META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION
PARTNERS IN HEALTH INTEGRATION

NEWSLETTER

PROGRAM INNOVATION

Timmins Acute Medical Withdrawal Management Program

Louisa Marion-Bellemare MD CCFP
Julie Samson MD CCFP(EM)
Family Physicians, Timmins

By the spring of 2020 the opiate poisoning crisis in Ontario had escalated across the province, including our city of Timmins. Our emergency room at the Timmins & District Hospital saw increasing numbers of overdoses requiring resuscitation and Narcan. The situation was desperate and immediate action was needed to address the need for acute treatment of patients with OUD. We organized an online crisis meeting for administrators and leaders and presented a detailed report to Timmins City Council.

As a result, our hospital agreed to fund two acute medical withdrawal management beds, as there was no access to medical detox in our city or district. Our hospital funding for AMCT (Addiction Medical Consultation Team) coincided with the opening of these beds, allowing us to initiate comprehensive care of people with mostly opiate use disorder.

Our multidisciplinary team - including a supportive nursing staff - developed an innovative approach to rapidly induce patients with sublingual buprenorphine to 32 mg within 1-3 days, followed by a buprenorphine depot injection prior to discharge at day 2-4. In the 5 months from the opening of these two detox beds in December 2020, we treated a total of 53 patients with OUD, and 68% received depot buprenorphine. The average length of stay was 3.3 days. With this rapid titration approach to OUD, what typically would take days or weeks is now accomplished in a much shorter time. And the faster bed turnover allows us to provide lifesaving treatment to more patients.

To provide a complete circle of care, our team also coordinates social issues and ensures appropriate discharge planning and follow-up, including referral to hospital-based Community Withdrawal Management services, RAAM clinics, and other medical addiction clinics.

We are currently in the process of performing a 6-month chart review to assess treatment retention, dropout rates and treatment satisfaction, with the goal of gathering similar data at 1 year. While we are pleased with the success of the inpatient depot buprenorphine administration so far, there is much work to be done to build expanded addiction services for people in the Timmins area. We are just getting started!

(See media link at bottom of newsletter for further information.)

FACES OF THE FIELD

Alexander Caudarella MDCM CCFP ABAM (dipl)
Substance Use Physician, Toronto

I really like working in the substance use field! People come to you with hopes, goals and dreams they want help refining or achieving, and your only responsibility is to use the tools you have to help make them come true. No other area of medicine encourages you to centre the voices of the people and clients you work with quite as much. However, during this tragic and ongoing opioid crisis, an increasingly toxic and potent drug supply can make these goals feel harder and harder to achieve.

As the medical director of substance use services at Toronto's St. Michaels Hospital and the physician lead for substance use at Inner City Health Associates (ICHA), I've had the unique opportunity to work with amazing colleagues to try and lower barriers and improve access to care during this pandemic. With 200 physicians and nurses, ICHA along with partner organizations provides primary healthcare services to homeless and precariously housed individuals across Toronto.

I'm excited to say our most recent project will launch this summer: the ICHA/ Inner City Family Health Team Substance Use Hub. This hub aims to centre as many of a person's goals as possible under one roof. Services will include substance use treatment, harm reduction, mental health and primary care both on-site and in outreach. Most importantly, the hub will focus on building provider capacity through shared care, outreach and teaching.

There are hundreds of physicians and nurse practitioners working in the various shelters/hotels in Toronto, and the only hope at successfully tackling this crisis is if most people are able to provide quality care to people who use drugs.

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Join the META:PHI Google group:
E-mail laurie.smith@wchospital.ca to be added.

EVENTS

RAAM monthly videoconferences will resume in September

Nurses	Sept 8	9 am
Counsellors	Sept 10	9 am
Prescribers	Sept 14	8 am

META:PHI Webinar Sept 8 7 pm

META:PHI Conference Sept 24 -25
Online registration available soon

PERSPECTIVES

What it's Like to Start Working in Addictions Medicine, with Big Ideas

Jonny Grek, Family Physician and NOSM Faculty
Kenora, ON

As a young physician with ideas aplenty, you want to make a difference in this human tragedy (the opiate epidemic). A tragedy that, when I was training in the UK, was really only considered a major problem '*over there*'.

Arriving in Kenora, Northwestern Ontario, with fresh-faced enthusiasm (and naivety) I figured I'd give it a go at making a difference.

As I soon discovered, however, the world of addictions medicine is a tough place to practice - especially during the height of the dual '-demics' (opiate & COVID). Too many barriers, too many lives lost, and too many sleepless nights wondering who will be next. All amongst a backdrop of an "institutionalized contempt for the poor".

In Kenora, we have opiate agonist therapy (OAT) prescribers, but few pharmacists able to dispense it. Most local pharmacies do not have the capacity to provide daily observed therapy; and many individuals on OAT have been banned from pharmacies (and/or the supermarkets in which they are situated) due to erratic behaviour. '*Those people*' want to live and they want to be on buprenorphine. But they cannot behave like the rest of us - so they get fired, banned, or just swept aside. Patients are not allowed to make mistakes, especially not '*those*' patients.

I've been told to just accept this and move on.

So I did – by applying for and receiving a grant through Northern Ontario Academic Medicine Association (NOAMA). Titled "Does employing a drug dispensing machine improve patient outcomes in an opiate agonist therapy program (suboxone) for patients with severe opioid use disorder: a prospective study", this project has the potential to change the narrative. What if we decrease the stigma and error potential by removing one of the human interactions in the chain, thereby not confining our patients to strict timelines and best behavior? Not because *they* cannot be trusted, but because *the system* cannot be trusted to be flexible to their needs in that moment. It's simple: turn up to the machine, scan your fingerprints, receive your daily buprenorphine, and leave - minimal room for frosty human interaction.

Trouble is, not everyone thinks like this. And not everyone wants you to succeed, especially in what can feel like the dog-eat-dog world of addictions. "Great idea - good luck with that"; "Horrible idea - good luck with that"; "Try not to care so much"; "Rather you than me, mate".

I just hope we can bring together enough energy to make the project take off, before the fatigue to make change becomes overwhelming. Just one last push, and we might be onto something…..

IN THE NEWS

Timmins Tag Team (Globe and Mail)

BC's Opioid Substitution System (The Tyee)

Opioid Crisis Requires Decriminalization (Toronto Star)

$4.5 Billion Deal with Purdue Pharma (New York Times)

Ontario Expanding Support for Addictions Treatment (Ontario.ca)

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Interested in being featured in a future issue? E-mail laurie.smith@wchospital.ca.