META:PHI NEWSLETTER
MENTORING, EDUCATION, AND CLINICAL TOOLS FOR ADDICTION — PARTNERS IN HEALTH INTEGRATION
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PROGRAM INNOVATION

These Pills & Booze *DO* Mix: The Toronto Community Hep C Program and Moss Park CTS Mobile Crisis Response Team

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The Toronto Community Hep C Program (TCHCP) focuses on meeting people where they are. Often, this means ensuring barriers to care are addressed and, when possible, dismantled to ensure equitable, high quality, and responsive care. Sometimes, meeting people where they are at is geographic, as seen with the co-location of care in places where people already access services.

The Moss Park Consumption and Treatment Service (CTS), administered by South Riverdale Community Health Centre, works closely with the TCHCP. A specialized Hep C nurse and support workers with lived experience are on site weekly. They provide low barrier access, supported by research, and co-developed with people with lived experience of HCV.

The success of the program lies in the fact that the team is embedded in the community. In partnership with community organizations, and through taking time to develop relationships with people, the TCHCP connects people with treatment, wherever they may be. They support the relationships people already have, and develop new ones within the context of health care delivery that listens to, and is informed by the experience of people living with hepatitis C. Working to a full scope of practice and supporting outreach workers to provide testing and treatment navigation, the TCHCP nurse draws blood work, communicates results, and initiates Hep C treatment. Partnering with infectious disease and hepatology specialists, the TCHCP team treats people with complicated clinical presentations and those who are not treatment naive. They provide comprehensive STBBI testing, treatment, monitoring, and proof of cure testing, recognizing that HCV does not exist in isolation and transmission dynamics often point to shared exposure risks.

As a flexible and mobile model of care, the TCHCP often works within the community and meets people where they are living or staying: offering testing and treatment to their extended network, and providing on-treatment support around medication adherence while also engaging multidisciplinary teams to enhance financial, social, and medical stability. Deeply invested in community development, the TCHCP also provides clinical support and guidance to providers interested in HCV care. In recent years, the TCHCP team has provided mentorship to the nursing team at Moss Park CTS to increase the availability of testing and care to people accessing services at the CTS. This partnership supports increased continuity of care and helps to decrease barriers for those seeking care.

There are no expectations or requirements around people's substance use to access the supports offered by the TCHCP, or to engage in treatment. It's about supporting people where they're at, finding acceptance there, and delivering the high quality of care that they deserve.

Key references:

Understanding real-world adherence in the directly acting antiviral era: A prospective evaluation of adherence among people with a history of drug use at a community-based program in Toronto, Canada (K. Mason, et al., International Journal of Drug Policy (2017), http://dx.doi.org/10.1016/j.drugpo.2017.05.025)

Peer outreach point-of-case testing as a bridge to hepatitis C care for people who inject drugs in Toronto, Canada (J. Broad, et al., International Journal of Drug Policy (2020), https://doi.org/10.1016/j.drugpo.2020.102755

Integrated supervised consumption services and hepatitis C testing and treatment among people who inject drugs in Toronto, Canada: A cross-sectional analysis - Models of care delivery (Z. Greenwald, et al., Journal of Viral Hepatitis (2022), https://doi.org/10.1111/jvh.13780

Rapid hepatitis C virus point-of-care RNA testing and treatment at an integrated supervised consumption service in Toronto, Canada: a prospective, observational cohort study (B. Lettner, et al., The Lancet Regional Health Americas (2003), https://doi.org/10.1016/j.lana.2023.100490

FACES FROM THE FIELD

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In my role as a nurse practitioner working with the Royal Ottawa Mental Health Centre and Montfort Renaissance Inc., I provide care at the Ottawa Withdrawal Management Centre (OWMC), a 28-bed non-medical residential withdrawal management facility, as well as at two residential stabilization programs (two 10-bed facilities with stays of up to 3 months), and at the Royal's RAAM Clinic. I am fortunate to be able to provide access to evidence-based interventions including alcohol withdrawal management, provision of anti-craving medications, and initiation of Opioid Agonist Treatment. When time permits, I also address various primary health care concerns and concurrent mental health conditions.

Before my integration as an NP within the OWMC, there were many missed opportunities to initiate evidence-based treatments such as suboxone or methadone for opioids, and naltrexone or acamprosate for alcohol. Additionally, there were many preventable and costly emergency department visits for poorly controlled withdrawal symptoms or to obtain an appropriate diazepam taper prescription prior to a client's admission to the withdrawal management program. We all know that people who use substances often experience stigma and discrimination when seeking care at hospital - not to mention the increasing burden on emergency departments since the Covid-19 pandemic. I am heartened that I have been able to reduce the centre's reliance on the ED and improve the quality of care within the organization. However, it can be challenging being the only healthcare provider on site, and I am simply unable see all of the clients during their short stays. We desperately need more funding for addictions care in Ontario and the rest of Canada.

I started working in the addiction field as part of my first job as a registered nurse in a harm reduction-based HIV clinic. In that role I helped create a RAAM clinic pathway and a supervised consumption service. Upon completing the NP program, I found a job posting for my current role, which was exactly what I was looking for - a nurse practitioner position in addiction medicine. One of my mentors once made the analogy that the field of addictions is like a microscope under which we can examine the effects and the importance of the social determinants of health more closely. The complex interplay of these factors makes each individual so unique and interesting to work with.

Working in this field has allowed me to be part of so many individual journeys to better health and wellbeing, whatever that may mean to each person. It is the kindness, gratitude, and steadfast determination of my clients that fuel me to continue working in this rewarding field.

In the Media

Addiction Medicine Consult Services in Atlantic Canada Filter

PERSPECTIVES

Iron Sharpens Iron: Solutions for Interprofessional Collaboration with Community Pharmacists

Ainko Ramanathan MPharm, PharmD, RPh
Clinical Pharmacist (Mental Health), Niagara Health

In the community, prescribers and pharmacists work in silos with the prescription being the primary, if not only, mode of communication between each other. This suffices in most cases but depends on the prescriber anticipating every barrier to the patient receiving their medication, such as back orders, LU codes, insurance coverage, allergies and interactions, human error, etc. With Opioid Use Disorder (OUD), this workflow can be the difference between a patient receiving treatment or not, which can also be equated to life or death. I feel interprofessional collaboration is the first step to adapting workflow to meet patients' needs.

Inpatient care in hospital settings leverages the strength of interdisciplinary teams as opposed to a physician alone. Order sets are one tool used in hospitals that can be adopted in the community care setting. The algorithmic instructions approved by the prescriber in hospital allows nurses to make decisions for their patients in real time when needs are expressed. Like nurses, community pharmacists are armed with an arsenal of medications (certainly more than any pyxis machine). But pharmacists do not have the scope to administer them without a prescription.

In OUD, buprenorphine-based inductions are especially tricky as there is risk of precipitated withdrawal. For patients receiving virtual care, micro or macroinductions are difficult if the prescriber is not there to address their symptomatic needs; however, pharmacists must always be present if medications are being dispensed to patients. An order set in the community can act like a medical directive allowing pharmacists to provide specific medications when needed. For example, an order set to micro-induct a patient onto buprenorphine could look like this: *If your patient experiences nausea, give ___mg dimenhydrinate or ondansetron; for pain, give ____mg acetaminophen +/- or an NSAID; sweating ___ mg clonidine or oxybutynin; uncontrolled withdrawal symptoms - buprenorphine ___ mg.*
This would have been helpful in a situation where I was given a prescription for a buprenorphine microinduction. There was little guidance except for the patient to follow the buprenorphine titration protocol, and hydromorphone to be taken if experiencing symptoms of withdrawal. It did not succeed, and I felt like we had failed the patient.

A similar approach is already being adopted in Edmonton, Alberta. At CSAM 2021, Dr Matt Rose presented his model where he provided a pharmacy team an algorithm for assessing and dispensing Kadian to methadone patients. If a patient presents to the pharmacy and is in withdrawal despite their methadone dose, the pharmacist follows the algorithm laid out by the physician. By doing so, the pharmacist is able to meet the needs of the patients in a manner that the physician would if they were there.

Another adoption of the hospital system is to discuss the treatment plans and needs of mutual patients with pharmacists, like rounds. Recognizing that this cannot be done for every patient, inclusion/exclusion criteria could be set to target those patients who would benefit the most. I have informally done this with physicians and often find this simple collaboration helps us better understand what would benefit a particular patient. Of course it would be impossible for physicians to act on these suggestions with every pharmacist they interact with. It is more realistic to focus efforts with pharmacists/a particular pharmacy that fulfils the needs of the patients.

Speaking from my own experience as a mentor to pharmacy students, I've noticed a positive trend where the students are already compassionate and motivated to help those with OUD despite the limited academic exposure they have (relative to other subjects). This is a stark difference from the sentiments I heard during my time in pharmacy school. For example, one student I know volunteers at a safe injection site. This to me shows we have come a long way. Now is the time for addiction physicians to form connections with pharmacists who are equally passionate about addressing the opioid crisis. By forming clinical partnerships outside of our walls, we can reduce stigma, improve the experience of our patients, and change the way we practice healthcare in the community. It is time to strike while the iron is hot.

Thoughts from a Semi-Retired Addiction Doctor

Methadone - the Forgotten Drug?

Meldon Kahan MD CCFP FRCPC
Medical Director, META:PHI

It appears that many newer Opioid Agonist Treatment (OAT) providers are reluctant to prescribe methadone, preferring buprenorphine as the first line OAT medication. Buprenorphine is of course safer than methadone; it is unlikely to suppress respiration even if taken in high doses. This means that it is safer to prescribe take-home doses of buprenorphine, even early in treatment. This has implications for staffing – RAAM clinics don't need a prescriber on site every day for buprenorphine scripts, whereas patients on daily observed methadone sometimes need same-day prescriptions because they have missed several days or their clinic appointment.

However, methadone is still a critically important OAT medication, especially for people who use fentanyl. There is good evidence that methadone has higher treatment retention rates than sublingual buprenorphine, probably because it is more potent than buprenorphine at higher doses, and thus more effective at relieving withdrawal symptoms and cravings.

Also, methadone is easier to start, as there is no concern about precipitated withdrawal. Methadone is titrated more gradually than buprenorphine because it accumulates in the serum over several days; adding Slow-Release Oral Morphine (SROM) can help relieve withdrawal symptoms until the methadone reaches a therapeutic dose.

Methadone has a reputation as a dangerous drug that should only be prescribed by specially trained clinicians. For many years, the CPSO required physicians to pass a special course, and it audited them yearly to check for compliance with their rules on dosing and take-home doses. But restrictions on methadone are counterproductive in the fentanyl era. Methadone should be prescribed on site in all health care settings, including EDs and hospitals. This will only happen if generalist clinicians are able to prescribe methadone. But methadone toxicity is much less likely in fentanyl users, because their opioid tolerance is extraordinarily high. One mg of fentanyl is equivalent to about 100 mg of morphine, and some patients use more than 100 mg of fentanyl per day = equiivalent to 10,000 mg of oral morphine! In contrast, methadone 60 mg (a dose that can be reached in the first 7-10 days of titration) is equivalent to only 480 mg of morphine. (Mind you, diverted methadone is still a cause of death in Ontario, suggesting that gradual titration is still the right approach.)

META:PHI is currently revising its 2022 guidance document on methadone for people who use fentanyl (https://www.metaphi.ca/resource-library/). The guidance document suggests that all four opioid agonist medications – methadone, buprenorphine/naloxone, buprenorphine extended release, and SROM – be considered when deciding on initial treatment. This is in part because patients often have strong opinions as to which medication they want to try – 'I was on methadone for five years and hated it' or 'I was on methadone for five years and did really well on it'.

So for prescribers who have not yet tried methadone, METAPHI will be preparing some educational materials – watch for them. Also, if you have any questions about methadone, feel free to post them on the listserv – there are lots of old timers like me who would be delighted to respond.

EVENTS

2024 Webinar Series - Session #3
Measurement-based Care for Substance Use Disorders
James McKillop
Wed April 17, 7-8:30 pm Register **HERE**

RAAM Monthly Videoconference Dialogue Series
Follow-up to March 20 webinar 'Considerations in the Care of People Who Use Stimulants ' Tuesday April 2, 8-8:45 am

Addiction NP Videoconference Discussion
Wed April 24, 12-1 pm
To join any of these events contact laurie.smith@wchospital.ca