GIM Grand Rounds

January 24th, 2025

Management of Inpatients with Opioid Use Disorder

Tally Mogus MD CCFP (AM) ISAM

Jessica Kirkwood MD CCFP (AM)

Presenter Disclosures

Speaker: Dr. Tally Mogus

Relationships with Financial Sponsors:

Speaker’s honoraria/Travel/Accommodations: None

Grants/Research Funding: None

Other: Worked at BMHC/Radius since 2010-2012, 2015-present, Cups/The Alex in Calgary 2012-2015, ARCH since 2016

Presenter Disclosures

Speaker: Dr. Jessica Kirkwood

Relationships with Financial Sponsors:

Speaker's honoraria/Travel/Accommodations: CFPC, ACFP, PEIP, MEME, CPSS

Grants/Research Funding: None directly

Other: Worked at BMHC/Radius since 2012, Correctional Experience, Associate Professor UofA

Objectives

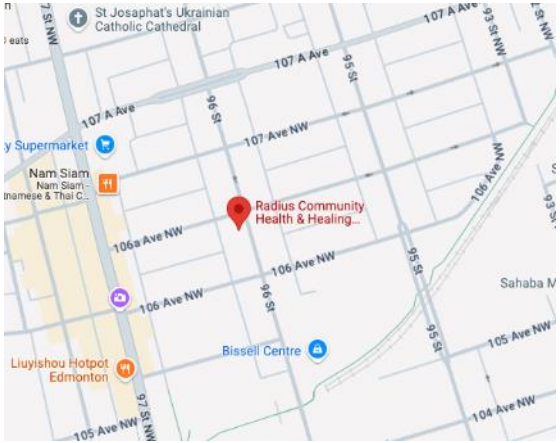
1) Understand Opioid Use Disorder (OUD) and use of Opioid Agonist Therapy (OAT) to manage

2) Clarify legislation around prescribing opioids in hospital

3) Specific issues regarding the treatment of inpatients with OUD

4) Provide resources for prescribers and patients

5) Our (not so) hidden agenda…



Radius

Compassionate care without barriers

Types of OAT

- Methadone
- Buprenorphine/Naloxone (Suboxone)
- Extended-release Buprenorphine (Sublocade)
- Slow-Release Oral Morphine (Kadian)
- Injectable hydromorphone/diacetylmorphine (iOAT)

- Fentanyl/Morphine/Methadone **(Full Agonist)** = a fast car going 180 Km per hour

Naloxone **(Antagonist)** = 0 Km per hour

Buprenorphine **(Partial Agonist)** = A car going 50 Km per hour

Table 2. Decision Support Tool for Selecting OAT

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	Extended-release buprenorphine		
Retention in treatment	May be slightly lower than methadone; retention improves at higher doses (above 16mg)	Substantially higher than placebo	Potentially slightly better treatment retention than buprenorphine/naloxone	Non-inferior to methadone
Initiation				
Requires withdrawal prior to induction	Traditional induction: Yes. Requires moderate withdrawal prior to induction Low-dose induction: No. Does not require prior withdrawal, allowing for comfortable start	No. Does not require a period of withdrawal, but requires prior stabilization on sublingual buprenorphine/naloxone	No. Does not require a period of withdrawal. May be easier to initiate	No. Does not require a period of withdrawal. Comparable process to methadone, with faster titration

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

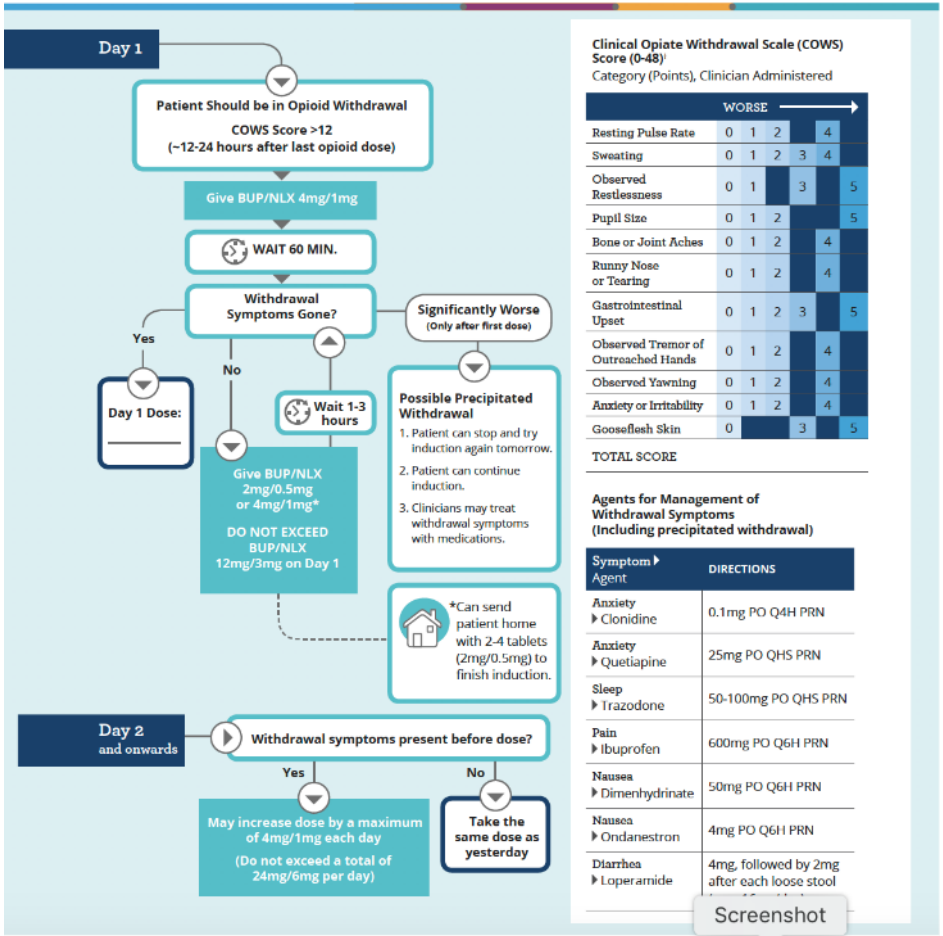
COWS Clinical Opiate Withdrawal Scale

Wesson & Ling, J Psychoactive Drugs. 2003 Apr-Jun;35(2):253-9.

Resting Pulse Rate: _____beats/minute *Measured after patient is sitting or lying for one minute* 0 Pulse rate 80 or below 1 Pulse rate 81-100 2 Pulse rate 101-120 4 Pulse rate greater than 120	GI Upset: *over last 1/2 hour* 0 No GI symptoms 1 Stomach cramps 2 Nausea or loose stool 3 Vomiting or diarrhea *5* Multiple episodes of diarrhea or vomiting
Sweating: *over past 1/2 hour not accounted for by room temperature or patient activity.* 0 No report of chills or flushing 1 Subjective report of chills or flushing 2 Flushed or observable moistness on face 3 Beads of sweat *on* brow or face 4 Sweat streaming off face	Tremor *observation of outstretched hands* 0 No tremor 1 Tremor can be felt, but not observed 2 Slight tremor observable 4 Gross tremor or muscle twitching
Restlessness *Observation during assessment* 0 Able to sit still 1 Reports difficulty sifting still, but is able to do so 3 Frequent shifting or extraneous movements of legs/arms 5 Unable to sit still for more than a few seconds	Yawning *Observation during assessment* 0 No yawning 1 Yawning once or twice during assessment 2 Yawning three or more times during assessment 4 Yawning several times/minute
Pupil size 0 Pupils pinned or normal size for room light 1 Pupils possibly larger than normal for room light 2 Pupils moderately dilated *5* Pupils so dilated that only the rim of the iris is visible	Anxiety or irritability 0 None 1 Patient reports increasing irritability or anxiousness 2 Patient obviously irritable anxious 4 Patient so irritable or anxious that participation in the assessment is difficult
Bone or Joint aches *If patient was having pain previously, only the additional component attributed to opiates withdrawal is scored* 0 Not present 1 Mild diffuse discomfort 2 Patient reports severe diffuse aching of joints/ muscles 4 Patient is rubbing joints or muscles and is unable to sit still because of discomfort	Gooseflesh skin 0 Skin is smooth 3 Piloerrection of skin can be felt or hairs standing up on arms *5* Prominent piloerrection
Runny nose or tearing *Not accounted for by cold symptoms or allergies* 0 Not present 1 Nasal stuffiness or unusually moist eyes 2 Nose running or tearing 4 Nose constantly running or tears streaming down cheeks	Total Score _____ The total score is the sum of all 11 items Initials of person completing Assessment:_____

Score: 5-12 mild; 13-24 moderate; 25-36 moderately severe; more than 36 = severe withdrawal

Buprenorphine/Naloxone (BUP/NLX) Induction Flow Diagram



Clinical Opiate Withdrawal Scale (COWS) Score (0-48)[1]

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					

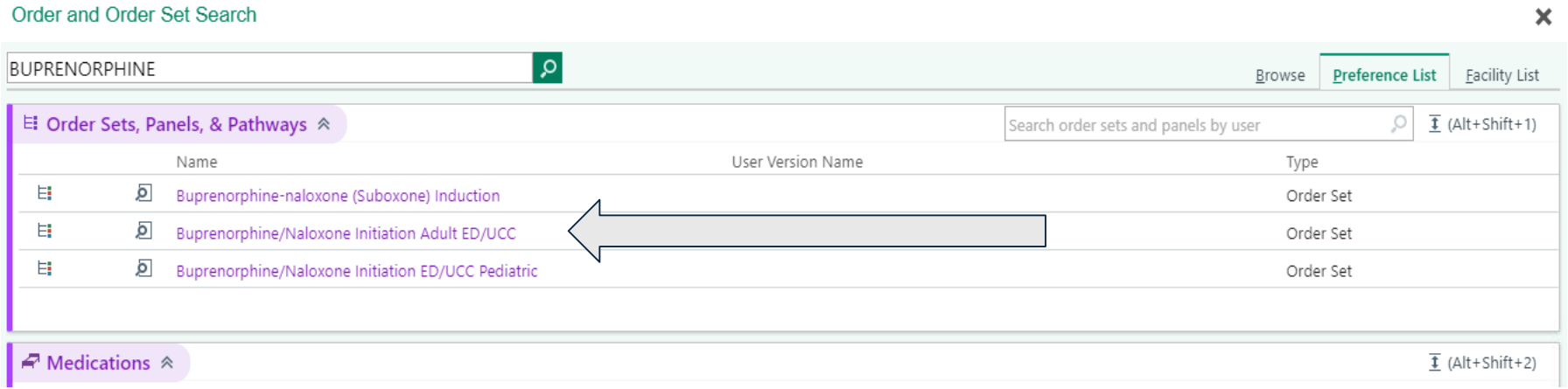
Agents for Management of Withdrawal Symptoms (Including precipitated withdrawal)

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

Screenshot

Korownyk et al. CFP May 2019

Bup/Nlx order set



Order Sets

Orders

Clear All Orders

Buprenorphine/Naloxone Initiation Adult ED/UCC

Manage User Versions | Remove Order Sets

The Opioid Use Disorder Telephone Consultation Line is available 0800-2000 hours daily including weekends and statutory holidays.

Inclusion Criteria *(Please ensure all inclusion criteria are met)*	Exclusion Criteria
• Age 18 years or older. If the patient is under the age of 18, consider calling the Opioid Use Disorder Telephone Consultation Line OR discuss with an Addictions and/or Pediatric consultant. • Suspicion of opioid use disorder • Patient willing to engage in buprenorphine/naloxone	• Allergy to buprenorphine or naloxone • Being admitted for medical/psychiatric concern • Severe liver dysfunction • Currently prescribed or using methadone, or buprenorphine/naloxone • Clinical signs of sedative/depressive impairment or intoxication (*DO NOT use ETOH level in isolation
Pregnant patients ARE NOT EXCLUDED from taking buprenorphine/naloxone but will likely benefit from expert consultation or opinion to guide dosing, other management considerations, and follow-up. Opiate withdrawal is a risk to the fetus and may increase the risk of spontaneous abortion / premature labour, or other complications. Consider calling the Opioid Use Disorder Telephone Consultation Line or discuss with the OB-GYN consultant on call or providing consultation.	

Most recent documented Clinical Opioid Withdrawal Score (COWS): No data recorded

General

Isolation

Click for more

Patient Care

Patient Care Assessments

- [x] Nursing Communication
  Until discontinued, Starting today at 11:23, Until Specified
  ** Determine TIME since LAST opioid use ** Initiate buprenorphine/naloxone at least 12 hours since last short acting opioid (e.g. fentanyl, heroin, crushed OxyContin, Percocet) ** Initiate buprenorphine/naloxone at least 24 hours since last long acting opioid (e.g. PO OxyContin, Hydromorph Contin, OxyNeo) ** Initiate buprenorphine/naloxone at least 72 hours since last methadone dose
- [x] Nursing Communication
  Until discontinued, Starting today at 11:23, Until Specified
  Perform Clinical Opiate Withdrawal Scale (COWS) score now

Medications

buprenorphine-naloxone (suboxone) - ED or Home Induction

- [ ] ED Induction
- [ ] Home Induction
- [ ] naloxone black kit ($0.01)
  1 each, other - see admin instructions, once, Withdraw naloxone and inject as directed on Naloxone Kit instruction insert. Provide kit.

Discharge

Discharge Referrals and Teaching

Order Sets

buprenorphine-naloxone (suboxone) - ED or Home Induction

- [x] ED Induction
  - [x] Nursing Communication
    Until discontinued, Starting today at 11:28, Until Specified
    Perform Clinical Opiate Withdrawal Scale (COWS) score prior to first dose of buprenorphine/naloxone and then once again after 1 hour for Emergency Department Induction. Patient to be NPO for 30 minutes after tablet dissolves following each administration.
  - [x] Notify Most Responsible Health Practitioner (MRHP)
    Until discontinued, Starting today at 11:28, Until Specified
    if signs of precipitated withdrawal (Patient complaining of marked worsening symptoms of opioid withdrawal within 30 minutes of the first dose of buprenorphine/naloxone).
  - [x] Notify Most Responsible Health Practitioner (MRHP) ⓘ
    Until discontinued, Starting today at 11:28, Until Specified
    After second buprenorphine/naloxone dose, inform MRHP for possible patient discharge.
  - [x] buprenorphine-naloxone 2 - 0.5 mg per tablet 1 tablet ($1.51)
    1 tablet, sublingual, once, today at 11:28, For 1 dose
    Dose 1:
    To be given only if sufficient time since LAST opioid use and Clinical Opioid Withdrawal Score (COWS) score is greater than or equal to 12
    Nurse to observe all buprenorphine-naloxone doses to ensure taken sublingually and tablet dissolves
    Patient to stay NPO for 30 minutes after tablet dissolves
    Reassess COWS 1 hour after administration of buprenorphine-naloxone
    CAUTION: High Alert Medication.
    Maximum MME/Day: 60 MME/Day for this order
  - [x] buprenorphine-naloxone 2 - 0.5 mg per tablet 2 tablet ($1.51)
    2 tablet, sublingual, once, today at 12:28, For 1 dose
    Dose 2:
    To be given only if at 1 hour following dose 1, COWS remains the same or improves and patient shows NO signs of precipitated withdrawal (Patient complaining of marked worsening symptoms of opioid withdrawal within 30 minutes of the first dose of buprenorphine-naloxone)
    Nurse to observe all buprenorphine/naloxone doses to ensure taken sublingually and tablet dissolves
    Patient to stay NPO for 30 minutes after tablet dissolves
    CAUTION: High Alert Medication.
    Maximum MME/Day: 120 MME/Day for this order
  - [ ] buprenorphine-naloxone TO TAKE HOME
- [ ] Home Induction
- [ ] naloxone black kit ($0.01)
  1 each, other - see admin instructions, once, Withdraw naloxone and inject as directed on Naloxone Kit instruction insert. Provide kit.

Bup/Nlx Rapid Microinduction

Rapid Microinduction Suboxone (q3h):

buprenorphine-naloxone 2-0.5 mg per tablet
0.25 tablet, sublingual, every 3 hours, For 8 doses
Witness tablet to dissolve under the tongue.

Followed By:
buprenorphine-naloxone 2-0.5 mg per tablet
0.5 tablet, sublingual, every 3 hours, For 8 doses
Witness tablet to dissolve under the tongue.

Followed By:
buprenorphine-naloxone 2-0.5 mg per tablet
1 tablet, sublingual, every 3 hours, For 8 doses
Witness tablet to dissolve under the tongue.


How to decide?

	Buprenorphine-based formulations		Methadone	SROM
	Buprenorphine/naloxone	Extended-release buprenorphine		
	nervous system (CNS) depressants	central nervous system (CNS) depressants		
Drug-drug interactions	Few	Few	Higher potential for adverse drug-drug interactions (e.g., antibiotics, antidepressants, antiretrovirals)	Fewer than methadone
QT prolongation	Low likelihood	Low likelihood	Associated	Not associated
Risk of precipitated withdrawal during initiation	Yes	No	No	No
Side effects				
Side effects	Milder side effect profile	Medication adverse effects are similar to buprenorphine/naloxone	More severe dose-dependent side effect profile (e.g., sedation, weight gain,	Comparable to methadone, though less well-described

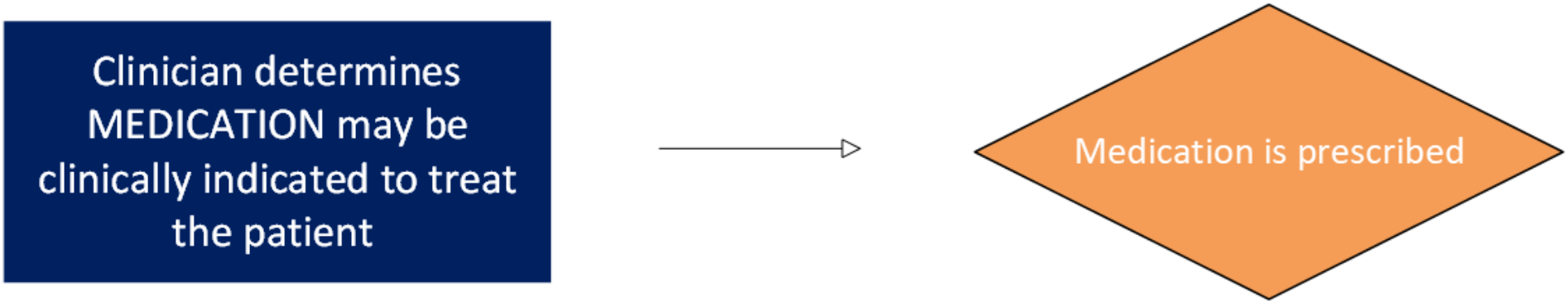
Available at: https://www.bccsu.ca/opioid-use-disorder/

What about missed doses?

Medication	Consecutive Days that can be missed before dose needs to be changed/lowered
Buprenorphine/Naloxone (with no other opioid use)	Up to 5
Buprenorphine/Naloxone (with other opioid use)	4-5 (discuss risk of precipitated withdrawal)
Methadone	Up to 3
SROM (Kadian)	Up to 3

Inpatient Considerations

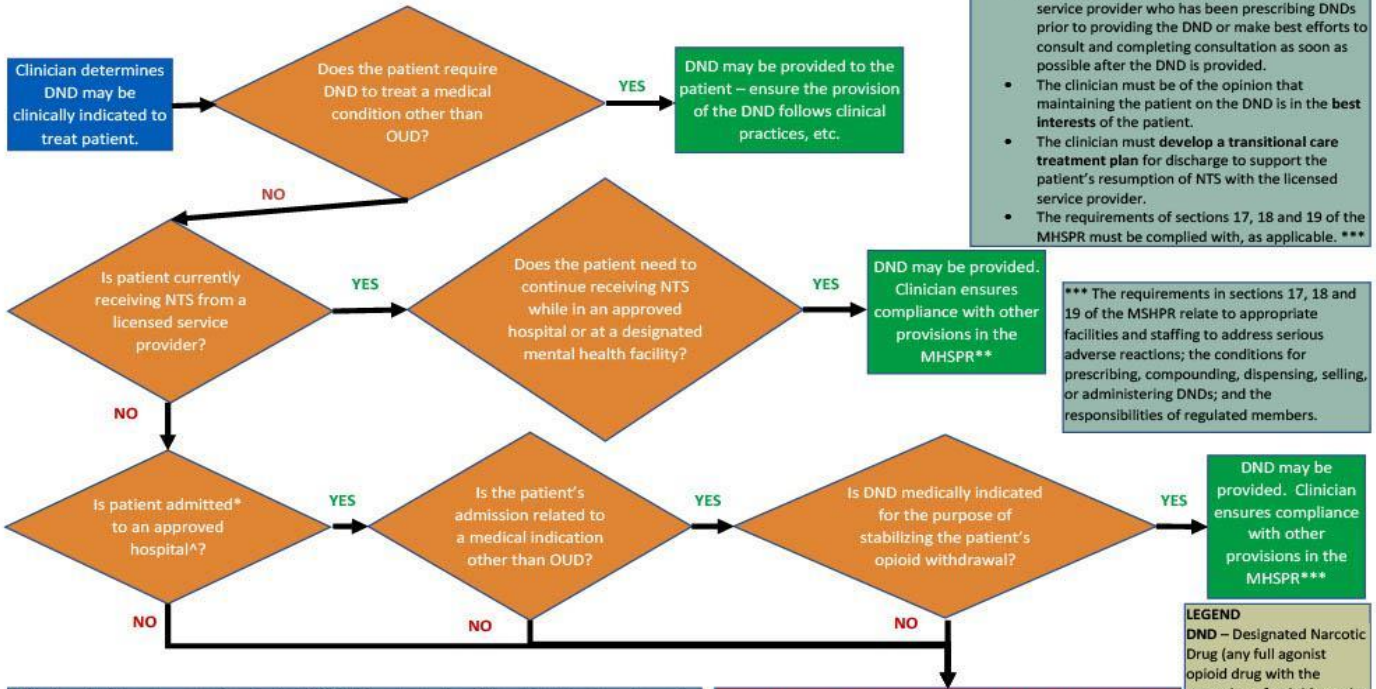
What we used to do……



Alberta Health Services

Flowchart: Provision of Designated Narcotic Drug outside of an AHS ODP Clinic Licensed to provide NTS – January 2024

Mental Health Services Protection Regulation (MHSPR)



** The following additional requirements must be met to permit a patient to continue to receive NTS:

- The clinician must **consult** with the licensed service provider who has been prescribing DNDs prior to providing the DND or make best efforts to consult and completing consultation as soon as possible after the DND is provided.
- The clinician must be of the opinion that maintaining the patient on the DND is in the **best interests** of the patient.
- The clinician must **develop a transitional care treatment plan** for discharge to support the patient's resumption of NTS with the licensed service provider.
- The requirements of sections 17, 18 and 19 of the MHSPR must be complied with, as applicable. ***

*** The requirements in sections 17, 18 and 19 of the MSHPR relate to appropriate facilities and staffing to address serious adverse reactions; the conditions for prescribing, compounding, dispensing, selling, or administering DNDs; and the responsibilities of regulated members.

* The hospital-based exemptions in the MHSPR do not apply until a patient has been formally admitted as an inpatient of an approved hospital. For the purpose of the MHSPR, a patient is considered to be admitted to an approved hospital when they have been assigned a most responsible practitioner (either emergency department physician or consulting physician) and are at or beyond the assessment phase of the ED Patient Journey Map.

- DND should only be prescribed when the ED patient has been assigned a most responsible practitioner, and that practitioner believes there is a risk to the person's receipt of appropriate treatment if the medication is delayed until the person is admitted as an inpatient.

^The current listing of approved hospitals is available online at: Consolidated schedule of approved hospitals (Ministerial Order 31/2015) - Open Government (alberta.ca)

LEGEND

DND – Designated Narcotic Drug (any full agonist opioid drug with the exception of opioid agonist treatment medications (buprenorphine, methadone, or slow-release oral morphine)

Licensed service provider = AHS ODP Clinic

NTS – Narcotic Transition Services

OUD – Opioid Use Disorder

New Regulations

In In October 2022, the Government of Alberta amended the Mental Health Services Protection Regulation (MHSPR) and released the Community Protection and Opioid Stewardship (CPOS) Standards.


Community Protection and Opioid Stewardship Standards

Mental Health Services Protection Regulation


Province of Alberta

MENTAL HEALTH SERVICES PROTECTION ACT

MENTAL HEALTH SERVICES PROTECTION REGULATION

Alberta Regulation 114/2021

With amendments up to and including Alberta Regulation 125/2024
Current as of June 21, 2024

Office Consolidation

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Alberta King's Printer
Suite 700, Park Plaza
10611 - 98 Avenue
Edmonton, AB T5K 2P7
Phone: 780-427-4952

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Timeline

- October 5, 2022: Amendment to Mental Health Services Protection Regulation released
- November 15, 2022: AHS legal flags “other indications” in section 13
- November 25, 2022: ARCH, provincial, zonal, and site leadership meeting– no changes in current practice for acute care
- Jan 24, 2023 – AMH shares a draft of clarification document
- Feb 10 – ARCH leadership presents concerns to AMH and AHS legal
- Feb 23 and March 8 – AMH requests cases for legal to review
- March 7 – ARCH expresses concerns about confusing NTS communication and compliance
- March 17 and May 24: Meeting with ARCH, site and zonal leadership - continue current practice while waiting for clarification from AMH
- March: ARCH meets with CPSA – implications of potential non-compliance
- June 2023: Version of FAQ and Clinical Scenario shared
- March 2024 - FAQ and Clinical Scenario documents released by zonal leadership

Slide courtesy Dr. S. Klassen

Fines

According to the MHSP(Act):

Administrative penalties

18(1) *If a director is of the opinion that a person*

(a) has contravened this Act or the regulations, or

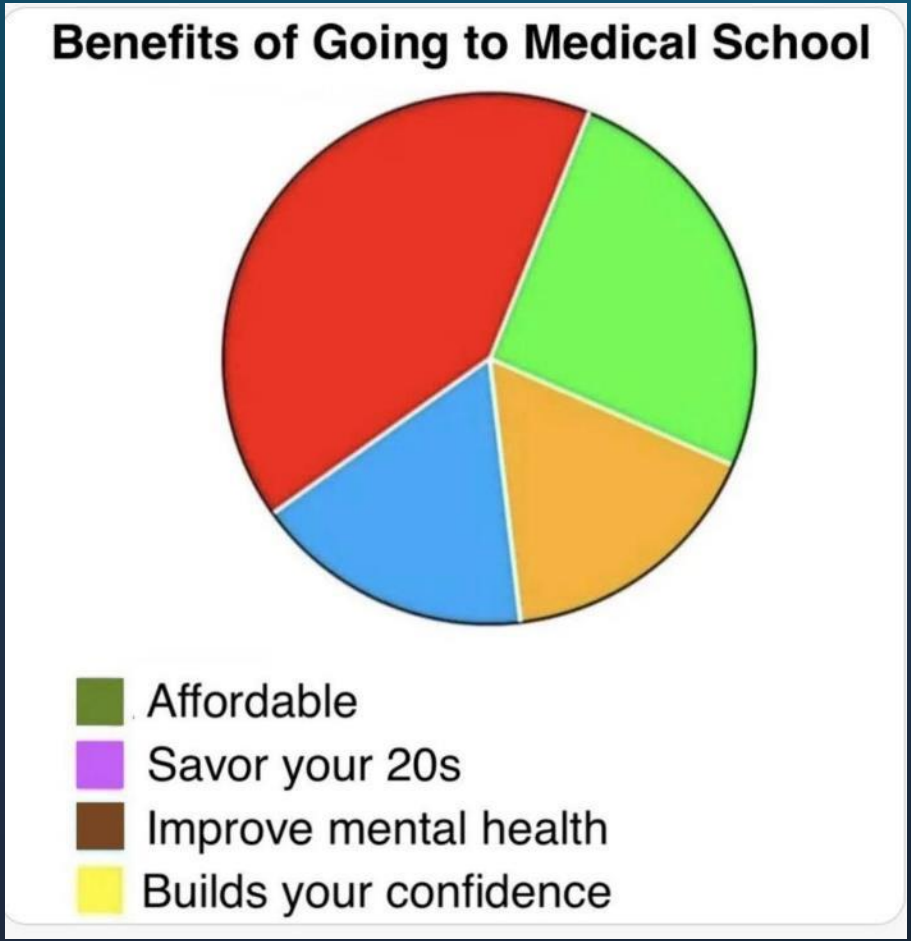
(b) has contravened an order made under this Act,

the director may, by notice in writing given to the person, require the person to pay to the Crown an administrative penalty in the amount set out in the notice.

(2) *The amount of the administrative penalty must not exceed*

(a) ***$10 000 for each contravention****, or*

(b) for a contravention that continues for more than one day, $10 000 for each day or part of a day on which the contravention occurs or continues to a ***total that does not exceed $100 000****.*


Benefits of Going to Medical School
Affordable
Savor your 20s
Improve mental health
Builds your confidence

MHPSR and OUD

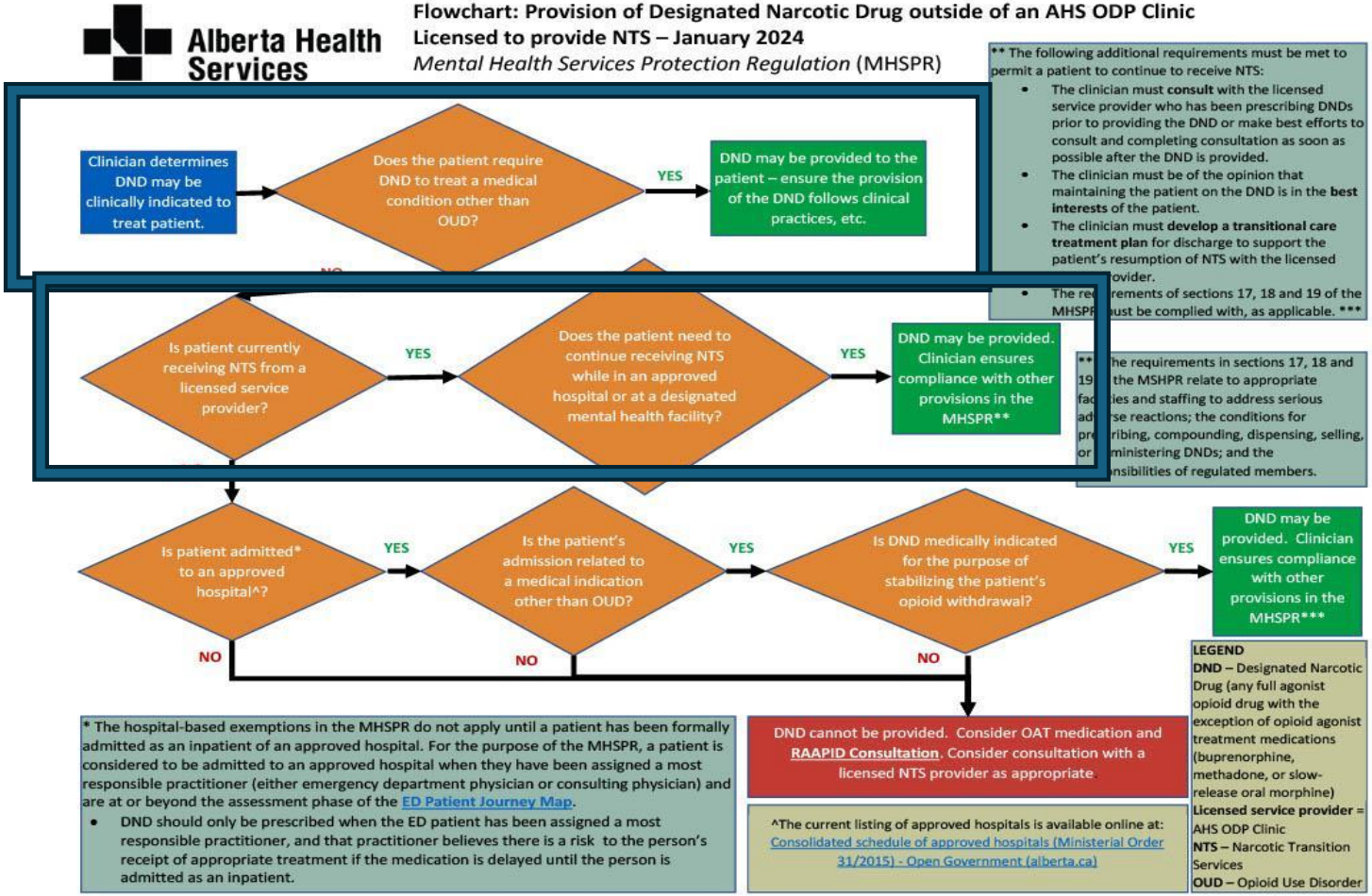
Regulates the prescription of opioids for people with opioid use disorder (OUD)

* Designated Narcotic Drugs (**DND**s): any full agonist opioid medication except methadone or slow release oral morphine (ex. morphine, hydromorphone, fentanyl…)

* **Does not** regulate long-acting Opioid Agonist Treatment (OAT) medications: buprenorphine, methadone or slow-release oral morphine.

* **Does not** regulate short-acting opioids for conditions other than OUD

Slide adapted from Dr. S. Klassen



Hospital Based Exemptions Flow Chart

Narcotic Transition Services (NTS)

- Introduced through an amendment of MHSPR
- Only licensed Recovery Alberta programs can provide NTS
- Use of DNDs (PO, IM, IV)-most often hydromorphone
- For severe OUD who have not been able to initiate or stabilize on oral opioid agonist therapy
- Includes self-administered injectable opioid agonist treatment (iOAT)
- Focus is on transition to opioid agonist therapy

How to identify NTS patients

On Connect Care:

Patient Care Coordination Note

[redacted] Wed 15/Jan/2025 15:50

Client attends Narcotic Transition Services (NTS) at the Opioid Dependency Program (ODP) for **opioid therapy** and case management. Please review the Exceptional Care Plan and call the ODP clinic directly if this client presents for care at any other AHS or Recovery Alberta program, facility, or service. The Exceptional Care Plan contains after hours guidance.

Edmonton ODEAC 106th St
Edmonton ODEAC is open 7 days/week from 0700-1900hr
780-342-7810

On Netcare:

HYDROMORPHONE HP 50 MG/ML VIAL (Hydromorphone HCL/Preservative Free)
Prescribed: 2025-Jan-03 Route: Injection Status: Filled
INJECTABLE OAT JAN 3-28/25: INJECT 160 MG (3.2 ML) IV/IM 3 TIMES DAILY (WITNESSED DAILY)

[redacted] MD)
+1780342-7810
(780) 670-9892
0 Refills

Dispenses:

2025-Jan-19 **HYDROMORPHONE HP 50 MG/ML VIAL**
4 mL for 1 days
INJECTABLE OAT JAN 3-28/25: INJECT 160 MG (3.2 ML) IV/IM 3 TIMES DAILY (WITNESSED DAILY)

Shoppers Drug Mart #6029
(780) 670-9892

NTS Inpatients

Communicate with the community NTS prescriber on admission regarding prescribing community DNDs while admitted (PO/IV/IM hydromorphone).

Can prescribe other DNDs prn

Make a plan for discharge “transitional care treatment plan” back to community to avoid interruptions in NTS

Alberta Health Services

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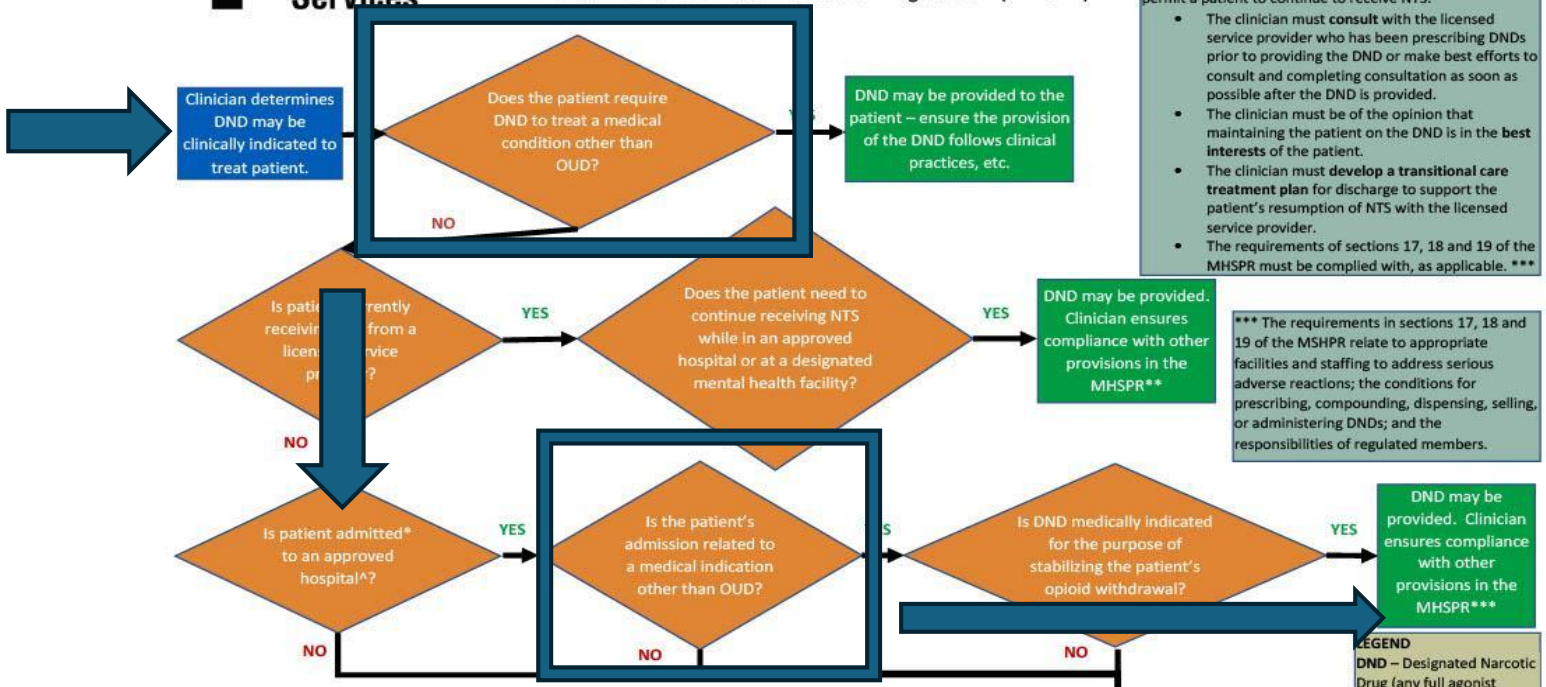
Mental Health Services Protection Regulation (MHSPR)



** The following additional requirements must be met to permit a patient to continue to receive NTS:

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- DND should only be prescribed when the ED patient has been assigned a most responsible practitioner, and that practitioner believes there is a risk to the person's receipt of appropriate treatment if the medication is delayed until the person is admitted as an inpatient.

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Licensed service provider = AHS ODP Clinic

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OUD – Opioid Use Disorder

MHSPR and Inpatient care of OUD

Hospital-based Exemption from the Regulation:

Section 13(c): permits use of DNDs to treat opioid withdrawal IF the patient is admitted for “**other indications”** and will support retention in hospital

MHSPR and Inpatient Care of OUD

What is considered to be "other indications" within the definition of NTS?

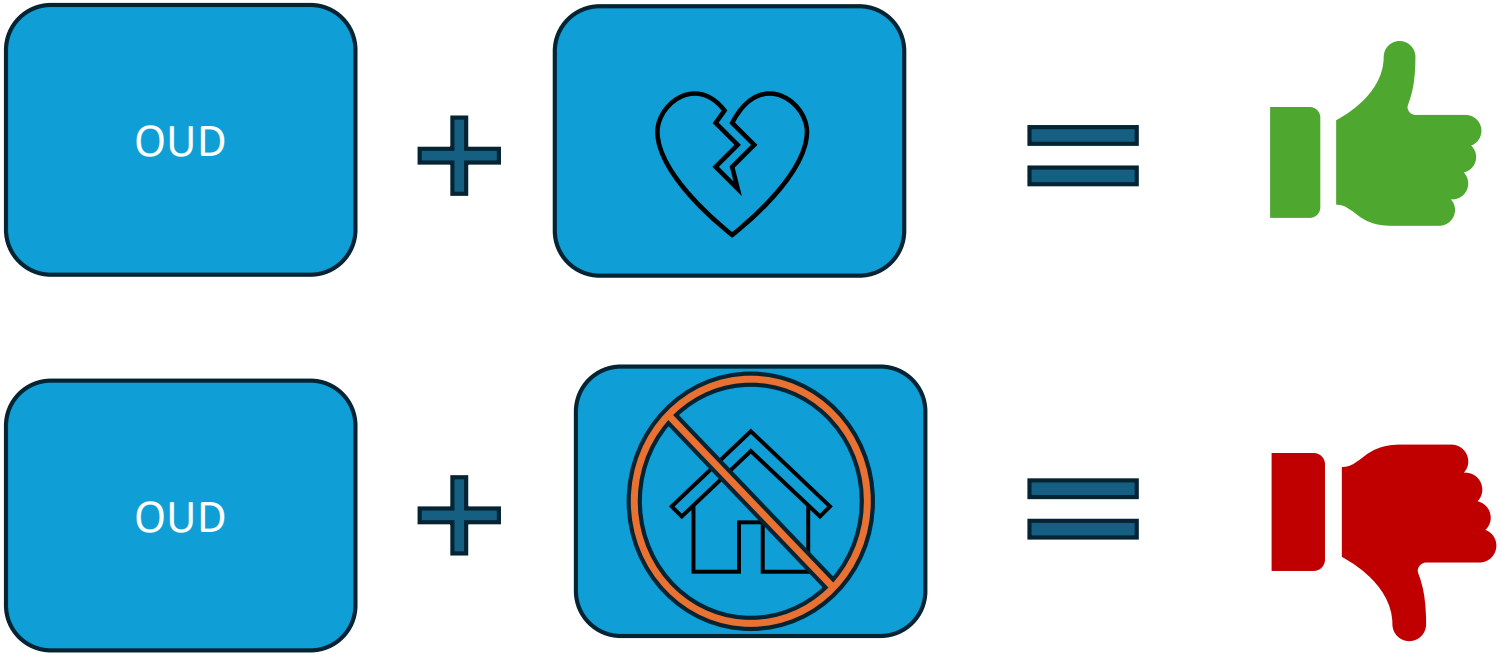
"Other indications" means a medical condition, **other than** an OUD, for which the patient is being treated, including primary and/or comorbid addiction and/or psychiatric disorder(s).

- "Other indications" do not include psychosocial diagnoses (V-Codes).

The following question helps guide practitioners on determining "other indications": *But for the opioid use disorder or psychosocial factors, would this patient be admitted to hospital?*

- If *yes*, then this supports that the patient may qualify for treatment for "other indications".

MHSPR and Inpatient Care of OUD



FAQ Document

if-amh-Hosptial-Based-Exemptions-FAQ-Mental-Health-Services-Protection-Regulation

MHSPR and Inpatient Care of OUD Clinical Scenarios

Meant to provide clarity for Section 13(c): Exemption “for other indications” by providing clinical scenarios

- Not exempt (cannot provide short-acting opioids for opioid withdrawal)
  - Recent and/or recurrent poisonings
  - Psychosocial issues only
- Exempt (can provide short-acting opioids for opioid withdrawal)
  - Opioid poisoning needing care in ED
  - Any symptoms warranting a workup
  - Withdrawal from other substances (ie. Etoh, BDZ)
  - Pregnancy monitoring and/or risk assessment
  - Acute medical or psychiatric conditions
  - Pre-existing medical/psychiatric/developmental conditions that in combination with opioid withdrawal warrant admission
  - FTT

Slide courtesy Dr. S. Klassen

Documentation

Given the October 2022 amendment to the Mental Health Services Protection Regulation (MHSPR), it was discussed with the patient that the provision of short-acting opioids, while hospitalized and undergoing medical treatment, is a temporary measure to help treat opioid withdrawal symptoms and will be discontinued once their symptoms stabilize, and prior to discharge. By default, these are given in liquid form via oral witnessed ingestion.

According to the MHSPR's hospital-based exemptions, this patient is eligible for short-acting opioids to stabilize acute opioid withdrawal because of:

- Acute medical or psychiatric disorder
- Acute pain or symptoms warranting investigation
- Withdrawal from stimulants, benzodiazepines, alcohol or xylazine
- Opioid poisoning requiring ED care
- Pregnancy monitoring and/or risk assessment
- New or pre-existing medical or psychiatric conditions (***) that in combination with opioid withdrawal, increase risk of harm and warrant admission

Alberta Health Services

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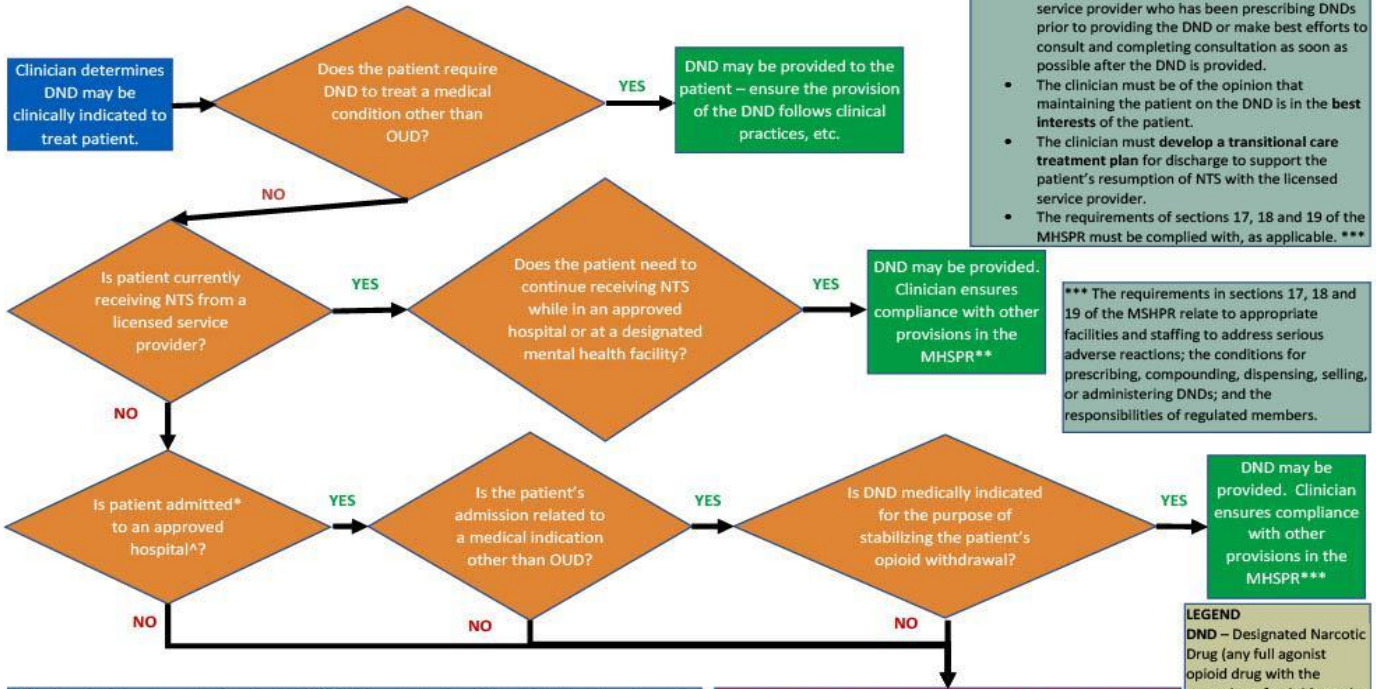


** The following additional requirements must be met to permit a patient to continue to receive NTS:

- The clinician must **consult** with the licensed service provider who has been prescribing DNDs prior to providing the DND or make best efforts to consult and completing consultation as soon as possible after the DND is provided.
- The clinician must be of the opinion that maintaining the patient on the DND is in the **best interests** of the patient.
- The clinician must **develop a transitional care treatment plan** for discharge to support the patient's resumption of NTS with the licensed service provider.
- The requirements of sections 17, 18 and 19 of the MHSPR must be complied with, as applicable. ***

*** The requirements in sections 17, 18 and 19 of the MSHPR relate to appropriate facilities and staffing to address serious adverse reactions; the conditions for prescribing, compounding, dispensing, selling, or administering DNDs; and the responsibilities of regulated members.

* The hospital-based exemptions in the MHSPR do not apply until a patient has been formally admitted as an inpatient of an approved hospital. For the purpose of the MHSPR, a patient is considered to be admitted to an approved hospital when they have been assigned a most responsible practitioner (either emergency department physician or consulting physician) and are at or beyond the assessment phase of the ED Patient Journey Map.

- DND should only be prescribed when the ED patient has been assigned a most responsible practitioner, and that practitioner believes there is a risk to the person's receipt of appropriate treatment if the medication is delayed until the person is admitted as an inpatient.

^The current listing of approved hospitals is available online at: Consolidated schedule of approved hospitals (Ministerial Order 31/2015) - Open Government (alberta.ca)

LEGEND

DND – Designated Narcotic Drug (any full agonist opioid drug with the exception of opioid agonist treatment medications (buprenorphine, methadone, or slow-release oral morphine)

Licensed service provider = AHS ODP Clinic

NTS – Narcotic Transition Services

OUD – Opioid Use Disorder

Specific Patient Scenarios

https://www.ualberta.ca/en/critical-care/index.html

Opioid Withdrawal Management

Opioid Tolerance:

Tolerance level	Average fentanyl use
Low	Non daily use of fentanyl
Low	1-2 “points” (or multiple “hoots”) per day of street fentanyl
Moderate	3-5 “points” daily
High	≥6 “points” daily

*10 points = 1 gram

Patient is in withdrawal

Low Tolerance	2-4 mg liquid hydromorphone (HM) (or 10-20 mg Morphine oral solution) po q3-4 h prn for “pain, cravings, withdrawal”
Moderate Tolerance	4-6 mg liquid HM (20-30 mg MOS) po q2-4h prn
High Tolerance	6-8 mg liquid HM (30-40 mg MOS)po q2-4h prn

- write “witness dosing, do not dose if sedated”
- these doses are conservative, I have low threshold to increase these doses in the quantity, reduce dose interval
- if patient says they are in withdrawal, believe them (I don’t use COWS scores)
- can document pupil size/sweating/piloerection/sedation as non subjective measures of opiate w/d
- remember IM naloxone orders on chart for emergencies
- symptomatic mgmt with loperamide, dimenhydrinate, clonidine (sweating/anxiety), ibuprofen, acetaminophen

Patient delirious or had a seizure?

- Illicit fentanyl is cut with all kinds of substances, including benzos or CNS depressants such as xylazine (and some that we likely cannot detect)
- In heavy daily users, admission to hospital and abrupt cessation of street sourced fentanyl can cause symptoms of benzo withdrawal- delirium, seizures, psychosis
- Keep this in mind if medical work up is negative EVEN with negative urine drug screen

Patient has just overdosed

- Talk to the patient- did they use illicit opioids?
- If so, why aren't they using the prns (DNDs)?
- Does the dose of the prn need to be HIGHER to treat their cravings?
- Do they need to go UP on their opioid agonist treatment?
- How can we support them to not use, or use in a safer way, while admitted?

Patient is sedated

Sedation: is there a medical reason?

Are they using illicit drugs?

If not, and we think the prns are causing sedation, reduce the dose/increase the interval

OAT doses can also be reduced if there's more persistent sedation, but please do so in consultation with an expert.

Patient has Post Op/Acute pain issues

Acute Pain Service involvement early-post op lidocaine/ketamine infusions

People with OUD/and people on bup/nlx generally need higher prn opioid doses for acute pain

Multimodal Pain Mgmt:

- Pregabalin (50mg BID start)
- Gabapentin (100mg TID start)
- Amitriptyline/nortriptyline qhs (25 mg/10mg)
- Nabilone (0.5-1 mg BID, max 2mg TID)
- Duloxetine (30 mg start)
- ATC NSAIDS and Tylenol
- Ketamine po 30 mins prior to dressing changes

Discharge Planning

Credit:mokee81

But I can’t prescribe methadone!

6. A regulated member who TEMPORARILY prescribes OAT for a patient in an inpatient or correctional facility **must**:

   a. prescribe only for the duration of the patient’s stay or incarceration, and **may** prescribe up to the first 120 hours after discharge/release after notifying the patient’s community prescriber;

   b. restrict OAT prescribing to daily, witnessed doses and not provide take-home doses for unwitnessed use;

   c. consult with the patient’s current prescriber or appropriate delegate before making any changes to the OAT prescription, or introducing any new medications with the potential to interact with OAT; and

   d. collaborate with the community prescriber, other regulated health professionals and multidisciplinary team members involved in the patient’s care at transitions between treatment settings.

https://cpsa.ca/wp-content/uploads/2020/05/Safe-Prescribing-for-OUD.pdf

How will I know if they have a community OAT provider?

- Ask the patient
- Check Netcare for recent OAT Rx
- Get help from your team

Kinnon Ross RN BScN BA
Clinical Nurse Educator

What if they don’t have an OAT provider?

▾ Discharge

▾ Discharge Referrals and Teaching

The following link provides information about: Treatment Services for Youth, educational resources, mental health support, information for parents, and information about PChAD.
http://ahsweb.ca/HEE/Treatment_services_for_youth

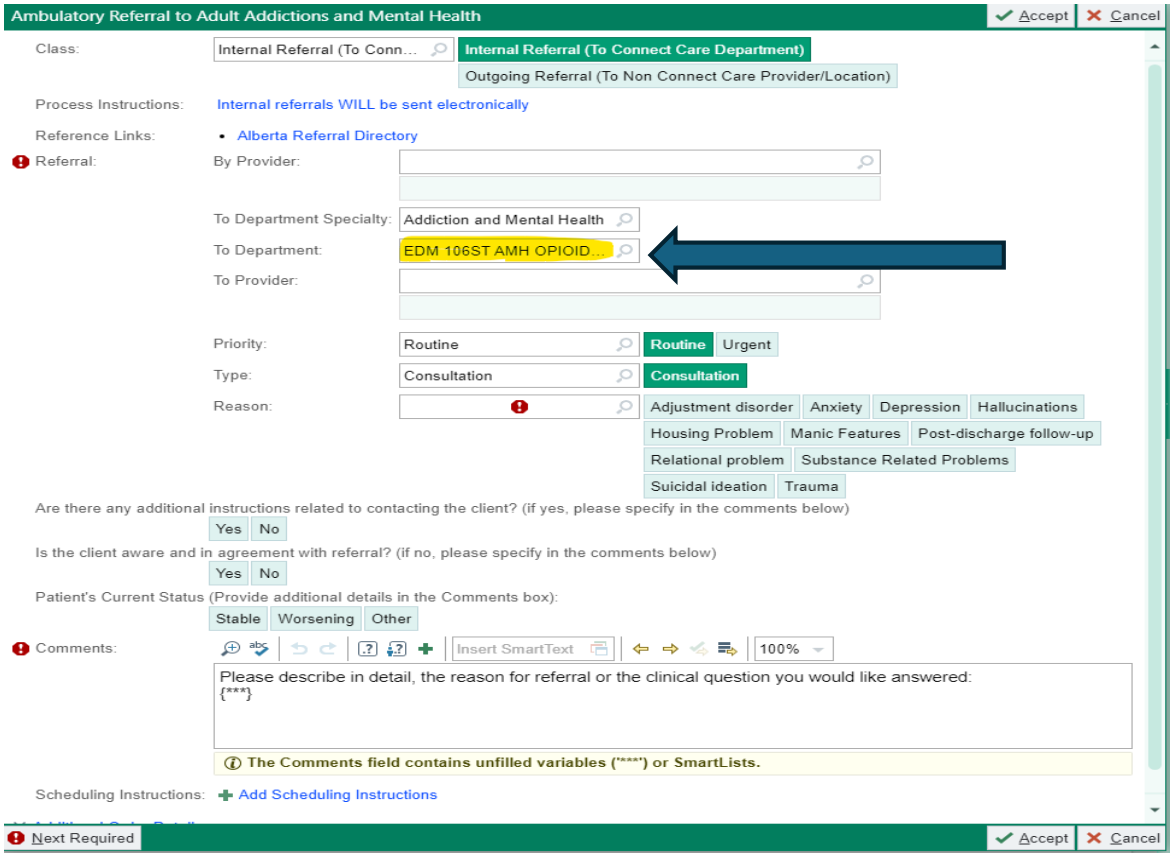
- Calgary Opioid Use Disorder Treatment Clinic Referral Listing
- Edmonton Opioid Use Disorder Treatment Clinic Referral Listing
- North, Central, South Zone Opioid Use Disorder Treatment Clinic Referral Listing
- Buprenorphine/Naloxone (Suboxone®) Initiation in Emergency Departments/Urgent Care Centres Referral

☐ Ambulatory Referral to Adult Addictions and Mental Health

Edmonton OUD treatment referral listing

Edmonton Opioid Dependency Program (AHS ODP) Strathcona Phone: 780-405-8193 Fax: 780-342-7826	Unit 1A-301, Strathcona Community Hospital, 9000 Emerald Drive, Sherwood Park, AB, T8H 0J3 **Open Wednesday by appointment only.** This is a satellite location of the Edmonton Opioid Dependency Program (AHS ODP) Downtown (see above).
Ideal Medical Center Phone: 780-756-1234 Fax: 780-756-7562	12147, 82nd Street NW, Edmonton, AB, T5B 2W8 www.idealmedical.ca **Open Monday to Thursday from 9:00am to 5:00pm and Saturday from 10:00am to 2:00pm.** If the clinic is closed, including on a statutory holiday, patients can be referred to the Virtual Opioid Dependency Program (see above).
Metro City Medical Clinic Edmonton Phone: 780-429-3991 Fax: 780-429-3988	10419, 102nd Avenue, Edmonton, AB, T5J 0B4 www.metrocitymedicalclinic.ca **Open Monday to Friday from 9:00am to 4:00pm, and Saturday and Sunday from 9:00am to 1:00pm.** If the clinic is closed, patients can present to the co-located pharmacy for bridging doses until the clinic is open.
Savera Medical Centre Phone: 780-761-6767 Fax: 780-761-6769	2nd floor, 6730 75th Street NW, Edmonton, AB, T6E 6T9 www.saveramedicalcentre.ca **Open Monday to Friday from 9:00am to 5:00pm and Saturday, Sunday, and statutory holidays from 10:00am to 2:00pm.** If the clinic is closed, patients can be referred to the Virtual Opioid Dependency Program (see above).

Ambulatory Referral to AMH



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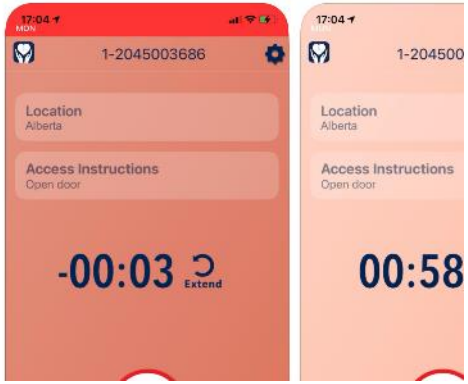
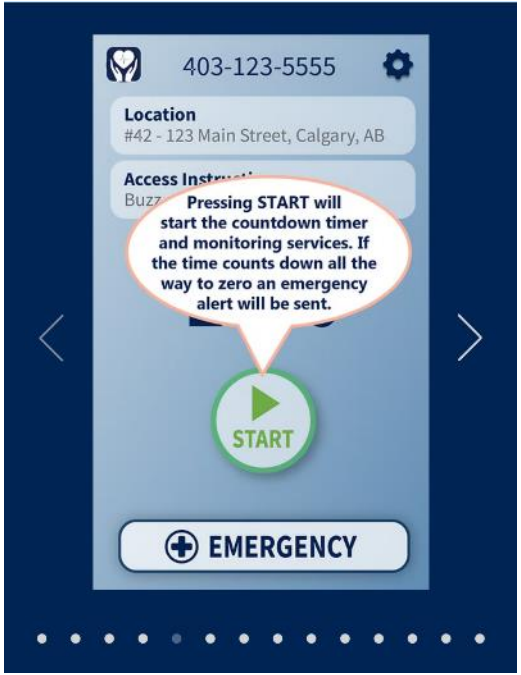
Version 1.4.1 — 2y ago

Bug fixes and performance improvements

Preview





Your Friendly Neighbourhood Radius Providers

MDs:
Sara Axford
Cameron Barr
Nancy Easton
Jonathan Hesje
Jess Kirkwood
Linda Lam
Tally Mogus
Francesco Mosaico
Aulora Oleynick
Mat Rose
Bailey Sorochan
Niran Vijayaratnam

Radius
Compassionate care without barriers

NPs:
Ashley Devenney
Amy Nihls
Sandi Schaefer
Paola Yip

RPh:
Andrew Noh

Phone:
780-422-7333


WORD
TO YOUR
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EARTH

Questions?