ICHA | Inner City Health Associates

Risk Mitigation/Safer Opioid Supply in the ESSP Program

Version 1.0

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(A) Rationale and Scope

For years, Toronto has experienced an unprecedented number of overdose and substance use related deaths. This crisis began long before the current COVID-19 pandemic with increasingly toxic street drug supplies. Unfortunately, the situation has only worsened during the pandemic requiring urgent action. ICHA has increasingly been providing services in short- and medium-term hotel-based shelters (ESSP) for people either experiencing COVID or requiring isolation for treatment or protection. The organization is committed to a broad spectrum of substance use support.

The following document seeks to adapt significant work done by community safer opioid supply prescribers and documents they have authored, national CRISM guidelines on substance use care in shelter settings, and BC guidelines for risk mitigation in pandemic prescribing. Its use is intended exclusively for use within the ESSP program at this time.

The primary care in ESSP is primarily administered by nurse practitioners whose hours and availability are hotel dependent. This work is complemented by a hotel-specific team of primary care physicians, addiction medicine specialists, harm reduction workers and shelter staff. It is encouraged that each hotel develops the most comprehensive and team-based approach to this programming. However, with fluctuations of COVID numbers and primary care needs, the capacity of individual hotels to initiate and continue safer opioid supply prescribing will vary.

This program attempts to leverage the enhanced support available in some hotels accounting for unique issues in staffing, issues with observation and dispensing of medications, and continuity of care. This document should be considered a living protocol to be adapted and grown as more services are added to the hotels in question. As prescribers outside of the shelter and hotel systems participating in risk mitigation prescribing are limited, the scope of this program will for the time being will be limited to the period which people are housed in these temporary facilities. It is the intention of the program centrally to have between 100 and 150 clients in the coming months. It is acknowledged that the hotel environment and supports remain different than existing community SOS programs and that adjustments will be required to minimize risk of iatrogenic harm and maximize benefit.

The work will be evaluated concurrently. Good and comprehensive record keeping will be key to ensuring comprehensive evaluations. The below offers a framework, however clinicians are encouraged to utilize sound clinical judgement in their approach and deviation from these suggestions as they see fit. This document ideally, should be used in conjunction with ICHA's substance use manual including ongoing use of other addiction medicine and harm reduction concepts and medications.

(B) Qualifications and Observation

1) Client Qualifications:

- Daily non-prescribed opioid use leading to withdrawal with cessation
    - (+) Previous trials of OAT and/or not interested in **only** OAT
    - OR to support OAT titration for those with high tolerances to opioids

2) Consent Process

- A standardized consent document should be discussed with each client that includes the protocols for missed doses, missed follow up etc. (*See Appendix II.)*

3) Risk stratifying

Risk Factors 1 (HIGH RISK)

- Concurrent use of Alcohol/benzodiazepines
- Active psychosis or suicidality
- Severe respiratory disease/evidence of significant respiratory disease on physical examination
- Severe liver disease or evidence of severe liver disease on physical/blood work
- Uncontrolled/unmanaged seizure disorder
- Unstable medical disease or clinical frailty

Risk Factors 2 (MEDIUM RISK)

- Concurrent prescriptions for other sedating medications
- Any chronic medical condition that could impact respiration/sedation risk

4) Tier Observation System

High Observation -> Any Risk Factor 1, OR multiple Risk Factor 2
Medium Observation-> Any Risk Factor 2
Low Observation -> Absences of any risk factors

High Observation

- HM doses individually dispensed and observed in setting able to respond to OD
    - Transitions to dispensing will be case-by-case dependent but likely longer than one week on observed.

Medium Observation

- HM doses individually dispensed and observed by clinical staff or support staff
    - Once observation for 3-5 days on this model if client tolerates doses can transition to daily dispensed

Low Observation

- Daily dispensed

All clients should be encouraged to use on site OPS service if available
All Kadian/Methadone will be daily dispensed and observed

At this point, only the COVID recovery site has the ability to dispense and observe medications on site. Therefore, for the ESSP program the first segment of enrolled clients should be in the low barrier setting. Case-by-case exceptions in which clients are willing to visit local pharmacies more than once per day can be implemented at the provider's discretion.

It is encouraged that there be a relationship between the prescribers, the hotel and pharmacy that allows for daily delivery of medications. This will decrease the barriers to access and hopefully improve uptake. This has successfully been accomplished in a number of hotels.

The recovery site, given the need for strict isolation, has developed lower barriers for entry into risk mitigation. As a result, there may be clients initiated on RM during a COVID Recovery Site admission who meet medium or high-risk criteria. Continuation of prescribing if transfer is planned to an ESSP site will be examined on a case-by-case basis. First, the case will be brought to the ICHA substance use physician lead, ESSP medical director and ESSP nursing manager by email. If appropriate, a case conference between the Recovery Site MD, Addictions MD, HR team member, and nurse practitioner at the accepting site will be arranged. The client will be invited to join the second half of the case conference. The decision about whether or not to continue prescribing upon discharge from the Recovery Site will be by consensus. The case conference summary and care plan will be documented in the OSCAR chart.

(C) Dosing Guidance

1) Initial Dosing

	Hydromorphone (Brand Name Dilaudid only) 8mg tablets	Kadian (slow release oral morphine) *ALWAYS OBSERVED	Methadone *ALWAYS OBSERVED
Use uncertain	2-4 tabs (16-32mg)	100mg	10-20mg
<1g of fentanyl/day	6-8 tabs (48-64mg)	200mg	30mg
>1g of fentanyl/day	12-14 tabs (96-112mg)	200mg	30mg

- In order to mitigate withdrawal in between doses of short acting hydromorphone and/or to support transition to OAT, it should be strongly encouraged to prescribe hydromorphone with either Kadian or Methadone as a long-acting backbone.

Note that reports from people who use fentanyl are that approx. 4-6 tabs of HM 8mg (32-48mg) are equivalent to 1 “point” of fentanyl

2) Titration

	Hydromorphone (Brand Name Dilaudid only) 8mg tablets	Kadian (slow release oral morphine) *ALWAYS OBSERVED	Methadone *ALWAYS OBSERVED

<1g of fentanyl/day	4-8 tabs (32-64mg) q 24 hrs	Up to 100mg q48 hrs	As per CPSO guidelines
>1g of fentanyl/day	6-8 tabs (48-64mg) q 24 hrs	Up to 200mg q48 hr until a total of 600mg with further increases of up to 100mg q48 hrs	As per CPSO guidelines

- Due to the pharmacology of Methadone and Kadian, the effect of a dose change may not be fully felt by the client until they have had at least 3 consecutive days of Methadone or 2 of Kadian.
    - Due to this, caution should be taken with concurrent increase in hydromorphone and Methadone or Kadian at the same visit.

3) Recommended Limits

Given a large group of prescribers and cross-coverage, the program will have broad recommendations on dosing limits. These suggestions can be exceeded however the prescriber may be responsible for filling and bridging these prescriptions and a discussion around who the subsequent community prescriber will be, should be initiated. Prescribers are encouraged to bring complex cases for group discussion.

Hydromorphone (Brand Name Dilaudid only) 8mg tablets	Kadian (slow release oral morphine) *ALWAYS OBSERVED	Methadone *ALWAYS OBSERVED
24 tablets (192mg)**	1500 mg / day	150mg

4) Missed Doses

There is a risk of decreased tolerance when doses are missed, increasing the risk of overdose in the re-initiation phase. The loss of tolerance is quicker for shorter acting opiates (hydromorphone) than for longer acting opiates (SROM or methadone).

Decisions around the management of missed doses should be individualized based on the client's unique circumstances, including whether or not they have been abstinent from non-prescribed opiates (highest risk of tolerance loss), maintained their use of non-prescribed opiates, or increased their use of non-prescribed opiates (lower risk of tolerance loss).

The following recommendations can be used as a guide for dose adjustments:

SROM:

As per the BCCSU guidelines:

Number of missed days	Dose Reduction
1	Maintain regular dose
2	40% reduction
3	60% reduction
4	80% reduction
5	Re-start at initiation dose

METHADONE:

As per CPSO guidelines:

Number of missed days	Dose Reduction
1 or 2	Maintain regular dose
3	50% reduction
4 or more	Re-start at initiation dose

As per META:PHI: ***For those continuing to use fentanyl during days of missed methadone who are likely to have protected some tolerance although amounts and reliability can be highly variable and considerable caution is required***

Number of missed days	Dose Reduction
1, 2 or 3	Maintain regular dose
4	50% reduction
5 or more	Re-start at initiation dose

HYDROMORPHONE:

Number of missed days	Dose Reduction
1	Maintain regular dose
2	50% reduction
3	Re-start at initiation dose

- As a short-acting opiate, hydromorphone doses can be titrated quickly (every 24 hours). In this re-initiation phase, doses can be re-started higher than the above guide or escalated quicker if additional safety measures are in place (for example, multiple trips to the pharmacy per day).

(C) Follow-up and Monitoring

SOS is a harm reduction measure and recognizes that stability is impacted by a variety of factors. Complete cessation of street drug use and stabilization are not requirements of the program.

1) Follow up

- It should be attempted to see clients 2-3X/week in the first week of enrollment and initiation - with a goal to be seen a minimum of once weekly.
- Week 2 and onwards, clients can be seen weekly until greater stability (either drug use, social or health) has been achieved. This will frequently depend on goals set by the client themselves.
- Once maintenance doses have been achieved, clients can switch to q2-4 week appointments as needed.

Note: Not all visits must be with prescriber. More frequent contact with any team member can lead to better stabilization however we encourage open communication between various team members.

- Prescriber should be notified if:
    - Doses are missed
    - Increasing non rx'd drug use
    - Concern for diversion
    - medical/mental health destabilization
    - Changes in alcohol/benzodiazepine consumption
    - Safety issues
    - Imminent discharge

2) Missed Appointments

- Scripts should be bridged after a single missed appointment
- After two consecutive missed follow ups, HM doses can be reduced by 2-6 tabs/missed appointment with clear instructions provided to the pharmacist to visit the prescriber.

3) Urine Drug Screens (UDS)

- A urine drug screen should be completed at intake. Exceptions can be made but should be carefully justified in documentation.

- A Urine Drug Screen must be completed in the first 4 weeks of the program. If a UDS is not provided, further increases in doses will be delayed.
- UDS if possible can be completed q4 weeks to ensure presence of prescribed opioids, to monitor other drug use and to help people who use substances better understand their drug supply (drug checking services should also be advertised to clients).

4) Diversion

The increased risk of diversion associated with unsupervised doses is recognized. In keeping with the assumptions of the program, participants will not be automatically discharged from the programs if diversion is suspected and/or occurring. Suspected diversion will be discussed in the context of client goals, personal benefit in the program and the need for adjustments to treatment.

(D) Discontinuation/Transfer Out of Program

At this time, unfortunately the majority of community SOS prescribers are unable to take new clients. As well, the availability of risk mitigation prescriptions in the community remains low.

It is hoped that these hotels will remain for the existing future however in this context for clients in whom discharge either forcibly from the shelter or voluntarily is a real possibility alternate continuation plans must be considered. When possible, a warm referral to community SOS program should be accomplished early and planned carefully. For many clients unfortunately this will not be possible.

It should be made clear during the consent and initiation process that the therapy is initiated in the hotel system may not be able to be continued upon discharge. As well, for clients in whom continuation of SOS risk mitigation prescribing after discharge is unlikely prescribers are strongly encouraged to titrate long-acting agents including methadone, Suboxone, or SROM to levels associated with single agent treatment so that this medication can be continued upon discharge and the client will be less likely to experience withdrawal or a sudden reduction in tolerance upon the removal or cessation of hydromorphone prescribing.

References

META:PHI reference

Methadone Maintenance Treatment, Program Standards and Clinical Guidelines, CPSO 2011: Accessed at:https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/your-practice/quality-in-practice/assessments/mmt-guidelines.pdf

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British Columbia Centre on Substance Use. Risk Mitigation In the Context of Dual Public Health Emergencies. March 2020.

Hales, J., Kolla, G., Man, T., O'Reilly, E., Rai, N., Sereda, A. (2020). *Safer Opioid Supply Programs (SOS): A Harm Reduction Informed Guiding Document for Primary Care Teams*. Available online: https://bit.ly/3dR3b8m

Appendices

***Appendix I**: ESSP and COVID recovery site services*

COVID Recovery Site

Current Resources *(funded through March 2021 -> anticipate continued funding with similar model through May-June 2021 depending on COVID prevalence, with scaled-down model July - Dec 2021 ish.)*

- 24/7 on-demand access to OPS and/or witnessed use by harm reduction worker, nurse or peer worker
- OD response including oxygen, naloxone, bag-valve mask and 911 activation
- 24/7 nursing presence for medication dispensing/observation - maintain stock Dilaudid, stimulants for rapid initiation
- In-person episodic care model for acute issues, virtual consultations/advice from addictions service for OAT initiation and titration + opioid and stimulant risk mitigation.

Hotel	Operator	Operator HR support	Clinical Support	Social/HR Support	OD Rate
Bond Place	Dixon Hall	Yes	ESSP Clinic	- OPS The Works - The Works HR Outreach - MDOT MH CM -HR worker from DH (Pedram)	High
Victoria	Dixon Hall	Yes	ESSP Clinic	- The Works HR Outreach - MDOT MH CM	Moderate
Strathcona	Dixon Hall / Homes First	Yes	ESSP Clinic	- PQW HR Workers+peers - MDOT MH CM	Moderate

Delta	Homes First	Yes	ESSP Clinic	- PQW HR Workers+peers - MDOT MH CM's - Pharmacy on-site - Homes First HR worker - Peer Workers	High
Edward	Fred Victor	Yes	ESSP Clinic	- PQW HR Workers +peers - MDOT MH CM - Pharmacy on-site - Social Worker 5 day/week - FV HR workers - Housing Workers - TNG Peer Workers - OPS The Works (pending)	High
RoeHampton	SSHA	Unknown	ESSP Clinic	- OPS The Works (pending) - MDOT MH CM (new referrals on hold)	High
Comfort Inn	Christie Ossington NC	Unknown	ESSP Clinic		Moderate
BLC	Homes First	Yes	ESSP Clinic	-PQW Peer Outreach -Homes First ICM -The Works Mobile Van -Housing Workers	High
St. James	Street Haven	Yes		- PQW HR workers+Peers	Low
69 Frasier	St. Felix	Yes		- PQW Peer Outreach - PQW HR Worker + Peers	High
Toronto Plaza	COSTI	Yes		- PQW HR Worker + Peers	Unknown
EconoLodge	Good Shepherd	No	GS Nurse 1xweek	- PQW HR Worker + Peers	Moderate

545 Lakeshore	Homes First	Yes		- PQW Peer Outreach - PQW HR Worker	High
Howard Johnson	Christie Ossington NC	Unknown			Unknown
Alexandra	SSHA				Unknown
Women's Res	SSHA				Unknown

Appendix II: *Consent Form*

CONSENT for Opioid Treatment at the _____ Hotel Clinic
Client Names (first, last):
DOB:
HC number:
CLIENT AGREEMENT:

I understand and agree that:

1. I am being started/continued on the following medication: **Suboxone/Methadone/Kadian (long term) and Dilaudid (this can be continued for the duration of stay at the shelter hotel.)**
2. While I receive opioid treatment at the _____, I will only get opioid prescriptions from the Inner City Health Associates (ICHA) Nurse Practitioner or Physician and will not get any from any other clinics/prescribers at the same time.
3. For my safety, I give consent for my prescriber to communicate with my pharmacist and with any other healthcare providers involved in my care, and to check my Connecting Ontario profile.
4. I can expect confidentiality from my health care providers unless I am a danger to myself or others, I understand there is a duty to report.
5. I will work with my opioid treatment prescriber to set goals and review these regularly and change them if needed.
6. If I decide I want to change my prescriber and/or pharmacist, I will communicate this to them and we will work together to transfer my care.
7. I can decide if I want to continue, stop or change my treatment plan at any time. I agree to make this decision in discussion with my prescriber.
8. **If I miss my daily dispensed dose, this will lead to a lower dose after a certain number of days (depending on the medication), or a complete restart if I miss too many doses. This is done for my safety as missing doses may lead to a decrease in tolerance.**
9. I agree to receive my daily dose from **_____(pharmacy)** and understand that I will not receive carries at this time. My prescriptions will last 1 week only initially
10. If I leave the program, I will work with my prescriber and pharmacist to transfer my care to a clinic and pharmacy in the community. I understand that this does not guarantee the same prescription once I go to a new provider and **I understand that it may be difficult to find another prescriber for these medications.**

11. I will be asked to provide urine for testing on a regular basis.
12. I will be expected to avoid or decrease using other sedating substances or medications, such as alcohol, sleeping pills, pain pills, OTC meds, or street drugs, while taking opioid treatment, as this increases my risk for overdose and death.
13. It is recommended that I inform any health care provider I receive care from (including any dentists) that I am taking these medications.
14. I shall treat others and will be treated with respect. Ongoing disrespectful behaviour may result in a decision to transfer care to another clinic.
15. **It has been recommended to me to keep a naloxone kit on hand**, access Harm Reduction supplies if needed, and try to keep myself and others safe.
16. I agree to use this medication only for myself and will not sell or give it to anyone else as there is a risk of causing overdose or death to that person.
17. I will keep my daily dispensed meds in a safe place and If I lose any of the medication I will not be able to get another prescription the same day.

PRESCRIBER AGREEMENT:

I confirm that:
1. This form has been reviewed in detail with the client and they understand it fully.
2. The client was given time to ask questions and seek clarification before signing.
3. The different opioid use disorder medication options available where reviewed and the client agrees to receiving this medication**: Suboxone/Methadone/Kadian (long term) and Dilaudid (short term)**
4. Connecting Ontario was reviewed to identify other prescribed medications, and will be checked at subsequent clinic visits.
5. A plan with goals (short term and long term) was established with the client, and will be reviewed and documented on regularly during our collaboration.

CLIENT NAME: _____ DATE:
CLIENT SIGNATURE: _____

PRESCRIBER NAME: _____ DATE:
PRESCRIBER SIGNATURE: _____

INTERPRETER NAME (IF APPLICABLE):_____ DATE:

INTERPRETER SIGNATURE:
_____

Client Identified Goals:
_____

_____

Appendix III: *Intake template*

Intake

Substance Use History

Alcohol	Current:	**Cocaine**	Current:
	Hx:		Hx:
	Any Hx of withdrawal seizures or DTs?		
Cigarettes	#/day:	**Non-prescribed opioids (down) Heroin/Fentanyl/ Carfentanil**	Current:
	Years Smoked:		Hx:
	If applicable – able to quit during previous pregnancy?		
Crystal Methamphetamine	Current:		Route of Administration:
	Hx:	**Cannabis**	Current:
Prescription Opiates	Current:		History:
	Hx:		Route of Administration:
Chronic Pain	Y/N:	**Other**s/Benzodiazepines:(Specify)	Current:
Describe Condition:			History:

When was last opioid use use:

- **Less than 24 Hours ago**
- **Days ago**
- **More than one week ago**

Have you had an overdose in the past month? Y/N
Ever? Y/N

Currently using clean supplies/SCS?: Y/N

How much do you spend per week on drugs/alcohol?

- **Less than $100**
- **$100-299**
- **$300-999**
- **Greater than $1000**

Social history:

Most Recent Housing:

Income:

Drug Plan?

Occupation: employed / unemployed / self-employed / retired / student

Food access & nutrition:

Immigration status:

Social supports/Important relationships:

Drivers License (Y/N):

Current substance use related prescriptions:

Current Opioid Agonist Therapy

- **Methadone**
    - Current Dose [Type here]
    - Length of time prescribed (years) [Type here]
    - Last dose [Insert Date] [Insert Time]
- **Suboxone**
    - Current Dose [Type here]
    - Length of time prescribed (years) [Type here]
    - Last dose [Insert Date] [Insert Time]
- SROM (Kadian)
    - Current Dose [Type here]
    - Length of time prescribed (years) [Type here]
- Last dose [Insert Date] [Insert Time]

Carries: Y / N

Rx MD [Type here]
Pharmacy Name [Type here]
Pharmacy Telephone # [Type here]
Connecting Ontario checked: Y/N
Has a Naloxone kit? Y/N

Previous Treatment History

Medications **Treatments** **Harm Reduction**	Program Type	How Long?	Outcome/Comment

Primary Substance Use Disorder Diagnosis:
Substance name:

Substance Use Disorder Assessment (Y/N):
-Build up Tolerance:
-Experience Withdrawal if stop using:
-Use more than intended:
-Get Cravings:
-Been unsuccessful cutting down:
-Has give up activities:
-Use despite negative effects:
-Failure to fulfill roles (parent/job/family):
-Recurrent use in hazardous situations (ie alone, no naloxone present):

-Continued use despite social/interpersonal problems:

-**Severity**: [mild (2-3); moderate (4-5), severe (>6)]:

Physical Exam/Mental Status
Current signs of intoxication or withdrawal:
Any visible concerns of infection/wounds:
Other relevant physical findings:
Mental status:

Management plan
Treatment plan for substance use disorder: [Type here]
Transfer of Care: [Type here]
Treatment of Co-morbid conditions
Psychiatric: [Type here]
Medical: [Type here]
Education with regards to pregnancy and substance use: [Type here]
Blood Work: [Type here]
Follow Up Plan: [Type here]

Discussed with client:
1. Dilaudid is added to OAT as a harm reduction practice to decrease the need to use of street opioids.
2. Injecting Dilaudid tablets is off-label.

3. Injecting Dilaudid increases the risk of infections, abscesses, blood clots, endocarditis, sepsis, OD and death.
4. Safer ways to use Dilaudid include use of pill crusher, clean equipment, cooking x 10 secs to potentially lower infection risks, anti-septic self injection.
5. Receiving a prescription for Dilaudid may be time-limited as the Enhanced Shelter Support Program may close. The client may not receive this from other prescribers in the community. If the program closes, the client may be tapered off Dilaudids and/or switched to long-acting OAT to help with the need for opioids when leaving the program.
6. This medication is prescribed for use by client only and should not be shared with others. If medication is diverted, this may mean that the prescriber will discontinue the prescription. If others need it, they can be referred to the program for assessment.
7. Urine Drug Screen monitoring will be part of receiving OAT and iOAT.
8. There is increased risk of OD/death if this medication is used together with other sedatives such as benzodiazepines, ETOH, sleeping medication, stimulants and other street opioids.
9. The client should seek immediate medical care if they experience fever, jaundice, abdominal pain, severe joint or back pain, or have any other medical concerns.

Substance use Follow-Up

Substance use since last visit

☐ None

Type	Ongoing Use (Y/N)	Frequency (Same, Inc or Dec since last visit	Amount	Route
Opioids				
Cocaine				
Methamphetamine				
Benzodiazepines				
Cannabis				
Alcohol				
Nicotine				
[Type here]				
[Type here]				

Current Opioid agonist therapy or SOS: «methadone» add dose
«buprenorphine» add dose
«hydromorphone»add dose
Patient reported concerns regarding current dose: [Type here]
Symptoms of opioid intoxication or withdrawal: [Type here]
Reported sedation or intoxication with dose: Y /N
Reported withdrawal at current dose:
Acute medical or psychiatric concerns today: [Type here]
Patient's goal for the coming week: [Type here]

Physical exam:

POC UDS Toxicology Results:

Plan: [Type here]

Appendix IV**:** *Letter template for Hospitalists/Other Clinicians*

Dear Healthcare Providers,

This letter is to inform you that [Patient Name] is being followed by the Inner City Health Associates at [SITE], and is currently being prescribed opiates as part of our Risk Mitigation Prescribing Program.

This program provides patients who are at a high risk of overdose and death with opioid replacement using both a long-acting opiate, including methadone or slow release oral morphine (brand name Kadian), and short-acting opiates, including Hydromorphone IR 8 mg tablets. This enables patients to use a predictable opioid supply, rather than a poisonous street supply, with the goal of reducing the risk of overdose, death, and other complications associated with illicit street opiate use.

The patient and I have discussed the risks and benefits of this program, as well as other opioid agonist treatments including Methadone, buprenorphine-naloxone (trade name Suboxone), and slow release oral morphine (SROM, trade name Kadian) only.

As of this letter's date, [DATE], [PATIENT NAME] is receiving the following prescription:

Long Acting Backbone:
Kadian xxx mg, daily observed once daily, open capsules on apple sauce or other

OR

Methadone xx mg, daily observed once daily

Short Acting Opiates:
Hydromorphone IR 8 mg tablets, xx tablets po/IV q4h PRN, dispense xx tablets once daily

FOR EMERGENCY PROVIDERS:

Please continue this patient's medications, in particular the short acting opiates, while the patient is receiving care in the emergency department.

If there are concerns that the patient is not taking their full prescription and may have a lower tolerance than expected, consider decreasing the dose, observing more closely, and titrating the dose quickly to ensure adequate pain control.

Please note that if the patient is using additional illicit opiates on top of their prescription, they may have higher tolerance than expected and require higher doses of opiates to adequately relieve their pain.

Should there be any queries or concerns regarding this patient's prescriptions, please contact me at the number listed on this letter or call [PHONE NUMBER]. I would be happy to provide support around the management of this patient's opioids.

FOR INPATIENT PROVIDERS:

Please kindly continue this patient's medications, including both the long-acting backbone and short-acting opiates, while the patient is admitted. Please titrate medications as needed to meet the needs of the patient. Please note that patients with high baseline opiate use may require higher doses for adequate pain control of acutely painful conditions.

If appropriate and desired by the patient, please convert the current hydromorphone prescription to standing IV doses +/- additional IV PRN hydromorphone doses while admitted. Given the high dose of opioids, please avoid benzodiazepines unless deemed medically necessary. If benzodiazepines are used in hospital, please monitor opioid requirements closely.

Should there be any queries or concerns regarding this patient's prescriptions, please contact me at the number listed on this letter or call [PHONE NUMBER]. I would be happy to provide support around the management of this patient's opioids.

Thank you for your assistance in providing care to our mutual patient. I look forward to being in touch.

Sincerely,

[PRESCRIBER]
[SITE]
[ICHA INFORMATION]
[ON-CALL NUMBER]

Appendix V*: Letter template for Pharmacists*

Dear Pharmacist,

_____ is followed at _____ . Based on my evaluation and our program's criteria, they are eligible for the Safer Opioid Supply Program. The patient underwent a thorough assessment and all prescriptions are determined relative to the patient's current drug use patterns and account for opioid tolerance.

This program provides patients who are at high risk of overdose/overdose deaths with opioid replacement using SROM(Kadian) and Hydromorphone IR (Dilaudid) 8mg tablets. This enables the

patient to use predictable and safer doses of opioids rather than the poisonous street supply thereby significantly reducing their risk of death from overdose as well as medical complications associated with illicit street supply use. The patient and I have discussed the risks and benefits of this program, as well as alternative options including Methadone, Buprenorphine-naloxone, or Sustained Release Oral Morphine only.

Based on questions we have previously received from pharmacists we wanted to clarify some aspects of the prescription:

Daily observed therapy (DOT) Kadian:

- The daily Kadian is to be observed daily unless script specifies otherwise.
- If a patient presents to the pharmacy intoxicated, the daily observed dose is to be held and the patient's provider is to be notified.
- If you suspect the patient is not swallowing DOT doses, please inform patient's provider. Alternative arrangements can be made including sprinkling the contents of the capsule into ensure (a prescription for ensure would be provided).
- As the patient's tolerance decreases, the patient MAY refuse to take their full dose of Kadian at the pharmacy. Please notify us when this occurs. Their refusal to take the full amount of DOT Kadian should not impact their dilaudid prescription.

Daily dispensed Dilaudid:

- The Dilaudid 8mg (brand name only) is to be dispensed daily. Physicians should indicate the amount of tablets to be dispensed daily.
- These do not need to be observed unless otherwise specified.

Missed doses:

- If a participant misses 3 or more consecutive days of their daily dispense medications, they may have decreased tolerance for the medications, and they will be required to be reassessed by the prescribing physician or nurse practitioner to restart the program. Please notify us when this occurs.

We will ensure to place start and end dates on all prescriptions. As requested by some pharmacies, we will also include the patient's follow-up appointment on the prescription so pharmacy staff can remind the patient.

Thank you for working with our team and our clients on this program. At any time during the program we also welcome questions around prescriptions, the program, and what we can do to better work with our pharmacist colleagues.

Sincerely,

_____

Prescriber Name

***Appendix VI**: Brand and drug shortage considerations*

1. Methadone

Some clients have reported both in BC and Ontario That the Methadose brand of methadone has been less effective and does not seem to last the full 24 hours. If this is a concern for the client you are seeing please order metadol-D and be sure to indicate DNS or do not substitute.

Methadone is generally the cheapest and most available. There are no anticipated or reported shortages at this time.

2. Buprenorphine

There have not been reports of differences in effectiveness between brands of different Brands of buprenorphine however each brand carries a slightly different taste which can for certain clients can be significant as they must hold the dissolved product in their mouth for 15 minutes.

3. Kadian

there is no generic availability of Kadian. There have been occasional shortages. Generally, the same total daily dose of morphine is provided as a divided daily dose of M-eslon q 12 hours. Generally the morning dose is observed in the afternoon dose carried. This should only be limited to the time Of shortage.

If there are concerns about the clients stability it can be considered to have the client go twice a day to the pharmacy or the on-call substance use team can be consulted to provide advice on how the dosing can be converted back to methadone.

4. Hydromorphone

Hydromorphone Is preferentially ordered As dilaudid.
During shortages of Dilaudid 8 mg tablets, Dilaudid 4 mg tablets are preferential.

If both name brand formulations are unavailable a generic can be prescribed. However, it should be noted that the dissolving and utilization of these generic brands is highly variable and potentially problematic. As a result, client should be advised of the risk potential and consideration of shift towards an oral agent discussed again with the client.