



# ACFP Opioid Crisis Response

Task Force  
Recommendations



ALBERTA COLLEGE of  
FAMILY PHYSICIANS

*Advancing excellence in family practice*

## How to use this document:

The following pages represent eight areas of our system that influence the care of patients with chronic pain, on opioid treatment, with opioid dependency, or opioid use disorder.

On each page the five patient profiles represent an increase in risk, complexity, and level of care needed.

The format of this document is meant to depict that a patient can move up the scale of risk if not managed well.

If you provide care or have the ability to influence how care is provided through your advocacy, leadership, education, or research, we ask that you use this document to inform your approach.

*The ACFP Opioid Crisis Response Task Force*

# The Opioid Crisis and Family Medicine

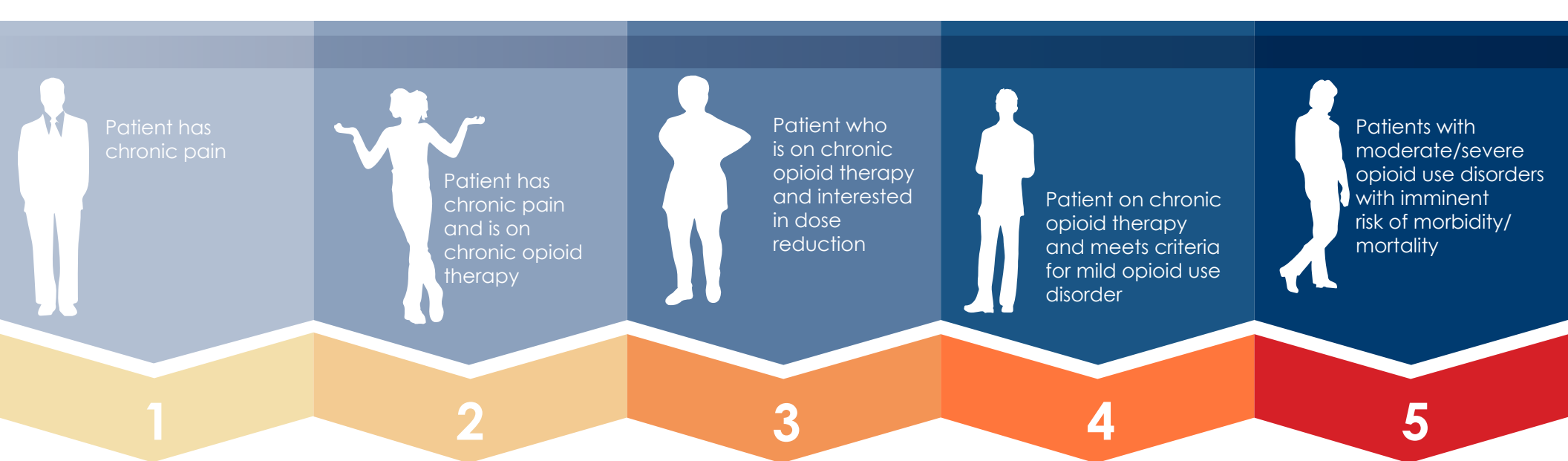
In Alberta there were 343 deaths in 2016 from apparent drug overdose due to fentanyl compared to 257 deaths in 2015. Of those, 89% occurred in large urban centers but 85% were outside of the urban core. From 2014 to 2016 the amount of opioids dispensed from community pharmacies increased by 23% to approximately 1,034,000 in Q4 of 2016. (Taken from the Alberta Health, Opioids, and Substances of Misuse Report, 2016 Q4)

The opioid crisis in Alberta and across Canada has shone a light on how opioids are prescribed and monitored in health care. There is an increased scrutiny of the need for opioids, opioid safety, and monitoring of chronic opioid therapy. There also is an increased understanding of the risks and complications of long-term opioid therapy, such as development of opioid dependency, opioid use disorders, and resulting increased rates of morbidity and mortality.

Family physicians are often times the entry point for people into the health care system whether it be through the Patient's Medical Home or family practice clinic, or an episode requiring emergent care where a family physician treats them. By virtue of a family physician's role, they are often asked to support patients who suffer from acute or chronic pain and may require pharmacological treatment such as opioids and other alternative treatments. As well, patients are approaching their family physicians to support them through reducing their dosage of opioids, providing access to opioid replacement therapy, and the ongoing maintenance of their successful dependency treatment program.

The formation of the Alberta College of Family Physicians' Opioid Crisis Response Task Force in December of 2016 exemplifies the desire of family physicians to communicate the barriers they encounter when serving their patients with complex chronic conditions, and to provide recommendations for solutions to the opioid crisis and chronic disease management. The Task Force is comprised of a variety of family physicians working in high risk communities, chronic pain management, palliative care, comprehensive family practice, and emergency rooms. It is the vision of the Task Force to advocate and develop strategies for minor adjustments in provision of services to drastic systemic changes that will support better and more comprehensive care for their patients and, ultimately, reverse the trajectory of the opioid crisis.

We ask that you please consider the following recommendations based on evidence, experience, and dedication of family physicians who have served patients in this realm.



 Patient has chronic pain

1

Patient is formally attached to a Patient's Medical Home, with a family physician and access to multi-disciplinary team support.

Optimize treatment strategies of pharmacological therapy with non-opioid agents and non-pharmacological therapies (physiotherapy, massage therapy, acupuncture, exercise, etc).

Discuss patient self-management as the guiding treatment principle.

Discuss function-optimization as the goal of treatment.

Patient-centred education and counselling around disease expectation and their illness experience of chronic pain.

 Patient has chronic pain and is on chronic opioid therapy

2

Patient is formally attached to a Patient's Medical Home, with a family physician and access to multi-disciplinary team support.


Access to timely consultation with chronic pain specialists, as needed.

Initiation of opioids following:

- Informed consent around the risks and complications of potential long-term opioid use,
- Documented addiction assessment, using a validated addiction screening tool,
- Informed by clinical context and guidelines with respect to palliative and cancer care, and non-cancer chronic pain.

PMH team monitors and supports patient through ongoing assessment of opioids and chronic pain, including:

- Functional assessment at every visit,
- Medication review through NetCare, medication use patterns, medication seeking-behaviours,
- Review of non-pharmacologic and self-management strategies.

 Patient who is on chronic opioid therapy and interested in dose reduction

3

Patient is formally attached to a Patient's Medical Home, with a family physician and access to multi-disciplinary team support.

Team trained and supported to offer buprenorphine/naloxone (Suboxone) or methadone prescribing including the availability of psychological counselling and supports.

Approach down-titration slowly using established evidence-based guidelines and best practices.

Anticipate worsening of underlying chronic pain, and support withdrawal symptoms with non-opioid therapies.

Access to timely consultation with addiction specialists, as needed.

Continue to support the non-pharmacological and self-management strategies in chronic pain.

 Patient on chronic opioid therapy and meets criteria for mild opioid use disorder

4

Patient is formally attached to a Patient's Medical Home, with a family physician and access to multi-disciplinary team support.

Engaging patient using principles of motivational interviewing and trauma-informed care to understand any resistance to change with respect to chronic opioid therapy.

Offer opioid substitution therapy with either methadone or buprenorphine/naloxone (Suboxone).

Interdisciplinary care with mental health specialists to address the psychosocial aspects of chronic pain and opioid use disorders.

Chronic opioid dependency treatment offered and either referral or treatment is repeatedly offered.

Ongoing prescribing using a harm reduction approach.

Timely consultation or referral is available from chronic pain specialists and opioid dependency treatment clinic/specialists.

 Patients with moderate/severe opioid use disorders with imminent risk of morbidity/mortality

5

Patient is formally attached to a Patient's Medical Home, with a family physician and access to multi-disciplinary team support.

Principles used to engage patient in care:

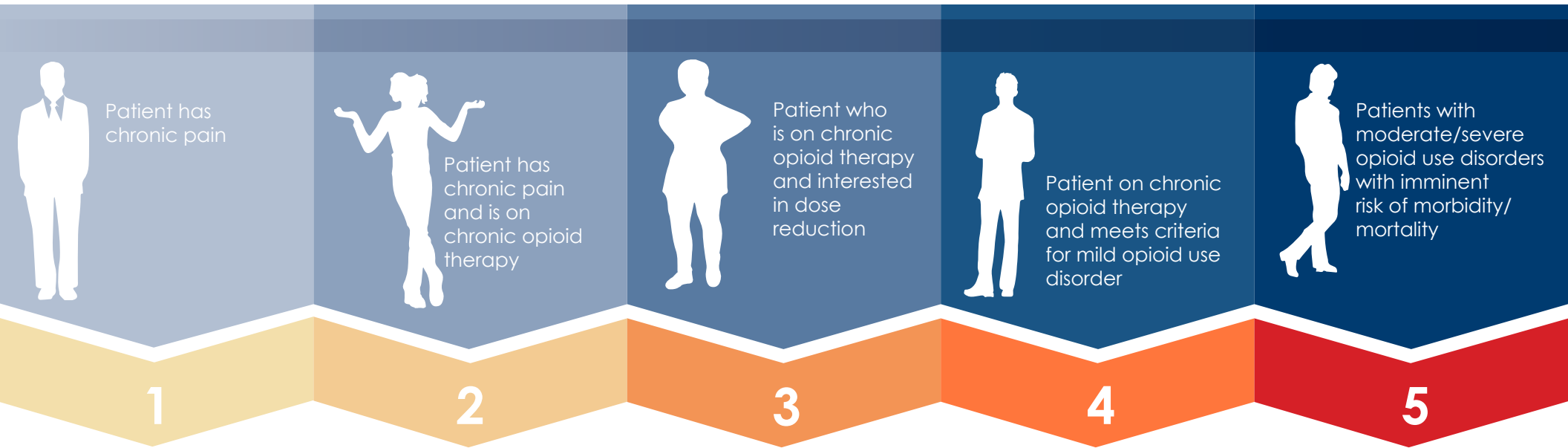
- harm reduction: provision of Take Home Naloxone Kit, referral to medical detox facilities, ensuring access to safe consumption sites where possible and supplies, etc.,
- trauma-informed care,
- motivational interviewing.

MUST offer opioid substitution therapy with either methadone or buprenorphine/naloxone (Suboxone), with referral to opioid dependency programs.

Offer management of acute withdrawal symptoms with pharmacological therapies.

Offer mental health supports, with specific focus on supports in the domains of social, financial, occupational, justice, and basic material needs.

Timely consultation or referral is available from chronic pain specialists and opioid dependency treatment clinic/specialists.



Primary Care Networks and Health Zones fully support—through funding, staff, promotion, and communication—the recommendations listed in the previous section on the Patient's Medical Home and community.

As part of the chronic disease management mandate of the Primary Care Networks and Zones, the Patients Medical Home multi-disciplinary teams (family physician clinics) have access to resources for the treatment of patients with chronic pain including motivational interviewing, massage therapy, physiotherapy, acupuncture, exercise, etc.

Primary Care Network and Health Zone facilitate linkages to local chronic pain specialist consultation and training as needed.

Primary Care Networks and Health Zones fully support—through funding, staff, promotion, and communication—the recommendations listed in the previous section on the Patient's Medical Home and community.

Ongoing support for patient screening, education, initiation, monitoring, and support within Primary Care Network services, Health Zone, and community for patients on chronic opioid therapy.

Primary Care Network and Health Zone facilitate linkages to local chronic pain specialist consultation and training as needed.

Primary Care Networks and Health Zones fully support—through funding, staff, promotion, and communication—the recommendations listed in the previous section on the Patient's Medical Home and community.

Funding required for provision of shared services for family physician clinics and teams such as:

- Pharmacists,
- Addictions counsellors,
- Supervised site for opioid dependency treatment,
- 24/7 phone or online support for patients on opioid dependency treatment.

Formal or informal mentorship with physicians and providers within the Primary Care Network and Health Zone to support dose reduction or replacement therapy through shadowing and consultation services.

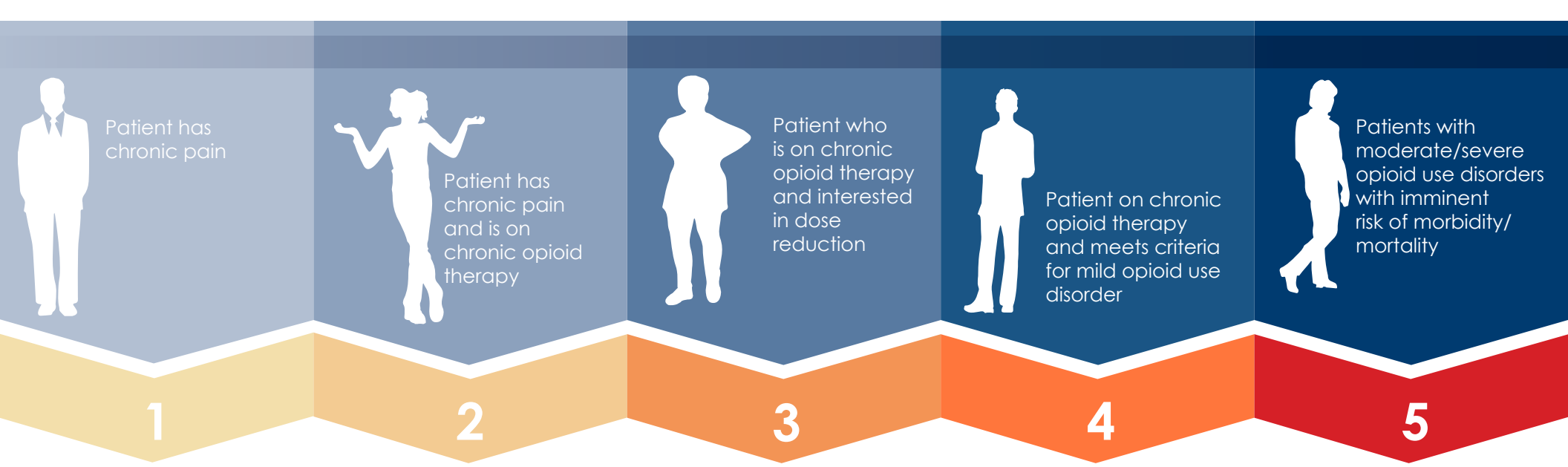
Primary Care Networks and Health Zones fully support—through funding, staff, promotion, and communication—the recommendations listed in the previous section on Patient's Medical Home and community.

Facilitate access to local counselling services and treatment centres for patients who are looking for help.

Support local strategies to reach out to the patients who are resistant to change.

Primary Care Networks and Health Zones fully support—through funding, staff, promotion, coalition building, and communication—the recommendations listed in the previous section on Patient's Medical Home and community.

Recognizing that this is a particularly vulnerable population with specialized needs, the Primary Care Networks will support communities of practice to care for their patients with a trauma-informed approach and intentional staffing.



Develop and deliver primary care-based Continuing Professional Development (CPD) using evidence-based and best practice processes that is informed by guidelines and standards such as Guidelines for Chronic Non-Cancer Pain Management, the Pain Society of Alberta, and College of Physicians and Surgeons of Alberta (CPSA) including:

- Neurobiology of chronic pain,
- Initial assessment of chronic pain,
- Best practices in follow up assessment in chronic pain,
- Pharmacology review of non-opioid agents in chronic pain.

Dedicated primary care based CPD that builds competency around:

- Addressing the psychosocial impacts of chronic disease/chronic pain,
- Using motivational interviewing techniques to engage patients in active self-management of their chronic condition,
- Communication and counselling strategies for patients to help build an understanding of disease, and manage expectations around medications and functional optimization,
- Awareness of non-pharmacological strategies for management of chronic pain (i.e. physiotherapy, occupational therapy, interventional pain management, etc.), and integration of these modalities in approach to chronic pain management.

Develop and deliver primary care-based CPD using evidence-based and best practice processes that is informed by guidelines and standards such as Guidelines for Chronic Non-Cancer Pain Management, the Pain Society of Alberta, and CPSA including:

- Indications for initiation of opioids in chronic pain management,
- Setting minimum standards of clinical assessment and documentation for initiation of opioids on chronic pain management,
- Setting minimum standards of clinical re-assessment for opioid use and chronic pain management.

Dedicated primary care based CPD that builds competency around the evidence of opioid use in chronic pain management including:

- Common side effects of opioid therapy,
- Monitoring of opioid therapy,
- Common signs and symptoms of opioid use disorder, differentiation from "pseudoaddiction" and poorly controlled chronic pain syndrome,
- Utility of urine drug screens on the monitoring of chronic opioid therapy,
- Practice tools in chronic opioid therapy (i.e. use of medication agreements, consent to share information with pharmacy, etc.).

Develop and deliver primary care-based CPD using evidence-based and best practice processes that is informed by guidelines and standards such as Guidelines for Chronic Non-Cancer Pain Management, the Pain Society of Alberta, and CPSA including:

- Appropriate management of opioid dose reduction,
- Anticipation of symptoms requiring medication management during opioid dose reduction.

Dedicated primary care based CPD that builds competency around:

- The utility of opioid substitution therapy (methadone, buprenorphine/naloxone) to assist patients in tapering from high dose chronic opioid therapy.

Develop and deliver primary care-based CPD using evidence-based and best practice processes that is informed by guidelines and standards such as Guidelines for Chronic Non-Cancer Pain Management, Canadian Society of Addiction Medicine, the Pain Society of Alberta, and CPSA.

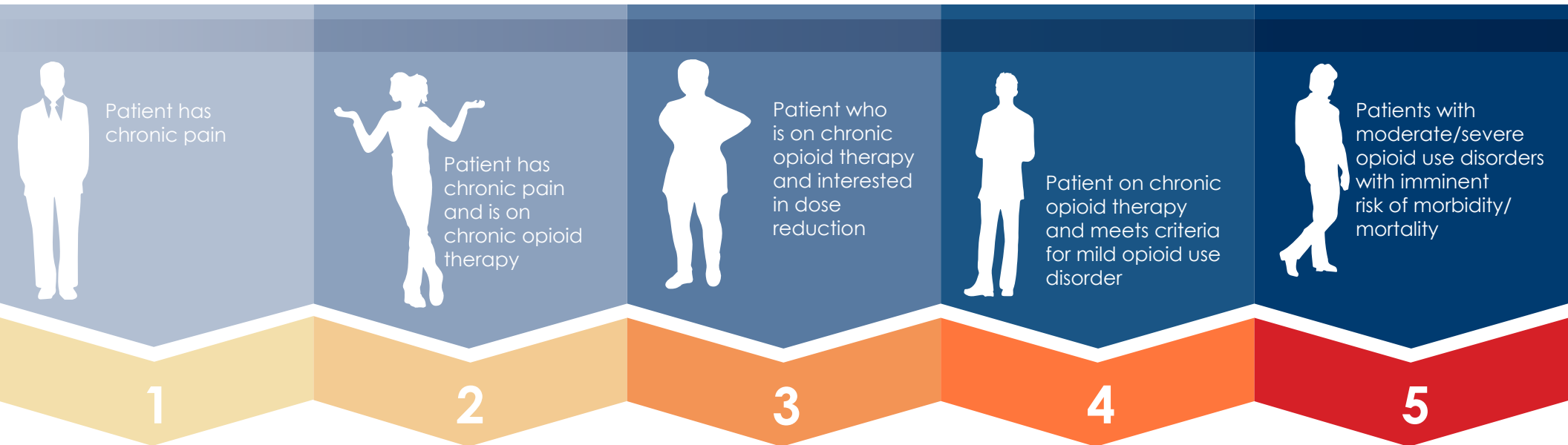
Dedicated primary care based CPD that builds competency around:

- Use of motivational interviewing to understand any resistance to treatment and patient engagement in care in chronic pain management,
- Assessment and diagnosis of opioid use disorders, based on DSM-V criteria,
- Safety strategies in prescribing high dose chronic opioid therapy,
- Trauma-informed care.

Develop primary care-based CPD using evidence-based and best practice processes that is guided by policies and guidelines produced by the Canadian Society of Addiction Medicine, Alberta Health Services, and CPSA.

Dedicated primary care based CPD that builds competency around:

- assessment and diagnosis of opioid use disorders, based on DSM-V criteria,
- harm reduction: Counselling for patients,
- evidence for effectiveness for Opioid Substitution Therapy (methadone, buprenorphine/naloxone),
- pharmacological management of opioid withdrawal/detoxification,
- drug-drug interactions between illicit substances and medical disorders, in the setting of polysubstance use,
- use of trauma-informed care and motivational interviewing in assessment of patient with opioid use disorder,
- awareness of social agencies and government assistance programs for patients as they engage with addictions programs,
- awareness of and referral to Addictions Programming locally and provincially, tailored to patient's health values and priorities.



Dedicated resources to timely inventory of evidence regarding best and promising practices.

Identify gaps for family physicians and allied health providers in the delivery of chronic pain care in community and address them in a timely matter.

Circulate and refer family physicians to existing evidence-based guidelines and tools available.

Family physicians collaboratively create or promote existing effective acute and chronic pain tools and guidance documents for use in a primary care setting based on best evidence and new National guidelines.

Create online resource page that offers links and tools to be used in a primary care setting for pain management.

Create tools that increase health literacy and self-management knowledge for patients.

Circulate and refer family physicians to existing guidelines and tools available.

Family physicians collaboratively create new or promote existing effective chronic opioid therapy tools and guidance documents for use in a primary care setting based on best evidence and new national guidelines.

Create online resource page that offers links and tools to be used in a primary care setting for pain management including opioid therapy.

Create tools that increase health literacy and self-management knowledge for patients.

Promote that the CPSA no longer requires physicians to complete a course on buprenorphine/naloxone prescribing in order to start a patient on opioid replacement therapy.

Circulate and refer family physicians to existing guidelines and tools available.

Family physicians collaboratively create new opioid replacement therapy tools and guidance documents for use in a primary care setting based on best evidence and new national guidelines.

Create online resource page that offers links and tools to be used in a primary care setting for pain management including opioid therapy.

Distribute and create CPD on the new Standard of Practice on Drugs of Potential Abuse/Misuse and the requirements placed on physicians.

Create tools that increase health literacy and self-management knowledge for patients.

Enhance and support the diagnosis of and intervention for addiction in primary care.

Create or adapt cost-effective, practical, and validated tools and resources for early identification, screening, and intervention in a primary care setting.

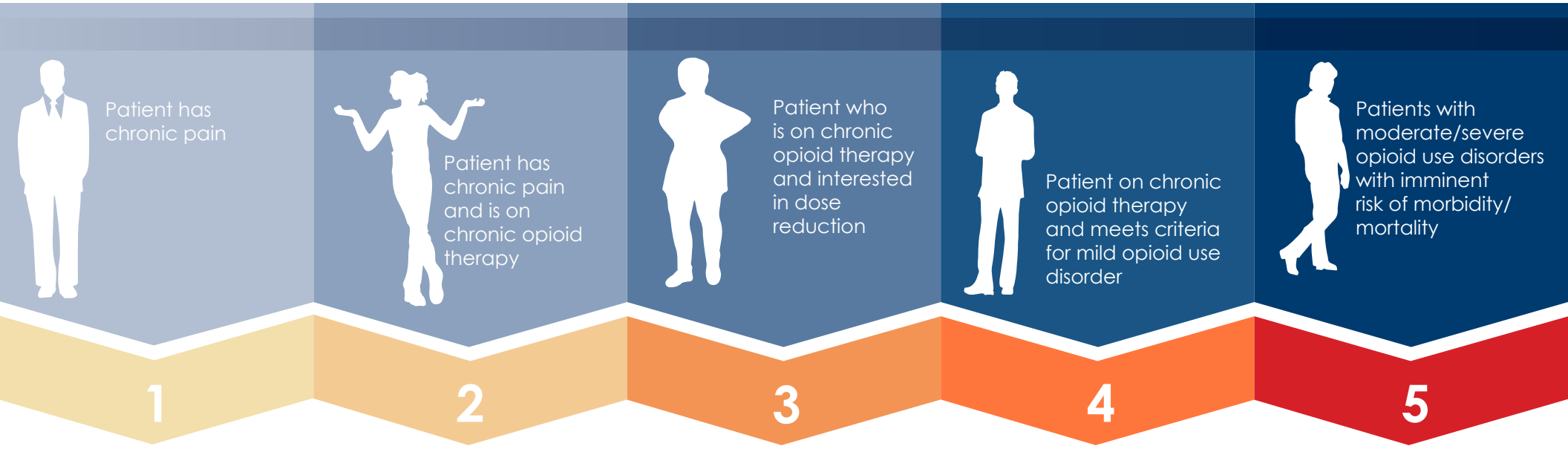
Promote and translate available harm reduction prescribing guidelines.

Create and implement a "Talk to Me" multi-dimensional public awareness campaign with targeted tools for use in primary care such as coaching techniques and scripts for family physician teams to be used at the point of care.

Create tools that increase health literacy and self-management knowledge for patients.

Knowledge translation, tools, and guidelines to support safe, involuntary tapering in high risk situations.





Postgraduate Family Medicine provides training in safe and appropriate opioid prescribing through dedicated academic sessions.

Residents attend the Chronic Pain Clinic for their Ambulatory Clinical Experiences.

Residents are exposed to pain management through all of their clinical rotations, including in their home family medicine clinics, in emergency room, urgent care, internal medicine, etc.

Postgraduate Family Medicine provides training in safe and appropriate opioid prescribing through dedicated academic sessions.

Residents attend the Chronic Pain Clinic for their Ambulatory Clinical Experiences.

Residents are exposed to pain management and chronic opioid therapy through all of their clinical rotations, including in their home family medicine clinics, in emergency room, urgent care, internal medicine, etc.

Residents receive training in addictions medicine through a series of Ambulatory Clinic Experiences and attendance at the Opioid Dependency Clinic in Calgary.

Substance abuse to be covered in the undergrad curriculum during the "communications" course as a curriculum objective in the family medicine clerkship rotation and during this rotation the expectation that students are exposed to substance abuse in clinic.

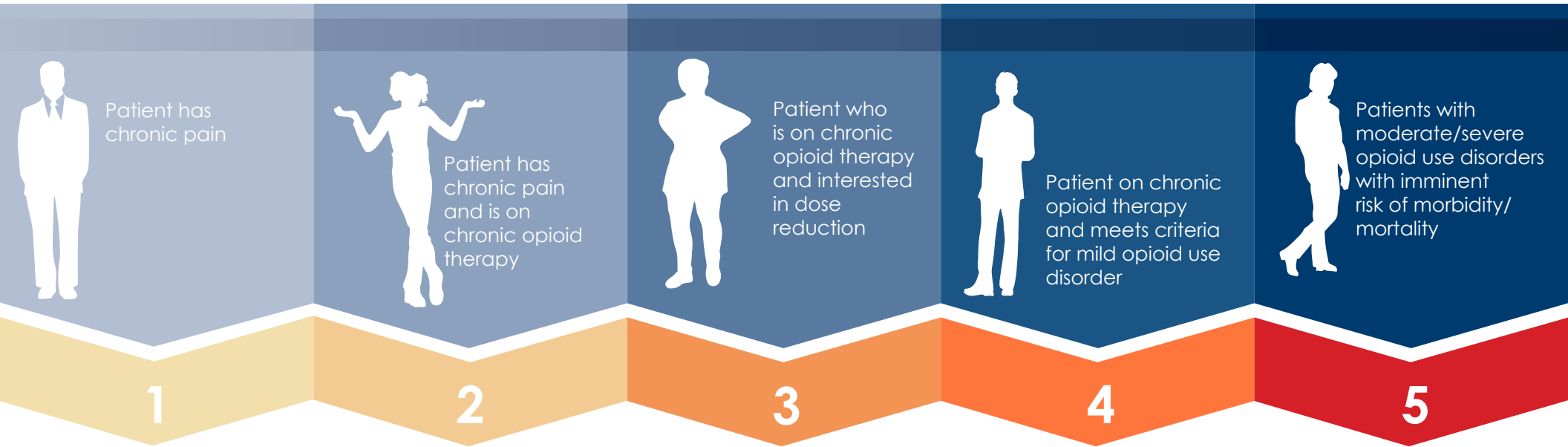
All preceptors need to be reminded that opioid management is a curriculum objective and to include time and teaching around opioid use disorder.

The College of Family Physicians of Canada add questions focusing on opioid use disorder to the family medicine exam.

Where residents see themselves working in a population requiring enhanced skills in this area, recommend the 1-year R3 Enhanced Skills Program in Addictions Medicine.

All medical students are required to attend the population health course delivered on addictions and homelessness theme.

Improved supports of community preceptors so students have better exposure to this vulnerable population in a community setting.



 Patient has chronic pain

1

Primary Care Networks and Health Zones collaborate to provide access to non-pharmacological treatments and supports for patients with chronic pain in the Patient's Medical Home or community where possible.

Work with Pain Society and Section of Chronic Pain to ensure awareness and alignment on appropriateness and alternative treatments.

Family Physicians lead the work with the Strategic Clinical Networks in creating pain management care pathways for patients in collaboration with the multi-disciplinary primary care team members and specialists in the respective Strategic Clinical Network.


 Patient has chronic pain and is on chronic opioid therapy

2

Primary Care Networks and Health Zones collaborate to provide access to non-pharmacological treatments and supports for patients with chronic pain in the Patient's Medical Home or community where possible.

Work with Pain Society and Section of Chronic Pain to ensure awareness and alignment on appropriateness and alternative treatments.

Family Physicians lead the work with the Strategic Clinical Networks in creating pain management and chronic opioid therapy care pathways for patients in collaboration with the multi-disciplinary primary care team members and specialists in the respective Strategic Clinical Network.

 Patient who is on chronic opioid therapy and interested in dose reduction

3

Host collaborative planning sessions on opioid management in primary care with all stakeholders and organizations represented.

Work with the College of Pharmacists:

- To ensure capacity/preparedness of community pharmacies to support opioid replacement therapy prescriptions and prescribers,
- Provide a listing of all pharmacists in Alberta that will dispense methadone and buprenorphine/naloxone on a daily basis and are open 7 days a week,
- Provide a list of 'expert' pharmacists that could be available to consult with physicians on opioid replacement therapy issues for specific patients or in general.

 Patient on chronic opioid therapy and meets criteria for mild opioid use disorder

4

Work together with organizations developing harm reduction programs including safe consumption sites and harm reduction housing.

Work with the Strategic Clinical Network that are creating mental health and addiction care pathways for patients in their clinical areas to ensure that a primary care pathway is developed by family physicians and teams working in a primary care setting.

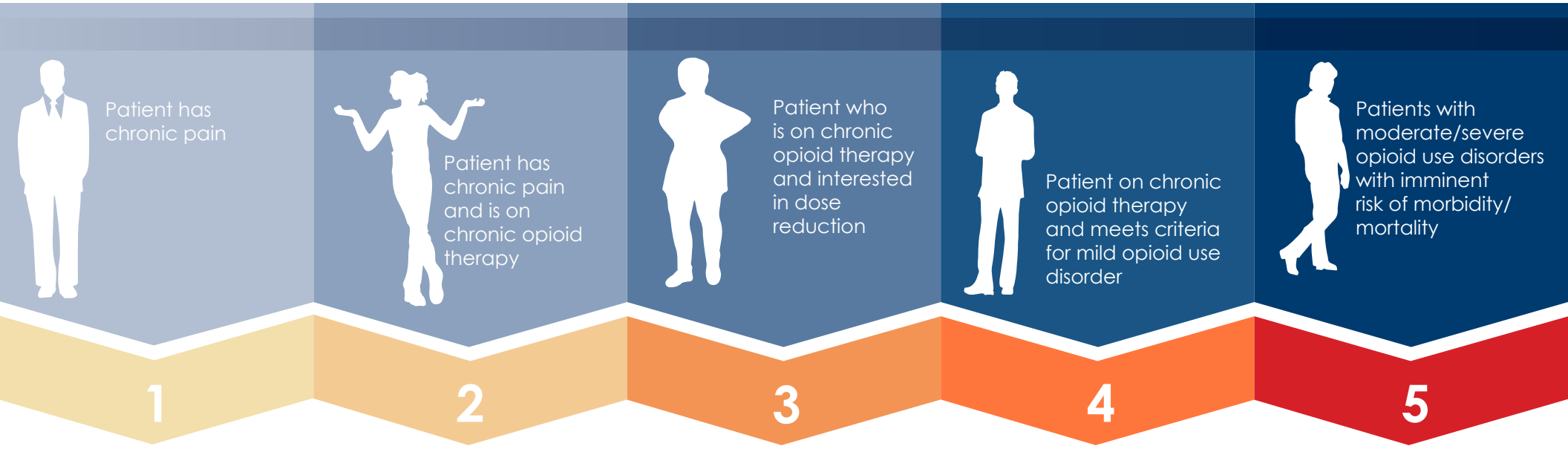
 Patients with moderate/severe opioid use disorders with imminent risk of morbidity/mortality

5

Support and promote knowledge and referral systems for programs liaising between primary community care and acute care for high-risk, high system users. (In Calgary, for example, this work is done by Connect2Care, the Downtown Outreach Addictions Partnership team, the EMS City Centre Community Paramedics team, the Street CCRED (Community Capacity, Research, Education and Development) Collaborative, and housing agency staff and case, and housing agency staff and case management.)

Collaborate with organizations representing and with influence in mental health supports, and supports in the domains of social, financial, occupational, justice, and basic material needs.





Educate public on the value of being formally attached to a Patient's Medical Home, with a family physician and access to multi-disciplinary team support.

Educate the public and patients regarding the value of treatment strategies of pharmacological therapy with non-opioid agents, and non-pharmacological therapies (physiotherapy, massage therapy, acupuncture, exercise, etc).

Educate patients with self-management as the guiding treatment principle and that function-optimization is the goal of treatment.

Patient-centred education and counselling around disease expectation and their illness experience of chronic pain.

Educate public on the value of being formally attached to a Patient's Medical Home, with a family physician and access to multi-disciplinary team support.

Educate the public and patients regarding the value of treatment strategies of pharmacological therapy with non-opioid agents, and non-pharmacological therapies (physiotherapy, massage therapy, acupuncture, exercise, etc).

Educate patients with self-management as the guiding treatment principle and that function-optimization is the goal of treatment.

Patient-centred education and counselling around disease expectation and their illness experience of chronic pain.

Educate public so addiction/opioid dependence is recognized more as an illness and patients are encouraged to get proper treatment, rather than being stigmatized/negatively viewed and more likely to use in secret and avoid getting assistance.

Education around how/where people with addiction/dependence problems can get help.

Public education involves aspects of anti-stigma campaigns so that addiction/opioid dependence is recognized more as an illness and patients are encouraged to get proper treatment, rather than being stigmatized/negatively viewed and more likely to use in secret and avoid getting assistance.

Educate the public that harm reduction saves lives and that they can be a part of that strategy.

Reduce stigma so that saving lives of those with addiction/dependence is seen as a valid goal rather than just law enforcement approaches.

Create a "Talk to Me" public awareness campaign that encourages patients to connect with their family physician about their concerns utilizing commercials, web ads, social media and other methods to reach patients, families, and care givers.

Create an online navigation system for at risk patients (like Medical Assistance in Dying.)

Public education involves aspects of anti-stigma campaigns, so that addiction/opioid dependence is recognized more as an illness and patients are encouraged to get proper treatment, rather than being stigmatized/negatively viewed and more likely to use in secret and avoid getting assistance.

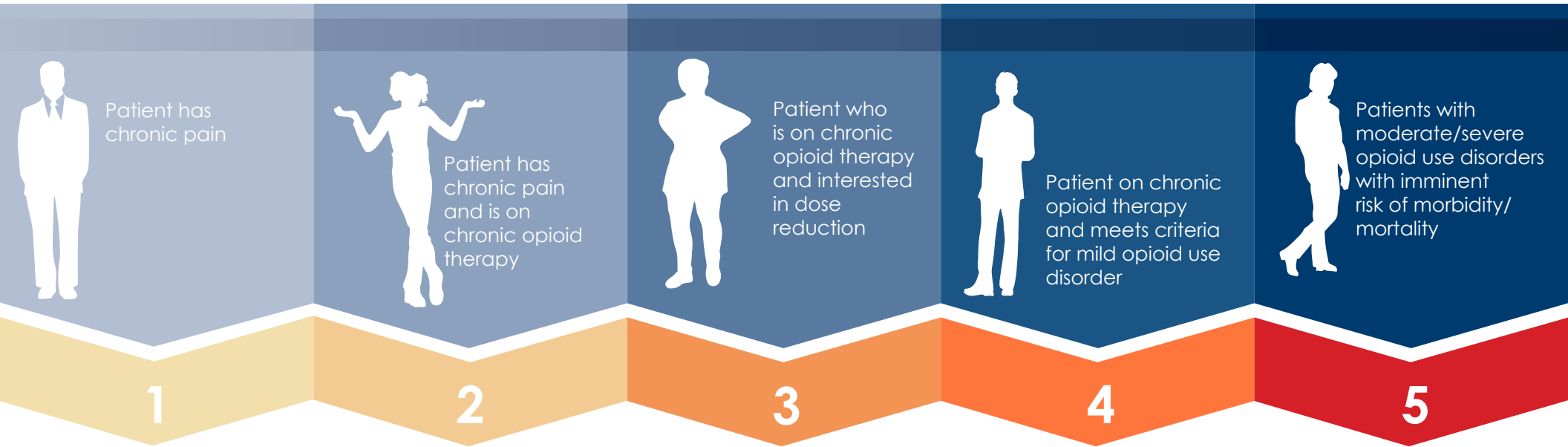
Educate the public that harm reduction saves lives and that they can be a part of that strategy.

Reduce stigma so that saving lives of those with addiction/dependence is seen as a valid goal rather than just law enforcement approaches.

Create a "Talk to Me" public awareness campaign that encourages patients to connect with their family physician about their concerns utilizing commercials, web ads, social media, and other methods to reach patients, families, and care givers.

Create an online navigation system for at risk patients (like Medical Assistance in Dying.)

# Public Education



Family physicians to be funded to create the primary care pathways for chronic pain in collaboration with specialists.

Advocate for additional resources and supports in family physician clinics and Primary Care Networks to support pain management in community.

Work with Pain Society and Section of Chronic Pain to ensure awareness and alignment on appropriateness and alternative treatments.

Amend prescribing or adopt new billing codes to reflect effort and time for managing opioid replacement therapy in primary care including dialogue with the patients and their multi-disciplinary care providers.

Advocate for additional resources and supports in family physician clinics and Primary Care Networks to support the introduction and ongoing implementation of opioid dependency treatment in community.

Advocate for additional resources and supports in family physician clinics and Primary Care Networks to support the introduction and ongoing implementation of opioid dependency treatment in community.

Advocate for policy and legislative change to reduce the distribution of fentanyl or other illegal substances being brought into communities.



## Task Force Members

Dr. Fred Janke, Chair  
Dr. Justin Balko  
Dr. Cameron Barr  
Dr. Srini Chary  
Dr. Ted Findlay

Dr. Tina Korownyk  
Dr. Bonnie Larson  
Dr. Jazmin Marlinga  
Dr. Tally Mogus  
Dr. Jovita Ojadi

Ms. Terri Potter  
Dr. Jennifer Walker  
Dr. Monica Wickland-Weller

## For Further Information

- 1) Chang Y, Zhu KL, Florez ID, et al. Attitudes toward the Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain: A qualitative study. *J Opioid Manag.* 2016;12:377-387.
- 2) Lalonde L, Leroux-Lapointe V, Choinière M, et al. Knowledge, attitudes and beliefs about chronic noncancer pain in primary care: A Canadian survey of physicians and pharmacists. *Pain Res Manag* 2014;19(5):241-50.
- 3) Allen MJM, Asbridge MM, MacDougall PC, et al. Self-reported practices in opioid management of chronic noncancer pain: A survey of Canadian family physicians. *Pain Res Manag* 2013;18(4):177-184.
- 4) Jamison RN, Serrailier J, Michna E. Assessment and treatment of abuse risk in opioid prescribing for chronic pain. *Pain Res Treat.* 2011;2011:941808.
- 5) Volkow ND, McLellan AT. Opioid Abuse in Chronic Pain--Misconceptions and Mitigation Strategies. *N Engl J Med.* 2016 Mar 31;374(13):1253-63.
- 6) Dowell D, Haegerich TM, Chou R. CDC Guideline for Prescribing Opioids for Chronic Pain - United States, 2016. *MMWR Recomm Rep.* 2016 Mar 18;65(1):1-49.
- 7) Brusse JW, Guyatt GH, Carrasco A, et al. The 2017 Draft Recommendations for Use of Opioids in Chronic Non-Cancer Pain - National pain center. [http://nationalpaincentre.mcmaster.ca/documents/Opioids\\_guideline\\_English\\_30Jan2017\\_correctnumbering..pdf](http://nationalpaincentre.mcmaster.ca/documents/Opioids_guideline_English_30Jan2017_correctnumbering..pdf). (Last accessed February 13, 2017).
- 8) Allan GM, McCormack JP, Korownyk C, et al. The future of guidelines: Primary care focused, patient oriented, evidence based and simplified. *Maturitas.* 2017 Jan;95:61-62.
- 9) Greenfield S, Steinberg EP, Auerbach A, et al. Clinical practice guidelines we can trust. Washington, DC: Institute of Medicine; 2011. Available from: [www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx](http://www.iom.edu/Reports/2011/Clinical-Practice-Guidelines-We-Can-Trust.aspx). (Last accessed August 15, 2014).

## Contact Information

Please contact Dr. Fred Janke, Task Force Chair and President of the Alberta College of Family Physicians at [acfpres@acfp.ca](mailto:acfpres@acfp.ca) or 780-488-2395 or visit our website at [www.acfp.ca](http://www.acfp.ca).



Alberta College of Family Physicians  
Centre 170, #370, 10403-172 Street  
Edmonton, Alberta T5S 1K9  
Tel: 780-488-2395 | Toll Free: 1-800-361-0607 (Alberta only)  
[www.acfp.ca](http://www.acfp.ca)

