Toward integrated care and improved access to pharmacotherapy for patients with opioid use disorder: an addiction medicine physician's perspective

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The opioid crisis has been steadily growing worse in recent years, and has become even more dire since the COVID-19 pandemic began, with significant increases in apparent opioid-related deaths in Canada year over year.[1] Healthcare professionals are better able to address the crisis effectively when they are supported to work collaboratively. This article will explore various ways physicians and pharmacists can effectively work together to optimize treatment for people with opioid use disorder (OUD), from the perspective of a physician working in addiction medicine.

Most primary care physicians are well-aware of the opioid crisis and know that OUD is treatable. Yet for a variety of valid reasons, not all primary care physicians feel sufficiently prepared or supported to offer pharmacotherapy to such patients. Reducing systemic barriers to allow primary care physicians to be better supported and to work more collaboratively with both addiction medicine physicians and pharmacists would improve patient access to care. In addition, pharmacists play an important role in patient accessibility to a variety of treatment options for OUD, which could be further expanded if certain regulatory barriers were addressed. In terms of sheer numbers, primary care physicians and pharmacists are significantly more accessible than specially trained addiction medicine physicians. Optimizing the role of both primary care and pharmacy in the provision of pharmacotherapy for patients with opioid use disorder would improve access to this evidence-based intervention, with the ultimate goal of reducing opioid-related morbidity and mortality.

Primary Care and Addiction Medicine

As with many other areas of medicine in Canada, primary care physicians and physicians with more specialized training are often working in silos. Unfortunately, this systemic problem also affects the collaborative relationship between primary care and addiction medicine physicians. There is potential for easier and more seamless collaboration between these two groups.

Some primary care physicians feel comfortable offering treatment to people with OUD, while others are perhaps more hesitant. Residency programs often include only a small amount of teaching on addiction medicine. Without additional training, it is understandable that some physicians may not feel comfortable prescribing treatments they don't have training in, especially when it comes to potentially complicated or challenging cases. Primary care physicians would benefit from more options to allow for easier and more flexible collaboration with addiction medicine physicians. This would help increase access to treatment by expanding the pool of physicians able to offer pharmacological treatment to patients with OUD.

Mechanisms could be put in place to facilitate consultation, communication, and collaboration between primary care physicians and addiction medicine physicians that would allow for bridging of this gap. Ideally, all family physicians should feel that they have clear, easy-to-access options for either referring their patients with OUD for experienced consultation or receiving support and guidance on how best to treat them. Some examples of such programs include the eConsult service in Ontario which uses secure e-messaging to connect primary care providers and specialists, the ECHO model and programs such as the Ontario College of Family Practice's Practising Well. The Rapid Access to Consultative Expertise (RACE) program in British Columbia is another great example making use of a centralized phone line connecting physicians with specialists within a number of hours.[2] Specialist Link in Calgary, Alberta was modeled on the RACE program.[3] All of these programs facilitate communication and collaboration.

Physicians and Pharmacists

Pharmacists have the capacity and training to enable them to offer a broad suite of services which is complementary to those provided by physicians, including patient counselling, dispensing, and in some cases, administration of medication. There are many opportunities for collaboration between physicians and pharmacists to optimize treatment accessibility, and to improve patient outcomes and patient experience.

In Canada at the present time, many patients have reasonably good access to oral and sublingual forms of pharmacotherapy for opioid use disorder, however, some patients still face significant geographical barriers to accessing the full range of treatment options currently available. For example, the long-acting formulation of injectable buprenorphine is currently not available in all communities, nor is the sustained-release buprenorphine implant, which requires a minor surgical procedure every six months. Long-acting treatments offer several benefits, including less interference in a patient's life and work due to a reduced requirement for clinic and pharmacy visits and a lower risk to the public due to reduced potential for diversion or misuse.

The Canadian Research Initiative in Substance Misuse (CRISM) recommends buprenorphine as a first-line treatment for OUD.[4] However, the availability of clinicians trained and authorized to administer these longer-acting treatments is quite limited at present and as a consequence, this limits the ability of all Canadian patients with opioid use disorder to have access to the full range of pharmacological treatments. In terms of numbers, there are many more pharmacists distributed across Canada than physicians. One example of a solution to the above challenge is to involve them, where possible, in the administration of long-acting buprenorphine.

Due to regulatory barriers in some provinces, not all Canadian pharmacists are able to offer this service easily at this time. As it stands, the injection of narcotics must be formally delegated to the pharmacists in some provinces, such as in Ontario.[5] This places a significant burden of responsibility on the physician to evaluate the competence of each pharmacist they might delegate this task to, which is logistically challenging at best, and pragmatically nearly impossible given the large number of pharmacies in any geographical area.

This regulatory requirement is difficult to navigate in a community setting, both for physicians and pharmacists. A practical alternative would be to adjust regulatory requirements to include injection of subcutaneous buprenorphine as part of the scope of practice of pharmacists. Pharmacists would then be accountable to their own regulatory body for this practice, who would determine any necessary training requirements. This would remove a significant barrier to pharmacists who wish to be able to provide this service and would allow for more direct oversight of this part of their practice by their own regulatory body. Ultimately, this would increase patient access to treatment across all geographical areas, both in terms of increased availability of medication administration, and freeing up limited physician resources.

Conclusion

In this article, I have highlighted several ways that the integration of primary care, addiction medicine, and pharmacy can further optimize the collaborative care collectively provided by these professionals to patients with OUD. I have made suggestions regarding how to improve patient access to the full spectrum of treatment options to optimize patient outcomes and experience. I have highlighted the regulatory barrier that currently prevents pharmacists in some provinces from providing all treatment options to their patients and have suggested a regulatory change to eliminate this barrier.

Patients benefit when the healthcare system fosters collaboration between healthcare professionals, and the opioid crisis is no exception. With clearly defined mechanisms for collaborative care between primary care physicians, addiction medicine physicians, and pharmacists, we can move forward in unison toward the goal of reducing the burden of the opioid crisis on patients and on society at large.

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