National Collaborating Centre for Determinants of Health

Centre de collaboration nationale des déterminants de la santé

Mobilizing opioid agonist therapy to bridge gaps during COVID-19

The Mobile Opioid Agonist Therapy (MOAT) team was developed in response to the rapidly changing environment caused by COVID-19 in Calgary, Alberta. With the virus spreading quickly through our community and the introduction of social distancing mandates, individuals faced new barriers in addiction treatment. So, we decided to bring the treatment to them.

When the pandemic hit Calgary, we were providing critical injectable opioid agonist therapy (iOAT) up to three times a day to folks who use substances in our community.[1] The virus itself, and the many public health mandates that came with it, created insurmountable barriers for our clinic and those we served. Although there was a high risk of transmission of COVID-19 within the clinic, which we were attempting to navigate, we quickly realized that a larger challenge was that folks could no longer physically get to the clinic. Changed bus routes or shutdowns were blocking access. The barriers didn't end there. Even if someone could reach the clinic, they still had to pass an overwhelming amount of screening questions and comply with protective measures to make it inside.

[1] Injectable opioid agonist therapy, used in treatment for severe opioid use disorder, refers to taking prescription medication that is dispensed daily (sometimes multiple times per day) to help manage cravings and withdrawal symptoms. This treatment is usually self-administered under supervision of a medical professional. (Source: https://www.alberta.ca/opioid-agonist-therapy-gap-coverage-program.aspx)

This Equity in Action story is distilled from an interview with Alana Wade (RN) and Cristina Zaganelli (NP) from Alberta Health Services. Their leadership team includes Dr. Ron Lim (Medical Director) and Stacey Whitman (former Injectable Opioid Agonist Therapy Manager.) The interview took place in March 2022, and its details should be considered within the context of that time period.

We needed to figure out a way to continue providing treatment to our clients. During the first lockdown, in a meeting with our clinical leadership, we talked about what our pandemic response would look like. We thought: Wouldn't it be great if we could just bring the treatment to our clients? Right then and there, we crunched some numbers and determined that 75% of our current clients were housed. Theoretically, it was feasible to bring the treatment door to door.

The next question became: What do we do now? We quickly divided up the work and redeployed two of our available nurses. Within 48 hours of that initial meeting, we received the go-ahead for an outreach model, acquired a vehicle and had a 2-week timeframe to pull together a staffing group to get it going. The 48-hour turnaround was remarkable and rare; COVID-19 has been a great revealer in that sense.

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Initiatives have moved ahead rapidly during emergency response efforts despite barriers we have faced with similar projects in the past.

We then picked up a map and plotted out where the folks we served were located. Our newly created MOAT team started out with two to three clients to see how it went, then slowly built on this and started gaining momentum. Soon we were out in the community for 12-hour shifts, bringing iOAT to folks in various living arrangements, from isolation hotels to homes to permanent supportive housing sites.

Shifting from an acute, medical focus to a holistic, upstream focus

We watched the program evolve from an emergency response to a more in-depth and meaningful engagement that went beyond keeping people safe in the moment. When the immediate emergency of requiring iOAT subsided, we were still welcomed into clients' spaces, which was an immense privilege.

Because we had access to a client's space, we had insight into their life in a way that we never had before. Suddenly we had the ability to look inside their fridge with them and assess their food access. We could connect them with resources, figure out their bus pass and route to reach a grocery store or facilitate food hamper deliveries. Being in their space with them, we were better able to understand their day-to-day realities.

In their personal space, we got to see a different presentation of the person. Upon entering their home, we could immediately see how much light was in their rooms or how they were maintaining their space, which can reflect mental health status. We also got to know our clients in a more intimate setting. In clinical spaces we get a clinical impression, whereas here, we got to see the expression of people's personality through their artwork and decoration. This whole process allowed us to move beyond the focus of disease and addiction and truly understand the person as a whole.

Recognizing and overcoming systemic barriers for folks who use substances

Being in a client's personal space or home shifts the power dynamic. They were more likely to talk to us in the privacy of their own space, identifying their goals as well as barriers they currently face. When we sat down with a person and puzzled out what it looks like for them to get to an appointment or to get downtown for their medications, we started to see that our system is riddled with so many more barriers than we could have fathomed. For example, it can be difficult to use the transit system if you don't already have a low-income bus pass and it can be difficult to get a low-income bus pass if you don't have identification. And to address just those two issues, the client would need to access several different services, in a particular order and in different locations.

Being in their space, we better understood folks' frustration with existing barriers. When we were in the clinical setting, we would offer suggestions to our clients and wonder why they didn't follow through. What we didn't see before is the person in their space, frustrated by the barriers and losing hope because they can't figure out a way to get around them. You can really appreciate the struggles people are enduring when you sit down with them and talk it through, so we started to navigate with them through the system. Thus, our team moved from a sole focus on iOAT and transitioned to providing wraparound services for folks. The medication we offer is what gets us in the door, but the all-encompassing support of our team is what keeps them opening it and engaging.

One of the key successes of the MOAT service is the stability it offers folks. Often when clients start OAT, you see many "failed" attempts in the beginning because people face so many barriers to access the pharmacy for those initial doses while they are in withdrawal. Missed doses result in cancelled prescriptions, creating additional work and frustration for clients. Bringing medication to our clients has been instrumental in helping them stay consistent with the treatment, especially in those challenging early days of treatment. With this stability, clients can begin to see the benefits OAT can provide for them (for example, achieving control of an opioid use disorder or safety from reliance on the incredibly toxic illicit drug supply.)

Providing wrap-around services through outreach as a harm reduction approach

This program allowed us to "walk the talk" in the most obvious way — we were able to expand what the clinic could do while also serving folks within their own environment and community. Originally, when we started, our MOAT team mostly consisted of registered nurses, a mental health clinician, an outreach worker, pharmacists, a nurse practitioner and a physician. Our team now consists of registered nurses, mental health clinicians, outreach workers, peer support workers, pharmacists, social workers, addiction counselors, a physician and a nurse practitioner. The dialogue between our staff and clients has been transformative, we understand each other so much better and are able to collaborate based on the self-identified needs of the individual. Our team is also now able to monitor people who hadn't previously engaged with in-office clinics or any support services, leading to a more comprehensive response built on addressing upstream determinants.

This initiative embodied the definition of harm reduction: meeting the individual where they are at. We were there on all kinds of days — it didn't matter what was going on for them. We were there when folks were experiencing challenges, when folks accepted us back into their space to help again, and when they were ready to move forward. That consistency helped to build relationships and keep clients engaged in services.

Seizing opportunities to implement new models of care

The pace of Canadian pandemic response acted as a catalyst to bring forward this initiative, try out something new and modify it along the way. Clinic leadership gave us more leeway because this type of response had not existed before, thus we were able to create exactly what we needed without relying on a template. In this case, there was a genuine desire to help this population in a way that was different. Then, because it demonstrated valuable outcomes, like rapid stabilization of OAT and communicable disease treatment[2], we were able to make the case for longevity and sustainability beyond the pandemic and we were successful in receiving further funding.

The main barrier we faced was lack of housing. We have the capacity to serve housed folks, but we know that unhoused folks are even more vulnerable and need our services as well. We recently discovered that eviction was the number one reason for discharge from our program, further highlighting the importance of safe housing – a fundamental determinant of health and well-being. We just haven't had enough capacity to identify and follow up with this more mobile group.

This work was so meaningful to us because we were continuously learning from our clients, and we saw such a difference in the folks that we serve. These individuals often don't see themselves as deserving of the care that they need

because of the systematic exposure to barriers, prejudice, racism and stigma. Through the persistence and continuity of our program, folks have gained pride in themselves and their growth, and they have also become more self-sufficient.

This work provided community and opportunity to people who didn't have either. When people have that, and they trust that it is there to stay, what they do with it is amazing.

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[2] The MOAT team observed positive outcomes in treating sexually transmitted infections and Hepatitis C and in stabilizing HIV antiretroviral treatment.

LESSONS LEARNED:

1. Current systems create structural barriers and cycles of injustices that further entrench people in inequities. Service providers can support clients through holistic, person-centered approaches and by navigating systems with clients.
2. Services that prioritize stability for clients, for example by reducing barriers to accessing addiction treatment, promote positive outcomes for clients.
3. Strategic partnerships between Public Health and Primary Care can result in rapid development and implementation of new models of care that better support folks who use substances (e.g., outreach models built on harm reduction principles).
4. Housing is key to improve equity for folks who use substances. Stable housing improves service access not only through in-home delivery models but also by strengthening the foundation for clients to use and benefit from other services provided through varied care models.

BACKGROUND

The story behind the "MOAT" name: As we were rapidly deploying our newly formed outreach team, we talked about a catchy name to identify our team. Health care loves acronyms, but we also like meaningful and explanatory titles. So, MOAT was born: the Mobile Opioid Agonist Therapy team and initiative designed to create a "moat" of safety around our most vulnerable clients.

KEYWORDS

Access to health services, COVID-19, Food security, Stigma and discrimination, Substance use

To learn more about the initiative described in this story, contact the National Collaborating Centre for Determinants of Health at nccdh@stfx.ca.

Do you have an idea for an Equity in Action story? If you have heard of other health equity-promoting COVID-19 pandemic response initiatives in Canada that we should share, please let us know.