align Work with Other Priorities

Look for opportunities to leverage the knowledge assets created through this initiative with advancing provincial work, such as the AB Surgical Initiative and the AB Pain Strategy. In addition, there may be opportunities to share findings from this work with the AB Government Mental Health and Addictions Advisory Council to ensure that evidence informed principles inform resource decisions moving forward in order to meet the needs of patients across the care continuum.

Find other opportunities to align this work. The best way forward for this work is to find sources of additional funding. In the absence of specific PHC ORI money, provincial stakeholders should look for other funding opportunities with which this work can align.

Zones & PCNs have a Key Role in Forwarding this Work

Integrate PHC ORI assets within Patient Medical Home (PMH). Becoming a PMH requires that the family physician and health care team commit to changing the way the care is delivered in pursuit of continual improvement supported by appropriate funding and infrastructure. By integrating opioid related care into this process, this important work can be advanced through this broader vision.

Implement and test development pathways. This evaluation found that while many pathways have been developed, few have had the chance to implement, test, and revise. Moving forward, these pathways must be tested and assessed, or there is the possibility that the investment in their development may result in wasted effort.

Continue to offer OAT and harm reduction practices to patients that require it. The PHC ORI established that these are effective ways of supporting patients at risk of/with OUD. Scientific evidence supports these practices and it aligns with health's core principle of patient-centred care. PCNs and clinics can continue to work in this manner and harm reduction can be integrated with recovery. PCNs and clinics can formalize harm reduction by writing it into their practice policies.

Zones and PCNs should continue to come together and collaborate. The PHC ORI grant work emphasized the power of collaboration and trusting relationships. Some zones already had this work underway and found the grant strengthened this for them. Continued efforts to share information and learnings across zones should continue.

Scaling Opportunities

There are several activities that can be scaled across the province, or the country.

Share training, education, resources, and tools nationally. Many effective training, education, resources, and tools were developed from this grant and can continue to be shared nationally.

Further scaling of the Opioid Change Package. The AMA Opioid Change Package was an effective mechanism that forwarded the PHC ORI work. This package ultimately helped transfer learnings into practice settings and should be considered as an essential tool/format in supporting change to guide improvement work.

Scale/adapt pathways across the province. While pathways are not fully transferable across contexts and require local adaptation, there is opportunity to examine how these can be shared through Plan Do Study Act cycles of "testing" to advance this work across the province.

Scale ORC work with Alberta Works. Practice Facilitators working in the Opioid Response Coordinator (ORC) role in the North zone were successful in streamlining the approval process for individuals needing financial assistance for OUD treatment. Prior to this work, individuals were waiting up to one week for approval, but as a result of the ORC's advocacy efforts, applications are now placed on high priority by Alberta Works and patients typically receive approval within one day. This is a significant change that should be examined in other regions to improve access to help for patients at risk/with OUD.

Increase Efforts at Engagement with Particular Populations

Increased efforts at engagement should occur across the province with individuals with lived experience (IWLE) as well as with Indigenous communities.

Increase efforts at engaging Individuals with Lived Experience (IWLE). Some significant success occurred working with IWLE in this grant, noting how powerful this engagement was for both practitioners and the IWLE. The evaluation also found that this was challenging for others and some zones were unsuccessful in their engagement with IWLE. Further and continued engagement with IWLE should occur, and additional supports for this work should be considered.

Increase efforts engaging with Indigenous communities. It is well understood that opioids and OUD have a disproportionate effect on Indigenous peoples and their communities. Working with Indigenous communities was identified in the early conceptualization of the grant and was reconfirmed in the interim report. However, this evaluation revealed that little further work was conducted in Year 2 of the grant activities. Concerted efforts are needed to meaningfully engage with Indigenous communities to disrupt the impact of the opioid crisis.

Conclusion

The PHC ORI grant resulted in numerous successes while also uncovering important challenges. Over the last two years within primary health care, the following important outcomes have been achieved: demonstrable growth and maturing of relationships; targeted activities which enabled a rapid response to address a societal concern; assessments, posters and tools designed to facilitate meaningful conversations between patients, providers and planners around aspects related to social determinants of health (i.e., stigma, adverse childhood events); service plans enacted; emerging examples of management continuity of care between addiction specialists and primary care teams; and, perhaps most importantly, examples of meaningful engagement of individuals with lived experience to guide planning activities.

Foundationally, this grant was anchored by system-level change management processes – the first of which to be governed by a multi-stakeholder provincial partnership lead by the ACFP, between AHS, AMA and the Zone PCN Committees. Strong project management and leadership vision at multiple levels (provincial, zonal and PCN/clinic level) challenged all involved to attempt to achieve as much as is possible in a relatively short initiative, in a fiscally accountable way, considering that systems change was the goal.

Looking back, the PHC ORI interim evaluation report (2019) readily acknowledged that momentum throughout primary care was going to take time to build; this summary evaluation report, written less than a year later, was able to triangulate multiple data sources and determine meaningful progress in the key thematic areas outlined in this report.

"In order to have a fully integrated health system that can respond effectively and efficiently to crisis will require us to continue to look for ways of working together, to share successes, to build trust and collaboration, and to drive policy and legislation that allows for resource reallocation and patient centred strategies. The people that joined forces to respond to the opioid crisis recognize the value of this integration, and we need a system that supports this ongoing way of working together. Thank you to all of you who had a role in the PHC ORI! We made a difference."

Terri Potter, PHC ORI Executive Lead, ACFP

Due to its foundational role in the health system, primary health care has often been asked to participate in numerous initiatives reaching across the continuum of care. Through this evaluation, the evaluation team has heard it is often difficult to generate interest amongst clinicians because there are often many meaningful change-driven projects to choose from within this province and even nationally. Determining which initiative physicians choose to dedicate time, attention and clinic resources often means they are forgoing other work that may address patient, organization or provincial needs. Because of the funding attached to this particular initiative, many clinicians noted that it was easier to generate colleague interest and momentum. It enhanced the ability for collective discussions on "hard" topics, as well as delivering tailored activities across this province. Initiative funding allowed for dedicated time to have discussions that spanned from planning to education/training and mentorship.

While this report highlights the progress made against the goals and objectives put forth in the proposal, the work cannot stop. The opioid crisis continues to claim lives and devastate families. Recent data indicates deaths from illicit opioid use is declining;[20] a trend that lends towards optimism that the opioid efforts across sectors and the province is helping. Yet, even with this occurring, overdoses continue as does hospitalizations and death. This will continue to be a challenge to our health system and reinforces the importance of carrying on the work begun through the PHC ORI grant; it is our collective responsibility to improve the quality of life of those with OUD and save lives.

[20]French (2020). *Opioids deaths down from last year, says latest government report.* Retrieved from https://edmontonjournal.com/news/politics/opioid-deaths-down-from-last-year-says-latest-government-report/