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COLLEGE OF PHYSICIANS & SURGEONS OF ALBERTA

ADVICE TO THE PROFESSION

Safe Prescribing for Opioid Use Disorder

The College of Physicians & Surgeons of Alberta (CPSA) provides advice to the profession to support physicians in implementing the CPSA Standards of Practice. This advice does not define a standard of practice, nor should it be interpreted as legal advice.

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Safe Prescribing for Opioid Use Disorder

Scope

Opioid Use Disorder (OUD) is one of the most challenging forms of addiction and a major contributing factor to the recent rise in opioid-related morbidity and mortality. In recent years, the non-medical use of pharmaceutical opioids and the emergence of highly potent, illegally manufactured opioids have increasingly impacted the evolving landscape of opioid use.

OUD is best conceptualized as a chronic, relapsing illness which has the potential to be in sustained, long-term remission with appropriate treatment. OUD can involve misuse of prescribed opioid medications, use of diverted opioid medications or use of illicitly manufactured heroin, fentanyl or fentanyl analogues. For more information, refer to the DSM on Diagnostic Criteria for OUD.[1]

The intention of the *Safe Prescribing for Opioid Use Disorder* standard of practice is to provide physicians with clear requirements that allow for safe and responsible management of OUD with evidence-supported, full opioid agonist treatments. The standard is deliberately nonprescriptive in requiring use of specific treatment guidelines, as the treatment modalities for OUD are changing rapidly. It is our expectation that physicians provide care based on the most current guidelines and recommendations available, as well as evidence-based best practices (see Appendix A). Opioid Agonist Treatments (OAT) are described in the medication list provided (see Appendix B).

The current guidelines strongly recommend buprenorphine/naloxone and methadone as the first-line treatments for OUD. The advantages provided by buprenorphine/naloxone are well-recognized and include a superior safety profile, greater flexibility and patient autonomy (which allows for earlier take-home dosing), and unobserved home inductions where appropriate. The use of buprenorphine/naloxone can be safely provided with access to laboratory services and a collaborative relationship with a community pharmacist.

Physicians **must not** refuse to accept patients from an initiating prescriber based on access to services. There is no difference in how services would be accessed to support other areas of practice, and the access can be indirect: the services do not need to be located in the same location as the physician, nor in the same location to each other.

[1] DSM-5 Clinical Diagnostic Criteria for Opioid Use Disorder

There are **no** requirements for an approval from the CPSA to prescribe buprenorphine/naloxone, or proof of certain educational or training certification. The expectation is that physicians will acquire the required knowledge and skills to diagnose OUD and provide front-line treatment and medication in accordance with the current guidelines and best practice information, as they would for any other chronic medical condition and medication. For the purpose of this standard, buprenorphine/naloxone is excluded.

Providing safe and compassionate care

Evidence-informed, comprehensive treatment is known to improve the lives of patients who are in pain and living with OUD. These patients need patient-centered, holistic care, delivered with compassion and support.

It is **never** acceptable to abruptly discontinue a patient's prescription opioids because an opioid use disorder is suspected or diagnosed. Patients with OUD, as those living with any other chronic/relapsing illness, benefit most when engaged as partners in their care along with their physician. Actions that undermine such a relationship are not only problematic for obvious reasons, but can also put a patient at serious risks in the context of a contaminated drug supply. For complex patients or where the diagnosis of an OUD is challenging, a consultation with an experienced OAT provider is strongly recommended. (see Appendix C).

It is **never** acceptable to abruptly discontinue a patient's prescription opioids because an opioid use disorder is suspected or diagnosed.

Patients with OUD may benefit from harm-reduction interventions, including education about:

- sterile syringe use and safer injection practices, to reduce the risk of blood-borne (HIV, hepatitis C) and soft tissue infections;
- access to take-home naloxone; and
- syringe distribution programs and supervised consumption services, to reduce the risk of blood-borne infection and fatal overdose (particularly amongst high-risk patients or

patients with ongoing opioid use).

Stigma is a major barrier to seeking treatment and maintaining recovery, and respectfully treating people who use substances improves health outcomes and helps save lives. All efforts should be taken to reduce stigma, which contributes to isolation and means patients are less likely to access services. We must all work to change the conversation about OUD. Language matters and we support and encourage the use of language that puts people first, reflects the medical nature of OUD and promotes recovery.

"We must all confront the intangible and often devastating effects of stigma. The key to recovery is support and compassion. Patients in pain and patients with a substance use disorder need comprehensive treatment, not judgment." - Patrice A. Harris, MD, MA, chair AMA Opioid Task Force"

Education and experience

Knowledgeable and experienced physicians are an integral part of providing patient-centered care in the treatment of OUD. The ability to choose the most appropriate treatment in complex situations, in the context of rapidly evolving treatment options, requires that physicians have current knowledge, relevant experiential training and can maintain their knowledge and skills through Continuing Professional Development (CPD).

Physicians who do not have an OAT approval[2] must complete a CPSA-recognized Opioid Dependence Training Program and provide evidence of experiential training, supervision, mentorship and/or completion of an approved preceptor-based course or residency.

To provide readily-accessible education and experiential training options for physicians, the Alberta Opioid Dependency Virtual Training Program was developed by Alberta Health Services (AHS), in collaboration with the CME Office at Calgary's Cumming School of Medicine. The focus of this program is to give healthcare providers the knowledge, skills and attitudes necessary to provide care to patients with OUD by teaching the complex

[2] Per clause 1 of the *Safe Prescribing for Opioid use Disorder* standard of practice, OAT approval refers to full opioid agonist therapies for opioid use disorder treatment.

integration of technical and behavioral competencies required for addiction and mental health in day-to-day clinical practice. AHS also has the Alberta ODT Virtual Training Program available through Provincial Addiction Curricula & Experiential Skills Training (PACES), which can be accessed at any time through their website.

Successful completion of this program will meet the educational and experiential training required for an approval to initiate OAT for OUD. Upon completion of this course, a certification of completion is provided directly to the CPSA, and an approval is granted without the need for physicians to submit an application or any other evidence.

The program takes a proactive approach—it streamlines the approval process and provides Alberta physicians with access to education and training necessary to ensure competency in OAT, regardless of their location. Physicians who complete other recognized courses (e.g., BC Center on Substance Use (BCCSU) or Center for Addiction and Mental Health (CAMH)) need to submit the following to obtain an approval to initiate OAT for OUD:

- an application for approval;
- evidence of course completion; and
- evidence to support experiential training.

Physicians who presently have an OAT approval (formerly known as a Methadone Exemption/Methadone Approval) for initiating or maintaining treatment for patients with OUD will not be required to have any further training to maintain their approval. It is expected that these physicians maintain their competence in OAT through ongoing education (as part of their mandatory CPD) and provide evidence of the relevant Continuing Medical Education (CME) upon request.

Renewal requirements for prescribing approvals for OAT have been relaxed from those under the previous Health Canada Methadone Program. Physicians with a CPSA approval to initiate OAT (or a pre-existing Methadone Exemption/Approval for initiation) will now only need to renew their prescribing approval once every five years. Physicians with a prescribing approval to maintain OAT are exempt from the renewal requirement. The physician will receive notification of renewal from the CPSA and renew by return email.

Appropriate settings, continuity and transfer of care

OAT for OUD must be initiated where there is access to Alberta Netcare/PIN data, medical laboratory services and pharmacy services. Physicians are expected to be able to refer patients to appropriate multidisciplinary support and other resources and services, as indicated by patient preference and suitability to the patient's care. These services do not necessarily need to be located at the same site as the clinic providing OAT for OUD, but should be easily accessible for collaboration and continuity of care. Evidence shows that pharmacotherapy should not be offered in isolation, but rather should include ongoing assessment, monitoring and support for all aspects of physical, emotional, mental and spiritual health. These are equally important components of treating OUD—addressing these needs should be considered the standard of care. Evidence-based psychosocial supports focused on individual circumstances (e.g., housing, employment, etc.) and other survival needs (e.g., social assistance) may also be helpful in supporting recovery from OUD.

CONTINUITY OF CARE

Continuity of care is also an important aspect of medical management in all settings. In the absence of the initiating provider, physicians must have access to other prescribers with the ability to prescribe OAT. It is expected that physicians working within groups have a process to manage continuity of care and provide coverage for each other. This may be challenging for those who work in rural or remote locations, but physicians need to be aware of the resources available to help manage this aspect of their practice. Alberta's Virtual Opioid Dependence Program supports physicians in rural/remote locations in maintaining continuity of care for their patients. The AHS Opioid Use Disorder Telephone Consultation service, a province-wide, e-consult service, is another resource for prescribers.

Continuity of care remains a vital part of patient safety and maintaining prescribers must have arrangements in place to provide patient care in their absence. Collaboration with colleagues, mentoring networks and educational resources will ensure that patient safety is not compromised.

Patients who are hospitalized, treated in emergency room settings or who are incarcerated are particularly vulnerable to loss of continuity of care. Physicians who temporarily provide OAT in these circumstances must ensure the patient has a sufficient amount of medication on discharge to allow them to contact their community physician. The community

physician must also be notified of their patient's discharge. Direct contact with the community physician is preferred, to allow timely communication about the patient's treatment while under the temporary prescriber. Written communication should also be provided to the community physician.

If a change in medication becomes necessary during the course of the patient's hospitalization, emergency room stay or incarceration, the temporary prescriber must consult with the initiating prescriber or a qualified colleague to ensure any changes are made appropriately and safely. It is expected that all initiating prescribers have a process in place which allows for prompt accessibility of themselves or a delegate prescriber. In the event of urgent or emergent situations, it is expected that the temporary prescriber use best practices to inform their clinical decision.

Collaboration between prescribers during transitions of care is essential to providing continuity and safe patient care.

TRANSFER OF CARE

Stable patients can be maintained in a community setting by their primary care provider. Transfer of care to a community physician requires the initiating prescriber to provide the maintaining physician with a letter of support (sample letter) and an information checklist. The letter of support should indicate that the initiating prescriber (or appropriate delegate) will be available to provide support, accessibility and advice to the maintaining physician. The information checklist should provide the maintaining prescriber with information about any potential risks from the OAT, possible adverse effects and red flags that may indicate a loss of stability requiring further consultation with the initiating prescriber (or their delegate).

The success of transferring the care of stable patients to community physicians is dependent on the ability of the initiating prescriber to provide accessible support for the maintaining physician, so patient care is provided safely. Establishing and maintaining a collaborative environment between both physicians is an integral part of this success.

It is expected that community physicians will accept transfer of care to maintain prescribing of OAT for stable patients and provide patient-centered, holistic care to patients with OUD. Evidence demonstrates that patients receiving team-based health care have improved outcomes, more patient satisfaction and reduced use of hospital, emergency room and specialty clinic services. This treatment also has the advantage of

integrating addiction, medical and psychiatric services into mainstream services, reducing the stigma of addiction and the professional isolation of medical staff. Patients may prefer to receive treatment for their OUD in specialty clinics, so it is necessary to support patients as they integrate into a team-based health care setting.

An approval for maintaining a patient on OAT for OUD is provided to the maintaining physician upon receipt of a support letter from the initiating prescriber. After accepting a patient transfer from the initiating physician, the maintaining prescriber must complete an approved educational course within six months. Module 5 of the Alberta Opioid Dependence Virtual Training Program meets this educational requirement. This online program is free and can be used for CME credits. The program also streamlines the approval process by providing the CPSA with confirmation of completion.

Physicians who already hold an approval for OAT for OUD–Patient Specific are **not** required to complete further educational training to maintain treatment for present or future patients. It is expected that physicians ensure their competency through relevant CME.

When a physician with an approval to maintain OAT for OUD accepts the responsibility of maintaining OAT for OUD for additional patients, a letter of support from the initiating prescriber is required for each additional patient.

Injectable opioid agonist treatment

Injectable OAT (iOAT) is an evidence-based, high-intensity treatment option for patients with OUD who have not benefited from other treatments. It is important to note that the use of iOAT should be considered an integral component of the continuum of care for OUD, rather than a response to the opioid overdose emergency. The expansion of OUD treatment programs to include iOAT must be implemented in a way that supports long-term sustainability.

Optimizing patient safety is an important factor in the designation of iOAT as an alternative intervention, when oral OAT has not been successful. It is important to remember that any frequently-administered injectable treatment comes with higher risks of cutaneous and infectious complications. It should be considered that intravenous or intramuscular injections such as iOAT have a more rapid onset of action, and peak effects (including respiratory depression) are reached faster than with oral ingestion of high-dose, full agonist opioid medications.

To provide iOAT, physicians **must** have an active CPSA approval to initiate or maintain OAT for OUD. Doses must be administered in a facility operated by AHS, or in a community setting approved by the CPSA, with sterile supplies, safe conditions and qualified staff trained to intervene in the event of an emergency.

Community settings that wish to provide this treatment option must submit a letter of intent to Methadone.Info@cpsa.ab.ca, outlining the policies and procedures under which their setting will operate. It is expected the policies and procedures provided will adhere to other recognized models of care for this type of practice, such as those in use by AHS or the BCCSU guideline documents. The physician competency requirements are outlined in Appendix D, and additional training for all physicians providing this option in the community is strongly recommended.

The guidance document from BCCSU (Injectable Opioid Agonist Treatment for Opioid Use Disorder) outlines the current best practices available. Physicians using this treatment option are expected to be familiar with these guidelines (or other recognized iOAT guidelines/best practices) and practice within them.

Conclusion

A stepped and integrated-care approach, where choice and intensity of treatment is continually adjusted to accommodate both the circumstances and preferences of patients, while recognizing that many individuals may benefit from the ability to move between evidence-based treatments, is an integral part of the safe, effective and sustainability of treatment for OUD.

Educational and training resources

CPSA Physician Prescribing Practices: Prescribing Resources and Tools

Provincial Addiction Curricula & Experiential Skills Training (PACES)

ODT Virtual Health Training Sessions: 2020-2021

Alberta Opioid Dependence Virtual Training Program

CAMH – Opioid Dependence Treatment Core Course

British Columbia Center for Substance Use

Reducing Stigma Resources

Naloxone Kits – where to access

Supervised Consumption Services

Safe Needle Disposal/Needle Exchange Programs – Streetworks, Turning Point Society, Safeworks

Appendix A: Current guidelines for the management of OUD

Best Practices for the Treatment of Opioid Use Disorder

British Columbia Center for Substance Use – OUD Guidelines

CRISM National Guidelines for the Clinical Management of OUD

American Society of Addiction Medicine – National Guidelines for the use of Medication in the treatment of addiction involving opioid use

Appendix B: Medications Including in the Treatment of OUD

- Methadone
- Slow-release oral morphine
- Injectable OAT (hydromorphone)
- Medical-grade heroin (diacetylmorphine)

Appendix C: Specialty Clinics and Consult Resources

Virtual Opioid Dependency Program (AHS)
Opioid Agonist Therapy, Emergency Medication Treatment & Transition Support
Phone: 1-844-383-7688
Fax: 403-783-7610

Opioid Use Disorder – AHS Telephone Consult
This telephone consult service is for primary care physicians and prescribers seeking advice regarding:

- Initiating and managing opioid agonist therapy
- Prescribing drugs like buprenorphine/naloxone, methadone or naloxone
- Treating patients with existing opioid use disorder

- Managing opioid withdrawal and consideration of opioid agonist therapy

This service will not provide advice on pain management using opioids or alternatives. Primary care providers who want to consult a pain management specialist may benefit from resources listed by the Calgary Pain Management Centre.

For patients **north** of Red Deer, access the service by calling RAAPID North at 1-800-282-9911 or 1-780-735-0811.

For patients **south** of Red Deer, call RAAPID South at 1-800-661-1700 or 403-944-4488.

Addiction and Mental Health – Opioid Dependency Program

Alberta Health Services' Opioid Dependency Program (ODP) clinics are available in Edmonton, Calgary, Fort McMurray, Cardston, Grande Prairie, High Prairie and through the Rural ODP clinic, which serves patients from 60 central Alberta communities.

What is an eReferral advice request?

An eReferral advice request is a secure and efficient process within Alberta Netcare, for physician-to-physician advice. *Addiction, Medicine & Mental Health – Opioid Agonist Therapy* joined eReferral in February 2018.

If you have a non-urgent question, are seeking guidance with the management of a patient's opioid use disorder, or are wondering if a referral is appropriate, send an advice request. The response target is five calendar days.

Appendix D: Example framework for prescriber competencies

Injectable Opioid Agonist Treatment for Opioid Use Disorder (BCCSU)

Example Framework for Prescriber Competencies (excerpted from AHS IOAT Medical Protocols)

Due to the intensity of this model of care and highly supervised nature of this medical intervention, it is important that prescribers have experience with OAT prescription and an up-to-date understanding of the evidence and best practices with regard to iOAT provision.

As such, prescribers who wish to administer iOAT must meet the following criteria:

- Licensed to practice medicine in Alberta by CPSA or Nurse Practitioner by CARNA.
- Hold a methadone exemption/OAT approval.

Prescribers should obtain knowledge and competency in addiction medicine, OAT and iOAT through the following resources:

- AAAP – American Academy of Addiction Psychiatry
- Certification in Addiction Medicine and/or Addiction Psychiatry via CSAM (Canadian Society of Addiction Medicine), ISAM(International Certification in Addiction Medicine), ABAM(American Board of Addiction Medicine)
- College of Family Physicians of Canada Certificate of Added Competence (CAC) in Addiction Medicine
- Fellowship and/or Residency training in Addiction Medicine
- At least two years of clinical experience in Addiction Medicine/Psychiatry
- At least two years of clinical experience in OAT
- Extra training completed in iOAT (i.e. the iOAT module of the Provincial Opioid Addiction Treatment Support Program offered through the BCCSU, or equivalent)