OPIOID DE-IMPLEMENTATION INITIATIVE (TIER 2):

A PILOT IMPLEMENTATION OF THE STAGED SCREENING AND ASSESSMENT TOOLS IN PRIMARY CARE AND BUILDING A SHARED CARE PATHWAY

A REPORT ON THE EVALUATION OF THE PILOT IMPLEMENTATION

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EXECUTIVE SUMMARY

Tier 2 of the Opioid De-Implementation Initiative was a pilot project aimed at fostering coordination and collaboration between primary care and the publicly funded community addiction sector, as well as strengthening the ability of primary care pilot sites to identify mental health and addiction issues and connect patients with appropriate services. Two key activities were undertaken to realize the goals of this pilot project: (1), implement the use of the *Staged Screening and Assessment Tools (GAIN-SS CAMH Modified, MMS, and GAIN Q3 MI ONT)* in primary care and (2), develop a shared care pathway between primary care sites and their local mental health and addictions agencies. This report describes the evaluation and lessons learned of this pilot's implementation at five primary care pilot sites. The pilot project ran from July 2018 to March 2020.

For this report, an evaluation framework was developed for a post-test only design, where data was collected once after the pilot was implemented. Quantitative data sources included document reviews (e.g., agency action plans), secondary administration data (e.g., Local Health Integration Network websites), and a satisfaction survey. Due to the low number of responses (n<5), the results of the satisfaction survey were excluded during the analysis. Interviews were the only qualitative data source; four individuals participated in these interviews. Both quantitative and qualitative sources were analyzed and used to form the basis of the lessons learned and recommendations.

There were five categories of lessons learned identified. A few findings across the categories are provided below:

1. **Screening tools (GAIN-SS CAMH Modified, MMS):** Although there was very little use of the screening tools, qualitative data revealed that they can be useful in primary care settings and for building a shared care pathway to addiction services.
2. **Assessment tool (GAIN Q3 MI ONT):** Qualitative data suggested that the assessment tool may not fit the needs of primary care at this time. However, qualitative data also suggested that it may be appropriate in primary care settings with on-site mental health and addiction services (i.e., a "one-stop shop"). Due to limited data, these findings were not conclusive.
3. **Shared care pathway and relationships:** There were several factors identified which may impact the level of ease and strength with which a pathway can be developed (e.g., time, existing relationships, commitment). The co-development of a pathway and relationships between primary care and their local mental health and addictions agencies has been acknowledged as an important facet for realizing the primary goals of Tier 2.
4. **Staff engagement:** Greater levels of engagement facilitated uptake of the pilot's implementation, whereas lower or lack of engagement was a barrier to uptake.
5. **EMR/Data systems:** The ability to integrate the screening and/or assessment tools into existing EMR/data systems of primary care sites was a contributing factor to the adoptability of the tools.

While the sample size of the data was too small to generate conclusive suggestions around the use of the *Staged Screening and Assessment Tools* in primary care and the co-development of a shared care pathway between primary care and the addictions sector, the recommendations of this report are outlined as follows:

1. Consider further investigating the value of both the screening and assessment tools in primary care, if feasible. The lessons learned highlighted some key factors that should be considered prior to any future exploration.
2. Consider the continued and expanded development of a shared care pathway between primary care sites and their local mental health and addictions agencies, recognizing an extended period of time is required to witness the pathways' fruition.

INTRODUCTION

BACKGROUND

In a call to action for addressing the opioid crisis in Canada,[1] the broader project, *A System-Wide Approach to De-implementation of High-Risk Opioid Prescribing and Use,* was developed and undertaken to contribute to a collective response. The overarching objectives of this project were to de-implement high-risk, low-value opioid prescribing practices in primary care and to bolster the prevention, early detection, and management of adverse effects in patients who have been prescribed opioids.

Implementation of this project, which included the process of reducing or discontinuing practices that are no longer evidence based, encompassed three tiers:

1. Tier 1: Fostering better clinical guidance in order to facilitate improved patient screening and assessment, and safer opioid prescribing practices;
2. Tier 2: Building a stronger shared care pathway between primary care and addiction services; and
3. Tier 3: Operationalizing a cross-sectoral response to the opioid crisis by enhancing capacity of community partners to collaborate and leverage resources.

The second tier, *Tier 2 of the Opioid De-Implementation Initiative: Implementing the Staged Screening and Assessment Tools (GAIN-SS CAMH Modified, MMS, and GAIN Q3 MI ONT),* is the focus of this report (hereinafter referred to as "*Tier 2 of the Opioid De-Implementation Initiative*", "Tier 2", or "the pilot", interchangeably).

This report describes the goals and implementation evaluation of *Tier 2 of the Opioid De-Implementation Initiative*, the pilot implementation process at the five participating primary care sites, and lessons learned from this work.

GOAL OF THE PROGRAM

The primary goals of *Tier 2 of the Opioid De-Implementation Initiative* within the broader project*, A System-Wide Approach to De-implementation of High-Risk Opioid Prescribing and Use*, were twofold: (1), to enhance coordination and collaboration between primary care and the publicly funded community addiction sector; and (2), to enhance capacity of the primary care pilot sites to identify mental health and addiction issues and connect patients with appropriate services.

These goals were realized by undertaking two key activities:

1. Supporting implementation of the *Staged Screening and Assessment Tools (GAIN-SS CAMH Modified, MMS, and GAIN Q3 MI ONT)*[2] in the primary care pilot sites. These *Staged Screening and Assessment (SS&A)* tools are currently being used in the addictions sector, as mandated by the Ministry of Health (MOH). Given that primary care is out of this mandate's scope, for funding reasons, the SS&A tools are not mandated for use in the primary care setting.
2. Co-developing a referral/shared care pathway between the primary care pilot sites and their respective local addictions agencies in order to foster a warm handoff approach.

PILOT SITES AND KEY PARTNERS

The following five primary care sites participated in *Tier 2 of the Opioid De-Implementation Initiative*:

1. Atikokan Family Health Team
2. Greenstone Family Health Team
3. Le Centre de Santé Communautaire du Temiskaming (CSC Du Temiskaming)
4. West Parry Sound Health Centre
5. Thames Valley Family Health Team

A sixth site, Brock Community Health Centre, was initially selected to participate in the pilot but withdrew before initial implementation began. No reason was provided for their withdrawal.

Key partners included the following:

1. Ministry of Health (MOH)
2. Association of Family Health Team of Ontario (AFHTO)

Funding for this pilot was made available from the Ministry of Health (MOH). This work was a collaboration between the Provincial System Support Program (PSSP) at the Centre for Addiction and Mental Health (CAMH) and the participating family health teams (FHTs) and community health centres (CHCs).

TIMELINE OF PILOT SITE SELECTION AND SS&A IMPLEMENTATION

Time Period	SS&A Implementation Milestone
July 2018	Primary care sites interested in the pilot engaged in calls with the PSSP team to learn more about *Tier 2 of the Opioid De-Implementation Initiative*. Interested sites completed a readiness assessment survey to indicate their interest in participating.
August 2018	Using a modified version of *The Hexagon Discussion and Analysis Tool,*[3] six primary care sites were selected as pilot sites based on site need, fit, readiness, and capacity.
October 2018	Designated staff from four of the six primary care pilot sites began the Local Trainer training process through *Chestnut Health Systems*,[4] the proprietor of the SS&A tools. Local Trainers are individuals who are able to administer SS&A and train others in using the tools. Training typically lasts six months.
November 2018	PSSP Implementation Specialists were matched with SS&A leads of each primary care pilot site for implementation support.
January 2019	Certified Local Trainers were matched with clinicians from their own or another primary care pilot site to begin training Site Interviewers, who will be able to administer SS&A. Training typically lasts three months.
December 2018	Brock Community Health Centre withdrew from the pilot. Five primary care pilot sites remained.
June 2019	Administration of the screening tools (GAIN-SS CAMH Modified, MMS) began for at least one of the five primary care pilot sites. Administration of the SS&A tools, for the rest of the sites was staggered thereafter (if there was an opportunity for its use).

August 2019	Thames Valley Family Health Team elected to discontinue training a Local Trainer and discontinue use of the assessment tool (GAIN Q3 MI ONT).
March 2020	Funding for pilot implementation ended. Beyond the pilot, primary care pilot sites were able to choose whether they continued to use the SS&A tools or not.

EVALUATION AND METHODOLOGY

PURPOSE OF EVALUATION

The purpose of this evaluation was to understand the pilot implementation of *Tier 2 of the Opioid De-Implementation initiative* at the five primary care pilot sites. The findings of this evaluation informed lessons learned around the key activities of Tier 2: (1), implementation of the SS&A tools in the five primary care pilot sites; and (2), the development of a referral/shared care pathway between the five primary care pilot sites and their respective local addictions agencies.

SCOPE OF EVALUATION

This evaluation was a post-test only design, where data was collected once after the pilot was implemented. An evaluation framework was developed to build and explore questions that would aid in understanding the pilot implementation at the five primary care pilot sites (refer to the Appendix for details on the evaluation framework).

DATA COLLECTION AND ANALYSIS

QUANTITATIVE SOURCES

A review of project-related documents was conducted to collect information around the profile of the five primary care pilot sites and the local mental health and addictions agencies in their respective communities. Project-related documents were provided by the relevant PSSP Implementation Specialists overseeing the Tier 2 pilot. Local Health Integration Network (LHIN) websites (e.g., www.northwesthealthline.ca, www.southwesthealthline.ca) and main websites of the five primary care pilot sites (e.g., www.atikokanfht.com) were also used to solicit this information.

A satisfaction survey consisting of 21 questions (refer to the Appendix for details on the survey), with responses on a 5-point Likert scale, was developed and administered through SurveyMonkey (www.surveymonkey.com). The survey was open between August 1st, 2020 and Sept 4th, 2020. Of the 15 individuals that were invited to engage in the survey, four individuals participated. Due to this low number of responses (n<5), the results of the satisfaction survey were neither included nor used for analysis in this report.

Data Source	Time of Collection	Analysis
Document review (e.g., training tracking sheet, readiness assessments, agency action plans, project updates)	August 2020	Descriptive
Satisfaction surveys	August 2020	Excluded in the analysis

Secondary administrative data (e.g., Local Health Integration Network websites)	September 2020	Descriptive

QUALITATIVE SOURCES

Two versions of an interview guide consisting of 19-21 questions (refer to the Appendix for the interview guides) were developed and administered virtually via WebEx (www.webex.com), an online meeting platform. Only audio was used during the interviews. One PSSP Evaluator conducted and facilitated the interviews, while a second was present to take notes. Two different versions of the interview guide were administered depending on the type of staff role the participant held. Interviews were scheduled and conducted in August 2020. Of the 15 individuals that were invited to engage in the interviews, four individuals participated. Paraphrasing of the interview responses was done in an attempt to preserve anonymity, where possible.

Data Source	Time of Collection	Analysis
Interviews	August 2020	Thematic

RECRUITMENT OF PARTICIPANTS

Key informants were identified by the primary PSSP Implementation Specialist overseeing the Tier 2 pilot. The primary Implementation Specialist emailed the key informants between June 2020 – July 2020 around a request to participate in the evaluation, which would consist of participating in either the satisfaction survey, interview, or both.

The primary PSSP Evaluator then followed up with these individuals within the same week of initial contact with further information around the evaluation and provided consent forms for participation. A follow-up was initiated by the primary PSSP Evaluator if there was no response within approximately two weeks of the initial recruitment email. Interviews were scheduled and/or the hyperlink to the satisfaction survey was provided upon receipt of a signed consent form by the participant.

A last follow-up email was sent to those who had not responded to the initial recruitment email by the primary PSSP Implementation Specialist on August 31st, 2020. This email requested participation in the satisfaction survey only.

RESULTS

QUANTITATIVE MEASURES

SITE PROFILES

Profile information for each of the five primary care pilot sites was collected to understand the type of staff involved at each site and the patient community they serve (Table 1). As of September 2020, four of the five pilot sites have at least one site interviewer that is certified; previously, there was at least one site interviewer that was certified at each site. Only one pilot site (CSC Du Temiskaming) has at least one local trainer that is certified; previously there was another certified at West Parry Sound Health Centre. There is a variety of different staff roles identified at all pilot sites that have in-house mental health and addictions

clinical capacity. However, Atikokan FHT and Greenstone FHT reported that they do not have in-house expertise for the treatment of addictions. As well, there is a range of staff and patient volume across the pilot sites, with Atikokan FHT having the lowest number of staff and patient volume and Thames Valley FHT having the highest number of staff and patient volume out of all the pilot sites.

Table 1. Profile of the primary care pilot sites

	Atikokan Family Health Team	Greenstone Family Health Team	CSC Du Temiskaming	West Parry Sound Health Centre	Thames Valley Family Health Team
# of site interviewers[a]	1	1	1	2	None
# of local trainers[a]	None	None	1	None	None
# of healthcare staff at each site[b]	8	5	20	15	225
Type of staff roles[b]	Dietician, Mental Health Worker, Nurse Practitioner, Pharmacist, Physician, Registered Nurse, Registered Practical Nurse, Social Worker	Health Educator, Nurse Practitioner, Physician, Registered Nurse, Social Worker	Dietician, Health Promotion Worker, Mental Health Case Manager, Nurse Practitioner, Physician, Registered Nurse, Social Worker	Addictions Counsellor, Nurse Practitioner, Physician, Registered Nurse, Social Worker	Dietician, Nurse Practitioner, Occupational Therapist, Pharmacist, Physician, Quality Improvement Specialist, Registered Nurse, Respiratory Therapist, Social Worker
Patient volume[b,c]	1,291	3,017	Not Reported	22,190	128,090
LHIN	North West	North West	North East	North East	South West
Regional catchment area	Rainy River	Thunder Bay	Nipissing-Temiskaming	Parry Sound	Elgin, London-Middlesex, Oxford
In-house expertise for treatment of addictions	No	No	Yes	Yes	Yes
In-house mental health and addictions clinical capacity (e.g., social workers)	Yes	Yes	Yes	Yes	Yes

Footnotes:

[a] As of January 2021

[b] Determined using either one of, or a combination of the following data sources: 2018 readiness assessment surveys, LHIN websites, and the main websites of the five primary care pilot sites. Main websites were scanned first to identify the most up-to-date information. If this was not reported or did not specify when it was last updated, then the 2018 readiness assessment surveys were used to report this information. This information may not be accurate during the time this pilot unfolded and at the time this report was published

[c] Number of active patients served (who had at least one visit between Jan 1st, 2017 – Dec 31st, 2017)

ADDICTIONS AGENCIES

Profile information for the local addictions agencies within the same community of each of the five primary care pilot sites was collected to understand the type and amount of addictions services and programs that were available (Table 2). Categories of addictions services and programs were identified using the LHIN websites of the pilot sites. The number of services and programs was counted for each pilot site, after filtering for their specific regional catchment areas. Although there may be services or programs housed outside of the pilot site's regional catchment area that still serves that area, these are not included in the total count.

There is a variety of addictions services and programs available across the pilot sites. However, West Parry Sound Health Centre and Thames Valley FHT are the only sites that have at least one agency type in their community. These two sites also have the highest count of total local addictions agencies among the five sites. Categories with the smallest presence across all pilot sites include community withdrawal management, residential withdrawal management, self-abuse, and sex and love addictions.

Table 2. Type of local addictions agencies in each of the pilot sites' community

	Atikokan Family Health Team	Greenstone Family Health Team	CSC Du Temiskaming	West Parry Sound Health Centre[a]	Thames Valley Family Health Team[b]
# of total local addictions agencies[c,d,e]	**71**	**45**	**61**	**117**	**142**
Addiction Education and Prevention	16	9	1	11	9
Addiction Support Groups	15	5	7	13	19
Alcohol and Drug Addiction Assessment and Treatment	22	17	29	55	31
Community Withdrawal Management	None	None	None	4	7
Housing for People with Addictions	2	10	2	6	13
Opioid Dependence			6	6	29
Problem Gambling	14	2	5	4	13
Residential Treatment for People with Addictions	None	None	2	5	7
Residential Withdrawal Management	None	None	None	1	3
Self-Abuse	None	None	None	None	4
Sex and Love Addictions	None	None	None	1	None
Smoking Cessation	2	2	9	11	7

Footnotes:

[a] www.NorthEasthealthline.ca combines service and program searches for Parry Sound with Sudbury and Manitoulin regions

[b] www.SouthWesthealthline.ca combines services searches for Oxford with the Norfolk region. Therefore, services for this regional catchment area includes Elgin, London-Middlesex, Oxford, and Norfolk

[c] May include duplicates as an organization may provide more than one type of service/program. For example, an organization may provide both problem gambling and smoking cessation services, which are separate categories
[d] Only agencies that are located within each pilot site's regional catchment area was included. Agencies outside of the regional catchment area that may still provide services/programs were excluded. Agencies included in this count may not have an established or existing relationship with the pilot sites
[e] This information, as well as the sub-count of the agency types, may not be accurate during the time this pilot unfolded and at the time this report was published

MENTAL HEALTH AGENCIES

Profile information for the local mental health agencies within the same community of each of the five primary care pilot sites was collected to understand the type and amount of mental health services and programs that were available (Table 3). Categories of mental services and programs were identified using the LHIN websites of the pilot sites. The number of services and programs were counted for each pilot site, after filtering for their specific regional catchment areas. Although there may be services or programs housed outside of the pilot site's regional catchment area that still serves that area, these are not included in the total count.

There is a variety of mental health services and programs available across the pilot sites. CSC Du Temiskaming, West Parry Sound Health Centre, and Thames Valley FHT have the most diverse agency type in their community. These sites also have the highest count of total local mental health agencies among the five sites. Categories with the smallest presence across all pilot sites include advocacy and social action for people with mental illness, consent, capacity, and patient's rights, crisis lines, employment assistance for people with mental illness, mental health forensic programs, and self-abuse.

Table 3. Type of local mental health agencies in each of the pilot sites' community

	Atikokan Family Health Team	Greenstone Family Health Team	CSC Du Temiskaming	West Parry Sound Health Centre[a]	Thames Valley Family Health Team[b]
# of total local mental health agencies[c,d,e]	**83**	**68**	**147**	**255**	**451**
Advocacy and Social Action for People with Mental Illness	None	None	None	None	9
Affective Disorders	None	1	2	7	25
Alzheimer's Disease and Related Dementias	1	None	3	9	11
Anger Management	None	1	2	2	11
Anxiety Disorders	None	None	2	7	25
Bereavement Support		6	3	9	14
Community Mental Health Programs	12	5	26	47	35
Consent, Capacity, and Patient's Rights	None	None	None	None	3
Counselling - Family, Couple, Individual	33	23	17	42	24
Crisis Intervention	7	7	11	17	23
Crisis Lines	None	None	None	1	None
Dementia	1	None	3	9	11
Depression	None	1	2	7	25
Eating Disorders	None	None	2	2	14

Employment Assistance for People with Mental Illness	None	None	None	1	None
Hoarding	None	None	None	1	2
Housing and Residential Care for People with Mental Illness	3	None	6	4	22
Mental Health Courts and Diversion Programs	1	None	6	5	8
Mental Health for Children and Youth	8	2	7	18	24
Mental Health for People with Intellectual Disabilities	1	1	11	3	10
Mental Health for Seniors	2	1	7	11	12
Mental Health Forensic Programs	None	None	1	None	None
Mental Health Hospital Programs	None	None	5	4	22
Mental Health Peer and Family Programs	2	4	7	4	6
Mental Health Promotion	9	11	2	11	15
Mood and Anxiety Disorders	None	1	2	7	25
Obsessive Compulsive Disorder	None	1	2	7	25
Panic Disorder	None	1	2	7	25
Postpartum Depression	1	None	1	8	2
Psychosis	None	None	3	2	6
Recreational and Social Programs for People with Mental Illness	1	None	3	1	9
Schizophrenia	None	None	4	2	2
Self-Abuse	None	None	None	None	3
Suicide	1	2	5	None	3

Footnotes:

[a] www.NorthEasthealthline.ca combines service and program searches for Parry Sound with Sudbury and Manitoulin regions

[b] www.SouthWesthealthline.ca combines services searches for Oxford with the Norfolk region. Therefore, services for this regional catchment area includes Elgin, London-Middlesex, Oxford, and Norfolk

[c] May include duplicates as an organization may provide more than one type of service/program. For example, an organization may provide both anxiety disorder and depression services, which are separate categories

[d] Only agencies that are located within each pilot site's regional catchment area was included. Agencies outside of the regional catchment area that may still provide services/programs were excluded. Agencies included in this count may not have an established or existing relationship with the pilot sites

[e] This information, as well as the sub-count of the agency types, may not be accurate during the time this pilot unfolded and at the time this report was published

QUALITATIVE MEASURES

SCREENING TOOLS

Utilization

"It hasn't been a need thus far … we know our patients and we have the information."

Three of the four interviewees reported that they did not use the screening tools. Two individuals mentioned that because their site was unable to build the screening tools within their data systems, the tools were not used. Another individual commented that they found the screening tools not necessary to use, given that they know their patients very well; this individual further stated that their site would have used the screening tools if it was more beneficial. For the individual that did use the screening tools, the tools were administered electronically, however they reported that there was not enough demand for its use at their site (i.e., there were few new community member referrals and few clients to screen, even before COVID-19 had unfolded).

Barriers to uptake

"It would be a hassle to re-learn it on the EMR if we first taught it on pen/paper and then switch."

There were several key reasons cited for little or lack of screening tool usage. One reason was EMR/data system challenges, including language barriers. Two individuals reported that the tools were not compatible with their existing systems, and although pen and paper administration was an alternative, manually calculating scores was too lengthy for staff to do. At the time of the interviews, these sites reported that integration of the tools onto their existing systems would require further external expertise (e.g., JavaScript programmer). Progress around this, however, was delayed. Furthermore, one individual reported that if the screening tools were to be scaled up at their sister sites, individual site permission for downloading and implementing it would be required.

In relation to data system challenges, one individual commented that the screening tools were unable to be built or used in French, which was their community's primary language; they found the translated version of the tool not accurate enough for it to be used by staff/for patients. This also contributed to the lack of buy-in and engagement from staff and/or patients. Other reasons for lack of buy-in and engagement were staff attitudes, such as their stance on how the tools may impact their current work processes (i.e., buy-in is based on providers' opinions on whether changing their current practices are worthwhile), entrenched disinterest in past initiatives, and lack of a champion for the pilot.

Another implementation barrier noted was that one individual's site had an established screening method of what worked best for them and their patients. This site had a strong relationship with their patients already, as well as knowledge of and access to their health history prior to the pilot's implementation. Further, they highlighted that they already held strong connections with their local addictions agencies. As such, they felt that it was not necessary to conduct screenings. Another individual reported that staff found other well-known tools, such as the *Patient Health Questionnaire (PHQ-9)* or *Generalized Anxiety Disorder scale (GAD-7),* easier and quicker to use, despite these not being substance use screeners.

Facilitators of uptake

"It was great. No complaints. The support was excellent."

As screening tool use was quite limited, only a few facilitators for their uptake were noted. First was implementation support, to which all individuals stated that they were satisfied with training, orientation, and implementation support provided by the PSSP implementation team. This spurred initial interest in adopting the tools. They quoted that the training was valuable and that it was a positive experience. To add to this, one individual reported that their site's decision to not use the screening tools was not influenced by the implementation support received, and that it was due to external factors beyond their control.

Additionally, one individual highlighted the significance of the screening tools as a result of their existing knowledge of using the tool in the mental health and addictions sector. Another individual mentioned that the screening tools capture a lot more depth and understanding than the PHQ-9 and GAD-7 does.

Sustainability

"Screening is appropriate. It can be used anywhere and it's standardized."

With the exception of one individual that mentioned the screening tools were not necessary, three individuals reported that the screening tools were a need in their community and were appropriate for primary care. One individual reported that it would be helpful if screening tools were implemented in primary care, as it would encourage standardization across both primary care and the mental health and addictions sectors.

When asked of their next steps around the use of the screening tools beyond the pilot, all individuals reported that more time, resources, and buy-in is required to witness more adoption. For example, one individual stated that the tools were part of their strategic planning and discussions within a newly formed task force group. Another individual highlighted that while the tools do have a place in primary care, there must be others on board to strengthen buy-in.

ASSESSMENT TOOL

Utilization

"There isn't enough demand for the GAIN Q3."

Three of the four interviewees reported that there were very few opportunities to use the assessment tool, whereas one individual stated that their site did not use it at all. For the three individuals that did use the assessment tool, the tool was administered electronically, however they reported that there was not enough demand for its use at their site (i.e., there were few new community member referrals and few clients to assess). For the individual that did not use the assessment tool, they stated that since the local mental health and addictions agencies in their community were already conducting assessments, their site did not see it necessary to conduct it themselves.

Barriers to uptake

"Buy-in is on an individual basis … The more tools and forms thrown at them (service providers), the more resistance is met."

There were several, key reasons cited for little or lack of assessment tool usage. One significant reason was its complexity and length. The majority of individuals mentioned that it made more sense for mental health and addictions services to conduct the assessments, due to their stronger capacity and expertise. One individual highlighted that its complexity and length was also frustrating for some of their patients; some patients became impatient during lengthy sessions, which challenged staff to support them and maintain their engagement.

Similarly to the screening tools, there was lack of buy-in and engagement from staff. Reasons for this were staff attitudes, such as their stance on how the tools may impact their current work processes (i.e., disrupting workflow and their current practices for patient care), entrenched disinterest in past initiatives, and lack of an accurate translation of the assessment tool in one site's primary language (French).

Facilitators of uptake

"Wish that I can do the GAIN Q3 to help define treatment. It's very thorough and invites conversations."

While individuals declared that the assessment tool was not a right fit for their site, they pointed out a few benefits for potentially adopting the assessment tool. One is the depth of knowledge gained from using the tool, which benefits both the staff and patients. Two individuals reported that the assessment is thorough and invites conversation, and provides a lot more information than their previous assessment practices.

All individuals reported that they were satisfied with training, orientation, and implementation support provided by the PSSP implementation team. This spurred initial interest in adopting the assessment tool. They quoted that the training was valuable and that it was a positive experience. There was no indication from any of the individuals that their site's decision to discontinue using the assessment tool was influenced by initial and continued implementation support.

Sustainability

"Addictions organizations doing the GAIN Q3 are doing it well. So, it's not appropriate at this time."

With the exception of one individual that mentioned the assessment tool would be somewhat beneficial for their site, the rest of the individuals raised that the assessment tool was not particularly appropriate for primary care. Individuals highlighted that although there is a clear need for its use for the community, it is more appropriate for mental health and addictions services to be conducting the assessments. Refraining from the duplication of services was also cited as a key reason.

When asked of their next steps around the use of the assessment tool beyond the pilot, most individuals reported that it was not appropriate at this time. One individual surmised that if their site housed on-site mental health and addiction services (i.e., a "one-stop shop"), then perhaps adoption of the tool would be appropriate. In addition, this individual reported that staff consistency and stabilization, as well as becoming more familiar with the tools, would be required for it to be potentially sustainable.

SHARED CARE PATHWAY AND RELATIONSHIPS

Utilization

"Very satisfied with building connections. Great to see what others are doing."

All four individuals reported that they attempted to leverage opportunities to develop and/or strengthen relationships with their local mental health and addictions agencies, where possible. However, the individuals varied in degree of how those relationships were used and how those changed due to the pilot. Some individuals mentioned that existing shared care pathways were consistently used, and that there were already strong connections. Conversely, one individual mentioned that there was no movement in building a pathway.

Challenges

"Every site is on a different EMR. Client data has to be entered at every single site."

Of what was shared by the interviewees, three primary challenges in building and/or strengthening the shared care pathway were noted. One individual shared that the social determinants of health readily impact their patients' ability to access local services. Thus, their site's ability to cast a wider network of relationships was inherently limited by how far and how much their patients can access. Another challenge noted was staff's entrenched disinterest in past initiatives and resistance in changing the status quo (i.e., what they are used to). The third challenge was EMR/data system considerations, where linking data to sister sites would require a great deal of work around acquiring individual site permissions for downloading and accessing patient health information.

Facilitators

"Some staff from this site also work at other sites and can bring that knowledge to those sites."

There were two notable facilitators for building and/or strengthening the shared care pathway. The first was having many and/or existing relationships and leveraging them, which is more advantageous than having fewer and/or lack of existing relationships. The second was a training and knowledge exchange meeting, where staff from both primary care and mental health and addictions convened to share lessons learned. As a result of this meeting, staff learned more about other sites and local services, and were able to bring that knowledge back to other colleagues.

Sustainability

"Yes, there is a place. But we can't be the only one on board though."

All individuals agreed that a shared care pathway is both appropriate for, and a need, in their community. One individual further acknowledged that for communities with little to no clear pathways, the development of one would be beneficial. Another individual commented that knowledge of local services is important for patient care and that pathways can only be strengthened if primary care and mental health and addictions are committed to working together.

Some key considerations were highlighted when individuals were asked to share their thoughts around next steps beyond the pilot. The first was that the full potential of relationships and pathways was not realized during the pilot, as this will likely take a long time to come to fruition. This goes in hand with the second

consideration, which is the requirement for multiple community partners to be involved and committed, as a pathway cannot be developed alone. The third is the need for financial resources and increased capacity, in order to build a more streamlined EMR/data system that can easily track patients' health information and aid in transition planning.

CONCLUSIONS

LIMITATIONS

There were noteworthy limitations that may have impacted the findings of this report. The first of which stems from the scope of this evaluation. Given that a one-group, post-test only design was used (i.e., data was only collected at one point after the pilot was implemented), there is a risk of recall bias from the participants (inaccurate recollection of past experiences) and lack of strong evidence for change as a result of the pilot being implemented. As well, data for the site profiles was partially collected from readiness assessment surveys received in 2018, LHIN websites, and the main websites of the five primary care pilot sites, which may not be accurate during the time this pilot unfolded. This limitation extends to the data for the profile of the mental health and addictions agencies as well.

The second stems from the low sample size of participants, with only four individuals having participated in the survey and/or interviews. Due to this low number of responses, the results of the satisfaction survey were neither included nor used for analysis in this report. In reference to the interviews, the experiences and responses shared by each individual may not be entirely reflective of their respective site's experience and opinions, and may not be generalizable to other primary care sites outside of this pilot. As well, these opinions may not be representative of the true context across each of the five primary care pilot sites' implementation experience, as well as sites' individual staff experiences. Furthermore, time and resource constraints of the interviews may not have allowed a fuller exploration and understanding of participants' experience with the pilot.

Last was COVID-19, which impacted the way health and mental health and addictions care was being delivered, upon announcement of a state of emergency in Ontario in March 2020. As a result of this, individuals who were initially solicited for participation in either the survey or interviews were unable to participate due to COVID-19 related priorities and commitments (i.e., redeployment) that required their immediate attention.

A pre-test, post-test evaluation design may have allowed a greater understanding in any potential change occurring at the primary care pilot sites before and after pilot implementation. Additionally, a larger sample size of participants, in both the survey and interviews, would have revealed a greater detail of the context of each pilot site and any differences in individual staff experiences. This would have enabled the inclusion and analysis of the satisfaction survey results, which could have been used to triangulate with the qualitative data, thereby strengthening the findings. As such, it would have been preferable to begin recruitment of the participants in the survey and interview before funding for the pilot implementation had ended in March 2020; though, this timing would also have been impacted by COVID-19. Administrating the survey and interview beforehand may have mitigated the low sample size if more individuals participated prior to COVID-19 unfolding.

LESSONS LEARNED

Screening tools (GAIN-SS CAMH Modified, MMS)

- Although there was very little to lack of use of the screening tools in the primary care pilot sites, three of the four interviewees acknowledged that it can be useful and important in primary care. More time, resources, and buy-in are likely required to witness more adoption of the tool in primary care, if enabled.
- The screening tools may not initially appear to be as valuable for communities with low demand (i.e., low patient referral) or smaller communities where the primary care providers already have an established and strong understanding of their patient population. Different implementation strategies may need to be employed to highlight the (add-on) value of the tool in these settings.

Assessment tool (GAIN Q3 MI ONT)

- The assessment tool does not appear to be a good fit in primary care at this time due to a number of factors. These include the fact that there is limited staff capacity to deliver the assessments and that the local mental health and addictions agencies have better expertise and capacity to conduct them.
- The assessment tool, however, may be appropriate in settings with on-site mental health and addictions services (i.e., a "one-stop shop"). This may be important to consider in communities with lesser diversity in mental health and addictions service types, as identified in Table 2 and 3 of this report. To highlight an example, it was identified that there is no agency specializing in community withdrawal management in three of the five primary pilot sites' regional catchment area.
- A scan of the profile of local mental health and addictions agencies at the pilot sites speaks to the availability and capacity of providers who have greater expertise in administering the assessment tool.
- Of those who were trained to use the assessment tool, they acknowledged that it does indeed provide further depth and understanding of the patient's health and treatment planning.

Shared care pathway and relationships

- Building a shared care pathway with little to no existing relationships can be challenging.
- A considerable amount of time is required for relationships and the shared care pathway between primary care and their local mental health and addictions agencies to reach their full potential. As such, the timeframe of this pilot was not long enough to witness the pathway's fruition for each of the primary care pilot sites.
- A scan of the profile of local mental health and addictions agencies at the pilot sites speaks to the potential of a large range of relationships and pathways that can be created. However, this is challenged by the little context revealed as to what can be done to build and/or strengthen this pathway, given the short timeframe of the pilot. It is noteworthy that developing trust and rapport to strengthen the pathway requires consistent and committed effort from all parties involved.

Staff engagement

- The level of staff engagement for the pilot (to either the adoption of the screening tools, the assessment tool, and/or building a shared care pathway) can be dependent on a number of factors. These include perceived ease of using the tools and/or building a shared care pathway (e.g., appropriate language translation), how readily they are able to adopt (e.g., staff capacity, EMR/data systems are compatible), and perceived importance and need at their primary care organization and/or community.
- Staff engagement and knowledge may be improved through participation in lessons learned and knowledge exchange interactions between primary care and mental health and addictions providers.
- Continued and consistent implementation support can foster staff engagement.

EMR/Data systems

- There are challenges around the integration of the screening tools into existing EMR/data systems of the pilot sites, and these challenges may vary from site to site.
- Continued engagement (e.g., staff buy-in, champion for initiatives) and implementation support may mitigate these challenges by championing the need for, and importance of, integrating the screening tools into sites' EMR/data systems.

RECOMMENDATION

To recap, the primary goals of *Tier 2 of the Opioid De-Implementation Initiative* were twofold: (1), to enhance coordination and collaboration between primary care and the publicly funded community addiction sector; and (2), to enhance capacity of the primary care pilot sites to identify mental health and addiction issues and connect patients with appropriate services.

Two key activities would aid in realizing these goals:

1. Supporting implementation of the Staged Screening and Assessment Tools (GAIN-SS CAMH Modified, MMS, and GAIN Q3 MI ONT) in the primary care pilot sites.
2. Co-developing a referral/shared care pathway between the primary care pilot sites and their respective local addictions agencies

Based on the limited findings and low sample size of this report, further investigation is needed to explore the value of the screening tools in primary care. Although there was evidence of little to no utilization of the screening tools among the four individuals interviewed, there was acknowledgement that it can be useful and important in primary care. There appears to be some potential of the screening tools' usage in primary care, provided there is staff buy-in, patient demand, and the necessary infrastructure (EMR/data systems) in place.

As for the assessment tool, it is also recommended to further explore its value within primary care. Although the limited findings from the four interviews suggest that there is little to no interest in its continued use at their sites, this may not be generalizable for primary care as a whole. The assessment tool may be considered for continued use in primary care only if it is appropriate and necessary, such as for primary care sites with on-site mental health and addiction services (i.e., a "one-stop shop"). While the

assessment tool does provide a deeper understanding of patients' health and treatment planning, a great deal of expertise and capacity is required for its conduct. For both the screening and assessment tools, it is noteworthy that any future investigation during the climate of COVID-19 may be challenging (e.g., participation in implementation and evaluation) if any, due to there being COVID-19 related priorities and commitments (i.e., redeployment) being experienced by the health care system.

Last, it is recommended to consider the continued and expanded development of a shared care pathway between primary care sites and their local mental health and addictions agencies, recognizing an extended period of time is required to witness the pathways' fruition. Given that there was little context revealed as to what can be done to build and/or strengthen this pathway, further investigation is needed. There was acknowledgement among all interviewees that building and/or strengthening this pathway and relationships is valuable, thereby warranting its further exploration.

APPENDIX

EVALUATION FRAMEWORK

Opioid De-Implementation Initiative (Tier 2): An evaluation of the pilot implementation of the Staged Screening and Assessment Tools in primary care and building a shared care pathway

Overall Program Goals:

1. Implement the use of the Staged Screening and Assessment Tools (GAIN-SS CAMH Modified, MMS, and GAIN Q3 MI ONT) in primary care (5 pilot sites)
2. Build a referral/shared care pathway between the primary care sites (5 pilot sites) and the local addictions agencies

Evaluation Goal:

1. Understand how the pilot, with the above program goals in mind, was implemented in each of the primary care pilot sites

Evaluation Questions	Sub-Evaluation Questions (if applicable)	Measures	Data Sources
Implementation Outcomes			
What is the profile of the local addictions agencies in the communities of the primary care pilot sites?		• # of local addictions agencies in each community • Count and frequency of local addictions agencies in each community by type • Staff description of local addictions agencies in respective community	• Document review (e.g., training tracking sheet, readiness assessments, agency action plans, project updates) • Secondary administrative data (e.g., public health unit websites) • Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs

What is the profile of each of the primary care pilot sites involved?		• # of site interviewers • # of local trainers • # of staff at each site • Type of staff roles • Patient volume • Catchment area • Staff description of site profile	• Document review (e.g., training tracking sheet, readiness assessments, agency action plans, project updates) • Secondary administrative data (e.g., public health unit websites) • Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
How has the program been implemented?	How are clients being screened and/or assessed?	• Screening processes of clients • Assessment processes of clients	• Document review (e.g., training tracking sheet, readiness assessments, agency action plans, project updates) • Qualitative interview with site interviewers • Qualitative interview with local trainers
	What is the level of adoption of the program (Was it being used? To what extent?)	• Utility of screening tools (GAIN-SS CAMH Modified and MMS) • Utility of assessment tool (GAIN Q3 MI ONT) • Capacity in building a shared care pathway	• Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
	What is the level of appropriateness of the program's implementation in primary care?	• Appropriateness of screening tools (GAIN-SS CAMH Modified and MMS) • Appropriateness of assessment tool (GAIN Q3 MI ONT) • Appropriateness of building a shared care pathway with local addictions agencies	• Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
	Which components of the program are working well? Not working well?	• Benefits of Tier 2 of the Opioid De-	• Qualitative interview with site interviewers

		Implementation initiative • Drawbacks of Tier 2 of the Opioid De-Implementation initiative	• Qualitative interview with local trainers • Qualitative interview with site EDs
	What was the implementation experience like for the staff at the primary care pilot sites?	• Staff's experience of implementation of Tier 2 of the Opioid De-Implementation initiative	• Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
	What was training and orientation to the program like for the staff at the primary care pilot sites (Specific to available supports and capacity)?	• Staff's experience of training and orientation to Tier 2 of the Opioid De-Implementation initiative	• Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
	What factors impeded or facilitated the delivery of the program?	• Barriers of Tier 2 of the Opioid De-Implementation initiative • Facilitators of Tier 2 of the Opioid De-Implementation initiative	• Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
Service Outcomes			
To what extent were staff at the primary care pilot sites satisfied with their participation of the program?*		• % of staff satisfied with program participation • Staff satisfaction of program participation	• Satisfaction survey with site interviewers • Satisfaction survey with local trainers • Satisfaction survey with site EDs • Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
To what extent do staff at the primary care pilot sites perceive whether program continuation is important (among the Ministry of Health's priorities) and relevant to the needs of clients in their community?		• % of staff's perception of the importance of program continuation in primary care • % of staff's perception of program need in their community • Staff perception of the importance of program	• Satisfaction survey with site interviewers • Satisfaction survey with local trainers • Satisfaction survey with site EDs • Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs

		• continuation in primary care • Staff perception of program need in their community	
How is the program affecting staff at the primary care pilot sites?	Were there positive effects?	Positive effects of Tier 2 of the Opioid De-Implementation initiative	• Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs
	Were there negative effects?	Negative effects of Tier 2 of the Opioid De-Implementation initiative	• Qualitative interview with site interviewers • Qualitative interview with local trainers • Qualitative interview with site EDs

Data sources legend: Specific measures may be captured by specific data sources as indicated by the font color (Document review – Orange; Qualitative interviews – Green; Satisfaction surveys - Blue). Black font indicates that multiple data sources may capture information for one or more specific measure(s).
Footnotes: * While satisfaction is a subjective measure, it is important to collect information on attitudes (i.e., feelings, values, beliefs) even if the program does not have any affective goals. Programs produce attitudes, which may influence program implementation. Satisfaction with respect to the involvement and functioning of staff's roles in implementing the program is captured according to the following domains: orientation and support, screening and assessment processes, and relationships and communication.

SATISFACTION SURVEY

Questions	Responses
In reference to Tier 2 of the Opioid De-Implementation initiative *(implementing the Staged Screening and Assessment Tools (SS&A) in primary care and building a shared care pathway with the local addictions agencies*), please rate your satisfaction of the following: **Orientation and Support** 1. Receiving accurate information about this initiative 2. Being able to understand the information about this initiative 3. The training and onboarding sessions associated with the site interviewer certification process 4. The training and onboarding sessions associated with the local trainer certification process 5. The supports and resources available to me to carry out my role in this initiative (e.g., CAMH-PSSP support and coordination) 6. My capacity to participate in this initiative, specific to my role and responsibilities **Screening and Assessment Processes**	**5-point Likert Scale:** • Very Satisfied • Satisfied • Neither satisfied nor dissatisfied • Dissatisfied • Very Dissatisfied • N/A (Option available for Questions 4, 8, and 10)

7. Using the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)* at my primary care organization 8. Using the *Staged Assessment Tool (GAIN Q3 MI ONT)* at my primary care organization 9. The data system/platform (e.g., Catalyst, DATIS) used to document and track results from client screenings 10. The data system/platform (e.g., Catalyst, DATIS, GAIN ABS) used to document and track results from client assessments *Note: Those who answer dissatisfied or very dissatisfied to questions 7-10 will be prompted an open-ended question to clarify the reasoning behind their response.* **Relationships and Communication** 11. The development of a shared care pathway between my primary care organization and the local addictions agencies in my community in relation to this initiative 12. The relationship my primary care organization has with the local addictions agencies in my community 13. Having the opportunity to share my feedback around this initiative at my primary care organization 14. Being involved in decision-making processes related to this initiative at my primary care organization 15. Communication between those involved with this initiative at my primary care organization and in my community (e.g., frequency of communication, notification of updates, etc.)	
Please select the response that best represents your opinion on the following statements: 1. There is a need for a shared care pathway between primary care and local addictions agencies in my community 2. There is a need for using the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)* at primary care organizations in my community 3. There is a need for using the *Staged Assessment Tool (GAIN Q3 MI ONT)* at primary care organizations in my community 4. Among the Ministry of Health's priorities that I am aware of, continuing to establish a shared care pathway between primary care and local addictions agencies is important 5. Among the Ministry of Health's priorities that I am aware of, continuing to implement the use of the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)* in primary care is important 6. Among the Ministry of Health's priorities that I am aware of, continuing to implement the use of the *Staged Assessment Tool (GAIN Q3 MI ONT)* in primary care is important	**5-point Likert Scale:** • Strongly Agree • Agree • Neutral • Disagree • Strongly Disagree
Is there anything else you would like to share?	**Open-Ended Text**

INTERVIEW GUIDE (SITE INTERVIEWER AND LOCAL TRAINER)

Great, let's get started:

Question	Probe
Can you tell me about the Opioid De-Implementation initiative you participated in?	N/A

Let's talk a little more about your organization and the community it serves:

Question	Probe
What are the local addictions agencies like in your community (e.g., what types, large/small)?	N/A
Can you tell me about your primary care organization (e.g., large/small, patient volume/type, programs offered)?	N/A

Now let's talk about initiative itself:

Question	Probe
Can you describe what your experience was like for any type of training or orientation you were involved with?	• Can you tell me more about the types of support, if any, that were available to you? • How did this affect your capacity in your role? • Is there anything that you would change to make the process better?
Can you walk me through the process of screening clients? What about the process of assessing clients?	• Can you tell me more about the data system or platform (e.g., Catalyst, DATIS) used to document and track the results from screening and assessment?
How was it like for you to use the staged screening tools (GAIN-SS CAMH Modified and MMS)? What about using the staged assessment tool (GAIN Q3 MI ONT)? In what way has this initiative contributed to building a shared care pathway with the local addictions agencies?	• How has this changed over time (i.e., from the start of implementation to now)? • Why/why not do you continue to use the screening tools? The assessment tool? • Can you speak to why usage for the GAIN Q3 was low? What do you think caused this?
Can you tell me what worked well with using the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)*? What didn't work well? Can you tell me what worked well with using the *Staged Assessment Tool (GAIN Q3 MI ONT)?* What didn't work well?	N/A

Can you tell me what worked well with building a shared care pathway with the local addictions agencies in your community? What didn't work well?	
What was helpful for you in using the Staged Screening Tools (GAIN-SS CAMH Modified, MMS)? What challenges did you encounter? What was helpful for you in using the Staged Assessment Tool (GAIN Q3 MI ONT)? What challenges did you encounter? What was helpful for building a shared care pathway with the local addictions agencies in your community? What challenges did you encounter?	N/A

We'll go into questions regarding your experience about having participated in the initiative:

Question	Probe
What was your overall experience like during the implementation process of this initiative?	• Is there anything that you would change to make the process better?
How would you describe your general level of satisfaction towards your participation in this initiative?	• Is there anything that you would change to make the process better?
What are your thoughts around whether this initiative is appropriate for your primary care organization, with respect to: • Using the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)?* • Using the *Staged Assessment Tool (GAIN Q3 MI ONT)?* • Building a shared care pathway with the local addictions agencies in your community?	N/A
Was there anything positive that happened because of this initiative? Was there anything negative that happened because of this initiative?	• What do you think caused this? • How did this affect the relationship you have with the local addictions agencies? • How did this affect the shared care pathway? • How did this affect the way the SS&A tools were used? • How did this affect quality of patient care?

Last, we'll go into the remaining questions regarding the future of the initiative:

Question	Probe

What are your thoughts around whether this initiative should continue to be implemented in a primary care setting (e.g., scaling up, increased funding)?
 	
What are your thoughts around whether this is a need in your community?
	• Can you speak to more about:
	  ○ Building a shared care pathway with the local addictions agencies
	  ○ The use of staged screening tools
	  ○ The use of the staged assessment tool
	• Among the Ministry of Health's priorities that you may be aware of, how important is this initiative?
	• Where does your primary care organization currently stand in continuing with this initiative?

Is there anything else you would like to share?	N/A

INTERVIEW GUIDE (EXEUCTIVE DIRECTORS AND SS&A/TIER 2 LEAD)

Great, let's get started:

Question	Probe
Can you tell me about the Opioid De-Implementation initiative you participated in?	N/A

Let's talk a little more about your organization and the community it serves:

Question	Probe
What are the local addictions agencies like in your community (e.g., what types, large/small)?	N/A
Can you tell me about your primary care organization (e.g., large/small, patient volume/type, programs offered)?	N/A

Now let's talk about initiative itself:

Question	Probe
Can you describe what your experience was like for any type of training or orientation you were involved with?	• Can you tell me more about the types of support, if any, that were available to you? • How did this affect your capacity in your role?

	• Is there anything that you would change to make the process better?
How are staff using the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)?* How are staff using the *Staged Assessment Tool (GAIN Q3 MI ONT)?* In what way has this initiative contributed to building a shared care pathway with the local addictions agencies?	• How has this changed over time (i.e., from the start of implementation to now)? • Why/why not do you continue to use the screening tools? The assessment tool? • Can you speak to why usage for the GAIN Q3 was low? What do you think caused this? • Can you tell me more about the data system or platform (e.g., Catalyst, DATIS) used to document and track the results from screening and assessment?
Can you tell me what worked well with using the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)*? What didn't work well? Can you tell me what worked well with using the *Staged Assessment Tool (GAIN Q3 MI ONT)?* What didn't work well? Can you tell me what worked well with building a shared care pathway with the local addictions agencies in your community? What didn't work well?	N/A
What was helpful for your primary care organization in using the Staged Screening Tools (GAIN-SS CAMH Modified, MMS)? What challenges did you encounter? What was helpful for your primary care organization in using the Staged Assessment Tool (GAIN Q3 MI ONT)? What challenges did you encounter? What was helpful for building a shared care pathway with the local addictions agencies in your community? What challenges did you encounter?	N/A

We'll go into questions regarding your experience about having participated in the initiative:

Question	Probe
What was your overall experience like during the implementation process of this initiative?	• Is there anything that you would change to make the process better?
How would you describe your general level of satisfaction towards your participation in this initiative?	• Is there anything that you would change to make the process better?
What are your thoughts around whether this initiative is appropriate for your primary care organization, with respect to: • Using the *Staged Screening Tools (GAIN-SS CAMH Modified, MMS)?* • Using the *Staged Assessment Tool (GAIN Q3 MI ONT)?* • Building a shared care pathway with the local addictions agencies in your community?	N/A
Was there anything positive that happened because of this initiative? Was there anything negative that happened because of this initiative?	• What do you think caused this? • How did this affect the relationship you have with the local addictions agencies? • How did this affect the shared care pathway? • How did this affect the way the SS&A tools were used? • How did this affect quality of patient care?

Last, we'll go into the remaining questions regarding the future of the initiative:

Question	Probe

What are your thoughts around whether this initiative should continue to be implemented in a primary care setting (e.g., scaling up, increased funding)?
 	
What are your thoughts around whether this is a need in your community?
	• Can you speak to more about:
	  ○ Building a shared care pathway with the local addictions agencies
	  ○ The use of staged screening tools
	  ○ The use of the staged assessment tool
	• Among the Ministry of Health's priorities that you may be aware of, how important is this initiative?
	• Where does your primary care organization currently stand in continuing with this initiative?

Is there anything else you would like to share?	N/A

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