

Unanswered Questions from ME PD Event 2021

- 1. Just looking at the BC guidelines for iOAT - very interesting and resource intensive from the pharmacy perspective. Any idea how many pharmacies are doing this in BC?**

Based on information obtained from the British Columbia Centre on Substance Use (BCCSU) and the College of Pharmacists of BC, it is not believed that there are any pharmacies in BC providing iOAT in the manner outlined in the [Professional Practice Policy-67: Injectable Opioid Agonist Therapy](#). PPP-67 aligns with a model of care developed by the BCCSU <https://www.bccsu.ca/opioid-use-disorder/>, and it would be a challenge for a typical community pharmacy to provide care in this manner (e.g., there are specific space and staffing requirements, as well as significant public funding).

The most common type of practice are robust community-based clinics, often nurse-led, which provide iOAT and other treatments, in collaboration with a community pharmacy that provides iOAT and sometimes other medication to those clinics.

An example of a multi-disciplinary care model is Providence Crosstown Clinic in Vancouver <https://www.providencehealthcare.org/hospitals-residences/providence-crosstown-clinic>

- 2. What role, if any, do the high caffeinated drinks play in overdoses?**

The role of caffeine in drug overdoses is not known at this time.

- 3. Do you have any data about Naloxone Kit usage in MB? Are we able to track efficacy of current practices in giving out Naloxone kits?**

The latest published provincial public health data on opioid misuse and overdose in Manitoba can be found on the following page:

<https://www.gov.mb.ca/health/publichealth/surveillance/opioid.html>

More specific data on naloxone usage between October 1 – December 31, 2018 (the latest published data) can be found at the following link:

https://www.gov.mb.ca/health/publichealth/surveillance/docs/opioid/2018/q4_opioid.pdf

However, the quarterly opioid reports above were replaced with the more broad problematic substance use reports in 2019, which can be found at the following link:

<https://www.gov.mb.ca/health/publichealth/surveillance/problematic.html>.

In addition, the Winnipeg Fire and Paramedic Services (WFPS) reports publicly on naloxone administrations and substance related calls. The MB collaborative data portal packages this information in one of the knowledge portals here <http://www.mbcdp.ca/overdose-and-drug-related-harms.html>

As data on naloxone usage depends on distribution sites reporting back to the province, the data does not provide a full and accurate picture. Therefore, the number of kits sent out to distribution sites is usually the number provided in reports. Based on information provided by the provincial Take Home Naloxone Program, there were over 13,000 kits sent to distribution sites in 2021, which is roughly double what was sent out for distribution in 2020.

4. Should CPhM/CPSM put a limit on day supply for any medication that can contribute to overdose like gabapentin or SSRI?

A universal supply limit on all psychoactive/sedating medications has significant practical and cost implications to patients, which must be balanced carefully with patient and public safety. At this time, prescriber and pharmacist education is key, in combination with a targeted approach on dispensing limits for opioids, benzodiazepines and z-drugs (which are known to be a significant risk to patient and public safety).

Regardless, dispensing limits for psychoactive/sedating medications are appropriate in some patients in some situations. For instance, in patients at higher risk in terms of the overall medication profile and medical history.

It would be useful to evaluate the impact of current limits on opioids and benzodiazepines/z-drugs in Manitoba over time. This data may help answer this question, although not a simple study question.

5. In primary care, are there options to support future opioid tapering when attempts (with an interdisciplinary team) have failed?

More case details would be needed to make a specific recommendation, but generally, one or two failed attempts does not mean long term failure. Re-attempting with different strategies is worthwhile (e.g., referral for a trial of buprenorphine), keeping in mind that dose reductions are also a form of success.