OATP Opioid Agonist Therapy Program

ANNUAL REPORT 2021

April 1, 2021, to March 31, 2022

Respectfully submitted by:
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Nicole Bootsman, Pharmacist Manager PRP/OATP
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June 30, 2022

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OPIOID AGONIST THERAPY PROGRAM
ANNUAL REPORT 2021

Program Overview

Since 2001, the Opioid Agonist Therapy Program (OATP) has been administered by the College of Physicians and Surgeons of Saskatchewan (CPSS) on behalf of the Ministry of Health, Community Care Branch. The Program is responsible for educating, monitoring, supporting, and recommending physicians for CPSS approval to prescribe opioid agonist therapy (OAT). Staff from the OATP are also responsible for the Prescription Review Program (PRP). The OATP Clinical Manager provides clinical expertise on a contract basis.

Qualified and licensed clinical staff, including the Pharmacist Manager PRP/OATP, program Pharmacist, Analyst (Pharmacy Technician) and the OATP clinical Manager (licensed medical physician) are authorized to provide clinical advice, information, and analysis for the program. Operations oversight including human resources, reporting and administrative support are provided by the Operations Manager and the Administrative Assistant.

Enquiries, Collaboration and Outreach

Staff logged 256 calls related to the program between April 1, 2021 – March 31, 2022. Examples of calls include pharmacists calling to confirm OAT approval for physicians, physicians seeking pharmaceutical advice regarding patient care, pharmacists asking for clarification/support for prescriptions they are filling and the public reporting alleged misuse of medications. Phone calls often involve assisting with coordination of care for patients. The team also communicates with physicians who may be interested in obtaining approval to provide OAT. Those conversations are not included in the number above as they are often ongoing and can span several months or longer.

To simplify the process for pharmacists to confirm a physician has the appropriate approval to prescribe either methadone or buprenorphine/naloxone for opioid use disorder, the OATP worked with the Saskatchewan Health Information Resources Program (SHIRP) to include the list on their website (https://shirp.usask.ca/). The list is updated as new prescribers are approved and/or providers indicate they are no longer providing OAT services. The list is not publicly available and is only used for confirmation purposes.

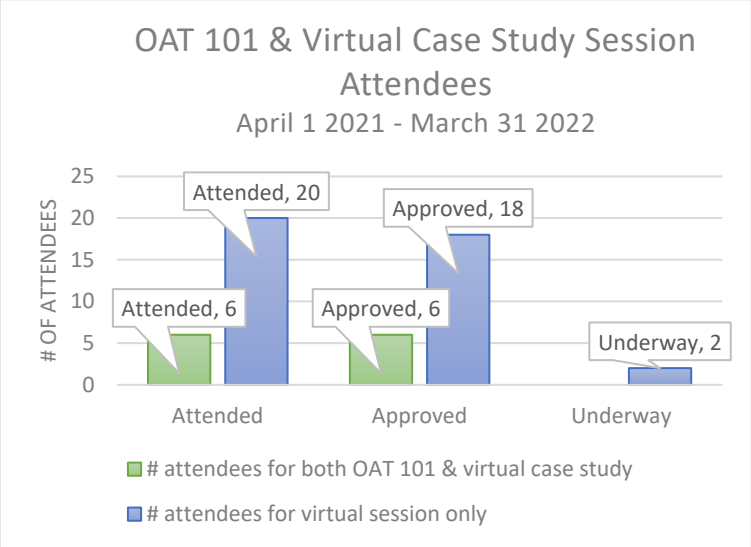
The Pharmacist Manager, PRP/OATP and the OATP Clinical Manager are both members of the core working group of Advancing Interprofessional Management of Substance Use Disorders in Saskatchewan (AIMS-SK), providing valuable input to the group

OAT Education and Training

OAT/OUD educational sessions continued to be offered via the Extension for Community Healthcare Outcomes (ECHO®) Platform and have been well attended. Funding for the sessions was provided through the opioid Emergency Treatment Fund (ETF), as approved by the Ministry of Health, Community Care Branch. Sessions included:

- Treating Pain in Patients with Substance Use Disorder – Dr. Larissa Kiesman (62 attendees)
- Trauma Informed Care – Erin Beckwell MSW, RSW (88 attendees)
- Pregnancy and Substance Use Disorder – Dr. Morris Markentin (72 attendees)

The CPSS OAT 101 in-person education session and CPSS OAT virtual patient case study, created as pilots in early 2020 by the Pharmacist Manger, PRP/OATP and the OATP Clinical Manager, continued to assist physicians obtain the necessary education and training required to be considered by CPSS for approval. Nine virtual and one in-person session were held between April 1, 2021, and March 31, 2022, with a total of twenty-six attendees as shown in the graph below.



The in-person CPSS educational session was held in Yorkton and the nine CPSS virtual case studies were held with substantial outreach to physicians all over Saskatchewan (see map next page).

Of the six physicians who participated in the CPSS in-person educational session and CPSS virtual case study, all six (100%) received OAT approval. Twenty physicians participated in a CPSS virtual case study and received their educational program training through an online course, with 18 (90%) receiving OAT approval and two (10%) still working through outstanding administrative requirements (e.g. policy signing).

Over the past fiscal year, the cost of to deliver these sessions was approximately $8,900 (travel-associated costs and Clinical OAT Manager/Pharmacist Manager salary costs). For comparison, after the last OAT conference, at a cost of approximately $40,000, fourteen physicians were approved.

A survey sent to attendees after each session has received positive feedback such as:

> "It was useful to discuss cases with an experiences provider to see how he prescribed and manages in a real-world scenario."
>
> "I was able to ask questions around the cases we discussed. I felt like I could call or text my mentor if I had any questions and he would remember who I was and would be willing to advise me."

Completing in-person direct training can be difficult and the CPSS virtual case studies provide easier access to this vital training. Increasing the number of approved providers in rural and remote locations enables patients to receive care closer to home and takes some patient burden off urban providers.

Both the in-person sessions and virtual case studies are scheduled around the interest and availability of the physicians, usually outside of regular business/clinic hours. More sessions will be planned as physicians commit to completing the sessions. A maximum of three physicians attends each virtual case study to maximize collaboration.

Practice Location	# of approved providers who attended virtual case study only
Carlyle	1
Ile a la Crosse	5
La Loche	1
Prince Albert	1
Regina	9
Saskatoon	1
Total	**18**

Practice Location	# of physicians approved who attended both an in-person OAT 101 and virtual mentorship
Yorkton	6
Total	**6**

Audits

Four audits for new OAT prescribers were initiated along with one audit for an experienced OAT provider. The audit for the experienced provider was part of a CPSS referral. Three previously initiated audits were also finalized during this period.

Each audit begins with the Analyst reviewing patient data against pre-set criteria and providing results to the pharmacist for review. A letter is then sent to the physician requesting approximately nine patient charts to review for the audit along with a self audit form for them to complete and a patient chart of their choosing. The returned charts and self audit require a thorough review and then feedback and recommendations are provided back to the physician. OAT audits allow new providers to self assess their skills and can also be informative for experienced providers. The audit allows the OATP Clinical Manager and the program pharmacists to offer advice and suggestions for improved care and can also highlight potential concerns early on.

Monitoring and Referrals

Methadone and buprenorphine/naloxone prescribing is monitored through the PRP. Both medications are included in the provincially designated panel of prescription medications with known misuse, abuse and potential diversion by patients. There are several reasons a letter may be sent to a physician including potential diversion, multiple prescribers, or to understand the physician's prescribing rationale, even if a particular issue has not been identified.

Types of Correspondence (April 1, 2021 – March 31, 2022)	Letters specific to OAT
Alert – letters sent to physicians to alert them of potential diversion, early fills, or other patient concerns and includes specific advice and follow-up analysis. Typically has not required a response in the past, but specific questions regarding safeguards were added in January 2022, which require a response.	**9** Alerts sent to **5** physicians regarding **9** patients
Law Enforcement Requests – when a patient's medication profile (related to dispenses of methadone and/or bup/nx) is provided to law enforcement for an active investigation.	**9**
Non-approved OAT Letters – sent to physicians who are identified as prescribing either methadone or buprenorphine/naloxone for opioid use disorder without having appropriate CPSS approval. A response is requested, and physicians are given information on the OAT approval process.	**63** letters sent to **61** physicians **2** of the **61** physicians went on to receive OAT approval and **9** others have expressed interest

Follow up on Alert letters involves reviewing patient profiles and previous correspondence to determine if anything concerning needs to be addressed. Based on that analysis, a follow-up letter may be sent to the physician, or it may be determined that the profile requires further analysis at a later date.

Referrals

- Four referrals were made to CPSS regarding physicians either not meeting the standards of practice for OAT, or for failing to provide information as requested.
- Referrals were also made to other regulatory bodies so they can follow up with their own members as they see appropriate. The following referrals were made between April 1, 2021, and March 31, 2022.
    - Saskatchewan College of Pharmacy Professionals – 4
    - College of Registered Nurses of Saskatchewan – 4

OAT Standards and Guidelines

To keep current with the rapidly changing and lethal drug supply in Saskatchewan, the Pharmacist Manager, PRP/OATP and the OATP Clinical Manager began an early review of the current OAT Standards and Guidelines (prior to the sunset date). This involved countless hours of work researching current best practices, reviewing standards and guidelines from other provinces and gathering feedback from experts in the field of addictions medicine. National standards and best practices were then incorporated in the standards and guidelines and feedback was obtained from stakeholders as well as all OAT providers in Saskatchewan.

In June 2021, current OAT providers were invited to provide feedback and suggest updates to the OAT Standards and Guidelines for consideration (***Appendix A***).

Key stakeholders (Saskatchewan Medical Association, Saskatchewan College for Pharmacy Professionals, Pharmacy Association of Saskatchewan, College of Registered Nurses of Saskatchewan and the Ministry of Health) were invited in September 2021 to provide feedback on proposed changes to the OAT Standards and Guidelines

All OAT providers received a letter in April 2022 via email outlining the recently approved updates/changes to the OAT Standards and Guidelines. (***Appendix B***).

Saskatchewan OAT Prescribers

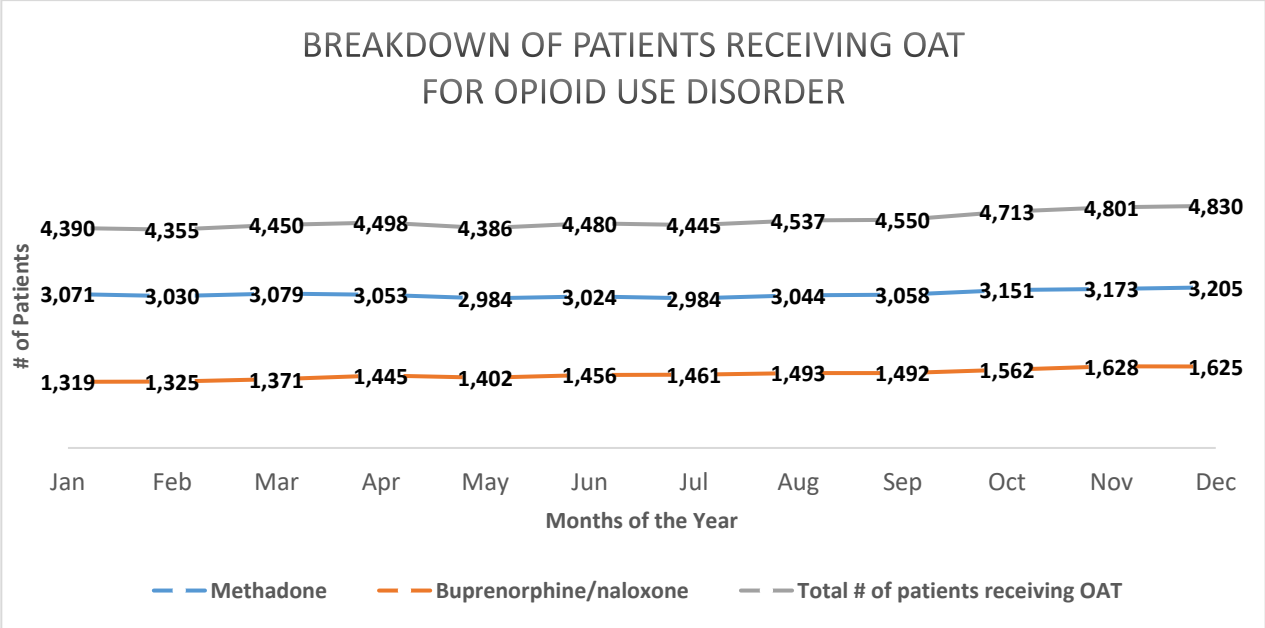
As of March 31, 2022, 150 physicians were approved to prescribe methadone and/or buprenorphine/naloxone for opioid use disorder. That is an increase of thirty-one providers over the same period last year. *This report captures physicians only*. Nurse Practitioners are also able to obtain prescribing authority through their regulatory body. In certain circumstances, pharmacists have also been granted OAT prescribing authority (e.g. Exemption 56)

121 physicians - initiate both methadone and buprenorphine/naloxone
seven physicians - initiate methadone only
six physicians - maintain methadone only
five physicians - maintain methadone and initiate buprenorphine/naloxone
one physician - maintain both methadone and buprenorphine/naloxone
nine physicians - initiate buprenorphine/naloxone only
one physician - maintain buprenorphine/naloxone only

A map of physicians authorized to prescribe OAT in Saskatchewan is contained in ***Appendix C***.

Saskatchewan Residents Receiving OAT

The table below outlines the breakdown of Saskatchewan patients who received either methadone or buprenorphine/naloxone as well as the total number Saskatchewan residents receiving OAT for *opioid use disorder (OUD)* in 2021[1]:



[1]Bup/nx does not have separate DINs for OAT, so we are unable to provide separate data for OUD

Appendix A: OAT Standards and Guidelines – 2021 Request for Feedback

101 - 2174 Airport Drive
SASKATOON, SK S7L 6M6
Business: (306) 244-7355
Fax: General: (306) 244-0090
Email: oatp@cps.sk.ca
www.cps.sk.ca

June 9, 2021

Dear Dr. OAT Provider,

One of the activities of the Opioid Agonist Therapy Program (OATP) is to regularly review and revise the *CPSS OATP Standards and Guidelines for the Treatment of Opioid Use Disorder*.

As part of our next scheduled review, we would like to provide you with the opportunity to offer suggestions for potential revisions. For every recommendation that you provide, please specify whether the suggestion is **evidence-based** (with reference) or **expert opinion**. Please feel free to utilize the attached, fillable chart to provide your feedback.

As a reminder:

> ***Standards*** *define a minimum acceptable level of care to ensure patient safety. Standards are a mandatory requirement.*
>
> ***Guidelines*** *provide direction that "should" be followed when managing specific issues. In OAT, guidelines provide direction and recommendations for effectiveness and optimal patient care. Guidelines assist Initiating, Maintaining and Temporary Prescribers in making clinical decisions about patients, and may be adopted, modified, or rejected according to clinical needs, individual patient considerations, local resources, and physician discretion. A physician must exercise reasonable discretion and have justifiable reasons when there is a decision to not follow a guideline. In every instance, the reasons for not following a guideline must be well documented.*

Please be advised that while each suggestion will be considered, the advice may not be incorporated into the revised document. All feedback will be reviewed and assessed by our own provincial experts and provided to the CPSS Council for consideration, as applicable.

Please provide your feedback by **June 23, 2021** to Nicole.Bootsman@cps.sk.ca.

As always, don't hesitate to contact us if you have any questions.

Kind regards,

Dr. Morris Markentin MD, CCFP, FCFP
Clinical Manager
Opioid Agonist Therapy Program

Nicole Bootsman BSc(Hons), BSP
Pharmacist Manager
Opioid Agonist Therapy Program

Existing Standard/Guideline	Suggested Modification(s)	Source(s)

Appendix B: OAT Standards and Guidelines: Update Communication

101 - 2174 Airport Drive
SASKATOON, SK S7L 6M6
Business: (306) 244-7355
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April 14, 2022

Dear OAT Provider,

You may recall that we requested your input on the *Opioid Agonist Therapy Standards and Guidelines* revision. In addition to our OAT physician providers, we also consulted with the following organizations:

- Saskatchewan Medical Association
- Saskatchewan College of Pharmacy Professionals
- Pharmacy Association of Saskatchewan
- Saskatchewan Registered Nurses Association
- Ministry of Health – Mental Health and Addictions

After thorough discussions regarding the feedback provided (and a huge thank you for the substantial participation!), we finally have our newly revised document, available on our website. Now that we have the revision completed, we will continue working with the Saskatchewan Medical Association to roll out standardized templates which will be able to be integrated into your EMR. Stay tuned!

The main revisions are summarized below for your convenience. We acknowledge that this is a lengthy document, reflective of the complex nature of opioid use disorder. The document is intended to ensure standardized, evidence-based care throughout Saskatchewan. Where evidence is lacking, we have consulted with local experts and national best practice guidance. Please be sure to review the revised document in its entirety.

(OAT Standards & Guidelines)

Please do not hesitate to contact us if you have any questions.

Sincerely,

Dr. Morris Markentin MD, CCFP, FCFP
Clinical Manager
Opioid Agonist Therapy Program

Nicole Bootsman BSc(Hons), BSP
Pharmacist Manager
Opioid Agonist Therapy Program

Opioid Agonist Therapy Standards and Guidelines for the Treatment of Opioid Use Disorder: Summary of the 2022 Update

General

- The document refers to "opioid use disorder" opposed to "addiction" and "misuse" rather than "abuse".
- Person-centered language has been utilized (e.g. "OAT patients" changed to "patients with OUD").
- Gender-neutral language has been used throughout the document ("their"/"they" rather than "he/she").
- Applicable links have been updated.
- Drug trends in Saskatchewan have been updated to include the highly potent illicit supplies contributing to opioid harms (pg. 8).
- Emphasis on individual values and beliefs (based on community, land and culture) have been highlighted as important considerations for treatment options (pg. 11).
- Pregabalin (in addition to gabapentin) is highlighted as a high-risk medication (pg. 63, 85).

New Sections

- A new section entitled *Buprenorphine Implant/Depot* has been added (pg. 14).
- A new section on *Microdosing and Macrodosing* has been added (pg. 43).
- A new section entitled Special Situations: Acute and Chronic Pain Considerations has been added (pg. 85).
- A new section entitled *Considerations for Surgery* has been added (pg. 86).
- A new section entitled *Slow-Release Oral Morphine (SROM)* has been added (pg. 49).
- A metabolism chart for stimulants has been added (pg. 153).
- A suggested Transfer of Care Template has been provided (pg. 127).

OAT Prescribing Authorization

- The method of receiving direct training in OAT has been revised to permit CPSS approved case-based virtual learning (pgs. 19 & 20).
- Notation regarding access to an updated OAT physician prescriber list on Saskatchewan Health Information Resources Program (SHIRP) has been added. (pg. 21)
- Prescribers must avoid financial conflicts of interest when choosing medications, pharmacies, and dispensing schedules (pg. 35).

OAT Prescriptions

- Authorization of verbal prescriptions in limited circumstances has been included as authorized by recent changes to federal legislation and the bylaw amendment approved by the CPSS Council (pg. 35).

Assessment

- The importance of behavioral and social supports, optimizing the determinants of health and addressing psychosocial factors that influence substance use and quality of life have been emphasized as important components of recovery (pg. 11).
- Psychosocial treatment, based on individual needs, should be considered alongside all pharmacological treatments for OUD but a patient's decision to decline psychosocial treatment or the absence of available treatment should not preclude or delay pharmacological treatment of OUD (pg. 34).
- Assessment for domestic violence has been added as part of a comprehensive assessment (pg. 121).

- The *Initial Patient Assessment Form* has been simplified (pg. 118).

Trauma-Informed Care & Harm Reduction

- Trauma-informed care has been updated to include emphasis on inclusion of care environments that are culturally safe and appropriate with trauma awareness (pg. 10).
- A comprehensive harm reduction approach (e.g. outreach services, access to naloxone, sterile drug consumption equipment, supervised consumption services, education on harm reduction practices, infectious disease testing, access to primary care, access to vaccinations, appropriate referrals to other health and social services) should be offered to patients regularly (pg. 11).

Neonates, Children & Adolescents

- Dogmatic adherence to Finnegan's scoring is to be avoided for assessment for neonatal opioid withdrawal (pg. 77-78).
- Information regarding confidentiality requirements when treating persons under the age of 18 years has been added (pg. 74).

Pregnancy

Note: there may be further updates to come once the Society of Obstetricians and Gynecologists of Canada (SOGC) publishes their guideline

- Guidance related to pregnancy/breast-feeding has been updated (pg. 75).

Methadone

- Pharmacology details have been limited to pertinent information for prescribers (pg. 15).
- Management for cases of compromised renal function has been included (pg. 15).
- Tolerance to high-potency opioids from daily use and UDS confirmation of recent opioid use has been added as additional potential consideration for low risk of methadone toxicity dosing (pg. 45).
- Established tolerance via patient history or collateral information, or changes in drug metabolism (e.g. over age 65, taking medications that inhibit CYP450 3A4) has been added as additional potential considerations for moderate risk of methadone toxicity dosing (pg. 45).
- Intermittent opioid use, unknown tolerance to opioids due to unclear history or lack of collateral information, use of low-potency opioids (e.g. codeine) have been added as additional potential considerations for high risk of methadone toxicity dosing (pg. 45).
- Updated dosing chart (pg. 46):

Patient Factors	Initial Dose	Dose Increase	Frequency
Low Risk of Methadone Toxicity	30 mg or less	10 mg or less	No more than every 3-5 days during early and late stabilization
Moderate Risk of Methadone Toxicity	20 mg or less	10 mg or less	No more than every 3-5 days during early and late stabilization
High Risk of Methadone Toxicity	10 mg or less	5 mg or less	No more than every 5 days during early and late stabilization

- Recommendation that when assessing post-dose sedation at peak serum levels for patients on high doses of methadone, arrange a follow-up in clinic 2-4 hours post witnessed dose at the pharmacy (pg. 47).
- For observed emesis by a health care provider within 15 minutes of an observed methadone dose, a replacement dose of methadone of no more than 50% of the regular dose should be offered (pg. 51).
- Notation that for patients who use illicit fentanyl regularly, doses of 100mg or higher may be required (pg. 47).
- Updated methadone missed doses protocol (pg. 51):

Methadone missed doses protocol	
Missed Days (Consecutive)	**Suggested Dose Adjustment**
1 to 2	Same dose (No change) unless there are concerns about loss of tolerance or adverse events
3	Restart at 50% of previous dose
4+	Restart at 5 to 30 mg (depending on tolerance)

Electrocardiograms

- Additional criteria for electrocardiograms and management of prolonged QTc for patients prescribed methadone have been added (pg. 54).
- For all patients prescribed methadone doses greater than 120 mg/day, ECGs must be obtained (changed from 100 mg/day in the previous Standards and Guidelines). Lack of ECGs should not be a barrier to receiving OAT (pg. 54).

Buprenorphine/Naloxone

- Bup/Nx now appears before methadone to emphasize Bup/Nx as the preferred treatment option.
- Pharmacology details have been limited to pertinent information for prescribers (pg. 13).
- Optional transition to long-acting preparations (monthly injections or subdermal implants) has been noted as an advantage for Bup/Nx (pg. 38).
- The recommendation of Bup/Nx office-based induction has been removed and emphasis on pharmacy and/or conditional home-based induction has been included (pg. 40).
- For conventional Bup/Nx initiation, precipitated withdrawal must be assessed within one to three hours to determine if additional doses (one or two 2mg tablets) are necessary (pg. 44).
- The recommendation to consider “microdosing” for patients who cannot tolerate the significant period of abstinence needed to initiate Bup/Nx with conventional induction has been added (pg. 44).

Corrections & Corrections-Based Temporary Prescribers (CBTPs)

- Emphasis regarding importance of maintaining OAT during corrections admission unless contraindicated and that care standards in a correctional facility must meet those of treatment standards in the community (pg. 27).
- CBTPs must confirm whether the patient has been receiving take-home doses and the last dispense date of take-home doses in addition to the daily dose and date/time of last administration (pg. 27).

- For patients receiving methadone from a CBTP, the provider must order an ECG if clinically indicated (e.g. the patient is on more than 120mg of methadone or has risk factors for prolonged QTc) (pg. 28).
- CBTPs must make every attempt to educate the patient about the potential for relapse and dangers of overdose, particularly in the lead-up to release. The patient should receive a take-home naloxone kit and overdose prevention training prior to release (pg. 28).
- For CBTP, prior to discharge, early coordination with the community-based prescriber and dispensing pharmacy is important, especially if hospital discharge is premature or unexpected (pg. 29).
- Guideline for CBTPs: work with the patient to avoid discontinuing OAT simply as a consequence of non-reassuring UDS results (pg. 29).

- Notation that medications dispensed during federal incarceration do not appear on PIP and recommendation for enhanced communication between the CBTP and community provider (pg. 29).

Hospital-Based Temporary Prescribers (HBTPs)

- Emphasis regarding importance of maintaining OAT during hospital admission unless contraindicated (pg. 24).
- HBTPs must confirm whether the patient has been receiving take-home doses and the last dispense date of take-home doses in addition to the daily dose and date/time of last administration (pg. 24).
- For patients receiving methadone from a HBTP, the provider must order an ECG if clinically indicated (e.g. the patient is on more than 120mg of methadone or has risk factors for prolonged QTc) (pg. 25).
- Prior to discharge, early coordination with the community-based prescriber and dispensing pharmacy is important, especially if hospital discharge is premature or unexpected (pg. 26).

Urine Drug Screening

- Information regarding management for lack of attendance or tampered urine drug screen has been added (pg. 53).
- Random urine drug screening has been updated to stress that screening is not intended to be used punitively; rather, it is one tool in a comprehensive risk assessment to provide information about exposures and risks, promote patient safety, guide care decisions such as adequacy of dose and monitoring progress toward treatment goals (pg. 52).

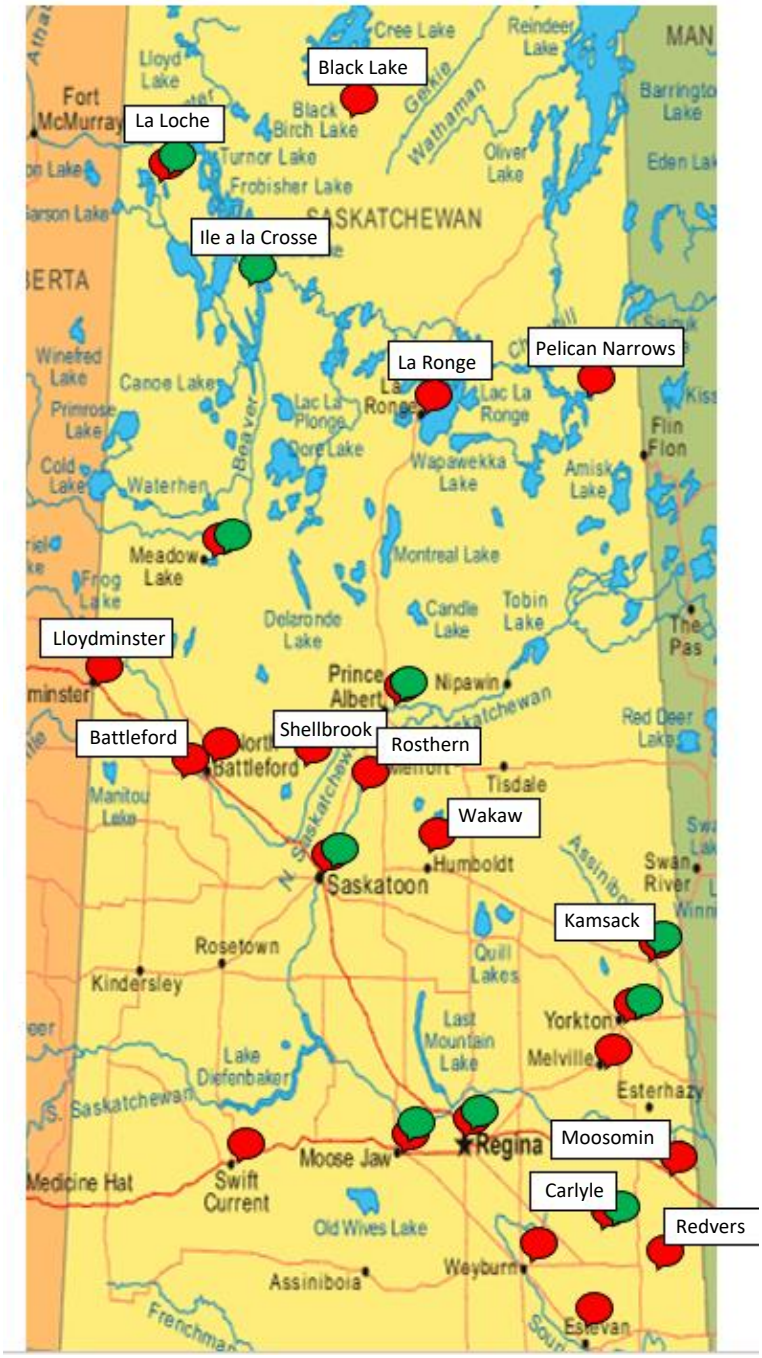
Take-Home Doses

- Explanation of guest dosing has been included for consideration when patients do not qualify for take-home doses (pgs. 60 & 62).
- Methadone take-home dose criteria has been modified (pg. 60-62).

Voluntary Withdrawal

- Maintenance of an “open door” approach to care is encouraged so that patients feel welcomed back in cases of relapse or if further support is required (pg. 67).

Appendix C: Map of physicians approved to provide OAT for opioid use disorder



City	# of providers
Battleford	1
Black Lake	2
Carlyle	2
Estevan	4
Ile a la Crosse	4
Kamsack	1
La Loche	3
La Ronge	6
Lloydminster	2
Meadow Lake	2
Melville	1
Moose Jaw	9
Moosomin	1
North Battleford	2
Pelican Narrows	1
Prince Albert	17
Redvers	1
Regina	44
Rosthern	4
Saskatoon	22
Shellbrook	2
Swift Current	3
Wakaw	1
Weyburn	1
Yorkton	9
Out of Province	5
Total	**150**

LEGEND

= existing locations where physicians are providing

T = new locations where physicians are providing OAT

Both = the physician is approved to prescribe both methadone and buprenorphine/naloxone

*These numbers indicate the total number of physicians approved to provide OAT for opioid use disorder. This does not represent how many physicians may be prescribing at any given time.