Primary Care Networks
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Primary Care Clinic Buprenorphine/ Naloxone (Suboxone®) Initiation Pathway and Toolkit

Primary Care Clinic Buprenorphine/Naloxone (Suboxone®) Initiation

Roles and Responsibilities:

- Primary Care Provider (PCP) and Patient
- Primary Care Provider Or Clinic

OAT – Opioid Agonist Therapy

OUD – Opioid Use Disorder

ODP – Opioid Dependency Program

iOAT – Injectable Opioid Agonist Therapy

Addiction issue identified by Patient/ Primary Care Provider

Conversation between Patient and Primary Care Provider about Patient goals and treatment/ harm reduction options

Patient is suitable for OAT?

No → Refer to alternate treatment options and continue care

Yes

Conversation between Patient and Primary Care Provider about OAT options

Patient is suitable for Buprenorphine/ Naloxone (Suboxone®)?

No → Referral to other OAT options (e.g. ODP, Methadone, iOAT)

Yes

Primary Care Clinic plans for treatment:

- Provide education to patient and family
- Identify medication coverage
- Identify preferred pharmacy
- Engage psychosocial supports
- Provide a Naloxone Kit
- Decide on Clinic vs Home Induction

Developing a relationship with a community pharmacy near your clinic can be beneficial for you and your patients with OUD

Buprenorphine/Naloxone (BUP/NLX) Induction Flow Diagram

PEER

Day 1

Patient should be in Opioid Withdrawal. COWS Score >12

Give BUP/NLX 4mg/1mg

Wait 60 minutes

Withdrawal Symptoms Gone?

- Yes → Day 1 Dose
- No → Wait 1-3 hrs → Give BUP/NLX 2mg/0.5mg or 4mg/1mg
- Significantly Worse → Possible Precipitated Withdrawal

Day 2 and onwards

Withdrawal symptoms present before dose?

- Yes → May increase dose by 4mg/1mg each day
- No → Take same dose as yesterday

Harm reduction strategies should be utilized across the treatment spectrum. Evidence-based harm reduction should be offered to all, including but not limited to:

- Education regarding safer use
- Access to sterile syringes, needles, and other supplies
- Access to Naloxone Kits
- Access to Supervised Injection Services/Supervised Consumption Services

Primary Care Clinic provides follow-up care:

- Schedule first follow-up appointment 1-2 weeks after initiation and subsequent appointments as appropriate
- Ask specific follow-up questions (Appendix C)
- Use interval Urine Drug Screening (UDS) as monitoring tool (Appendix H)
- Prescribe carries (take home doses) based on patient stability
- Engage psychosocial supports, if needed, to aid in relapse prevention

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Primary Care Clinic Buprenorphine/Naloxone (Suboxone®) Initiation Process Chart

PROCESS	DETAILS	WHERE/WHO DOES IT?	SUPPORTING RESOURCES OR TRAINING
Addiction issue identified by Patient/Primary Care Provider	• Ensure a non-judgemental and supportive approach when discussing concerns with patients.	• Primary Care Clinic - Patient - Primary Care Physician/ Nurse Practitioner/ Nurse/Mental Health Care Provider (i.e. Behavior Health Consultant, Psychologist)	• Prescription Opioid Misuse Index (POMI) screening tool, with additional questions to screen for use of non-prescription opioids, and list of common opioid names and withdrawal symptoms (Appendix A) • DSM – 5 Opioid Use Disorder (OUD) Diagnostic Criteria (Appendix B) • Talking Points – Discussing OUD with your patient (Appendix C)
Conversation between Patient and Primary Care Provider about Patient goals and treatment/harm reduction options	• Be aware that the patient may not agree that their opioid use is a problem and may not be willing to abstain from opioids. • Harm reduction approaches such as naloxone kits and needle exchanges should be explored if a patient is not open to making changes, consider referral to these and other harm reduction options as appropriate. • Subsequent appointments can be a good opportunity to continue this conversation. The patient may decide they are ready to explore Opioid Agonist Therapy (OAT) options at a future time.	• Primary Care Clinic - Patient - Primary Care Provider - Other team members such as Nurse/Mental Health Care Provider may be able to provide support with education on harm reduction strategies and goal setting with the patient	• Towards Optimized Practice (TOP): Tools for Practice - Spread the Word • Motivational Interviewing Techniques: Facilitating change in the general practice setting • Talking Points – Discussing OUD with your patient (Appendix C) • Stages of Change and Associated Interventions (Appendix D) • SMART Recovery Change Plan Worksheet (Appendix E) • Addiction and Mental Health Resource List (Appendix F)
Patient is suitable for OAT?	• If patient is not suitable for OAT, consider referral to alternate treatment options and continue care.	• Primary Care Clinic - Primary Care Provider - Other team members such as Nurse/Mental Health Care Provider may be able to provide support with the assessment	• Addiction and Mental Health Resource List (Appendix F) • Patient Assessment for Opioid Agonist Treatment (Appendix G) • Sample Lab Requisition (Appendix H)
Conversation between Patient and Primary Care Provider about OAT options	• Provide education to patients about each option (i.e. dosing requirements, side effects, commitment level).	• Primary Care Clinic - Patient - Primary Care Provider	• Suboxone® and you brochure • Suboxone®: A Handbook for Patients • Talking Points – Discussing buprenorphine-naloxone (Suboxone®) with your patient and Patients living with chronic pain (Appendix C)

PROCESS	DETAILS	WHERE/WHO DOES IT?	SUPPORTING RESOURCES OR TRAINING
Patient is suitable for Buprenorphine/Naloxone (Suboxone®)?	• If patient is not suitable for Suboxone® in a primary care setting, explore referral to alternate OAT treatment options such as the Opioid Dependency Program (ODP), Methadone clinics, Injectable Opioid Agonist Therapy (iOAT), Virtual Opioid Dependency Program (VODP).	• Primary Care Clinic - Primary Care Provider - Patient	• Addiction and Mental Health Resource List (Appendix F)
Primary Care Clinic plans for treatment	• It is important to set patients up for success in OAT treatment. Consider using the following interventions: - Provide education to patient and family - Identify medication coverage - Identify preferred pharmacy - Engage psychosocial supports - Provide a Naloxone Kit - Decide on Home vs Clinic Induction (dependent upon physician and patient comfort level)	• Primary Care Clinic - Patient - Primary Care Provider - Other team members, such as Nurse/Mental Health Care Provider, may be able to provide support with identifying medication coverage, connecting with pharmacy and providing psychosocial support for the patient	• Talking Points - Preparing the patient to start treatment on buprenorphine-naloxone (Suboxone®) and Handling patient concerns (Appendix C) • Sample Lab Requisition (Appendix H)
Primary Care Provider and Patient initiate Suboxone®	• Take into consideration the patient's pattern of use, type of opioid (long vs. short-acting) and route. • Consider an early morning appointment early in the week to allow ample opportunity for follow-up/troubleshooting if needed. • Prescribing Considerations: - To prevent an extension of Suboxone® be sure to include the date, duration and last date of dosing. - Indicate the frequency of dispensing for Suboxone®. - Provide instructions regarding missed doses of Suboxone® (ie. restart, adjust therapy, or contact office for missed doses). • Determine if the patient will take first dose at pharmacy or bring their medication to the clinic for witnessed dosing. • Ensure the patient is aware that treatment cannot take place if they are not in withdrawal or unable to provide informed consent. If this occurs, reschedule or consider home induction.	• Primary Care Clinic - Primary Care Provider - Patient - Pharmacist	• PEER Guideline: Managing Opioid Use Disorder in Primary Care – Suboxone® Initiation Algorithm (Appendix I) • Billing Codes (Appendix J)

PROCESS	DETAILS	WHERE/WHO DOES IT?	SUPPORTING RESOURCES OR TRAINING
Primary Care Clinic provides follow-up care	• Effective follow-up care can ensure that patients continue to have success in OAT treatment and allow for any issues that arise to be dealt with appropriately. Consider using the following interventions as part of follow-up care: - Schedule first follow-up appointment 1-2 weeks after initiation and subsequent appointments as appropriate. - Ask specific follow-up questions (Appendix C). - If you are having difficulty with achieving a stable dose, see Appendix K. - Use interval Urine Drug Screening (UDS) as routine monitoring tool. - Prescribe carries (take home doses) based on patient stability. - Engage psychosocial supports if needed to aid in relapse prevention. • If interruption in treatment occurs, reassess and provide care as appropriate.	• Primary Care Clinic - Primary Care Provider - Patient - Pharmacist - Other team members, such as Nurse/Mental Health Care Provider, may be able to provide support with follow-up care as appropriate	• Talking Points - Follow up Questions and UDS that show signs of opioids and/or other drug use (Appendix C) • Addiction and Mental Health Resource List (Appendix F) • Sample Lab Requisition (Appendix H) • Billing Codes (Appendix J) • Patients who do not stabilize on buprenorphine-naloxone (Suboxone®) (Appendix K)

LINKS TO RESOURCES:

- Towards Optimized Practice (TOP): Tools for Practice - Spread the Word: https://gomainpro.ca/wp-content/uploads/tools-for-practice/1568407923_naloxonetfp243fv.pdf
- Motivational Interviewing Techniques: Facilitating change in the general practice setting: https://www.racgp.org.au/afp/2012/september/motivational-interviewing-techniques/
- Suboxone® and you brochure: http://www.topalbertadoctors.org/file/-suboxone-brochure-lkd.pdf
- Suboxone®: A Handbook for Patients: https://static1.squarespace.com/static/59ae9fb39f8dce4ac7df6c4f/t/5a429bfee2c4836cd1f40a29/1514314754970/Suboxone_handbook.pdf
- PEER Guideline: Managing Opioid Use Disorder in Primary Care – Suboxone Initiation Algorithm (Figure 2): https://acfp.ca/wp-content/uploads/2019/05/OUD-Guideline-CFP.pdf

APPENDIX A - ADAPTED PRESCRIPTION OPIOID MISUSE INDEX (POMI)

Using the POMI Information for Physicians

The Prescription Opioid Misuse Index (POMI) is a case finding tool that can be useful in patients receiving prescription opioids where a diagnosis of opioid use disorder is suspected.

Two additional questions have been added to the POMI to screen for non-prescription opioid use.

A score of two or more makes the diagnosis more likely.

PEER PATIENTS EXPERIENCE EVIDENCE RESEARCH

Questions	Response (Circle one)	
1. Do you ever use more of your medication, that is, take a higher dose, than is prescribed for you?	**YES**	**NO**
2. Do you ever use your medication more often, that is, shorten the time between doses, than is prescribed for you?	**YES**	**NO**
3. Do you ever need early refills for your pain medication?	**YES**	**NO**
4. Do you ever feel high or get a buzz after using your pain medication?	**YES**	**NO**
5. Do you ever take your pain medication because you are upset, using the medication to relieve or cope with problems other than pain?	**YES**	**NO**
6. Have you ever gone to multiple physicians, including emergency room doctors, seeking more of your pain medication?	**YES**	**NO**

Additional screening questions for non-prescription opioid use:

7. Have you ever taken an opiate medication that was not prescribed to you?	**YES**	**NO**
8. Have you ever purchased opiates illicitly (i.e. on the street)?	**YES**	**NO**

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APPENDIX A - CON'T

Opioids are strong painkillers; these drugs contain opium or opium-like substances and are used to relieve pain. Tolerance can also occur, meaning that long-term users must increase their doses to achieve the same effect or high. Overuse of opioids can easily lead to addiction.

Examples of common opioid medications and street names:

Generic Name	Trade Name	Street Names
Codeine	Tylenol® 2, 3, 4 (codeine & acetaminophen)	T1, T2, T3, T4, 3s, 4s, Phosphates, Tec 30s, Cody, Captain Cody
Fentanyl	Abstral®, Duragesic®, Onsolis®	Down, Fent, Fakes, Sticky, Nerps, Beans
Hydromorphone	Dilaudid®	Dillies, Pickles, 4s, 8s
Oxycodone	OxyNEO®, Percocet®, Oxycocet®, Percodan®	Oxys, OCs, Apo, Greenies, Perc's
Morphine	Doloral®, Statex®, M.O.S.®	Pins and Needles, Greys, Peaches, Purple, Reds, M, Morph, Red Rockets
Meperidine	Demerol®	Demmies

Examples of opioids that are illicit (illegal): Fentanyl (Down, Fent, Fakes), Heroin (Pants, Down, Dizz, Scage)

Reference: Canadian Centre for Substance Use and Addiction (CCSA). (2017). Canadian Drug Summary: Prescription Opioids [PDF file]. Retrieved from https://www.ccsa.ca/sites/default/files/2019-04/CCSA-Canadian-Drug-Summary-Prescription-Opioids-2017-en.pdf, with additional input from patients of the Edmonton IOAT clinic.

Some Short-Term Effects of Opioids:	Some Long-Term Effects of Opioids:
• Nausea and vomiting • Constipation • Drowsiness • Tiny pupils • Vision problems • Anxiety • Trouble concentrating • Decreased appetite	• Depression • Serious constipation • Body changes making natural painkillers so small pain seems worse • Hypotestosteronism • Amenorrhea • Increased risk osteoporosis/osteopenia (with decades of opioid use usually)

The body adapts to the presence of the drug and withdrawal symptoms occur if use is reduced or stopped. Withdrawal can be very difficult and dangerous, and it is recommended that it is best to stop with medical support. Replacement therapy may be a good alternative.

Withdrawal Symptoms:

• Craving • Irritability • Stomach cramps • Nausea and vomiting/puking • Chills • Can't sleep	• Sweating • Muscle and bone pain • Runny nose • Diarrhea • Shakes • Cold • Craving dreams	• Restlessness and trouble sleeping • Weakness • Yawning • Goose bumps/chills ("cold turkey effect") • Itchy bones

APPENDIX B - DSM-5 CLINICAL DIAGNOSTIC CRITERIA FOR OPIOID USE DISORDER

1	Opioids are often taken in larger amounts or over a longer period than was intended.	The presence of at least 2 of these symptoms indicates an Opioid Use Disorder (OUD) The severity of the OUD is defined as: **MILD**: The presence of 2 to 3 symptoms **MODERATE:** The presence of 4 to 5 symptoms **SEVERE:** The presence of 6 or more symptoms
2	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.	
3	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.	
4	Craving or a strong desire to use opioids.	
5	Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.	
6	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.	
7	Important social, occupational, or recreational activities are given up or reduced because of opioid use.	
8	Recurrent opioid use in situations in which it is physically hazardous.	
9	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.	
10	Tolerance,* as defined by either of the following: a) Need for markedly increased amounts of opioids to achieve intoxication or desired effect; b) Markedly diminished effect with continued use of the same amount of opioid.	
11	Withdrawal,* as manifested by either of the following: a) Characteristic opioid withdrawal syndrome; b) Same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms	

To be eligible for methadone, buprenorphine/naloxone (Suboxone™), or slow release oral morphine agonist treatment (SROM), patients must meet DSM-5 criteria for opioid use disorder.

* Patients who are prescribed opioid medications for analgesia may exhibit these two criteria (withdrawal and tolerance) but would not necessarily be considered to have a substance use disorder.

Reference:

1. American Psychiatric Association. Diagnostic and statistical manual of mental disorders: DSM-5.™ 5th ed. Arlington, VA: American Psychiatric Publishing, Inc.

APPENDIX C - TALKING POINTS

DISCUSSING OPIOID USE DISORDER (OUD) WITH YOUR PATIENT:

- "Opioids change the brain and the body in ways that can make it hard to stop using." [1]
- "OUD has nothing to do with character, willpower, or morals. Many good and strong people have an alcohol or drug problem. People with OUD find that once they start using opioids, it is no longer about choice." [2]
- "You have been diagnosed with this disorder because you have repeatedly tried but have been unable to cut down or stop your opioid use. People with OUD have lost control over their use and regularly consume more than they intend to, despite knowing that it's harmful to them." [2]

Note: If patients are unable or uninterested in starting treatment at this time, keep the door open for future treatment and begin building a rapport. Identify and address patient-centered goals. Follow up on patient goals regularly and consider motivational interviewing and harm reduction counseling. [3]

- "I know that you are not interested in starting treatment at this time, but how about we create some goals to work towards?"

DISCUSSING BUPRENORPHINE-NALOXONE (SUBOXONE®) WITH YOUR PATIENT:

- "At the right dose, buprenorphine-naloxone (Suboxone®) controls withdrawal symptoms for 24 hours so that you feel "normal" and not sick or high. Although some people think that this is just replacing one opioid with another, the idea is that by taking a medication as prescribed and getting rid of cravings, you will be able to break the patterns associated with misusing drugs and focus on getting healthy."

PATIENTS LIVING WITH CHRONIC PAIN:

- "I know that you have pain, and no one is questioning that. But I am worried that the risks of opioids are now outweighing the benefits for you."
- "Your OUD is probably making your pain worse. This is because you go through withdrawal every day as the opioid wears off, and withdrawal greatly increases your perception of pain. If you treat your OUD with buprenorphine-naloxone (Suboxone®), you will likely experience a decrease in your chronic pain as well as an improvement in your daily life." [2]
- "If you are on opioids and are worried about switching to another treatment because of your pain, you should know that other options such as buprenorphine-naloxone (Suboxone®) will effectively relieve your pain."

PREPARING THE PATIENT TO START TREATMENT ON BUPRENORPHINE-NALOXONE (SUBOXONE®)

- "You will need to stop all opioids at least 12-24 hours before starting buprenorphine-naloxone (Suboxone®)."
- "When your opioids begin to wear off, you will experience withdrawal. Symptoms of withdrawal include muscle aches, nausea and vomiting, cramps, chills, sweating, yawning, and goosebumps. People also experience insomnia, anxiety, fatigue, and powerful cravings."
- "To help with withdrawal symptoms, you may take:
  - Clonidine 0. 1 mg every 8 hours (by prescription)—many people do not need this
  - Ibuprofen up to 600 mg every 8 hours
  - Acetaminophen up to 1000 mg (2 Extra Strength) every 6 hours
  - Dimenhydrinate 50 mg every 6 hours
  - Walking, resting, hot baths or showers can help (but not right after taking clonidine)"
- "It is important to be in withdrawal before you start buprenorphine-naloxone (Suboxone®) in order to avoid precipitated withdrawal, which is like the worst flu of your life." [4]

APPENDIX C - TALKING POINTS CONTINUED

HANDLING PATIENT CONCERNS

- "Let's talk about your questions and concerns so that you will understand the benefits and drawbacks to this treatment. I understand that you are worried about starting buprenorphine-naloxone (Suboxone®) but know that most people feel significantly better when they use this option."

STOPPING TREATMENT SUDDENLY

- "It is important not to stop taking buprenorphine-naloxone (Suboxone®) suddenly or you will experience withdrawal."

FOLLOW – UP QUESTIONS:

Ask about withdrawal symptoms or cravings; sometimes patients require minor dose adjustments of 2–4 mg/day.

- "Have you had any withdrawal symptoms?"
- "Have you had any cravings lately?"

Ask about any substance use.

- "Have you been using any substances to cope with withdrawal?"

Ask about overall mood and functioning.

- "How have you been feeling?"
- "Are you able to complete chores and tasks during the day?"
- "Are you attending work?"

URINE DRUG SCREENS (UDS) THAT SHOW SIGNS OF OPIOIDS AND/OR OTHER DRUG USE

- "Your UDS results show that you have been using opioids. Why is that? Are you using opioids to cope with withdrawal symptoms? Are you feeling pain? It is normal to feel pain, and we want to understand why you are experiencing this discomfort. As your provider, I want to support you."
- "Your UDS results show continuous substance use, and I think we should talk to a specialist to discuss adjusting your OAT to address the issues that you are facing."

Adapted from the Centre for Effective Practice. (November 2018). Opioid Use Disorder Tool: Ontario, Toronto: Centre for Effective Practice.

References

[1] Government of Canada. About Opioids. 2018. [cited 2018 June 20]. Available from: https://www.canada.ca/en/health-canada/services/substance-abuse/prescription-drug-abuse/opioids/about.html#a4

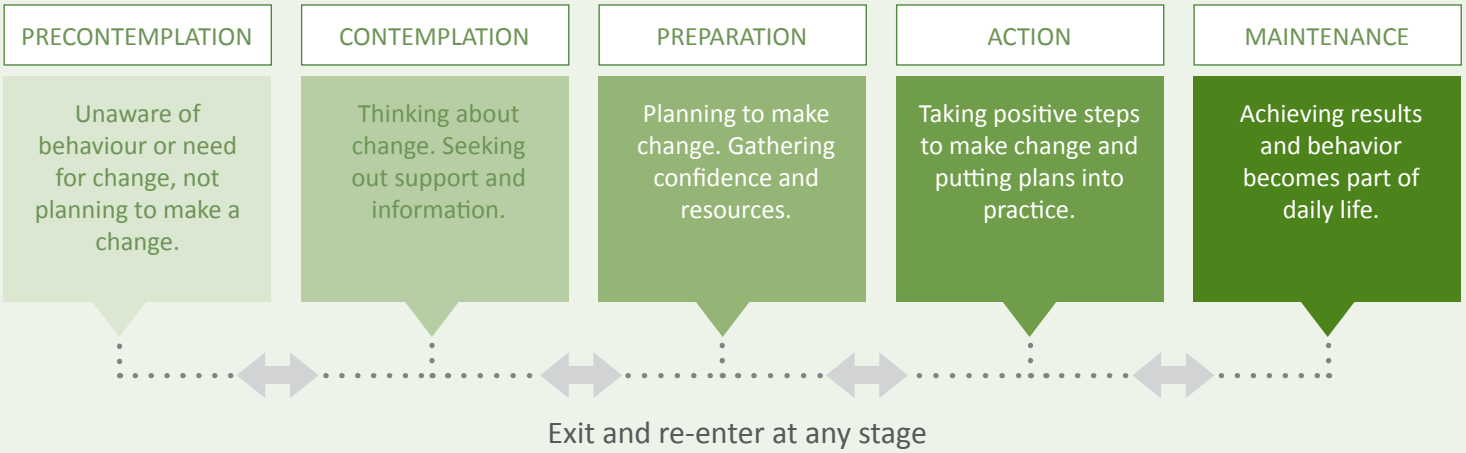
[2] Women's College Hospital (WCH). Opioid Use Disorders A Guide for Patients. 2017. [cited 2018 August 10]. Available from: https://www.womenscollegehospital.ca/assets/pdf/MetaPhi/OUD_book.pdf

[3] British Columbia (BC) Guidelines. Opioid Use Disorder: Diagnosis and Management in Primary Care. 2018. [cited 2018 July 5]. Available from: https://www2.gov.bc.ca/gov/content/health/practitioner-professional-resources/bc-guidelines/opioid-use-disorder

[4] Machealth. Buprenorphine Reference Guide. 2018. [cited 2018 October 30]. Available from: https://machealth.ca/programs/opioids_clinical_primer/m/buprenorphine_rg_and_course_handouts/2403

APPENDIX D - STAGES OF CHANGE AND ASSOCIATED INTERVENTIONS

Stages of Change Model



Matching Opioid Use Disorder (OUD) interventions to the stages of change

PRECONTEMPLATION	CONTEMPLATION	PREPARATION	ACTION	MAINTENANCE
Build trust and relationship Avoid confrontation Explore impact on major life areas Provide information/ harm reduction tips Encourage self-monitoring and personalise the risk	Validate lack of readiness Build motivation and confidence in one's ability to make change "Motivational Interviewing"	Identify obstacles and assist in problem solving Goal setting – small initial steps Identify support systems	Skill development - managing cravings - refusal/social skills - mindfulness Combat feelings of loss and reiterate long term benefits Identify high risk situations Discuss 'lapse' and a 'relapse' Explore alternatives	Discuss triggers for relapse Discuss coping with relapse Reassess motivation & barriers Reinforce future goals

APPENDIX E - CHANGE PLAN WORKSHEET

SMART Recovery®
Self-Management and Recovery Training

Changes I want to make:	
How important is it to me to make these changes? (1-10 scale)	
How confident am I that I can make these changes? (1-10 scale)	
The most important reasons I want to make these changes are:	
The steps I plan to take in changing are:	
How other people can help me	
Person	Kind of help
I will know my plan is working when:	
Some things that could interfere with my plan are:	

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APPENDIX F - ADDICTION AND MENTAL HEALTH RESOURCE LIST

LINKS TO RESOURCES:

Alternate Opioid Agonist Therapy (OAT) Clinics in Edmonton:

- **Panorama**
  10106 111 Ave, 780-471-4434 (Ph), 780-471-4438 (Fax)
- **Metro City**
  10419 102 Ave, 780-429-3991 (Ph), 780-429-3988 (Fax)
- **Savera Medical Centre**
  6730 75 St, 780-761-6767 (Ph), 780-761-6769 (Fax)
- **Alberta Health Services (AHS) Injectable Opioid Agonist Therapy (iOAT) Clinic**
  - Intensive treatment with injectable prescription HYDROmorphone for patients diagnosed with moderate to severe Opioid Use Disorder (OUD) who have been unsuccessful with oral OAT options. By referral only. 780-342-7810 (Ph)
- All **Emergency Departments** in the Edmonton Zone can start patients on Suboxone® then refer to the Opioid Dependency Program (ODP) for continued care.

Supervised Consumption Sites in Edmonton:

- **Boyle Street Community Services**
  10116 105 Ave, Open 7 days a week, closed 10:30 AM to 12:00 PM
  Morning – First intake at 8:30 AM, last intake 10:30 AM
  Afternoon/Evening – First intake at 12:00 PM, last intake 7:30 PM
- **The George Spady Society**
  10015 105A Ave, Open 7 days a week
  First intake at 8:30 PM, last intake at 7:00 AM
- **Boyle McCauley Health Centre**
  10628 96 St, Open Monday to Saturday
  Monday to Thursday – First intake at 8:30 AM, last intake at 7:30 PM
  Friday – First intake at 8:30 AM, last intake at 3:30 PM
  Saturday – First intake at 9:00 AM, last intake at 12:00 PM

Additional supports:

- ODP Edmonton: 10010 102A Ave, 1st Floor; 780-422-1302 (Ph)
- ODP Satellite Clinics (Sherwood Park, Northgate and Edmonton West PCN): 780-405-8193 (Ph)
- VODP (Virtual Opioid Dependency Program): 1-844-383-688 (Ph)
  - Patients seen by telehealth at AHS locations across Alberta
- OUD Consultation Line: 1-800-282-9911 or 1-780-735-0811 (8:00 AM to 5:00 PM daily)
- AHS Addiction and Mental Health Intake: 780-424-2424 (Ph) (24/7)
- AHS Addiction Services Edmonton: 10010 102A Avenue, 2nd Floor; 780-427-2736 (Ph)
  - Walk-in intake available Monday, Tuesday, Thursday, Friday 8:00 AM to 3:00 PM, Wednesday 8:00 AM to 12:00 PM
  - Provides outpatient services such as individual and group counselling and psychiatry.
- AHS Addiction Recovery Centre (Inpatient Detoxification Services): 10302 107 St, 780-427-4291 (Ph)
  - Assessment from 9:30 to 10:30 AM daily, admission based on triage and bed availability.
  - Medically supported detox, average length of stay is 4-7 days.
- Momentum Counselling: 780-757-0900 (Ph)
  - Counselling services on a walk-in basis with affordable fees https://www.momentumcounselling.org/#
- City of Edmonton Short-Term Counselling Services (for individuals or families, no cost): 780-496-4777 (Ph)
- Narcotics Anonymous: 780-421-4429 (Ph)
  - Mutual aid meetings daily, www.eana.ca
- Opiates Anonymous:
  - Opiate specific mutual aid group, Edmonton Meeting Sunday 7 PM at Recovery Acres, 6329 118 Ave

APPENDIX G - PATIENT ASSESSMENT FOR OPIOID AGONIST TREATMENT

After confirming that your patient meets criteria for Opioid Use Disorder (OUD), a comprehensive patient history and assessment should be taken prior to the prescription of Opioid Agonist Treatment (OAT) to ensure that such treatment is indicated and appropriate. The following checklist provides guidance for a thorough assessment.

Substance Use

- ☐ Substance use history including type of drug, amount, frequency, route, age of first use, last use
- ☐ Withdrawal symptoms
- ☐ Overdose history

Medical History

- ☐ Medications (past and present)
- ☐ Allergies
- ☐ Lab tests (consider CBC, electrolytes, renal panel, liver panel, Hep A/B/C serologies, STI panel (including HIV), pregnancy, ECG, Urine Drug Screen to confirm presence of opioids)
- ☐ Complications of substance use (abscesses, sepsis, endocarditis, etc.)
- ☐ Psychiatric history

Psychosocial History

- ☐ Prior drug treatment including trials of OAT
- ☐ Screen for process addiction such as gambling, sex, etc.
- ☐ Legal history and any current legal issues
- ☐ Financial concerns
- ☐ Employment history
- ☐ Family history
- ☐ Social/emotional supports

Note:
A trauma-informed approach should be used when taking this history. The patient may not be comfortable talking about all these topics until a positive working relationship and the feeling of safety have been established. It is not required to have a complete psychosocial history in order to start OAT.

Starting OAT

- ☐ Document that the patient meets DSM-5 criteria for OUD
- ☐ Assess and document stage of change (Appendix D)
- ☐ Create and document a treatment plan including patient goals (Appendix E – Change Plan Worksheet)
- ☐ Check Netcare to avoid duplication of prescription and drug interactions with current medications
- ☐ Document rationale for therapeutic choices (i.e. buprenorphine/naloxone vs methadone)
- ☐ Provide harm reduction education including a naloxone kit

Contraindications and Cautions:

- Allergy to buprenorphine or naloxone
- Severe respiratory insufficiency
- Proceed with caution if patient is taking respiratory depressants such as benzodiazepines or using alcohol (provide education and document discussion regarding risks)
- Proceed with caution if patient is pregnant as precipitated withdrawal could cause fetal loss
- Consider expert input

Adapted from:

British Columbia Centre on Substance Use. (August 29, 2017). Patient Assessment for Opioid Agonist Treatment: Vancouver. British Columbia: British Columbia Centre on Substance Use.

Centre for Effective Practice. (November 2018). Opioid Use Disorder Tool: Ontario. Toronto: Centre for Effective Practice.

APPENDIX H - SAMPLE LAB REQUISITION

Note: If requesting a pre-treatment Urine Drug Screen (UDS) select Opioid Dependency Panel and General Toxicology Panel. If requesting a UDS for routine monitoring you will need to select Buprenorphine under Treatment Regimen.

DynaLIFE MEDICAL LABS

GENERAL LABORATORY REQUISITION

*Dyna***LIFE** Medical Labs 1 (800) 661-9876 or (780) 451-3702
Alberta Public Laboratories 1 (877) 868-6848
Appointment Booking & Locations: www.dynalife.ca or www.albertapubliclabs.ca

Scanning Label or Accession # *(lab only)*

Patient

PHN / Healthcare Number Expiry:_____	Alternate Identifier		
Legal Last Name	Legal First Name	Middle Name	Date of Birth *(dd-Mon-yyyy)*
Preferred Name	☐ Male ☐ Female ☐ X (Non-Binary/Prefer not to Disclose)		Phone
Address	City / Town	Province	Postal Code

Provider(s)

Authorizing Provider Name *(Last, First, Middle)*		
Address		
Provider ID	Submitter ID	Phone
Clinic / Building Name		

Copy To 1

Authorizing Provider Name *(Last, First, Middle)*
Address
Phone
Clinic / Building Name

Copy To 2

Authorizing Provider Name *(Last, First, Middle)*
Address
Phone
Clinic / Building Name

Collection	Date *(dd-Mon-yyyy)*	Time *(24h)*	Location	Collector ID

☐ Routine ☐ Stat	Requisition Date	Ⓕ Denotes a **Fasting Test** Ⓘ Refer to Patient Instruction Sheet	Hours Fasting _____	☐ Third Party Bill? Client _____

Hematology / Coagulation
- ☐ CBC and Differential ☐ CBC no Differential
- ☐ D-dimer
- ☐ Fibrinogen
- ☐ INR
- ☐ Reticulocyte Count

General Chemistry
- ☐ Albumin
- ☐ Alkaline Phosphatase (ALP)
- ☐ Alanine Aminotransferase (ALT)
- Bilirubin ☐ Total ☐ Total and Conjugated
- ☐ Calcium
- ☐ C-Reactive Protein (CRP)
- ☐ Creatine Kinase (CK)
- ☐ Creatinine (eGFR)
- ☐ Electrolyte Panel ☐ Sodium ☐
- ☐ Ferritin
- ☐ Gamma Glutamyl Transferase (GG
- ☐ Glucose Fasting Ⓕ Ⓘ
- ☐ Glucose Gestational Diabetes Scr
- ☐ Glucose Tolerance, Gestational, 2
- ☐ Glucose Random
- ☐ Glucose Tolerance, 2h Ⓕ Ⓘ
- ☐ Hemoglobin A1c
- ☐ HCG, Serum (Quantitative)
- Immunoglobulins ☐ A (IgA) ☐ G (IgG
- ☐ Lipase
- ☐ Magnesium
- ☐ Phosphate
- ☐ Prostate Specific Antigen (PSA)
- ☐ Protein Electrophoresis-Serum
- ☐ Total Protein
- ☐ Urate
- ☐ Lipid Panel ☐ Cholesterol ☐ Triglycerides Ⓕ

Endocrine
- Cortisol
  - ☐ Random ☐ AM (0700-1000) ☐ PM (1500-1800)
- ☐ Estradiol
- ☐ Follicle Stimulating Hormone (FSH)
- ☐ Luteinizing Hormone (LH)
- ☐ Parathyroid Hormone (PTH)
- ☐ Progesterone
- ☐ Prolactin
- Testosterone, Total
  - ☐ Random ☐ AM (0700-1000) ☐ PM (1500-1800)
- ☐ Thyroid Stimulating Hormone (TSH)

Urine Drug Testing Panels
Reason for Request _____
- ☑ Opioid Dependency Panel
  - What is the Treatment Regimen?
    - ☑ Buprenorphine ☐ Methadone
    - ☐ Morphine ☐ Hydromorphone
    - ☐ Other _____
- ☑ General Toxicology Panel

- ☐ Electrocardiogram

Edmonton ECG to be read by
- ☐ DynaLIFE Panel ☐ Other _____

Calgary see separate ECG Requisition

Transfusion Medicine
- ☐ Direct Antiglobulin Test (DAT)
- ☐ RHIG Eligibility, Prenatal

Type & Screen - separate process required, contact lab

Clinical Information

Drug Levels / Monitoring
- ☐ Ethanol (Blood)

Therapeutic Drug Monitoring
- Dose Route ☐ Oral ☐ IV ☐ Other
- Dose Regimen _____
- How Long on Current Regimen? _____
- Date of Last Dose? _____
- Time of Last Dose/IV Start _____
- If IV, Complete Time _____
- Date of Next Dose _____
- Time of Next Dose _____
- ☐ Carbamazepine ☐ Phenobarbital
- ☐ Cyclosporine Pre Dose ☐ Sirolimus
- ☐ Cyclosporine 2h Post ☐ Tacrolimus
- ☐ Digoxin ☐ Theophylline
- ☐ Lithium ☐ Valproate
- ☐ Phenytoin ☐ Other _____

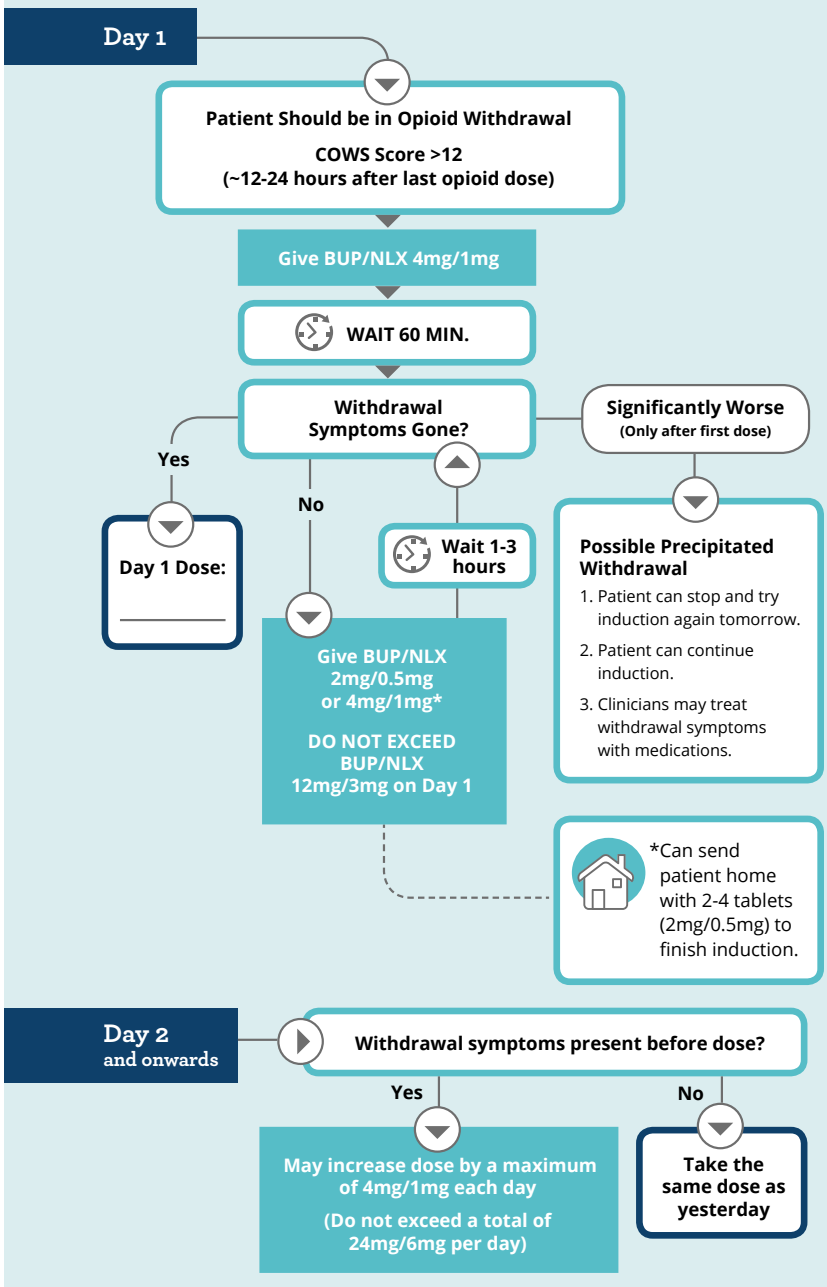
Antibiotics
- Gentamicin ☐ Pre ☐ Post ☐ Interval ☐ Other
- Tobramycin ☐ Pre ☐ Post ☐ Interval ☐ Other
- Vancomycin ☐ Pre ☐ Other

Urine Drug Testing Panels
Reason for Request _____
- ☐ Opioid Dependency Panel
  - What is the Treatment Regimen?
    - ☐ Buprenorphine ☐ Methadone
    - ☐ Morphine ☐ Hydromorphone
    - ☐ Other _____
- ☐ General Toxicology Panel

Primary Care Networks EDMONTON AND AREA

APPENDIX I - PEER BUPRENORPHINE/NALOXONE INDUCTION FLOW DIAGRAM

Buprenorphine/Naloxone (BUP/NLX) Induction Flow Diagram



Clinical Opiate Withdrawal Scale (COWS) Score (0-48)†

Category (Points), Clinician Administered

	WORSE →					
Resting Pulse Rate	0	1	2		4	
Sweating	0	1	2	3	4	
Observed Restlessness	0	1		3		5
Pupil Size	0	1	2			5
Bone or Joint Aches	0	1	2		4	
Runny Nose or Tearing	0	1	2		4	
Gastrointestinal Upset	0	1	2	3		5
Observed Tremor of Outreached Hands	0	1	2		4	
Observed Yawning	0	1	2		4	
Anxiety or Irritability	0	1	2		4	
Gooseflesh Skin	0			3		5
TOTAL SCORE						

Agents for Management of Withdrawal Symptoms (Including precipitated withdrawal)

Symptom ▸ Agent	DIRECTIONS
Anxiety ▸ Clonidine	0.1mg PO Q4H PRN
Anxiety ▸ Quetiapine	25mg PO QHS PRN
Sleep ▸ Trazodone	50-100mg PO QHS PRN
Pain ▸ Ibuprofen	600mg PO Q6H PRN
Nausea ▸ Dimenhydrinate	50mg PO Q6H PRN
Nausea ▸ Ondanestron	4mg PO Q6H PRN
Diarrhea ▸ Loperamide	4mg, followed by 2mg after each loose stool (max:16mg/day)

† Full COWS Scoring Available at: https://www.drugabuse.gov/sites/default/files/files/ClinicalOpiateWithdrawalScale.pdf
For home induction, use patient administered Subjective Opiate Withdrawal Scale (SOWS) scoring available at: http://www.bccsu.ca/wp-content/uploads/2017/08/SOWS.pdf

Last Revision Date Sept. 10 2019

APPENDIX J - BILLING CODES

The Alberta Medical Association (AMA) has created a "tool box" of useful billing codes which can be used when seeing and treating patients living with opioid use disorder or other substance use disorders.

Here are some things to consider when using these codes:

- 08.19G ($47.54 per 15 minutes or major portion thereof)
  - Only time with direct patient contact can be billed
  - Requires a psychiatric diagnosis within the chart, and on the claim submitted
    - e.g. 304.0 (drug dependence – morphine type), 305 (non-dependent abuse of drugs)
- 03.03A ($38.03)
  - Unlike the 08.19G, time that is not spent directly with the patient in order to complete activities, such as care coordination, reviewing records, and completing charting, can be billed as long as these activities are completed on the same day that the patient is seen.
  - Use the CMGP modifier at 15, 25, 35 minutes and so on to claim for additional time spent related to patient care activities.

Chronic Pain:

The Schedule of Medical Benefits also has billing codes which apply to the management of patients with chronic pain. In order for family physicians to use these codes, the patient must have been assessed previously by an interdisciplinary chronic pain clinic (defined by GR 4.2.5 – see below) and been referred back to their primary care provider for ongoing management.

GR 4.2.5:

Chronic Pain: Defined as pain which persists past the normal time of healing, is associated with protracted illness or is a severe symptom of a recurring condition.

Interdisciplinary Chronic Pain Program: Defined as a comprehensive, coordinated, interdisciplinary program for persons complaining of chronic pain. The interdisciplinary team consists of a medical director; other team members will include psychologist(s) and/or psychiatrist(s), physiotherapist(s) and/or occupational therapist(s) and may include anesthetist(s) and other professional personnel. Treatment is delivered by a coordinated team within the same site by an interdisciplinary chronic pain program.

The name of the chronic pain clinic which originally assessed the patient must be identified in the patient's chart. This can be done by retaining a copy of the latest consult note and/or discharge letter from the chronic pain clinic within the patient's chart.

There is no defined timeframe for how long after a patient has been discharged from a chronic pain clinic that the family physician is able to use these billing codes. If a patient's care transfers to a new family physician, the new physician must obtain sufficient documentation of the patient being seen at an interdisciplinary chronic pain clinic before they can use these billing codes (e.g. obtain a copy of the discharge letter from the pain clinic).

Some billing codes which may be applicable to treating chronic pain include:

- 03.05O Direct management, reassessment, education and/or general counselling of a patient with chronic pain, per 15 minutes or portion thereof ($44.90)
- 03.05X Formal, scheduled, professional interview with relative(s) relating to the care and treatment of a patient with chronic pain on behalf of a specific patient, full 15 minutes or major portion thereof for the first call when only one call is claimed ($51.98)

  1. Both services are to be claimed in the name of the patient. For family and team conference, physicians' records should include the names of attendees, their role, and in the case of family members, their relationship to the patient.
- 03.05V Formal, scheduled, professional interview relating to the care and treatment of a patient with chronic pain with other physicians, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, per 15 minutes ($41.99)

APPENDIX J - BILLING CODES CONTINUED

1. This service is to be claimed by the physician most responsible for the patient where the physician spends a minimum of 30 minutes with medical and/or para-medical personnel regarding the management of chronic pain.

- 03.05W Second and subsequent physician attendance at a formal, scheduled, professional interview relating to the care and treatment of a patient with chronic pain with other physicians, family, and/or direct therapeutic supervision of allied health professionals or community agencies, on behalf of a specific patient, per 15 minutes ($27.39)

  1. This service is to be claimed by the physician most responsible for the patient where the physician spends a minimum of 30 minutes with medical and/or para-medical personnel regarding the management of chronic pain.

Special Scenarios:

- Multiple encounters with the same patient on the same day
  - e.g. Starting Suboxone® in office and bringing the patient back later in the day to assess withdrawal symptoms
    - The second "visit" will count as the same encounter as the first as the physician has requested the patient to return for reassessment
    - Additional time for the second "visit" can be billed with the CMGP modifier on top of the first visit's 03.03A
  - e.g. Patient having significant side-effects from Suboxone® start seeks further medical attention from the physician
    - This is a separate encounter as it was initiated by the patient
    - Physician to physician contact for advice on patient management
  - e.g. Calling RAAPID or the Opioid Dependency Program (ODP) to obtain advice on a patient case
    - Aim is to prevent the patient from needing to be seen by the specialist and to maintain the care of the patient in the hands of the primary care provider
    - Does NOT apply for clarifications (e.g. dosages or titration schedules)
    - 03.01LG/LH/LI can be billed depending on the time of day the call occurs

APPENDIX K - PATIENTS WHO DO NOT STABILIZE ON BUPRENORPHINE-NALOXONE (SUBOXONE®)

If a patient fails to stabilize on buprenorphine-naloxone, try to identify if there are other mental health issues that are impacting stabilization:

- Ask: "How is your mood?" "Are you experiencing a lot of anxiety?"
- Consider the Patient Health Questionnaire (PHQ- 9) and the Generalized Anxiety Disorder 7-item (GAD-7) scale for further screening
- Also, consider having a discussion with the patient about an alternative in treatment modalities. This could include remaining on buprenorphine-naloxone (Suboxone®) and referring the patient for more intensive counseling or to a residential treatment program
- It could involve referring the patient to a physician experienced in addiction medicine for consideration of an alternate Opioid Agonist Therapy (OAT)

If the patient displays persistent, problematic use of non-opioid substances, consideration should be given to refer the patient for intensive psychosocial treatment or to consult with a physician experienced in addiction medicine for the management of these disorders.

If treatment is not effective or patient is not able to tolerate buprenorphine-naloxone (Suboxone®), try consulting experts and specialists through the OUD Consultation Line (1-800-282-9911 or 1-780-735-0811, 8 AM to 5 PM daily) to pinpoint the cause, before exploring other OAT options.

Consider the following screening questions to identify the cause of the patient not stabilizing:

Is the dose adequate? →	Ask "Are you experiencing withdrawal symptoms?"
Is the patient using other illicit substances? →	Ask "Are you taking any substances to cope with your withdrawal?"
Is the patient experiencing perceived withdrawal symptoms? →	Ask "Are you experiencing pain? shakiness? sweats?"
Are there other active health issues present in the patient? →	Ask "Do you have any chronic conditions?"
Are there factors present in the patient's life that are putting them at risk? →	Ask "Are you able to access your pharmacy easily?" and/or "How are things at home?"

*The PHQ-9, GAD-7 and other helpful screening tools for primary care can be found at: https://www.phqscreeners.com/select-screener/36

Adapted from the Centre for Effective Practice. (November 2018). Opioid Use Disorder Tool: Ontario. Toronto: Centre for Effective Practice.