PROVINCIAL OPIOID ADDICTION TREATMENT SUPPORT PROGRAM

PRECEPTORSHIP WORKBOOK FOR HOSPITAL SETTINGS

BRITISH COLUMBIA CENTRE ON SUBSTANCE USE
Networking researchers, educators & care providers

About the British Columbia Centre on Substance Use

The BC Centre on Substance Use (BCCSU) is a new provincially networked resource with a mandate to develop, implement and evaluate evidence-based approaches to substance use and addiction. The BCCSU seeks to achieve these goals through integrated activities of its three core functions: research and evaluation, education and training, and clinical care guidance. With the support of the province of British Columbia, the BCCSU aims to help establish world leading educational, research and public health, and clinical practices across the spectrum of substance use. Although physically located in Vancouver, BC, the BCCSU is a provincially networked resource for researchers, educators and care providers as well as people who use substances, family advocates, support groups, and the recovery community.

The BCCSU, in collaboration with the BC Ministry of Health, has released a new provincial clinical care guideline for British Columbia, *A Guideline for the Clinical Management of Opioid Use Disorder*. Effective June 5, 2017, this guideline is the provincial reference tool for all health care professionals in BC involved in treating patients with opioid use disorders.

Disclaimer for Health Care Providers

The recommendations and key takeaways from this workbook reflect the BC Guideline for the Clinical Management of Opioid Use Disorder. The BC guideline recommendations represent the view of the Provincial Guideline committee, arrived at after careful consideration of the available scientific evidence and external expert peer review. When exercising clinical judgment in the treatment of opioid use disorder, health care professionals in the province of British Columbia are expected to take the guideline recommendations fully into account, alongside the individual needs, preferences and values of patients, their families and other service users, and in light of 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 of the College of Physicians and Surgeons of British Columbia (CPSBC) and any other relevant governing bodies.

The patient cases and prescriptions in this workbook are provided as learning examples only. Application of the recommendations presented both in this workbook and in the Provincial Guideline do not override the responsibility of health care professionals to make decisions appropriate to the circumstances of each individual patient, in consultation with that patient and their guardian(s) or family members, and, when appropriate, external experts (e.g., specialty consultation – see p. 28 for Resources in BC).

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Overview

As part of the BCCSU's provincial mandate to provide leadership in substance use and addiction research, education, and clinical care guidance, the BCCSU launched the Provincial Opioid Addiction Treatment Support Program (POATSP) in July 2017.

Historically, the College of Physicians and Surgeons of British Columbia (CPSBC) has provided regulation, education and care guidance for opioid agonist treatment (OAT) in the province. However, as of June 5, 2017, the BCCSU has been mandated by the Ministry of Health to provide educational and clinical care guidance activities for all healthcare professionals prescribing OAT. This includes recommendations to Health Canada regarding exemption authorizations for physicians who wish to prescribe methadone for opioid use disorder under section 56 of the *Controlled Drugs and Substances Act*. The BCCSU will also work with the College of Registered Nurses of BC (CRNBC) to optimize the methadone exemption process for nurse practitioners as the authorization to prescribe full OAT takes effect.

Although specific prevalence estimates for opioid use disorder and treatment capacity needs in BC are lacking, a critical shortage of health care professionals trained in addiction medicine in BC has been identified. Specifically, significant inconsistencies in OAT provider availability across regions exist, with particularly low numbers in the Northern and Island Health Authorities. This shortage results in some patients and their families travelling long distances to receive treatment, while others turn to (or continue) illegal and non-medical opioid use to address cravings and to alleviate withdrawal symptoms. There is an urgent need to scale up access to evidence-based addiction care, education, and training, and to employ innovative health delivery models to better serve all British Columbians.

The new POATSP has replaced the provincial methadone program previously regulated by the CPSBC and has been expanded to include the full range of medications used to treat opioid addiction (i.e., methadone, buprenorphine/naloxone, and slow-release oral morphine). However, as part of its regulatory function, the CPSBC will continue their Prescription Review Program in accordance with the core principles for safe and effective prescribing practices as per the CPSBC Guidelines and Standards for the Safe Prescribing of Drugs with Potential Misuse/Diversion.

The new online learning platform for the POATSP has been developed in partnership with Continuing Professional Development (CPD) at the UBC Faculty of Medicine and will serve to improve accessibility to high-quality education for the clinical management of opioid use disorder and the new preceptorship program will offer enhanced opportunities for clinical training.

Preceptorship goals and process

The goal of the BCCSU preceptorship program is to promote understanding and application of the new BC Guideline for the Clinical Management of Opioid Use Disorder in a supervised clinical setting. The BCCSU mandates the completion of a preceptorship of at least two half-day sessions before an application for an authorization to prescribe methadone (i.e., a full methadone exemption) for the treatment of opioid use disorder can be considered.

For methadone:

In order to complete the preceptorship requirement to obtain a methadone exemption:

1. Applicants must select a name from the list of approved preceptors that is provided upon completion of the online modules of the Provincial Opioid Addiction Treatment Program and contact the chosen preceptor's office directly to confirm availability. The applicant must report the scheduling of this preceptorship through an online survey-tool.
2. Applicants must print out and complete either the Hospital-Based or Community-Based Case Workbook before the scheduled preceptorship. This workbook will be reviewed together with the preceptor throughout the two half-day sessions.
3. During the two half-day sessions, the preceptor will be required to complete a review of the workbook, ensure the diversion agreement is signed, and provide the BCCSU with their assessment of whether or not to recommend the prescriber for a federal section 56 exemption. This will be done through a secure online form sent to the BCCSU directly by the preceptor.
4. The BCCSU will then contact the applicant regarding successful or unsuccessful completion of the preceptorship and to address any concerns brought forth in the preceptorship.

For other OAT:

For physicians who intend to take on more advanced prescribing, such as slow release oral morphine, it is recommended that clinicians complete a preceptorship with a preceptor who has specific experience with that medication. When scheduling a preceptorship, the list of preceptors also includes which medications they routinely prescribe.

For physicians, it is not mandatory to complete a preceptorship for buprenorphine/naloxone alone but it should be noted that this medication will be discussed during a methadone preceptorship. For nurse practitioners intending to prescribe buprenorphine/naloxone, the College of Registered Nurses of BC requires a preceptorship for buprenorphine/naloxone, which will be tailored to that specific medication.

Note to preceptees:

This guide outlines five case scenarios of individuals receiving treatment with methadone or buprenorphine/naloxone in the hospital. Each case has a brief description followed by three to seven guiding questions that are designed to guide reflection on the clinical scenario presented and how to manage the patient and fill out their hospital order form.

This is intended as a learning exercise. If you have any questions or require clarification while reviewing these cases, do not hesitate to reach out to your preceptor for guidance.

Note to preceptors:

In conjunction with the case scenarios above, the preceptor training package includes: a list of important topics to be covered during the preceptorship, with emphasis on patient safety and strategies to prevent diversion; solutions to the guiding questions posed in each case; key takeaways for each case presented; and additional reference materials (e.g. calendars with dates of prescription highlighted for reference, filled prescription forms).

Filled prescriptions, responses to the guiding questions, and any questions or required clarification on the patient cases should be reviewed together with the preceptee upon completion of the workbook during the two-day training period.

Glossary

Buprenorphine/naloxone
A combination of buprenorphine, a long-acting synthetic opioid a partial mu (μ), and naloxone, an opioid antagonist, in a 4:1 ratio, respectively. In Canada, this formulation is available as a sublingual tablet. Naloxone has poor oral bioavailability when swallowed or administered sublingually, and is included to deter non-medical injection and diversion. When buprenorphine/naloxone is taken as directed sublingually, the naloxone component has negligible effects and the therapeutic effect of buprenorphine predominates.

DWI
Daily Witnessed Ingestion

Methadone
A long-acting synthetic opioid that acts as a full mu (μ) opioid receptor agonist. It has a half-life of approximately 24 to 36 hours and is well absorbed. In Canada, it is most frequently administered as an oral solution, generally given as a single daily dose. Methadone pills are also available in a limited context (e.g., for travel). Currently, methadone is classified as a controlled drug in accordance with section 56 of the Controlled Drugs and Substances Act, requiring clinicians to hold an exemption from Health Canada in order to prescribe it for treatment of opioid use disorder or pain.

OAT
Opioid Agonist Treatment

PO
Per os, i.e., taken orally

SL
Sublingual administration

SROM
Slow-release oral morphine

UDT
Urine Drug Testing

Preceptor Checklist

A comprehensive patient history and assessment should be conducted prior to prescription of opioid agonist treatment, to ensure that such treatment is indicated and appropriate. The ***Patient Assessment for Opioid Agonist Treatment Checklist*** can be found on the online Resource Page at www.bccsu.ca and is summarized under "Initiation of OAT" on the following page.

Note to preceptees: Following is a list of required skills for prescribing OAT. You may wish to fill out this checklist with your preceptor throughout your training and review any unchecked boxes before the end of your preceptorship.

Patient Assessment for Opioid Agonist Treatment Checklist	✓
Initiation of OAT	
Criteria for starting OAT: document that the patient meets DSM-5 criteria for opioid use disorder; assess and document stage of change; create and document a treatment plan including patient goals; check PharmaNet to avoid duplication of prescriptions and drug interactions with current medications; document rationale for therapeutic choices (methadone vs. buprenorphine)	
Full medical history: psychiatric history, surgical history, medications, allergies, PharmaNet, review of systems, general review of health and any other health-related concerns	
Substance use history: type of drug, amount, route, age of first use, frequency of drug use, last use; withdrawal symptoms; overdose history; drug costs per day and source of money; document discussion regarding avoiding alcohol and respiratory depressants such as benzodiazepines	
Complete physical exam, including check for intoxication, withdrawal, track marks	
Biopsychosocial assessment: prior drug treatment (pharmacological, withdrawal management, residential treatment, support groups, counselling, relapse prevention); screen for process addiction such as sex, crime, spending, or gambling; legal history and current legal issues; financial concerns; employment history; family history; social/emotional supports; additional areas of concern for patient (e.g., sexual abuse, violence, child at risk, unsafe sex, other)	
Laboratory assessment and examinations: tests for CBC, electolytes, urea, creatinine, INR, and albumin; HIV test; Hepatitis C test; liver function test; sexually transmitted infections screen; pregancy test (if applicable); urine drug test confirming opioid use	
Contact with previous community OAT prescriber and/or family physician	
Informed consent (to obtain and document)	
Buprenorphine/naloxone as first-line OAT	
Other treatment options (methadone, SROM)	
Harm reduction education, including: the importance of using clean equipment (e.g. needles, syringes, pipes etc.), accessing supervised consumption sites, owning a take-home naloxone kit and training in proper use, performing test injections, and recommending use with a sober friend	
Women's health including contraception	
Considerations for pregnancy and adolescents	
On-demand access to addiction medicine specialist advice (RACE line) for any questions	
Benefits of OAT ** Note to new prescribers: review the following benefits of OAT with the patient*	
Reduced or discontinued injection opioid use	
Reduced or discontinued use of other psychoactive substances	
Improved mental and physical health	
Reduced involvement with the criminal justice system	
Improved living situation	
Improved social and personal relationships	
Improved vocational and employment opportunities	
Prescribing	
Methadone	
Initial dose	
Maintenance/goal dose	
Missed doses	
Writing prescriptions	
Co-prescribing benzodiazepines	

Safety: QTC, drug-drug interactions (e.g. CNS depressants, MAOIs, serotonergic drugs, naltrexone, antiretroviral medications, azole anti-fungal medications, antibiotics)	
Buprenorphine/naloxone	
Initial dose and induction	
Maintenance/goal dose	
Missed doses	
Writing prescriptions	
Co-prescribing benzodiazepines	
Safety: drug-drug interactions (alcohol, benzodiazepines, other CNS depressants, naltrexone, CYP3A4 inhibitors/inducers, MAOIs)	
Slow-Release Oral Morphine (SROM)	
Initial dose and induction	
Stabilization	
Missed doses	
Writing prescriptions	
Co-prescribing benzodiazepines	
Safety: drug-drug interactions (e.g., alcohol, CNS depressants, naltrexone, muscle relaxants, MAOIs, diuretics)	
UDT	
When to order UDT	
Collection frequency	
Collection procedure (random, supervised, witnessed)	
Interpreting UDT results	
Psychosocial Treatment Intervention Groups (e.g. SMART Recovery, Seeking Safety)	
Support	
Housing	
Recommend local resources	
Strategies to Prevent Diversion/Carry Policy (Take-home Dosing)	
Criteria for initiating carries	
Carry schedule	
Prescription for carries	
Exceptions to carry recommendation	
Reassessment of carry privileges	
Billing	
OAT Billing: T0039 **Make it clear that if a physician wants to bill for an office visit separate from the T0039 billing code, they need to talk about medical issues other than opioid use disorder with the patient.*	
UDT Billing: P15039	
Billing for hospital visits unrelated to OAT	
Precautions	
Tapering patients off of OAT	
Withdrawal management alone is not advised	
Safety issues regarding concurrent alcohol and/or benzodiazepine use	
Review and sign treatment agreement and carry agreement	

Cases

Case #1 – Jamiu

Continuation of methadone – split dosing

Jamiu is a 63-year-old male who was started on methadone 6 months ago for the treatment of opioid use disorder. He presents to hospital for dyspnea, fever, and a productive cough. He has been diagnosed with pneumonia and is on antibiotics.

Jamiu is currently receiving a methadone dose of 120mg daily. His most recent dose increase was two days ago, from 110mg. His community pharmacy confirms that his last dose was this morning (prior to presentation at the hospital), at which time he received 120mg.

When you see Jamiu he looks lethargic but rouses to voice alone. His oxygen saturation is 96 percent on 2L via nasal prongs. You want to continue his methadone prescription but are concerned about his respiratory status. Accordingly, you decide to split his dose into 40mg taken three times a day and write some parameters for the nurses to follow.

Questions

1. What is the purpose of dividing Jamiu's 120mg dose of methadone daily into 40mg taken three times a day?

2. Are there concerns about prescribing an opioid agonist (i.e., methadone) to Jamiu given the risk of respiratory depression with opioids and his concurrent respiratory infection? (If so, what instructions can be specified on the prescription to help moderate this risk?)

3. What should be done regarding Jamiu's community prescription for methadone, given that he is in hospital and won't be needing his usual doses dispensed from the community pharmacy?

4. When should Jamiu be scheduled to receive his first dose of 40mg of methadone?

5. How would you write Jamiu's methadone prescription?

6. After four days Jamiu is scheduled to be discharged from the hospital (he is finished with his IV antibiotics and is given a further six-day course of oral antibiotics to take home). How would you write his methadone prescription at discharge (assuming DWI)?

7. What oral antibiotics would you prescribe for Jamiu given that he is also on methadone?

Case #2 – Valeria

New methadone start

Valeria is a 43-year-old female with a five-year history of opioid use disorder. She presents to hospital for management of septic arthritis in her knee. Valeria expresses that she is interested in starting on opioid agonist treatment. She has tried buprenorphine/naloxone in the past, but was unsuccessful with two prior inductions due to the discomfort of opioid withdrawal. Valeria is interested in starting on methadone. You would like to write her a prescription for methadone starting today.

Questions

1. What is the recommended dose for a patient such as Valeria starting on methadone for the first time?

2. What is the importance of starting Valeria's methadone dosing conservatively and then titrating up?

3. At what rate can Valeria's methadone dose be safely increased while she is an inpatient? (Hint: Valeria is receiving a greater degree of medical supervision than a person starting OAT in the community would be.)

4. How would you write the order for Valeria's first dose of methadone?

5. After 14 days in the hospital for the septic arthritis in her knee, Valeria is ready to be discharged from the hospital. What needs to be set up prior to her discharge? (Hint: Ideally this should have been set up at the time Valeria was started on methadone so that it would already be in place when she is ready to be discharged.)

Case #3 – Kahlila

On methadone but missed doses

Kahlila is a 30-year-old female who has been on methadone for the past five years. She has recently relapsed and has missed her last three doses. She has been admitted to hospital for a fractured ankle and is requesting that her methadone be continued. In the community, Kahlila's dose was 100mg per day administered via daily witnessed ingestion. You call her community pharmacy and confirm that her last witnessed dose was three days ago (100mg DWI). You subsequently cancel her community methadone prescription and would like to prescribe 50mg of methadone PO daily starting today.

Questions

1. Why did Kahlila's methadone dose need to be decreased from 100mg down to 50mg?

2. How would you write the prescription for the first dose of Kahlila's methadone (that she is scheduled to receive immediately)?

3. How quickly can Kahlila's methadone dose be titrated up to her usual dose of 100mg daily? What strategy would you use to increase her doses?

4. How would you manage Kahlila's acute pain from her ankle fracture?

5. Why was it necessary to call the community pharmacy to cancel Kahlila's methadone prescription, even though she plans to continue with OAT following her discharge from the hospital?

Case #4 – Jeffrey

Buprenorphine/naloxone induction

Jeffrey is a 30-year-old male with a two-year history of opioid use disorder. He has been admitted to hospital for management of his asthma. He is not currently in respiratory distress and is stable on the ward. He requests to see you to start on buprenorphine/naloxone for treatment of his opioid use disorder. You would like to initiate a buprenorphine/naloxone induction during his hospitalization. You explain the risk of precipitated withdrawal and confirm Jeffrey's last use of heroin was over 12 hours prior. He received no opiods in hospital and his COWS score is 14. You give him an initial 2mg SL dose of buprenorphine/naloxone and reassess him one hour later. His withdrawal symptoms have improved. You would like to allow him access to 12mg total over the next 24 hours to treat his withdrawal symptoms.

Questions

1. Is there any need for urine drug testing prior to initiating Jeffrey on buprenorphine/naloxone (Suboxone)? When, if at all, is urine drug testing indicated for patients with opioid use disorder presenting in hospital settings?

2. What is the purpose of including naloxone in the formulation?

3. How would you write Jeffrey's buprenorphine/naloxone prescription for his first day in the hospital? (Hint: The plan is to allow him access to 12mg of buprenorphine total over the first 24 hours as needed to treat his withdrawal symptoms; keep in mind that he has already received an initial 2mg SL.) How frequently do you need to re-assess Jeffrey's COWS score?

4. You see Jeffrey the next day and he feels much better. However, he found out that he woke up with some withdrawal this morning and would like to go up on his buprenorphine dose. How would you write Jeffrey's buprenorphine/naloxone prescription for his second day in the hospital? (Note: For the purposes of this question, we are assuming that Jeffrey took 12mg on day one; keep in mind that his dose may need to be titrated up further on day two.)

5. You see Jeffrey the next day (day three of his admission). He feels much better, but is still having some cravings and he was dreaming about heroin last night. How would you write Jeffrey's buprenorphine/naloxone prescription for his third day in the hospital? What is the maximum dose of buprenorphine/naloxone that can be prescribed?

6. What needs to be set up for Jeffrey to ensure that he will be able to continue oral agonist treatment with buprenorphine/naloxone after he is discharged?

Case # 5 – Maryam

Pregnant woman with OUD wants to start OAT

Maryam is a 23-year-old female who is three months pregnant. She has an opioid use disorder and has been admitted to the hospital for nausea and vomiting. Maryam would like to start on opioid agonist treatment. On discussion with her, she agrees to take methadone.

Questions

1. What medications are approved for the treatment of opioid use disorder in pregnant women?

2. Why does buprenorphine prescribed for pregnant women require a submission to Health Canada's Special Access Programme?

3. How would you write Maryam's initial prescription for methadone?

Diversion agreement

By signing below, I understand it is my responsibility to take all reasonable steps to prevent harm to patients and the public from opioid agonist treatment medications. To this end, I endeavor to prescribe safely and to balance patient needs with public protection from the likely harms associated with misuse, non-medical use, or diversion of opioid agonist treatment medications.

I am committed to seeking opportunities for ongoing learning to maintain and improve my professional knowledge and skills related to prescribing opioid agonist treatment and to monitor patients appropriately. I am aware of existing resources, contacts and tools that I may use to assist me in making clinical decisions related to the treatment of individuals with opioid use disorders and commit to seeking out advice and assistance when needed.

Following the training I have received, I will provide safe, effective treatment and monitoring for patients with opioid use disorder. I will endeavor to reduce opportunities for misuse, non-medical use or diversion of opioid agonist treatment medications through safe prescribing practices.

_____	_____	_____
Name, Prescriber	Signature, Prescriber	DD/MM/YYYY

_____	_____	_____
Name, Witness (Clinical Preceptor)	Signature, Witness (Clinical Preceptor)	DD/MM/YYYY

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Resources

BCCSU Guideline for the Clinical Management of Opioid Use Disorder:

- Available at www.bccsu.ca

Provincial Opioid Addiction Treatment Support Program:

- Online Modules
- Resource Page
- Available at www.bccsu.ca

BCCSU Online Addiction Medicine Diploma:

- Register at www.bccsu.ca

Rapid Access to Consultative Expertise (RACE) Line:

- The RACE line allows primary care practitioners to rapidly connect with and receive treatment advice from a specialist, often eliminating the need for a face-to-face specialist consult or emergency department referral. To connect with an Addiction Medicine specialist, call the RACE line (604.682.2344) or download the RACE app at www.raceconnect.ca/race-app
- Primary care physicians may be eligible to receive CME "Linking Learning to Practice" credit for using RACE in patient care.
- Visit www.raceconnect.ca for more information on how to implement RACE in your practice.

Questions? Contact education@cfenet.ubc.ca

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NOTES