Invitation to participate in Offers of Care Opportunity

What is the Offers of Care Demonstration Project?

To demonstrate the exceptional work primary care practices are embarking on to care for their patients using opioids, we are asking you to participate in **a demonstration project to test new measurement approaches for documenting offers of care.**

Currently there is an emphasis on the Primary Health Care Opioid Response Initiative (PHCORI)'s urgent response focused on increasing the capacity of primary care to deliver Opioid Agonist Therapy (OAT) and increasing the supply of life-saving Naloxone. Alongside the urgent response, addressing the underlying conditions contributing to the opioid crisis will require more than just increasing the supply of OAT and naloxone. This is why the AMA Accelerating Change Transformation Team (ACTT) developed a Change Package and strategies to address care management for patients using opioids in primary care.

Given the complex nature of OUD, it is likely that multiple encounters, and offers of care, will be required before a patient initiates on OAT. Measuring offers of care will help teams understand where process improvements can be made, as both provider behaviours (e.g. patient centeredness) and patient behaviours (e.g. readiness to change) affect the outcome of an offer of OAT.

What does participation look like?

For each physician that participates, the demonstration project will involve the submission of a baseline measure and a single follow-up measure after ~6 months. The AMA will provide up to 20 hours of consulting time to work with your clinic, PCN, and/or Zone Opioid Working Group to support EMR optimization for these measures. Your anonymized data will be used in aggregate to develop an understanding of the ability to use the EMR to track offers of care.

What are the benefits to participating?

The benefits of participating in this demonstration project are:

- Track, measure, and analyze data that would be meaningful for quality improvement
- Build capacity for optimizing the EMR to enable better data standardization and running searches
- Implement process changes that are aligned with Patient's Medical Home transformation that would benefit your paneled patients, beyond your patients using opioids
- Access to direct support from an AMA consultant
- Demonstrate the breadth and quality of work that primary care is doing to address the opioid crisis

What are the next steps?

If you would like to learn more or participate in this demonstration project, please contact Wanda Truong at Wanda.Truong@albertadoctors.org (403-471-1672) or Bonnie Lakusta at Bonnie.Lakusta@albertadoctors.org (780-777-4121).

What are the measures?

A **Team Assessment** will be facilitated by your improvement facilitator to identify behaviours and processes that may have room for improvement.

A **Data Form** in Excel with the following measures will be completed and submitted to the AMA at two intervals: baseline and ~6-month follow-up.

Required Measures	Definition	Rationale
# patients with OUD	A sub-population from the total # of paneled patients using opioids, this is the # of patients with documented OUD.	The urgent response recommends primary care providers identify patients with OUD as this subgroup may be at high risk of overdose.
# patients with OUD offered OAT from the patient's medical home	# of offers of OAT to patients with OUD or referrals to a physician who can prescribe OAT will be documented in a standardized field in the EMR.	The urgent response recommends that patients with OUD be offered OAT. Counting the number of patients on OAT would likely underestimate the number of offers of OAT, as both provider behaviours (e.g. patient centredness) and patient behaviours (e.g. readiness to change) affect the outcome of the offer. It is likely that multiple encounters, and offers, will be required before a patient initiates on OAT.
# of patients with OUD on OAT	# of patients with OUD who have initiated treatment with opioid agonist therapy	This will serve as a comparison to the number of offers of OAT, to better understand how many offers are being accepted.
Optional Measures	**Definition**	**Rationale**
# patients with OUD assessed with a standardized tool (e.g., POMI tool)	# of patients with OUD that were screened for OUD using an assessment tool (e.g. POMI)	Using a consistent tool to assess for OUD will ensure that identifying patients is standardized.
# patients with OUD with a documented opioid checklist	# of patients with OUD with a documented opioid checklist searchable in the EMR (sometimes referred to as a contract or patient-provider agreement).	A potentially better practice for patient-centred care is to have a conversation about opioid safety, risks and benefits for a patient initiating opioid or during a follow-up. An opioid checklist is a re-conceptualization of an opioid contract as a conversation tool.
# patients with OUD with at least 1 assessment completed	# of patients with OUD with at least one assessment of pain, function, mental health or side effects documented in the EMR.	Optimal management of patients using opioids includes assessing part of their health that may be affected by opioids, including pain levels, functional assessments, mental health and side effects.
# patients with OUD with a documented care plan	# of patients with OUD with a documented care plan in the EMR.	A potentially better practice to support patient self-management and care management of complex health needs patients includes engaging in the care planning process. Patients using opioids may have complex health needs and may benefit from a comprehensive care plan.
# patients with OUD with an overdue reassessment	# of overdue reassessments will be counted using reminders in the EMR	A key behaviour change to support longitudinal continuous relationships with patients is to ensure follow up with patients at appropriate time intervals.

Opioid Offer of Care Demonstration Project – Participation Form

If you are interested in participating in the Opioid Measurement Project, the following provides an overview of the implementation process:

1. Complete the readiness checklist
2. Complete the demographic details
3. To enroll, submit the readiness checklist and demographics form to Bonnie Lakusta bonnie.lakusta@albertadoctors.org

Once we have received your interest in participating we will connect you with a dedicated EMR and Measurement Support to orient you to the project and help your team establish baseline measures.

Readiness Checklist

Measurement of process changes is a critical component of quality improvement. However implementation of measurement requires a certain level of capability. This checklist outlines a set of "readiness" criteria to help you determine if your practice is well positioned to start implementing EMR measurements of process improvements[1]. This information will not be used to exclude participants. It may not be feasible to complete all suggestions listed below, but working through this will optimally set you up for success in this project.

Yes / Working On / Not Yet	Team
	Recruitment
☐☐☐	A clinical champion has been identified and commitment to engage in QI has been established.
☐☐☐	An improvement team that represents all areas of the clinic has been identified. At minimum, that would include one physician, one other co-located health professional, MOA, receptionist and/or a patient representative.
	Establish Improvement Team Meetings
☐☐☐	Expectations for meetings (including agenda, frequency, team roles) have been discussed.
☐☐☐	Ongoing communication strategies with others at the clinic have been established.
	EMR
	Data standardization
☐☐☐	Clinic team understands that putting in information in the EMR in the right place in a standardized way every time makes for better information reporting in the EMR for panel work.
	Panel Identification
☐☐☐	Clinic team has consistently achieved a patient confirmation rate of 90% or greater.
	Proactive Panel Management
☐☐☐	Clinic team is able to generate reports using searchable criteria (e.g. screening maneuvers)
☐☐☐	Proactive patient needs are automated in the EMR (e.g. rules, triggers, reminders, flowsheets)
	Disease Management
☐☐☐	Advanced clinical decision supports, such as Rules/ Reminders/ Goals/ Notifications, are used to flag patients requiring *follow-up care* (e.g. A physician or team member has a process to identify patients who are due for follow-up related to a specific condition)

[1] Measures are described in the Opioid Change Package and supporting documentation

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Demographics

Name of Physician	**Name of clinic**
Name of Primary Care Network	**Postal code of clinic**
Average patient volume per clinic day (estimate is fine)	

Type of Practice	◯ Solo practitioner	◯ 2 – 3 physicians in regular practice	◯ 4 – 8 physicians in regular practice	◯ >8 physicians in regular practice

Next steps

Once you have been enrolled to the project, the immediate next steps will involve the following:

1. Orientation to project with AMA EMR and Measurement Consultant
2. Complete the quality improvement Team Assessment tool with your care team.
3. Submit the Team Assessment and baseline measures to Bonnie Lakusta bonnie.lakusta@albertadoctors.org

We look forward to working with you and your team to optimize EMR and measurement to implement opioid process improvements!