

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

<u>ADDICTON</u>	<u>Total:22</u>	
Dr. Olajide Adelugba		Corman Park
* Dr. Johanna Kaiser		La Ronge
Dr. Johannes Kleingeld		La Ronge
Dr. Kevin Dautremont		Moose Jaw
Dr. Erin Hamilton		North Battleford
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

<u>PAIN</u>	<u>Total:65</u>	
* 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 Boucher		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 Egbujoo	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 Helliard	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 initiate 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

**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	315 - 10th Street East Saskatoon, SK S7N 0C8

Gore-Hickman	Patrick	Wall Street ENT Clinic	230 - 140 Wall Street Saskatoon, SK S7K 1N4
Groves	Sean	La Ronge Medical Clinic	Box 240 La Ronge, SK S0J 1L0
Hamilton	Erin	Battlefords Family Health Centre	103 - 1192 - 101st Street North Battleford, SK S9A 0Z6
Hussain	Mohammad		2727 - 2nd Avenue West Prince Albert, SK S6V 5E5
Jooravan	Sujeeth		24 - 111 Rosewood Gate North Saskatoon, SK S7V 0E5
Kabongo	Tshipita	Integrated Wellness & Health Balance Center	2318 - 9th Avenue North Regina, SK S4R 8C5
Kamel	Jelisia	Southwest Medi-Centre	1530 Winnie Street NE Swift Current, SK S9H 1R5
Kgobisa	Lettie	La Loche Health Centre	112 - 6345 Rochdale Blvd Regina, SK S4X 2R1
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	Box 58, Site 300, RR 3 Saskatoon, SK S7K 3J6
Maya	Nomtandazo	Prince Albert Cornerstone Medical Clinic	Box 22040 CornerStone 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	410 - 2101 Heseltine Road Regina, SK S4V 3H1
Michel	Joseph	Lakeshore Medical Clinic	1380 - 23rd Avenue

			Regina, SK S4S 3S5
Mitchell	Cheryl	Martensville Collective Health and Wellness	805 - 241 - 5th Avenue North Saskatoon, SK S7K 2P3
Moolla	Hasan	Battleford Medical Clinic	Box 1171 Battleford, SK S0M 0E0
Nair	Ratheesh	Broad Street Clinic	2227 Winslow Bay Regina, SK S4V 0T9
Neethling	Bertram	La Loche Health Centre	Cherry Lane PO Box 21030 Penticton, BC V2A 6W6
Nwadike	Uche	Broad Street Clinic	60 Coombe Drive Prince Albert, SK S6X 0A9
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.	Box 1333 Tisdale, SK S0E 1T0
Owonikoko	Onasegun	Prince Albert Co-Operative Health Centre/Community Clinic	52 Smiley Drive Prince Albert, SK S6X 0B3
Parekh	Vipul	Prince Albert Co-Operative Health Centre/Community Clinic	699 Sylvan Road Prince Albert, SK S6V 7S2
Patel	Rajnikant		2625 Dewdney Avenue Regina, SK S4T 0X4
Patel	Kalpna		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		24 - 111 Rosewood Gate North Saskatoon, SK S7V 0E5
Robertson	Archie		408 - 23rd Street West Prince Albert, SK S6V 4M1
Rooke	Edward	Saskatoon Community Clinic	Box 101, RR3 Saskatoon, SK S7K 3J6
Rossouw	Francois	Victoria Hospital Emergency Department	RR 4, Site 1, Comp 215 Prince Albert, SK S6V 5R2
Sayeed	Mohammed	Family Medical Clinic	4806 - 50th Street Lloydminster, SK S9V 0M9
Serunkuma	Ivan	Prince Albert Cornerstone Medical Clinic	205- 1896 - 15th Avenue East Prince Albert, SK S6V 7V2
Smit	Shawn	Idylwyld Medical Centre	1216A Idylwyld Drive North Saskatoon, SK S7L 0Z9
Stevens	John-Michael	Angelique Canada Health Centre	J.M. Stevens Medical Professional Corpor 353 Lakeridge Dr. Warman, SK S0K 0A1
Syed	Asma	Royal University Hospital, Psychiatry Department	1401 - 902 Spadina Crescent East Saskatoon, SK S7K 0G8
Terrett	Luke	Royal University Hospital Emergency Department	312 Saskatchewan Crescent West Saskatoon, SK S7M 0A4
Velestuk	Jordan	Queen City Medical	316 Emerald Park Road Emerald Park, SK S4L 0C4
Wegner	Sandra	LIFEBRIDGE Health Centre	RR #8, Site 811 Box 10 Saskatoon, SK S7K 1M2
Wildenboer	Wilhelmina	Rochdale Crossing Medical Clinic	3 Kennedy Crescent Regina, SK S4R 6G3
Zacher	Edward		1018 King Crescent Saskatoon, SK S7K 0N8

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

1. Continuing Education				
<i>**For INITIATING Physicians ONLY. Maintaining (or Non-Initiating Physicians, skip to question 2)</i>				
	YES	NO		
1.1 Have you acquired your methadone exemption within the last two years?	<input type="checkbox"/> Skip to question 1.2	<input type="checkbox"/> Proceed to question 1.3	Yes	18
			No	22
1.2 Have you completed a recognized course on the fundamentals of addiction medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	19
			No	1
1.3 Have you been treating opioid use disorder for 5 years or more?	<input type="checkbox"/> Proceed to question 1.4	<input type="checkbox"/> Proceed to question 2	Yes	17
			No	23
1.4 Have you completed 30 hours of formal Continuing Education (CME) in addictions medicine?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	41
			No	4
2.2 Do you have access to laboratory services?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	44
			No	1
2.3 Do you have access to pharmacy services?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<input type="checkbox"/>	<input type="checkbox"/>	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)?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	41
			No	2

3. Prescriptions				
	YES	NO		
3.1 Do you write methadone prescriptions by hand on a personalized prescription pad?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	18
			No	26
3.2 Do you create methadone prescriptions using an electronic EMR?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	41
			No	4
3.4 Do all prescriptions written for methadone contain: <ul style="list-style-type: none"> • 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? 	<input type="checkbox"/>	<input type="checkbox"/>	Yes	44
			No	0
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	41
	<input type="checkbox"/>	<input type="checkbox"/>	No	3
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	44
	<input type="checkbox"/>	<input type="checkbox"/>	No	0
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	44
	<input type="checkbox"/>	<input type="checkbox"/>	No	0
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	44
	<input type="checkbox"/>	<input type="checkbox"/>	No	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)? <i>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.</i>	<input type="checkbox"/>	<input type="checkbox"/>	Yes	42
			No	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	43
			No	2

4. Patient Assessment for Admission to MMT

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

	YES	NO		
			Yes	32
			No	4
4.1 Are the following documented for each patient in his/her chart or medical record?			Yes	29
			No	8
<ul style="list-style-type: none"> • Medical history, including cardiovascular 	<input type="checkbox"/>	<input type="checkbox"/>	Yes	37
<ul style="list-style-type: none"> • Appropriate physical examination 	<input type="checkbox"/>	<input type="checkbox"/>	No	0
<ul style="list-style-type: none"> • Pattern of drug use 	<input type="checkbox"/>	<input type="checkbox"/>	Yes	34
<ul style="list-style-type: none"> • Addiction treatment history 	<input type="checkbox"/>	<input type="checkbox"/>	No	2
<ul style="list-style-type: none"> • Psychiatric history and mental status 	<input type="checkbox"/>	<input type="checkbox"/>	Yes	35
<ul style="list-style-type: none"> • High-risk behaviour 	<input type="checkbox"/>	<input type="checkbox"/>	No	2
<ul style="list-style-type: none"> • Social situation 	<input type="checkbox"/>	<input type="checkbox"/>	Yes	34
<ul style="list-style-type: none"> • Details on chronic or recurrent pain 	<input type="checkbox"/>	<input type="checkbox"/>	No	3
			Yes	35
			No	1
			Yes	31
			No	6
4.2 Do you review the patient's prescribing profile from PIP prior to initiating MMT?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	34
			No	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	28
			No	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	28
			No	8
4.5 Does the patient sign an MMT agreement upon initiation of MMT?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	34
			No	3
Is a copy of the agreement kept on the patient chart?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	35
			No	2
Is the dispensing pharmacy provided with a copy of the agreement?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	10
			No	25
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	16

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)?			No	20
4.7 Do you document the patient's treatment plan on the patient's chart or medical record?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	34
			No	2
4.8 Is an ECG always performed on initiation of MMT?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	25
			No	8
4.9 Is a urine drug screen obtained from patients prior to the initiation of methadone?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	38
			No	0
4.10 Do you notify CPSS of a patient's discharge from MMT?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	22
			No	12
4.11 Are pregnant women given priority for admission into MMT over other applicants?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	33
			No	5
4.12 For patients under 18 years of age, do you consult with another MMT provider prior to initiating MMT?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	17
			No	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	36
			No	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?	<input type="checkbox"/>	<input type="checkbox"/> Not applicable to me <input type="checkbox"/>	Yes	33
			No	0
			N/A	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	38
			No	2
5.3 After a patient is stable, is he/she seen by a physician at least every 3 months?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	38
			No	3

6. Methadone Dosing							
INITIATION PHASE							
<i>*Remember: patients are at highest risk of methadone overdose in the first two weeks of MMT</i>							
				YES	NO		
6.1 Do you dose methadone based on the following criteria:				<input type="checkbox"/>	<input type="checkbox"/>	Yes	37
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?				<input type="checkbox"/>	<input type="checkbox"/>	Yes	39
						No	0
STABILIZATION PHASE (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?				<input type="checkbox"/>	<input type="checkbox"/>	Yes	7
						No	31
6.4 Do you collect a UDS at every visit during the stabilization phase?				<input type="checkbox"/>	<input type="checkbox"/>	Yes	32
						No	6
6.5 Do you query possible pregnancy with female patients regularly?				<input type="checkbox"/>	<input type="checkbox"/>	Yes	33
						No	6
MAINTENANCE PHASE (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?				<input type="checkbox"/>	<input type="checkbox"/> Not applicable to me <input type="checkbox"/>	Yes	13
						No	0
						N/A	27
6.7 As a MAINTAINING Physician, do you consult with the INITIATING Physician before adjusting the				<input type="checkbox"/>	<input type="checkbox"/>	Yes	4
						No	0

methadone dose when a patient shows more than one indicator of instability?		Not applicable to me <input type="checkbox"/>	N/A	37
6.8 Do you administer a UDS at least every 3 months to every patient?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	33
			No	3
SPLIT DOSAGES (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 split dosages, have you documented one of the following: <ul style="list-style-type: none"> Withdrawal symptoms within 24 hours of the daily dose? Symptoms of excessive methadone dose in the 4 hours following a single daily dosage? 	<input type="checkbox"/>	<input type="checkbox"/> Not applicable to me – I have no patients receiving a split dose <input type="checkbox"/>	Yes	26
			No	0
			N/A	15
6.10 In patients receiving split dosages, do they either: <ul style="list-style-type: none"> Attend the pharmacy twice a day for DWI? Or Are eligible for carries? 	<input type="checkbox"/>	<input type="checkbox"/> Not applicable to me – I have no patients receiving a split dose <input type="checkbox"/>	Yes	27
			No	0
			N/A	13

7. Spoiled, Lost & Missed Doses				
<i>** 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.</i>				
	YES	NO		
7.1 Are all reports of vomited, lost or missed doses documented on the patient's chart or medical record?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	37
			No	3
7.2 Are all replacement doses given only as witnessed ingestion?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	38
			No	1
7.3 Are all missed doses communicated to the INITIATING Physician?	<input type="checkbox"/>	<input type="checkbox"/> Not applicable to me <input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	37
			No	2
8.2 For patients receiving carries, do you require: <ul style="list-style-type: none"> A locked box or storage container for any carried doses? That empty bottles be returned to the pharmacy for proper disposal? 	<input type="checkbox"/>	<input type="checkbox"/>	Yes	38
			No	1
			Yes	37
			No	1
8.3 Do inappropriately used, lost, stolen or spoiled carried doses results in the loss of carry privileges for patients?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	34
			No	3

9. Methadone & Other Medications				
	YES	NO		
9.1 Are you familiar with other medications that interact with methadone and can cause: <ul style="list-style-type: none"> QTc prolongation? CNS depression? Inhibition or induction of cytochrome systems involved in the metabolism of methadone? 	<input type="checkbox"/>	<input type="checkbox"/>	Yes	41
			No	1
			Yes	42
			No	0
			Yes	39
			No	3
9.2 Do you always inform patients about the interactions of benzodiazepines, gabapentin, and other opioids with methadone?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	38
			No	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?	<input type="checkbox"/>	<input type="checkbox"/>	Yes	35
			No	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? <i>Exception: pharmacy closure (e.g. not open on Sundays)</i>	<input type="checkbox"/>	<input type="checkbox"/> Not applicable to me <input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/> Not applicable to me <input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>	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: <ul style="list-style-type: none"> • 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? 		Not applicable to me <input type="checkbox"/>	N/A	17
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	17
	<input type="checkbox"/>	<input type="checkbox"/>	No	1
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	17
	<input type="checkbox"/>	<input type="checkbox"/>	No	1
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	16
	<input type="checkbox"/>	<input type="checkbox"/>	No	1
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	14
	<input type="checkbox"/>	<input type="checkbox"/>	No	4
	<input type="checkbox"/>	<input type="checkbox"/>	Yes	11
<input type="checkbox"/>	<input type="checkbox"/>	No	7	
<input type="checkbox"/>	<input type="checkbox"/>	Yes	15	
<input type="checkbox"/>	<input type="checkbox"/>	No	3	
			Yes	16
			No	2

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

The areas highlighted below were identified as opportunities for improvement:

- 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
<p>2.1 Do you access the Pharmaceutical Information Program (PIP) before prescribing/renewing a prescription for every patient at every encounter?</p> <p>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.</p>	YES
<p>2.2 Do you have access to laboratory services?</p> <p>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.</p>	YES
<p>2.3 Do you have access to pharmacy services?</p> <p>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.</p>	YES
<p>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?</p> <p>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.</p>	YES
<p>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)?</p> <p>There are no notes in the patient records indicating that the patient has been seen by any other providers to receive non-pharm support.</p>	YES

Prescriptions

On-Site Observations	Self-Audit Results Section 3
<p>3.1 Do you write methadone prescriptions by hand on a personalized prescription pad?</p> <p>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.</p>	YES
<p>3.2 Do you create methadone prescriptions using an electronic EMR?</p> <p>All records are paper. No EMR.</p>	NO
<p>3.3 Do you transmit all methadone prescription, whether written by hand or generated electronically, via fax directly to the dispensing pharmacy?</p> <p>This could not be determined based on the information in the patient record. There was no documentation related to which pharmacy the patient uses.</p>	YES
<p>3.4 Do all prescriptions written for methadone contain:</p> <ul style="list-style-type: none"> • 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? <p>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.</p>	YES to all
<p>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)?</p> <p>This could not be determined based on the patient records.</p>	YES
<p>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?</p> <p>This could not be determined.</p>	YES

Patient Assessment for Admission to MMT

On-Site Observations	Self-Audit Results Section 4
<p>4.1 Are the following documented for each patient in his/her chart or medical record?</p> <ul style="list-style-type: none"> • Medical history, including cardiovascular • Appropriate physical examination • Pattern of drug use • Addiction treatment history • Psychiatric history and mental status • High-risk behaviour • Social situation • Details on chronic or recurrent pain <p>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.</p>	<p>NO</p> <p>NO</p> <p>YES</p> <p>YES</p> <p>YES</p> <p>NO</p> <p>YES</p> <p>NO</p>
<p>4.2 Do you review the patient's prescribing profile from PIP prior to initiating MMT?</p> <p>Also addressed in 2.1.</p>	<p>NO</p>
<p>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?</p> <p>No evidence of this was found in the patient records.</p>	<p>YES</p>
<p>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?</p> <p>No evidence of this was found in the patient records.</p>	<p>YES</p>
<p>4.5 Does the patient sign an MMT agreement upon initiation of MMT?</p> <p>Is a copy of the agreement kept on the patient chart?</p> <p>Is the dispensing pharmacy provided with a copy of the agreement?</p> <p>A copy of the treatment agreement was found in patient charts.</p>	<p>YES</p> <p>NO</p>
<p>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)?</p> <p>No evidence of this was found in the patient records.</p>	<p>YES</p>

<p>4.7 Do you document the patient’s treatment plan on the patient’s chart or medical record?</p> <p>No evidence of this was found in the patient records.</p>	<p>YES</p>
<p>4.8 Is an ECG always performed on initiation of MMT?</p> <p>An ECG was found in one patient chart, but not in all.</p>	<p>NO</p>
<p>4.9 Is a urine drug screen obtained from patients prior to the initiation of methadone?</p> <p>UDS appear to be done on intake.</p>	<p>YES</p>
<p>4.10 Do you notify CPSS of a patient’s discharge from MMT?</p> <p>Confirmed this with Nicole McLean (admin for OATP), that cessation forms are not sent to CPSS.</p>	<p>NO</p>
<p>4.11 Are pregnant women given priority for admission into MMT over other applicants?</p> <p>Cannot be determined based on the patient records reviewed, however there is the question “Are you pregnant?” on an intake form.</p>	<p>YES</p>
<p>4.12 For patients under 18 years of age, do you consult with another MMT provider prior to initiating MMT?</p> <p>Did not review the charts of any individual under the age of 18 years; cannot confirm.</p>	<p>NO</p>
<p>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?</p> <p>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.</p>	<p>YES</p>

<p style="text-align: center;">Clinical Visits</p>	
<p>On-Site Observations</p>	<p>Self-Audit Results Section 5</p>
<p>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?</p> <p>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.</p>	<p>YES</p>

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

<h2>Methadone Dosing</h2>																	
<h3><u>INITIATION PHASE</u></h3>																	
On-Site Observations	Self-Audit Results Section 6																
<p>6.1 Do you dose methadone based on the following criteria:</p> <table border="1" data-bbox="203 1150 1003 1444" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="background-color: #e0e0e0;">Patient Risk of Methadone Toxicity</th> <th style="background-color: #e0e0e0;">Initial Dose</th> <th style="background-color: #e0e0e0;">Dose Increase</th> <th style="background-color: #e0e0e0;">Frequency During Early & Late Stabilization</th> </tr> </thead> <tbody> <tr> <td>Low</td> <td>≤30mg</td> <td>10mg</td> <td>No more than every 3 days</td> </tr> <tr> <td>Moderate</td> <td>≤20mg</td> <td>10mg</td> <td>No more than every 4 days</td> </tr> <tr> <td>High</td> <td>≤10mg</td> <td>≤5mg</td> <td>No more than every 5 days</td> </tr> </tbody> </table> <p>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).</p>	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	<p>YES</p>
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														
<p>6.2 Do patients receive daily witnessed ingestion during initiation phase?</p> <p>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.</p>	<p>YES</p>																

<u>STABILIZATION PHASE</u> (Generally doses $\geq 60\text{mg}$; Usual target dose: 60 to 120mg)	
<p>6.3 Are doses ever increased by $\geq 10\text{mg}$ every 5 to 7 days during stabilization phase?</p> <p>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.</p>	YES
<p>6.4 Do you collect a UDS at every visit during the stabilization phase?</p> <p>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.</p>	YES
<p>6.5 Do you query possible pregnancy with female patients regularly?</p> <p>This could not be determined based on the patient records.</p>	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)	
<p>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?</p>	N/A
<p>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?</p>	N/A
<p>6.8 Do you administer a UDS at least every 3 months to every patient?</p> <p><i>See comments in 6.4</i></p>	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)	
<p>6.9 In patients receiving split dosages, have you documented one of the following:</p> <ul style="list-style-type: none"> • Withdrawal symptoms within 24 hours of the daily dose? • Symptoms of excessive methadone dose in the 4 hours following a single daily dosage? <p>There was no documentation suggesting that any patient was receiving split dosages.</p>	N/A

<p>6.10 In patients receiving split dosages, do they either:</p> <ul style="list-style-type: none"> • Attend the pharmacy twice a day for DWI? Or • Are eligible for carries? 	N/A
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Spoiled, Lost & Missed Doses	
On-Site Observations	Self-Audit Results Section 7
<p>7.1 Are all reports of vomited, lost or missed doses documented on the patient's chart or medical record?</p> <p>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.</p>	YES
<p>7.2 Are all replacement doses given only as witnessed ingestion?</p> <p>This could not be determined based on the patient records.</p>	YES
<p>7.3 Are all missed doses communicated to the INITIATING Physician?</p>	N/A

Carries	
On-Site Observations	Self-Audit Results Section 8
<p>8.1 Do you document the rationale for providing a patient with carries on the patient chart or medical record?</p> <p>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.</p>	YES
<p>8.2 For patients receiving carries, do you require:</p> <ul style="list-style-type: none"> • A locked box or storage container for any carried doses? • That empty bottles be returned to the pharmacy for proper disposal? <p>This could not be determined based on the patient records.</p>	YES/NO YES
<p>8.3 Do inappropriately used, lost, stolen or spoiled carried doses results in the loss of carry privileges for patients?</p> <p>This could not be determined based on the patient records.</p>	YES

Methadone & Other Medications

On-Site Observations	Self-Audit Results Section 9
<p>9.1 Are you familiar with other medications that interact with methadone and can cause:</p> <ul style="list-style-type: none"> • QTc prolongation? • CNS depression? • Inhibition or induction of cytochrome systems involved in the metabolism of methadone? <p><i>Not something that is evaluated in the on-site audit.</i></p>	YES to all
<p>9.2 Do you always inform patients about the interactions of benzodiazepines, gabapentin, and other opioids with methadone?</p> <p>No evidence of this was found in the patient records.</p>	YES
<p>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?</p> <p>No evidence of this was found in the patient records of either co-prescribing or the discussion.</p>	YES

Discontinuation

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

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

Transfer of Care	
On-Site Observations	Self-Audit Results Section 11
<p>11.1 As an INITIATING Physicians, when transferring to a MAINTAINING Physician, do you provide the following information:</p> <ul style="list-style-type: none"> • 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? <p>This could not be determined based on the patient records as a patient who was transferred to another prescriber was not reviewed.</p>	<p>YES</p> <p>YES</p> <p>YES</p> <p>YES</p> <p>NO</p> <p>NO</p> <p>YES</p>

Overview of the 2016 Methadone and Suboxone Opioid Substitution Therapy Conference



Saskatchewan
Methadone and Suboxone Opioid Substitution Therapy
CONFERENCE 2016

AGENDA

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 Carriers 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	

