MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1098535

PREPARED FOR: Honourable Judy Darcy, Ministry of Mental Health and Addictions and Honourable Adrian Dix, Minister of Health
- FOR INFORMATION

TITLE: Analysis of Health Authorities' Injectable Hydromorphone Plans

PURPOSE: To summarize analysis of health authorities' plans for injectable hydromorphone expansion and recommended next steps.

BACKGROUND:
In May 2017, the Ministry of Health directed Vancouver Coastal Health to expand injectable hydromorphone treatment (injectable HDM) at Crosstown clinic by 50 patients and offer injectable HDM elsewhere in downtown Vancouver for an additional 50 patients. Fraser Health was directed to plan injectable HDM for 50 patients in Surrey. Direction was included that these projects were to be planned based on a supply of hydromorphone through health authority pharmacy systems in order to address pharmacy practice requirements and supply chain issues (detailed in Cliff # 1084362).

On October 10, 2017 Minister Darcy approved the BC Centre on Substance Use (BCCSU) draft guidance for injectable HDM and directed all regional health authorities (HAs) to submit plans by October 30, 2017 for the initial phase of implementing injectable HDM programs across BC.

All health authorities have submitted implementation plans for 2017/18. These plans vary in the level of detail available and in the models and approaches taken. Ministry staff identified the required criteria for the initial phase of implementation (Appendix A); summarized the various models/approaches and determined based on the criteria which approaches can be supported for immediate implementation (Appendix B); and assessed the HA plans for feasibility for the initial phase of the implementation (Appendix C). Outstanding dependencies for implementation were also identified (Appendix D).

If the feasible projects are implemented as planned, injectable HDM would expand by about 164 patients from a baseline of 87 to a total capacity of about 251 patients by the end of 2017/18. A number of constraints, including prescriber supervision of patient induction, will likely limit the number of patients in treatment to fewer than the total capacity within that time frame.

DISCUSSION:
The complexity and risks of expanding injectable HDM warrant carefully controlled expansion to ensure maximum patient and community safety, while expeditiously responding to the opioid overdose emergency. In particular, access to and distribution of hydromorphone needs to be governed by mechanisms which ensure that professional, regulatory, and fiscal requirements are met. (See Cliff #1098645 for discussion)

Based on the criteria identified for the initial implementation (Appendix A), the analysis identified Crosstown, St. Paul's, PHS-Pier Health Pharmacy, Surrey, and Kelowna clinics as the most feasible for initial implementation. If health authority supply of hydromorphone can be readily accessed, clinics at the Dr. Peter Centre, VCH Downtown Community Health Centers, and the Richmond Anne Vogel Primary Care Clinic could also be feasible for initial implementation.

Crosstown: Will be expanding by 50 clients by end of 2017/18 for total of 85 injectable hydromorphone clients (and 81 existing diacetylmorphine clients). Hydromorphone will be provided through the contracted on-site pharmacy (which is transitioning to a HA pharmacy) using the health authority supply chain.

St. Paul's: Plans to serve 24 clients by end of 2017/18, with ultimate goal to reach capacity of 50 clients. Hydromorphone will be provided by St. Paul's hospital pharmacy or Crosstown Clinic pharmacy (to be determined).

PHS-Pier Health Pharmacy: Currently has 50 clients as part of a BCCSU-supported pilot project and will require further work on accountability and supply chain to support expansion. Potential to expand to 70 from 50 clients by the end of 2017/18. Currently reliant on PharmaCare for hydromorphone costs.

Surrey: Proposed expansion of an existing primary care clinic, planned to open March 31, 2018, with initiation of 4-5 clients weekly until a capacity of 50 patients is reached. Hydromorphone will be compounded at a health authority pharmacy, with daily transportation to the site.

Kelowna: Interior Health is proposing that the service be integrated with the Rapid Access OAT clinic planned to open February 1, 2018, and will initiate 5 injectable HDM patients by March 31, 2018. Hospital pharmacy support is available as the immediately feasible option.

For these and other proposed injectable HDM services, additional work is required to address space, staffing, supply and budget issues. Ministries staff will work with HAs, professional Colleges, BCCSU and other relevant stakeholders to resolve these issues and enable expansion of injectable HDM in BC.

ADVICE:

- Support VCH, FHA and IHA to implement the sites and capacity identified in the list above. Staff will continue to work with these HAs on further development and refinement of the implementation plans using the guidance provided in the appendices.
- Staff will work with NHA and Island Health to identify feasible options with the hope of implementation within this fiscal year.
- The Injectable OAT Implementation Coordination Working Group will address the non-pharmaceutical dependencies outlined in Appendix C.
- The new Pharmacy and Supply Working Group will address pharmaceutical supply dependencies outlined in Appendix C.
- PSD will update PharmaCare coverage of injectable HDM to enable the Special Authority program to address patient safety concerns and resource planning issues for injectable HDM, with ongoing support for all current patients.

Appendix A: Initial Phase of Hydromorphone Treatment Expansion – Criteria for Immediate Implementation – Draft November 24, 2017

Principles

Mandatory criteria to be included in health authority (HA) implementation plans

- **Safety:** HAs identify safety considerations and demonstrate how safety will be maintained for patients, providers, community members
- **Cost effectiveness:** HAs demonstrate how their drug supply options are the most cost effective option available, s.17
- **Operational efficacy:** HAs identify how the implementation approach demonstrates operational efficiency including leveraging existing services and infrastructure, aligning with services across the continuum, supports orders of magnitude approach, etc.
- **Optimal reach and impact:** HAs demonstrate how location and service delivery approach support optimal reach and impact in areas of need.
- **Engagement:** HAs demonstrate how they will engage patients/ people who use drugs and other community stakeholders in the development, implementation, and evaluation of the service.

Model of Care

Mandatory criteria to be included when describing service delivery approach and model of care

- Governance and oversight – HAs to demonstrate how they will implement clinical care oversight and quality assurance mechanisms including ongoing monitoring and reporting of service utilization and client outcomes
- Prescribers have appropriate training and authorized special authority
- Supervision of injections performed by health professionals with appropriate training and authority
- Provision of medical treatment/care complemented with psychosocial supports and linkages to other community based services including peer supports.
- Integration with continuum of care – HAs to demonstrate how hydromorphone treatment services fit within the larger continuum of care. This includes identifying referral pathways to hydromorphone treatment and transition pathways to less intensive treatment options as appropriate

Pharmaceutical Practice and Drug Supply

Mandatory criteria for all new projects (i.e. projects with no existing patients)

- Funded through HA
- Access to HA drug supply chain

Mandatory for all projects

- Compliant with all applicable professional practice and regulatory requirements for narcotics handling, including patient-specific preparation, record keeping, transportation and storage.
- Witnessed injection in an environment with supplies and appropriately trained staff for IV injection procedure, patient observation, and adverse event emergency response.

Additional criteria:

- Use of a sterile compounding facility is required for all new projects where possible. This will not be used to disqualify an otherwise qualified project, but where multiple options for drug supply are available, the option with access to sterile compounding is the required option.

Appendix B: Analysis of proposed models/approaches – Draft November 24 2017

1. Prescriber/patient care setting
Where does a patient go to access the service (induction) and receive associated care?

- A. HA owned/operated clinic (e.g. Crosstown)
- B. HA contracted community partner clinic
- C. Private physician office (no HA contracted support)
- D. Harm Reduction Site

2. Injection supervision setting
Once stabilized, where does a patient go to receive their 2+ times daily supervised dose of injectable hydromorphone and associated care?

- HA owned/operated clinic
- B. HA contracted community partner (i.e. clinic, pharmacy)
- C. Community pharmacy
- D. Harm Reduction Site
- E. Housing/ Residence

3. Drug Supply
How are the medications sourced?

- A. HA Hospital Pharmacy Supply direct
- B. HA Hospital Pharmacy Supply – contracted
- C. Community Pharmacy (Pharmacare coverage)

Legend:

- Supported option for initial phase of implementation
- Possibly supported option – protect existing pilots and consider expansion on a case by case basis
- Not supported for immediate implementation or expansion. Further work required to address risks and barriers.

Notes/Explanation:

1. **Prescriber/patient care setting:**

A: Delivery within an HA owned/operated clinic setting (e.g. Crosstown model) supports patient safety and quality care.
B: Delivery within an HA contracted community partner can support patient safety and quality care with oversight from the HA.
C: Private physician offices without contracted HA support currently are not equipped to provide the level of care required.
D: Harm Reduction sites for delivery of injectable hydromorphone for harm reduction purposes rather than treatment are not staffed or set up for assessment, prescribing or dose titration. No standard dose for harm reduction exists. Transportation of drug supply to these sites is also an issue under current Health Canada regulation.

2. **Injection supervision setting:**

A: Health authority clinics currently may not have space to support this without additional investments but is ideal setting for supporting patient safety and quality care.
B: Partnering with community providers adds flexibility for meeting patients where they are and creates faster options for space, but adds complexity for transportation of drugs to delivery site.
C: Community pharmacies are not currently an appropriate setting for care delivery outside of current pilot sites due to outstanding professional, regulatory and drug supply considerations.
D: Harm reduction sites may be an appropriate setting for supervised consumption for stable clients, however transportation of drug supply to these sites is an issue.
E. Housing-based treatment is being piloted in Vancouver with PHS Community Services, but faces regulatory barriers for transportation of drugs as well as transportation related safety concerns.

3. **Drug Supply:**

A. HA/hospital pharmacies have the most favourable drug pricing and some are set up for sterile compounding required for preparation of multiple doses at one time. This also supports predictable drug demand/supply.
B. HAs contract with service delivery sites but utilize HA/hospital pharmacies for drug supply (similar to BC Transplant).
C. s.17 Very few pharmacies are set up for sterile compounding needed for efficient dose preparation. This is currently not an option.

Appendix C – Hydromorphone Treatment Initial Implementation Plans Summary - November 24, 2017

Overview

In May 2017, the Ministry of Health directed Providence Health Care and Vancouver Coastal Health to expand hydromorphone treatment for people with opioid use disorder this fiscal year. Direction was to increase Crosstown clinic by 50 patients, and offer hydromorphone treatment elsewhere in downtown Vancouver for an additional 50 patients. Fraser Health was directed to plan for hydromorphone treatment for 50 patients in Surrey, and return to the Ministry for direction before implementing. It was the expectation of that the health authorities would supply hydromorphone through health authority-based pharmacies.

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On October 10 Minister Darcy approved draft guidelines for hydromorphone treatment prepared by the BCCSU, which were published on the BCCSU website on October 11.

All health authorities were subsequently directed to submit implementation plans for hydromorphone treatment initiation.

Health authorities were provided with a planning template and planning considerations document, and two teleconferences with ministry staff have been held to clarify direction and answer questions. The second teleconference included the Registrar and staff from the College of Pharmacists to discuss the College's plans wrt pharmacist standards and policies for hydromorphone treatment and to clarify issues with respect to a potential role of community pharmacists.

A working group has been formed to address pharmaceutical issues, review options, determine the most appropriate approach and as needed, and build the selected approach into the larger hydromorphone treatment implementation plan. This working group includes representatives from the both ministries, health authority pharmaceutical services (urban and rural perspectives), and the College of Pharmacists.

All health authorities have submitted their initial plans. Ministry staff have reviewed the plans and have been seeking clarification about the details.

Concurrent with this activity cost estimates are being made in preparation for a funding request to support expansion of this service in subsequent years.

Plans submitted indicate a variety of proposed settings for hydromorphone treatment services:

1. *Comprehensive* stand-alone hydromorphone treatment service
2. *Integrated* hydromorphone treatment service within pre-established services such as a community health centre
3. *Stand-alone* primary care with pharmacy-based hydromorphone treatment service
4. *Supportive housing* based hydromorphone treatment service
5. *Harm reduction* based hydromorphone treatment service e.g. within overdose prevention or supervised consumption services

If implemented as planned hydromorphone treatment would expand by 149 patients from a baseline of 87 patients, to a total of 236 patients by the end of 2017/18. However a number of constraints make it unlikely that full expansion will be realized in that time frame.

Within these settings the proposed supply of hydromorphone varied between provision by health authority pharmacy (which use 50 ml multi-dose vials where sterile compounding is available, and may otherwise use 1mL ampules) and by community pharmacies (which use 1 ml ampules). s.17
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Summary of Projects

Each project is described below and assessed for its feasibility for implementation as part of the initial phase of iOAT implementation and expansion. The projects are summarized below as Table 1. The letter code and colour in Table 1 corresponds to the analytic framework presented in Appendix B.

Island Health and Northern Health do not yet have sufficient planning in place to assess feasibility and patient numbers, further planning work is in progress.

Table 1: Summary of Projects

HA	Project	Prescriber / Patient Care	Supervised Consumption	Drug Supply	# of Patients
Fraser		**A**	**A**	**A**	**50**
Interior	Kelowna General Hospital (KGH)	**A**	**A**	**A**	**10**
(alternate)	KGH + HA Clinic	**A**	**A**	**A**	**10**
(alternate)	Comm. Pharmacy + HA Clinic	**A**	**A**	***C -> B***	**10**
Northern		?	?	?	**0**
Vancouver Coastal	Crosstown (Providence)	**A**	**A**	**B**	**50 New**
	PHS - Pier Pharmacy	**B**	***C***	***C***	**20 New**
	PHS - Molson	**B**	***D***	***C***	**30**
	PHS - Housing-based	**B**	***E***	***C***	**30**
	St Paul's Hospital	**A**	**A**	**A**	**24**
	Dr Peter Center	**B**	**B**	**A**	**10**
	VCH Community Health Centres	**A**	**A**	***C -> A***	**20**
	Richmond Primary Care Clinic	**A**	**A**	***C -> A***	s.22
Vancouver Island	Proposal as written	?	?	?	
	PHS partnership	***C***	***E***	***C***	
	Cool-Aid Partnership	B	B	***C***	

Colour Code	
	Feasible
	Feasible with work
	Not Feasible for Initial Phase

Note: The notation C -> A marks a project that, as submitted, was assessed as C, but has capacity to be assessed as A with work during the initial implementation phase.

Table 2: Total number of New Patients for Initial Phase of Implementation

Health Authority	Number of Patients
Fraser	50 patients
Interior	10 patients
Northern	0 patients
Vancouver Coastal	34 patients (79 with work)
VCH/Providence	50 patients
Vancouver Island	0 patients
TOTAL	134-189 patients

Vancouver Coastal Health

Vancouver Coastal Health plans include the following:

- Through Providence Health Care
  - Crosstown Clinic (*Comprehensive*) expansion – 50 additional clients by end of 2017/18 for total of 166 clients.
    - Pharmaceutical services through contracted on-site pharmacy using health authority priced hydromorphone.
      Feasibility: Feasible as are currently expanding 2-4 clients/week as planned.

  - St. Paul's Hospital (*Comprehensive*) – 24 clients by end of 2017/18. Will continue to add patients until the target number of 50 patients is reached.
    - Pharmaceutical services through St. Paul's hospital pharmacy or Crosstown Clinic pharmacy (to be determined).
      Feasibility: Feasible if space issues addressed. Potential availability of hydromorphone through Crosstown or hospital pharmacy should facilitate implementation.

- Through PHS Community Services
  - Pier Health Services Pharmacy with support from PHS Community Services and Vancouver Native Health Society (*Integrated*) – 20 additional clients to bring total to 70 clients by end 2017/18 (current enrollment to be verified).
    - Pharmaceutical services through community pharmacy.
    - Hydromorphone supply reliant on PharmaCare-paid community pharmacy drug cost.

Feasibility: Feasible as this is currently operating and further expansion is happening. There is a need to shift to health authority supplied hydromorphone or otherwise resolve supply.

- Molson Overdose Prevention Site (*Harm reduction*) – 30 clients by end of 2017/18 (none currently being served).
  - Pharmaceutical services through Community Apothecary community pharmacy delivering hydromorphone.
  - Hydromorphone supply reliant on PharmaCare-paid community pharmacy drug cost.

  Feasibility: *Not feasible at this time*. Uncertainties about staffing for assessment, prescribing or dose titration. No standard dose for harm reduction exists. Transportation of drug supply to these sites is an issue under current Health Canada regulation. Access to drug supply is also an outstanding issue.

- Alexander St Residence (*Supportive housing*) – 20 additional clients by end of 2017/18 s.22
  - Pharmaceutical services through Community Apothecary community pharmacy delivering hydromorphone.
  - Hydromorphone supply reliant on PharmaCare-paid community pharmacy drug cost.

  Feasibility: *Not feasible at this time.* Transportation of drug supply to this site is an issue under current Health Canada regulation. Significant work to be done to address patient and health practitioner safety prior to expansion. Supply chain issue to be addressed.

- Through Dr. Peter Centre (*Integrated,* potential for clients to transition to *Stand-alone*)
  - 10 clients by end of 2017/18 fiscal year.
    - Pharmaceutical services through Lower Mainland Pharmacy Services or Crosstown Clinic pharmacy (to be determined). Proposed to work toward setting up a partnership with the Shopper's Drugmart on Davie St. that is located 1 block away and is open 24 hours. The rationale for including a community pharmacy is to provide some flow through within the program, so that clients could begin with the treatment delivered at Dr. Peter Centre, then transition to the community pharmacy once they were stabilized on the treatment (e.g. post 6 months). The component would rely on a PharmaCare-paid drug supply.

Feasibility: Feasible if implemented using hydromorphone supplied through Crosstown or hospital pharmacy. Future transition to community pharmacy is contrary to ministry direction for initial phase, can be addressed as part of future phases, .

- VCH Downtown Community Health Center (*Integrated*)
  - 20 clients by end of 2017/18 fiscal year (none currently enrolled).
    - Pharmaceutical services to be determined. Proposed as reliant on community pharmacy.

  Feasibility: Not feasible unless plan is to work to implement health authority supply of hydromorphone.

- Richmond Anne Vogel Primary Care Clinic (*Integrated*)
  - 5 clients by end of 2017/18 fiscal year (none currently enrolled)
    - Pharmaceutical services may use the pharmacy at Richmond Hospital. If able to use the community pharmacy, this would give more options for implementation at significant increased drug cost.

  Feasibility: Feasible with work to implement health authority supply of hydromorphone

Fraser Health

Fraser Health is planning hydromorphone treatment service as an expansion of an existing primary care clinic that focuses on HIV/HCV care and OAT, serving the area of North Surrey / Whalley (*Integrated*).

Compounding of drugs will occur at a health authority pharmacy at either Surrey Memorial Hospital or the Langley Shared Services Facility, with daily transportation to the site.

Hydromorphone treatment service are planned to open March 31, 2018, with initiation of 4-5 clients weekly until a maximum capacity of 50 patients is reached.

Feasibility: Feasible as relying on health authority supply. Transportation of drug supply to this site is an issue under current Health Canada regulation.

Island Health

Island Health plans to consult with Portland Hotel Society wrt to potential to use Johnson St. Victoria, Community facility (*Supportive housing*); and consult with Cool Aid Health Centre, Victoria (*Integrated*) to explore options and identify feasibility for implementation this fiscal year. BC Housing will be involved in both consultations.

Hope is to identify 5-8 individuals suitable for hydromorphone treatment in Victoria by March 31, 2018.

Pharmaceutical services are to be determined.

Feasibility: *Not feasible until further details provided*. Will depend on ability to access hydromorphone from health authority supply, and resolution of transportation of drug supply issue under current Health Canada regulation.

Interior Health

Interior Health is prioritizing the Central Okanagan (Kelowna) for hydromorphone treatment services and proposing that the hydromorphone treatment service be integrated with and co-located with the Rapid Access OAT clinic (*Integrated*) which is planned to open February 1, 2018. They hope to bring on 5 hydromorphone treatment patients by March 31, 2018.

Pharmaceutical services are to be determined. Options for both hospital pharmacy preparation and contracted community pharmacy preparation were presented.

Feasibility: Feasible if implemented with health authority supply of hydromorphone.

Northern Health

Prince George would be the initiation community.

Considering co-locating with an overdose prevention service or supervised consumption service (*Harm reduction*) or the University Hospital of Northern B.C. (UHNBC)/Rapid Access Addiction Clinic/OAT Clinic (*Integrated*).

Estimating 5-10 patients, potentially by June 30 2018.

Pharmaceutical services are to be determined. May not have capability for sterile compounding.

Feasibility: *Not feasible until further details provided*. Will depend on ability to access hydromorphone from health authority supply, and resolution of transportation of drug supply issue under Health Canada regulation.

Appendix D: Hydromorphone Treatment Implementation Key Dependencies Draft November 24, 2017

The following lists and describes key dependencies that have been identified which need to be in place to support implementation of health authority plans for expansion of hydromorphone treatment services, and the plans needed to address these issues (indicated by ``>``).

People

1. Patients

Plans need to describe how patients/the community of people who use drugs will be involved in the development, implementation and evaluation of the service.

> Request to be made of health authorities.

2. Prescribers

Training requirements for prescribers need to be in place.

> Request made to College of Physicians and Surgeons (CPSBC) and College of Registered Nurses (CRNBC) for advice

Additional guidance documents/tools needed are:

- training courses and supports
  > BCCSU developing
- guidance on transition from induction clinic to treatment setting
  > Request to be made to BCCSU
- 7 day/ week treatment
  > Request to be made to BCCSU
- access to PharmaNet
  > Follow up with health authorities to be done

3. Dispensers

Training requirements for dispensers need to be in place.

Additional guidance documents/tools needed are:

- PharmaNet entry requirements
  > College of Pharmacists (CPBC) is drafting standard requirements for injectable hydromorphone PharmaNet data entry

- Tracking of inventory, including wastage
  > Must adhere to current policies and regulations. CPBC may include iOAT-specific requirements in future standards and guidelines
- Quality assurance program that evaluates both registrant competency and compliance with pharmacy standards specific to hydromorphone treatment
  > CPBC is considering, not a short-term option. Similar requirement could be implemented with limited number of pharmacies by contract in short term. Request to be made regarding status.

4. Injection Supervisors

- Guidance on supervising injection
  > BCCSU guidance needs clarification of minimum required skills. CPBC will incorporate into future standards and guidelines and may require further work by College of Registered Nurses and the College of Physicians and Surgeons.

5. Support Staff (technical and professional)

No key dependencies identified.

> BCCSU guidance needs clarification on which health professionals are able to perform which activities.

Product

- Mechanisms in place to ensure medications are purchased through the health authority pharmacy supply chain, which is much less (7 times less) expensive than through community pharmacies billing PharmaCare
  > Pharmacy Services and Supply Working Group working on resolution.
- Sterile compounding requirements
  > CPBC to clarify requirements, required where possible due to significant drug supply cost savings s.17
- Supply limitations
  > Pharmacy Services and Supply Working Group liaising with manufacturer to assess capacity and timing to increase production to meet demand
- Authorizations to transport hydromorphone
  > Health Canada to issue clarification. Must comply with existing regulations and professional practice.

Place

- Adequate space

  > Health authorities to be queried on status and need to additional support

- Adequate security

  > Lower Mainland Pharmacy Services to work with health authorities on clarifying requirements

Performance

- Description of the evaluation plan

  > BCCSU developing revised plan. Health authorities to be engaged to ensure plans are complementary and coordinated. BCCSU does not yet have information sharing agreement in place.

- Short-term evaluation plans may need to be developed with each HA.

Governance, Clinical Oversight, Quality Assurance and Management

- Description of how the service will be supervised and managed
- Description of quality assurance and accountability mechanisms
- Description of how the service be connected the broader mental health and substance use service continuum

> To be developed by Ministries of Health, Mental Health and Addictions and HA staff.

MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff # 1100622

PREPARED FOR: Honourable Judy Darcy, Minister of Mental Health and Addictions - **FOR INFORMATION**

TITLE: Implementation of injectable opioid agonist treatment (iOAT)

PURPOSE: To provide an update on progress and next steps to implement iOAT.

BACKGROUND:

- Guidelines for iOAT were released in October 2017, and plans have been developed to support implementation.
- It's anticipated 275-280 individuals could be receiving iOAT by March 31, 2018, and 400 by December 31, 2018.
- The rough estimate for the provincial demand is approximately 1,000 individuals.
- Currently there are 200 patients on iOAT.
- The pace to bring new clients onto iOAT is determined in part by the following factors:
  - iOAT is an intensive service and requires time on the part of the provider and client to induct onto treatment.
  - Currently, there are a limited number of physicians with expertise to initiate patients onto iOAT.
  - The number of clients will fluctuate:
    - Clients' experiences with iOAT vary, with Crosstown experiencing some attrition and others taking longer to induct.
    - Some clients elect alternate treatment (e.g., oral OAT).

DISCUSSION:

Implementation is moving ahead, focused on the following areas and deadlines:

<u>Costs</u>

Comprehensive costing for all models will be complete in early February 2017.

- The cost of hydromorphone. The cost varies depending on:
  - The specific drug product size and how it's compounded.
  - The supply chain source s.17

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- Setting and staffing model.

- Costs for prescriber care, supervised injection and psychosocial supports vary depending on the settings in which services are offered and approach to psychosocial supports.

Professional Standards and Supports

- Liability concerns related to pharmacy support and the time requirements.
  - Need to include in scope for pharmacists' practice (determination expected early February 2018).
  - Need to address insurance for pharmacists delivering iOAT (TBD).
  - Need for training of pharmacists (tracking of inventory wastage, disposal of unused drugs) (April 2018).

Regulatory Requirements

Need clarity on Health Canada regulations for transportation of narcotics (clarity is expected by mid-January 2018).

Quality Assurance and Oversight

- Opportunity to consider a range of ways to deliver iOAT beyond the Crosstown model. Also, an opportunity to determine the degree to which models of care
- Will be standardized (January 2018).
- Need for criteria and process for HAs to contract with community pharmacies (January 2018).
- Monitoring mechanisms are needed to determine the quality of iOAT services and ensure patient and health care provider safety (February 2018).
- Need to train health care providers. (BCCSU training implemented Decemeber 2017). Need to encourage providers to attend.
- Guidelines for safety of providers delivering iOAT to housing sites (mid 2018).
- Guidelines for delivery of iOAT in harm reduction sites (mid 2018).

ADVICE:

Move ahead with implementation. Ministry of Health and Ministry of Mental Health and Addictions will work together to determine the timelines on the envelopes of work in order to meet the client goals for March 31, 2018 and December 31, 2018.

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MINISTRY OF HEALTH
INFORMATION BRIEFING NOTE

Cliff #1098645

PREPARED FOR: Ministers Judy Darcy and Adrian Dix **- FOR INFORMATION**

TITLE: BCCSU Pharmacy Model for Injectable Hydromorphone Treatment

PURPOSE: To respond to the British Columbia Centre on Substance Use advice regarding community pharmacy-based treatment in the context of the initial phase of implementation of injectable hydromorphone treatment.

BACKGROUND:
On October 10, 2017 Minister Darcy approved the "Injectable Opioid Agonist Treatment (iOAT) for Opioid Use Disorder Guidance Document" (the iOAT Guidance document) produced by the BC Centre on Substance Use (BCCSU) and directed all health authorities (HA) to submit plans for initiating iOAT with hydromorphone by October 30, 2017. HAs were further directed to submit plans based on treatment in HA clinics which are to be supplied by HA pharmacy resources and supply chain.

On November 17, 2017, the Ministry of Mental Health and Addictions (MMHA) received a document from the BCCSU titled "Briefing Note: Injectable Opioid Agonist Pharmacy-Based Program Oversight and Sustainability" (the BCCSU BN). Ministry of Health (MoH) staff were not consulted in the development of this briefing note.

The BCCSU BN asserts that "the pharmacy-based model for iOAT has the most potential for rapid scalability to other parts of the province" and provides recommendations for action for MoH and MMHA to support the pharmacy-based model for iOAT in BC.

DISCUSSION:
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s.13 . The BCCSU BN makes a number of recommended actions; a detailed response to each recommendation is attached as Appendix A.

The BCCSU BN addresses many but not all of the outstanding dependencies for iOAT in a community pharmacy setting that were identified through the government's review process for the iOAT Guidance document, which was led by the Inter-ministerial Opioid Substitution Treatment Steering Committee (the Committee). Recommendations 1 to 6 were specifically addressed in the briefing note approved by the Committee on October 10, 2017(see Appendix B). Executive review of the Committee's advice did not occur due to MMHA approval and publication of the iOAT Guidance document on October 11, 2017.

The work of the Committee informed the direction given to the HAs for the initial phase of the implementation of iOAT in BC (See Cliff # 1098535 for summary of initial phase). The initial phase will focus on the HA-delivered clinic-based iOAT model for immediate implementation while work continues on the elements identified by the Committee review, now reinforced by the BCCSU recommendations. The goal of the initial phase of iOAT implementation is to launch treatment programs that provide the necessary elements for patient success and complement the continued expansion of access to oral OAT (i.e. Suboxone, methadone and slow release oral morphine).

As described by the BCCSU guidance document, iOAT is an intensive treatment requiring up to 30 minutes of post-treatment observation for each dose, up to 3 times per patient per day. This requires physical space, time, and appropriately trained staff, over and above the existing demands of the current health system.

Individuals who are most likely to receive and benefit from iOAT are those with the highest, most complex care needs. The evidence of the efficacy of iOAT from the European programs and from the SALOME trial in Vancouver is predicated on a clinic-based treatment model, with other patient support services (e.g. case management) engaged to retain these patients in treatment.

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ADVICE:
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Date: November 27, 2017

Appendix A: MoH Response to BCCSU Recommendations

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Withheld pursuant to/removed as

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APPENDIX C: Summary Feedback on the BCCSU iOAT Guidance Document

This document was originally prepared for the Provincial Mental Health and Substance Use Working Group and summarizes concerns, gaps in information, and general feedback on the BCCSU iOAT Guidance Document from the following organizations:

- Ministry of Health
    - Population and Public Health Division
    - Primary and Community Care Division (including Mental Health and Substance Use)
    - Pharmaceutical Services Division
    - Workforce planning, Compensation and Beneficiary Services Division
    - Clinical Integration, Regulation and Education Division
    - Professional Regulation and Oversight
    - Emergency Medical Assistants Licensing
- Regulatory Colleges
    - College of Physicians and Surgeons
    - College of Registered Nurses
    - College of Pharmacists
- Ministry of Social Development and Poverty Reduction

This appendix is a summary developed from the feedback received from the listed organizations and of the three Information Briefing Notes developed by Pharmaceutical Services Division (Cliff # 1089777), Primary and Community Care Policy Division (Cliff # 1090508), and Population and Public Health Division (Cliff # 1094838). Each IBN received signoff from the appropriate executive.

s.13,s.17

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Page 27 to/à Page 28

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