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MANITOBA OPIOID AGONIST THERAPY RECOMMENDED PRACTICE MANUAL

1.8 Recommendations for the In-Hospital Care of Individuals with Opioid Use Disorder

GENERAL CONSIDERATIONS

This section addresses several important issues related to caring for individuals with an opioid use disorder (OUD) in hospital, while highlighting continuity of care between healthcare facilities and the community. PART 1 will review who can prescribe methadone and buprenorphine/naloxone in hospitals. PART 2 will provide recommendations for managing the specific care of individuals with OUD while admitted to hospital.

A period of hospitalization can present both opportunities and significant risks for individuals with OUD. In fact, those affected by this illness often fear hospitalization due to the anticipated discomfort of opioid withdrawal and general lack of access to adequate prescribed opioids to treat withdrawal and/or pain, safe spaces to use, harm reduction supplies, and support services that may be more readily available in the community. This can lead to affected individuals avoiding hospitalization despite medical need, or postponing presentation to the emergency department until their illness has progressed to critical severity.

Despite the above-mentioned risks, an emergency room presentation and/or hospital admission presents a valuable opportunity for addiction medicine intervention and harm reduction. Additionally, hospitalization is an opportunity for patients already on opioid agonist therapy (OAT) to be assessed and observed with a view on optimizing OAT dosing. This can also be an opportunity to address concurrent substance use, other medical and mental health issues, and evaluate the need for more intensive community-based supports.

PART 1 – PRESCRIBING OAT IN HOSPITAL

WHO MAY PRESCRIBE METHADONE & BUPRENORPHINE IN HOSPITAL?

Please note that the federal methadone exemption no longer exists. Both methadone and buprenorphine/naloxone prescribing approvals are now provincially regulated by the prescriber's respective regulatory authority. In Manitoba, this includes the College of Physicians & Surgeons of Manitoba (CPSM) for physicians and the College of Registered Nurses of Manitoba (CRNM) for RN(Nurse Practitioners). Please see Application, Training, & Regulatory Requirements to Provide OAT for further details.

Prescribing methadone and buprenorphine for OUD in-hospital is specifically discussed in this section to guide patient care for hospital administrators, care providers, and regulators.

Recommendations in this section are guided by the principles of access to care, continuity of care, equity, patient safety, and optimal utilization of current expert resources.

Continuing Care In Hospital

A licensed physician/RN(Nurse Practitioner) practicing in a hospital in Manitoba *does not* need to apply for approval to prescribe methadone or buprenorphine/naloxone for continuation of therapy as long as the patient is:

- An inpatient of the hospital,
- Under their care,
- Currently on methadone or buprenorphine/naloxone in the community, and
- Prescribed the *same dose* or a *lower dose* as in the community.

For dose increases, new methadone or buprenorphine/naloxone starts or restarts in hospital, including take-home (carry) dosing recommendations, please refer to the sections below.

Dose Increases

For methadone and buprenorphine/naloxone, dose increases are permitted in hospital if the licenced physician/RN(Nurse Practitioner) caring for the patient documents a discussion with the patient's community OAT prescriber or a physician member of the Health Sciences Centre (HSC) Addiction Consult Team. The on-call physician can be reached by contacting HSC paging.

The inpatient order needs to include the phrase "as discussed with Dr. _____ (name of the approved prescriber with whom the increase was discussed)".

New OAT Starts

For methadone and buprenorphine/naloxone, new starts (inductions) are permitted in hospital if the licensed physician/RN(Nurse Practitioner) caring for the patient documents a discussion with a physician member of the HSC Addiction Consult Team. The on-call physician can be reached by contacting HSC paging.

These on-call physicians have the expertise to determine if a buprenorphine/naloxone or methadone start by an inexperienced prescriber of OAT is advisable with phone guidance from the HSC consult physician. Several factors are considered in this decision, including the patient's overall health and medication regimen, current acute medical and mental health conditions, the hospital environment, in-patient care resources and staffing level, as well as available options for continuing OAT care in the patient's home community post discharge.

A virtual consultation may be suggested by the consulting physician to facilitate an enhanced remote patient assessment and appropriate care recommendations. However, this is at the discretion of the consulting physician and not a requirement.

Inpatient orders for new starts need to include the phrase "as discussed with Dr. _____ (name of the approved physician from the HSC Addiction Consult Team)".

OAT Restarts

An inpatient restart of methadone or buprenorphine/naloxone is defined as a methadone or buprenorphine induction in an inpatient who was prescribed methadone or buprenorphine for OAT in the community during the **30 days *preceding* hospital admission** AND **treatment was *discontinued* for a minimum of 3 days for methadone or 6 days for buprenorphine prior to the admission date.**

For methadone and buprenorphine/naloxone, restarts are permitted in hospital if the licenced physician/RN(Nurse Practitioner) caring for the patient documents a discussion with a physician member of the HSC Addiction Consult Team. The on-call physician can be reached by contacting HSC paging.

These on-call physicians have the expertise to determine if a buprenorphine/naloxone or methadone restart by an inexperienced prescriber of OAT is advisable with phone guidance from the HSC consult physician. Several factors are considered in this decision, including the patient's overall health and medication regimen, current acute medical and mental health conditions, the hospital environment, inpatient care resources and staffing level, as well as available options for continuing OAT care in the patient's home community post discharge.

Inpatient orders for restarts need to include the phrase "as discussed with Dr. _____ (name of the approved physician from the HSC Addiction Consult Team)".

Discharge Prescriptions for OAT Medications

Hospital teams need to notify the patient's community pharmacy and community-based prescriber/clinic of the admission on the first day of admission, or as soon as possible thereafter, to facilitate coordination of a discharge prescription and to notify them that any current OAT prescriptions must be put on hold or cancelled if needed.

It is important for hospital teams to note that **only an approved buprenorphine/naloxone or methadone prescriber may provide a buprenorphine or methadone discharge prescription (utilizing the M3P format) for continuing care at a community pharmacy**. It is therefore important to involve the patient's community pharmacy and community prescriber/clinic in discharge planning *as early as possible*. This communication should **not** happen only at the time of discharge if it can be avoided, especially if a new M3P discharge prescription is needed to facilitate safe discharge.

For hospital admissions during which **no dose changes occurred** for existing methadone or buprenorphine/naloxone prescriptions, the community pharmacy may be able to reactivate the patient's existing OAT prescription that was put on hold during admission, if the end date on the prescription has not lapsed. This needs to be confirmed by the inpatient team (inpatient pharmacist or treating physician if no pharmacist available) prior to discharge, to ensure continuity of care upon discharge.

If a dose change occurs during admission, the inpatient team is responsible for notifying the patient's community pharmacy of the dose change as soon as possible after it occurs. The pharmacy can then cancel their prescription "on hold" and try to acquire a new prescription for discharge in case the patient comes to the pharmacy unexpectedly (e.g., they discharge themselves). In general, a discharge prescription can be arranged by contacting the patient's community prescriber/clinic to request a new prescription be sent to the patient's pharmacy.

The HSC Addiction Consult Team may be able to provide a bridging discharge prescription for patients **on whom they were consulted.**

For both new starts and restarts of methadone and buprenorphine/naloxone in hospital, an approved prescriber from the HSC Addiction Consult Team may be able to provide a bridging discharge prescription to facilitate discharge, *if* arrangements are in place for follow-up with an approved community-based OAT prescriber who will then assume responsibility for the patient's ongoing OAT care.

Clinical Assistants (CAs) & Physician Assistants (PAs)

A clinical assistant (CA) or physician assistant (PA) cannot independently prescribe methadone or buprenorphine/naloxone in hospital and cannot provide a discharge prescription for these medications.

Inpatient orders for continuing care, dose increases, new starts, or restarts of methadone and buprenorphine/naloxone may be signed by a CA or PA if they include the phrase "as discussed with attending physician" on the signature line. Such orders require a documented conversation with the supervising attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

The same requirements as for attending physicians apply to CAs and PAs in terms of the need for a documented conversation with an approved prescriber as outlined above for dose increases, new starts, and restarts of methadone and buprenorphine/naloxone.

Residents

A resident may prescribe **buprenorphine/naloxone** in hospital for the purpose of continuing care at the *same or lower dose*.

Inpatient orders for **methadone** for the purpose of continuing care at the *same or lower dose* may be signed by a resident if they include the phrase "as discussed with attending physician" on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

Inpatient orders for dose increases, new starts, or restarts of **buprenorphine/naloxone** or **methadone** may be signed by a resident if they include the phrase "as discussed with attending physician" on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

The same requirements as for attending physicians apply to residents in terms of the need for a documented conversation with an approved prescriber as outlined above for dose increases, new starts, and restarts of methadone and buprenorphine/naloxone.

Residents cannot provide a discharge prescription for methadone or buprenorphine/naloxone.

Fellows

The same recommendations as for residents apply to fellows who hold an educational licence.

Fellows who hold a full licence, but who are not CPSM-approved prescribers of methadone and/or buprenorphine/naloxone, must follow the same requirements as all other licensed physicians/attending physicians in hospital.

Fellows who hold a full licence and who are CPSM-approved to prescribe methadone and/or buprenorphine/naloxone can order continuing care, dose increases, restarts, and new starts of the medication(s) for which they hold a prescribing approval.

Fellows cannot provide a discharge prescription for methadone or buprenorphine/naloxone unless the fellow holds a full licence and the relevant CPSM approval to prescribe methadone and/or buprenorphine/naloxone.

Take-home dosing (carries) for Inpatients

A licensed physician can, at their discretion, prescribe a "pass med" to an inpatient who is temporarily leaving the hospital and is later returning to the hospital. One or more methadone or buprenorphine/naloxone dose(s) must be dispensed by the hospital pharmacy and the patient must still be a patient of the hospital.

Methadone or buprenorphine/naloxone should **only** be provided as a "pass med" if the patient was previously receiving carries in the community and continues to meet the requirements for take-home dosing in the community as outlined elsewhere in this manual (see respective chapters for methadone and buprenorphine take-home dosing recommendations). If the hospital prescriber is in doubt, take-home doses should first be discussed with the patient's community OAT prescriber. The hospital pharmacy should notify the community pharmacy of any such pass meds provided to prevent double dosing.

Hospitals cannot provide take-home methadone doses to facilitate discharge. A discharge prescription needs to be arranged as outlined above *before* discharge can occur.

For buprenorphine/naloxone, one to two take-home doses provided by the hospital pharmacy is acceptable if discharge is unexpected or occurs on a weekend or holiday and the inpatient team is unable to reach the community OAT prescriber. The community pharmacy needs to be notified of any take-home doses provided upon discharge or as soon as possible to prevent double dosing. The community OAT prescriber/clinic needs to be notified upon discharge or as soon as possible after discharge as well.

CAs, PAs, residents, and fellows with an educational licence can sign pass med orders and orders for one to two take-home doses of **buprenorphine/naloxone** upon discharge if they include the phrase "as discussed with attending physician" on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

CAs, PAs, residents, and fellows with an educational licence can sign pass med orders for **methadone** if they include the phrase "as discussed with attending physician" on the signature line. Such orders require a documented conversation with the attending physician and **need to be co-signed by the attending physician as soon as possible and within 48 hours.**

PART 2 - TREATING PATIENTS WITH OUD IN HOSPITAL

Emergency visits and hospital stays can be difficult for patients with OUD, as outlined in GENERAL CONSIDERATIONS. In addition to acute illness, injury, or exacerbations of existing chronic medical conditions, individuals with OUD often present to hospital in withdrawal and/or with serious complications of substance use (e.g., overdose, deep tissue infection, septicemia, endocarditis, osteomyelitis, delirium). This is an opportune time to engage patients in harm reduction and addiction care for overall improved health outcomes. Likewise, patients already on OAT may be admitted for unplanned or planned care, and this can be an opportunity to optimize therapy.

Effective in-hospital care of patients with OUD should use a patient-centered, trauma-informed, and harm-reduction approach. Key components include:

- **Treat Withdrawal**. Manage acute opioid withdrawal. If the patient is already on OAT, ensure treatment is continued.
- **Treat Acute Pain**. Maximize non-opioid pharmacotherapy and other modalities as able and continue/maximize existing OAT dosing as appropriate. If additional opioid analgesia is indicated, patients with baseline opioid tolerance may need greater dose escalation to achieve an adequate response.
- **Offer Harm Reduction**. Provide harm-reduction education, resources, and supplies to all patients as able, even if patients are not ready to engage in addiction treatment (see **Appendix H** for resources).
- **Connect to Addiction Services**. As able/available, consult addiction medicine, facilitate access to OAT induction, and/or refer to community services.
- **Continuity of Care**. Connect with the community pharmacy, current OAT provider/clinic, and/or addiction services in discharge planning. Build safety into the discharge medication plan.

EMERGENCY DEPARTMENT/URGENT CARE OF INDIVIDUALS WITH OUD

Ideally, for patients with OUD seeking emergent care, the emergency department/urgent care (ED/UC) can be a doorway to addiction medicine care. Harm reduction should be emphasized.

Support Access to OAT

OAT induction should be pursued in the ED/UC if patients agree and treatment is indicated. In emergency departments/urgent care settings in Manitoba, ongoing efforts are focused on developing suitable resources, standardized orders, and care maps to support OAT induction and referral for community follow-up.

If possible, consult the HSC Addiction Consult Team as outlined in PART 1, for recommendations regarding the feasibility of a buprenorphine/naloxone induction in your practice setting. The on-call physician can be reached by contacting HSC paging. Alternatively, an ED/UC physician with CPSM approval to prescribe buprenorphine/naloxone can start buprenorphine if indicated. A plan for follow-up with a community-based OAT prescriber or local RAAM clinic is a critical aspect of care planning.

For select patients an unwitnessed ("home") induction may be considered. Alternatively, others may benefit from a micro-dosing induction over the Conventional Buprenorphine Induction. Please see the respective chapters, Recommendations for Unwitnessed Induction with Buprenorphine/naloxone and Recommendations for Buprenorphine/naloxone Induction Using the Micro-dosing Method for details on these approaches. Again, such inductions may be initiated by the HSC Addiction Consult Team, or by an approved buprenorphine/naloxone prescriber.

As buprenorphine/naloxone is considered first-line therapy for the treatment of OUD it should be used preferentially for ED/UC inductions. Please refer to Recommendations for OUD for further guidance on treatment approaches. Consideration for methadone as an alternative to buprenorphine/naloxone induction may be appropriate in some patients (please see Recommendations for Methadone Induction, Titration, & Stabilization), however methadone inductions in the ED/UC must be done by a prescriber with a CPSM approval to prescribe methadone or in consultation with the HSC Addiction Consult Team.

If induction cannot be arranged in ED/UC, patients can be directed to a local Rapid Access to Addiction Medicine (RAAM) Clinic or community-based OAT provider in the area. Due to the potentially life-threatening nature of OUD, it is important for emergent care settings to be aware of local resources for OAT induction.

Provide Harm Reduction & Resources

Harm reduction in ED/UC can include access to naloxone kits, sterile drug consumption supplies, and education on safer use (see **Appendix H** for resources). A harm reduction approach can be used with patients irrespective of their readiness to engage with addictions care. Community resource lists for same-day/next-day care and harm reduction supplies can be kept on-hand for ED/UC staff to provide directly to patients.

At minimum, patients can be directed to Street Connections for information on how to access naloxone kits, safer use supplies, and support in the community. In consultation, the Addiction Consult Team may also be available to offer harm-reduction teaching, supplies, and OAT induction, as appropriate. Again, patients can also be directed to a local RAAM Clinic if these resources cannot be offered in the ED/UC.

Administer Dose for Patients on OAT in ED/UC

Patients already on OAT should have their dose administered in a timely manner if they have yet to receive their daily dose, particularly if an extended stay in the ED/UC is anticipated. Ask patients if they have taken their dose for that day and confirm this with their community pharmacy. Do not rely on DPIN information alone in this regard, as a dose may be entered into DPIN before it is administered to the patient at the community pharmacy. Similarly, check with the community pharmacy if any take-home doses were released and ask the patient if the dose(s) were consumed. **Obtaining collateral from the patient's community pharmacy and community OAT prescriber/clinic is essential**, particularly around take-home doses.

If the patient has take-home doses with them but they have not consumed their dose that day, do not delay the patient's dose if the hospital pharmacy/urgent care setting cannot provide a timely dose. The patient should be allowed to consume the take-home dose in the emergent care setting to prevent withdrawal. Communication with the community pharmacy and community-based OAT clinic is imperative in such situations.

Missed OAT Doses

If the community pharmacy can provide reliable collateral information and the patient has missed one or more doses in community prior to presenting to the ED/UC, refer to the Ongoing Care chapter for recommendations on the management of missed doses.

However, if the available collateral is minimal and the patient's report uncertain, monitor for opioid withdrawal symptoms to determine if further withdrawal management is required. The Clinical Opiate Withdrawal Scale (COWS) can be used to assess and document withdrawal (see **Appendix I**). Withdrawal should be managed using short-acting opioids in this situation, using the approach outlined in the INPATIENT CARE section below.

All doses administered in ED/UC must be reported to the patient's community pharmacy and to the OAT provider/clinic to prevent double dosing or miscommunication. Please see the CONTINUITY OF CARE & DISCHARGE PLANNING section below for further recommendations.

Treat Opioid Withdrawal

Managing acute opioid withdrawal in the ED/UC is of utmost importance. Adequately treating withdrawal can facilitate the assessment and treatment of other presenting conditions. It enables patients with OUD to engage in their own care, make informed treatment decisions, and stay the course if ongoing or longer-term hospital care is required. See the INPATIENT CARE section below for a detailed approach to treating opioid withdrawal.

Treat Acute Pain

In general, acute pain in patients with OUD should be managed similarly to someone who is not on OAT, with additional considerations to ensure adequate analgesia and patient safety.

Patients on OAT with acute pain will typically require pain management *in addition to* their buprenorphine/naloxone or methadone dose. It is important to recognize that the maintenance opioid for OUD is the baseline for preventing withdrawal and does not provide significant pain relief.

If patients present in opioid withdrawal, managing the withdrawal effectively will be essential to treating acute pain.

The initial management of acute pain should take into consideration the type/source of pain and the evidence for managing that particular pain. Often non-opioid analgesics are recommended as first-line treatment and the approach should be the same for someone on OAT. The section Managing Acute, Chronic, & Perioperative Pain provides detailed recommendations for managing pain in the context of OAT.

For the most part, if acute pain would normally require the use of opioid analgesics, it would also be appropriate for the patient on OAT. **Given the baseline tolerance of patients on OAT to opioids, doses may need to be escalated to achieve an adequate response**. The prescriber should start at doses similar to those used in a patient not on OAT and reassess early in order to provide adequate pain management. Additionally, it is important for the ED/UC prescriber to discuss the short-term nature of the opioid analgesic with the patient, as appropriate.

The CONTINUITY OF CARE & DISCHARGE PLANNING section below outlines recommendations for medication management, particularly if opioid analgesics and/or sedating/psychoactive medications are provided upon discharge. Generally, prescriptions for such medications from emergent care settings should be short-term (e.g., ≤ 3 days) with controlled dispensing for safety.

Access Mental Health Care

If patients present to ED/UC with psychiatric symptoms of a mental health disorder and consultation with a Psychiatric Emergency Nurse (PEN) and/or Psychiatry is warranted, these services can also provide harm-reduction support and addiction treatment suggestions. Patients with severe psychiatric instability may require preliminary stabilization of their symptoms prior to making informed decisions about their addiction medicine care. However, managing acute opioid withdrawal in these individuals is also helpful to promote stability and engagement in overall care.

INPATIENT CARE OF INDIVIDUALS WITH OUD

Patients in Opioid Withdrawal

Patients who use opioids regularly and who are admitted to hospital typically do not have access to their usual supply, equipment, and supports. This can lead to significant suffering from both physical and emotional symptoms of withdrawal. Managing this withdrawal in

hospital helps patients engage in ongoing medical care. It can decrease higher-risk or drug seeking behaviours, improve presence and compliance with medical care, and decrease the risks associated with illicit use. The HSC Addiction Consult Team can assist with withdrawal management, but **any inpatient team should manage withdrawal if this service is not available or if patients refuse addiction care**.

If patients do agree to treatment of their OUD, ideally OAT can be started in hospital *when indicated*. As outlined in PART 1, *New Starts*, *Restarts*, and *Dose Increases* require a documented discussion with a physician member of the Addiction Consult Team. The on-call physician can be reached by contacting HSC paging. Ideally, patients agreeing to treatment can be started on OAT *instead* of treating withdrawal with other opioids, if suitable resources are available to support induction and community follow-up.

Treating Opioid Withdrawal for Inpatients

If OAT induction is not yet indicated or available, acute withdrawal can be managed with scheduled and PRN doses of a short-acting, oral opioid, such as morphine or hydromorphone. Oral liquid formulations, with orders for direct observation of administration, will help limit potential misuse (e.g., intravenous injection) or diversion. **Communicate with nursing staff about the importance of direct observation of each dose for safety.**

Given the baseline tolerance of patients with OUD, opioid doses may need to be escalated to achieve an adequate response. The practitioner can start at doses similar to those used in an opioid-naïve patient but make dosing available at shorter intervals to facilitate rapid dose escalation, if indicated for withdrawal management. Additionally, reassess early and frequently to provide adequate withdrawal management.

An example of an order for harm reduction opioid dosing may be: ‘Morphine oral liquid 10-20 mg po q 1h PRN witnessed, for pain or withdrawal. Hold if sedated or RR < 10’. Note that this is an example only and that many patients will require higher dosing. While some patients may require lower amounts, the use of PRNs (with hold orders based on parameters of opioid toxicity) allows for more liberal dosing to minimize undertreatment of withdrawal, which may limit engagement in care.

The use of PRNs can be monitored to titrate scheduled doses until opioid withdrawal is eliminated or adequately suppressed over a 24-hour period, without sedation. For example, if a patient uses 200 mg of oral morphine through PRNs in the first 24 hours of admission and appears comfortable on reassessment, you may add a scheduled dose of ‘Morphine oral liquid 20 mg po q 3h witnessed’ and continue a smaller amount of PRN morphine.

Alternatively, if that same patient uses 200 mg or oral morphine but is in clinical opioid withdrawal or reports needing to source illicit opioids, you may add a scheduled dose of ‘Morphine oral liquid 25 mg po q 3h witnessed’ and continue a more liberal amount of PRNs, reassessing daily until stable dosing is achieved.

This approach can allow patients to further engage in ongoing medical care and facilitate pain management if needed. If acute opioid withdrawal and pain are adequately managed, PRNs may be reduced or discontinued as dosing stability is achieved.

Discuss this treatment goal transparently with the patient and care team – neither underdosing nor dosing to sedation are appropriate. Additionally, it is important for the prescriber and patient to discuss the interim nature of this opioid therapy as a bridge to OAT induction and/or discharge. Should a patient decline OAT induction, harm reduction opioid dosing should terminate at discharge, or be converted to daily witnessed SROM (i.e., Kadian®) at tapering doses in the community, and the patient should receive information about where they can access OAT. Please see the CONTINUITY OF CARE & DISCHARGE PLANNING section below, specifically *Discharge Prescriptions*.

The COWS (**Appendix I**) can be used to assess and document the severity of opioid withdrawal while establishing the opioid regimen; this helpful clinical tool utilizes objective and subjective measures of withdrawal and can assist in determining appropriate dosing.

Acute & Perioperative Pain

If acute pain persists, PRNs may still be required for breakthrough pain, procedures (e.g., dressing changes), or sessions with physiotherapy and occupational therapy.

Again, for patients on OAT, it is important to recognize that the maintenance opioid the patient is taking for OUD (e.g., buprenorphine or methadone) is the baseline for preventing withdrawal and does not provide significant pain relief.

If possible, OAT should be continued at the current dose while acute pain is managed *in addition* to this baseline therapy for withdrawal management. The same applies to the perioperative period.

In general, patients should be managed like any other patient who presents similarly but that does not have OUD, with additional considerations to ensure adequate analgesia and patient safety. See Managing Acute, Chronic, & Perioperative Pain for further recommendations around pain management for patients with OUD.

Other Medications for Symptomatic Management

The risks and benefits of prescribing non-opioid medications for symptomatic withdrawal management must also be carefully considered (see **Appendix J**). Regularly scheduled acetaminophen and ibuprofen may be sufficient. Use extra caution when prescribing symptomatic management medications with sedating properties.

Benzodiazepines and/or Z-drugs should be avoided in patients with OUD and polypharmacy with multiple sedating/psychoactive medications should be minimized.

Benzodiazepines & Z-drugs Increase Risk of Overdose

Patients already using benzodiazepines/Z-drugs are higher-risk and caution is indicated when establishing a suitable opioid regimen to manage withdrawal and/or pain.

A thorough history of benzodiazepine/Z-drug use and further review with the Addiction Consult Team may be necessary. This includes use via prescribed and/or illicit sources. A strategy for benzodiazepine/Z-drug management (even for stable long-term prescriptions), including diagnosis of potential sedative-hypnotic use disorder, must be part of the overall treatment plan. See the Managing Polypharmacy section MANAGING PRESCRIBED AND ILLICIT BENZODIAZEPINES & Z-DRUG USE for detailed guidance.

If significant mood, anxiety, or other psychiatric symptoms persist once opioid withdrawal is adequately suppressed, consultation with the Psychiatric Liaison/Psychiatry may be warranted.

Other Safety Considerations

For safety reasons, case by case, there may be times when hospital teams forgo inpatient administration of opioids to treat withdrawal. Harm-reduction should still be emphasized – see HARM REDUCTION FOR INPATIENTS below for details. The Addiction Consult Team can provide guidance for complicated or higher-risk situations. Treatment agreements may be used to encourage communication, delineate expectations, and minimize conflicts between staff and patients. This may be particularly useful for lengthier hospital stays.

For patients on prescribed opioids, benzodiazepines/Z-drugs, and/or OAT, hospital teams must notify the patient's community pharmacy and prescriber/clinic of the admission on the first day, or as soon as possible thereafter. It is essential to hold or cancel dispensing of these community prescriptions during admission for safety, to avoid potential double dosing or diversion.

Being aware of the hospital admission also allows the community prescriber and pharmacy to plan ahead and potentially assist with the OAT discharge prescription (which can only be written by an approved OAT prescriber). The community OAT prescriber may also be able to advise the hospital provider on discharge medication management to increase patient safety upon discharge.

Inpatients on OAT

Patients who are stable on OAT should generally have their dose continued in hospital, as described under *Continuing Care In Hospital* in PART 1.

If a patient is on OAT but unstable (i.e., their dose is subtherapeutic and/or they were supplementing with other opioids prior to admission), they may also require opioid withdrawal management. Ideally, their opioid agonist could be titrated as described in *Dose Increases*, with the guidance of an approved buprenorphine/naloxone or methadone prescriber.

If consultation is not available in a timely manner to make titration possible, a short-acting oral liquid opioid, with witnessed administration, can be used in the interim. Dosing should offset the OAT dose, i.e., if their daily OAT dose wears off by the evening, the additional opioid can be scheduled in the evening and/or before bed to treat withdrawal throughout the night. This should be discontinued prior to discharge.

An inpatient stay can provide valuable observational information about how an unstable patient on OAT is doing on their dose. Collateral information from the in-hospital provider regarding withdrawal observed can alert the community prescriber that further OAT dose titration is indicated.

Perinatal Patients

Pregnancy can be a stressful experience for anyone, but it can also be a time of increased motivation. Pregnancy may present a valuable opportunity to engage individuals who use drugs in addiction care to improve maternal and fetal health outcomes.

Untreated OUD in pregnancy is associated with numerous adverse fetal and maternal outcomes. Significant opioid withdrawal in pregnancy is a medical emergency and requires urgent and effective management to prevent miscarriage/preterm labour, low birth weight, and the associated complications of prematurity.

OAT is the standard of care for pregnant patients with OUD – please refer to the Pregnancy chapter of this manual for detailed recommendations.

Perinatal hospital admissions are an ideal time for OAT induction and/or to optimize OAT dosing. Pregnancy is also an indication for inpatient OAT induction. Admission can also facilitate connection to ongoing addiction care and other services, such as high-risk obstetrics, social work, and primary care.

Individuals already stable on OAT may require dose increases during pregnancy as the body and metabolism change. Titration can proceed as described in *Dose Increases*, with the guidance of an approved buprenorphine/naloxone or methadone prescriber. Reciprocally, some women require *dose decreases* post-partum and should be monitored for sedation.

HARM REDUCTION FOR INPATIENTS

Inpatient admission is an opportune time to engage patients in harm-reduction strategies. Harm reduction is used along the continuum of treatment approaches for OUD, to promote safety and improve health outcomes with patients, regardless of their readiness to stop or decrease substance use. There is **ample evidence to support harm-reduction interventions for all people who use opioids**, including those engaged in OAT or other treatment.

Specific interventions with strong evidence include:

- Harm reduction supply distribution (e.g., needle/syringe programs)
- Supervised consumption/overdose prevention sites, and
- Take-home naloxone training/kits.

These interventions should be made widely available with low barriers to help reduce opioid-related harms – this includes the ED/UC as well as inpatient units.

See **Appendix H** for a detailed list of online resources that can be shared with patients, including downloadable handouts and ways to access naloxone kits. Services and options may vary from location to location, but inpatient harm reduction approaches can include:

- Prescribing/facilitating access to take-home naloxone kits, education, or at minimum connecting patients to community resources to access kits.
- In-hospital access to sterile drug consumption equipment (e.g., clean pipes, glass stems, filters, needles, and other supplies for safer injection techniques). Consider bedside access to supplies.
- Education on safer injection, smoking, and insufflation techniques.
- Supervised consumption spaces in hospital.
- Testing of substances being used, at bedside or through a drug testing service.
- Referrals to addiction medicine or other health and social services, including supporting access to primary care.
- Vaccinations and Sexually Transmitted and Blood Borne Infection (STBBI) testing.

Offer STBBI Testing

Comprehensive testing for STBBIs should be offered to all patients with OUD. Inpatient admission is an excellent time to offer and order this testing and arrange potential follow up with specialized services (e.g., hepatology or HIV clinics).

Initial screening should include testing for HIV, hepatitis A, B, and C, as well as syphilis, chlamydia, and gonorrhea, including throat and rectal swabs if indicated.

Patients at significant and ongoing risk of infection should be offered STBBI screening every 6 to 12 months. Repeat testing may be customized based on individual risk factors. Please see the chapter Prevention, Screening, & Management of HIV & Hepatitis C in Individuals with OUD for further guidance.

PLANNED HOSPITAL ADMISSION IN THE CONTEXT OF OUD

Planned hospital admission is warranted for some patients with OUD, often to optimize care and to further evaluate and mitigate significant safety concerns. Criteria for inpatient admission can include:

- Pregnancy and perinatally.
- Concurrent polypharmacy or polysubstance use, particularly high-risk alcohol and/or sedatives/hypnotic use.
- Complex medication transitions, such as methadone to buprenorphine/naloxone, or from high-dose long-acting or high-potency opioids (e.g., fentanyl) to buprenorphine or methadone, particularly in the context of complex medical or psychosocial issues.
- Failed and/or higher-risk community OAT inductions (e.g., due to geography/travel, safety concerns, or psychosocial factors).
- Concurrent and/or acute medical conditions that cannot be reliably treated in the community given patient instability within the context of substance use (e.g., pneumonia, endocarditis, osteomyelitis, advanced HIV).
- For emergent investigation of other medical issues with risk of morbidity or mortality, that cannot be reliably investigated in the community given patient instability within the context of substance use.

Some planned admissions may warrant referral for admission to the HSC Addiction Unit for specialized care. Others may be arranged in collaboration with local hospitals, or other services, such as Obstetrics, Surgery, or Medicine, and with or without HSC Addiction Consult Team collaboration.

Winnipeg Health Sciences Centre Addiction Unit

Community providers may consult with the HSC Addiction Unit team to arrange admission for patients who require medical management of their substance use disorder(s), including those who meet the criteria above.

The Addiction Unit (AU) is a small inpatient unit specializing in medical management of substance use disorder. Patients requiring *specific medical intervention* for withdrawal management, stabilization, and access to treatment services are considered for admission. Admissions may be planned following assessment in emergency or through one of the outpatient clinics associated with the program, the Complex Addiction & Recovery Medical Assessment (CARMA) Clinic, the Alcohol Recovery Clinic (ARC), or the Rapid Access to Addiction Medicine (RAAM) clinics.

Given the waitlist for specialist consultation in CARMA, community OAT providers may wish to consult with the HSC Addiction Program Medical Director or the AU attending physician directly to facilitate more urgent admission.

Transfers from other HSC units or St. Boniface General Hospital may also be arranged by the HSC Addiction Consult Team and the AU attending physician. Transfers from attending physicians in other community hospitals may be arranged with the AU attending directly. The on-call physicians can be reached by contacting HSC paging.

Please note that AU is a limited resource that serves all of Manitoba. There may be a wait time for planned admissions and not all admission requests can be accommodated.

Addiction Unit Treatment Agreement

The AU has a treatment agreement that patients must agree to prior to admission. Like other treatment agreements, this is intended to support informed consent and treatment planning, as well as delineate expectations, manage boundaries, and minimize conflicts between staff and patients.

The agreement also promotes safety for this vulnerable patient population. Admission is voluntary and some patients may not agree to admission as the expectations feel too restrictive, particularly around off-ward passes, smoking, and visitors. Since admission is voluntary, patients must have the capacity to agree to admission and contract for safety if needed. The AU cannot admit involuntary patients under the Mental Health Act – these patients would require psychiatric assessment and intervention.

CONTINUITY OF CARE & DISCHARGE PLANNING FOR PATIENTS WITH OUD

Ideally, communication for continuity of care and discharge planning should start on the first day of admission or as soon as possible thereafter. Verifying medications and sharing collateral is essential to safe inpatient care. Likewise, upon discharge, informing the community providers and pharmacy about changes in medical status, medications, or OAT dosing, and highlighting any new safety concerns, promotes a safer transition back to community.

Even for short stays in urgent care or emergency, or brief admissions, when OAT doses are administered in hospital a member of the hospital team must inform the community pharmacy (and ideally the OAT provider/clinic) to prevent double dosing or miscommunications about missed doses.

Discharge Prescriptions

Only an approved buprenorphine/naloxone or methadone prescriber may provide a buprenorphine or methadone discharge prescription for continuing care at a community pharmacy. See the PART 1 section *Discharge Prescriptions for OAT Medications* for details.

If opioids were provided in hospital for interim management of opioid withdrawal, a discharge prescription for this indication is *not an expectation*. As previously described, attempts can be made to help patients access OAT, addiction care, and harm reduction services. Discharge prescriptions for new benzodiazepines/Z-drugs should also be avoided in patients with OUD.

If OAT was not started in hospital for some reason for a patient with OUD (e.g., patient choice, limited resources or length of stay, or discharge is to a rural/remote location without feasible access to OAT), then interim options for bridging or tapering prescriptions may be explored. Please see Alternative Treatment Approaches for OUD Including SROM (Kadian®) for possible approaches to such situations.

Communication is Paramount for Medication Safety

If opioid analgesics or other sedating/psychoactive medications are started in hospital and still indicated upon discharge, prescriptions should be short-term with restricted dispensing for safety.

For patients on OAT, communication with the patient's community pharmacy and OAT prescriber is essential to build safety and continuity of care into the medication management plan. Ideally the patient has one prescriber, or identified group of prescribers, responsible for their OAT and other sedating/psychoactive medications in the community, including any additional opioids used for pain management. Similarly, best practice is to utilize one community pharmacy for all medications dispensed. The patient's community pharmacy and OAT prescriber can help determine dispensing intervals upon discharge, which should mirror the OAT schedule in most cases.

STRONG RECOMMENDATION: REMINDER TO DISPENSE WITH OAT

Typically, all psychoactive/sedating medications should be dispensed with OAT, i.e., on the same schedule as OAT. Communicating with the patient's pharmacy about the plan for managing these medications is essential. Controlled dispensing instructions, such as "dispense as per OAT schedule", must be written on all relevant prescriptions. Please see the Managing Polypharmacy in OAT chapter for further medication safety recommendations.

Discharge prescriptions for any opioid analgesics or sedating/psychoactive medications should be time-limited to align with follow up in the OAT clinic. The OAT prescriber can then take over management of any new or continued medications. Discharge prescriptions for any additional opioids should include a note that it is to be used in conjunction with the patient's OAT, to avoid any interruptions to OAT care at the receiving pharmacy.

Ensuring such information is clearly communicated at the time of discharge from hospital is extremely important. **A "warm handoff" between all parties involved, including the patient, can ensure a common understanding of the care plan, identify potential issues, and set timelines for follow-up**.

NIHB Client Safety Program

Patients on OAT whose medications are covered by Non-Insured Health Benefits (NIHB) for First Nations and Inuit are enrolled in the NIHB Client Safety Program. These patients are required to have a *sole prescriber* (or identified group of prescribers) as a provision for coverage of opioids, benzodiazepines, stimulants, gabapentinoids, and/or nabilone (i.e., restricted medications).

When patients are initiated in a community pharmacy on buprenorphine/naloxone, methadone, or SROM to treat OUD, they are automatically enrolled in this program. Often the sole prescriber will be their regular OAT prescriber (or group of prescribers), and this should be considered when developing the discharge plan. If any of these restricted medications are prescribed by a clinician not listed as the sole prescriber through NIHB, prescription costs will not be covered.

Mitigating Risk of Misuse of Additional Opioids

As noted, additional opioids prescribed upon discharge for pain management **must be dispensed at the same interval as OAT**. Limiting the medication supply dispensed at one time can help mitigate potential misuse of the opioid analgesic.

For example, if the patient is on daily dispensed OAT, the new opioid analgesic should also be dispensed daily. If significant concern for misuse exists, *witnessed* daily dosing may be implemented, depending on the formulation of the opioid. For patients with routine take-home doses (carries) of OAT, the number of days' supply of the opioid analgesic should not exceed the number of carry days dispensed. If the patient has weekly carries (i.e., OAT is witnessed once weekly), it may be prudent to initially dispense the opioid analgesic at shorter intervals to mitigate risk of misuse.

IN SUMMARY

While emergency visits and hospital stays can be difficult for patients with OUD, they also present a valuable opportunity for addiction medicine intervention and harm reduction. Treating withdrawal and pain as required, providing harm-reduction education, resources, and supplies, and connecting patients to community supports are all essential to overall improved health outcomes for patients with OUD. Diligence in medication management and communication with the community pharmacy and OAT provider/clinic are equally essential for continuity of care and a safe transition back to the community.

Appendix H

HARM REDUCTION RESOURCES

Toward the Heart

Homepage https://towardtheheart.com/

Resource Page https://towardtheheart.com/a-z-resource-page

Safer Use https://towardtheheart.com/safer-use

Safer Tablet Injection Handout
https://towardtheheart.com/assets/uploads/1614902572pDb5cFkV7mmEnHjxavvOVi3tufpOC0dEHfyCNU0.pdf

Safer Smoking Supplies Handout
https://towardtheheart.com/assets/uploads/1603734665AaiyNXgI3ehtneE3DYxXVLbMpIwErO8i80bVlGp.pdf

Street Connections

Homepage https://www.streetconnections.ca/index.php

Van Information https://streetconnections.ca/van-information

Find a location for supplies, condoms, testing, & naloxone
https://www.streetconnections.ca/service_map.php

CATIE (HIV & Hepatitis C Information)

Homepage https://www.catie.ca/

Choosing a Vein Handout http://librarypdf.catie.ca/ATI-70000s/70162.pdf

Safer Use Videos https://www.catie.ca/safer-substance-use-video-series

Safer Injection & Smoking Information
https://www.catie.ca/prevention-prevention-methods/safer-injecting-and-smoking-supplies

National Harm Reduction Coalition

Homepage https://harmreduction.org/

Resources https://harmreduction.org/all-resources/#safer-drug-use

Safer Drug Use Handout https://harmreduction.org/issues/safer-drug-use/facts/

Manitoba Harm Reduction Network

Homepage https://mhrn.ca/

Appendix I[1]

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

CLINICAL OPIATE WITHDRAWAL SCALE[1]

For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opiate withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

Patient's name: _____ Date and Time: _____/_____/____:____

Reason for assessment: _____

Resting Pulse Rate _____ beats/minute *Measured after patient is sitting or lying for one minute* 0 pulse rate 80 or below 1 pulse rate 81–100 2 pulse rate 101–120 4 pulse rate greater than 120	**GI Upset** *over last ½ hour* 0 no GI symptoms 1 stomach cramps 2 nausea or loose stool 3 vomiting or diarrhea 5 multiple episodes of diarrhea or vomiting
Sweating *over past ½ hour not accounted for by room temperature or patient activity* 0 no report of chills or flushing 1 subjective report of chills or flushing 2 flushed or observable moistness on face 3 beads of sweat on brow or face 4 sweat streaming off face	**Tremor** *observation of outstretched hands* 0 no tremor 1 tremor can be felt, but not observed 2 slight tremor observable 4 gross tremor or muscle twitching
Restlessness *observation during assessment* 0 able to sit still 1 reports difficulty sitting still, but is able to do so 3 frequent shifting or extraneous movements of legs/arms 5 unable to sit still for more than a few seconds	**Yawning** *observation during assessment* 0 no yawning 1 yawning once or twice during assessment 2 yawning three or more times during assessment 4 yawning several times/minute
Pupil Size 0 pupils pinned or normal size for room light 1 pupils possibly larger than normal for room light 2 pupils moderately dilated 5 pupils so dilated that only the rim of the iris is visible	**Anxiety or Irritability** 0 none 1 patient reports increasing irritability or anxiousness 2 patient obviously irritable anxious 4 patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint Aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 not present 1 mild diffuse discomfort 2 patient reports severe diffuse aching of joints/muscles 4 patient is rubbing joints or muscles and is unable to sit still because of discomfort	**Gooseflesh Skin** 0 skin is smooth 3 piloerrection of skin can be felt or hairs standing up on arms 5 prominent piloerrection
Runny Nose or Tearing *Not accounted for by cold symptoms or allergies* 0 not present 1 nasal stuffiness or unusually moist eyes 2 nose running or tearing 4 nose constantly running or tears streaming down cheeks	**Total Score** _____ *The total score is the sum of all 11 items.* Initials of person completing assessment: _____

Score: 5–12 = mild; 13–24: moderate; 25–36 = moderately severe; more than 36 = severe withdrawal

Reference:

1. Wesson DR, Ling W. The Clinical Opiate Withdrawal Scale (COWS). J Psychoactive Drugs. 2003;35(2):253–259.

More information:
www.bccsu.ca

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[1] From https://www.bccsu.ca/wp-content/uploads/2017/08/Clinical-Opiate-Withdrawal-Scale.pdf

Appendix J

NON-OPIOID MEDICATION FOR SYMPTOMATIC MANAGEMENT OF OPIOID WITHDRAWAL

The following non-opioid medications may be useful to treat symptoms of opioid withdrawal.

Prescribers should exercise caution with all sedating medications during OAT induction, as they may interfere with the assessment of withdrawal severity and increase the risk of fatal overdose. In the absence of precipitated withdrawal (in the context of buprenorphine induction), many prescribers prefer to avoid these medications entirely during induction.

- Acetaminophen 500-1000 mg PO Q4-6h PRN for muscle pain (to a maximum dose of 4000 mg in 24 hours, or as appropriate based on known liver function/impairment).
- Ibuprofen 400 mg PO Q6-8H PRN for muscle pain.
- Ondansetron 4 mg PO Q6H PRN for nausea.
- Loperamide 4 mg PO PRN for diarrhea, then 2 mg PO after each loose stool, up to a maximum of 16 mg in 24 hrs.
- Trazodone 50-100 mg PO QHS PRN for insomnia.
- Quetiapine 25-50 mg PO QHS PRN for anxiety/insomnia.
- Clonidine 0.1 mg PO QHS PRN for opioid withdrawal symptoms and insomnia. Clonidine can be titrated up to 0.2 mg PO BID for severe withdrawal, but caution is advised due to the potential risks of sedation, hypotension, and diversion.