Expanding Access to General Surgery & Pain Management

February 8th | 5:30 – 8:00 pm

4 Mainpro-C Credits
Agenda

5:45  Welcome and Introductions
5:55  ONE ID, ONE Mail, ConnectingOntario, eConsult
6:10  Keynote Address - Toronto Academic Pain Medicine Institute (TAPMI)
6:50  Keynote Address – General Surgery
7:15  Break-Out Session
7:40  Summary of Feedback and Group Discussion
7:55  Closing Remarks
Top 10 Ways to Use SCOPE

Number 10!
Welcome

Dr. Pauline Pariser
Clinical Lead, Mid-West Sub-Region
SCOPE Physician Lead
ONE ID, ONE Mail, ConnectingOntario & eConsult
ConnectingOntario

eHealth Ontario is leading the integration of digital health care systems across the province to improve patient care by enhancing clinician access to health care information where and when it is needed most.

- The data and information captured in each patient’s digital health record comes from organizations across the continuum of care.
  - Hospitals, community care access centres, regional cancer centres (labs, etc.)

- The information is available to authorized health care providers at the touch of a button, enabling more informed decision-making and better patient experiences.

EHR includes:
- Cardiovascular reports
- Respiratory reports
- CCAC data
- Allergy information
- Neurophysiology reports
- Medication information (from hospital)
- Infection control information
- Lab reports
- Hospital discharge summaries
- Emergency dept. reports
- Diagnostic Imaging reports (e.g., X-rays)
  + AND MORE
Overview of ONE Mail

What is ONE Mail?

- A service that allows secure email communications between healthcare providers who are registered ONE Mail users
- Approved for the use of sending patient information quickly and securely between subscribers of the service

Why use ONE Mail?

- More efficient than paper-based processes
- Reduce costs of faxing and couriering personal health information
- Enables collaboration among care team members while protecting patient information
Onboarding Process

In general, it takes 3 months for sites to prepare for and get access to the ConnectingOntario ClinicalViewer and ONE Mail in a joint implementation.

Kick-Off: Complete Readiness Assessment, Staff List Template and Client Information Form

Primary Contact Coordination and Liaison

Privacy Assessment*
*Part of the ConnectingOntario ClinicalViewer implementation only

Security Assessment*

Legal Agreements Execution

ONE ID Set-up (If required)

Training and Go-Live

Month 1

Month 2

Month 3

Variations in timelines depend on the size of the site and the number of Health Information Custodians.
What is ONE® ID?

ONE® ID is eHealth Ontario’s identity and access management service; a set of systems and processes which enables trusted and secure access to eHealth applications for healthcare providers throughout the province.

The identity information of perspective users is verified through a managed registration process.

How Does ONE® ID Work?

This identity information is entered into the ONE® ID system and used to create a credential (user account) which is tied to the registrant’s “real world” identity.

This credential, in turn, is enrolled for access to the appropriate services.
Next steps for access to ConnectingOntario and ONE Mail

- Attend a Kick-Off meeting with eHealth Ontario (if you haven’t already). During which we will:
  - Provide an overview of the ConnectingOntario ClinicalViewer (including a demo) and ONE Mail
  - Review the onboarding process
  - Discuss roles and responsibilities
  - Complete the Client Information Form, Readiness Assessment and Staff List template
Top 10 Ways to Use SCOPE

Number 9!
What is an eConsult?

• Recent studies show that **Ontarians often wait too long** and have to travel too far to benefit from a specialist’s advice. When a specialist’s advice is needed, the level of collaboration amongst providers varies greatly.

• **Virtual Care:** An eConsult occurs when a family physician or nurse practitioner (requesting clinician) electronically sends a question to a specialist.

• **The CMPA has assessed the eConsult flow** of care and determined that it provides an opportunity to improve efficiency, enhance patient care, expand access to specialists and provides a clear audit trail of the specialist’s advice given to the requesting clinician for the suggested care of the patient. Read CMPA’s assessment
Pilot Progress

January 2015 – December 2016

37,500+ eConsults completed (within an average of 3 days)

8,300+ Family Physicians

336 Specialists

120+ Specialties
eConsult enables physicians to engage in a secured, electronic dialogue with specialists to manage patient care, without the need for face-to-face visit.

80% survey respondents agree that eConsult provides a positive experience for patients.¹

99% family physicians and specialists believe eConsult improves patient care.¹

40% reduction of unnecessary referrals to specialists and focuses treatment for patients on a priority basis.²

3 Days the average response time for eConsult across all regions.

1. Data Source - OntarioMD Phase 1: Provincial eConsult Initiative Benefits Evaluation Study (Author: Deloitte as objective 3rd party evaluator)
How do I get eConsult and what are the next steps?

1. EXPRESS INTEREST
   • Send email to econsult@ontariomd.com expressing your interest in using eConsult

2. SIGN UP WITH ONTARIOMD
   • Conduct OneID registration - which involves a **10 minute videoconference/in-person meeting**
   • Complete agreements for compensation (Specialists only)

3. REGISTER WITH OTN
   • Complete Terms of Service agreement with OTN (pre-requisite to agree to electronically to complete your registration)
   • You will then receive “Welcome Note” email from OTN indicating you are live on the OTNHub

4. USE eCONSULT
   • OTN initiate StartSmart to walk them through system and sign on
   • OntarioMD will initiate on-site visit to support ongoing use
Top 10 Ways to Use SCOPE

Number 8!
Toronto Academic Pain Medicine Institute

February 8, 2017
Opioid Delisting: A Management Guide
Karen Ng, ParmD – TAPMI Clinical Pharmacist

Buprenorphine 101
Dr. Tania Di Renna – TAPMI Medical Director

TAPMI Overview and How to Refer
Laura Pus, MBA – TAPMI Administrative Director
The inappropriate use, abuse, and diversion of prescription opioids has emerged as a significant public health and safety issue in Canada.
De-listed opioids will not be considered under Exceptional Access Program (EAP) or the Compassionate Review Policy (CRP)

Lower-strength, long-acting opioids will continue to be funded under the ODB program

As of January 2017 the following opioids were delisted from the ODB

- MS Contin 200 MG SR Tab
- Novo-morphine SR 200 Mg
- M-Eslon 200 mg ER Cap
- Demerol 50mg tab
- Hydromorph
  - Contin 24 mg
  - Contin 30 mg
- Fentanyl Transdermal patch
  - 75 mcg
  - 100 mcg
Exceptions to the legislation

Access to high strength long acting opioids is maintained for patients requiring palliative care

- Palliative Care Facilitated Access (PCFA) mechanism, for registered PCFA prescribers through the OMA
- Exceptional Access Program (EAP) Telephone Request Service (TRS) for physicians who are not PCFA prescribers
Opioid tapering: patient care tips

Functional Goal Setting - gradual gains

Optimize adjuvant medications, and other non-pharm approaches to pain management

Anticipate withdrawal symptoms and be proactive in managing.

Caution patients that loss of opioid tolerance can occur as soon as 3-7 days of abstinence ➔ at risk for overdose if they resume their original opioid dose.
General considerations for opioid tapering

1. **Benefits of tapering** include improved health, mood, function and reduction in pain intensity.

2. **Duration of a taper** can range from a few weeks to several months.

3. **Tapering schedule may be held/reassessed** at any point if pain/function deteriorates or withdrawal symptoms are severe.

4. Engage in a **shared patient clinician decision-making process** based on comprehensive patient assessment, and the agreed upon treatment plan.
Opioid tapering/weaning

The rate of the taper can vary

- Taper can range from 10% of the total daily dose every 3 days, weekly, bi-weekly or monthly

- Once 1/3 of the original dose is reached, smaller dose reductions (e.g. 5% every 2-4+ weeks) may be required

Patients unable to complete the taper may stay at lower opioid doses if their mood and functioning improve

Schedule frequent follow ups (e.g. weekly, bi-weekly).

- Ask about pain status, withdrawal symptoms and possible benefits of the reduction

- Use urine drug screening to assess compliance.
Opioid dose reduction options

Rotation/Switching

Evidence to support the practice of opioid switching is largely anecdotal or based on observational and uncontrolled studies

Rationale based on the wide inter-individual variability in sensitivity to opioids and unique patient response.

- Calculate the equianalgesic dose of the new opioid using an equianalgesic dosing table
- Reduce the above dose by 25-50% to account for incomplete cross tolerance
- Consider supplemental IR opioid during the titration process to minimize withdrawal or breakthrough pain.
- Contact patient in ~3-days for a “tolerance check” to assess for over-sedation and to ensure that pain relief is comparable to the pre-switch treatment.
Withdrawal symptoms

**Early**

Central nervous system arousal
- anxiety / restlessness
- mild insomnia

Autonomic symptoms
- sweating
- rapid short respirations
- runny nose, tearing eyes
- yawning
- dilated reactive pupils

Pain
- abdominal pain

**Late**

Central nervous system arousal
- insomnia
- irritability/restlessness
- tremor

Autonomic symptoms
- runny nose, tearing eyes
- rapid short respirations
- yawning
- pilo-erection
- nausea, vomiting, diarrhea
- fevers, chills

Pain
- diffuse muscle spasms/aches
- abdominal pain

**Prolonged**

Psychological
- dysphoria
- anxiety
- depression

Central nervous system arousal
- insomnia
- irritability/restlessness

Other
- bradycardia
- decreased body temperature
- Cravings
<table>
<thead>
<tr>
<th>Withdrawal Symptom</th>
<th>Medication Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nausea and vomiting</strong></td>
<td>• Dimenhydramine (Gravol®) 50-100mg q4-6 hprn</td>
</tr>
<tr>
<td></td>
<td>• Natural Gravol (ginger) 20mg q4hprn</td>
</tr>
<tr>
<td></td>
<td>• Prochlorperazine (Stemetil®) 5 mg three times a day as required</td>
</tr>
<tr>
<td></td>
<td>For severe nausea/vomiting</td>
</tr>
<tr>
<td></td>
<td>• Ondansetron 4–8 mg, every 12 hours as required</td>
</tr>
<tr>
<td><strong>Diarrhea</strong></td>
<td>• Loperamide 4mg for diarrhea, then 2mg po as needed for loose bowel movements (max 16mg/24 hours)</td>
</tr>
<tr>
<td><strong>Skeletal muscle cramps</strong></td>
<td>• Acetaminophen 325-650mg po q4hprn</td>
</tr>
<tr>
<td></td>
<td>• NSAIDs</td>
</tr>
<tr>
<td><strong>Autonomic symptoms</strong></td>
<td>• Clonidine 0.1mg twice daily</td>
</tr>
<tr>
<td></td>
<td>Initial test dose 0.1mg x1; check BP &amp; HR 1 hr later</td>
</tr>
<tr>
<td></td>
<td>(if BP &lt;90/60, postural hypotension, or HR &lt;60, do not prescribe further).</td>
</tr>
<tr>
<td></td>
<td>May titrate up to 4 times daily.</td>
</tr>
<tr>
<td></td>
<td>May continue clonidine until off of opioids for 3-5 days * Clonidine must be tapered.</td>
</tr>
<tr>
<td><strong>Insomnia</strong></td>
<td>• Trazodone 50-100mg qhs x 4 days then as needed</td>
</tr>
</tbody>
</table>
Agenda

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Buprenorphine patch (butrans)

- mcg
- PAIN

Suboxone (Buprenorphine+Naloxone)

- Mg
- PAIN/Opioid induced hyperalgesia
  (not approved in Canada for this use)
- Opioid Dependence
**Buprenorphine - Pharmacology**

- **PARTIAL mu opioid AGONIST**
  - “ceiling effect”
  - high affinity causing withdrawal

- **Kappa opioid ANTAGONIST**
  - Possible therapeutic applications as animal models show antidepressive, anxiolytic, stress relieving, and anti-addictive properties with κ antagonists

- **PEAK effect 1-4 hours**
- **24-60 hour HALF LIFE**
Buprenorphine in primary care

- In Ontario- no restrictions on who can prescribe
- No training requirements
- Recommendations:
  - on completion of prescribing course,
  - one day observership
  - ongoing CME in opioid dependency treatment
- Buprenorphine/naloxone maintenance treatment can be prescribed to patients in either a primary care setting (level 1 evidence) or chronic pain or addictions specialist (level 1 evidence)
Drug coverage stipulations

Covered under ODB (suboxone)

No plan:

$4.00 2mg/0.5
$6.00 for 8mg/2mg

Special access application for Buprenorphine (only) tablets for pregnant patients


**Treatment comparison**

**Buprenorphine compared to Placebo** in maintenance programs

- Cochrane Library systematic review looking at all RCTs up to 2006:
  Buprenorphine superior to Placebo in retaining patients in treatment

**Buprenorphine compared to Methadone** in maintenance programs

- Cochrane Library systematic review looking at all RCTs up to 2006:
  Buprenorphine slightly poorer – equal efficacy compared to methadone
Buprenorphine/Naloxone for Opioid Dependence:

Clinical Practice Guideline

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#1 establish diagnosis of substance dependence

**DSM 4 Criteria for Substance Dependence** - At least 3 of the following in the last 12 months:

- Tolerance
- Withdrawal
- Taking larger amounts than intended
- Unsuccessful efforts to reduce drug use
- Preoccupation with the drug – great deal of time spent acquiring and using it
- Reduction of important activities because of the drug
- Continued use despite knowledge of drug-related physical or psychological problems
#1 establish diagnosis of substance dependence

**Features of prescription opioid dependence**

- Unsanctioned use
- Alters the route of delivery
- Accesses opioids from other source
- Repeated or severe withdrawal symptoms
- Social features
- Patient’s views on their opioid use
# Patient selection

#2 rule out contraindications to buprenorphine/naloxone

- Pregnancy
- Allergy
- Severe liver dysfunction
- Acute severe Respiratory illness
- Decreased LOC
- Paralytic ileus
- Inability to provide informed consent
- Possible elevated transaminases (beyond 3-5x ULN)
## Example buprenorphine patient assessment checklist

### History
- Establish DSM diagnosis of opioid dependence
- Amount, pattern and route of opioid use. Access degree of tolerance
- Withdrawal symptoms
- Other drug use (alcohol, cocaine, opioids, benzodiazepines, cannabis, nicotine)
- Consequences of use (physical, social, occupational, legal, financial)
- Social situation, including safety of children living at home
- Depression, anxiety, psychosis, suicidal ideation
- Spousal, child abuse
- Previous treatment attempts
- If injection drug use: sharing of injection equipment; history of hepatitis B, C, and/or HIV
- High-risk sexual activity (involvement in the sex trade, or sexual activity while impaired)
- Driving
- Possibility of pregnancy

### Physical
- Mental status examination
- Vital signs
- Track marks
- Liver, spleen
- Cardiovascular, respiratory

### Laboratory
- CBC, MCV
- GGT, AST, ALT
- B-HCG
- Hepatitis B, C, HIV
- TB skin testing if high-risk
- Urine drug test
Patient selection

#3 urine drug screening

<table>
<thead>
<tr>
<th>Chromatography or Mass Spectrometry</th>
<th>Immunoassay</th>
</tr>
</thead>
</table>
| Differentiates: codeine, morphine, oxycodone, hydromorphone, heroin  
More sensitive for semisynthetic & synthetic opioids | Does not differentiate between various opioids.  
Low sensitivity for semi-synthetic and synthetic opioids |
| Does not react to poppy seeds. | Will show false positives with poppy seeds |
| Shorter drug detection timeframe  
(1-2 days) | Longer drug detection timeframe  
(5-7 days) *will vary according to the drug’s concentration in urine & the assay’s cutoff concentration |
| Expensive & may take longer to get results | Inexpensive and rapid results |
Sample buprenorphine/naloxone treatment agreement

Client name: ______________________
Health record #: ____________________

The prescribing and dispensing of buprenorphine is regulated by provincial and federal guidelines, as well as by policies unique to this facility. The purpose of this agreement is both to inform you about buprenorphine/naloxone maintenance therapy and to document that you agree to the rules and obligations contained in this agreement.

Acknowledgments

I acknowledge that:

1. Buprenorphine is a partial opioid antagonist (opioids are drugs like heroin, codeine, morphine, Percocet, etc.), and will result in the development of physical dependence to this medication. Sudden decreases in dose or discontinuation of this medication will likely lead to symptoms of opioid withdrawal.

2. I am already physically dependent on at least one type of opioid and that I have been unable to discontinue my use of opioids.

3. I have tried to the best of my ability other possible treatments for opioid dependence, and that these attempts have been unsuccessful.

4. Taking any mood-altering substance with buprenorphine can be potentially dangerous. There have been reported deaths caused by the combination of buprenorphine with alcohol, opioids, cocaine, barbiturates and/or tranquilizers (e.g., Valium, Ativan, etc.).

5. I may voluntarily withdraw from the buprenorphine treatment program at any time.

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Sample induction algorithm

1. **Patient has been prepared for induction**
   - If no, return to previous step.
   - If yes, proceed to **Patient presents for induction**.

2. **Patient presents for induction**
   - If no, return to previous step.
   - If yes, proceed to **Satisfactory withdrawal? (CDWS >12)**.

3. **Satisfactory withdrawal? (CDWS >12)**
   - If no, **Do not prescribe Buprenorphine. Patient should return later in day or next day in more severe withdrawal**.
   - If yes, proceed to **Moderate withdrawal (CDWS 13-24)**.

4. **Moderate withdrawal (CDWS 13-24)**
   - **Precipitated withdrawal?**
     - If yes, **Administer 2mg Buprenorphine**.
     - If no, proceed to **1 hr later**.

5. **1 hr later**
   - **Withdrawal symptoms satisfactorily relieved?**
     - If no, **Consider additional dose (upto a maximum of 8mg on Day 1)**.
     - If yes, proceed to **Day 1 dose established**.

6. **Day 1 dose established**
   - **Withdrawal symptoms relieved?**
     - If no, **Consider managing withdrawal symptomatically (i.e., clonidine)**.
     - If yes, proceed to **Prescribe day 1 dose for next 1-2 days observed**.

7. **Prescribe day 1 dose for next 1-2 days observed**
   - **Consider managing withdrawal symptomatically (i.e., clonidine)**.
   - **Return the following day for dose titration**.

8. **Severe withdrawal (CDWS 25+)**
   - **1 hr later**
     - **Precipitated withdrawal?**
       - If yes, **Administer 4mg Buprenorphine**.
       - If no, proceed to **3 hrs later**.

9. **3 hrs later**
   - **Withdrawal symptoms satisfactorily relieved?**
     - If no, **Consider additional dose (upto a maximum of 8mg on Day 1)**.
     - If yes, proceed to **Day 1 dose established**.

10. **Day 1 dose established**
    - **Withdrawal symptoms relieved?**
      - If no, **Consider managing withdrawal symptomatically (i.e., clonidine)**.
      - If yes, proceed to **Prescribe day 1 dose for next 1-2 days observed**.

11. **Prescribe day 1 dose for next 1-2 days observed**
    - **Consider managing withdrawal symptomatically (i.e., clonidine)**.
    - **Return the following day for dose titration**.
**Clinical Opiate Withdrawals Scale (COWS)**

<table>
<thead>
<tr>
<th>Patient Name: _________________________</th>
<th>Date and Time: _______ / _____ / _____: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reason for the Assessment:</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Resting Pulse Rate: _______</th>
<th>GI Upset: over last ½ hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>beats/minute</td>
<td>0 – no GI symptoms</td>
</tr>
<tr>
<td><em>Measured after patient is sitting or lying for one minute</em></td>
<td>1 – stomach cramps</td>
</tr>
<tr>
<td></td>
<td>2 – nausea or loose stool</td>
</tr>
<tr>
<td></td>
<td>3 – vomiting or diarrhea</td>
</tr>
<tr>
<td></td>
<td>4 – multiple episodes of diarrhea or vomiting</td>
</tr>
<tr>
<td>0 – pulse rate 80 or below</td>
<td>1 – pupils possibly larger than normal for room light</td>
</tr>
<tr>
<td>1 – pulse rate 81-100</td>
<td>2 – pupils moderately dilated</td>
</tr>
<tr>
<td>2 – pulse rate 101-12</td>
<td>4 – pupils so dilated that only the rim of the iris is visible</td>
</tr>
<tr>
<td>4 – pulse rate greater than 120</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sweating: over past ½ hour not accounted for by room temperature or patient activity</th>
<th>Tremor: observation of outstretched hands</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – no report of chills or flushing</td>
<td>0 – no tremor</td>
</tr>
<tr>
<td>1 – subjective report of chills or flushing</td>
<td>1 – tremor can be felt, but not observed</td>
</tr>
<tr>
<td>2 – flush or observable moisture on face</td>
<td>2 – slight tremor observed</td>
</tr>
<tr>
<td>3 – beads of sweat on brow or face</td>
<td>4 – gross tremor or muscle twitching</td>
</tr>
<tr>
<td>4 – sweat streaming off face</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Restlessness: observation during assessment</th>
<th>Yawning: observation during assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – able to sit still</td>
<td>0 – no yawning</td>
</tr>
<tr>
<td>1 – reports difficulty sitting still, but is able to do so</td>
<td>1 – yawning once or twice during assessment</td>
</tr>
<tr>
<td>3 – frequent shifting or extraneous movements of legs/arms</td>
<td>2 – yawning three or more times during assessment</td>
</tr>
<tr>
<td>5 – unable to sit still more than a few seconds</td>
<td>4 – yawning several times/minute</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bone or Joint Aches: if patient was having pain previously, only the additional component attributed to opiate withdrawal is scored</th>
<th>Anxiety or Irritability:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – not present</td>
<td>0 – none</td>
</tr>
<tr>
<td>1 – patient reports increasing irritability or anxiousness</td>
<td>1 – patient reports increasing irritability or anxiousness</td>
</tr>
<tr>
<td>2 – patient obviously irritable anxious</td>
<td></td>
</tr>
<tr>
<td>4 – patient so irritable or anxious that participation in the assessment is difficult</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gooseflesh Skin:</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – skin is smooth</td>
</tr>
<tr>
<td>3 – piloerection of skin can be felt, or hairs standing up on arms</td>
</tr>
<tr>
<td>5 – prominent piloerection</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Runny Nose or Tearing: not accounted for by cold symptoms or allergies</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – not present</td>
</tr>
<tr>
<td>1 – nasal stuffiness or unusually moist eyes</td>
</tr>
<tr>
<td>2 – nose running or tearing</td>
</tr>
<tr>
<td>4 – nose constantly running or tears streaming down cheeks</td>
</tr>
</tbody>
</table>

**Total Score: _____________**

The total score is the sum of all 11 items.
Prescription example

- Observed dosing services
- Confirm affordability
- Fax scripts
**Agenda**

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**TAPMI Goals**

**Clinical**
- Interdisciplinary team of chronic pain experts.
- Model of care ensures patients are seen *as quickly as possible*.

**Educational**
- Help patients understand their role in managing pain and setting goals.
- Provide support to healthcare practitioners in the community.

**Research**
- Long term outcomes studies to evaluate impact.
- Conduct research across the 5 partner hospitals.
- Collaborate with other pain centers in Ontario.
A TAPMI care plan is evidence based and tailors to the patients’ individual needs.

Patient education
Patient goal setting, self management, coping skills and pacing.

Psychological interventions
Cognitive Behavioural Therapy and Mindfulness Based Stress Reduction

Physical therapy
Physiotherapy assessments and tailored exercise program to increase physical activity levels

Pharmacy
Resource for opioid stewardship, Medication evaluation and assessment, patient education

Social work
Psychosocial assessments, individual counselling, assistance in accessing treatments and community resources

Interventional therapies
State of the art interventional therapies such as ultrasound or fluoroscopic guided nerve blocks and radiofrequency ablation

Medical therapies
Assessment and treatment for a variety of pain diagnoses

Substance Use
Advice or treatment for patients with substance use disorder
Types of pain treated

- Abdominal Pain
- Head Pain
- Musculoskeletal Pain
- Neuropathic Pain
- Substance Use Disorder
- Widespread Pain
TAPMI services for SCOPE providers

- First to access to Centralized Intake for all TAPMI resources
- First to access centralized care planning
- Exclusive Access to TAPMI pain pharmacy supports through the SCOPE Nurse Navigator
- First to access primary care practice-based supports (coming soon)
### When to consider a referral to central intake

<table>
<thead>
<tr>
<th>Calendar Icon</th>
<th>Pill Icon</th>
<th>Clock Icon</th>
</tr>
</thead>
</table>
| Patient has persistent pain beyond 3 months that is not responding to current treatment, and is showing evidence of:  
  - Declining physical functioning  
  - Increasing psychological stress  
  - Absence from work or multiple emergency facility utilizations for pain management | You would like guidance on patient opioid use, withdrawal or weaning. | Consider early (less than 6 months from start of symptoms) referrals for:  
  - Suspected CRPS  
  - Acute intervertebral disc herniation with radiculopathy  
  - Post herpetic neuralgia  
  - Aberrant opioid use  
  - Palliative (expected length of survival < 3 months) |
How to make a referral

1. Print off referral form from the TAPMI website (www.TAPMIpain.ca) and fax to TAPMI Central Intake.

2. Your patient’s referral will be assessed by nursing at TAPMI Central Intake and sent to the most appropriate clinic with the next available appointment.

3. Your patient will be contacted directly with an appointment by the clinic. You will be notified via fax once an appointment has been booked.
Accessing chronic pain pharmacy supports

- Urgent advice
- Access to specialty care
- Access to community services
- Access to acute services
- Access to medical imaging services
Chronic pain pharmacy supports

1. Response within 72 hour - 1 week
2. Best possible medication history
3. Opioid medication management
4. Adjuvant pain medication optimization
5. Motivational interviewing for change management (medication compliance and opioid taper)
6. Patient medication counselling
7. Drug therapy monitoring
8. Medication misuse screening
The hub for chronic pain care in the GTA.

Toronto Academic Pain Medicine Institute (TAPMI) is the only single comprehensive interdisciplinary academic pain program serving as the hub for chronic pain care in Toronto.
Questions & Applause

www.TAPMIPain.ca
Top 10 Ways to Use SCOPE

Number 7!
Top 10 Ways to Use SCOPE

Number 6!
The “New” Department of Surgery at Women’s College Hospital

David Urbach MD
Surgeon-in-Chief
Women’s College Hospital
February 8, 2017
Objectives

1. Present an overview of the new Department of Surgery at Women’s College Hospital
2. Describe our strategic vision
3. Identify System Pressures/areas of Local Need
WCH Department of Surgery

1915

2016
WCH Reincorporation 2006

Resumed operating as an independent hospital under the Public Hospitals Act

Construction of new hospital
  No inpatient unit
  No Emergency Department/Urgent Care Centre
  No duplication of existing services

10 Operating Rooms
  8 major
  2 minor

Acute Ambulatory Care Unit (AACU)
Strategic Plan 2011-2016

OUR 3 CORPORATE DIRECTIVES
Drive the Innovation Agenda | Strengthen our Capacity to Lead from our Mandate | Grow our Academic Impact

WHO WE ARE
Our Vision & Mission
Canada’s leading academic, ambulatory hospital and a world leader in women’s health. We advance and advocate for the health of women and improve healthcare options for all by developing, researching, teaching and delivering new treatments and models of integrated care.

WHAT WE DO
Our 3 Areas of Focus
Health for Women
Health System Solutions
Complex Chronic Conditions

HOW WE DO IT
Our 6 Innovation Streams
Driving systemic solutions in healthcare for women
Preventing acute care admission and readmission
Enabling superior coordinated care
Transforming inpatient care models to outpatient care
Enabling system integration and care transitions
Building the virtual hospital

WHY WE DO IT
Our Impact on the Health System
To deliver cost-effective healthcare solutions
To improve the quality of care transitions
To offer equitable and accessible care
To train the healthcare professionals of the future

OUR VALUES
Equity ■ Safety ■ Innovation ■ Relationships ■ Leadership ■ Collaboration
Surgical Programs

General Surgery
  Breast (cancer, high risk)
  Thyroid
  Hernia/Gall Bladder
Orthopedics
  Sports medicine
  Soft tissue trauma
Plastic Surgery
  Breast reconstruction
  Hand surgery
Urology
  Fertility
### Who we are: Surgical Staff

<table>
<thead>
<tr>
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<tr>
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<td>Courtesy</td>
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The Business Side

Post-Construction Operating Plan (PCOP)
Until April 1, 2019
Clinic visits and surgical procedures

Health System Funding Reform
Quality-Based Procedures
  Breast
  Thyroid
  Joint surgery
Core Areas of Focus

- Deep expertise & strategic alignment
- Health systems solutions
- Surgical Innovation
### Addressing System Pressures

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<th>Specialty</th>
<th>Partnership</th>
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<th>Sept. 2016/17 YTD</th>
<th>Comments (start date)</th>
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<td>*Hand</td>
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<td>Trauma</td>
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<tr>
<td>Hernia/Gall Bladder</td>
<td>UHN</td>
<td>43</td>
<td>136</td>
<td>Jan 2016</td>
</tr>
</tbody>
</table>

**TOTAL**                     |             | **558**        | **623**           |

**YE projected volume**       |             | **1,246**      | **Target (1,370)**|

New volumes from partners is now ~20% of overall volumes
Recent Innovations

Outpatient thyroid surgery
Outpatient breast reconstruction
Surgical recovery Apps
Soft tissue trauma injury urgent block
New Initiatives

- Trans Surgery
- Hernia Centre
- Gall Bladder Centre
- Lymphedema
- Anorectal
- Foot and Ankle
- Hand
Guiding Principles

Address system pressure/local need
Central referral and triage
Programs “live” at the hospital
Must be suitable for ambulatory surgery
Create systems to enable ambulatory surgery
  Technologies
  Process Innovation
  Community Partnerships
“Push the envelope” wherever possible
Feedback?
Top 10 Ways to Use SCOPE

Number 5!
Top 10 Ways to Use SCOPE

Number 4!
Breakout
Breakout Session

1. How can we improve chronic pain services in Toronto?
2. What are the most common chronic pain services needs?
3. What general surgeries do you find most difficult to access?
4. What are your biggest needs for elective surgical services?

- General surgery
- Orthopedics
- Plastic surgery
- Urology
Top 10 Ways to Use SCOPE

Number 3!
Summary of Feedback and Group Discussion

Dr. Pauline Pariser
Top 10 Ways to Use SCOPE

Number 2!
Closing Remarks

Dr. Pauline Pariser
Top 10 Ways to Use SCOPE

Number 1!
Thank You!