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# MANITOBA OPIOID AGONIST THERAPY RECOMMENDED PRACTICE MANUAL

## 1.15 Recommendations for Continuity of Care in Opioid Agonist Therapy: Residential Treatment, Travelling, Incarceration & RAAM Clinics

## GENERAL CONSIDERATIONS

This chapter summarizes recommendations to promote continuity of care for patients on opioid agonist therapy (OAT). As a long-term treatment, it is not uncommon for patients on OAT to transfer between care providers and pharmacies, as housing and life circumstances change, nor is it uncommon for patients to move between community and institutional settings.

Specifically, this section addresses continuity of care for patients participating in residential treatment, as well patients on OAT who are travelling in Manitoba, out-of-province, and internationally. Key considerations are also addressed for the care of incarcerated patients. Lastly, the role of Rapid Access to Addiction Medicine (RAAM) clinics in Manitoba is reviewed, along with the importance of transfer of care of patients from this interim service to long-term OAT providers.

Further recommendations for continuity of care are also addressed in the In-Hospital Care chapter, particularly considerations for discharge planning and medication management.

Communication and collaboration remain paramount to ensure patient safety on OAT, along the entire continuum of care. A “warm handoff” where all parties are involved (including the patient) can ensure a common understanding of the care plan, identify potential issues, and set timelines for follow up as needed.

## SPECIFIC CONSIDERATIONS: RESIDENTIAL TREATMENT

Residential treatment programs offer a valuable period of treatment intensification for patients on OAT. This can be beneficial for patients who are struggling with ongoing substance use and/or those who wish to further develop coping and relapse-prevention skills. The recommendations discussed below should be considered for patients who express interest in attending residential treatment while on OAT.

### *Stable OAT Dose Continued*

**It is important for a patient's stable OAT dose to be continued while in residential treatment**. This promotes the patient's ongoing medical stability and enables them to optimally participate in the psychosocial components of residential treatment.

It is thus important to ensure that a treatment agency/center is supportive of the patient's choice to participate in OAT, prior to engaging that agency/center in further planning. It is also important to consider the program's geographic location, proximity of the closest pharmacy that offers OAT services, and the need for witnessed dosing when making these arrangements.

### *Pharmacy Considerations*

Like any other patient, patients on OAT have the right to work with a pharmacy of their choice. However, certain residential treatment centers have established relationships and processes with specific pharmacies that will provide all medications for the patients in their program.

These arrangements may be in place due to proximity of the particular pharmacy for the purpose of witnessed dosing of OAT, or simply to standardize processes upon patient intake for medication dispensing, delivery, and administration.

It is often more practical for patients entering residential treatment to receive their medication from the program's designated pharmacy for the duration of their stay. **Communication between the patient's usual community pharmacy, the pharmacy serving the treatment center, OAT clinic staff, and residential program staff is therefore essential**. This communication can facilitate a smooth transition into treatment and back to the usual community pharmacy once the program is completed.

### *Maintain Witnessed Dosing & Medication Standards*

When a residential treatment center relies on a particular pharmacy to deliver medications for patients in their program, all the usual standards for witnessed dosing and safe medication transport, delivery, storage, and record keeping must be maintained.

Participation in residential treatment *does **not** exempt patients on OAT from the typical witnessed dosing schedule* as prescribed by their OAT provider. They will still need to attend a local pharmacy for witnessed dosing while in treatment.

Patients who would normally receive take-home (carry) doses of OAT may be eligible to have their carries securely stored in the treatment center and then handed to them for self-administration, as part of the routine medication administration at the facility. If carry doses will be stored in the facility, the provider and pharmacy must be confident that the facility is able and willing to provide secure storage of OAT doses. This may include confirming that there are policies in place to ensure a secure lockup system exists, that is only accessible to authorized staff. Many treatment centers simply prefer for patients on OAT to attend a local pharmacy for witnessed dosing seven days a week (regardless of the patient's carry status).

Residential treatment centers may on rare occasions have staff on site who are able to witness OAT doses. Eligible staff include pharmacists, authorized prescribers, RNs, RN(NP)s, LPNs, and RPNs with the necessary knowledge and skill to appropriately witness OAT doses. If such staff are available, witnessed dosing may be handled on site by the qualified staff. As above, the provider and pharmacist must be confident that the facility will be able and willing to store OAT doses securely. Additionally, prescribers may need to provide authorization and/or a new prescription to the applicable pharmacy to allow doses to be supplied and witnessed at the facility. All residential treatment centers are encouraged to have a formal medication management policy/procedure manual in place that addresses the needs of all patients, including those on OAT.

### *Communication for Prescription Coordination*

**Treatment centers must notify the patient's community pharmacy and community-based prescriber/treatment team of a planned admission into residential treatment**. This should ideally occur prior to the planned admission date or, if that is not possible, on the first day of admission. This communication can help coordinate the OAT prescription for the duration of the treatment program.

The treatment center must also notify the community pharmacy and prescriber/treatment team when the patient leaves the program, to coordinate a new OAT prescription for the patient's preferred pharmacy, ideally prior to completion and *before* the patient departs. If the patient decides to leave or is discharged from the treatment centre prematurely, the community pharmacy and OAT prescriber/treatment team must be notified *right away*.

### *Dose & Medication Changes*

Clear and timely communication between the treatment center staff and the community pharmacy/treatment team is especially important when changes occur to the OAT dose or other medications while the patient is in treatment. **If an OAT dose change occurs during admission, the treatment center staff must notify the patient's community pharmacy and prescriber of the dose change *as soon as possible* after it occurs**. This allows for the pharmacy to proactively acquire a new OAT prescription for discharge in case the patient presents to the pharmacy unexpectedly (i.e., they leave the program prematurely).

# SPECIFIC CONSIDERATIONS: CARING FOR TRAVELLING PATIENTS

At times patients on OAT may travel within Manitoba, elsewhere in Canada, or even internationally. Travel may be required for essential reasons such as medical appointments, work opportunities, and important life events such as funerals, weddings, etc. Conversely, travel may also be for non-essential reasons, such as vacation. Both stable and unstable patients will request accommodation of their travel plans. **Supporting these plans, as long as it is safe and practically possible, is an important component of long-term treatment retention**.

OAT treatment teams, in collaboration with the patient's community pharmacy, are encouraged to accommodate travel requests whenever possible. Occasionally creative planning, such as arranging guest dosing, may be required to balance the needs of the patient with considerations for patient and community safety.

All patients on OAT should be counselled about their clinic's travel request policy. Depending on the hours and availability of case management resources, it may be reasonable to require patients on OAT to provide a period of advance notice regarding planned travel. However, occasionally patients will travel without advance notice and the OAT provider may be contacted when the patient is already enroute. This section will provide recommendations on how to best manage the most common scenarios involving travel and OAT.

## CLINICALLY STABLE PATIENTS & EXTRA CARRIES

Patients who are clinically stable and who have participated in OAT treatment for extended periods may be eligible for take-home (carry) doses to accommodate their travel plans. Providers may consider this option when patients already have several regular take-home doses as part of their routine treatment plan. Extra carry doses, in addition to their usual carry schedule, may be authorized to facilitate travel at the prescriber's discretion.

### *Authorizing Travel Carries*

Clinical judgement must be used regarding how many additional carry doses can be authorized based on:

- The patient's overall stability,
- Record of UDT results in recent weeks/months,
- History of responsible medication use/storage,
- The travel plan,
- Where the patient will be staying and who else is residing in that location, and
- The patient's ability to store carry doses safely while travelling.

This risk-benefit assessment must be documented when authorizing travel carries in addition to the patient's normal dosing schedule.

## CLINICALLY UNSTABLE PATIENTS

When a patient is generally unstable and does not have routine take-home doses, it may also occasionally be appropriate to authorize a limited number of travel carries. For example, this could be considered with a patient who must travel to a medical appointment and who (due to the transportation schedule) will not be able to reasonably attend the pharmacy on the travel day. One travel carry, stored in a locked box, may be appropriate to support the patient's overall medical care.

However, should an extended stay away from home be required for any reason, unstable patients **should not** typically be provided with multiple carry doses. Instead, OAT providers are encouraged to explore *Guest Dosing* options.

### *Guest Dosing*

Guest dosing involves providing a pharmacy, other than the patient's regular community pharmacy, with an OAT prescription so that the patient may attend the interim *host* pharmacy for witnessed *guest* dosing for a limited time to facilitate travel. The guest dosing pharmacy may also be asked to provide the patient with a carry dose for travel home, as needed.

There should be a discussion with the potential guest dosing pharmacy prior to faxing the prescription to ensure the pharmacy can provide OAT services and is able to accommodate a new patient and the specific medications they are taking. The prescriber/treatment team should also explore the following in advance of the patient's departure date to prevent treatment delays at the receiving pharmacy:

- If the pharmacy is outside of Manitoba, it may have special requirements, such as a copy of the prescriber's Certificate of Practice or other verification procedures.
- It is also important for the prescriber to ensure that the guest dosing pharmacist understands the witnessed dosing expectations, especially if OAT dosing guidelines in that location/jurisdiction vary from those in Manitoba. For instance, pharmacist expectations for the buprenorphine witnessing process can vary significantly from province to province (e.g., some may not need to confirm tablets have been self-administered and/or sufficiently dissolved). Verbal collaboration with the out-of-province pharmacist can be useful to ensure that everyone understands what is expected.
- Include all witnessed dose instructions on the prescription, along with carry dose authorizations.

- Prescription writing requirements may also vary from province to province. Some provinces require that prescriptions be written on a special form, or may have different requirements surrounding the legitimacy of faxed OAT prescriptions. Additionally, some provinces may use different units of measure to describe OAT doses (e.g., mL vs mg for methadone). **It is imperative to be very clear on the units of measure when providing prescriptions to out-of-province pharmacies to prevent significant dosing errors**.

When prescribers provide a new prescription for guest dosing temporarily at a different pharmacy, it must be remembered that *any new prescription cancels the old prescription* (see Relationship with Pharmacy & Prescriptions for OAT). Accordingly, the old prescription at the previous pharmacy will be canceled.

It is also important for prescribers to coordinate with the pharmacy that the patient will attend upon their return from travel (i.e., the regular community pharmacy). This could mean proactively sending another prescription to the regular pharmacy to be initiated upon return from travel, and/or requiring the patient to contact the prescriber/clinic staff after their return to arrange for a new prescription.

**Communication between the prescriber/treatment team, the patient's regular pharmacy, and the guest dosing pharmacy is essential for medication safety, to prevent double dosing, and to ensure continuity of care**.

The plan must also be documented in the patient's medical record, including the clinical rationale for the number of travel carries and the guest dosing arrangements.

Travel carries must always be stored in a locked box and patients must understand that they are responsible for the safety and security of their travel carries. Patients must also be aware that lost or stolen medication will not be replaced.

### *Patients Travelling Outside of Manitoba*

For patients travelling outside of Manitoba, all the above-mentioned recommendations still apply. However, providers also need to be mindful of legal and liability issues surrounding the location of the medical care to be provided. This alters the approach to care when patients travel out of the province or internationally.

The legal interpretation of the Regulated Health Professions Act, Regulations, and common law concludes that the **location of medical care in Manitoba is the location of the patient**. The CPSM Standard of Practice for Virtual Medicine reinforces this[1]. The onus is on the care provider to determine the patient's location if providing care virtually.

Likewise, the CRNM resources on Telepractice and Guidance on Telepractice also put limitations on cross-border care[2,3].

A Manitoba prescriber cannot provide care to a Manitoba patient in *another country* by virtual care/phone call to renew or adjust a prescription while the patient is travelling. This applies not only to OAT but to all prescriptions. CPSM registration does not extend to the provision of medical care in that country. Likewise, medical liability insurance may not cover a Manitoba physician or RN(Nurse Practitioner) who provides care to a patient while in another country.

Similarly, CPSM registration does not extend to the provision of medical care in *another province*. Manitoba-registered physicians wanting to provide care in another province will need to be aware of and comply with licensing and liability requirements in that Canadian jurisdiction. RN(NP)s are expected to contact the regulatory body in the province/territory where the patient resides to determine if they need to be registered in that jurisdiction before providing healthcare services in that location.

It is important for OAT providers to make their patients aware of these limitations before they travel. **The patient should be informed that once they have left the province, they will need to seek care locally if their travel plans change and/or/if other medical care is needed** (e.g., to extend prescriptions or for dose adjustments). Hence, pre-planning for guest dosing is important if this is to be pursued. The Manitoba provider can advise a local OAT prescriber and share collateral information, but they cannot actively provide the medical care.

Pharmacists should also notify the OAT prescriber if a patient asks about interprovincial or international travel, so that the patient can be made aware of the importance of planning ahead. The Information Sheet on Virtual Medicine Across Provincial and International Borders may be a helpful resource for physicians and pharmacists providing care to travelling patients[4].

### *Additional Recommendations for International Travel*

For patients travelling internationally, the following is also recommended:

- Consider providing the patient with a travel letter for their prescriptions. This letter can state that the patient is carrying medication for their own personal use, especially when crossing international borders. This can be presented to customs officials if they are questioned about the medication they are carrying. Contact information for the prescriber/clinic team should be included in this letter.
- Medication should be transported in the original labelled containers and packed in carry-on luggage, in case checked baggage is lost.
- For patients on methadone, consideration can be given to prescribing methadone tablets for the duration of travel, if appropriate, to avoid patients carrying multiple vials of diluted liquid methadone (most airports have fluid restrictions, and this avoids the possibility of leakage). A separate prescription is required to prescribe methadone tablets for travel, and the regular community pharmacy may require a new prescription

for liquid methadone upon return from travel. Additionally, it may be beneficial to forewarn patients that methadone tablets may not be covered (for OAT) by provincial and federal drug coverage programs.

## TRANSFER OF CARE FOR PATIENTS RELOCATING

### *Moving Within Manitoba*

All patients should be encouraged to advise their OAT provider and pharmacy regarding any plans to relocate. The OAT team can then facilitate transfer of care, as needed. This could involve simply transferring to a new pharmacy closer to the patient's new home, or to a new OAT provider and pharmacy if moving a great distance between cities, towns, or regions. As with any transfer of care, communicating in advance and sharing the patient's history, status, and treatment plan is critical to a safe and smooth transition between providers. One or more carry doses may be appropriate to facilitate travel and relocation, based on clinical stability (similar to the outlined approach for interim travel carries).

If the patient is relocating to a region without any OAT providers, the treatment team may have to problem solve providing care over a distance in collaboration with the patient. The provider should be prepared to be flexible and employ novel approaches to providing OAT, to promote equity in access to care. **This can include a blended model of virtual appointments and in-person assessment**. Occasionally, partnerships with local healthcare providers who are willing to assist with in-person assessment may also be a useful strategy. See FREQUENCY OF ASSESSMENTS in the Ongoing Care chapter for further guidance.

### *Moving Out of Province*

Patients should be also encouraged to advise their OAT provider and pharmacy *as soon as possible* regarding any plans to move out of province. This will allow the OAT team to facilitate transfer of care by actively supporting the patient to find a new OAT provider. Such facilitation can be a formal referral to an identified program that is accepting new patients, or simply practical information on how to access OAT care in a new community, if that community offers same-day resources.

**For planned departures, a bridging prescription for guest dosing may be appropriate for up to one month**. Again, one or more carry doses may be appropriate to facilitate travel and relocation, based on clinical stability (similar to the outlined approach for interim travel carries).

It is important to clearly communicate with the patient about the maximum duration of a bridging prescription for out-of-province travel or relocation, as well as the limitations of ongoing care given the Virtual Medicine Standard and the legal/liability considerations for cross-border care. These conversations should be clearly documented in the medical record.

# SPECIFIC CONSIDERATIONS: CARING FOR INCARCERATED PATIENTS

This section discusses unique considerations for the care of patients on OAT in correctional settings. This includes the importance of continuity of care when patients transition from corrections facilities to the community, and vice versa.

Opioid use, withdrawal, and associated high-risk behaviours occur commonly in correctional settings. Opioid-related deaths are also increasing among incarcerated people[5]. In the two weeks after release, an individual's risk of overdose is further increased (up to fifty times), compared to that of the general population[6].

OUD in the correctional setting should be managed with evidence-based care and OAT is the recommended therapy, with buprenorphine/naloxone as first-line treatment.

### *Resources Vary Between Facilities*

The availability of OAT varies dramatically between different corrections facilities in Manitoba, particularly between federal and provincial settings. OAT diversion is also known to be problematic within corrections facilities, including issues of intimidation, with patients on OAT being targeted for their medication. As a result, institutions have various protocols in place aimed at protecting patients and preventing diversion.

It is also known that the spread of HIV and viral hepatitis (hepatitis C) is problematic in correctional settings. Substance use in prisons and the lack of harm reduction measures increase risk for hepatitis C and HIV, particularly through riskier injection practices such as reusing equipment. Access to harm reduction supplies, along with timely diagnosis and treatment, varies between institutions and remains an urgent priority.

## PROVINCIAL CORRECTIONS

Provincial corrections facilities in Manitoba typically do not offer access to medical assessment of OUD and OAT induction onsite. It is also customary practice in the provincial correctional system in Manitoba to *not* permit increases in OAT dosing while a patient is incarcerated.

Providers should thus consider the following:

- When an individual has a known OUD, it is ideal to stabilize them on OAT prior to incarceration, as dose changes may be more difficult once incarcerated.
- Ideally, OAT dosing should still be titrated to an optimal dose even during a period of incarceration if possible. Clinical assessment could be arranged to occur in-person (the patient is typically escorted to the prescriber's practice location) or virtually (video assessment is preferred). Collaboration with the medical unit staff at the facility is typically required to make such arrangements.

- If patients already on OAT do not have access to onsite OAT care while incarcerated, the **community prescriber is responsible to ensure access to a continued OAT prescription throughout the period of incarceration**. Communication with the facility's medical staff is imperative. If no dose changes are requested/required, the community provider may not see the patient for extended periods. It is acceptable to continue the OAT prescription at the same dose regardless, if no concerning information is received from medical staff at the facility. A call to check in with medical staff, upon faxing refill prescriptions every 3-6 months, is good practice to ensure lines of communication remain open.
- It is not unusual for undesirable prescriptions such as benzodiazepines/Z-drugs to be tapered/discontinued by medical staff in corrections facilities. If a patient is clinically stable upon release from such a facility, benzodiazepines/Z-drugs should not be restarted, unless critical for patient safety (these medications are typically contraindicated with OAT).
- Most institutions use a specific pharmacy to supply and deliver all inmate medications to the facility's medical unit. These pharmacies are typically proficient in dispensing OAT. However, if that is not the case, the prescriber may need to liaise with the facility to ensure OAT is continued. A new prescription will need to be provided to the pharmacy contracted to supply and deliver OAT to that facility for witnessed self-administration by nursing staff on site.
- Pre-trial detention centres (e.g., Winnipeg Remand Centre) may not use a specific pharmacy to provide OAT to their facility. As such, the OAT prescriber may need to authorize delivery of OAT doses from the *regular* community pharmacy to the pre-trial detention centre for witnessed self-administration by nursing staff at the facility.
- **With release from the provincial system, communication with the OAT provider around the release date is critical so that a prescription can be sent to a community pharmacy for continued care**. Planning for transition into the community in anticipation of release is key to prevent missed doses and relapse upon release. Should an individual be released unexpectedly, for instance after a court appearance, it remains the community prescriber's responsibility to provide a discharge prescription to the patient's pharmacy of choice upon learning of the release. These occurrences are another reason why OAT prescribers must maintain an on-call system to respond to urgent calls from pharmacies and other healthcare providers, including after hours.

## FEDERAL CORRECTIONS

In federal institutions there is capacity for the onsite assessment and treatment of OUD, including OAT. OAT can be initiated and continued with appropriate dose adjustments directed by the onsite prescriber(s).

However, there can be a significant waiting period before inmates are seen for assessment and induction, given limited resources/significant waitlists. Therefore, starting OAT in the community as soon as possible is still indicated, even if arrest and potential federal incarceration is imminent, so that OAT can be ideally continued in the federal facility.

Other considerations for federal institutions include:

- If patients already on OAT are incarcerated in a federal facility, their OAT will likely be continued. Prescribers employed by Correctional Service Canada provide ongoing care prescriptions for inmates on OAT, along with financial coverage of same by Correctional Service Canada.

- When individuals are released or paroled from the federal system into the community, coverage and prescriptions from Correctional Services Canada may continue for up to 28 days from date of release. Prior to COVID-19, this period was 14 days but was increased given pandemic-related limitations in timely access to community care, including OAT providers. Corrections staff must attempt to arrange community follow-up prior to day 28. This may include finding an OAT provider who can take over the individual's care if OAT was started in prison or started in another province prior to incarceration.

  During this 28-day period of coverage, the inmate and their personal/professional supports must be encouraged to maintain communication with the new OAT provider to schedule/confirm an intake appointment and to arrange medication coverage, if this was not possible or confirmed prior to release.

- **If an inmate is being transferred from a federal to provincial facility, a community provider must be found**. This is a known system challenge and therefore bridging prescriptions from community OAT providers are occasionally requested prior to the provider being able to assess the individual. If such a prescription can be provided with reasonable safety, based on reliable collateral information and subject to daily dispensing, then a time-limited prescription is recommended to bridge the patient until they can be seen for assessment and ongoing care with the new community provider.

## MEDICATION & SUBSTANCE USE REVIEW FOR INCARCERATION TRANSITIONS

At any point of transition (between corrections facilities or into the community) it is strongly recommended that the patient's medication record (e.g., DPIN or E-Chart) be reviewed and/or verified with the community pharmacy or facility medical staff. This will help ensure dosing accuracy of OAT and other medications as applicable during the transition.

Some transitions may require more urgent clinical assessment of the patient to assess/observe for sedation or withdrawal and review recent substance use, as they may have missed OAT doses and/or they may have been supplementing with other opioids.

Likewise, assessment of other substance use is also important upon incarceration or release. Patients using alcohol or benzodiazepines/Z-drugs (either in the community or illicitly while incarcerated) may require further medical management and collaboration with the facility medical unit staff. Patients have also reported illicit use of bupropion and gabapentin while incarcerated, and may present to intake or follow-up appointments seeking these medications. Careful assessment and medication planning is key to mitigating the risks of polypharmacy. See Managing Polypharmacy & Polysubstance Use for more detailed recommendations.

#### 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.

## SPECIALTY POPULATIONS & INCARCERATION

### *Pregnancy*

For female inmates with OUD, pregnancy is a time of utmost importance to ensure seamless OAT care. If not already on OAT, pregnant individuals with a suspected OUD should be urgently assessed (and/or referred) for initiation of treatment.

If already on OAT, regular reassessments are recommended as ongoing dose adjustments may be required, particularly during the third trimester. See the Treatment of OUD in Pregnancy chapter for detailed recommendations around pregnancy.

### *STBBI Testing*

**It is highly recommended to offer** Sexually Transmitted and Blood Borne Infection (STBBI) **testing to all patients upon release from incarceration, and at appropriate clinical intervals thereafter.** 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.

# RAPID ACCESS TO ADDICTION MEDICINE CLINICS

As in other parts of Canada, the landscape of addiction medicine in Manitoba has evolved rapidly over the last few years. These changes have been driven primarily by the escalating opioid crisis and public demand for accessible addiction treatment services.

## *Low-Barriers Access to Addiction Care*

Federal and provincial reports have all outlined a chronic state of underfunding of mental health and addiction services, along with the need for increased access to evidence-based addiction treatments. Initiatives are now underway to improve awareness and training for healthcare providers, to enable earlier recognition and treatment of substance use disorders within a standardized and evidence-based treatment framework. This goes hand-in-hand with community advocacy to improve access to a wide variety of harm reduction strategies, both embedded within treatment services and in a variety of public spaces.

Regrettably, there remains much stigma around accessing care for individuals with substance use disorders. For individuals and families, it can be very difficult to accept that substance use is problematic, and the experience is often associated with feelings of shame, guilt, fear, and/or anger. This translates into poor and often delayed access to care and complications of untreated disease.

The rollout of Rapid Access to Addiction Medicine (RAAM) clinics in Manitoba began in the fall of 2018. With subsequent expansions, there are now six RAAM clinics located across all five Regional Health Authorities. **These clinics represent a significant increase in the availability of low-barrier addiction assessment and treatment for Manitobans**.

The RAAM clinic model was established by the Mentoring, Education, and clinical Tools for Addiction: Partners in Health Integration (META:PHI) group. It is a low-barrier, walk-in style clinic that adults (ages 18+) can attend to get help for substance use disorders, including OUD. **No appointment or formal referral is required**.

## *The RAAM Clinic Role in the Healthcare System*

RAAM clinics provide time-limited medical addiction care, including pharmacotherapy such as OAT, brief counselling, and referrals to community services. The RAAM model plays a key role in reducing overall harms and improving general health outcomes. Ultimately, this reduces the risk of serious complications such as overdose or contracting STBBIs.

Individuals who access RAAM services are typically stabilized with evidence-based substance use disorder treatments. Patients are then transferred to longer-term services for ongoing care that is typically provided by primary care providers or specialists. **It is essential for RAAM clinics to build collaborative connections with both acute and chronic care services, to support**

**patients along the continuum of disease and recovery**. This ensures continuity and safety of care plans developed at RAAM.

In the context of OUD, RAAM clinics may be utilized to initiate OAT, stabilize complex patients, assist with crisis management, offer consultation, and to support case management where appropriate. RAAM also provides an on-call service in Manitoba as a resource for other professionals who are managing individuals connected with RAAM, to collaborate on care.

**RAAM clinics do not provide emergency services** for people needing urgent medical attention for serious physical or mental health illnesses such as overdose, psychosis (e.g., paranoia, delusions, hallucinations), agitation, suicidal or homicidal ideations, or who require police and/or security involvement.

### *Capacity Building & Transfer of Care*

RAAM clinics are meant to function within the health system as a whole, providing an intermediary bridge (i.e., intervention and stabilization) along the care continuum. RAAM typically follows an individual for up to six months before the transfer to ongoing care occurs. However, as with the rollout of RAAM in other provinces, a major hurdle has been capacity building within the system to allow timely transition of patients to longer-term care providers.

RAAM clinic team members include nurses, counsellors, physician assistants, nurse practitioners, and physicians, all of whom are valuable resources to other care providers and patients. Prescribers are encouraged to be aware of local RAAM resources to support patients along the continuum of care. **OAT providers are also encouraged to collaborate with RAAM on transfers of care, as able, to support patient flow within the system and to ensure ongoing capacity for rapid access and stabilization**. OAT providers who are open to accepting transfers of care from RAAM are strongly encouraged to provide their contact information and preferred method of referral to the RAAM clinic coordinators/medical directors.

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