META:PHI
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION | PARTNERS IN HEALTH INTEGRATION
NEWSLETTER
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INPATIENT ADDICTION MEDICINE ISSUE

Changing the Way We Deliver Care at Health Sciences North

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During the Covid-19 pandemic, substance use increased in most parts of the province. Over the last three years at Sudbury's Health Sciences North (HSN), substance-use presentations increased almost 50 per cent in the Emergency Department; and across Northeastern Ontario, the leading cause of death for those under 50 is opioid overdose.

In response to this, and in an effort to better serve those who use substances, HSN introduced two programs – the Addictions Medicine Unit (AMU) in 2021, and the Addictions Medicine Consult Service (AMCS) in 2019. These programs have been pivotal in addressing the growing challenge of substance use disorders (SUDs). The specialized teams that make up these programs provide direct patient care but also enhance the overall approach to addictions medicine at the hospital through research and education, fostering a holistic and integrated healthcare environment.

The 20 bed AMU offers a dedicated space for patients who require more intensive care for their SUDs. The unit is designed to provide a safe and supportive environment where patients can receive concurrent treatment for both their medical condition and SUD. The AMU and AMCS clinical manager, Catherine Watson, describes the treatment approach as comprehensive, addressing both the physical and psychological aspects of addiction. The dynamic team includes physicians who specialize in addictions, addiction psychiatrists, nurses, addiction workers, a social worker, ward clerks, peer support, and community workers. Since its inception, the AMU has seen over 1,300 patients and was recently named a Leading Practice Organization by Accreditation Canada.

The AMCS is a multidisciplinary team, including addictions medicine specialists, a registered nurse, and a nurse practitioner, as well as access to addictions psychiatrists and a social worker. The team offers expert consultation for inpatients with SUDs, either as a primary issue or as a comorbidity, but for those who are generally more medically, socially and psychologically stable than patients requiring care on the AMU. The AMCS provides recommendations for medication management of withdrawal symptoms, initiates anti-craving medications for opioid and alcohol use disorders, and connects patients with outpatient treatment services and community resources upon discharge.

Beyond direct patient care, our teams play an educational role within the hospital through offering training sessions and workshops for other healthcare providers and learners, promoting best practices in managing SUDs, and participating in research. These activities help to establish best practices and to destigmatize addiction, encourage more proactive screening and intervention, and ultimately improve patient outcomes.

Early intervention and appropriate management of SUDs through these types of services can lead to reduced hospital readmissions, lower healthcare costs, and better overall health for patients. A recent peer-reviewed publication at HSN demonstrated that providing specialized addiction services like AMCS and AMU reduced the likelihood of patients returning to the Emergency Department within 30 days of initial presentation.

The AMU and AMCS are essential components of a comprehensive hospital-based approach to addressing SUDs. They provide critical care, educate other healthcare providers, contribute to the body of research aimed at improving patient outcomes, and foster a more inclusive and effective healthcare system. By prioritizing addiction medicine, hospitals can play a pivotal role in addressing the complex and pervasive challenge of SUDs.

Integrating Supervised Consumption Services into Acute Care Hospitals

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The Royal Alexandra Hospital is a large acute care hospital located in the heart of downtown Edmonton, Alberta. To better meet patient-identified needs, an inpatient addiction medicine consult service, the Addiction Recovery Community Health (ARCH) team, was launched in 2014. The team offers withdrawal management, substance use disorder treatment initiation, connection to community-based addiction and primary care, and a variety of health promotion and social services. Early qualitative evaluations of the team identified many benefits, however several opportunities for improvement were also noted (Hyshka 2019). These included expanding available interventions to include in-hospital supervised consumption services, managed alcohol protocols, injectable opioid agonist treatments, and the integration of peer support workers into the multidisciplinary team approach.

Based on this feedback, work began to offer supervised consumption services to admitted patients. A vacant ward was retrofitted to include an intake area, 2 consumption rooms (with 2 booths each), and a post-use monitoring area. One of the booths was designed to be wheelchair accessible. An exemption from the Controlled Drugs and Substances Act was granted by Health Canada to operate the site. After eligible patients sign an informed consent form and a patient agreement, they are able to access the service to use pre-obtained substances via intravenous, oral or nasal routes. The service opened to hospital inpatients on April 2, 2018 and the eligibility criteria were expanded to include emergency department patients on October 1, 2019 (Dong 2020).

Evaluation of the service from the patients' perspective identified many benefits (Kosteniuk 2021). These included preventing drug-related health risks for themselves (e.g., unattended overdose in hospital), hospital staff, other patients, and visitors (e.g., unsafe disposal of used supplies). Patients also felt protected from real or perceived social violence in the context of criminalization of substance use. Despite this, participants also worried that accessing the supervised consumption service may be associated with negative consequences such as being targeted by law enforcement or hospital protective services, experiencing stigmatization on the unit, or having pain or withdrawal medications changed. A lack of supervised inhalation was also identified as a barrier to accessing the service.

Further research on the impacts of the service is ongoing and includes examining staff perspectives and participant health impacts. Incorporating a space for inhalation use is a future goal to accommodate the changes in substance use patterns in the community.

After six years of operation, the service has become an integral part of the care provided at the Royal Alexandra Hospital. People who use drugs can require hospitalization for many different reasons and at any point in their recovery journey. Offering a supervised consumption service has been an important tool to mitigate stigma associated with substance use and provide a full and holistic continuum of evidence-informed treatments and services. It facilitates engagement with care, relationship building, and contributes to a safer experience for patients, staff, and visitors.

Save the Date: META:PHI Virtual Conference, April 4-5, 2025

A Pilot ACS at University Health Network with Lessons from A Scoping Review

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In January 2023, Toronto's University Health Network launched a pilot addiction consult service (ACS) to help meet Ontario Mental Health and Addictions programming needs in these key areas: in-hospital substance use disorder (SUD) assessment and diagnosis, withdrawal management, pharmacotherapy, community supports, harm reduction, and discharge planning (Englander 2019). The service was advertised through email communications with inpatient unit managers, departmental leadership, presentations at nursing and medical team rounds, and featured on the UHN intranet. Operated through the Centre for Mental Health, the ACS enables all inpatient providers to request a consultation by an addiction physician, representing the departments of Family Medicine, Internal Medicine and Emergency Medicine.

Funding is a commonly-cited barrier to the implementation, maintenance and evaluation of ACS programs (Priest 2019), and there is no established standard or published consensus on their functions. Therefore, a scoping review was completed to understand the broadly-reported outcomes related to ACS (Rodger 2024). The key areas addressed in publications were pharmacotherapy use, acute care resource use, and outpatient follow-up rates. Other areas included educational outcomes for medical trainees, multidisciplinary healthcare team provider perspectives (emphasizing non-addiction physician impressions), and patient perspectives. To evaluate the UHN program, we incorporated medication recommendations, hospital use metrics, follow up, and provider perspectives into the evaluation work, with data from chart review and provider surveys.

In total, the service received 379 pages and 263 consult orders between January and June 2023. Most referrals were for General Internal Medicine patients. Addiction consult patients were more likely to use multiple substances, which may reflect a more detailed substance use history. While there was no difference in self-discharge rates, consult patients had a longer median length of stay (LOS) compared to pre-program LOS, which could signal that engagement was impacted by specialist involvement. A key finding was that patients who received a consult were much more likely to leave the hospital with a prescription for medications for substance use, meeting the gap identified where hospital providers who did not have addiction training indicated they were not confident prescribing pharmacotherapy. Providers appreciated the ACS' collaborative approach and educational benefits of current, evidence-based guidelines. They also found the consultation program valuable in emphasizing and enhancing patient-centered care and quality, longer LOS, and discharge planning.

Efforts are ongoing to expand the service across UHN and add multidisciplinary team members. Providers highlighted the medical and social complexity of patients who use substances, which reinforces the need for multidisciplinary teams. While physician specialist consultation is an important start, robust programs should include peer support workers and allied health professionals to provide patient-centered, wrap-around care. Resource limitations continue to hinder the development, activities and outputs of addiction consult programs. These programs have evolved out of necessity to provide care for a marginalized patient population who are not receiving evidence-based care in hospitals (Fiscella 2020, Brothers 2021, Campopiano von Klimo 2024). We need to develop hospital-based standards for multidisciplinary addiction consult services to ensure they are resourced to provide holistic care and evaluate ongoing impacts.

Read the full scoping review: Inpatient Addiction Consultation: A Scoping Review

THOUGHTS FROM A SEMI-RETIRED ADDICTION DOCTOR

Methadone:Time to "Go faster and higher?"

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Medical Director, META:PHI

Early in my career as an addiction doctor we were taught to 'start low and go slow' when prescribing methadone. It takes a week or two for the liver to build the enzymes that metabolize methadone. This means that methadone levels build up in the blood stream, and a dose that is barely adequate on day 1 could be fatal by day 3.

This advice served us well for many years. Patients who were addicted to OxyContin reliably improved while on methadone. Most stopped OxyContin by the time their methadone dose reached 80-100 mg. Fentanyl users are still protected against overdose while on methadone, but evidence suggests they have high rates of early treatment drop out. In a population-based study of opioid agonist treatment in British Columbia between 2008 and 2018 (Kurz 2022), only 50% of people started on methadone reached a dose of 60 mg before dropping out; 60 mg is considered the minimally effective dose. The retention rate at three months was only 36%. Most patients who drop out do so in the first few weeks of treatment.

The large early drop-out rates reflect, at least in part, a failure of current dosing protocols. Starting doses are set at 30 mg (40 mg in the new BCCSU guidelines), with an increase of 10-15 mg every 3-4 days. Thus, it can take a week or more to get to a dose of 60 mg, which is nowhere near an optimal dose for most patients. As a result, patients get stuck in a doom loop: Early in treatment they miss a few doses because the dose is too low to give them relief, so they use fentanyl instead of going to the pharmacy. And, as per protocol, the clinician lowers the dose even further, causing the patient to miss more doses and eventually drop out of treatment.

The dosing protocols for initial titration and for missed doses were designed to prevent methadone toxicity. But people who use fentanyl are not likely to be harmed by accelerated dosing protocols, in which 80 mg is reached within days rather than weeks. There is incomplete, but considerable, cross tolerance between opioids. Fentanyl 100 mg is equivalent to 10,000 mg of morphine, whereas methadone 80 mg is equivalent to only 640 mg of morphine. Furthermore, the theoretical risks of methadone toxicity are vastly outweighed by the real and common harms of underdosing: treatment drop out, relapse, and overdose.

I expect that the current protocols will soon be updated. There have been calls for more rapid titration of methadone for people who use fentanyl (Buresh 2022), and studies are currently underway to establish the safety of accelerated protocols.

EVENTS

2024 Webinar Series - Session #6
IABCs of Drug Testing– Understanding What a Test Can and Cannot Tell You
Melissa Snider-Adler
Wed Sept 18, 7-8:30 pm Register HERE

RAAM Monthly Videoconference Dialogue Series
Wed Sept 11, 12-12:45 pm

Addiction NP Videoconference Discussion
Wed Sept 25, 12-1 pm

To join any of these events contact laurie.smith@wchospital.ca