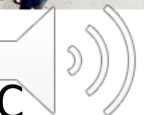
Dalla Lana
School of Public Health

Rose Schmidt, MPH, Phd (ABD)
PhD Candidate, Dalla Lana School of Public Health, University of Toronto

Ra.schmidt@mail.utoronto.ca

A sea of need – Safe opioid supply service provider accounts of strategies used to prioritize admission

Lisbon Addiction – November 2022



Guta A, Schmidt RA, Kaminski N, Kryszajtys D, Perri M, Rudzinski K, Kolla G, Kenny K, Challacombe L, Strike C

Study and Presentation Objectives

Study Objective: Explore from the perspective of clients and service providers:

- Experiences of delivering/ attending the program
- Relationships between clients and clinicians
- Perceived impact of the program

Presentation Objective: Explore prescriber – physician and nurse practitioner - challenges in setting admission priorities.

Methods	Qualitative study
Participants	4 SSP Partner sites in Ontario • People enrolled in SSP • **Prescribers, nurses, allied health at SSP, pharmacists**
Sampling	People enrolled - purposive – varied gender and race/ethnicity **Clinicians – census**
Recruitment	Staff assisted, snowball
Data Collection	In person, zoom and telephone Demographic survey and semi-structured, audio-recorded interviews
Data Analysis	Thematic analysis – team based Advisory group/team provided feedback on coding structure/themes

SAFE SUPPLY PROJECT

Ontario Model

Primary care model

- Serving marginalized communities in Community Health Centres

Safer opioid prescription includes:

a) Tablet hydromorphone

- Mostly take-home dosing

b) Longer-acting opioid as a “backbone”

- Dispensed daily
- E.g., slow-release oral morphine or methadone

- Variation within and across programs

Main Themes

1. Original admission priorities: Determining and implementing
2. Pandemic and overdoses: Problematized priorities
3. Struggle to meet demand for admissions
4. Control access: Stop phone intakes
5. Control access: Waitlists
6. Control access: Restrict eligibility
7. Focus on most marginalized increases pressure on primary care
8. Struggling with ethical challenges related to demand

Original Admission Priorities

- Prioritizing of individuals with: History of 'unsuccessful' opioid agonist treatment; History of overdose; Health/other complexities

> The criteria for getting on the program was people who use drugs daily… ***then we prioritized people who had overdoses, especially recently***.– RN

- Advancing social justice through admission priorities

> When we saw that 90% of [program] is white and then a large portion of that is male… we wanted to be ***more inclusive of racialized folks, people from the LGBTQ2+, women***, racialized from the LGBTQ2 community, ***people with disabilities***. -AH

Pandemic and Overdoses

- COVID and increased overdoses problematized priorities
- Limited onsite capacity to see patients

> So, ***during*** the [COVID] s***tay-at-home order, we actually had to close intake***, 'cause we couldn't have people face-to-face. So that's put a hold on the program. So ***COVID has really, really backed us up.*** -AH

- Supported patients started on SSP elsewhere

> …we're also trying to ***take people on who are being started on safer supply in other places, particularly the COVID-positive recovery hotels***, as well as the COVID-distancing hotels.- AH

Struggle to meet demand for admissions

- Huge demand for these programs (“sea of need”)
- Limited capacity/ Programs have a small staff complement

We are [an] extremely small team …. ***we have no backup for sick days and vacation***, so it’s been quite a journey […] to figure out how to really be r***ealistic about our capacity*** and also to start integrating more supports for staff, ***so that we can avoid burnout*** – AH

We need more capacity, which means more prescribers, because ***safe supply is almost like boutique program*** right now, for people who can get it. And we’re not going to see any kind of shift in community overdose or opioid outcomes until we have a hundred times more people on it, right.– Physician

Control Access: Stop phone intakes

- New procedures/criteria tested – adapted over time
  - Reduced phone intake times
  - Stop phone intake and do in person outreach

… the plan … just to stop doing phone intake … switch the focus more so, to doing ***community outreach***, to going to encampment sites and stuff like that to actually ***reach clients*** who are more – who doesn't [sic] access to phones, for example, right, or ***who have a harder time connecting.*** – NP

I made it so the criteria intakes were done Monday afternoon and evening ….the phone line was open for certain hours, and that's how we did it to control numbers of people. So, ***if it was open five days a week, eight hours a day, we would have way too many people to be able to go through, so we kept it very restricted.*** - RN

Control Access: Waitlists are a problem

- SSPs reach capacity created waitlist to manage demand
- Waitlists grew out of control

> The wait list was a huge problem**.** ***There's no room for a wait list on a program like this. <u>It's too urgent.</u>*** – RN

- Hard to find people again if too much time has elapsed

> And having a wait list – going through name after name of people and not knowing if, first of all, people's situation changes so often**…** ***so getting ahold of these people who have been on the wait list for a few months, their number has changed or they're no longer at the place that they gave the information for***… and one of them did overdose and die while waiting for the program. - RN

Control Access: Restrict eligibility

- Restricting eligibility to most complex clients and housing insecure

Because we're also selecting for the ***most complex*** [clients], and things emerge over time. – NP

- High acuity rates

So, we intake currently just what ***we prioritize to be most urgent*** and at-risk folks, especially women that are pregnant, have had a lot of recent O.D.s, have especially many other complex health concerns. – AH

And certainly ***people who are very marginalized*** – so people who continue to sleep rough or people with health conditions, like their HIV that we really need to get a good handle on, ***those people almost never come off of the weekly check-ins***. –Physician

Focus on marginalized increased pressure

- Slowed admissions
- But increased pressure on primary care resources

And I think we've probably ***hit the ceiling of how many people we can bring in*** until we start to stabilize the new intakes over the past year or so. And then it will go from there, right? We're ***in a very high acuity phase*** where, ***because of COVID*** and the suffering related to that, we brought in a lot of really complex patients. –Physician

Ethical challenges related to demand

- Limited staffing, going above and beyond
- Experiencing moral distress, and burnout

> We are saying no to a lot of people who are in real danger. That's the challenge of being ***a limited program in a huge sea of need***...It's causing a lot of personal and ***moral harm***... It's just a trap, to have to turn people away who desperately need the program... Even though we are harm reduction practitioners, it's not something we're used to doing. And it's hard to do. – NP

Conclusions

- SSPs were originally conceived through a combination of evidence and practice experience
  - Rapidly adapted to the changing reality of COVID and accelerating overdoses
- Providers used a range of strategies to screen in the highest acuity clients
  - This approach required significant efforts and resources
- Some programs have reallocated resources to greater nursing involvement

Study Team

SAFE SUPPLY PROJECT

Investigators

Adrian Guta
Ahmed Bayoumi
Anita Benoit
Carol Strike (NPI)
Emmet O'Reilly
Gillian Kolla
Jessica Hales
Katherine Rudzinski
Kathleen Kenny
Laurel Challacombe
Malika Sharma
Marilou Gagnon
Nanky Rai
Tony Antonio

Research Assistants, University of Toronto

David Kryszajtys
Melissa Perri
Natalie Kaminski
Rose Schmidt (Coordinator)

Thank you

We would like to thank the study participants for sharing their experiences and expertise with us

Dalla Lana
School of Public Health

Rose Schmidt, MPH, Phd (ABD)

PhD Candidate, Dalla Lana School of Public Health, University of Toronto

Ra.schmidt@mail.utoronto.ca

UNIVERSITY OF TORONTO
DALLA LANA SCHOOL OF PUBLIC HEALTH