Telemedicine support for addiction services

NATIONAL RAPID GUIDANCE

VERSION 1 GUIDANCE DOCUMENT

CRISM-ICRAS
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About the Canadian Research Initiative in Substance Misuse

Funded by the Canadian Institutes of Health Research (CIHR), the Canadian Research Initiative in Substance Misuse (CRISM) is a national research-practice-policy network focused on substance use disorders, comprising four large interdisciplinary regional teams (Nodes) representing British Columbia, the Prairie Provinces, Ontario, and Quebec/Atlantic. Each CRISM node includes regional research scientists, service providers, policy makers, community leaders, and people with lived experience of substance use disorders. CRISM's mission is to translate the best scientific evidence into clinical practice, health services, and policy change. More information about CRISM can be found at: https://crism.ca.

About this Document

This document is one of a series of six national guidance documents, rapidly developed by the CRISM network at the request of the Government of Canada. Collectively, the six documents address urgent needs of people who use substances, service providers, and decision makers in relation to the COVID-19 pandemic. The urgent nature of this work required rapid development and dissemination of this guidance. This, and the continuing evolution of the knowledge base regarding COVID-19, precluded CRISM from conducting a comprehensive review of the relevant literature. However, when available, scientific evidence is cited in support of the expert advice offered herein.

The guidance provided in this document is subject to change as new information becomes available. Readers should note that the intent of this document is to provide general guidance rather than detailed procedural and logistical advice. Readers are advised to consult local public health and medical authorities for specific input on navigating their own unique regulatory and policy environments, as necessary.

The CRISM/COVID-19 guidance documents cover the following topics:

- Supporting People Who Use Substances in Shelter Settings during the COVID-19 Pandemic
- Telemedicine Support for Addiction Services (this document)
- Harm Reduction Worker Safety
- Recovery Environments
- Supporting People Who Use Substances in Acute Care Settings during the COVID-19 Pandemic
- Strategies to Help Individuals Self-Isolate for People who use Drugs

Each document was developed by a core CRISM regional authorship committee, drawing on expert knowledge, available scientific evidence, and a review of relevant documentation from public health authorities. Draft documents produced by each authorship committee were reviewed by pan-Canadian panels of content and clinical experts, including people with lived and living experience of substance use. A Directed Operating Grant provided funding for this work to CRISM from the Canadian Institutes of Health Research (CIHR).

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Disclaimer for Health Care Providers

The recommendations in this guidance document represent the view of the national guidance document authorship committee members and external reviewers, arrived at after careful consideration of the scientific evidence, available literature, and external expert peer review. The application of the recommendations in this guidance document does not override the responsibility of healthcare professionals to make decisions appropriate to the needs, preferences and values of an individual patient, in consultation with the patient (and their guardian(s) or family members, when appropriate) and, when appropriate, external experts (e.g. specialty consultation). When exercising clinical judgment in the treatment of opioid use disorder, healthcare professionals are expected to take this guidance document into account while upholding their duties to adhere to the fundamental principles and values of the Canadian Medical Association Code of Ethics, especially: compassion, beneficence, non-maleficence, respect for persons, justice and accountability, as well as the required standards for good clinical practice defined by relevant governing bodies within regional or local jurisdictions. Nothing in this guidance document should be interpreted in a way that would be inconsistent with compliance with those duties.

Legal disclaimer

This document is intended to give an understanding of the growing role of telemedicine for healthcare access during the COVID-19 pandemic. This guidance document is not intended as a substitute for the advice or professional judgment of a healthcare professional. We cannot respond to patients or patient advocates requesting advice on issues related to medical conditions. If you need medical advice, please contact a local healthcare professional.

Conflict of Interest

In accordance with the Guidelines International Network's Principles for Disclosure of Interests and Management of Conflicts[1], authorship committee members and external reviewers were asked to disclose all sources and amounts of direct and indirect (i.e., research support) remuneration from industry, for-profit enterprises, and other entities that could potentially introduce real or perceived risk of bias. In addition, authorship committee members and external reviewers were asked to report indirect sources of bias, such as academic advancement, clinical revenue, and professional or public standing that could potentially influence interpretation of research evidence and formulation of recommendations. Of note, three of the authorship committee members and external reviewers are CRISM staff members.

No authorship committee members and external reviewers were excluded from participation due to direct financial conflicts of interest. Of the nineteen authorship committee members and external reviewers, one disclosed receipt of funds prior to Guidance document involvement from a commercial entity (Indivior Inc.) that could theoretically benefit from Guidance document recommendations. Six authorship committee members and external reviewers acknowledged that their employment involved the delivery of Opioid Agonist Therapy (OAT) to patients. Eight authorship committee members and external reviewers acknowledged their employment involved the support of delivery the Opioid Agonist Therapy programs. Seven authorship committee members and external reviewers acknowledged their employment involved engagement in developing OAT practice within their respective organization. Two authorship committee members and external reviewers acknowledged that their employment involved engagement in developing telemedicine practice within their respective organizations. Two authorship committee members and external reviewers acknowledged that they have publicly stated the need for measures to increase OAT or Safe supply in general, and in the context of COVID-19. Receipt of research or program funding support from non-profit agencies or institutions was not considered a direct conflict of interest. On review, none of the disclosed direct conflicts of interest were deemed to be of sufficient weight or relevance to warrant exclusion from the Guidance review committee. Additional details regarding the conflict of interest policy can be found in Appendix 1.

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1.0 Key points of the guidance document

- **This guidance document does not supersede a provider's clinical experience and decision-making skills.**

- **Healthcare providers should use the same high-quality standards as in-person clinical care when using telemedicine for addiction services. They should aim to provide assessment and treatment of physical and mental health conditions and other drug use-related concerns, provide prevention, harm reduction and other health information and counseling, as appropriate.**

- **Patient consent must be obtained and documented during the telemedicine consultation, and healthcare providers must provide the limitations of telemedicine (ex. limited physical examination, limits in sound, image, and security breaches).**

- **Healthcare providers utilizing telemedicine should follow the same documentation guidelines as a regular consultation.**

The following points pertain more specifically to opioid agonist therapy (OAT)

- **Prescribers should assess and document safety concerns and measures to address them when prescribing any psychoactive substance, and in particular for methadone and sustained released oral morphine, as per Opioid Agonist Treatment Guidelines.**

- **Prescribers must use clinical judgment to determine patient suitability for carries. Exceptional carries (beyond maximum carries allowed in guidelines) may be provided during the current pandemic due to specific circumstances and should be well justified and reassessed regularly.**

- **Prescribers should explore alternative measures for witness dosing including virtual communication and observational methods.**

- **Safe storage and risk of carries as per Opioid Agonist Treatment Guidelines should be discussed and documented, and prescribers and patients should remotely agree and document a Safe Carry Agreement.**

2.0 Purpose And Scope

On March 11, 2020, the World Health Organization declared COVID-19, caused by a novel coronavirus SARS-CoV-2, a pandemic, citing concern over alarming levels of spread and severity across the globe. The novel coronavirus has caused a national outbreak of respiratory infections in Canada since its discovery in December 2019. For most, this coronavirus causes only mild to moderate symptoms including fever and cough. However, people who use drugs (PWUD) have particular vulnerabilities that place them at risk of acquiring and transmitting SARS-CoV-2, such as poor housing and active addiction (factors that may make physical distancing challenging), as well as comorbid health conditions (e.g. COPD, HIV+) that may predispose to severe infection resulting in increased morbidity, mortality and healthcare system utilization.

The COVID-19 pandemic spurred professional bodies and provincial/territorial jurisdictions to recognize and clarify the growing role of telemedicine for healthcare access in times of confinement. In reviewing existing telemedicine guidelines, it was found that they were somewhat restrictive and lacked specific information on how to effectively support and provide access to care for patients requiring addiction-related healthcare services.

The purpose of this guidance document is to support healthcare providers to deliver telemedicine for addiction services during the COVID-19 pandemic. This document is intended to provide general guidance related to telemedicine focused on covering OAT and other addiction-related pharmacological treatments. It does not cover the use of telemedicine for non-pharmacological approaches. Furthermore, it does not provide guidance for specific populations or specific conditions, such as the comorbidity of mental health, pregnancy, or use in other populations.

2.1 INTENDED AUDIENCE

The target audience for this guidance document includes healthcare providers and pharmacists. The guidance contained in this document may also be relevant for policymakers, public health authorities, advocates, and other people working to support addiction services.

2.2 DEVELOPMENT

The content and recommendations of this guidance document are based on a review of the literature focused on consensus practice regarding access to telemedicine for OAT, and was reviewed by

the authorship committee members and external reviewers, some of whom are OAT prescribers who have been involved with the development and incorporation of telemedicine in their respective institutions. Search terms (see Appendix 2) were used to identify relevant research evidence within jurisdictions where telemedicine for addiction and/or OAT is known to be in place (see Appendix 3). These jurisdictions are: Ontario, Quebec, Australia, United Kingdom (UK), France, and the telemedicine services supported by the World Health Organization (WHO).

Recommendations were selected based on the general consensus for best practices found across the reviewed guideline and literature (referred to as 'best practice' in Table 1). A list of key points is also provided, based on common principles outlined in various guidance documents and expert opinions (referred to as 'consensus practice' in Table 1).

An independent CRISM committee of authorship committee members and external reviewers, made up of experts and people with lived and living experience from each regional CRISM node (n= 19), was assembled to participate and review this guidance document. The consensus of committee members was sought and secured through email and telephone communication, and tracked document review and revision. The draft guidance document and supporting materials were circulated to the committee for 2 rounds of review (May 4-12th, 2020), as well as a reviewer teleconference (May 8th, 2020). Feedback was collated and incorporated into a revised Version 1 Guidance Document.

2.3 DEFINITION OF TELEMEDICINE

We recognize that there are a number of terms used when referring to the use of information and communication technology to deliver healthcare. For the purposes of the following recommendations, the term “telemedicine” will be used as it is deemed to be the most relevant within the context of this report. We are basing this decision, using the definition for “telemedicine” set by the Federation of Medical Regulatory Authorities of Canada: “medical service provided remotely via information and communication technology.”[2] While this guidance document does not distinguish between the type of telemedicine that exists (teleconsultation, tele-expertise, telemonitoring, or teleassistance),[3] healthcare providers must be consistent with their specific jurisdiction’s regulations and guidelines.

3.0 Table 1: Summary of Recommendations for Telemedicine

RECOMMENDATION	BEST / CONSENSUS PRACTICE	NUMBER OF SOURCES FOUND
Telemedicine in General Practice		
1. If the healthcare provider evaluates that telemedicine is appropriate, if the patient provides informed consent, and if both the healthcare provider and patient have the appropriate technological means, telemedicine can be practiced. The risks and benefits of providing care by telemedicine compared to providing care in-person should be assessed. [2-7, 10-14]	Best Practice	11
2. The tools (telephone and video conferencing), platforms, and data used during telemedicine must be secured and respect the confidentiality of the consultation. Patient consent can be obtained verbally, unless written consent is required at the sign-up of the tool/ platform being used.[3,4,6,7,11-13,15]	Best Practice	8
3. Patient identification must be provided at each telemedicine consultation, including name and at least one of the following: date of birth, address, health card number, or other valid form of identification (which can also be displayed on the screen). The healthcare provider's documentation should include the same elements as a regular note, while also indicating the reason and method for providing telemedicine.[3,4,7,10,12]	Best Practice	5
Use of Telemedicine during a Pandemic		
4. During a pandemic, it is recommended that healthcare providers always consider using telemedicine to provide care, whenever possible. Each patient's eligibility for telemedicine should be reviewed individually.[4-7,9-13,16] Prescriptions should be transmitted verbally, electronically, by fax, or via secured electronic medical record (EMR) to protect pharmacists, patients, and pharmacy employees from the transmission of COVID-19 by reducing visits to the pharmacy.[4-7,9-13,16]	Consensus Practice	10
Utilizing Telemedicine to Provide OAT during COVID-19		
5. The renewal/ re-induction of OAT is allowed by telemedicine, when indicated as per standard of care guidelines. OAT can be initiated by telemedicine in situations where the prescriber judges that a delay in the start of OAT would entail a risk for the patient, and if conditions are appropriate. All patients are encouraged to obtain a take-home naloxone kit. Information on how to use the take-home naloxone kit and training, along with other harm reduction strategies, should be made available to patients and their support systems.[4-7,17,18]	Consensus Practice	6
6. Healthcare providers should provide increased support to patients via remote methods and maintain ongoing and open communication. Online resources should be offered to patients, and increased counselling services by phone or other platforms should be offered.[4,5,7,17,19]	Consensus Practice	5
7. Pharmacy delivery should be used if available, and authorized/ designated agents can be used to pick up or receive carries. Patients must have safe housing or safe storage for carries (i.e., a locked box). Virtual communication and other safe observation methods for supervised dosing should be utilized where available.[5-8,17]	Consensus Practice	5

4.0 Telemedicine

Recent developments in information and communications technologies (ICT) have made it possible for healthcare providers to practice medicine virtually and deliver medical services to areas where otherwise unavailable. As the delivery of telemedicine lends itself to potential violation of ethical obligations, such as professional secrecy, it is vital that telemedicine be used in ways that comply with current guidelines set out within each jurisdiction across Canada to protect the patients and clients that it seeks to serve.

4.1 TELEMEDICINE PROVIDERS

The healthcare provider using telemedicine must comply with their jurisdiction's standard or policy. In some Canadian provinces, a license to practice telemedicine must be obtained.

Healthcare providers using telemedicine services with patients outside their jurisdiction must comply with the laws and regulations of the territory in which the patients are located, in addition to the guidelines and policies of the providers' jurisdictions. The practice of telemedicine should be avoided where healthcare providers are likely to compromise the quality of their practice.

4.2 ASSESSING THE APPROPRIATE USE OF TELEMEDICINE

Healthcare providers should use discretion in deciding which patients are appropriate for care by telemedicine. Providers must assess the risks and benefits of care given by telemedicine compared to care given in-person. Both the provider and the patient must have the appropriate technological means for telemedicine to occur.

During a pandemic, the healthcare provider must also be cognizant of infection control considerations and consider the risk of contamination during a patient's visit to the clinic, hospital, and/or pharmacy. Given this risk, a new patient, who is not known to the provider, can be evaluated via telemedicine, if deemed appropriate.

During the COVID-19 pandemic, it is not necessary that a telemedicine consultation be done by the patient's treating healthcare provider, although this is preferable.[4]

4.3 TOOLS, PLATFORMS, PRIVACY, AND SECURITY

All tools (telephone and videoconferencing) and platforms used for telemedicine must be secured and must also respect confidentiality and privacy of all medical interviews and discussions with the patient. The healthcare provider is responsible for weighing the risks and benefits of using information and communication technology to carry out telemedicine.

Examples of platforms that may be used during telemedicine include:

- Those already included in properly secured electronic medical records (EMR);
- Those used by network establishments that have a telemedicine program; and,
- Secured telephone lines and/or direct dial toll-free (e.g. 1-800 number) and secured text messaging.

To maintain privacy and confidentiality, the physical environment of both the healthcare provider and the patient during the telemedicine session must be taken into account. Providers should conduct telemedicine in a quiet and enclosed room, whether in a home-office, or in a healthcare setting. Likewise, patients should be able to confirm that confidential information can be shared during the telemedicine session. Providers working from home should ensure that the storage and handling of patients' information is secured.

4.4 PROVIDER AND PATIENT IDENTIFICATION

Healthcare providers should identify themselves at the beginning of each new consultation, by providing their name, title, professional licensing body and medical license number, and any relevant contact information if needed. The provider must then ask the patient to identify themselves, by providing their name, date of birth, address, and the province of the consultation. The provider may request the patient’s health card to be displayed on the screen for further identification.

4.5 PATIENT CONSENT

Patient consent must be obtained at the beginning of the telemedicine session. The patient must understand the limitations of telemedicine and confirm that their setting is appropriate for exchanging confidential information. The healthcare provider must provide information regarding all possible technological limits, such as limits in sound, image, and security breaches, and the limits of medical

practice (ex. no physical examination).[4] All verbal and written consent should be documented in the patient's medical file.[20]

4.6 DOCUMENTATION

Healthcare providers should enter notes in the patient's medical file as soon as possible and should follow the same documentation guidelines as a regular consultation. The following details should also be included in the note:

- Technological means that have been used;
- The way in which the identification was made; and,
- The location of the patient during the telemedicine session (province and country).

Healthcare providers offering telemedicine services should have access to their EMR and should enter their notes there at the end of each meeting.

During a pandemic, if a healthcare provider does not have access to their EMR, or if they are still using paper files, they must add their note to the medical file as soon as possible, while protecting the confidentiality of the data. The healthcare provider is responsible for keeping notes secure and confidential. Once the notes have been placed in a patient's medical file, all other copies should be destroyed in a secure manner.

5.0 Telemedicine and COVID-19

When possible, use of telemedicine services is highly encouraged during the COVID-19 pandemic, except where a physical examination or in-person test is required.

Healthcare providers should assess the feasibility of providing telemedicine services according to each patient's needs and the risks of contamination due to clinic, hospital and/or pharmacy visits.

Assessments can be an important source of support to patients who no longer have access to meetings, groups or counselling. Clinical judgment should apply when determining frequency of clinic visits.[5]

Although not specifically covered in the current version of this guidance document, telemedicine consultations should aim for the high standard assessment and treatment of physical and mental health conditions and other drug use-related concerns, provide prevention, harm reduction, and other health information and counseling, as appropriate. Telemedicine should also be utilized as a method to check on mental health status as comorbidity is high and mental health issues are often exacerbated during pandemic times.

The following sections cover telemedicine in relation to pharmacotherapy.

6.0 Relaxation of Prescription Rules during COVID-19

Patients requiring addiction services often require medication in treating their addiction-related condition. This includes psychoactive medications that can be prescribed by telemedicine.

6.1 BENZODIAZEPINES AND PSYCHOSTIMULANTS

Provided that local licensing bodies do not object, the healthcare provider may prescribe benzodiazepines or psychostimulants to a previously known patient by telemedicine, as long as the provider ensures appropriate and timely follow-up, either in-person or by telemedicine (e.g. monitoring of weight and blood pressure in the case of a psychostimulant).[4]

In the case of a new patient, the healthcare provider is permitted to prescribe benzodiazepines or psychostimulants by telemedicine, if they judge and document in the medical file that it is medically indicated, following provincial guidelines and standards, and that a delay in initiating treatment will entail a risk to the patient. Appropriate and timely follow-up must be carried out, either in-person or by telemedicine.

For all patients, the prescribed quantity must be safe and take into account the patient's condition and the associated risks. Prescribers should document safety concerns and measures to address them when prescribing any psychoactive substance.

If the patient has a usual prescriber or primary care provider, ensure proper communication is provided to the usual prescriber or primary care provider regarding what was prescribed, and reasoning for it.

6.2 OPIOIDS

Opioid prescriptions may be renewed following a telemedicine consultation, according to the professional judgment of the prescriber, if the prescribing provider:

- Is the patient's treating provider;
- Is not the patient's treating provider, but has access to the patient's medical file kept by their treating provider; or,

- Is not the patient's treating provider, but has access to the patient's medical records and can trace their previous prescriptions.[4]

The prescribed quantity of opioids must be safe (to an individual and the public) and documented, and be accompanied by appropriate and timely follow-up, either in-person or by telemedicine.

For opioid renewal of a prescription or a new prescription, in the absence of a patient's medical file or records, the prescriber can prescribe only if the clinical situation warrants it and following provincial college guidelines. Opioid prescription in the context of opioid use disorder is covered in more details in the next section. If applicable, effort must be made to communicate a renewal or change in prescription to the patient's usual prescriber or primary care provider.

7.0 Opioid Agonist Treatment and Telemedicine during COVID-19

During the COVID-19 pandemic, it is essential that patients have continued and safe access to opioid agonist treatment (OAT) for their opioid use disorder. It is important to note that the following guideline should not supersede a provider's clinical experience and decision-making skills.

Healthcare providers should consider using telemedicine to provide continuous care for patients with opioid use disorder, taking into account each patient's needs, the fundamental concerns of stability, safety, storage, overdose risk, diversion risk, lapse or relapse, the new dangers associated with COVID-19, and current public health advice around physical distancing.[5] Providers should assume open, ongoing communication with patients. If it is not possible to provide care remotely, it may be more appropriate to continue in-person care. If performing a clinic in-person, then the clinic should follow the pandemic instructions given by their association, college, or Department of Health.

All decision-making processes should be recorded, including any deviations from these or standard guidelines, and clinical justifications should be made in the patient's record.

7.1 RENEWAL OF PRESCRIPTION/ RE-INDUCTION

The renewal of a prescription or the re-induction of OAT can be provided via telemedicine consultation if the healthcare provider can confirm the patient's medication history on the medical file or record, and if the provider judges that this is justified by the patient's condition and that previous therapy was well-tolerated (based on consultation with pharmacists).

7.2 INITIATION OF OAT

The initiation of OAT is authorized by telemedicine consultation only when the healthcare provider judges that a delay in the start of the treatment would entail a risk for the patient.

Conditions necessary to initiate OAT by telemedicine:

- The provider has the necessary elements to make a relevant diagnosis or differential diagnosis, following the College's guideline and standards.

- The provider obtains all relevant medical history, and a mental examination adapted to the situation occurs in a timely manner.

- The provider considers that a physical examination is not necessary or that it can be done later, in due time. An examination by a nurse can be done instead if the provider believes that all the tests performed by the nurse are sufficient for the moment. However, if a physical examination by a healthcare provider is deemed necessary in order to initiate and prescribe OAT, the provider will have to see the patient in-person to complete their assessment.

- The provider chooses the safest treatment under the circumstances and assesses the risks of toxicity, overdose and diversion of opioids, in relation to the treatment itself. When the provider does not have access to the patient's medical history or to information from a referent practitioner, OAT should be initiated at a low dose to begin and titrate up as per prudent OAT guidelines.

- The provider ensures that the patient has the necessary follow-up for their condition, either by telemedicine or in-person, while collaborating with the multidisciplinary team in place. The provider ensures that the required laboratory examinations, and if necessary, an electrocardiogram (ECG), are performed in a timely and feasible manner.

- During this pandemic period, the provider must weigh the risk of COVID-19 transmission (e.g. to other patients in a clinical setting) versus potential risks of telemedicine (e.g. inability to undertake a physical examination or tests).[18]

7.3 CLINICAL ASSESSMENTS OF SUITABILITY FOR CARRIES

OAT carries (i.e. take home dosing rather than daily witnessed ingestion) would enable healthcare providers to provide continuous care while ensuring that patients are safe in light of the COVID-19 pandemic, by reducing their number of visits to the pharmacy and to the clinic. When conditions allow, and public safety concerns can be considered, patients may be provided with additional carries.

Assessment of carries can be conducted using telemedicine. While applicable to the assessment of carries in general during COVID-19, this section covers specific guidance during telemedicine consultations.

Prescribers should use clinical judgment to determine whether the patient is suitable for carries. Urine drug detection samples (UDS) are not required for allowing carries. Prescribers should use clinical judgment to determine the maximum doses allowed for carries, in keeping with provincial

guidelines. OAT carries above the number allowed by guidelines to reduce risk for the patient during the COVID-19 pandemic should be justified and documented.

Given the inferior safety profile of methadone, patients with methadone carries are more likely to have respiratory depression and overdose than those with buprenorphine/ naloxone carries. Document that patient states they have the ability to safely store increased number of carries. Prescribers should continue their normal practice with respect to buprenorphine/ naloxone storage safety.

All healthcare providers should request that patients obtain naloxone overdose kits and become educated and trained on the use of naloxone. Lost or diverted methadone carries should be managed as per MMTG. Lost or diverted buprenorphine/ naloxone carries should be managed according to usual standard of care.

Patients may be considered suitable for carries if they have safe housing or safe storage (i.e. locked box).

If available, pharmacists should deliver carries to the patient. If pharmacy delivery is not available, a reliable agent (e.g. a family member or friend) may be designated to pick up or receive the carries.

7.4 OBSERVED DOSES

Authorized prescribers should explore alternative measures to support witnessed dosing, including virtual communication and observation methods. Verification can be completed by asking the patient to speak after taking the dose.[5,6] Witnessing the ingestion of carries may be difficult if the patient is isolating due to COVID-19 and the person delivering the carry dose does not have expert experience. Decisions regarding these cases should be taken on a case by case basis weighing risks and benefits.

Extra precautions should be considered while managing observed doses in-person, such as handling and disposal of dosing cups, and reduced contact by not requiring signatures for dosing.[17] Unless specified and required by the prescriber, the complete dissolution of the sublingual buprenorphine/ naloxone tablet does not need to be verified.

7.5 BUPRENORPHINE/ NALOXONE

The choice of the OAT pharmacotherapy for patients newly assessed should follow best practices and evidence-based recommendations, with buprenorphine/ naloxone being suggested as the preferred option when appropriate.[7]

Generally, doses of buprenorphine/ naloxone do not need to be witnessed, unless to address some specific clinical issue. Prescribers may prescribe up to four weeks of buprenorphine/ naloxone, in keeping with provincial guidelines. Prescribers should use clinical judgment to determine whether to be progressive with carries (e.g. advancing from one to four weeks).

Patients who are very stable may be assessed less frequently and be given carries for longer periods (e.g. every six to twelve weeks).[5]

It may be possible and helpful to move appropriate patients from tablet sub/supra-lingual buprenorphine to depot buprenorphine.[7] Whenever possible, maintain patients on Buvidal® Monthly or Sublocade® to reduce attendance.[6]

7.6 METHADONE

Given the inferior safety profile of methadone, patients with methadone carries are more likely to have respiratory depression and overdose than those with buprenorphine/ naloxone carries. It is therefore imperative to weigh the risks of community transmissions of COVID-19 against the risks of patient overdose death and the public health risk if methadone is used by someone other than whom the medication was prescribed.[5]

For those without carries, prescribers can introduce non-consecutive carries to reduce the frequency of pharmacy visits while reducing the risks of misuse/ diversion of larger amounts of methadone to patients without carries. Methadone safety should be assessed and documented, as per treatment guidelines. The suitability for consecutive carries should be considered based on risks, with, typically, up to a maximum of three consecutive doses treatment, and a maximum of six consecutive doses if the patient demonstrates stability.

Methadone carries above the number allowed by guidelines to reduce risk for the patient during the COVID-19 pandemic should be assessed on a case by case basis, justified and documented.

Advise patient that exceptional carries are being given due to current public health emergency. Discuss and document issues related to safe storage and risks of carries, including overdose and death, as per treatment guidelines.

A carry agreement should be remotely agreed to and documented in the chart.

At their observed doses, patients are seen by a pharmacist and assessed for sedation/ intoxication.

UDS are not required for low-risk patients but are required for higher-risk patients only if it will change clinical management.

Patients should not return used carry bottles at this time and should be advised and provided direction to ensure the used carry bottles are rinsed prior to disposal.[8]

7.6.1 New methadone starts

The initiation of methadone in methadone-naive patients requires a comprehensive assessment (virtual or in-person), and UDS should be done whenever possible.

Decision to prescribe methadone without UDS can only be made on a case by case basis and given that: i) the provider has the necessary elements to make a relevant diagnosis or differential diagnosis; and, ii) the provider assesses the safety of initiating methadone, the risks of toxicity, overdose and diversion of opioids, in relation to the treatment itself and provider communicates these risks to the patient.

Methadone initiation warrants more frequent clinical assessments, whether in-person or remotely. As a general rule, prescribers should consider waiting one month before initiating carries.[5] If not possible, patients should at least collect or have delivered their medicine daily from the pharmacy in the first week, followed by carries that are documented and justified.[6]

7.6.2 Methadone restarts

Patients restarting treatment must complete a virtual or in-person assessment.

7.7 SUSTAINED RELEASE ORAL MORPHINE

Sustained Release Oral Morphine is an approved agonist treatment for opioid use disorder in Canada, and telemedicine can be used as for the other OAT medications.

Sustained Release Oral Morphine is considered a high-risk substance for diversion. Providers should follow established guidelines within their jurisdiction when initiating or following up patients on Sustained Release Oral Morphine while using telemedicine.

Providers should use clinical judgment on a case by case basis and weigh benefits (e.g. reduced interactions in healthcare settings) and potential harms (e.g. risk of diversion) to adapt their practice, and before attributing additional carries during the COVID-19 pandemic. Patients should be followed and decisions should be reassessed regularly based on client response to care.

7.8 PATIENTS WHO HAVE MISSED DOSES

Patients who have missed doses considered as an interruption of treatment (according to provincial guidelines) should restart after a virtual assessment, without a UDS, but usually starting at a lower dose.[5,9]

7.9 SAFETY AND DOCUMENTATION

The safety of using carries and issues related to safe storage should be assessed, documented, and discussed with patients. Prescribers should consider possible misuse or diversion and overdose risk and discuss harm reduction strategies with patients. All healthcare providers should discuss obtaining naloxone overdose kits and educate the patients in the use of naloxone.

7.10 COMMUNICATION

Healthcare providers should provide increased support to patients via remote methods. Ongoing and close communication with prescribers is critical. Assessments can be an important source of support to patients who no longer have access to meetings, groups, or counselling. When a UDS is not required for carries, consider using technology to allow patients to connect with their provider without coming to the clinic.

Healthcare providers should utilize this as an opportunity to educate and inform patients that unless necessary, in-person visits to the clinic or to pharmacies should be avoided.

8.0 Expanded Roles of Pharmacists

As a result of the pandemic, the roles and scope of practice of pharmacists have expanded. Health Canada has, under Section 56(1) of the Controlled Drugs and Substances Act (CDSA), issued temporary exemptions for prescriptions of controlled substances. This permits pharmacists to extend prescriptions, transfer prescriptions to other pharmacists, permit prescribers to issue verbal orders, and allow pharmacy employees to deliver prescriptions of controlled substances. Prescribers, pharmacists, and other healthcare providers are encouraged to work closely together to identify the best possible solution and outcome for patients.

8.1 NON-PHARMACOLOGICAL PRESCRIPTIONS/ CONSULTATION REQUESTS

Documents related to non-pharmacological prescriptions/ requests for consultation must be transmitted securely to patients, for example via secured internet-type platforms, by fax, or directly by verbal order to designated professionals.

8.2 PHARMACOLOGICAL PRESCRIPTION

Healthcare providers should respect standards relating to individual prescriptions. When refilling prescriptions, especially for a patient that the provider does not know, the provider must ensure that the medication is still required, that it is well-tolerated, and that the dosage is appropriate for the patient's condition.

During a pandemic, it is recommended to send prescriptions by one of the following methods:

- Verbal transmission from doctor or authorized healthcare provider to pharmacist;
- Fax transmission, including directly via EMR; or,
- Transmission by electronic means (e.g. secured platforms).

8.3 PHARMACY DELIVERY

For patients who are COVID-19 positive under isolation, or are at high-risk, symptomatic, and/or quarantined, or are presumed or confirmed COVID-19, pharmacists should deliver prescriptions to patients, if such service is available. If it is not available, appropriate precautions must be taken in order for the patient, the pharmacist, pharmacy employees, and pharmacy clients to maintain social distancing and avoid the dangers associated with COVID-19.

9.0 Resources for Providers and Patients

See Appendix 4 for further online resources on substance use

- Use health messages and materials developed by credible public health sources (e.g. public health, CDC).

- Post signs at entrances and strategic places providing instruction on handwashing and coughing, use of cloth face coverings, and social distancing. For further guidance, please refer to other CRISM documents in this series, including: *Harm Reduction Worker Safety, and Supporting People Who Use Substances in Emergency Shelter Settings*.

- Provide educational materials about COVID-19 for non-French and non-English speakers or hearing impaired individuals.

  - Identify and address potential language, cultural, and disability barriers associated with communicating COVID-19 information to staff and patients.

- Ensure communication with clients and key partners about changes in program policies and/or changes in physical location.

- Identify communication platforms (e.g. hotline, automated text messaging, and websites) to help disseminate information inside and outside your organization.

9.1 COUNSELLING FOR PATIENTS

Offer increased counselling services by phone or other platforms, with the intent of providing up-to-date medical information, reassurance, and mindfulness de-stressing where appropriate (see Appendix 4 for more resources).

Appendix 1: Conflict of Interest Policy

Conflicts of interest were assessed using the Guidelines International Network's *Principles for Disclosure of Interests and Management of Conflicts*.[1] For this Guidance document, authorship committee members and external reviewers were required to disclose all sources and amounts of direct and indirect remuneration received in the past five years from industry, for-profit enterprises, and other entities (e.g. direct financial conflicts) that could introduce real, potential, or perceived risk of bias. In addition, authorship committee members and external reviewers were asked to disclose possible indirect conflicts of interest, such as academic advancement, clinical revenue, and professional or public standing that could potentially influence interpretation of evidence and formulation of recommendations.

Before the draft guidance document was circulated for review, two CRISM staff members independently reviewed the disclosure forms to screen potential authorship committee members and external reviewers who should be precluded from participation due to ongoing or current financial relationships (e.g. employment, paid consultancy or advisory board membership, stock ownership, intellectual property) with industry or commercial entities that could theoretically benefit from the guidance document recommendations. Consistent with the *Institute of Medicine Standards for Developing Trustworthy Clinical Practice Guidelines*,[24] any individual with a current, ongoing relationship with industry, who had received any remuneration or non-monetary support from industry within the past 12 months, or with a history of significant remuneration or non-monetary support from industry (defined for our purposes as cumulative receipt of more than $10,000 or equivalent value within the past five years), was excluded from participation on the guidance document prior to the review process. No authors nor contributors were excluded during initial screening as none met these criteria for exclusion.

Summary of disclosures

No current or ongoing direct conflicts of interest were disclosed by the nineteen authorship committee members and external reviewers. Of the nineteen authorship committee members and external reviewers, three are CRISM staff.

Of the nineteen authorship committee members and external reviewers, one disclosed receipt of funds prior to Guidance document involvement from a commercial entity (Indivior Inc.) that could theoretically benefit from Guidance document recommendations. Six authorship committee members and external reviewers acknowledged that their employment involved the delivery of OAT to patients.

Eight authorship committee members and external reviewers acknowledged their employment involved the support of delivery the OAT programs. Seven authorship committee members and external reviewers acknowledged their employment involved engagement in developing OAT practice within their respective organization. Two authorship committee members and external reviewers acknowledged that their employment involved engagement in developing telemedicine practice within their respective organizations. Two authorship committee members and external reviewers acknowledged that they have publicly stated the need for measures to increase OAT or Safe supply in general, and in the context of COVID-19. Receipt of research or program funding support from non-profit agencies or institutions was not considered a direct conflict of interest. On review, none of the disclosed direct conflicts of interest were deemed to be of sufficient weight or relevance to warrant exclusion from the Guidance document.

Approximately 60% (n=11) of authorship committee members and external reviewers disclosed potential indirect sources of bias (e.g. specialization in addiction medicine, advisory board and committee membership, involvement with telemedicine programs, provincial OAT programs, previous guideline development, research interests).

To mitigate the risk of bias while maximizing the contributions of members in their respective areas of expertise, authorship committee members and external reviewers were reminded to consider any influential factors or sources of bias during the review process. Authorship committee members and external reviewers with indirect potential sources of conflict contributed to review of sections related to their areas of expertise as well as the overarching guidance document content to ensure that a broad range of clinical and academic specializations was adequately represented. [24]

Appendix 2: Search Terms

- “COVID-19 Telemedicine Drug Users”
- “Telemedicine for People Who Use Drugs”
- “Opioid agonist therapy/ OAT COVID-19”
- “COVID-19 substance use”
- “COVID-19 Telemedicine OAT”
- “COVID-19 Telemedicine”
- “COVID-19 Telehealth”
- “COVID-19 Virtual Care”
- “COVID-19 Teleconsultation”
- “Virtual Care OAT”
- “Telemedicine OAT”

Appendix 3: Finding Tables

See on next page (p. 33 - 39).

Telemedicine

	ONTARIO			QUEBEC		WHO	AUSTRALIA	UK	FRANCE	
REFERENCE	Ontario Pharmacists Association (2020). Guide to Providing Virtual Care to Patients. Ontario Pharmacists Association. Link	Ontario MD (2020, March 20). Virtual Care and the 2019 Novel Coronavirus (COVID-19). OntarioMD. Link	Ontario MD (2020, April). Virtual Care: COVID-19 Guide. OntarioMD. Link	Collège des médecins du Québec (2020, April 1). Les téléconsultations réalisées par les médecins durant la pandémie de COVID-19. Guide à l'intention des médecins	Collège des médecins du Québec (2020, April 1). La télémédecine réalisée par les résidents et moniteurs durant la pandémie de COVID-19. Guide à l'intention des superviseurs, des résidents et des moniteurs	Strengthening the Health Systems Response to COVID-19 Technical working guidance #1 Maintaining the delivery of essential health care services freeing up resources for the COVID-19 response while mobilizing the health workforce for the COVID-19 response	The Royal Australasian College of Physicians (April 21, 2020) Interim guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: a national response	NHS (2020, March 27). Clinical guide for the management of remote consultations and remote working in secondary care during the coronavirus pandemic.	Ministère des Solidarités et de la Santé (2020, March 18). Recours à la téléconsultation dans le cadre de l'épidemie de coronavirus (COVID-19)	Ministère des Solidarités et de la Santé (2020, March 18). Prise en charge hors COVID-19.
RELEASE DATE	2020	March 2020	April, 2020	March 2020 (last update April 2020)	March 2020 (last update April 2020)	April 2020		March 2020	March 2020	April 2020
WHEN AND WITH WHAT PATIENTS TO USE VIRTUAL CARE	• COVID-19 positive patients or in self-isolation, elderly or vulnerable patients • For patient's understanding of medications and to resolve urgent medication management issues • Witnessing the ingestion of OAT • Demonstrating the use of a medical device	• Keep contact with patients with COVID-19 symptoms • Reassess patients virtually if worsening • Avoid unnecessary trips to the office • Manage chronic disease • Managing other acute illness not requiring a physical exam		• Assess contamination risk of a clinic or ER visit • Assess the feasibility of the teleconsultation according to patients' needs and the risks and benefits.	Exception due to the pandemic, residents/ monitors (RM) can perform telemedicine with supervisor's authorization.	Staff in quarantine with mild symptoms can take on remote tasks such as telemedicine, serving on a hotline to answer questions from concerned citizens, etc.	• Patients in OAT may require additional supports during periods of social isolation • Regular monitoring and reviews of patients recognising the potential gaps in clinical assessment arising from lack of physical examination and/ or investigation (urine drug screens). • Liaise with local and internet based services (e.g. online counselling, state/territory peer-based drug user groups) to assist clients during this time • Provide clinicians with links for both Harm Reduction Services and Mental Health supports for clients	• For patients not requiring physical examination or test, and can communicate via phone or video • Risk assessment should be carried out first	• Perform teleconsultation when physicians deem it appropriate for their patients • Perform primo-consultations on patients with COVID-19 symptoms • Follow-up with patients infected with COVID-19 and quarantining at home.	• Physicians can perform teleconsultations when they deem it appropriate for their patient. • In the pandemic context, for healthcare professionals, the use of teleconsultation is preferred
PLATFORMS TO USE/ PRIVACY AND SECURITY	• PHIPA compliant virtual platforms, where patient consent is usually collected when they register for the service • Video conferencing platforms, such as: - Skype and Teams by Microsoft - FaceTime by Apple - Zoom Basic - Google Hangouts - WhatsApp by Facebook • Ensure privacy and security of data are maintained • Develop policy on technologies and equipment to be used, privacy, obtaining patient consent, documentation procedures, response to a breach of confidentiality • Most up-to-date version of encrypted applications and two-factor authentication with strong passwords where possible		• Any direct-to-patient telephone, telemedicine and video calling platforms • Medical care virtual care platforms, such as: - Provincial virtual care platforms - EMR-integrated platforms - Stand alone platforms • Telephone calls and other video-conferencing platforms - Skype and Teams (Microsoft) - Facetime (Apple) - Zoom.us - Google Hangouts, and others	• The tools and platforms used must be secure and must ensure the confidentiality of the interview • For teleconsultations: - Platforms offered by the MSSS: Zoom Enterprise, Réact - EMR-integrated platforms - Other teleconsultation platforms already used by medical institutions • For prescriptions: verbal transmission to pharmacist, fax or EMR, electronic Dossier Santé Québec (DSQ) system	• The tools and platforms used must be secure and must ensure the confidentiality of the interview • Phone calls • For teleconsultations: - Platforms offered by the MSSS: Zoom Enterprise (also referred as Zoom Télésanté), Réact, Teams - EMR-integrated platforms - Other teleconsultation platforms already used by medical institutions • The platform cannot be determined by the monitor or the patient.		Standard telephone and special telehealth software with appropriate confidentiality protections.	• Phone, video • Platform such as Attend Anywhere	• Teleconsultations that do not require the exchange of medical documents can be performed with any audio-visual platform (e.g. whatsapp, skype, Facetime) • Each Regional Health Authority may chose best platform to support teleconsultation practice	

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	ONTARIO			QUEBEC		WHO	AUSTRALIA	UK	FRANCE	
IDENTITY VERIFICATION	Confirm identity of patient or their agent before providing virtual care			Patient identity: • Patient's health card displayed on the screen • The patient's file number (if applicable) • The doctors must identify themselves providing: name, title, College of physician status and contact information if needed	• Patient must display his/her health card OR list the digits of his/her health insurance card # and their date of birth (telephone) • Ask for the patient's file number (if applicable)			Verify patient ID: checking date of birth, address, etc.		
PATIENT CONSENT	Obtain consent from the patient to receive care virtually and, if using an unregulated platform, consent to the privacy aspects of virtual care should be obtained & documented	Record verbal consent was obtained when using a product that does not have explicit health care consent	Unless you are using virtual care technologies where consent from the patient is handled at sign-up, ask for patient's consent	• Obtain verbal consent from the patient to receive care virtually at the beginning of appt. & document this (patient's file) • Dr. must mention technological limits (sound, image, security breaches)	• Obtain verbal consent from the patient to receive care virtually at the beginning of the appointment • R/M must mention the technological limits (sound, image, security breaches)			Take and record verbal consent		
DOCUMENTATION	Include the reason for providing virtual care services (e.g. "Due to COVID-19, patient in self-isolation"), the time, date, and technology used, and relevant information from the interaction	Clinical notes to record virtual visits		• Technology / telecommunication system used • Means of identity verification • Patient location during teleconsultation • How consent was obtained (verbal or written)	Performed by R/M physically in their training institution (clinic/hospital): • Add notes to patient's file as usual with mention of the technology used Outside the training institution: • R/M must consult with supervisor on the best way to include notes to patient's file • R/M must keep a copy of the appointment notes until they're properly added to the patient's file. The R/M is responsible of destroying the copies once the file is complete			Document appointment notes and outcomes like face-to-face appointments		

COVID-19 & OAT/PWUD

	ONTARIO		CANADA	QUEBEC		AUSTRALIA	UK	FRANCE	EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION
REFERENCE	CAMH/ META:PHI/ OMA (2020, March 22). COVID-19: Opioid Agonist Treatment Guidance. CAMH. Link	Centre for Addiction and Mental Health (2020, March 27). Early Guidance for Pharmacists in Managing Opioid Agonist Treatment during the COVID-19 Pandemic. CAMH. Link	Karbi, J. and Brasch, J. (2020, March 28). A Harm Reduction Approach to Managing Opioid Use Disorder During COVID-19: A Brief Summary for Clinicians. CSAM. Link	Collège des médecins du QC, Ordre des infirmières du QC et l'Ordre des pharmaciens du QC. Lignes directrices TUO en lien avec la pandémie COVID-19 (temporaire). Link	Ordre des pharmaciens du Québec (2020, March 23). Substances désignées et activités professionnelles des pharmaciens - changements importants en contexte de pandémie. Link	The Royal Australasian College of Physicians (April 21, 2020). Interim guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: a national response. Link	Department of Health & Social Care (2020, April 15). COVID-19: Guidance for commissioners and providers of services for people who use drugs or alcohol. Government of UK. Link	Ministère des Solidarités et de la Santé (2020, April 8). Prise en charge hors COVID-19. Link	
RELEASE DATE	March 2020	March 2020	March 2020	March 2020	March 2020	April 2020	April 2020	April 2020	April 2020
PATIENTS WHO ARE ASYMPTOMATIC AND UNDER ISOLATION	• Pharmacy delivery should be used if available • Virtual communication may be used to support witnessed dosing • If pharmacy delivery unavailable, prescriber should closely coordinate patient attendance with pharmacy staff so that appropriate precautions can be taken	May release OAT doses to an authorized agent for pick up at the pharmacy or have the doses delivered				• Supply of TADs to a responsible carer from the dosing site • Delivery of TADs to place of residence of isolated patient.	• Nominate an individual to collect the dispensed medicine on their behalf, with written instruction of the patient, but community pharmacies will receive guidance about acceptable alternatives during the pandemic. • If the patient cannot nominate someone a staff member may, with agreed authorization, be able to collect and deliver the medicines.		
PATIENTS WHO ARE SYMPTOMATIC AND/OR QUARANTINED, OR PRESUMED OR CONFIRMED COVID-19	• Pharmacy delivery should be used if available • Virtual communication may be used to support witnessed dosing • All reasonable measures should be explored, including having a designated agent to pick up or receive the carries • Practice may need to be modified on an individual basis and risk assessment	May release OAT doses to an authorized agent for pick up at the pharmacy or have the doses delivered				• Supply of TADs to a responsible carer from the dosing site • Delivery of TADs to place of residence of isolated patient.	• Nominate an individual to collect the dispensed medicine on their behalf, with written instruction of the patient, but community pharmacies will receive guidance about acceptable alternatives during the pandemic. • If the patient cannot nominate someone a staff member may, with agreed authorization, be able to collect and deliver the medicines.		
CLINICAL ASSESSMENTS OF SUITABILITY FOR CARRIES	• Relates to social stability and an individual's ability to manage carries safely • Patients require safe storage for carries (i.e., a locked box) and safe housing • Patients not suitable for carriers if: - Intoxicated or sedated when assessed - Unstable psychiatric comorbidity (acutely suicidal or psychotic) - Recent overdose - Currently using illicit substances in high-risk ways	• Patients who may not have been suitable carriers as defined by existing guidelines should be reassessed as per the COVID-19 -Opioid Agonist Treatment Guidance document during the COVID-19 pandemic • Patients require safe storage for carries. • Pharmacists should not make any changes to the dosage of existing therapy unless approved by the prescriber	• Consider initiating or increasing carries if patient meets the following criteria: - Safe housing & safe storage (i.e. locked box) - No recent overdose - No high-risk use of illicit substances (e.g. concurrent alcohol or benzodiazepines, high-dose IV opioid use) - Stable psychiatric comorbidities (i.e. not actively suicidal, no psychosis)			• Conduct a risk assessment for TAD provision and examine risk mitigation strategies. • Suggest use of checklists, or structured instruments such as the Australian Treatment Outcomes Profile	• Services should be transferring most, if not all, patients from supervised consumption to take-home doses • Where possible, patients may be provided with up to 2 weeks' worth of take-home supply • Those considered at most risk of diversion or misuse and overdose, or those living in shared or hostel accommodation where it is impractical or high risk to store large quantities of OAT medicines, may be required to pick up their medication daily or at another frequency. Consideration should be given to mitigations that reduce risk, such as hostel staff holding medicines, pharmacy delivery of medicines if available, lock boxes.		

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	ONTARIO		CANADA	QUEBEC		AUSTRALIA	UK	FRANCE	EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION
OBSERVED DOSES		• Consider extra precautions, include care in the handling and disposal of dosing cups and reduced contact by not requiring signatures for dosing • Explore alternative measures to support witnessed dosing, including virtual communication and observation methods	• Pharmacy delivery where available • Virtual communication for supervised dosing where available • For symptomatic and/ or COVID-19 positive patients, designate a reliable agent to pick up or receive carries		• Unless required by the prescriber, there is no need to verify the complete dissolution of the sublingual tablet or the taking of methadone - Verification can be done by asking patient to speak after taking the dose	• High: Patients commencing methadone or LS buprenorphine: Supervised dosing for at least 14 days methadone, 3-7 days SL BNX. Consider direct induction to depot buprenorphine without need for SL dosing. • High: with one or more of the following: High risk use of other sedative drugs • Low risk recommendation: Methadone: 1 supervised dose & 6 TADs per week			
BUP/ NAL	• Perform clinical assessments of suitability for carries • UDS not required for carries • Witnessed dosing not required, unless to address some specific clinical issue • May extend scripts up to 4 weeks; prescriber to use clinical judgment to determine whether to be progressive with carries (e.g. advancing from 1-4 weeks) • Very stable patients may be assessed less frequently (e.g. every 6-12 weeks)		• UDS not required • Witnessed dosing not required • May extend scripts up to 4 weeks • Very stable patients may be assessed less frequently (e.g. every 6-12 weeks)			• Newly assessed: should usually be offered buprenorphine as first choice and will be able to take away unsupervised titration doses for up to 2 weeks. Those opting for methadone should collect their medicine daily from the pharmacy in the first week, followed by take-home doses. • If only remote assessments are possible and drug testing is not possible, it may be possible to proceed with buprenorphine titration in known opioid-dependent patients, based on an adequate history. This approach is unlikely to be suitable for methadone, where drug testing will usually be needed unless there is a clear history of opioid use and tolerance, in a known patient with evidence that opioids have been used in the last 24 hours.	• Unsupervised titration doses for up to 2 weeks • It may be possible and helpful to move a small number of patients from daily (or less frequent) • sub/supra-lingual bup to depot bup.		

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	ONTARIO		CANADA	QUEBEC		AUSTRALIA	UK	FRANCE	EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION
METHADONE	• Greater concerns with respiratory depression and overdose than bup/nal carries. Thus, the risks of community transmissions of COVID-19 must be weighed against the known risks of overdose death due to diversion to the community or to overuse of methadone carries by the patient • Non-consecutive carries are a way of reducing the frequency of pharmacy and the risks of misuse/diversion of larger amounts of methadone. At their observed doses, patients are seen by a pharmacist and assessed for sedation/ intoxication • **New methadone starts**: initiated in methadone-naive patients after a comprehensive assessment (virtual or in-person), including a UDS. This warrants more frequent clinical assessments, whether in-person or remotely. Consider waiting one month before initiating carries. • **Methadone restarts**: Complete a virtual or in-person assessment and offer bup/nal as a preferred treatment option. If a patient wishes to restart methadone and a UDS cannot be performed, prescribers should consider using a lower starting dose of methadone. • **Patients who have missed doses** (i.e. up to 7 missed doses of methadone or 14 missed doses of bup/nal): restart after an assessment (virtual), without a UDS.	• Consider delivering a smaller number of methadone carries at one time to enhance patient safety. E.g. if patient is authorized to receive 13 carries, deliver 6-7 doses weekly • Advise patients that the return of used carry bottles is not recommended at this time, and provide direction to ensure the used carry bottles are rinsed prior to disposal	• More caution required due to higher risk of overdose and diversion compared with buprenorphine/ naloxone • UDS not required for low-risk patients; required for higher-risk patients only if it will change clinical management • Consider suitability for consecutive carries dependent on risk, up to a maximum of 3 consecutive doses (see META:PHI "Carry Ladder" during COVID-19)				**New methadone starts:** should generally collect their medicine daily from the pharmacy in the first week, followed by take-home doses. **Methadone restart**: People restarting treatment who were taking methadone no more than 7 days ago may be able to return to methadone after careful assessment but usually starting at a lower dose, titrated up again and with only 2 to 3 days pick-up to start.		

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	ONTARIO		CANADA	QUEBEC		AUSTRALIA	UK	FRANCE	EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION
COMMUNICATION	• Verify contact information for all patients • Provide increased support to patients via remote methods • Provide contact information to pharmacy colleagues to troubleshoot clinical scenarios as they arise • Inform patients of your clinical decision. Explain the need to avoid in-person visits unless absolutely necessary • Virtual communications: opportunity to inform, educate, and model physical distancing • Offer online resources to patients • Offer increased counselling services via remote methods, with the intent of providing up-to-date medical information, reassurance and mindfulness • Assessments can be an important source of support to patients who no longer have access to meetings, groups or counselling. When a UDS is not required, consider using technology to allow patients to connect with their provider remotely	Ongoing and close communication with prescribes is critical. Pharmacists' assessments are valuable, particularly for decisions related to suitability for progressive carry doses.					Inform GPs of the changes in prescribing and amounts of OAT stored in homes where there are children, inform local children's social care services if they are involved or if there are concerns		• Stay updated on local level of transmission of COVID-19 through your local and state health departments. • Use health messages and materials developed by credible public health sources, such as your local and state public health departments or the Centers for Disease Control and Prevention (CDC). • Post signs at entrances and in strategic places providing instruction on hand washing and cough, use of cloth face coverings, and social distancing. • Provide educational materials about COVID-19 for non-English speakers or hearing impaired • Keep staff and clients up-to-date on changes in facility procedures. • Ensure communication with clients and key partners about changes in program policies and/or changes in physical location. • Identify communication platforms (e.g. hotline, automated text messaging, websites) to help disseminate information to those inside and outside your organization. • Identify and address potential language, cultural, and disability barriers associated with communicating COVID-19 information to workers, volunteers, and those you serve. Learn more about reaching people of diverse languages and cultures.

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	ONTARIO		CANADA	QUEBEC		AUSTRALIA	UK	FRANCE	EUROPEAN MONITORING CENTRE FOR DRUGS AND DRUG ADDICTION
SAFETY AND DOCUMENTATION	• Methadone carry safety should be assessed and documented, as per MMTG • Consider possible misuse or diversion and overdose risk • Advise patients that exceptional carries are being given due to current public health emergency, and MMTG standards will reapply once it is over • Discuss and document issues related to safe storage and risk of carries, including overdose and death • Document that patient states they have the ability to safely store increased number of carries • Patients should be directed to obtain naloxone overdose kits and educated in the use of naloxone • A carry agreement should be either signed or remotely agreed to and documented in the chart • Lost or diverted methadone carries should be managed as per MMTG. Lost or diverted bup/nal carries should be managed according to usual standard of care	Ensure all patients on OAT have a take-home naloxone kit and are trained on its use along with other harm reduction strategies				• Patient and carer education • Access to Take Home Naloxone • Engage carers in overseeing use of medications where possible • Regularly review patient conditions and use of medications • Document decision making regarding TADs and risk mitigation strategies. Communicat e with staff at dosing point. • Confer with a colleague if in doubt • Inform other key service providers of changes in treatment conditions, including the number of TADs in writing.	• Provision of take-home naloxone • Safe storage boxes, especially if there are children in the home • Information sharing with children's social care and other relevant professionals • Verbal and written harm reduction advice • Regular communication between patient and service, enabled by the provision of mobile phones or credit if needed		
GUIDELINES FOR EXTENDED REMOTE CARE	• Consider using remote methods to provide care • Review each patient's case individually, taking into account stability, safety, storage, overdose risk, diversion risk, lapse or relapse, the dangers associated with COVID-19 and current public health advice around social distancing • Record the decision-making process, any deviations from these or standard guidelines, and clinical justifications in the patient's record • Assume open ongoing communication with patient; if not possible remotely, it may be more appropriate to continue in-person care using standard carry parameters. • Should be done whenever possible to support physical distancing and reduce overall risks								

Appendix 4: Online Substance Use Resources Listing

Below is a list of online resources on substance use. Please note that this is not an exhaustive list of resources.

Clinical Support Resources for Patients and Healthcare Providers

Anxiety Canada's free MindShift™ CBT app
This app focuses on assisting in the management of anxiety using scientifically proven strategies (*free for iOS and Android devices*)

British Columbia Centre on Substance Use: COVID-19

Canadian Addiction Counsellors Certification Federation
Virtual addiction counselling

CATIE – Canada's source for HIV and hepatitis C information

College of Physicians and Surgeons of Newfoundland and Labrador - Opioid Agonist Treatment (OAT) Guidance during COVID-19

Community Addictions Peers Support Association (CAPSA) **and** **Breaking Free Online**
In response to COVID-19 and the increased risks for those with substance use disorders, the Community Addictions Peers Support Association (CAPSA) has partnered with Breaking Free Online to provide free access to Canadians (service code CAPSA2020)

Draft Emergency Carry Agreement

Nova Scotia Department of Health and Wellness: Points to Guide Clinical Decision for OAT Prescribers

Nova Scotia Health Authority (NSHA) Standard Operating Procedures for Opioid Use Disorder Treatment (OUDT) Programs
Documents included: Overview and Infection Control Practices SOP, New Admissions and Transfers SOP, Ongoing Client Being Prescribed Methadone SOP, and Clients in Self-Isolation or Quarantine SOP.

Providence Health Care Nursing Practice Standard Dispensing Injectable Opioid Agonist Therapy to Client With or at Risk of COVID-19

SMART Recovery Program
This website includes message boards, chat rooms, online meetings, and an online library of recovery resources

Take Home Naloxone
Free online naloxone training

Toward the Heart
Free online naloxone training

Harm Reduction Resources

Canadian Association of People Who Use Drugs (CAPUD)

Canadian Drug Policy Coalition: COVID-19 Harm Reduction Resources

International Network of People Who Used Drugs: COVID-19 Crisis: Harm Reduction Resources for People who Use Drugs

Mental Health and Substance Use Resources

Centre for Addiction and Mental Health (CAMH): Mental Health and the COVID-19 Pandemic

Narcotics Anonymous

Taking Care of Your Mental Health (COVID-19)

Wellness Together Canada: Mental Health and Substance Use Support

Indigenous Communities

Assembly of First Nations: COVID-19

First Nations Health Managers Association: COVID-19 Resources and Announcement
Up-to-date information on COVID-19

First Peoples Wellness Circle: COVID-19 Resources page

Provides printable Information Sheets for Mental Wellness for Community; Parents and Children; Elders and Seniors; and Health Professionals

Thunderbird Partnership Foundation: Harm Reduction during COVID-19

Support Resources for Healthcare Providers

Canadian Foundation for Healthcare Improvement (CFHI)

Supports partners to accelerate the identification, spread and scale of proven healthcare innovations. Webinar Series: Patient Partnership in a Time of COVID-19

Health Canada Subsection 56(1) Class Exemption for Patients, Practitioners and Pharmacists Prescribing and Providing Controlled Substances in Canada during the Coronavirus Pandemic

In response to the evolving health risk due to COVID-19, to maintain Canadians' access to controlled substances for medical treatments (e.g. treatment of substance use disorders and chronic pain), while they adhere to social distancing guidance from public health officials or if they need to self-isolate, Health Canada has issued exemptions for prescriptions of controlled substances under the Controlled Drugs and Substances Act (CDSA) and its Regulations.

Mental Health First Aid Canada

Resource hub which provides credible information and resources for mental health for the Healthcare professionals "Resources for Healthcare Sector"

Appendix 5: Health Canada Tool Kit

Health Canada has compiled a number of resources in an effort to provide clarity regarding the rules that apply for substance use disorder treatment or providing a pharmaceutical grade alternative to the toxic street supply in Canada, in the context of COVID-19. This includes:

- A regulatory pathways graphic;
- Frequently asked questions and answers related to the legislative and regulatory requirements for substance use disorder treatment/safer supply;
- A list of all relevant exemptions that have been issued under the Controlled Drugs and Substances Act;
- Formulary coverage under drug plans of medications used in substance use disorder treatment and as pharmaceutical grade alternatives to the illegal supply; and,
- Resources related to substance use disorder treatment and providing safer supply, both in general and during the COVID-19 pandemic.

https://www.dropbox.com/sh/x622qndzvmydsvm/AABi888G_Ase6T0-N1Pd3uboa?dl=0

References

1. Schünemann HJ, Al-Ansary LA, Forland F, et al. Guidelines international network: principles for disclosure of interests and management of conflicts in guidelines. Ann Intern Med 2015;163:548-53.

2. Federation of Medical Regulatory Authorities of Canada. FMRAC framework on telemedicine. Available: http://fmrac.ca/fmrac-framework-on-telemedicine. Accessed April 22, 2020.

3. Collège des médecins du Québec. November 2015. The physician, telemedicine and information and communications technologies: Practice guidelines. http://www.cmq.org/publications-pdf/p-1-2015-02-01-en-medecin-telemedecine-et-tic.pdf. Accessed April 22, 2020.

4. Collège des médecins du Québec. April 1, 2020. Les téléconsultations réalisées par les médecins durant la pandémie de COVID-19 : Guide à l'intention des médecins. http://www.cmq.org/publications-pdf/p-1-2020-03-31-fr-les-teleconsultations-realisees-par-les-medecins-durant-la-pandemie-de-COVID-19.pdf. Accessed April 20, 2020.

5. CAMH/ META:PHI/ OMA. March 22, 2020. COVID-19: Opioid Agonist Treatment Guidance. https://www.camh.ca/-/media/files/COVID-19-modifications-to-opioid-agonist-treatment-delivery-pdf.pdf?la=en&hash=261C3637119447097629A014996C3C422AD5DB05. Accessed April 21, 2020.

6. The Royal Australasian College of Physicians. April 21, 2020. Interim guidance for the delivery of medication assisted treatment of opioid dependence in response to COVID-19: a national response. https://www.racp.edu.au//docs/default-source/default-document-library/COVID-19/interim-guidance-delivery-of-medication-assisted-treatment-of-opiod-dependence-COVID-19.pdf?sfvrsn=e36eeb1a_4. Accessed April 22, 2020.

7. Department of Health & Social Care, Government of UK. April 15, 2020. COVID-19: Guidance for commissioners and providers of services for people who use drugs or alcohol. https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0044-Specialty-Guide-Virtual-Working-and-Coronavirus-27-March-20.pdf. Accessed April 22, 2020.

8. Karbi, J. and Brasch, J. March 28, 2020. A Harm Reduction Approach to Managing Opioid Use Disorder During COVID-19: A Brief Summary for Clinicians. CSAM. https://csam-smca.org/wp-content/uploads/2020/03/SummaryofOUDCOVID19_2.pdf. Accessed April 21, 2020.

9. Ministère des Solidarités et de la Santé, Gouvernement de la République Française. April 8, 2020. Prise en charge hors COVID-19. https://solidarites-sante.gouv.fr/IMG/pdf/soins-hors-COVID-19.pdf. Accessed April 24, 2020.

10. Ontario Pharmacists Association. 2020. Guide to Providing Virtual Care to Patients. https://www.opatoday.com/Media/Default/Default/Virtual%20Care.pdf. Accessed April 20, 2020.

11. Ontario MD. March 20, 2020. Virtual Care and the 2019 Novel Coronavirus (COVID-19). https://ontariomd.news/wp-content/uploads/2020/03/COVID-19-Bulletin-for-Physicians-Mar-20.pdf. Accessed April 21, 2020.

12. Collège des médecins du Québec. April 1, 2020. La télémédecine réalisée par les résidents et moniteurs durant la pandémie de COVID-19. Guide à l'intention des superviseurs, des résidents et des moniteur. http://www.cmq.org/publications-pdf/p-1-2020-03-31-fr-la-telemedecine-realisee-par-les-residents-et-moniteurs-durant-la-pandemie-de-COVID-19.pdf. Accessed April 23, 2020.

13. Ministère des Solidarités et de la Santé, Gouvernement de la République Française. March 18, 2020. Recours à la téléconsultation dans le cadre de l'épidémie de coronavirus (COVID-19). https://solidarites-sante.gouv.fr/IMG/pdf/COVID-19_teleconsultation-fiche-medecin.pdf. Accessed April 24, 2020.

14. Canadian Partnership against Cancer. July 2019. Virtual Care in Canada: Environmental Scan. https://s22457.pcdn.co/wp-content/uploads/2019/09/Virtual-Care-Environmental-Scan-EN.pdf. Accessed April 18, 2020.

15. Ontario MD. April 2020. Virtual Care: COVID-19 Guide. https://ontariomd.news/wp-content/uploads/2020/04/VC-Covid19-visual-V10.pdf. Accessed April 23, 2020.

16. World Health Organization. Strengthening the Health Systems Response to COVID-19: Technical Working Guidance #1: Maintaining the delivery of essential health care services freeing up resources for the COVID-19 response while mobilizing the health workforce for the COVID-19 response. http://www.euro.who.int/__data/assets/pdf_file/0007/436354/strengthening-health-systems-response-COVID-19-technical-guidance-1.pdf. Accessed April 25, 2020.

17. CAMH. March 27, 2020. Early Guidance for Pharmacists in Managing Opioid Agonist Treatment during the COVID-19 Pandemic. http://www.camh.ca/-/media/files/camh-COVID-19-oat-guidance-for-pharmacists-pdf.pdf?la=en&hash=ECEB406CEB7E973EE4A3B637520AAAA974D642B7. Accessed April 23, 2020.

18. Collège des médecins du Québec. April 8, 2020.Trouble lié à l'utilisation d'opioïdes (TUO): prescription d'un traitement par agonistes opioïdes (TAO) durant la pandémie. http://www.cmq.org/page/fr/COVID-19-trouble-lie-a-l-utilisation-d-opioides-tuo-prescription-d-un-traitement-par-agonistes-opioides-tao-durant-la-pandemie.aspx. Accessed April 24, 2020.

19. European Monitoring Centre for Drugs and Drug Addiction March 25, 2020. The implications of COVID-19 for people who use drugs (PWUD) and drug service providers http://www.emcdda.europa.eu/publications/topic-overviews/COVID-19-and-people-who-use-drugs. Accessed April 28, 2020.

20. Chow, M., & Thomas-Peter, K. 2014. British Columbia Mental Health & Substance Use Services - Practice Guidelines for Video-based Telehealth Services.

21. Royal College of Physicians and Surgeons of Canada. April 30, 2020. Telemedicine and virtual care guidelines (and other clinical resources for COVID-19). http://www.royalcollege.ca/rcsite/documents/about/COVID-19-resources-telemedicine-virtual-care-e#nwt. Accessed April 24, 2020.

22. Canadian Medical Association. Feburary 2020. Recommendations for Scaling Up Virtual Medical Services. https://www.cma.ca/sites/default/files/pdf/virtual-care/ReportoftheVirtualCareTaskForce.pdf. Accessed April 24, 2020.

23. British Columbia Centre on Substance Use. March 2020. Risk mitigation in the context of dual public health emergencies. https://www.bccsu.ca/wp-content/uploads/2020/04/Risk-Mitigation-in-the-Context-of-Dual-Public-Health-Emergencies-v1.5.pdf. Accessed April 26, 2020.

24. Committee on Standards for Developing Trustworthy Clinical Practice Guidelines, Board on Health Care Services, Institute of Medicine of the National Academies. Clinical practice guidelines we can trust. Graham R, Mancher M, Wolman DM, Greenfield S, Steinberg E, eds. Washington, DC: National Academies Press; 2011. At: https://www. nap.edu/read/13058/chapter/1. Accessed 21 Jun 2017.