PRECEPTORSHIP WORKBOOK: COMMUNITY SETTINGS

BRITISH COLUMBIA
CENTRE ON
SUBSTANCE USE

About the British Columbia Centre on Substance Use

The BC Centre on Substance Use (BCCSU) is a provincially-networked organization with a mandate to develop, help implement, and evaluate evidence-based approaches to substance use and addiction. The BCCSU seeks to improve the integration of best practices and care across the continuum of substance use through the collaborative development of evidence-based policies, guidelines, and standards. With the support of the Province of BC, the BCCSU aims to transform substance use policies and care by translating research into education and care guidance, thereby serving all British Columbians.

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.

Research and Evaluation—Leading an innovative multidisciplinary program of research, monitoring, evaluation and quality improvement activities to guide health system improvements in the area of substance use.

Education and Training—Strengthening addiction medicine education activities across disciplines, academic institutions, and health authorities, and training the next generation of interdisciplinary leaders in addiction medicine.

Clinical Care Guidance—Developing and helping implement evidence-based clinical practice guidelines, treatment pathways, and other practice support documents.

Disclaimer for Health Care Providers

The recommendations and key takeaways from this workbook reflect the recommendations published by the BCCSU and the BC Ministry of Health in *A Guideline for the Clinical Management of Opioid Use Disorder*. When exercising clinical judgement 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) or the British Columbia College of Nurses and Midwives (BCCNM) and any other relevant governing bodies.

Case studies and prescriptions

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 *A Guideline for the Clinical Management of Opioid Use Disorder* 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., speciality consultation).

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Overview

Since June 2017, the British Columbia Centre on Substance Use (BCCSU) has been responsible for the education and training pathways and clinical care guidance for opioid use disorder (OUD) treatment in BC. In response to the ongoing provincial overdose crisis, the province has made significant investments and improvements to mental health and substance use services. Among these investments is a package of essential interventions including increasing availability of naloxone, expanding overdose prevention services, and expanding access to evidence-based treatment options and care for individuals with OUD. The development of *A Guideline for the Clinical Management of Opioid Use Disorder* and its aligned training program, the *Provincial Opioid Addiction Treatment Support Program* (POATSP), are key elements in the provincial strategy to increase access to evidence-based treatment for opioid use disorder. The online learning platform for POATSP has been developed in partnership with The University of British Columbia Continuing Professional Development (UBC CPD) and serves to improve the accessibility of high-quality education for the clinical management of opioid use disorder.

Although specific prevalence estimates for OUD 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 provider availability across regions exist, with particularly low numbers in rural and remote settings. This shortage results in some patients and their families travelling long distances to receive treatment, while others turn to (or continue) illicit opioid use to address cravings and 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.

Education and Training Pathways

The BCCSU education and training requirements for prescribing oral OAT in British Columbia include:

Online modules in POATSP

Preceptorship Workbook: Community Settings (this workbook)

Two half-days of in-person preceptorship

Note: If you are a registered nurse (RN) or registered psychiatric nurse (RPN), you are currently accessing the incorrect workbook for your scope of practice.

Please email bccsu_education@bccsu.ubc.ca to obtain the RN/RPN Prescribing Workbook.

Process

1. Complete the required modules in the appropriate online **POATSP course stream** (8–10 hours)
2. Obtain a **POATSP Certification of Completion** in the online platform
   When accessing the certificate, instructions are provided to:
   - Schedule a **preceptorship**
   - Complete the **Preceptorship Form**, an online survey tool
   - Access this workbook
3. Schedule a **preceptorship**
   - Please review the preceptor contact sheet and directly communicate with a chosen preceptor to select mutually agreeable date(s)
4. Complete the online **Preceptorship Form**
5. Complete this workbook
6. Attend the two half-days of in-person preceptorship
7. Sign the **Safe Prescribing Agreement**, (page 59)
8. Complete any additional learning at the discretion of the preceptor

Once these steps above are completed by the preceptee, the preceptor will need to:

9. Complete **Preceptor Review Form** (sent via email to the selected preceptor)

The BCCSU will then issue a **Proof of Completion** letter to you via email. The next steps for ordering prescription pads are outlined in this letter.

Preceptorship Goals

The goal of the POATSP preceptorship is to promote understanding and application of the educational components contained within the online platform. During the preceptorship, the completed workbook will be reviewed together with the preceptor.

In order to complete the preceptorship requirements, preceptees must have:

1. Completed the required online modules in the POATSP course stream.
2. Secured a preceptorship as close as possible to their home community.
3. Report the scheduling of this preceptorship through the online **Preceptorship Form**.
4. Completed this workbook before the scheduled preceptorship.

Role of preceptors

Preceptors must:

1. Review the workbook.
2. Ensure the **Safe Prescribing Agreement** is discussed and signed.
3. Complete the **Preceptor Review Form** to provide an assessment and sign-off of the preceptees, based on competencies demonstrated and articulated through the preceptorship.

Glossary

Buprenorphine/naloxone

A combination of buprenorphine and naloxone in a 4:1 ratio. Buprenorphine is a long-acting synthetic opioid that acts as a partial mu (μ) opioid receptor agonist, and naloxone is an opioid antagonist. 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 injection and insufflation (snorting). When buprenorphine/naloxone is taken sublingually as directed, the naloxone component has negligible effects and the therapeutic effect of buprenorphine dominates.

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 96 hours and is well absorbed. In Canada, it is most frequently administered as an oral solution. Methadone tablets are also available in a limited context (e.g., for travel).

Micro-dosing induction

An induction strategy for buprenorphine/naloxone where the patient is prescribed small initial doses (e.g., 0.5mg/0.125mg buprenorphine/naloxone), which are slowly up-titrated while the patient continues prescribed or illicit opioid use. The other opioids are abruptly stopped or tapered down once a therapeutic buprenorphine/naloxone dose is reach. Micro-dosing inductions typically occur in community settings over a 5- to 10-day period; however, clinicians may use clinical judgment as to whether their patient requires a longer or shorter micro-dosing induction period.

Micro-dosing inductions are becoming increasingly common in parts of BC; however, more research is needed to determine optimal protocols. The micro-dosing protocols provided in this workbook for micro-dosing schedules are provided as examples of what is currently used in practice, and are subject to change as more information becomes available.

OAT

Opioid agonist treatment

OUD

Opioid use disorder

SL
Sublingual

Slow-release oral morphine (SROM)
A 24-hour formulation of morphine, a full agonist at the mu (μ) opioid receptor. It is taken orally once per day. Available in Canada under the brand name Kadian. It is currently approved for pain management. The use of SROM for treatment of opioid use disorder is considered off-label.

Traditional buprenorphine/naloxone induction
An induction strategy for buprenorphine/naloxone that requires a wash-out period of full agonists (whether prescribed or illicit) and for the patient to be in moderate withdrawal at the time of medication initiation, in order to prevent precipitated withdrawal. A traditional induction can occur in clinic or as a “home induction.”

UDT
Urine drug testing

Preceptor Checklist

Assess the preceptee for their knowledge and ability in the sections below:

Checklist item	✓
Prescriber approach with patients	
Obtaining feedback from the patient	
Trauma- and violence-informed care	
Culturally safe, patient-centred, and harm-reduction oriented care	
Potential benefits of OAT	
Reduced or discontinued opioid use	
Reduced risk of overdose and other drug-related harms	
Reduced of 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	
Connection with primary care	
Patient assessment before prescribing OAT	
Past medical history Review, if available	
PharmaNet review Access to the patient's PharmaNet records Review for current prescription of OAT medications and medications with potential drug–drug interactions	
Biopsychosocial assessment Prior substance use treatment (pharmacotherapy, withdrawal management, bed-based/inpatient treatment, support groups, counselling, relapse prevention), legal history and current legal issues, source of income/financial concerns, employment history, family history, social/emotional supports, additional areas of concern for patient (e.g., sexual abuse, violence, child at risk, high-risk sex)	
Full medical history Review psychiatric history, surgical history, medications, past experience with OAT, allergies, systems, health in general, and any other health-related concerns	
Physical exam Check for intoxication, withdrawal, puncture wounds	
Harm reduction Education on the importance of using sterile equipment (e.g., cookers, syringes, pipes), accessing supervised consumption and overdose prevention sites, take-home naloxone kit, using the Lifeguard app , performing a test dose, and recommending use with a person who is not using	

Diagnose OUD using the DSM-5	
Substance use history Type of substance, route of administration, age of first use, frequency of drug use and amount (in points and/or dollar value), last use, withdrawal symptoms, overdose history, sedative use	
Laboratory assessment and examinations Performing a urine drug test Ordering liver enzyme tests (ALT, GGT, total bilirubin, albumin); estimated glomerular filtration rate; tests for complete blood count, creatinine—serum/plasma, international normalized ratio; HIV test; hepatitis serology (B, C); sexually transmitted infection screen; pregnancy test, if applicable; ECG, if indicated	
Reproductive health, including contraception	
Considerations for adolescents, pregnant patients, and patients with poor hepatic function	
PharmaCare coverage (or private insurance) for OAT	
Completing the Plan G form	
Urine drug testing	
Informed consent	
Practical strategies for incorporating patient-centred care	
Planning UDTs (scheduled, random, supervised)	
Test frequency for each oral OAT medication	
Collection procedure	
Difference between immunoassay test and confirmatory lab testing	
Substances for inclusion	
Interpreting UDT results	
Managing unexpected results	
Preparing to prescribe OAT	
Writing prescriptions	
Safe storage of prescriptions	
Ordering lab tests	
Prescribing OAT	
Buprenorphine/naloxone	
Safety: Drug–drug interactions (e.g., naltrexone), comorbid conditions, alcohol or other sedative use	
Plan for induction—office or home, traditional or micro-dosing	
Initial dosing recommendations	
Therapeutic dose (individually titrated up to the point of cessation of illicit opioid use)	
Treatment plan (i.e., witnessed doses, take-home doses, or a combination)	
Missed doses	
Writing prescriptions	
Monitoring and follow-up, including documenting response to medication	
Methadone	
Safety: QT prolongation, drug–drug interactions (e.g., naltrexone, medications with the potential to prolong the QT interval), comorbid conditions, alcohol or other sedative use	

Missed doses	
Writing prescriptions	
Monitoring and follow-up, including documenting response to medication	
Slow-release oral morphine	
Safety: Drug–drug interactions, comorbid conditions, alcohol or other sedative use	
Initial dosing recommendations	
Therapeutic dose (individually titrated up to the point of cessation of illicit opioid use)	
Treatment plan (i.e., witnessed doses, take-home doses, or a combination)	
Missed doses	
Medication shortages	
Writing prescriptions	
Monitoring and follow-up, including documenting response to medication	
Strategies for safe prescribing	
Review and sign Safe Prescribing Agreement (page 59 of this workbook)	
Criteria for initiating take-home dosing	
Carry schedule	
Prescription for carries	
Monitoring take-home dosing	
Re-assessment of take-home dosing	
Psychosocial and community connection	
Community services and supports (e.g., access to social workers)	
Psychosocial treatment intervention groups (e.g., SMART Recovery, Seeking Safety)	
Support network	
Housing	
Recommended local resources	
Communication and collaboration	
Communicating with pharmacies	
Access to addiction medicine specialists (24/7 Addiction Medicine Clinician Support Line, RACEapp+, hospital-based Addiction Medicine Consult Team, Rapid Access Addiction Clinic)	
Documentation	
Patient meets the DSM-5 criteria for OUD	
Baseline assessment	
Discussion of avoiding alcohol and CNS depressants	
PharmaNet review	
Treatment plan, including patient goals	
Medication selection	
Medication prescribed, dose, indication, patient education	
Response to medication	
Length of prescription	

PharmaNet review	
Treatment plan, including patient goals	
Medication selection	
Medication prescribed, dose, indication, patient education	
Response to medication	
Length of prescription	
Other relevant information for the care team	
Any other consultation or referral related to the patient's care	
Precautions	
Tapering patients off of OAT	
Withdrawal management alone is not advised	
Safety issues with concurrent sedative use (e.g., alcohol, benzodiazepines)	
Billing	
Assessment for OAT induction: 13013	
Opioid agonist treatment induction: 13014	
Opioid agonist treatment billing: 00039	
Urine drug testing billing: 15039	

Cases

This workbook contains 9 case studies focusing on individuals receiving or seeking treatment with OAT medications. Each case has a brief description followed by guiding questions, which are designed to guide reflection on the clinical scenario presented and how to manage the patient including, when appropriate, writing a prescription.

Please note that these case scenarios were created to represent a wide variety of clinical scenarios and are for illustrative purposes only. They do not represent real patients. Completion of this workbook is intended as a learning exercise. If you have any questions or require clarification while reviewing these cases, please reach out to your preceptor for guidance.

Case 1: Jorge

Micro-dosing buprenorphine/naloxone induction

Clinic Date: September 20, 2021

Jorge, a 23-year-old man, is a new patient. He has been using fentanyl daily for over a year. He lives alone and is preparing to start university.

In his visit today, he states that he would like to stop using illicit opioids as he "wants to get his life back on track" and start treatment immediately. He expresses interest in starting opioid agonist treatment, but worries that having to go to the pharmacy every day will be challenging while he is studying. You discuss all of the oral OAT options, including the fact that buprenorphine/naloxone can often be provided as take-home doses immediately or shortly after starting treatment.

Jorge tells you that he is interested in trying buprenorphine/naloxone, but he expresses concern about the induction process, as a friend told him he would have to go into withdrawal when beginning buprenorphine/naloxone.

Patient name: Jorge A Romero
Date of birth: September 15, 1998
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 1: Questions

1. Is Jorge a good candidate for buprenorphine/naloxone? Why or why not?

2. What assessments should be performed before initiating buprenorphine/naloxone?

You discuss with Jorge his concerns about buprenorphine/naloxone inductions and he further explains that he does not want to experience opioid withdrawal. He says that he "has heard that the induction process can cause withdrawal."

3. How would you approach a discussion about the induction methods for buprenorphine/naloxone? (Hint: What are the methods for a buprenorphine/naloxone induction)

4. During a traditional buprenorphine/naloxone induction, how can the risk of precipitated withdrawal be minimized?

After discussing the buprenorphine/naloxone induction methods, Jorge would like to proceed with a micro-dosing buprenorphine/naloxone induction.

5. In what settings can a micro-dosing buprenorphine/naloxone induction occur?

6. What instructions should you give Jorge about how to take the buprenorphine/naloxone tablet?

7. What harm reduction should be provided for Jorge?

8. What follow up is required during a micro-dosing induction? When should Jorge's next follow up appointment be scheduled?

9. Complete the Controlled Prescription Program Form for a micro-dosing buprenorphine/naloxone induction starting on September 20, 2021. Use the following guiding questions to help complete the prescription.

What strength of buprenorphine/naloxone should be prescribed?

How many days are required for a micro-dosing induction?

Does a micro-dosing induction require witnessed ingestion?

What instructions should be included in the directions for use field?

Should the medication be packaged in a particular way?

SEPTEMBER 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

---------------BC CONTROLLED PRESCRIPTION FORM---------------

PERSONAL HEALTH NO.

PRESCRIBING DATE
DAY MONTH YEAR

PATIENT NAME
FIRST (GIVEN) MIDDLE / INITIAL LAST (SURNAME)

PATIENT ADDRESS
STREET
CITY PROVINCE

DATE OF BIRTH
DAY MONTH YEAR

Rx: DRUG NAME AND STRENGTH ONLY ONE DRUG PER FORM **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR END DATE: DAY MONTH YEAR

TOTAL DAILY DOSE
NUMERIC ALPHA mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC ALPHA

☐ NOT AUTHORIZED FOR DELIVERY

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID
0000000001

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SIGNATURE OF DISPENSING PHARMACIST

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SAMPLE

Case 2: Jorge, Continued

Take-home buprenorphine/naloxone doses

Clinic date: October 7, 2021

Jorge stabilizes on a daily buprenorphine/naloxone dose of 20mg/5mg buprenorphine/naloxone. During today's clinical visit, he tells you that he would like take-home buprenorphine/naloxone doses.

Patient name: Jorge A Romero
Date of birth: September 15, 1998
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 2: Questions

1. Is Jorge eligible for take-home buprenorphine/naloxone doses? What are the eligibility criteria?

2. Before prescribing take-home buprenorphine/naloxone doses, what should be discussed with Jorge?

3. What take-home dosing schedule would be appropriate for Jorge?

4. Complete the Controlled Prescription Program Form for take-home buprenorphine/naloxone starting on October 7, 2021. Use the guiding questions to help complete the prescription.

What strength of buprenorphine/naloxone should be prescribed?

How many days of witnessed ingestion are required?

When should doses be dispensed?

October 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

---------------BC CONTROLLED PRESCRIPTION FORM---------------

PERSONAL HEALTH NO.

PRESCRIBING DATE
DAY | MONTH | YEAR

PATIENT NAME
FIRST (GIVEN) | MIDDLE / INITIAL | LAST (SURNAME)

PATIENT ADDRESS
STREET
CITY | PROVINCE

DATE OF BIRTH
DAY | MONTH | YEAR

Rx: DRUG NAME AND STRENGTH | ONLY ONE DRUG PER FORM | **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC | ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE
NUMERIC | ALPHA | **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC | ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

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Case 3: Yuna

Continuation of a stable daily witnessed methadone dose

Clinic date: September 1, 2021

Yuna, a 50-year-old woman, comes into your clinic to refill her methadone prescription.

Yuna has been receiving methadone treatment for opioid use disorder for five months. She reports occasional ongoing cocaine use and always uses a supervised consumption site. She reports feeling good at 110mg methadone once daily, with no cravings or withdrawal symptoms Her last witnessed dose was this morning, just before her clinical visit.

Patient name: Yuna K Zhao
Date of birth: December 23, 1970
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 3: Questions

1. Clinically, how can you determine when an effective methadone stabilization dose has been reached?

2. Would you start transitioning Yuna to take-home dosing? Why or why not?

3. Should any changes in Yuna's treatment plan be made for her ongoing cocaine use?

4. Before writing the methadone prescription, what should be reviewed?

5. When should you schedule Yuna's next clinical appointment?

6. What should be included as part of Yuna's continuing care?

7. Complete the Controlled Prescription Program Form for Yuna to bring to her community pharmacy. Use the guiding questions to help complete the prescription.

What is Yuna's methadone dosage?

How long should the prescription be written for?

How many days per week is daily witnessed ingestion required?

What instructions should be included in the directions for use field?

SEPTEMBER 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		1	2	3	4	5
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PERSONAL HEALTH NO.

PRESCRIBING DATE
DAY MONTH YEAR

PATIENT NAME FIRST (GIVEN) MIDDLE / INITIAL LAST (SURNAME)

PATIENT ADDRESS STREET
CITY PROVINCE

DATE OF BIRTH
DAY MONTH YEAR

Rx: DRUG NAME AND STRENGTH ONLY ONE DRUG PER FORM **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE
NUMERIC ALPHA mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC ALPHA

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SAMPLE

Case 4: Sunita

Transitioning a patient who is stabilized on methadone to carry doses

Clinic date: September 1, 2021

Sunita, a 44-year-old woman, initiated methadone treatment for severe opioid use disorder 6 months ago at your clinic. This was the first time she had been on opioid agonist treatment. You up-titrated Sunita's dose over a period of 8 weeks to 100mg methadone once daily, daily witnessed ingestion.

Since Sunita was stabilized on methadone, you see her in clinic once per month for assessment. For the past 3 months, Sunita's UDTs have been consistently positive for methadone, negative for opiates, fentanyl, amphetamines, and cocaine. Sunita lives with her partner and has recently started a job at a bookstore.

In today's appointment, Sunita expresses an interest in take-home methadone doses so that she is able to go work without going to the pharmacy first.

Patient name: Sunita R Mukherjee
Date of birth: July 14, 1977
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 4: Questions

1. What are the benefits of take-home methadone doses?

2. What are the health risks of take-home methadone doses?

3. Should Sunita be considered for take-home methadone doses? Why or why not?

4. What patient criteria should be met prior to prescribing take-home doses?

5. What substances are recommended for inclusion when performing a UDT for all patients prescribed OAT?

6. What take-home dose schedule would you suggest for Sunita?

7. Sunita mentions that she would like to transition to take-home doses only. How should you respond to this? How can you facilitate this?

8. How should Sunita's take-home doses be monitored?

You write Sunita a prescription for 28 days, with witnessed ingestion six days a week and one carry dose on Sunday starting from Thursday, September 2.

9. Complete the Controlled Program Form for Sunita's methadone treatment. Use the guiding questions to help complete the prescription.

What daily methadone dose is Sunita prescribed?

What are the start and end dates of the prescription?

What is the total dose of methadone to be written on the prescription?

How many days per week are Sunita's methadone doses witnessed?

What day should Sunita's carry dose be dispensed?

SEPTEMBER 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

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PRESCRIBING DATE
DAY | MONTH | YEAR

PATIENT NAME
FIRST (GIVEN) | MIDDLE / INITIAL | LAST (SURNAME)

PATIENT ADDRESS
STREET
CITY | PROVINCE

DATE OF BIRTH
DAY | MONTH | YEAR

Rx: DRUG NAME AND STRENGTH | ONLY ONE DRUG PER FORM | **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC | ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY | MONTH | YEAR
END DATE: DAY | MONTH | YEAR

TOTAL DAILY DOSE
NUMERIC | ALPHA | **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC | ALPHA

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SAMPLE

10. When should Sunita's next clinical visit be? What is the purpose of this visit?

Case 5: Emil

Managing signs of clinical instability for a patient receiving take-home doses of methadone

Clinic date: May 6, 2021

Emil, a 23-year-old non-binary person who uses they/them pronouns, has been your patient for the past two years. They were stabilized on 80mg methadone once daily. Their UDT results have been as expected (i.e., positive for methadone and negative for other substances) consistently for the past 5 months. They have been prescribed take-home methadone for the past two months and attend the pharmacy twice per week for witnessed ingestion.

Emil's most recent random UDT is positive for cocaine and fentanyl. You call Emil into the office for an appointment and they miss their appointment, scheduled for May 5. They attend clinic on May 6.

Patient name: Emil L Khan
Date of birth: December 15, 1997
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 5: Questions

1. What are signs suggest that Emil requires a follow-up and reassessment?

2. What are some other signs for follow-up and reassessment?

3. What are the possible explanations for Emil's most recent UDT results?

4. How would you frame a discussion about Emil's UDT results? Why is it important to discuss these results?

After a conversation with Emil, they share that they have missed methadone doses.

5. What should be included in a discussion with Emil about missed doses?

6. How would you proceed in each of the following scenarios?

Scenario A: They report missing 1–2 consecutive days of methadone.

Scenario B: They report missing 5 or more doses of methadone on their last prescription.

Emil is not sure how many doses they have missed. They would like to continue methadone treatment. You check PharmaNet and Emil has missed 3 consecutive days of methadone doses. You explain to Emil that you would need to re-titrate them to a therapeutic methadone dose and return to witnessed doses.

7. Why does Emil's methadone dose need to be re-titrated?

8. Emil wishes to transition back to take-home doses as soon as possible. How do you approach this?

9. Complete the Controlled Prescription Program form for Scenario A, where you decrease Emil's dose to 50% of the original dose. Use the guiding questions to help complete the prescription.

What is Emil's new dose?

How many days should the prescription be written for?

How many days per week is daily witnessed ingestion required?

What instructions should be included in the directions for use field?

MAY 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

--------------BC CONTROLLED PRESCRIPTION FORM--------------

PERSONAL HEALTH NO.

PRESCRIBING DATE
DAY | MONTH | YEAR

PATIENT NAME
FIRST (GIVEN) | MIDDLE / INITIAL | LAST (SURNAME)

PATIENT ADDRESS
STREET
CITY | PROVINCE

DATE OF BIRTH
DAY | MONTH | YEAR

Rx: DRUG NAME AND STRENGTH | ONLY ONE DRUG PER FORM | **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC | ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE
NUMERIC | ALPHA | mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC | ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

SAMPLE

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID
0000000001

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Case 6: Deja

Writing a prescription for daily witnessed methadone for travel

Clinic date: August 4, 2021

Deja, a 44-year-old woman, has been a patient at your clinic for the past four months. She has been stable on 125mg methadone, daily witnessed ingestion, for two months.

Deja attends clinic today very upset as her aunt has suddenly passed away. She has to travel to Kelowna for the funeral and plans to spend three days there over the weekend of August 6–9. She will take her methadone at her usual pharmacy before leaving on the morning of August 6, and will return in time to receive her witnessed dose on August 9.

The last prescription you wrote for Deja ends on Friday, August 6. Deja needs two new methadone prescriptions: one for a pharmacy in Kelowna while she is travelling, and one for when she returns home.

Patient name: Deja K Smith
Date of birth: March 21, 1977
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 6: Questions

1. What preparations should be made to ensure that Deja is able to receive her witnessed dose in the pharmacy in Kelowna?

2. If Deja was travelling to a remote location that was a few hours away from a pharmacy, what possible approaches would ensure Deja has access to her methadone treatment?

Deja will be able to access a pharmacy while she is in Kelowna.

3. Complete the Controlled Prescription Program form for Deja to bring to the pharmacy in Kelowna. Use the guiding questions to help complete the prescription.

What start and end date should be written on Deja's prescription for her stay in Kelowna?

How many days witnessed ingestion should be specified?

AUGUST 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

---------------BC CONTROLLED PRESCRIPTION FORM---------------

PERSONAL HEALTH NO.

PRESCRIBING DATE DAY MONTH YEAR

PATIENT NAME FIRST (GIVEN) MIDDLE / INITIAL LAST (SURNAME)

PATIENT ADDRESS STREET

CITY PROVINCE

DATE OF BIRTH DAY MONTH YEAR

Rx: DRUG NAME AND STRENGTH ONLY ONE DRUG PER FORM **VOID IF ALTERED**

QUANTITY (IN UNITS)

NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE

NUMERIC ALPHA **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION

NUMERIC ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

SAMPLE

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID

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Case 7: Ahmad

Initiating slow-release oral morphine

Clinic date: September 6, 2021

Ahmad is a 37-year-old man with severe opioid use disorder. For the past 5 months, he has been prescribed 180mg methadone, daily witnessed ingestion. Ahmad continues to experience cravings and uses illicit opioids to manage them. During this time, Ahmad has overdosed once. Ahmad lives in a single room occupancy hotel in Vancouver's Downtown Eastside.

Today, Ahmad attends clinic feeling frustrated with his ongoing drug use, and tells you that he has not taken methadone for the past three weeks. He has been using fentanyl every day, multiple times a day (approximately 250mg per day).

You discuss with Ahmad his goals for treatment and he states that he wants to completely stop using illicit opioids, particularly following his overdose.

Patient name: Ahmad N Legi
Date of birth: August 24, 1984
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 7: Questions

1. What changes to the treatment plan can support Ahmad's goal of stopping illicit opioid use?

You discuss alternative OAT medication options with Ahmad.

2. What impacts the choice of OAT?

Ahmad does not think that buprenorphine/naloxone will manage his cravings and is interested in initiating SROM.

3. Why is SROM an appropriate option for Ahmad?

4. What dosing schedule should be used for initiating Ahmad on SROM?

5. What factors determine the titration rate of SROM?

6. Complete the Controlled Prescription Program form for initiating SROM. Use the guiding questions to help complete the prescription.

How many days should the prescription be written for?

How many days should be specified for daily witnessed ingestion?

What instructions should be written in directions for use field?

SEPTEMBER 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

---------------BC CONTROLLED PRESCRIPTION FORM---------------

PERSONAL HEALTH NO.

PRESCRIBING DATE DAY MONTH YEAR

PATIENT NAME FIRST (GIVEN) MIDDLE / INITIAL LAST (SURNAME)

PATIENT ADDRESS STREET CITY PROVINCE

DATE OF BIRTH DAY MONTH YEAR

Rx: DRUG NAME AND STRENGTH ONLY ONE DRUG PER FORM **VOID IF ALTERED**

QUANTITY (IN UNITS) NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE NUMERIC ALPHA **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION NUMERIC ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID
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SAMPLE

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7. If Ahmad cannot tolerate sprinkles, what instructions should be included on his prescription?

Over the next 2 weeks, you continue to up-titrate Ahmad's SROM dose. Ahmad is stabilized at 1,300mg SROM, once-daily.

8. What tests should be performed to monitor SROM treatment? How frequently should this take place?

9. There is a medication shortage for SROM. How should you proceed with Ahmad's treatment?

Case 8: Adebiyi

Slow-release oral morphine restart

Adebiyi, a 43-year-old man, has been a patient at your clinic for 8 months. He is currently prescribed 900mg SROM once daily, witnessed ingestion.

When he attends clinic today, he tells you that he has missed several doses of SROM. He thinks he has missed 5–6 doses, but is not sure exactly how many.

Patient name: Adebiyi K Evans
Date of birth: June 16, 1977
Personal health number: 1234 567 890
Address: 123 Main Street, Victoria, BC

Case 8: Questions

1. How can you check how many days Adebiyi has missed treatment?

Adebiyi shares that he missed treatment due to issues attending his pharmacy. He lost his housing and stayed with a friend out of town. He has since found temporary housing and will be able to attend a consistent pharmacy. He would like to continue SROM treatment. You check PharmaNet and call the pharmacy to confirm that Adebiyi has missed 6 days of SROM. Adebiyi has been using illicit opioids during this time to help with withdrawal and to manage his cravings.

2. As Adebiyi has missed doses, what changes to his treatment plan should be made? How will you discuss these changes with Adebiyi?

3. What factors impact Adebiyi's re-start dose?

4. What dose should Adebiyi be resumed at?

5. How should Adebiyi's active prescription be managed?

In a clinical appointment 6 months later, Adebiyi expresses that he would like to switch to a treatment with carries due to ongoing issues with housing. After a careful discussion, you decide together that buprenorphine/naloxone would be most appropriate.

6. What are the methods for transitioning from SROM to buprenorphine/naloxone?

7. What factors impact the transition strategy to buprenorphine/naloxone?

Adebiyi agrees to transition using a micro-dosing buprenorphine/naloxone induction.

8. What prescriptions will need to be written for Adebiyi during the buprenorphine/ naloxone induction?

10. Complete the two Controlled Prescription Program Forms: one for a micro-dosing buprenorphine/naloxone induction starting on June 8, 2021 and one to continue Adebiyi's SROM treatment during the micro-dosing induction. Use the following guiding questions to help complete the prescription.

When should Adebiyi's SROM treatment be stopped?

How many days should the SROM prescription be written for?

What information should be included in the directions for use field when co-prescribing two OAT?

JUNE 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30				

---------------BC CONTROLLED PRESCRIPTION FORM---------------

PERSONAL HEALTH NO.

PRESCRIBING DATE
DAY | MONTH | YEAR

PATIENT NAME
FIRST (GIVEN) | MIDDLE / INITIAL | LAST (SURNAME)

PATIENT ADDRESS
STREET
CITY | PROVINCE

DATE OF BIRTH
DAY | MONTH | YEAR

Rx: DRUG NAME AND STRENGTH | ONLY ONE DRUG PER FORM | **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC | ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY | MONTH | YEAR **END DATE:** DAY | MONTH | YEAR

TOTAL DAILY DOSE
NUMERIC | ALPHA | **mg/day**

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC | ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID
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---------------BC CONTROLLED PRESCRIPTION FORM---------------

PERSONAL HEALTH NO.

PRESCRIBING DATE
DAY | MONTH | YEAR

PATIENT NAME FIRST (GIVEN) MIDDLE / INITIAL LAST (SURNAME)

PATIENT ADDRESS STREET
CITY PROVINCE

DATE OF BIRTH
DAY | MONTH | YEAR

Rx: DRUG NAME AND STRENGTH ONLY ONE DRUG PER FORM **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC | ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE
NUMERIC | ALPHA mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC | ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID

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SAMPLE

Case 9: Jill

Continuing buprenorphine/naloxone

Clinic date: November 2, 2021

Jill, a 30-year-old woman, has been a patient at your clinic for the past five years. Jill was initially stabilized on methadone, but transitioned to buprenorphine/naloxone one year ago.

Jill attends clinic today for a refill of her buprenorphine/naloxone prescription. At this clinical visit, she is being transitioned to take-home doses with once-weekly witnessed doses at the pharmacy as she has now obtained stable housing. In the past, Jill found that daily pharmacy visits supported her stability and has not been interested in take-home buprenorphine/naloxone dosing until now.

To help answer the questions, watch the video excerpt of Jill's clinical visit (POATSP, Module 3: Triage, Assessment, and Treatment Planning) or read the transcript on page 57.

Note that the video of Jill's clinical visit is a short visit excerpt and does not show the breadth of patient education, guidance, and shared decision-making that should take place at a clinical appointment, particularly when a patient is transitioning to take-home doses.

When transitioning to take-home doses, the clinician should always weigh the advantages and potential risks with the individual in consideration of their history of clinical and social stability and factors that make daily witnessed dosing challenging. Additionally, the clinician should discuss ways to prevent diversion (e.g., safe storage) with the patient.

Case 9: Questions

1. What are some of the questions the prescriber asks Jill to find out about her substance use?

2. Which other specific substances could the prescriber have asked Jill about?

3. How does the prescriber assess whether Jill's current buprenorphine/naloxone dose is appropriate and meeting her needs?

4. What are some of the reasons that Jill provides for wanting to continue her treatment with buprenorphine/naloxone? Why are these important for the treating clinician to be aware of?

5. How does the prescriber extend support for social factors in Jill's life? List three examples.

6. Why is support for social factors an important component of care?

7. Jill asks whether she might be able to eventually taper off buprenorphine/naloxone completely. What is the best way to approach this?

8. If a patient states that tapering off opioid agonist treatment completely is their goal, what factors are involved in the decision to initiate a taper? What protocol should be used for tapering?

After discussing the risks and benefits associated with tapering, Jill has decided to stay on her current buprenorphine/naloxone dose and you will collaboratively re-assess one year from now.

9. Complete the prescription for Jill using the Controlled Prescription Program form below. Jill is currently prescribed 20mg/5mg buprenorphine/naloxone once daily, witnessed once weekly on Tuesdays. Use the guiding questions to help complete the prescription.

What strength of buprenorphine/naloxone should be prescribed?

How many days for daily witnessed ingestion should be specified?

When should carry doses be dispensed?

NOVEMBER 2021

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

---------------BC CONTROLLED PRESCRIPTION FORM---------------

PERSONAL HEALTH NO.

PRESCRIBING DATE
DAY MONTH YEAR

PATIENT NAME — FIRST (GIVEN) MIDDLE / INITIAL LAST (SURNAME)

PATIENT ADDRESS — STREET
CITY PROVINCE

DATE OF BIRTH
DAY MONTH YEAR

Rx: DRUG NAME AND STRENGTH ONLY ONE DRUG PER FORM **VOID IF ALTERED**

QUANTITY (IN UNITS)
NUMERIC ALPHA

THIS AREA MUST BE COMPLETED IN FULL FOR OPIOID AGONIST TREATMENT (OAT)

START DATE: DAY MONTH YEAR **END DATE:** DAY MONTH YEAR

TOTAL DAILY DOSE
NUMERIC ALPHA mg/day

NUMBER OF DAYS PER WEEK OF DAILY WITNESSED INGESTION
NUMERIC ALPHA

☐ **NOT AUTHORIZED FOR DELIVERY**

DIRECTION FOR USE, INDICATION FOR THERAPY, OR SPECIAL INSTRUCTIONS

NO REFILLS PERMITTED

VOID AFTER 5 DAYS
UNLESS PRESCRIPTION IS FOR OAT

PRESCRIBER'S SIGNATURE

PRESCRIBER'S CONTACT INFORMATION

PRESCRIBER ID

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SAMPLE

Video transcript for Case 9: Jill

Doctor: Hi, good morning!
Jill: Hey.
Dr: Hey Jill, how are you?
Jill: Yeah I'm fine, thanks.
Dr: Good, nice to see you.
Jill: Nice to see you too.
Dr: You're here for your Suboxone refill, right?
Jill: Yeah, I'm here to get that refill.
Dr: How was your month?
Jill: Good, I've been taking my prescription every day, so it's helping.
Dr: Any heroin use at all?
Jill: No, I've been clean—heroin, crack for a couple months now; since Feb 3rd.
Dr: Congratulations, that's lovely!
Jill: Thank you.
Dr: Are you thinking about the needle at all? Cravings?
Jill: No, no cravings at all… pretty good night's sleep. I'm not thinking about it at all.
Dr: And you'd been using a bit of alcohol in the past as well. Any alcohol in the past month?
Jill: No, nothing at all, not a drop.
Dr: Congratulations, that's wonderful! I had a look at your PharmaNet—you're on 20mg. It seems like probably 20mg is the right dose for you; do you think?
Jill: I think so. I'm not thinking about heroin, no cravings really, so I think that's probably good for me for now.
Dr: Ok, perfect. We can keep going with that. And I see you got housing this month?
Jill: Yeah… I'm pretty excited… I have my own apartment. I got it pretty quickly—my own space to call home. And I have my own bathroom; it's a change, but it's nice.
Dr: Yeah, it can be hard to transition from being homeless to having a house again; it's an adjustment.
Jill: Yeah, it's a big step, but like I said, it's nice to have my own bathroom, and just to have a place to call home, and to feel safer.
Dr: Yes—and are you visiting with your daughter these days?
Jill: Yeah, my mother has her. But I get to see her once a week. Trying to save up some money to get her more often.
Dr: Are those the supervised visits that you're doing?
Jill: Yeah, just the supervised visits once a week.
Dr: And how is that?
Jill: It's just so hard. I mean, I do get to see her once a week, and that's nice and special, but then saying goodbye! I just wish she was around all the time. I just love her so much. It's hard to know she's with somebody else.
Dr: Let me know what I can do to support that process; I'd be happy to write a letter to the Ministry or give a ring to your Ministry worker as well. You let me know. Chat with the Ministry and see what would help; and I'm happy to support you in that process.

Jill: Thank you.
Dr: Well, it's great that you're on Suboxone—because then I can put in a letter that you're on Suboxone, and we can talk about how your UDT's have been, and we can make a really strong case for you.
Jill: Actually, I have a question about that—is there a way I'll eventually get off Suboxone, or will I be on this forever?
Dr: Yeah for sure. You know, we don't know how long people have to stay on Suboxone, but the longer you're on it, generally the better for your health and for your safety. Your brain is healing right now; you have used heroin for quite a few years, and your brain changes because of heroin use, and Suboxone is letting your brain heal and giving you a break. And also, right now in BC things are so scary with all of the overdoses, so we want to keep you protected. I would like you to stay on it for at least another year, but we can always re-examine and see how your life is going.
Jill: Ok, yeah.
Dr: Because you really want things together—a good amount of time away from heroin, and have things really sorted out with lots of supports.
Jill: Yeah, I just really want my daughter back, so if this will help… I just want to feel good too, and have a normal life.
RN: Oh yeah, totally—you want to be free of the grind. And have you been going to any support groups?
Jill: Yeah, I went to this "Seeking Safety" group. It's really nice having people who understand what I went through, and really celebrating being clean. You know, I feel like this is a great accomplishment, and they all understand. It's helpful to have some friends.
Dr: Awesome… that's wonderful. And the other thing I wanted to chat about was smoking; how are the cigarettes going?
Jill: I'm still smoking like half a pack a day. I find it really relaxing… I get cravings for that. Heroin's out of my life, but this is a nice thing to have in my life to calm me down. I know it's not good for me, but just a habit.
Dr: Have you thought about the patch or the pill? There are medications to help you quit smoking.
Jill: Yeah, maybe one day. I'm not ready yet. Right now, I'm just really focusing on staying away from harder drugs like heroin, and I feel like I need to keep smoking for just a bit longer.
Dr: Sure. Let me know; I'm always happy to talk about that, if you want some support to stop smoking.
Jill: OK.
Dr: And for your other health—I see your pap is due next month, and you have a Mirena IUD, yes? Is that going well?
Jill: Yes, I like it. I don't have to worry about taking the pill everyday… that was annoying. And I don't even notice [the IUD] there.
Dr: Ok, and then your HIV, syphilis, and hep C screenings are due next month—we can do the bloodwork here in the clinic. And your hep A and B are up-to-date. Anything else you want to bring up today?
Jill: No, I just need that prescription filled.
Dr: I'll write you another month, once a week witnessed at the pharmacy. See you then.
Jill: Thank you so much.
Dr: You're welcome.

Safe Prescribing Agreement

By signing below, I understand that it is my responsibility to practice and prescribe in a trauma-informed and evidence-based manner, weighing the safety of my patient and the public with the risks of under-treatment of opioid use disorder. To that end, I will provide structure and safety measures with my prescriptions, and engage in collaborative discussions around risks and harm reduction with my patients.

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. I will also seek out advice and assistance, when needed or required within the scope of my practice.

Following the training I have received, I will provide safe and effective treatment and monitoring for patients with opioid use disorder. I will only practice within the scope of my training and by my professional standards of practice, as defined by my regulatory college, other guidance (e.g., decision support tools), and following the BCCSU's guidelines.

When providing education and guidance on safe prescribing practices to colleagues and learners, I will do so within the scope of my knowledge. Overall, I endeavor to improve the quality of care of opioid use disorder across our health care system.

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

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SUBSTANCE USE
Networking researchers, educators & care providers

Resources

Guideline for the Clinical Management of Opioid Use Disorder, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Opioid Use Disorder Practice Update, BCCSU

- Provides updates on the provision of OUD care in line with planned updates to the forthcoming provincial OUD Guideline
- Available at: https://www.bccsu.ca/opioid-use-disorder/

Urine Drug Testing in Patients Prescribed Opioid Agonist Treatment—Breakout Resource, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Treatment of Opioid Use Disorder During Pregnancy—Guideline Supplement, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Bulletins and practice support tools, BCCSU

- Available at: https://www.bccsu.ca/opioid-use-disorder/

Provincial Opioid Addiction Treatment Support Program Online Course, UBC CPD eLearning

- Available at: https://elearning.ubccpd.ca/course/view.php?id=63

British Columbia Extension for Community Healthcare Outcomes (BC ECHO) on Substance Use—Opioid Use Disorder

- The BC ECHO on Substance Use is an online community of practice, consisting of a series of online webinars on evidence-based approaches to OUD care
- Offers support to health care providers in BC and Yukon Territory
- Funding: Health Canada Substance Use and Addictions Program
- More information available at: https://bcechoonsubstanceuse.ca/

Opioid agonist treatment clinics accepting new patients

- Available at: https://www.bccsu.ca/oat-clinics-accepting-new-patients/

List of bed-based (also called residential) treatment and recovery services in BC

- Available at: https://www.bccsu.ca/recovery_services_in_bc/

Consulting addiction medicine specialists

24/7 Addiction Medicine Clinician Support Line

- Provides telephone consultation to physicians, nurse practitioners, nurses, midwives, and pharmacists who are involved in addiction and substance use care and treatment in BC
- The Support Line connects these health care providers to an addiction medicine specialist who has expertise and knowledge in addiction medicine (including emergency, acute, and community care)
- To speak to an addiction medicine specialist, call 778-945-7619
- Available 24 hours per day, 7 days per week, 365 days per year
- More information available at: https://www.bccsu.ca/24-7/

Rapid Access to Consultative Expertise (RACE) app+

- The RACEapp+ allows primary care providers or specialists 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
- Available for physicians and nurse practitioners
- Note that this is not available for registered nurses or registered psychiatric nurses
- Available Monday to Friday (excluding statutory holidays), 8.00am–5.00pm
- Download the RACE app at: www.raceconnect.ca/race-app

Questions? Contact bccsu_education@bccsu.ubc.ca

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Notes

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Networking researchers, educators & care providers