Methadone Program

Annual Report 2016

The Ministry of Health has been contracting with the College of Physicians and Surgeons of Saskatchewan (CPSS) since 2001 to operate the Methadone Program on its behalf. The object of the Program is to administer the methadone exemption process for Saskatchewan physicians. Currently, Dr Morris Markentin is the program manager, and Nicole Mclean provides administrative support.

In 2016, 19 new Saskatchewan prescribers applied for and received a methadone exemption from Health Canada. Six of these were for addiction, and 13 were for pain. Currently, there are 133 Saskatchewan physicians who hold a methadone exemption.

- 22 have an exemption for addiction
- 65 have an exemption for pain
- 46 hold an exemption for both indications

A list of practitioners authorized to prescribe methadone in Saskatchewan is contained in *Appendix 1*. This list indicates if the practitioner can prescribe for addiction, pain or both indications. It also lists their practice location.

In addition to methadone, the College has set a standard for the prescribing of buprenorphine for addiction (Regulatory Bylaw 19.1). In 2016, the number of physicians eligible to prescribe for the buprenorphine/naloxone combination was tracked for the first time. Currently, 57 physicians meet the requirements to prescribe.

A list of practitioners authorized to prescribe buprenorphine/naloxone for addiction in Saskatchewan is contained in *Appendix 2*.

In 2016, the Methadone Program also sent out self-audits to all physicians prescribing methadone for addiction in the community. Sixty-three prescribers completed and returned the self-audit. As well, one on-site audit was performed. The summarized results of the self-audit are available in *Appendix 3*. The report that resulted from the on-site audit is contained in *Appendix 4*, it has been anonymized.

The Methadone Program continues to update the *Saskatchewan Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction/Dependence* as appropriate. The last update was made April 1, 2016 to include buprenorphine/naloxone. The most current version of the document is available through the CPSS website at https://www.cps.sk.ca/iMIS/Documents/Legislation/Policies/STANDARD%20-%20SK%20OST%20Therapy%20Guidelines.pdf

The Methadone Program again offered its annual Opioid Substitution Therapy conference on April 22 and 23 in Saskatoon. The conference had 11 speakers, who spoke on 20 topics. The number of attendees was 225. An overview of the event is provided in *Appendix 5*.

Finally, below is a table outlining the number of Saskatchewan residents receiving methadone for 2016:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Average
NIHB	1125	1127	1123	1106	1135	1123	1152	1123	1127	1156	1357	1365	1168
Addiction	1795	1807	1804	1788	1849	1848	1871	1873	1858	1863	1981	1949	1857
Pain	10	9	10	12	10	16	16	19	13	19	20	23	15
Metadol	257	244	248	246	264	246	250	253	462	257	281	280	274
Total # Meth Patients	**2920**	**2934**	**2927**	**2894**	**2984**	**2971**	**3023**	**2996**	**2985**	**3019**	**3338**	**3314**	**3025**

Note: Total # Methadone Patient includes Addiction and NIHB only

Appendix 1

Practitioners Authorized to Prescribe Methadone in Saskatchewan

	ADDICTON	**Total:22**
	Dr. Olajide Adelugba	Corman Park
*	Dr. Johanna Kaiser	La Ronge
	Dr. Johannes Kleingeld	La Ronge
	Dr. Kevin Dautremont	Moose Jaw
	Dr. Erin Hamilton	North Batleford
	Dr. David Crawford	Prince Albert
	Dr. Olanrewaju Egbeyemi	Prince Albert
*	Dr. Nomtandazo Maya	Prince Albert
	Dr. Francois Rossouw	Prince Albert
*	Dr. Adewumi Adanlawo	Regina
	Dr. Mary Bohn	Regina
	Dr. Bernard Emokpare	Regina
	Dr. Jess Melle	Rosthern
	Dr. Azaad Baziany	Saskatoon
	Dr. John Dosman	Saskatoon
	Dr. Kevin Ledding	Saskatoon
*	Dr. Cassandra Pancyr	Saskatoon
	Dr. Akinlolu Peluola	Saskatoon
	Dr. Edward Rooke	Saskatoon
	Dr. Naveen Tandon	Saskatoon
*	Dr. Braden Bouchard	Victoria
	Dr. Melanie Press	Yorkton

	PAIN	**Total:65**
*	Dr. Lawrence Clein	
*	Dr. Jacqueline Bourgeois	Humboldt
	Dr. Nicola Macpherson	Maple Ridge
*	Dr. Abdulhamid Eshawesh	Melville
	Dr. Aletta Van Heerden	Moose Jaw
*	Dr. Herman Van Der Merwe	Moosomin
	Dr. John Rye	Prince Albert
*	Dr. Bradley McIntyre	Redvers
	Dr. Yakub Abu-Ghazaleh	Regina
	Dr. Jasmeen Bains	Regina
	Dr. Gregory Baumann	Regina
*	Dr. Lourens Blignaut	Regina
*	Dr. Mary Bohn	Regina
*	Dr. Hester Bouwer	Regina
	Dr. Theresa Bradel	Regina

*	Dr. Tanya Brown	Regina
*	Dr. Megan Clark	Regina
*	Dr. Vasuki Coomaran	Regina
*	Dr. Danielle Cutts	Regina
*	Dr. Enrique Filomeno Vela	Regina
	Dr. Joan Hamilton	Regina
*	Dr. Mohammad Haq	Regina
*	Dr. Eve Marie Johnson	Regina
**	Dr. Nivas Juggernath	Regina
*	Dr. Siva Karunakaran	Regina
	Dr. Alana Kilmury	Regina
*	Dr. Jennifer Kuzmicz	Regina
	Dr. Kathrine Lawrence	Regina
*	Dr. Sharon Leibel	Regina
*	Dr. Sarah Liskowich	Regina
*	Dr. Winston Lok	Regina
	Dr. Albertus Lotz	Regina
*	Dr. Sara Mahood	Regina
	Dr. John McMillan	Regina
	Dr. Mohamed Moolla	Regina
	Dr. Marie Morin	Regina
*	Dr. Elias Oluma	Regina
**	Dr. Donald Pikaluk	Regina
	Dr. Meena Pole	Regina
*	Dr. Clara Rocha Michaels	Regina
*	Dr. Bhanu Tikkisetty	Regina
*	Dr. Jacobus Van Heerden	Regina
*	Dr. Aldine Du Plessis	Saskatoon
	Dr. Hang Ha	Saskatoon
	Dr. Patricia Hizo-Abes	Saskatoon
	Dr. Judith Howsam	Saskatoon
	Dr. Andrea Johnson	Saskatoon
*	Dr. Michel Jutras	Saskatoon
	Dr. Meredith McKague	Saskatoon
	Dr. Nora McKee	Saskatoon
	Dr. Karen Mohr	Saskatoon
	Dr. Murray Opdahl	Saskatoon
	Dr. Kenneth Stakiw	Saskatoon
	Dr. Donald Stefiuk	Saskatoon
	Dr. Wendy Vogel	Saskatoon
	Dr. Grace Walker	Saskatoon
	Dr. Edward Zacher	Saskatoon
*	Dr. Hasantha Ovitigamuve Pathiran	Toronto
	Dr. Mahmood Beheshti	Weyburn
*	Dr. Jared Oberkirsch	Weyburn

*	Dr. Jessi Warren	Weyburn

BOTH **Total:46**

	Dr. Hasan Moolla	Battleford
*	Dr. G. Kielly	Belfast PO
	Dr. Olusegun Olusi	Fort Qu'Appelle
	Dr. Sean Groves	La Ronge
*	Dr. Mukhtar Ali	Lloydminster
	Dr. Raymond Rogers	Lloydminster
	Dr. Bertram Neethling	Pentcton
	Dr. Chamberlain Ajogwu	Port Stanley
	Dr. Jenny Balingit	Prince Albert
	Dr. Collins Egbujuo	Prince Albert
	Dr. Leo Lanoie	Prince Albert
	Dr. Uche Nwadike	Prince Albert
	Dr. Mohamed Adams	Regina
*	Dr. John Alport	Regina
	Dr. George Carson	Regina
	Dr. Carmen Johnson	Regina
	Dr. Tshipita Kabongo	Regina
*	Dr. Kish Lyster	Regina
	Dr. Radhika Marwah	Regina
*	Dr. Joanne McLeod	Regina
	Dr. Rajnikant Patel	Regina
	Dr. Kalpana Patel	Regina
	Dr. Ashis Paul	Regina
*	Dr. Ronald Taylor	Regina
*	Dr. Fouche Williams	Regina
	Dr. Brian Fern	Saskatoon
	Dr. Kali Gartner	Saskatoon
	Dr. Stephen Helliar	Saskatoon
	Dr. Morris Markentin	Saskatoon
	Dr. Gordon McAllister	Saskatoon
	Dr. Timothy Neumann	Saskatoon
	Dr. Larissa Pawluck	Saskatoon
	Dr. Ukesha Rattan	Saskatoon
	Dr. Ramesh Tandon	Saskatoon
	Dr. Sinisa Zerajic	Saskatoon
	Dr. Oluwole Oduntan	Yorkton

* 2nd Level Prescriber is a physician who will not initate new patents on methadone but who will have patents from their area that are already stabilized on methadone returned to their care for maintenance only. If you would like a copy of the policy, please contact the College of Physicians and Surgeon.

** Temporary Prescriber

Appendix 2

Practitioners Authorized to Prescribe Buprenorphine for Addiction in Saskatchewan

Last Name	First Name	Clinic Name	Clinic Address
Adams	Mohamed	Broad Street Clinic	2210 Broad Street Regina, SK S4P 4V6
Ajogwu	Chamberlain	CA Bell Medical Center	285 Bridge Street Port Stanley, ON N5L 1J5
Butt	Peter	Mental Health and Addiction Services	314 Duchess Street Saskatoon, SK S7K 0R1
Christie	Allison	The Medical Centre	2 - 137 King Street Estevan, SK S4A 2T5
Crawford	David	Cree Nation Treatment Haven	301 - 314 - 11th Street East Prince Albert, SK S6V 1A5
Das	Jyoti	Albert & Parliament Primary Health Care Centre	79 Plainsview Drive Regina, SK S4S 6K1
Du Plessis	Aldine	Avalon Medical Clinic	23 - 2605 Broadway Avenue Saskatoon, SK S7J 0Z5
Egbeyemi	Olanrewaju	Prince Albert Cornerstone Medical Clinic	Box 22040 CornerStone 100 - 800 - 15th Street East Prince Albert, SK S6V 8E3
Egbujuo	Collins	Shellbrook Primary Health Care Clinic	3 Delorme Bay Prince Albert, SK S6V 0H2
Emokpare	Bernard	Outpost Health Centre	180 - 4246 Albert Street Regina, SK S4S 3R9
Fern	Brian	College Park Medical Clinic	310 - 2600 - 8th Street East Saskatoon, SK S7H 0V7
Gartner	Kali	Saskatoon Community Clinic	455 – 2nd Avenue North Saskatoon, SK S7K 2C2
Gore-Hickman	Patrick	Wall Street ENT Clinic	230 - 140 Wall Street Saskatoon, SK S7K 1N4
Groves	Sean	La Ronge Medical Clinic	809 La Ronge Avenue La Ronge, SK S0J 1L0
Hamilton	Erin	Battlefords Family Health Centre	103 - 1192 - 101st Street North Battleford, SK S9A 0Z6
Hussain	Mohammad		
Jooravan	Sujeeth		
Kabongo	Tshipita	Integrated Wellness & Health Balance Center	2318 - 9th Avenue North Regina, SK S4R 8C5
Kamel	Jelisia	Southwest Medi-Centre	500 – 1 Springs Drive Swift Current, SK S9H 3X6

Kgobisa	Lettie	La Loche Health Centre	Dene Road La Loche SK, S0M 1G0
Lanoie	Leo	Prince Albert Co-Operative Health Centre/Community Clinic	110 - 8th Street East Prince Albert, SK S6V 0V7
Leibel	Sharon	Hillsdale Medical Clinic	1380G - 23rd Avenue Regina, SK S4S 3S5
Loutfy	Mona	Sexual Health Clinic	101 - 101 - 15th Street East Prince Albert, SK S6V 1G1
Markentin	Morris	Saskatoon Community Clinic	455 – 2nd Avenue North Saskatoon, SK S7K 2C2
Maya	Nomtandazo	Prince Albert Cornerstone Medical Clinic	100 - 800 - 15th Street East Prince Albert, SK S6V 8E3
McAllister	Gordon		175 - 8B - 3110 8th Street East Saskatoon, SK S7H 0W2
Mehta	Ashish	Northgate Medical Centre	2781 Avonhurst Drive Regina, SK S4R 3J3
Michel	Joseph	Lakeshore Medical Clinic	1380 - 23rd Avenue Regina, SK S4S 3S5
Mitchell	Cheryl	Martensville Collective Health and Wellness	531 Centennial Drive North Martensville, SK S0K 2T0
Moolla	Hasan	Battleford Medical Clinic	112 22 Street Battleford, SK S0M 0E0
Nair	Ratheesh	Broad Street Clinic	2210 Broad Street Regina, SK S4P 4V6
Neethling	Bertram	La Loche Health Centre	Dene Road La Loche, SK S0M 1G0
Nwadike	Uche	Broad Street Clinic	2210 Broad Street Regina, SK S4P 4V6
Odogwu	Edward	Prince Albert Mental Health Centre	Box 3003 Prince Albert, SK S6V 6G1
Olusi	Olusegun		Box 2126 Fort Qu'Appelle, SK S0G 1S0
Orhadje	Charles	Northeast Medical Centre Inc.	600 110 Ave Tisdale, SK S0E 1T0
Owonikoko	Onasegun	Prince Albert Co-Operative Health Centre/Community Clinic	110 – 8th Street East Prince Albert, SK S6V 0V7
Parekh	Vipul	Prince Albert Co-Operative Health Centre/Community Clinic	110 – 8th Street East Prince Albert, SK S6V 0V7
Patel	Rajnikant		2625 Dewdney Avenue Regina, SK S4T 0X4
Patel	Kalpana		2625 Dewdney Avenue Regina, SK S4T 0X4
Paul	Ashis	Broad Street Clinic	2210 Broad Street

			Regina, SK S4P 4V6
Pawluck	Larissa	West Side Community Clinic	1528 20th Street West Saskatoon, SK S7M 0Z6
Peluola	Akinlolu	Victory Medical Associates	329 - 20th Street West Saskatoon, SK S7M 0X1
Rattan	Ukesha		
Robertson	Archie		1200 – 24 Street West Prince Albert, SK S6V 5T4
Rooke	Edward	Saskatoon Community Clinic	1528 – 20th Street West Saskatoon, SK S7M 0Z6
Rossouw	Francois	Victoria Hospital Emergency Department	1200 – 24th Street West Prince Albert, SK S6V 5T4
Sayeed	Mohammed	Family Medical Clinic	4806 - 50th Street Lloydminster, SK S9V 0M9
Serunkuma	Ivan	Prince Albert Cornerstone Medical Clinic	100 - 800 - 15th Street East Prince Albert, SK S6V 8E3
Smit	Shawn	Idylwyld Medical Centre	1216 Idylwyld Drive North Saskatoon, SK S7L 0Z9
Stevens	John-Michael	Angelique Canada Health Centre	Pelican Narrows, SK S0P 0E0
Syed	Asma	Royal University Hospital, Psychiatry Department	103 Hospital Drive Saskatoon, SK S7N 0W8
Terrett	Luke	Royal University Hospital Emergency Department	103 Hospital Drive Saskatoon, SK S7N 0W8
Velestuk	Jordan	Queen City Medical	2306 – 9th Avenue N Regina, SK S4R 8C5
Wegner	Sandra	LIFEBRIDGE Health Centre	36 – 118 Cope Crescent Saskatoon, SK S7T 0X3
Wildenboer	Wilhelmina	Rochdale Crossing Medical Clinic	5875 Rochdale Blvd Regina, SK S4X 2P9
Zacher	Edward		

Appendix 3

Results of the Self-Audit for Methadone Prescribers Prescribing for Addiction in the Community Setting

1. Continuing Education

For INITIATING Physicians ONLY. Maintaining (or Non-Initiating Physicians, skip to question 2)

	YES	NO		
1.1 Have you acquired your methadone exemption within the last two years?	☐	☐	Yes	**18**

	Skip to question 1.2	Proceed to question 1.3	No	**22**
1.2 Have you completed a recognized course on the fundamentals of addiction medicine?	☐	☐	Yes	**19**
			No	**1**
1.3 Have you been treating opioid use disorder for 5 years or more?	☐ Proceed to question 1.4	☐ Proceed to question 2	Yes	**17**
			No	**23**
1.4 Have you completed 30 hours of formal Continuing Education (CME) in addictions medicine?	☐	☐	Yes	**19**
			No	**3**

2. Access to Resources & Continuity of Care

	YES	**NO**		
2.1 Do you regularly access the Pharmaceutical Information Program (PIP) before prescribing?	☐	☐	Yes	**41**
			No	**4**
2.2 Do you have access to laboratory services?	☐	☐	Yes	**44**
			No	**1**
2.3 Do you have access to pharmacy services?	☐	☐	Yes	**45**
			No	**0**
2.4 If you are away, or are suspending practice, do you ensure that your patients receive continued care from another physician trained in methadone maintenance therapy (MMT)?	☐	☐	Yes	**38**
			No	**5**
2.5 Do you provide non-pharmacological support to your patients and work collaboratively with other providers (e.g. provide access to counselling services, addiction services)?	☐	☐	Yes	**41**
			No	**2**

3. Prescriptions

	YES	**NO**		
3.1 Do you write methadone prescriptions by hand on a personalized prescription pad?	☐	☐	Yes	**18**
			No	**26**
3.2 Do you create methadone prescriptions using an electronic EMR?	☐	☐	Yes	**32**
			No	**13**
3.3 Do you transmit all methadone prescription, whether written by hand or generated electronically, via fax directly to the dispensing pharmacy?	☐	☐	Yes	**41**
			No	**4**

3.4 Do all prescriptions written for methadone contain: • **Start and end dates?** • **Days of the week to be supervised by daily witnessed ingestion (DWI)?** • **Carried doses (with the number and days of week that are to be given as take-home doses specified)?** • **Methadone dose written in numbers?** • **Any special instructions and extraordinary situations?**	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	Yes No Yes No Yes No Yes No Yes No	**44** **0** **41** **3** **44** **0** **44** **0** **44** **0**
3.5 Are all methadone prescriptions written for the oral suspension? (i.e. Are all prescriptions for the crystalline suspension, such as methadone to be combined with Tang, as opposed to a tablet formulation such as Metadol)? *Note: there may be exceptions when the tablet formulation may be appropriate. The rationale for the use of the tablet formulation should be well documented.*	☐	☐	Yes No	**42** **3**
3.6 Do you have a mechanism in place to facilitate communication between yourself and the dispensing pharmacy in regard to the management of spoiled, lost and missed doses?	☐	☐	Yes No	**43** **2**

4. Patient Assessment for Admission to MMT

For INITIATING Physicians ONLY. Maintaining (or Non-Initiating Physicians, skip to question 5)

	YES	**NO**		
4.1 Are the following documented for each patient in his/her chart or medical record? • **Medical history, including cardiovascular** • **Appropriate physical examination** • **Pattern of drug use** • **Addiction treatment history** • **Psychiatric history and mental status**	☐ ☐ ☐ ☐ ☐	☐ ☐ ☐ ☐ ☐	Yes No Yes No Yes No Yes No Yes No	**32** **4** **29** **8** **37** **0** **34** **2** **35**

• **High-risk behaviour** • **Social situation** • **Details on chronic or recurrent pain**	☐ ☐ ☐	☐ ☐ ☐	No Yes No Yes No Yes No	**2** **34** **3** **35** **1** **31** **6**
4.2 Do you review the patient's prescribing profile from PIP prior to initiating MMT?	☐	☐	Yes No	**34** **3**
4.3 Do you document your <u>discussion with the patient about all available treatment options other than MMT (e.g. tapering, abstinence) prior to admitting the patient to an MMT program</u> on his/her chart or medical record?	☐	☐	Yes No	**28** **9**
4.4 Do you document your discussion with the patient about the <u>risks of MMT (especially during initiation and with any dose increases), including the risk of arrhythmias</u>, on his/her chart or medication record?	☐	☐	Yes No	**28** **8**
4.5 Does the patient sign an MMT agreement upon initiation of MMT?	☐	☐	Yes No	**34** **3**
Is a copy of the agreement kept on the patient chart?	☐	☐	Yes No	**35** **2**
Is the dispensing pharmacy provided with a copy of the agreement?	☐	☐	Yes No	**10** **25**
4.6 Are all of the patient's prescribers from the previous 3 months informed of the initiation of MMT (or a reasonable effort made to do so)?	☐	☐	Yes No	**16** **20**
4.7 Do you document the patient's treatment plan on the patient's chart or medical record?	☐	☐	Yes No	**34** **2**
4.8 Is an ECG always performed on initiation of MMT?	☐	☐	Yes No	**25** **8**
4.9 Is a urine drug screen obtained from patients prior to the initiation of methadone?	☐	☐	Yes No	**38** **0**
4.10 Do you notify CPSS of a patient's discharge from MMT?	☐	☐	Yes No	**22** **12**
	☐	☐	Yes	**33**

4.11 Are pregnant women given priority for admission into MMT over other applicants?			No	**5**
4.12 For patients under 18 years of age, do you consult with another MMT provider prior to initiating MMT?	☐	☐	Yes No	**17** **12**
4.13 Are patients with concurrent medical conditions that may be considered to elevate risk, such as HIV, Hepatitis C or serious psychiatric illness, given priority for admission into MMT?	☐	☐	Yes No	**36** **2**

5. Clinical Visits

	YES	**NO**		
5.1 Are patients seen at least once per week during the first 14 days of treatment by the INITIATING Physician or another physician with a methadone exemption who can initiate?	☐	☐ Not applicable to me ☐	Yes No N/A	**33** **0** **10**
5.2 After 14 days of treatment, are patients seen by a physician every 1 to 4 weeks until the methadone dose is stable?	☐	☐	Yes No	**38** **2**
5.3 After a patient is stable, is he/she seen by a physician at least every 3 months?	☐	☐	Yes No	**38** **3**

6. Methadone Dosing

INITIATION PHASE

Remember: patients are at highest risk of methadone overdose in the first two weeks of MMT

	YES	**NO**		
6.1 Do you dose methadone based on the following criteria: **Patient Risk of** / **Initial Dose** / **Dose Increase** / **Frequency During Early & Late Stabilization**	☐	☐	Yes	**37**

Methadone Toxicity							
Low	≤30mg	10mg	No more than every 3 days			No	**2**
Moderate	≤20mg	10mg	No more than every 4 days				
High	≤10mg	≤5mg	No more than every 5 days				
6.2 Do patients receive daily witnessed ingestion during the initiation phase?				☐	☐	Yes	**39**
						No	**0**
<u>STABILIZATION PHASE</u> (Generally doses ≥60mg; Usual target dose: 60 to 120mg)							
6.3 Are doses ever increased by ≥10mg every 5 to 7 days during stabilization phase?				☐	☐	Yes	**7**
						No	**31**
6.4 Do you collect a UDS at every visit during the stabilization phase?				☐	☐	Yes	**32**
						No	**6**
6.5 Do you query possible pregnancy with female patients regularly?				☐	☐	Yes	**33**
						No	**6**
<u>MAINTENANCE PHASE</u> (Defined as no cravings, withdrawal, or active use; No sedation or other significant side effects; Typical dose range: 60 to 120mg)							
6.6 As an INITIATING Physician, do you ensure that a patient is stable for at least 3 months prior to transferring the patient to a MAINTAINING Physician?				☐	☐ Not applicable to me ☐	Yes	**13**
						No	**0**
						N/A	**27**
6.7 As a MAINTAINING Physician, do you consult with the INITIATING Physician before adjusting the methadone dose when a patient shows more than one indicator of instability?				☐	☐ Not applicable to me ☐	Yes	**4**
						No	**0**
						N/A	**37**
6.8 Do you administer a UDS at least every 3 months to every patient?				☐	☐	Yes	**33**
						No	**3**
<u>SPLIT DOSAGES</u> (May be required under certain clinical conditions such as the management of pregnancy, in patients with intrinsic rapid methadone metabolism [rare], or who are on medications that induce rapid metabolism of methadone; Split doses do not necessarily have to be equal)							

6.9 In patients receiving spilt dosages, have you documented one of the following: • **Withdrawal symptoms within 24 hours of the daily dose?** • **Symptoms of excessive methadone dose in the 4 hours following a single daily dosage?**	☐	☐ Not applicable to me – I have no patients receiving a split dose ☐	Yes	**26**
			No	**0**
			N/A	**15**
6.10 In patients receiving split dosages, do they either: • **Attend the pharmacy twice a day for DWI? Or** • **Are eligible for carries?**	☐	☐ Not applicable to me – I have no patients receiving a split dose ☐	Yes	**27**
			No	**0**
			N/A	**13**

7. Spoiled, Lost & Missed Doses

***** Remember that the risk of death from overdose is much greater than the risk of harm from mild withdrawal symptoms. Methadone absorption typically occurs within 30 to 60 minutes of ingestion – no dose replacement is required after 1 hour of ingestion.***

	YES	**NO**		
7.1 Are all reports of vomited, lost or missed doses documented on the patient's chart or medical record?	☐	☐	Yes	**37**
			No	**3**
7.2 Are all replacement doses given only as witnessed ingestion?	☐	☐	Yes	**38**
			No	**1**
7.3 Are all missed doses communicated to the INITIATING Physician?	☐	☐ Not applicable to me ☐	Yes	**12**
			No	**1**
			N/A	**28**

8. Carries

	YES	**NO**		
8.1 Do you document the rationale for providing a patient with carries on the patient chart or medical record?	☐	☐	Yes	**37**
			No	**2**
8.2 For patients receiving carries, do you require:	☐ ☐	☐ ☐	Yes	**38**
			No	**1**

• **A locked box or storage container for any carried doses?** • **That empty bottles be returned to the pharmacy for proper disposal?**			Yes No	**37** **1**
8.3 Do inappropriately used, lost, stolen or spoiled carried doses results in the loss of carry privileges for patients?	☐	☐	Yes No	**34** **3**

9. Methadone & Other Medications

	YES	NO		
9.1 Are you familiar with other medications that interact with methadone and can cause: • **QTc prolongation?** • **CNS depression?** • **Inhibition or induction of cytochrome systems involved in the metabolism of methadone?**	☐ ☐ ☐	☐ ☐ ☐	Yes No Yes No Yes No	**41** **1** **42** **0** **39** **3**
9.2 Do you always inform patients about the interactions of benzodiazepines, gabapentin, and other opioids with methadone?	☐	☐	Yes No	**38** **3**
9.3 When benzodiazepines are co-prescribed with methadone, are the patient's history, examination findings, and diagnoses leading to treatment with benzodiazepines well documented in the patient chart or medical record?	☐	☐	Yes No	**35** **4**

10. Discontinuation

INVOLUNTARY WITHDRAWAL

***For INITIATING Physicians ONLY.*

Reasons to transfer or cease MMT to a patient include:

- **Patient has been threatening or disruptive, or has shown violent behaviour toward a staff member or others**
- **Patient is consistently non-compliant with the treatment agreement**
- **Patient is at high risk for adverse outcomes & attempts to reduce the risk have failed**

Patient is believed to have diverted his/her methadone prescription

	YES	NO		
10.1 During involuntary withdrawal, are all carries revoked and all doses provided through daily witnessed ingestion? ***Exception: pharmacy closure (e.g. not open on Sundays)***	☐	☐ Not applicable to me ☐	Yes	**33**
			No	**0**
			N/A	**6**
10.2 Are patients undergoing involuntary withdrawal warned about the loss of tolerance and the risk of toxicity if he/she relapse to opioids?	☐	☐ Not applicable to me ☐	Yes	**28**
			No	**0**
			N/A	**9**
VOLUNTARY WITHDRAWAL				
10.3 Are patients undergoing voluntary withdrawal warned about the loss of tolerance and the risk of toxicity if he/she relapse to opioids?	☐	☐	Yes	**36**
			No	**1**
10.4 Are patients undergoing voluntary withdrawal seen regularly to assess their mood and withdrawal symptoms, and to provide supportive counselling?	☐	☐	Yes	**36**
			No	**1**

11. Transfer of Care

Patients that continue to be high risk, as they are not adequately stable and are not on a stable dose, must not be transferred to a maintaining methadone prescriber or to a community that does not have reasonable pharmacy access.
For INITIATING Physicians ONLY.

	YES	NO		
11.1 As an INITIATING Physicians, when transferring to a MAINTAINING Physician, do you provide the following information:		Not applicable to me ☐	N/A	**17**
			Yes	**17**
			No	**1**
• **The dose of methadone?**	☐	☐	Yes	**17**
			No	**1**
• **All prescribed medications?**	☐	☐	Yes	**16**
			No	**1**
• **Details on how many carries are permitted?**	☐	☐	Yes	**14**
			No	**4**
• **Frequency of UDS?**	☐	☐	Yes	**11**
			No	**7**
• **A copy of the treatment agreement?**	☐	☐	Yes	**15**
			No	**3**
• **Relevant clinical history of the patient?**	☐	☐	Yes	**16**
			No	**2**
• **Contact information for yourself?**	☐	☐		

Appendix 4

On-Site Methadone Audit for Dr. X

[Street Address]
[City], SK [Postal Code]
Performed on December 8, 2016 by Dr. Peter Butt and Julia Bareham

- Self-Audit was submitted by Dr X on December 30, 2016
- Dr. X has the ability to initiate methadone prescriptions (first level prescriber) for both pain and addiction.

Overall Impression

The methadone clinic attended by Dr. X is run privately, in conjunction with an on-site dispensary. This may create conflict with a patient's freedom to access other pharmacies or obtain carries. The patient volume was high with limited time for interaction and documentation. It was unclear what assessment was done, particularly at intake, and other primary health care or specialist services accessed or promoted for more comprehensive patient care. Nevertheless, both dosing and carries were conservative. In many instances, the responses to the Self-Audit could not be verified in the charts. This variance was significant. Either the standards or guidelines are not being met, or they are not being documented.

Summary of Suggested Changes

<u>The areas highlighted below were identified as opportunities for improvement:</u>

- Numerous patients seen in a short period of time. It was reported that the clinic hours were (at the longest), 7:00AM to possibly 10:30AM. On the day that was audited, approximately 50 patients were seen. This equates to ~4.2 minutes at most per patient encounter. Recommend spending more time with individual patients to ensure an appropriate assessment is performed/discussion is had at each encounter. ***Quality of care concern***
- Patient chart notes are nearly impossible to decipher. Another physician providing care would be challenged to read and make sense of them. Chart notes are also extremely brief and often only contain one line/sentence per patient encounter. Recommend that chart notes be written in a more legible way with increased documentation of individual progress, issues and care plan beyond methadone, as indicated. ***Patient safety concern***
- Documentation regarding PIP access is lacking. Recommend that PIP be accessed, especially prior to initiating MMT, and that it is clearly noted on the patient chart when PIP is accessed and reviewed. [2.1 & 4.2]

- Documentation regarding access to non-pharmacological support is lacking. Suggest documenting the name of the addictions counsellor and recommended frequency of interactions. [2.5]
- The transmission of faxes to the patient's pharmacy cannot be confirmed and there was usually no copy of the Rx on the chart. There was no documentation in the patient record indicating which pharmacy the patient uses. [3.3]
- Recommend that prior to the initiation of MMT, a medical history be taken (including CV), a physical exam performed, a discussion about high-risk behaviour be had with the patient and documented, and chronic or recurrent pain be assessed. [4.1] ***Patient safety concern***
- Ensure that both the discussion with the patient in regard to available treatment options and the risks of MMT is clearly documented in the patient record. [4.3 & 4.4]
- Ensure that efforts made to contact recent prescribers (in the past 3 months) are noted in the patient record. [4.6]
- Ensure that the treatment plan is documented in the patient record. [4.7]
- Recommend that an ECG and relevant blood work become a standard part of the patient encounter when a patient is being considered for the initiation of MMT. [4.8] ***Patient safety concern***
- Recommend that CPSS be informed of patients discharged from MMT as per the standards. A copy of the *Discharge Form* is available in Appendix P of the *OST Guidelines and Standards*. [4.10]
- Re-evaluate how UDSs are being used in MMT. There are numerous results for each patient. Unexpected UDS results do not seem to be addressed (no documentation to support that a conversation took place between the prescriber and the patient). [6.4 & 6.8]
- Ensure the rationale for providing carries is clearly documented. [8.1]
- Documentation regarding informing the patient about interactions of benzos, gabapentin, and other opioids is lacking. Recommend ensuring that is clearly documented in the patient record. [9.2]
- Indicate the need for such frequent visits, every 2 to 3 weeks. There was typically no indication of urgency to the follow-up, whether patients had negative or positive UDS results.

Practice Site Alignment with CPSS OST Standards

The sections below correspond to the methadone self-audit which is aligned with the standards from the *Saskatchewan Opioid Substitution Therapy Guidelines and Standards for the Treatment of Opioid Addiction/Dependence.*

The left column contains the observations from the on-site audit. The right column contains the information provided to CPSS by Dr. X on his/her self-audit.

Access to Resources & Continuity of Care	
On-Site Observations	**Self-Audit Results Section 2**
2.1 Do you access the Pharmaceutical Information Program (PIP) before prescribing/renewing a prescription for every patient at every encounter? Could not be determined by the patient record. The patient records did not contain a print out of the PIP profile, nor were there any notes in the patient profile indicating that the PIP profile was accessed.	YES
2.2 Do you have access to laboratory services? Based on the presence of UDS results, it is clear that Dr. X has access to lab services. However, blood work for infectious diseases was not routinely present.	YES
2.3 Do you have access to pharmacy services? Pharmacy X is connected to the clinic and dispenses methadone. Given the pharmacy business model, it was uncertain what influence this may have on access to other pharmacies and carries.	YES
2.4 If you are away, or are suspending practice, do you ensure that your patients receive continued care from another physician trained in MMT? Dr. X indicated that his/her spouse and fellow physician Dr. Y has his/her methadone exemption to help cover Dr. X in his/her absence. Dr. Z may also be available to cover for Dr. X.	YES
2.5 Do you provide non-pharmacological support to your patients and work collaboratively with other providers (e.g. provide access to counselling services, addiction services)? There are no notes in the patient records indicating that the patient has been seen by any other providers to receive non-pharm support.	YES

Prescriptions	
On-Site Observations	**Self-Audit Results Section 3**
3.1 Do you write methadone prescriptions by hand on a personalized prescription pad? One of the patient charts did contain a prescription that was on a personalized prescription pad. Most did not have a copy of the prescription however. Standard verification could not be made in most instances.	YES
3.2 Do you create methadone prescriptions using an electronic EMR? All records are paper. No EMR.	NO
3.3 Do you transmit all methadone prescription, whether written by hand or generated electronically, via fax directly to the dispensing pharmacy? This could not be determined based on the information in the patient record. There was no documentation related to which pharmacy the patient uses.	YES
3.4 Do all prescriptions written for methadone contain: • **Start and end dates?** • **Days of the week to be supervised by daily witnessed ingestion (DWI)?** • **Carried doses (with the number and days of week that are to be given as take-home doses specified)?** • **Methadone dose written in numbers?** • **Any special instructions and extraordinary situations?** A copy of a methadone prescription was not reviewed. There were notes in the patient record regarding the ratio of carries to witnessed ingestion. Start and end dates were also documented in the patient records but could not be correlated to an actual prescription.	YES to all
3.5 Are all methadone prescriptions written for the oral suspension? (i.e. Are all prescriptions for the crystalline suspension, such methadone to be combined with Tang, as opposed to a tablet formulation such as Metadol)? This could not be determined based on the patient records.	YES
3.6 Do you have a mechanism in place to facilitate communication between yourself and the dispensing pharmacy in regard to the management of spoiled, lost and missed doses? This could not be determined.	YES

Patient Assessment for Admission to MMT	
On-Site Observations	**Self-Audit Results Section 4**
4.1 Are the following documented for each patient in his/her chart or medical record?	
• **Medical history, including cardiovascular**	NO
• **Appropriate physical examination**	NO
• **Pattern of drug use**	YES
• **Addiction treatment history**	YES
• **Psychiatric history and mental status**	YES
• **High-risk behaviour**	NO
• **Social situation**	YES
• **Details on chronic or recurrent pain**	NO
Only anxiety and depression are listed on the intake form, with regard to psychiatric history. Physical health status and assessment was missing, which poses a significant risk during initiation.	
4.2 Do you review the patient's prescribing profile from PIP prior to initiating MMT? Also addressed in 2.1.	NO
4.3 Do you document your <u>discussion with the patient about all available treatment options other than MMT (e.g. tapering, abstinence) prior to admitting the patient to an MMT program</u> on his/her chart or medical record? No evidence of this was found in the patient records.	YES
4.4 Do you document your discussion with the patient about the <u>risks of MMT (especially during initiation and with any dose increases), including the risk of arrhythmias</u>, on his/her chart or medication record? No evidence of this was found in the patient records.	YES
4.5 Does the patient sign an MMT agreement upon initiation of MMT? **Is a copy of the agreement kept on the patient chart?** **Is the dispensing pharmacy provided with a copy of the agreement?** A copy of the treatment agreement was found in patient charts.	YES NO
4.6 Are all of a patient's prescribers from the previous 3 months informed of the initiation of MMT (or a reasonable effort made to do so)? No evidence of this was found in the patient records.	YES

4.7 Do you document the patient's treatment plan on the patient's chart or medical record? No evidence of this was found in the patient records.	YES
4.8 Is an ECG always performed on initiation of MMT? An ECG was found in one patient chart, but not in all.	NO
4.9 Is a urine drug screen obtained from patients prior to the initiation of methadone? UDS appear to be done on intake.	YES
4.10 Do you notify CPSS of a patient's discharge from MMT? Confirmed this with Nicole McLean (admin for OATP), that cessation forms are not sent to CPSS.	NO
4.11 Are pregnant women given priority for admission into MMT over other applicants? Cannot be determined based on the patient records reviewed, however there is the question "Are you pregnant?" on an intake form.	YES
4.12 For patients under 18 years of age, do you consult with another MMT provider prior to initiating MMT? Did not review the charts of any individual under the age of 18 years; cannot confirm.	NO
4.13 Are patients with concurrent medical conditions that may be considered to elevate risk, such as HIV, Hepatitis C or serious psychiatric illness, given priority for admission into MMT? Cannot be determined based on the patient records reviewed, however there are related questions on the intake form (re: HCV, HIV, anxiety or depression). The safety of initiation and management of significant health risks related to IVDU were not reliably and consistently documented.	YES

Clinical Visits	
On-Site Observations	**Self-Audit Results Section 5**
5.1 Are patients seen at least once per week during the first 14 days of treatment by the INITIATING Physician or another physician with a methadone exemption who can initiate? While it is not always clear from the documentation when the patient initiated therapy, it appears that are seen frequently in the beginning of treatment.	YES

5.2 After 14 days of treatment, are patients seen by a physician every 1 to 4 weeks until the methadone dose is stable? Again, this is not clear in the documentation, but it appears that patients are seen frequently all throughout their treatment by Dr. X.	YES
5.3 After a patient is stable, is he/she seen by a physician at least every 3 months? Frequency of visits was consistently high, every 2to 3 weeks, regardless of UDS results. The rationale for such frequent visits was not always clear.	NO (Comment: I do not have any stable patients to leave for 3 months with carries)

Methadone Dosing

INITIATION PHASE

On-Site Observations	Self-Audit Results Section 6
6.1 Do you dose methadone based on the following criteria: It appears that patients are usually started around the 30mg dose. No documentation was identified indicating the patient risk of methadone toxicity (this is not a requirement).	YES
6.2 Do patients receive daily witnessed ingestion during initiation phase? It appears that this is the case, but it is not explicitly stated in the patient records, and copies of the prescription with its carry schedule are typically absent. It is noted however when there is a carry to witness ratio in the front summary page and in the patient encounter notes, e.g. 1:6.	YES

Patient Risk of Methadone Toxicity	Initial Dose	Dose Increase	Frequency During Early & Late Stabilization
Low	≤30mg	10mg	No more than every 3 days
Moderate	≤20mg	10mg	No more than every 4 days
High	≤10mg	≤5mg	No more than every 5 days

<u>STABILIZATION PHASE</u> (Generally doses ≥60mg; Usual target dose: 60 to 120mg)	
6.3 Are doses ever increased by ≥10mg every 5 to 7 days during stabilization phase? Contrary to the self-audit report made by Dr. X, I did not see any instances of increases greater than 10mg in a small sample of patient records that were reviewed. Increases were usually 5mg to 10mg. This is reassuring.	YES
6.4 Do you collect a UDS at every visit during the stabilization phase? Each patient has numerous UDS results in his/her patient record. The use of UDSs may warrant a review for possible over usage, especially in the context of no documented clinical or therapeutic response to a positive screen.	YES
6.5 Do you query possible pregnancy with female patients regularly? This could not be determined based on the patient records.	YES
<u>MAINTENANCE PHASE</u> (Defined as no cravings, withdrawal, or active use; No sedation or other significant side effects; Typical dose range: 60 to 120mg)	
6.6 As an INITIATING Physician, do you ensure that a patient is stable for at least 3 months prior to transferring the patient to a MAINTAINING Physician?	**N/A**
6.7 As a MAINTAINING Physician, do you consult with the INITIATING Physician before adjusting the methadone dose when a patient shows more than one indicator of instability?	**N/A**
6.8 Do you administer a UDS at least every 3 months to every patient? *See comments in 6.4*	NO (Comment: more frequently)
<u>SPLIT DOSAGES</u> (May be required under certain clinical conditions such as the management of pregnancy, in patients with intrinsic rapid methadone metabolism [rare], or who are on medications that induce rapid metabolism of methadone; Split doses do not necessarily have to be equal)	
6.9 In patients receiving spilt dosages, have you documented one of the following: • **Withdrawal symptoms within 24 hours of the daily dose?** • **Symptoms of excessive methadone dose in the 4 hours following a single daily dosage?** There was no documentation suggesting that any patient was receiving split dosages.	**N/A**

6.10 In patients receiving split dosages, do they either: • **Attend the pharmacy twice a day for DWI?** **Or** • **Are eligible for carries?**	**N/A**

Spoiled, Lost & Missed Doses	
On-Site Observations	**Self-Audit Results Section 7**
7.1 Are all reports of vomited, lost or missed doses documented on the patient's chart or medical record? This could not be determined based on the patient records. It is possible that the patient records that were reviewed were those of patients who did not experience a vomited, lost or missed dose.	YES
7.2 Are all replacement doses given only as witnessed ingestion? This could not be determined based on the patient records.	YES
7.3 Are all missed doses communicated to the INITIATING Physician?	**N/A**

Carries	
On-Site Observations	**Self-Audit Results Section 8**
8.1 Do you document the rationale for providing a patient with carries on the patient chart or medical record? It is not obvious within the patient records what the rationale for carries may be . It is possible that there is a short statement within the patient record, but due to the poor handwriting, that cannot be determined.	YES
8.2 For patients receiving carries, do you require: • **A locked box or storage container for any carried doses?** • **That empty bottles be returned to the pharmacy for proper disposal?** This could not be determined based on the patient records.	YES/NO YES
8.3 Do inappropriately used, lost, stolen or spoiled carried doses results in the loss of carry privileges for patients? This could not be determined based on the patient records.	YES

Methadone & Other Medications	
On-Site Observations	**Self-Audit Results Section 9**
9.1 Are you familiar with other medications that interact with methadone and can cause: • **QTc prolongation?** • **CNS depression?** • **Inhibition or induction of cytochrome systems involved in the metabolism of methadone?** *Not something that is evaluated in the on-site audit.*	YES to all
9.2 Do you always inform patients about the interactions of benzodiazepines, gabapentin, and other opioids with methadone? No evidence of this was found in the patient records.	YES
9.3 When benzodiazepines are co-prescribed with methadone, are the patient's history, examination findings, and diagnoses leading to treatment with benzodiazepines well documented in the patient chart or medical record? No evidence of this was found in the patient records of either co-prescribing or the discussion.	YES

Discontinuation	
INVOLUNTARY WITHDRAWAL	
On-Site Observations	**Self-Audit Results Section 10**
10.1 During involuntary withdrawal, are all carries revoked and all doses provided through DWI? ***Exception: pharmacy closure (e.g. not open on Sundays)*** This could not be determined based on the patient records.	YES
10.2 Are patients undergoing involuntary withdrawal warned about the loss of tolerance and the risk of toxicity if he/she relapse to opioids? This could not be determined based on the patient records.	YES

VOLUNTARY WITHDRAWAL	
10.3 Are patients undergoing involuntary withdrawal warned about the loss of tolerance and the risk of toxicity if he/she relapse to opioids? This could not be determined based on the patient records.	YES
10.4 Are patients undergoing voluntary withdrawal seen regularly to assess their mood and withdrawal symptoms, and provide supportive counselling? This could not be determined based on the patient records.	YES

Transfer of Care	
On-Site Observations	**Self-Audit Results Section 11**
11.1 As an INITIATING Physicians, when transferring to a MAINTAINING Physician, do you provide the following information: • **The dose of methadone?** • **All prescribed medications?** • **Details on how many carries are permitted?** • **Frequency of UDS?** • **A copy of the treatment agreement?** • **Relevant clinical history of the patient?** • **Contact information for yourself?** This could not be determined based on the patient records as a patient who was transferred to another prescriber was not reviewed.	YES YES YES YES NO NO YES

Appendix 5

Overview of the 2016 Methadone and Suboxone Opioid Substitution Therapy Conference

AGENDA

Saskatchewan
Methadone and Suboxone Opioid Substitution Therapy
CONFERENCE 2016

Friday April 22, 2016		
Time Slot	**Topic**	**Speaker**
7:30 to 8:00	BREAKFAST	
8:00 to 8:10	Introduction	
8:10 to 8:30	Saskatchewan Methadone Guidelines & Standards: A quick review	Dr Markentin
8:30 to 9:10	What is Substance Use Disorder?	Dr Butt
9:10 to 9:30	Opioid Substitution Therapy – Weighing the risks & benefits	Dr Lanoie
9:30 to 9:45	Q & A	
9:45 to 10:00	COFFEE BREAK	
10:00 to 10:30	Professionalism	Brenda Senger
10:30 to 11:00	The Importance of the Team Approach	Dr Pawluck
11:00 to 11: 45	Who is Suitable for Opioid Substitution Therapy?	Courtney Morin
11:45 to 12:00	Q & A	
12:00 to 12:45	LUNCH	
12:45 to 1:15	Patient Assessment	Dr Markentin
1:15 to 2:15	Dosing	Dr Markentin
2:15 to 2:30	Q & A	
2:30 to 2:45	COFFEE BREAK	
2:45 to 3:15	Urine Drug Screening to Optimize Treatment	Dr Pawluck
3:15 to 4:00	The Role of Carries in Treatment	Dr Markentin
4:00 to 4:45	The Role of the Pharmacist	Kirsty Carlson
4:45 to 5:00	Q & A	
	Wrap-up	

Saturday April 23, 2016		
Time Slot	**Topic**	**Speaker**
8:00 to 8:30	BREAKFAST	
8:30 to 8:45	Fentanyl	Dr Butt
8:45 to 9:00	Take Home Naloxone Kits	Dr Butt
9:00 to 9:45	Recovery Streams	Ruth White
9:45 to 10:00	Q & A	
10:00 to 10:15	BREAK	
10:15 to 10:45	Athakakoop Cree Nation	Dr Crawford
10:45 to 11:30	Discharge: When is It Appropriate?	Dr Butt
11:30 to 12:15	Mental Health & Addiction Care Part 1	Dr Brennan
12:15 to 1:00	Lunch	
1:00 to 1:45	Mental Health & Addiction Care Part 2	Dr Brennan
1:45 to 2:30	Managing Co-Morbidities: Hep C, HIV & COPD	Dr Markentin
2:30 to 2:45	Q & A	
2:45 to 3:00	BREAK	
3:00 to 3:30	Managing Concurrent Pain & Addiction	Dr Lanoie
3:30 to 4:00	Opioid Substitution Therapy & Pregnancy	Dr Carson
4:00 to 4:15	Q & A	
	Wrap Up