CPSO METHADONE CONFERENCE 2016

Methadone Standards and Guidelines
ALL YOUR QUESTIONS ANSWERED…..

Methadone Program

Methadone Maintenance Treatment

Program Standards and Clinical Guidelines

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DISCLOSURE OF COMMERCIAL SUPPORT

- This program has not received financial support from any organization
- This program has not received any in-kind support
- Potential for conflict(s) of interest:
  - None

FACULTY/PRESENTER DISCLOSURE

- Faculty: Dr. Melissa Snider-Adler and Dr. Mike Franklyn
- Relationships with commercial interests:
  - Speakers Bureau/Honoraria: Indivior
- Faculty: Dr. Steve Bodley
- Relationships with commercial interests:
  - none

AGENDA

1. EMR NOTE TAKING – The Good, the Bad and The UGLY!
2. SPECIFIC COUNSELLING that MUST be documented
3. HIGH RISK PATIENTS
4. WITHDRAWALS vs. SIDE EFFECTS
5. BUPRENORPHINE TO METHADONE
6. TRAVEL CARRIES
7. URINE DRUG SCREEN WHEN THE PATIENT CANNOT LEAVE A SAMPLE
8. OPIOID USE DISORDER IN 2016

PROGRESS NOTES


KEEP
CALM
AND

THE GOOD THE BAD AND THE UGLY

Handwriting used to be the biggest issue

NOW IT IS COPYING AND PASTING FROM THE LAST NOTE WITHOUT REVIEWING OR MAKING CHANGES

OTHER ISSUES:

- **Conflicting information in the file**
- **Not enough information provided to justify the changes**
- **Notes are all exactly the same**
- **Information not documented (meds scripted)**

EXAMPLE CLINICAL NOTE A

Dose: 65mg
Carries: 4
Dose is not lasting – needing increase
Urine results: negative
Substance use: none
Withdrawals: none
Urges/cravings: none
Psychosocial: No changes
Plan: Increase dose

- SOAP format
- Conflicting information
- Not enough information to justify dose increase
- Not enough information in the plan
- The note does not tell the story
- What else was discussed?

EXAMPLE CLINICAL NOTE B

S: Follow up re: methadone treatment
Doing well, no complaints
Psychosocial – stable – no changes
Work – no changes
Substance use – none
Withdrawals – none
Side effects – none
Sedation – none
Methadone dose 65mg
CPSO level 4
O: Looks well, no signs of intoxication or withdrawals. Alert. Pupils not dilated or constricted. Normal gait and stance. Cognition normal.
UDS – EDDP positive, rest negative
A: SUD – stable on treatment
P: continue as above

2 WEEKS LATER…..

S: Follow up re: methadone treatment
Doing well, no complaints
Psychosocial – stable – no changes
Work – no changes
Substance use – none
Withdrawals – none
Side effects – none
Sedation – none
Methadone dose 65mg
CPSO level 4
O: Looks well, no signs of intoxication or withdrawals. Alert. Pupils not dilated or constricted. Normal gait and stance. Cognition normal.
UDS – EDDP positive, rest negative
A: SUD – stable on treatment
P: 5 carries

General Principles for Contents of Medical Records

CPSO Policy Statement #4-12 – Medical Records

…..the record must **tell the story of the patient's health care condition** and allow other health-care providers to read and understand the patient's health concerns or problems. Each record of a patient encounter, regardless of where the patient is seen, must include a **focused relevant history,** documentation of an **assessment** and an **appropriate focused physical exam** (when indicated), including a **provisional diagnosis** (where indicated), and a **management plan.**

Clinical Notes

CPSO Policy Statement #4-12 – Medical Records

Clinical notes must capture all relevant information from a patient encounter. This requires physicians to reflect on the care provided for a specific patient and document nuances of the encounter. **Templates and checklists** may be helpful tools for physicians, but **may not, on their own, meet the requirements for a complete clinical note**. **Physicians must avoid over-reliance on pre-populated templates and refrain from using overly general templates when documenting patient encounters**. Physicians should consider selecting an EMR that allows entry of free-text or that allows templates to be customized within the system to allow for greater descriptive detail. **Also, where patient information is entered into templates in advance, physicians must verify that the entries accurately reflect the nature of the encounter and provide all pertinent details about the patient's health status**.

COUNSELLING
that MUST be documented

KEY COUNSELLING

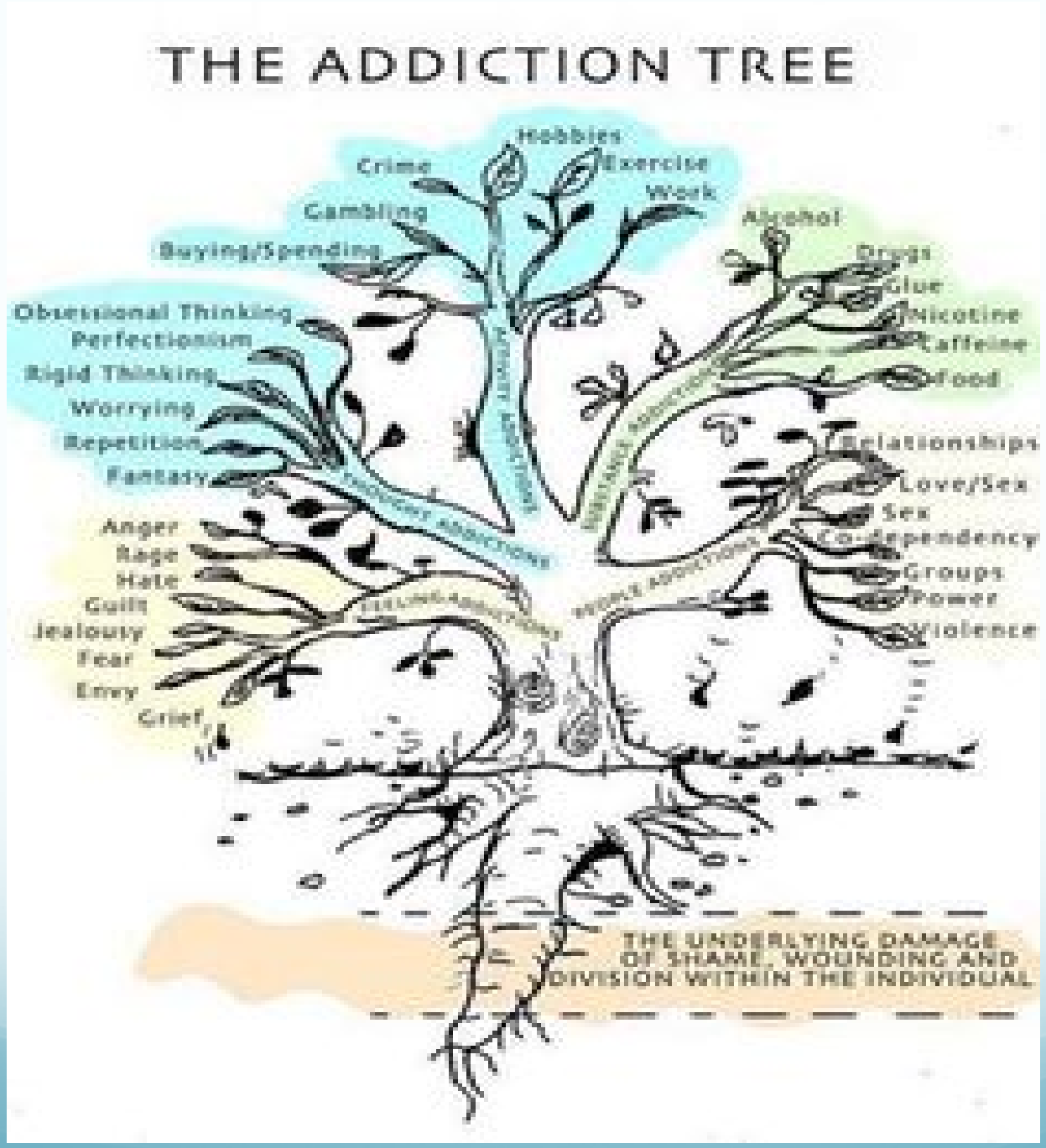
Points that need to be well documented

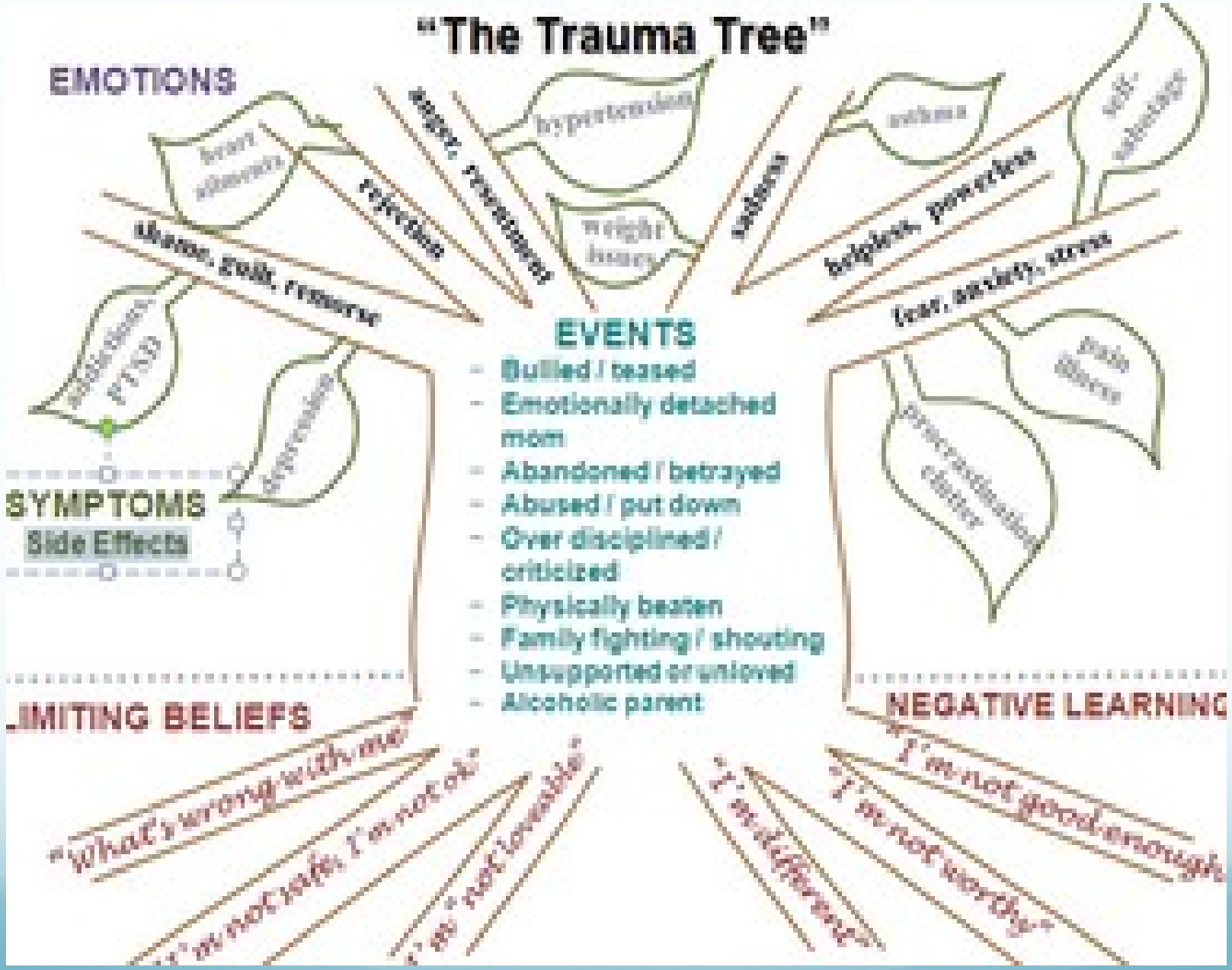
1. **INITIATING METHADONE**
   i. other options discussed - BUPRENORPHINE
   ii. Side effects and risks of methadone
   iii. avoiding OD in the first few weeks

2. **STARTING CARRIES need to document…**
   i. Their ability/stability to have carries
   ii. safe storage, risks of carries to a child or adult, lockbox etc.

3. **SPECIAL CARRIES/TRAVEL CARRIES**
   i. Details about trip (dates)
   ii. Reasons for needing extra carries

This is
My Story.


THE ADDICTION TREE
Hobbies
Crime
Exercise
Work
Gambling
Alcohol
Buying/Spending
Drugs
Glue
Obsessional Thinking
Nicotine
Perfectionism
Caffeine
Rigid Thinking
Food
Worrying
Repetition
Relationships
Fantasy
Love/Sex
Sex
Co-dependency
Anger
Rage
Groups
Hate
Power
Guilt
Violence
Jealousy
Fear
Envy
Grief
THE UNDERLYING DAMAGE
OF SHAME, WOUNDING AND
DIVISION WITHIN THE INDIVIDUAL


"The Trauma Tree"
EMOTIONS
shame, guilt, remorse
fear, anxiety, stress
EVENTS
- Bullied / teased
- Emotionally detached mom
- Abandoned / betrayed
- Abused / put down
- Over disciplined / criticized
- Physically beaten
- Family fighting / shouting
- Unsupported or unloved
- Alcoholic parent
SYMPTOMS
Side Effects
LIMITING BELIEFS
NEGATIVE LEARNING
"what's wrong with me"
"I'm not good enough"
"I'm not worthy"
"I'm not lovable"

COUNSELLING

- ADDICTION TREATMENT IS MORE THAN A PRESRIPTION
- NOTES SHOULD REFLECT THIS
  - Referral for counselling
  - Supportive counselling
  - Mindfulness
  - CBT
  - Exercise
  - Meditation/yoga
  - Past trauma

NEW STARTS

Mrs. Jones – CASE 1

Mrs. Jones is on chronic benzodiazepines (Valium 20mg bid recently discontinued by her GP) and is injecting 1 gram of heroin per day.

She will be starting methadone today. Her initial urine shows positive opiates and benzodiazepines. She is in obvious opiate withdrawal and has visible track marks. She states she hasn`t had any Valium for the past week, and is worried about having a seizure.

She insists that 20 mg of methadone will not be enough, as she was previously on methadone last year at a dose of 120mg, and she tells you she has an extra high tolerance as she has been injecting heroin for over 15 years.

What dose would you start this patient at?

CASE 1 - QUESTION 1

1. Start on 20 mg with reassurance
2. Start at 25 mg as it is under 30mg, and she has a known high tolerance
3. Start at 30mg given IV heroin use and increasing dose quickly will help stabilize her substance use and reduce the risks of ongoing use
4. Methadone is not indicated, she should be started on Bup/Naloxone

ANSWER TO QUESTION 1

Answer 1 only

Key point….

Patients who are on chronic benzodiazepines , or alcohol are high risk for overdose and should be started at **10-20mg regardless of opioid use history**.

HIGHER RISK OF OVERDOSE

- **Older Age (>65 YEARS OLD)**
- **Sedating medications (BENZODIAZEPINES)**
- **Structural heart disease**
  - Myocardial infarction, congestive heart failure, valvular disease, cardiomyopathy
- **COPD/Chronic Respiratory Illness**
- **Low potassium level**
- **Low prothrombin level**
- **Alcohol use Cocaine use**
- **Family or past history of long QT syndrome**

HIGHER RISK OF OVERDOSE

- **On medications that inhibit Cytochrome p450 3A4**
  - HIV antivirals e.g. indinavir
  - Antifungals e.g., Fluconazole, ketoconazole
  - Calcium channel blockers e.g., Diltiazem, verapamil
  - Antimicrobials e.g., Norfloxacin
  - Antidepressants e.g., Fluvoxamine
  - Contraceptives e.g., Mifepristone
  - Foods: e.g., grapefruit juice
- **On medications that prolong QTc**
  - Cardiac medications e.g., amiodarone, sotalol
  - Antipsychotics e.g., chlorpromazine, haloperidol, pimozide, thioridazine
  - Antibiotics e.g., clarithromycin, erythromycin
  - Anti-nausea drugs e.g., domperidone

MR. FIELDS– CASE 2

Mr. Fields has been on methadone for 2 years, stable with no substance use

Methadone dose 80mg

CPSO level 6

Patient comes to the clinic and states that for the last 1-2 weeks the dose has been wearing off

Patient states that he has withdrawals and needing his dose increased

NOW WHAT?

DO YOU NEED MORE INFORMATION?

MR. FIELDS – CASE 2

- Takes the dose at 0800
- withdrawals include sweats, lethargy, cravings
- No new medication
- No new vitamins
- No weight changes
- New job at factory – working midnights

IS THIS ENOUGH INFORMATION TO JUSTIFY INCREASING DOSE?

CASE 2 ANSWER

The physician should consider increasing the dose of methadone if the patient has **daily cravings**, **ongoing opioid use** which is due to and occurring when the dose is wearing off or **specific opioid withdrawal symptoms**.

Withdrawal symptoms can include:

- sweats (although this can be a side effect of higher dose methadone - if it occurs at or near the end of the dosing cycle, it can be due to withdrawals)
- shakes
- rhinitis
- myalgia
- insomnia (which may be due to many different factors)
- yawning
- anxiety
- restlessness
- agitation, irritability, edgy feeling
- nausea, stomach upset, diarrhea

CASE 2 ANSWER CONTINUED……

- Symptoms usually begin a **predictable number of hours after the methadone dose,** although there may be some daily variation with the patient's activity level and other factors. With each dose increase, the onset of symptoms is delayed and their severity is lessened.
- Alternative explanations should be sought if the patient has one isolated symptom (such as insomnia or sweats), or if the patient reports that the onset of symptoms is not related to the time of the dose.
- The physician should also enquire about **side effects,** such as constipation and sedation, as this may affect dosing decisions.

REQUIRED DOCUMENTATION

1) Cluster of withdrawal symptoms **- listing the specific withdrawals** that this patient has now

2) **Timing of withdrawal symptoms** (what time of day they appear in relation to the timing of their methadone dose)

3) **Specifics about ongoing drug use** and **timing of drug use:**

- opioid use at the end of the day may indicate inadequate methadone dose where use a few hours after dose may be to perk up from sedation due to dose, or simply due to habit of use.

4) Changes in mood and daily activities

5) side effects of methadone

6) any sedation from dose - looking specifically at the time frame of 3-6 hours after dosing

7) Use of alcohol or benzodiazepines or other sedating medications may indicate the need for caution in dose adjustment. It is important **to ask and document about other substance use**

S6.4 The MMT physician shall ensure the reason for all dosage adjustments are documented.

BUPRENORPHINE TO METHADONE

B.N. CASE 1

- B.N. has been on BUP/NALOXONE for 8 months.
- She has 6 carries and doses once a week at the pharmacy
- She has been stable on 16mg of BUP/NALOXONE
- However she has not been working for 6 months and is finding it expensive to dose. She owes the pharmacy money and is not sure how to pay
- She has been talking about changing to methadone as it would be less expensive
- Despite reviewing options and trying to find a solution, she decides that methadone would be better for her

B.N. CASE 1 CONTINUED

- She comes in to start and you decide to start her at 20mg
- She doses daily for 4 days.
- She is now having withdrawals 16 hours after dosing, including sweats, chills, restless, tossing and turning at night, runny nose
- She has not used any opioids/substances
- You increase her dose to 30mg
- She returns to the clinic and her dose is lasting 24 hours now
- She is asking about carries

CARRIES OR NOT?

- Stable patient with 6 carries on BUP/NALOXONE
- When can we start carries?
- Can you expedite carries?
- Can you change right back to 6 carries?

SUMMARY

- This can be treated as a restart in a patient who has not relapsed (ie. Missed doses due to circumstances beyond their control)
- **G8.12** During a relapse, the MMT physician should gradually reduce the take-home doses at a rate of one take- home dose per week for each week of problematic substance use, as determined by history or UDS. Take- home doses may be reinstated at the same rate, one dose per week for each week without problematic substance use.

M.T. CASE 2

- M.T. has been on methadone for 4 years
- He is from India and comes to tell you his grandmother has passed away
- He and his family will be travelling to India and will stay for 4 weeks
- He has not had any slips or relapses for years and has been stable at 75mg of methadone
- He has had 6 carries for at least 3 years or more
- He tells you that his brother was given Metadol instead of taking 4 weeks of methadone carry bottles to India with him. He would prefer this as well

METADOL OR NOT?

- Can you give Metadol?
- How long can you give carries for?
- What information do you need to verify the trip?
- What do you need to document?

SUMMARY

EXTNEDED CARRIES:

IF: Patient has not had problematic drug use for months, is clinically stable and receiving 3- 6 take-home doses per week.

- Give up to 2-4 weeks take-home doses for travel purposes.
- If more than 4 weeks of take-home doses is required, a second opinion with another MMT physician is suggested.

METADOL FOR THIS REASON IS OFF-LABEL USE requiring knowledge, good reasoning and documentation

P.P. CASE 3

- P.P. has been a patient at the clinic in the north end of town for the last 5 years.
- He has been taking methadone at 45mg and has had 6 carries for the last 2 years
- He recently is going through a divorce
- He has a history of enlarged prostate
- He has a history of anxiety disorder and recent increase in panic attacks and generalized anxiety
- He comes into get a second opinion about treatment options

P.P. CASE 3 CONTINUED

- He has been having trouble leaving urine drug screens weekly
- He often goes to the clinic and is there for hours trying to leave a urine drug screen
- He has missed doses as he cannot leave a urine sample and the clinic will not give him his dose without a urine drug screen
- He has not been able to pick up carries due to not being able to leave a urine drug screen
- He has missed work because of this
- He has had increasing anxiety now when coming into his clinic

URINE OR NOT?

- He is asking whether there are other options to leaving a urine drug screen?
- He is asking whether he can change clinics and have his blood taken instead?
- He heard about saliva tests and hair tests and is asking for this
- WHAT ARE THE OPTIONS?
- DOES HE NEED TO LEAVE A URINE DRUG SCREEN?

SUMMARY

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- In occasional circumstances, patients including those who have take-home doses, may provide UDS less often than once monthly if they are well known to the MMT physician over a number of years, they have long established clinical stability and drug use abstinence and are considered by the MMTphysician to be reliable historians. Less than monthly urine testing may also occur for patients who have ongoing drug use or who are chronically homeless and will not be seeking take-home doses.

G7.2 The MMT physician should have the UDS collection supervised, if possible, to verify the integrity of the UDS specimen.

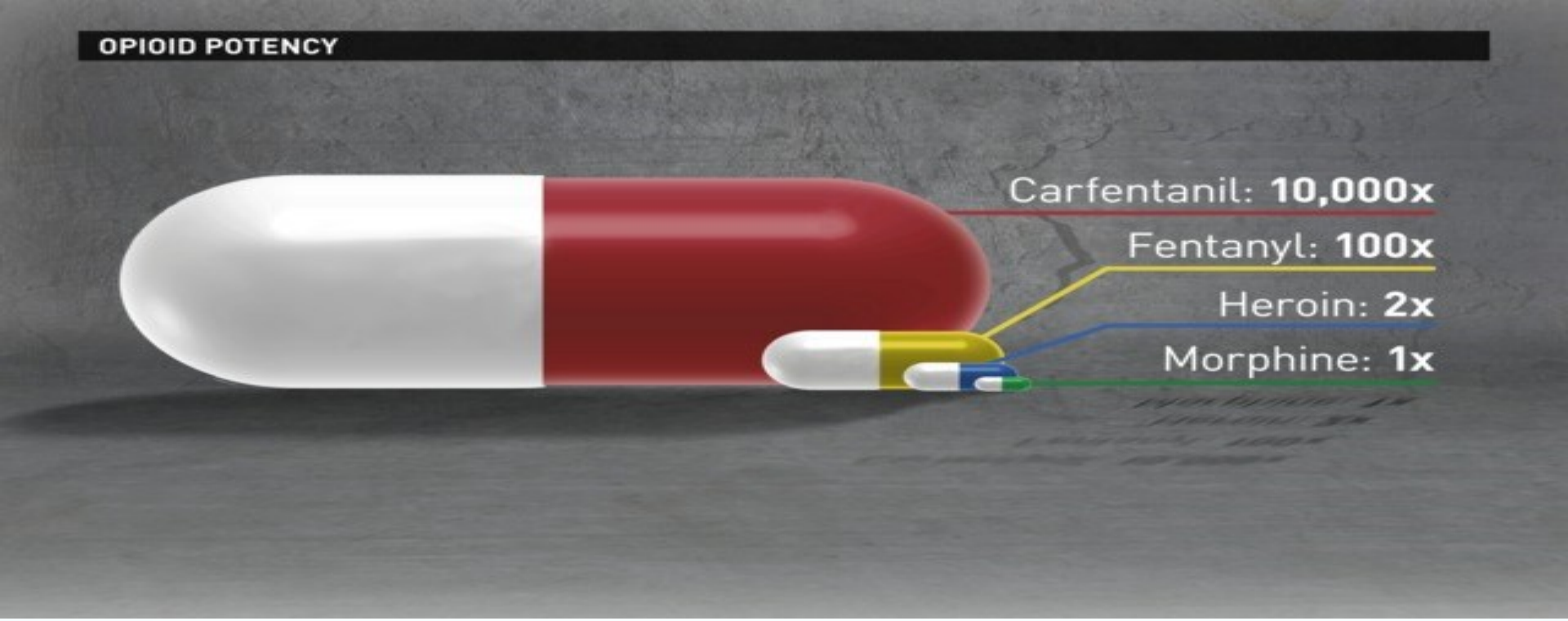
G7.3 If supervision is not possible, the MMT physician should ensure other measures such as creatinine or temperature monitoring are implemented.

7.3.1 Frequent UDS during Stabilization Phase

- Frequent UDS is defined as 4 times per month or more.
- Frequent urines may be collected once to twice a week during the stabilization phase. Twice weekly urines will more likely detect sporadic drug use and in some patients might facilitate more accurate self disclosure. The MMT physician should ensure that frequent twice weekly urines do not interfere with the patient's work or family obligations.

OTHER ISSUES IN 2016

- FENTANYL
- CARFENTANIL
- W-18
- HYDROMORPHONE
- ALCOHOL
- RITALIN/STIMULANTS
- METHAMPHETAMINE/AMPHETAMINE
- HALLUCINOGENS/DISSOCIATIVES….



It only takes
1 microgram
of Carfentanil in
humans for an effect.

Cocaine laced with fentanyl a growing concern: 9 overdoses in 20 minutes in Delta
Police warn recreational drug users at increasing risk as cheap fentanyl is used to buff other drugs

By Gavin Fisher, CBC News Posted: Sep 01, 2016 12:26 PM PT Last Updated: Sep 01, 2016 5:07 PM PT

'An exceptionally high toll': Fentanyl, overdoses claim 488 in B.C.
488 deaths represents a 61.6 per cent increase compared the same time period last year

By Jason Proctor and Karin Larsen, CBC News Posted: Sep 21, 2016 12:10 PM PT Last Updated: Sep 22, 2016 8:06 AM PT

Experts sound alarm after 40% increase of fentanyl-laced street drugs tested in Canada

Post Author Credit By Adam Miller and Andrew Russell Global News

“2016 is like no other year in Canadian drug history and there’s no turning back,”

“It’s probably never been a more dangerous time in Canadian history to be using illicit substances.”

Michael Parkinson, a drug strategy specialist with the Waterloo Regional Crime Prevention Council in Ontario.

KEY MESSAGE

COUNSELLING

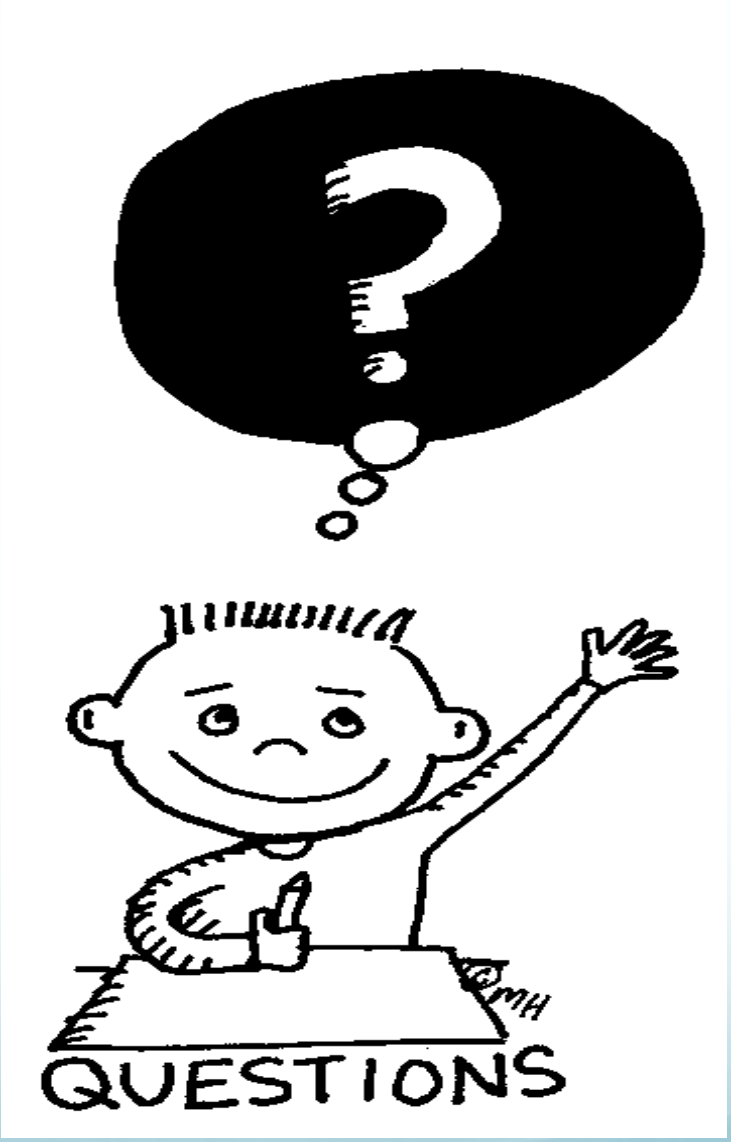
COUNSELLING

COUNSELLING

DOCUMENT

DOCUMENT

DOCUMENT


QUESTIONS