RAAM Clinic Toolkit
TRANSITION PLANNING

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INTRODUCTION

In the spirit of offering people-centred care, RAAMs clinics do not set firm limits on the length of time clients can engage with services. Instead, length of engagement is dependent on the individual client's needs, paired with considerations around clinic capacity. Transition planning should be initiated as part of the development of the client's treatment plan and continually revised throughout their care.

Transition planning should consider what the client's goals are in accessing RAAM clinic services, any ongoing mental or physical health concerns they may need support for, and any ongoing treatment they require beyond what is within the scope of the RAAM clinic. RAAM clinics are expected to connect clients to community agencies and offer support to the client's primary care provider as they take on the role of providing care for their substance use. For clients that do not have a primary care provider, efforts should be made to connect them with one where possible.

PROTOCOL FOR DISCHARGING RAAM CLINIC CLIENTS

Prior to transferring a client to community providers for ongoing follow-up, a plan for providing substance use medications (e.g., OAT, anti-craving medications) should be in place, and the client should have some degree of medical and social stability.

Steps to take before discharging a client:

1. Confirm with the community physician/nurse practitioner that they are willing to take over prescribing for any required medications using the consultation letter for transferring substance use disorder care to primary care (see below). If the client is deemed complex, consider discharge transfer to an addiction specialty clinic.
2. Confirm the appointment date with the community provider and ensure that prescriptions are written until the appointment date.
3. Confirm that a collaborative treatment plan with community services/counselling supports is in place.

4. For stable clients, ensure that an individualized relapse prevention plan is in place with information about how to access support or return to the RAAM clinic if needed.
    - RAAM clinic counsellors should refer to longer-term counselling and supports through established pathways early in treatment if required. Counsellors should support clients until transfer of care is complete.

RAAM clinic services may be discontinued for any of the reasons below:

1. The client chooses to not accept ongoing care from the RAAM clinic. This may result in a conversation with the care team and a formal discharge, or the client may just stop attending the clinic.
2. The client chooses to obtain addiction treatment/services with another care provider/clinic. This may result in a conversation with the care team and a formal discharge, or the client may just stop attending the clinic.
3. The care provider feels that a different program or clinic may meet the client's needs better than the RAAM clinic can. This may include the following scenarios:
    a. The client does not appear to be benefitting from the RAAM clinic interventions. Sometimes a different service will produce better results (e.g., increased engagement, decreased/safer substance use).,
    b. The new clinic offers services that the RAAM clinic does not.

    This decision to transfer care should be made mutually between provider and client as much as possible.
4. The client and the provider reach a mutual agreement of discharge/transfer back to the primary care provider after completion of services. The client is invited to return to the RAAM clinic if they feel they would benefit from its services again.
5. The client repeatedly demonstrates unacceptable behaviour as outlined in **Client Rights and Responsibilities** (see **Resources Specific to First Clinical Visit**). In this case, reasonable efforts should be made to transfer care to a different care provider, bridge prescriptions to that provider, or allow the client time to establish connections for ongoing care. Organizational risk mitigation teams should be involved in this process where available.

CONSULTATION LETTER FOR TRANSFERRING SUBSTANCE USE DISORDER CARE TO PRIMARY CARE[1]

This template letter can be adapted to suit the specific needs of your client and community. While the typical recipient of this letter may be a primary care provider, other types of community care providers may be willing and available to take over the client's substance use care, and this letter can be adapted accordingly. Further, the language and suggested resources should be personalized per the referring care provider's judgment.

[Date]

[Primary care provider name]
[Primary care clinic name]
[Primary care fax number]

Dear *[Primary care provider name],*

Re: *[Client name]*

I'm writing to let you know that your client has been started on *[medication name] [medication dose]* by the *[clinic name]* RAAM clinic for treatment of *[alcohol/opioid use disorder] [(AUD/OUD)]*.They pick up their medication *[weekly/bi-weekly, etc.]*, at *[pharmacy name]*.

[Client name] has attended the RAAM clinic since *[first RAAM appt date]*. *[Information about the client's current status and any relevant lab results, e.g. side effects from medication, current patterns of use, cravings currently experienced]*.

[AUD/OUD] is a chronic condition that has good evidence for treatment within the primary care setting. I would recommend that the patient remain on *[medication name]* for at least another *[timeframe, e.g., six to twelve months]*. At that time, you could discuss how they would feel about stopping it. In reassessing for continued use of this medication, I recommend considering the client's current pattern of use, their goals, current cravings, their management of triggers and stressors, social supports, environment, and engagement with counselling.

Please reach out to our clinic if you would like further support. If the client has a slip or their needs change, we would be pleased to reassess them on an urgent basis. Relapse is managed with an adjustment of anti-craving medications, crisis-oriented counselling and connection to community services, and treatment of withdrawal if necessary. I can be reached through the clinic at *[RAAM clinic phone number]*.

Thank you for your consideration. The FAQ below contains some information about managing substance use disorders in primary care.

Sincerely,

[RAAM clinician name]

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[1] Adapted from materials provided courtesy of the RAAM Hub and the Provincial Addition Medicine Primary Care Steering Committee (Manitoba).

FAQ

What is the process for becoming authorized to prescribe addiction medications?

- No special authorization is required in order for prescribers to prescribe naltrexone (Revia) and acamprosate (Campral).
- Physicians do not need special authorization to prescribe methadone or sublingual buprenorphine (Suboxone); however, they should ensure they have the knowledge, skill, and judgment to appropriately prescribe and manage opioid agonist therapy, as with all care and prescribing. See **CPSO's Advice to the Profession: Prescribing Drugs** for more information.
- Nurse practitioners must have participated in the appropriate educational courses to be authorized to prescribe controlled substances, including methadone and buprenorphine. See **NPs and Prescribing Controlled Substances** for more information.
- To administer extended-release buprenorphine injection (Sublocade), certification through the manufacturer is required in the form of a short module: **https://www.sublocadecertification.ca/**

What billing codes are available to support integration of AUD/OUD care into my practice?

- A957 is an addiction assessment equivalent to an A007 code.
- K680 is a time-based code for addiction counselling (equivalent to K005) that is outside the basket.
- Additional Opioid Agonist Maintenance Program (OAMP) codes can be billed depending on how many times in the month a client is seen and for time spent on team-based care.

Where can I get help managing a case?

- The referring RAAM clinic.
- **E-consults** provide clinicians with real-time access to addiction medicine expertise.

What happens if the client destabilizes or requires additional care outside of my scope?

- Clients can always return to the RAAM clinic.

What educational opportunities exist for continuing education on substance use care?

- META:PHI: **https://www.metaphi.ca/**
- Project ECHO: **https://camh.echoontario.ca/program-ampi/**
- BCCSU: **https://www.bccsu.ca/**
- Opioids Clinical Primer: **https://machealth.ca/programs/opioids_clinical_primer/**
- Opioid Use Disorder Treatment Course: **https://www.camh.ca/en/education/continuing-education-programs-and-courses/continuing-education-directory/opioid-use-disorder-treatment-oudt-course**
- Managing Alcohol Problems Course: **https://www.camh.ca/en/education/continuing-education-programs-and-courses/continuing-education-directory/managing-alcohol-use-problems**

Medication coverage/costs

- Methadone, sublingual buprenorphine, and slow-release oral morphine are covered by the following without requiring an LU code.
    - ODB
    - NIHB
    - Most private insurance plans
- Injectable buprenorphine XR requires an LU code for ODB coverage (LU 577). It is covered as a limited-use benefit by NIHB (no prior approval required).
- Acamprosate requires an LU code for ODB coverage (LU 531). It is covered by NIHB.
- Naltrexone requires an LU code for ODB coverage (LU 532). It is covered by NIHB.

Access to naloxone and harm reduction supplies

- Naloxone kits are widely available and should be offered to anyone/any household in which someone is using prescription or non-prescription opioids. Naloxone kits can be accessed in a variety of ways:
- Through participating pharmacies (no prescription required) and by prescription (e.g., NIHB covers intranasal naloxone kits up to maximum of 1 per day with Rx)
- Through Public Health Units (other harm reduction supplies also available) **https://www.ontario.ca/page/public-health-unit-locations**

Communicating with pharmacies

- Information to include on prescription for pharmacy to access support:
    - Clinic phone and fax number
    - Clinic on-call pager number

ROLE OF THE RAAM CLINIC WHEN PRIMARY CARE IS NOT ACCESSIBLE

Although the ultimate goal of a RAAM clinic is to transition stable clients back to their primary care providers, there are many communities where primary care is not readily accessible. This can impact RAAM clinics if it becomes difficult to transition stable clients out. In these circumstances, many clinics maintain ongoing prescribing relationships with clients for extended periods of time to ensure ongoing access to treatment. This may increase the caseload of RAAM clinic providers and impact wait times.

As part of the client's transition planning, those who do not have a primary care provider should be supported in attempting to connect with one. Building collaborative relationships with primary care clinics can assist in establishing connections with RAAM clinic clients. If the RAAM clinic is at capacity and supporting some clients who are ready for discharge, the clinic may consider referring clients to community addiction clinics for ongoing addiction management to create capacity for urgent community/emergency department/hospital referrals. Choosing the right community clinic is important, and involving the client in the decision of where to access care

next is paramount. Where feasible, the clinic should provide person-centred care that includes counselling and individualized care plans. It is the responsibility of the care team to effectively gauge which clients are likely to successfully transfer to other providers and which would benefit from continuing to receive care from the RAAM clinic.

Ongoing primary care is not within the scope of the RAAM clinic model. However, mental and physical health conditions are frequently found through assessment and interventions of RAAM clinic clients. Common presentations include soft tissue injuries and infections, alcohol-related liver disease, reproductive care needs, hepatitis C, HIV, infections, mood and anxiety disorders, and chronic pain.

There is no one-size-fits-all approach to treating mental and physical health conditions within a RAAM clinic; different clinics will have different organizational resources and/or partnerships that allow them to meet clients' health needs in different ways. For each RAAM clinic, it remains a quality target to provide treatment or referral for concurrent health needs that arise throughout the client's care (see **RAAM Clinic Quality Targets**, Quality Target 8).