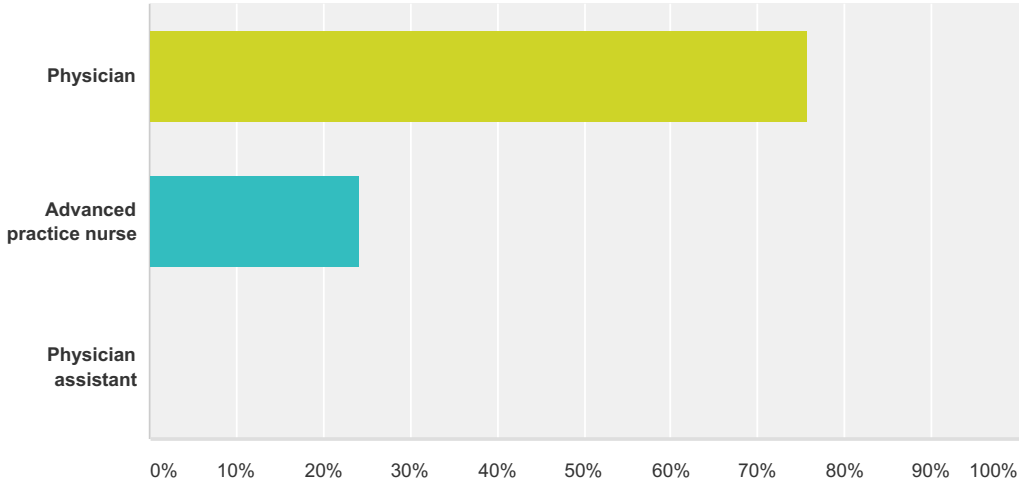
Q1 What is your discipline?

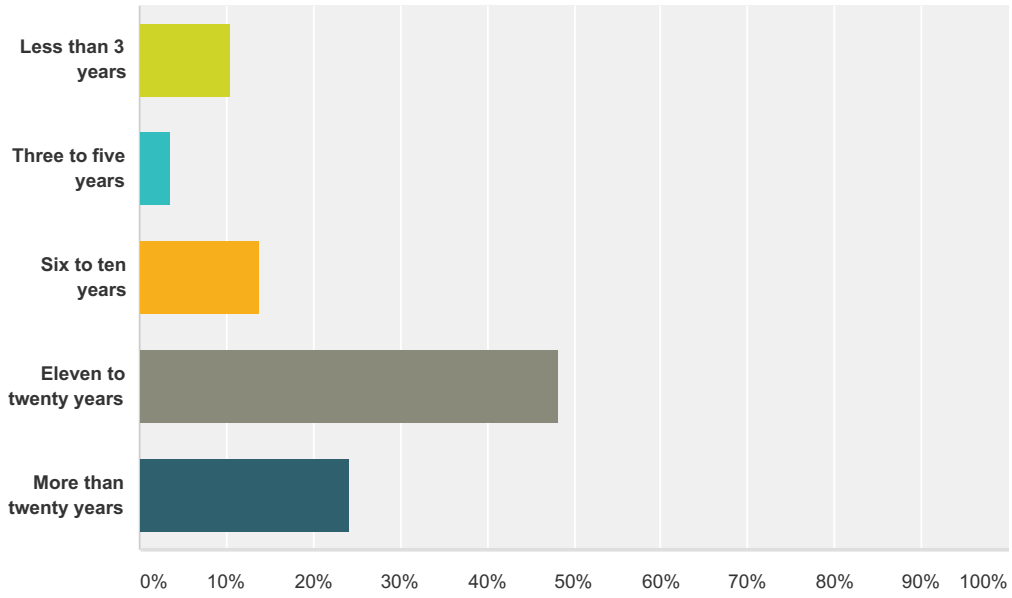
Answered: 29 Skipped: 0



Answer Choices	Responses	
Physician	**75.86%**	22
Advanced practice nurse	**24.14%**	7
Physician assistant	**0.00%**	0
Total		**29**

Q2 How long have you been a licensed health care practitioner?

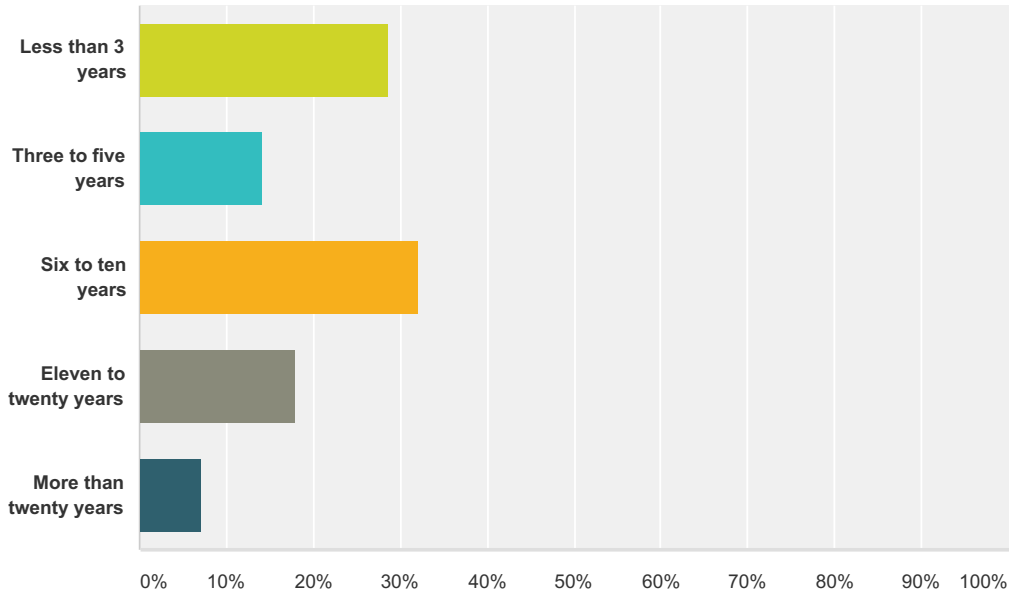
Answered: 29 Skipped: 0



Answer Choices	Responses	
Less than 3 years	**10.34%**	3
Three to five years	**3.45%**	1
Six to ten years	**13.79%**	4
Eleven to twenty years	**48.28%**	14
More than twenty years	**24.14%**	7
Total		**29**

Q3 How long have you practiced in hospice and palliative medicine?

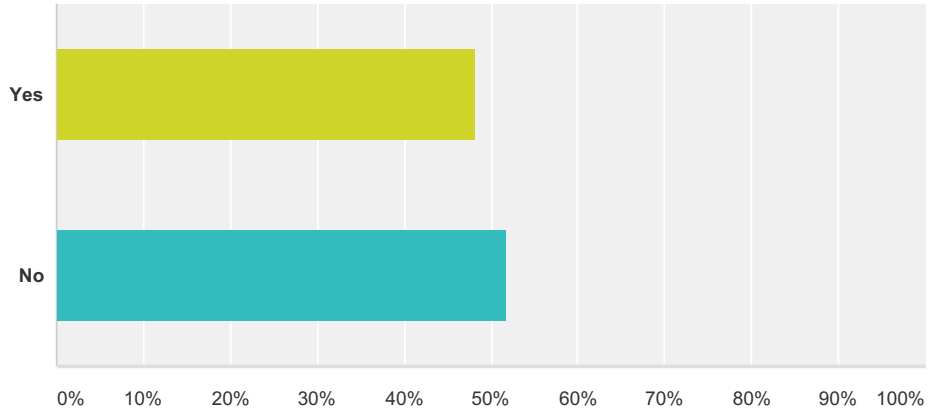
Answered: 28 Skipped: 1



Answer Choices	Responses	
Less than 3 years	**28.57%**	8
Three to five years	**14.29%**	4
Six to ten years	**32.14%**	9
Eleven to twenty years	**17.86%**	5
More than twenty years	**7.14%**	2
Total		**28**

Q4 Are you board certified in palliative care?

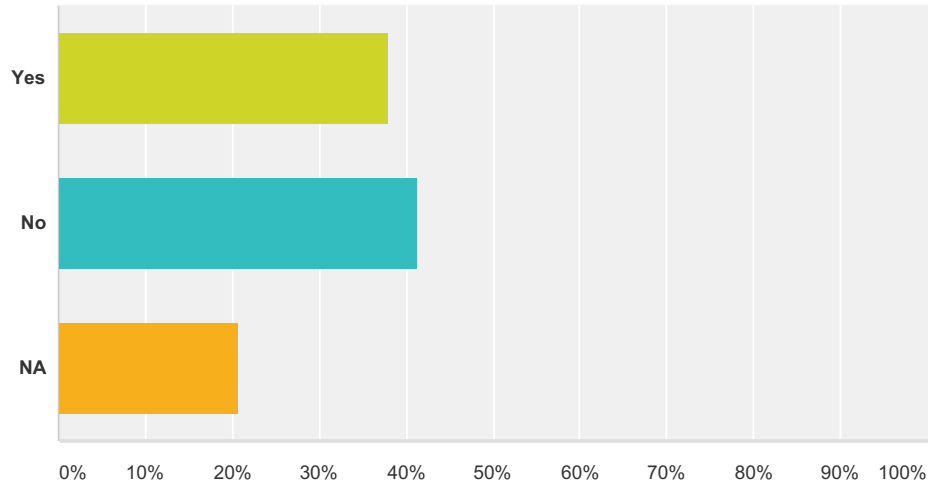
Answered: 29 Skipped: 0



Answer Choices	Responses	
Yes	**48.28%**	14
No	**51.72%**	15
Total		**29**

Q5 Are you certified as a Hospice Medical Director?

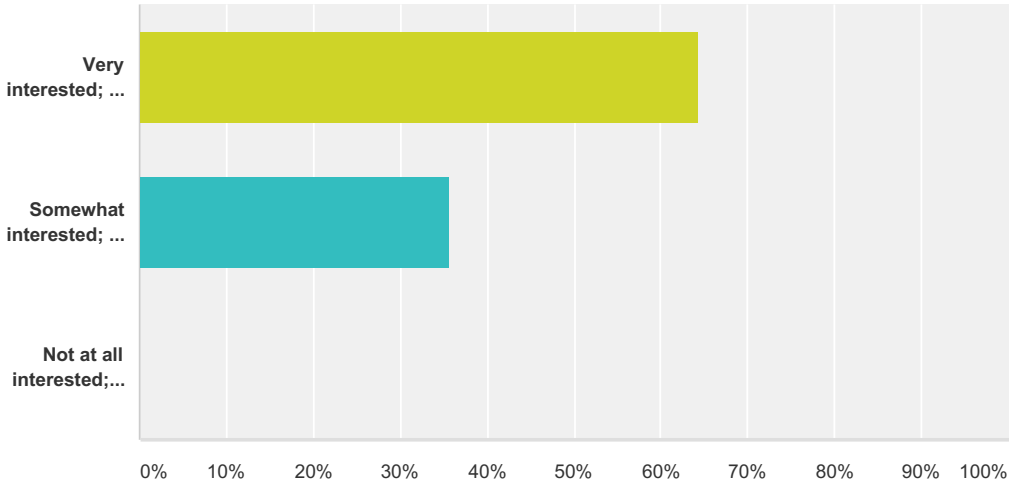
Answered: 29 Skipped: 0



Answer Choices	Responses	
Yes	**37.93%**	11
No	**41.38%**	12
NA	**20.69%**	6
Total		**29**

Q6 Which of the following best describes your level of interest in using methadone to treat pain in patients with an advanced illness?

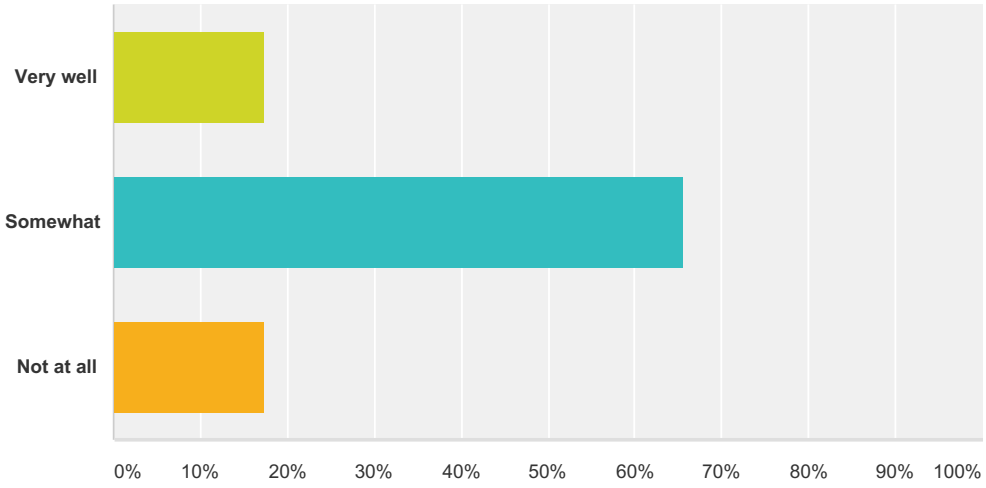
Answered: 28 Skipped: 1



Answer Choices	Responses	
Very interested; it should be one of our first-line long-acting opioid options	**64.29%**	18
Somewhat interested; may be used as a second or third line long-acting opioid option, or in difficult cases	**35.71%**	10
Not at all interested; burdens (risk to patient; dosing and monitoring difficulties) exceed benefits of therapy	**0.00%**	0
Total		**28**

Q7 How accurately are you able to list, explain and apply the pharmacokinetic and pharmacodynamic characteristics of methadone?

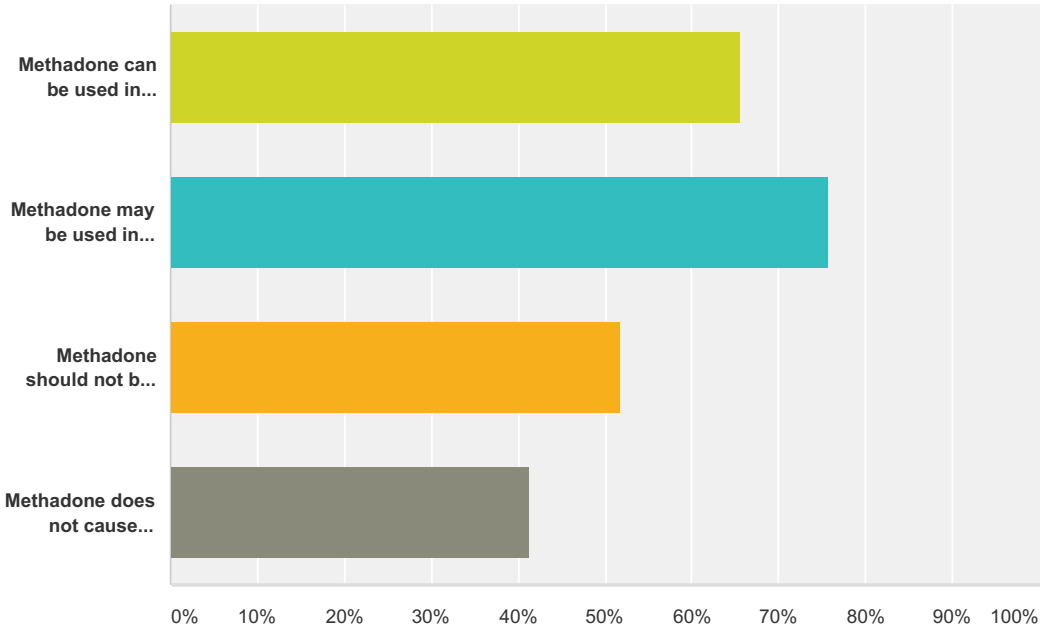
Answered: 29 Skipped: 0



Answer Choices	Responses	
Very well	**17.24%**	5
Somewhat	**65.52%**	19
Not at all	**17.24%**	5
Total		**29**

Q8 Which of the following is a true statement regarding the use of methadone? Select all that apply.

Answered: 29 Skipped: 0



Answer Choices	Responses	
Methadone can be used in patients with a true morphine/phenanthrene allergy	**65.52%**	19
Methadone may be used in patients with significant renal impairment	**75.86%**	22
Methadone should not be started within a week of patient death	**51.72%**	15
Methadone does not cause opioid-induced adverse effects as severely as other opioids	**41.38%**	12
Total Respondents: 29		

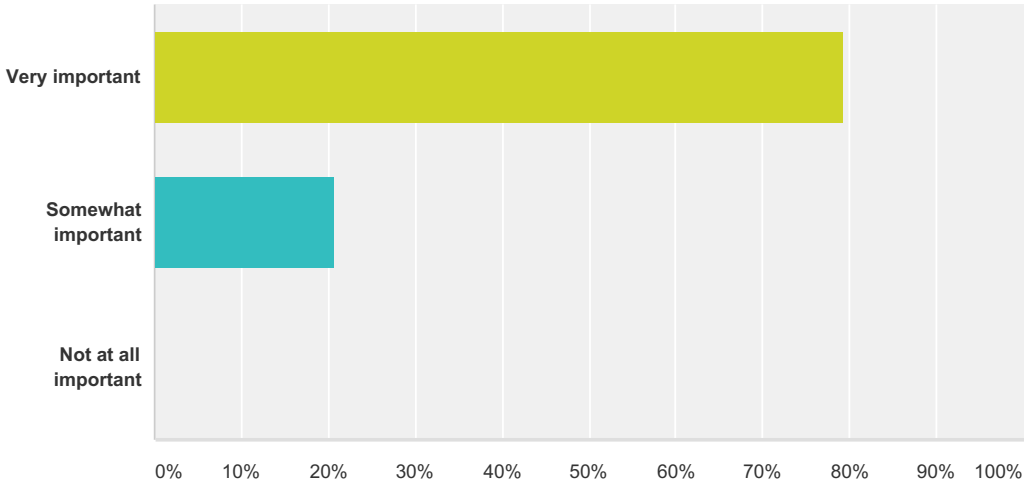
Q9 List three medications known to be strong inhibitors of methadone metabolism.

Answered: 21 Skipped: 8

#	Responses	Date
1	?	6/7/2016 5:02 PM
2	Cipro, Venlafaxine, Fluconazole	6/7/2016 3:42 PM
3	antifungals	6/7/2016 2:18 PM
4	Prozac, ketoconazole,	6/7/2016 2:02 PM
5	Antiretrovirals Antibiotics-quinolones, azoles Amiodarone	6/7/2016 1:55 PM
6	Ciprofloxacin Fluoxetine Fluconazole	6/7/2016 1:36 PM
7	phenytoin rifampin phenobarbital	6/7/2016 1:20 PM
8	abilify clarithromycin cardizem	6/7/2016 1:07 PM
9	Antibiotics, or anything that can prolong the QTC interval	6/7/2016 11:00 AM
10	???	6/7/2016 10:56 AM
11	do not know	6/7/2016 10:40 AM
12	benzodiazepines opiods	6/7/2016 7:07 AM
13	I would need to look this up	6/6/2016 10:07 PM
14	verapamil; erythro ketaconazol	6/6/2016 6:07 PM
15	Cipro, Azoles, Amiodarone	6/6/2016 1:21 PM
16	SSRI Quinolones Amiodarone	6/6/2016 11:16 AM
17	Cipro Retroviral Antifungals	6/6/2016 11:09 AM
18	Phenytoin Rifampicin Naloxone	6/6/2016 11:05 AM
19	Fluvoxamine Cimetidine Chlorpheniramine	6/6/2016 10:47 AM
20	Fluconazole Fluoroquinolones Protease inhibitors	6/6/2016 9:51 AM
21	amiodarone, rifampin, digoxin	6/6/2016 9:35 AM

Q10 How important do you believe it is for you to be able to list, explain and apply the pharmacokinetic and pharmacodynamic characteristics of methadone?

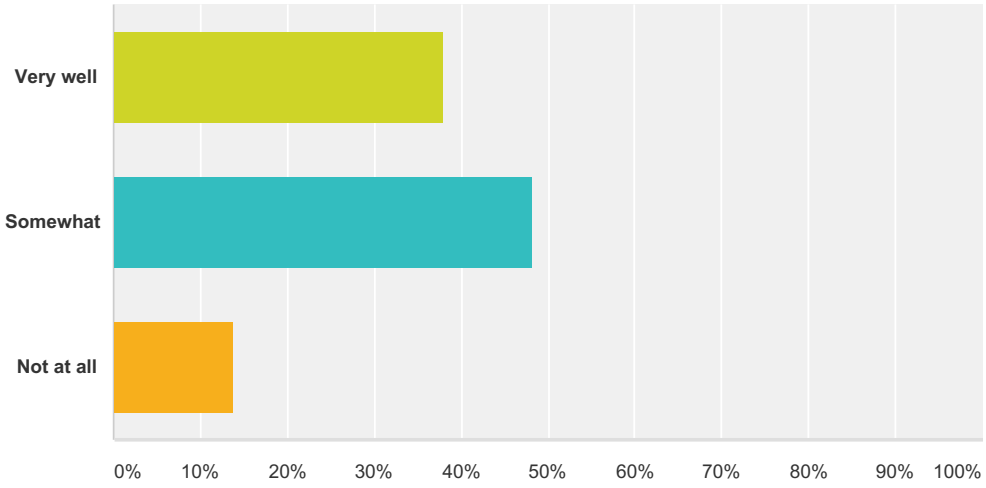
Answered: 29 Skipped: 0



Answer Choices	Responses	
Very important	**79.31%**	23
Somewhat important	**20.69%**	6
Not at all important	**0.00%**	0
Total		**29**

Q11 How skillfully are you able to recommend a monitoring plan and education for patients starting methadone therapy?

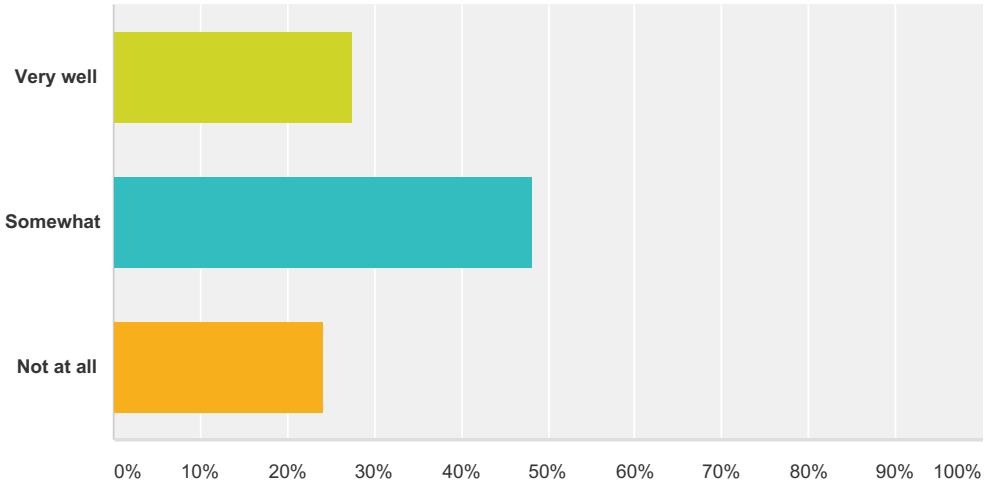
Answered: 29 Skipped: 0



Answer Choices	Responses	
Very well	**37.93%**	11
Somewhat	**48.28%**	14
Not at all	**13.79%**	4
Total		**29**

Q12 How accurately can you identify medications that may cause a clinically significant drug interaction with methadone?

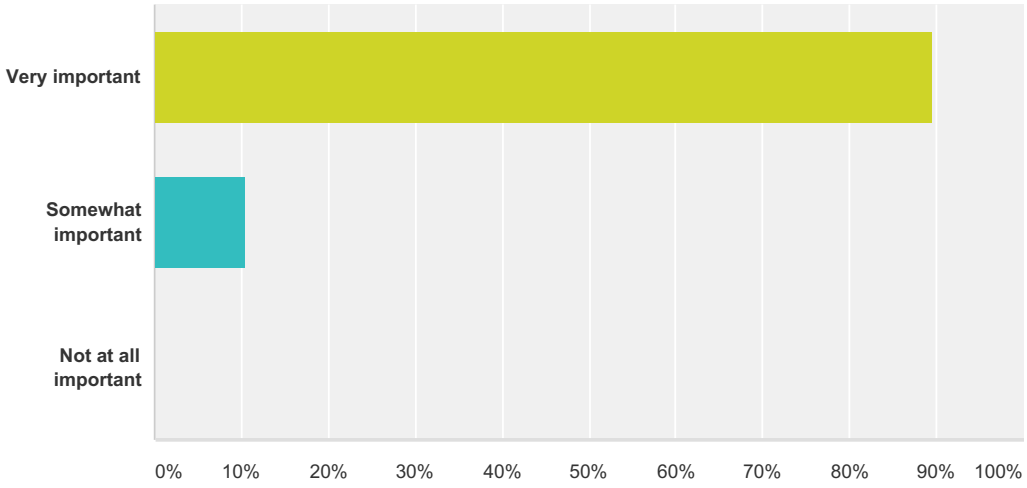
Answered: 29 Skipped: 0



Answer Choices	Responses	
Very well	**27.59%**	8
Somewhat	**48.28%**	14
Not at all	**24.14%**	7
Total		**29**

Q13 How important do you believe it is for you to be able to determine a starting dose of methadone in an opioid-naive patient?

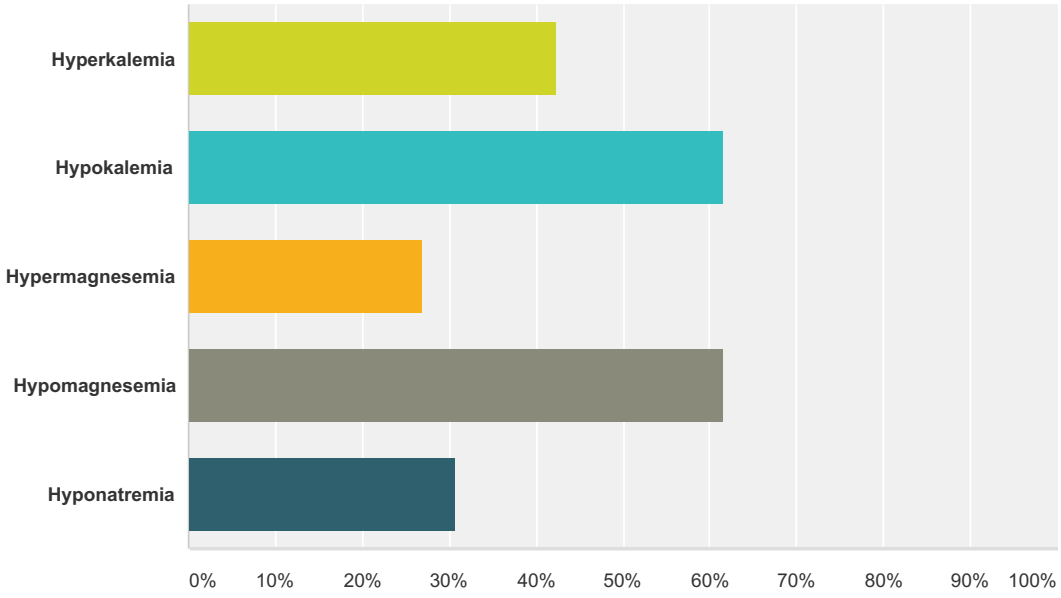
Answered: 29 Skipped: 0



Answer Choices	Responses	
Very important	**89.66%**	26
Somewhat important	**10.34%**	3
Not at all important	**0.00%**	0
Total		**29**

Q14 Which electrolyte abnormalities increase the risk of toxicity from methadone? Select all that apply.

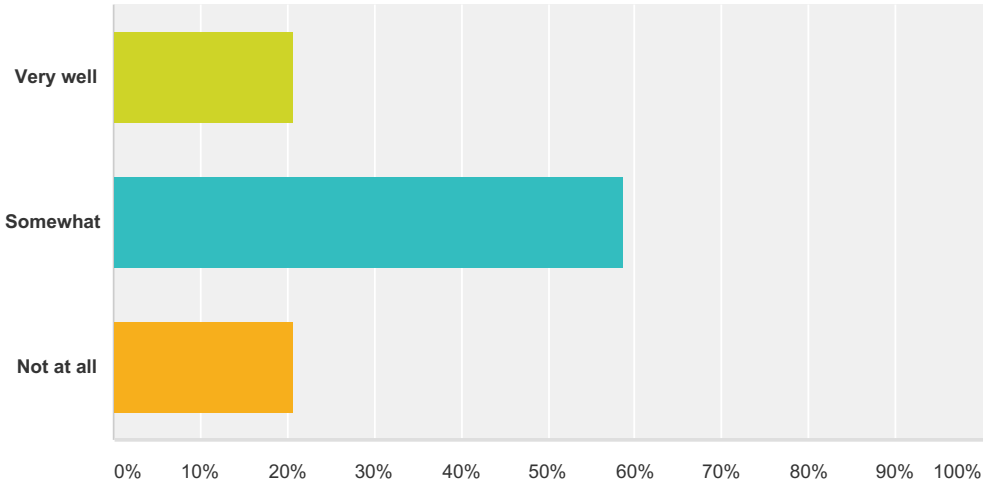
Answered: 26 Skipped: 3



Answer Choices	Responses	
Hyperkalemia	**42.31%**	11
Hypokalemia	**61.54%**	16
Hypermagnesemia	**26.92%**	7
Hypomagnesemia	**61.54%**	16
Hyponatremia	**30.77%**	8
Total Respondents: 26		

Q15 How accurately are you able to perform risk stratification for starting methadone in a patient with advanced illness?

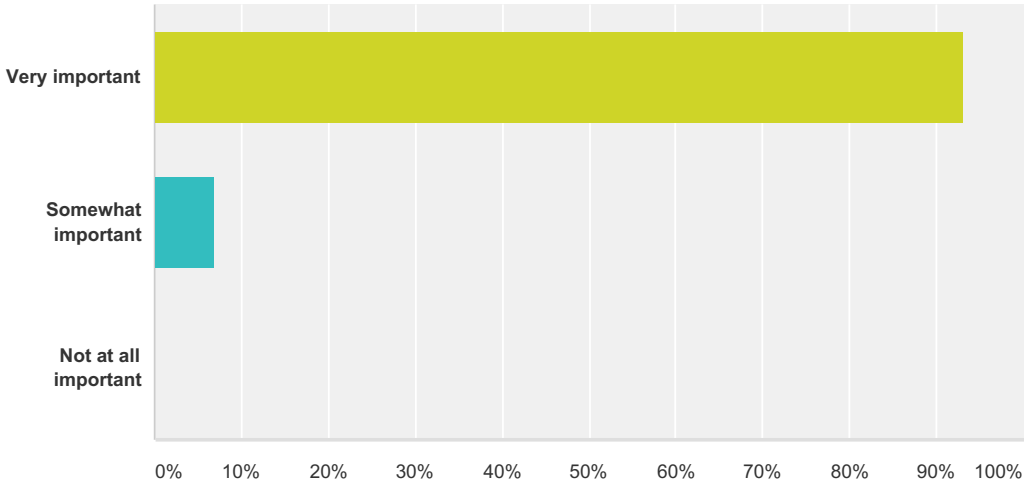
Answered: 29 Skipped: 0



Answer Choices	Responses	
Very well	**20.69%**	6
Somewhat	**58.62%**	17
Not at all	**20.69%**	6
Total		**29**

Q16 How important do you believe it is for you to be able to identify medications that may cause a clinically significant drug interaction with methadone?

Answered: 29 Skipped: 0



Answer Choices	Responses	
Very important	**93.10%**	27
Somewhat important	**6.90%**	2
Not at all important	**0.00%**	0
Total		**29**

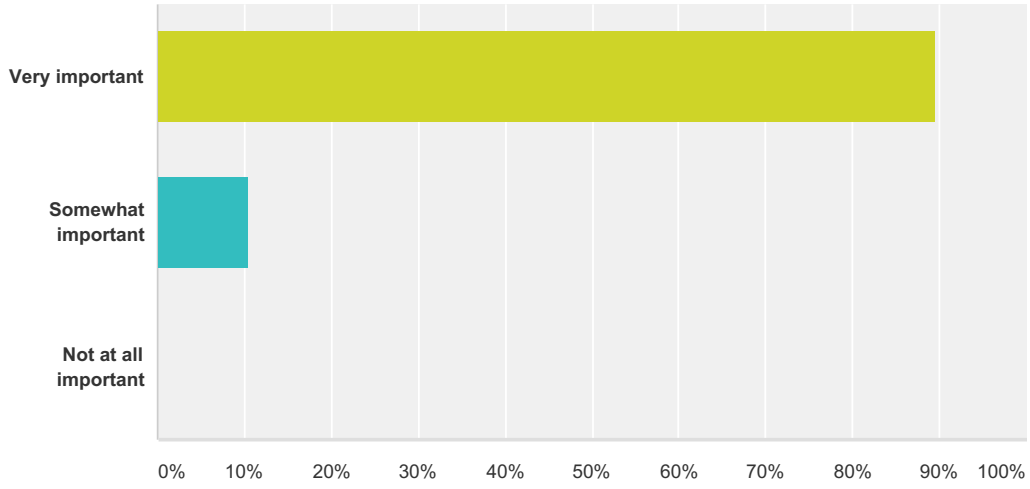
Q17 How often and for how long should the health care team assess the patient's response when starting methadone therapy (both therapeutic response and potential toxicity)?

Answered: 27 Skipped: 2

#	Responses	Date
1	5 days, once daily for routine pts twice daily up to CC or GIP for those like to have complications	6/7/2016 5:02 PM
2	Daily for 5 days	6/7/2016 3:50 PM
3	every 3 day initially, when pain is well managed, assess every week.	6/7/2016 3:42 PM
4	daily	6/7/2016 3:32 PM
5	at least daily x 5 days	6/7/2016 2:18 PM
6	24-48 hours	6/7/2016 2:02 PM
7	5 days initially, biweekly then monthly	6/7/2016 1:55 PM
8	3-5 days for efficacy of dosing and at least weekly there after.	6/7/2016 1:36 PM
9	dialy, for duration of therapy	6/7/2016 1:20 PM
10	frequently and on going	6/7/2016 1:07 PM
11	Ideally daily, but can be q3-5 days	6/7/2016 11:00 AM
12	5-7 days	6/7/2016 10:59 AM
13	5-7 days	6/7/2016 10:56 AM
14	do not know	6/7/2016 10:40 AM
15	Minimum 5 days then with each visit	6/7/2016 10:36 AM
16	Daily for one week.	6/7/2016 8:55 AM
17	upon onset and ongoing	6/7/2016 7:07 AM
18	Daily	6/7/2016 2:06 AM
19	Weekly	6/6/2016 10:07 PM
20	5 days	6/6/2016 6:07 PM
21	daily for 5-7 days	6/6/2016 1:21 PM
22	Daily x 5 days	6/6/2016 11:16 AM
23	Daily x 1 week then q week	6/6/2016 11:09 AM
24	We have avpolict for 5 days	6/6/2016 11:05 AM
25	after initiation of the medication for 5 days intensive follow up, after that every visit	6/6/2016 10:47 AM
26	5-7 days	6/6/2016 9:51 AM
27	daily for at least 5 days	6/6/2016 9:35 AM

Q18 How important do you believe it is for you to be able to determine a monitoring plan and education for patients/families/caregivers when introducing methadone?

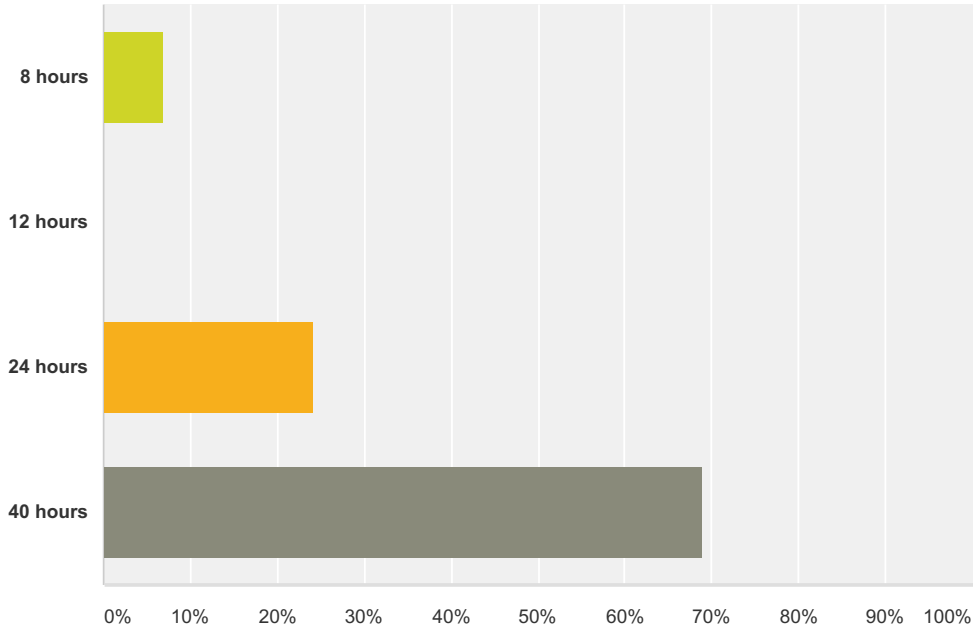
Answered: 29 Skipped: 0



Answer Choices	Responses	
Very important	**89.66%**	26
Somewhat important	**10.34%**	3
Not at all important	**0.00%**	0
Total		**29**

Q19 Which of the following best represents the average terminal elimination of half-life of methadone?

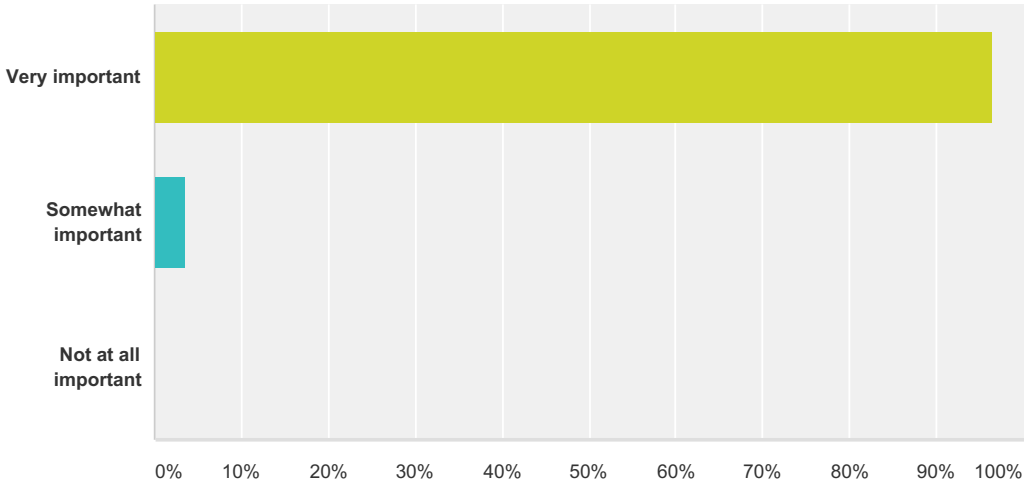
Answered: 29 Skipped: 0



Answer Choices	Responses	
8 hours	**6.90%**	2
12 hours	**0.00%**	0
24 hours	**24.14%**	7
40 hours	**68.97%**	20
Total		**29**

Q20 How important do you believe it is for a hospice/palliative medicine prescriber to be able to assess risks to the patient prior to starting methadone?

Answered: 29 Skipped: 0



Answer Choices	Responses	
Very important	**96.55%**	28
Somewhat important	**3.45%**	1
Not at all important	**0.00%**	0
Total		**29**

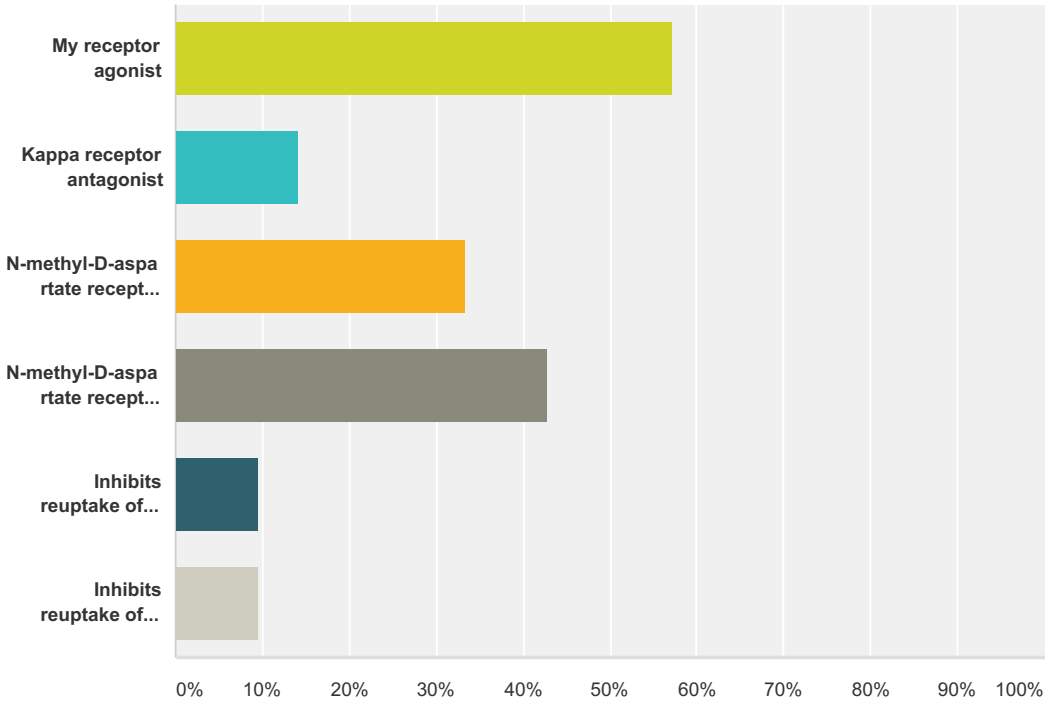
Q21 What monitoring instructions would you give the family caregiver for a patient starting methadone therapy?

Answered: 24 Skipped: 5

#	Responses	Date
1	watch for excessive sleepiness, increased pain or unusual behaviors like anxiety	6/7/2016 5:02 PM
2	Respiratory depression Neuro toxicity symptoms	6/7/2016 3:50 PM
3	constricted pupils, breathing too slow or too shallow, disorientation, sedation, nausea, vomiting, unconsciousness.	6/7/2016 3:42 PM
4	keep a good pain diary	6/7/2016 3:32 PM
5	Review and discuss signs of over sedation, ie snoring	6/7/2016 2:18 PM
6	Review withdrawal symptoms and unmanaged pain s/s	6/7/2016 2:02 PM
7	Take dose close to the time prescribed. Do not take extra dose if missed.	6/7/2016 1:55 PM
8	Monitor for signs of respirstory distress or altered conciousness	6/7/2016 1:36 PM
9	watch for sedation, constipation, pain assessment.	6/7/2016 1:20 PM
10	lethargy, respiratory depression	6/7/2016 1:07 PM
11	It takes 3-5 days before a pt can feel the effects of the medication, monitor bowels and use prophylactic stools softeners or laxatives, continue to utilize other short-acting opioid within the first few days, because it takes 3-5 days before you feel the effects of the methadone. If significant side effects, call provider, and do not take extra methadone prn (unless recommended by provider).	6/7/2016 11:00 AM
12	M/f lethargy and decreased LOC	6/7/2016 10:59 AM
13	Must wait 5-7 days to see any benefit	6/7/2016 10:56 AM
14	do not know, have not yet used it in practice	6/7/2016 10:40 AM
15	indications for allergic reactions, along with increased sleep, constipation, decreased respiratory rate.	6/7/2016 10:36 AM
16	Contact provider for any mental status changes	6/7/2016 8:55 AM
17	monitor level of consciousness, alertness sleepy	6/6/2016 6:07 PM
18	Observe every 3-4 hours for sedation	6/6/2016 1:21 PM
19	Monitor for lethargy, fatigue respiratory depression	6/6/2016 11:16 AM
20	Same as other opioids except peak effect is days (3-5)	6/6/2016 11:09 AM
21	Use the breakthrough especially during first 48 hours- there decreased use of breakthrouugh med from hour 60 to hour 72 (I have noted)	6/6/2016 11:05 AM
22	significant pain improvement in less than 48 hrs of initiating methadone, increased drowsiness, palpitations, myoclonus, imbalance, significant change in appetite.	6/6/2016 10:47 AM
23	Sleepiness Confusion Palpitations	6/6/2016 9:51 AM
24	increased sedation, confusion respiratory depression, increased snoring	6/6/2016 9:35 AM

Q22 Which of the following is one of the mechanisms of action of methadone? Select all that apply.

Answered: 21 Skipped: 8



Answer Choices	Responses	
My receptor agonist	**57.14%**	12
Kappa receptor antagonist	**14.29%**	3
N-methyl-D-aspartate receptor agonist	**33.33%**	7
N-methyl-D-aspartate receptor antagonist	**42.86%**	9
Inhibits reuptake of serotonin in CNS	**9.52%**	2
Inhibits reuptake of norepinephrine in CNS	**9.52%**	2
Total Respondents: 21		

Q23 List three medications known to be strong inducers of methadone metabolism.

Answered: 15 Skipped: 14

#	Responses	Date
1	?	6/7/2016 5:02 PM
2	Benzodiazepines, Ritonavir, fluvoxamine	6/7/2016 3:42 PM
3	don't know	6/7/2016 2:18 PM
4	Not sure	6/7/2016 1:55 PM
5	Phenobarbital Dexamethasone Phenytoin	6/7/2016 1:36 PM
6	amphetamines mao inhibitors itraconazole	6/7/2016 1:20 PM
7	rifampin, risperidone, phenytoin,	6/7/2016 1:07 PM
8	Antifungals, Rifampin?	6/7/2016 11:00 AM
9	???	6/7/2016 10:56 AM
10	do not know	6/7/2016 10:40 AM
11	Phenobarbital, Ritonavir, Rifampin	6/6/2016 1:21 PM
12	Rifampin. Steroids phenytoin	6/6/2016 11:16 AM
13	Retroviral, some antibiotics, psychotropics. Anticonvulsants	6/6/2016 11:09 AM
14	rifampin, phenytoin, phenobarbital, carbamazepine	6/6/2016 10:47 AM
15	Rifamain Barbiturates Dilantin	6/6/2016 9:51 AM

Q24 VB is an 84 year old woman with end-stage dementia. She has multiple co-morbid conditions including diabetes, dyslipidemia, seasonal allergies, hypertension, severe osteoarthritis in both hips and GERD. She has been exhibiting combative behavior that seems consistent with physical discomfort based on nonverbal cues. This behavior has not resolved with acetaminophen, and she is not a candidate for a NSAID, and other co-analgesics do not seem reasonable. She is not taking any medications known to interact with methadone, and she is opioid-naive. What dose of methadone would you recommend starting for VB?

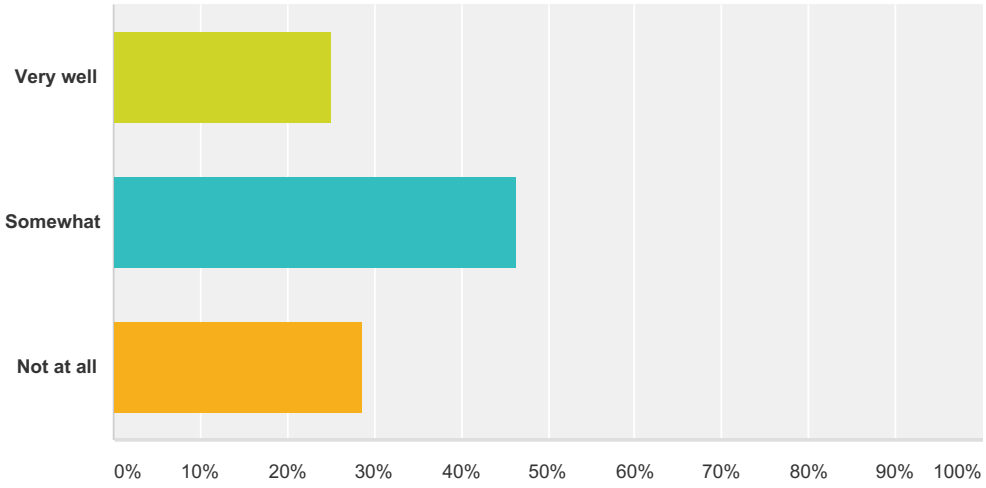
Answered: 23 Skipped: 6

#	Responses	Date
1	1 mg bid	6/7/2016 5:02 PM
2	2.5 mg q 12 h	6/7/2016 3:50 PM
3	10mg po tid	6/7/2016 3:42 PM
4	2.5mg po daily.	6/7/2016 3:32 PM
5	5mg	6/7/2016 3:17 PM
6	2.5mg po q 12hr	6/7/2016 2:18 PM
7	Not sure	6/7/2016 1:55 PM
8	2.5 mg q 12	6/7/2016 1:36 PM
9	2.5 mg every 12 hours.	6/7/2016 1:20 PM
10	there's multiple answers to this question, personally I would start the patient on 2.5mg po 12 there's different methods to skin a cat,	6/7/2016 1:07 PM
11	Methadone 2.5mg po bid or tid	6/7/2016 11:00 AM
12	2.5mg	6/7/2016 10:59 AM
13	5 mg po BID	6/7/2016 10:56 AM
14	5 mg q 12 hrs?	6/7/2016 10:40 AM
15	3mg q 12 with PRN of 2mg q4	6/7/2016 10:36 AM
16	2mg q12	6/6/2016 6:07 PM
17	1 mg at bedtime	6/6/2016 1:21 PM
18	Although not on Beers list, I would not start Methadone on an 84 yo without failing another opioid pain reliever first	6/6/2016 11:16 AM
19	2.5 bid	6/6/2016 11:09 AM
20	2mg po q 12 atc	6/6/2016 11:05 AM

21	Ideally would try using short acting morphine for 24-48 hrs to establish the daily opioid requirement in this case would treat at <30 mg daily opioid requirement. with factor of 1:10, would recommend 1 mg Q12H PO/SL	6/6/2016 10:47 AM
22	2.5mg daily	6/6/2016 9:51 AM
23	5mg BID	6/6/2016 9:35 AM

Q25 How accurately are you able to titrate a methadone dose safely and accurately based on a patient's response to therapy?

Answered: 28 Skipped: 1



Answer Choices	Responses	
Very well	**25.00%**	7
Somewhat	**46.43%**	13
Not at all	**28.57%**	8
Total		**28**

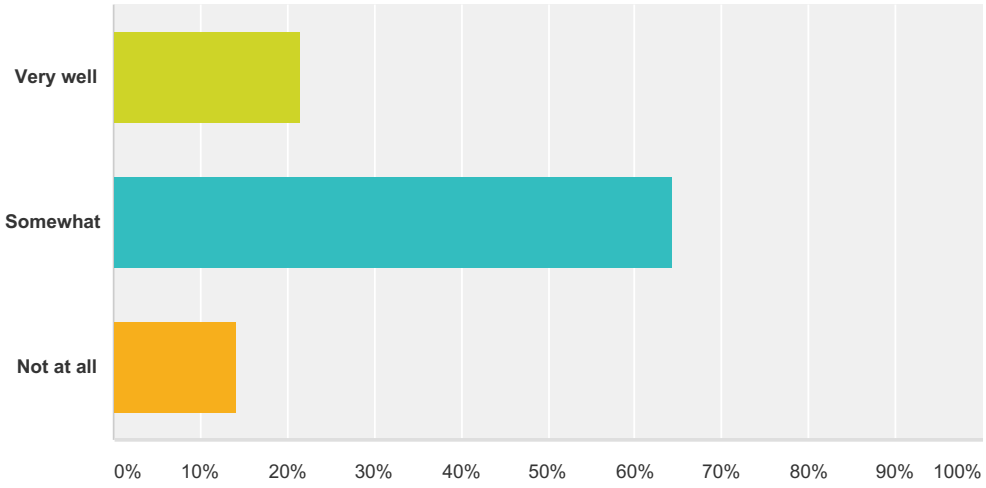
Q26 KR is a 64 year old woman admitted to hospice with stage 4 esophageal cancer. Her pain is visceral in nature, and acetaminophen has not controlled her pain. She is not a candidate for a nonsteroidal anti-inflammatory agent. She is not taking any medications known to interact with methadone, and she is opioid-naive. What dose of methadone would you recommend starting for KR?

Answered: 23 Skipped: 6

#	Responses	Date
1	1 mg bid	6/7/2016 5:02 PM
2	2.5 mg q 8 h	6/7/2016 3:50 PM
3	I would probably start the patient with morphine. however, to answer the question, I would start her with 10mg po tid.	6/7/2016 3:42 PM
4	2.5mg po BID.	6/7/2016 3:32 PM
5	5mg	6/7/2016 3:17 PM
6	2.5mg po q 12hr	6/7/2016 2:18 PM
7	Methadone 1mg bid	6/7/2016 1:55 PM
8	2.5 mg q 12	6/7/2016 1:36 PM
9	2.5 mg every 8 hours	6/7/2016 1:20 PM
10	as above frequency would be increased to q8	6/7/2016 1:07 PM
11	Methadone 2.5mg po tid	6/7/2016 11:00 AM
12	2.5	6/7/2016 10:59 AM
13	Unsure	6/7/2016 10:56 AM
14	5 -10 mg q 8 hrs?	6/7/2016 10:40 AM
15	5mg q 12 with 3 mg q 4 PRN	6/7/2016 10:36 AM
16	2 mg q12	6/6/2016 6:07 PM
17	2.5 mg BID	6/6/2016 1:21 PM
18	Liquid form or rectal 2.5 q 8 max	6/6/2016 11:16 AM
19	5 bid	6/6/2016 11:09 AM
20	5mg po q 12 atc	6/6/2016 11:05 AM
21	Ideally would try using short acting morphine for 24-48 hrs to establish the daily opioid requirement in this case would treat at <30 mg daily opioid requirement. with factor of 1:10, would recommend 1 mg Q12H PO/SL	6/6/2016 10:47 AM
22	2.5mg bid	6/6/2016 9:51 AM
23	5mg TID	6/6/2016 9:35 AM

Q27 How skillfully are you able to identify appropriate and inappropriate patients for methadone therapy?

Answered: 28 Skipped: 1



Answer Choices	Responses	
Very well	**21.43%**	6
Somewhat	**64.29%**	18
Not at all	**14.29%**	4
Total		**28**

Q28 WB is a 48 year old man admitted to hospice with end-stage AIDS. He is receiving transdermal fentanyl 50 mcg/h and oral morphine 20 mg every 2 hours as needed for pain (taking 1-2 doses per day). The only other medications he is taking is Kaletra and he refuses to discontinue therapy. He has a normal body habitus. You have decided to switch to methadone hoping to get an enhanced effect in treating his neuropathic pain. what methadone dose would you recommend to replace the transdermal fentanyl patch, and how would you time this transition (e.g., when do you remove transdermal fentanyl patch relative to starting methadone therapy)?

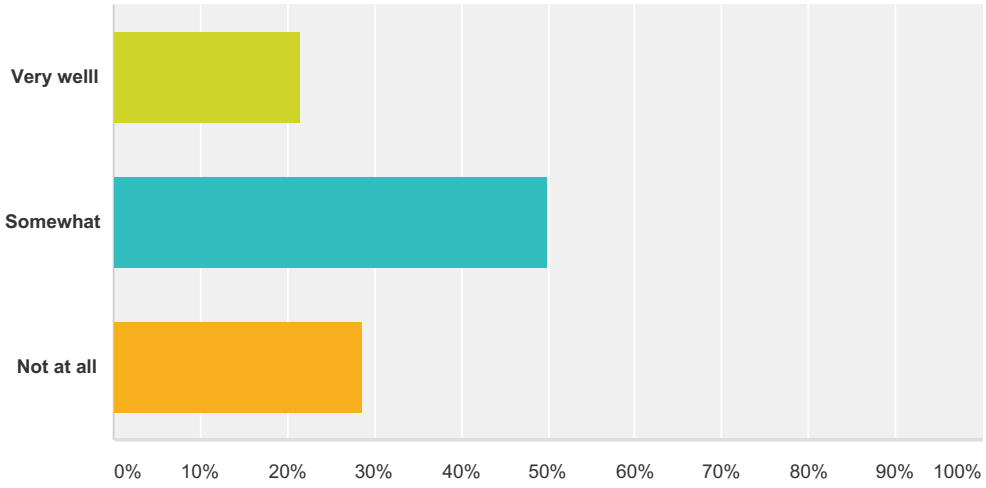
Answered: 17 Skipped: 12

#	Responses	Date
1	5mg q 8 hrs 6-8 hrs after first dose methadone	6/7/2016 5:02 PM
2	5mg po BID. stop Fentanyl patch after pt takes 1st dose Methadone. allow pt to take Morphine liberally in the first 3-5 days as needed for pain.	6/7/2016 3:32 PM
3	Not sure.	6/7/2016 1:55 PM
4	15 mg BID, removev fentanyl on day 2.	6/7/2016 1:20 PM
5	initiate patient on 2.5mg q8, transitioning off the fentanyl 3-5 days after initiating methadone	6/7/2016 1:07 PM
6	Possibly methadone 5mg po tid or 7.5mg po tid as Kaletra can also prolong the QTc interval? I am not sure about the timing of when to remove the patch. I think it would be taken off about 12 hours before full efficacy of the methadone is achieved, but not sure this is right (anywhere from 3-5 or up to 7 days)	6/7/2016 11:00 AM
7	???	6/7/2016 10:56 AM
8	do not know	6/7/2016 10:40 AM
9	I would call the pharmacist to assist with the conversion. The duragesic would come off 24 hrs after starting the Methadone	6/7/2016 10:36 AM
10	5 mg BID and remove patch 4 hours after first dose of methadone.	6/6/2016 6:07 PM
11	5 mg PO BID, may remove patch immediately but would probably start Methadone at the end of Fentanyl patch 72h if there is no immediate need to start Methadone earlier	6/6/2016 1:21 PM
12	Kaletra will decrease availability of Methadone. Max 5 TID with po meds for breakthrough after removal of patch. Cut patch in half.	6/6/2016 11:16 AM
13	Unsure	6/6/2016 11:09 AM
14	?	6/6/2016 11:05 AM
15	Kaletra is CYP inhibitor however with some inducing effects may possibly reduce the levels of Methadone. with fentanyl 50 mcg/hr ~ 150 Morphine PO with 1:10 factor 15 mg of Methadone would be target dose. I would start at 2.5 mg Q8H ATC PO for first 5 days if no effects would increase to 5 mg Q8H PO and go in 2.5 mg increments till desirable effects with out significant adverse effects. DC the Fentanyl patch on 3rd day after initiation of Methadone. cover with 20 mg morphine for breakthrough pain.	6/6/2016 10:47 AM

16	12 hours	6/6/2016 9:51 AM
17	10mg BID remove fentanyl patch 8-12 hours prior to first dose of methadone	6/6/2016 9:35 AM

Q29 How skillfully are you able to determine a starting dose of methadone in an opioid-tolerant patient (e.g., perform a conversion calculation to methadone)?

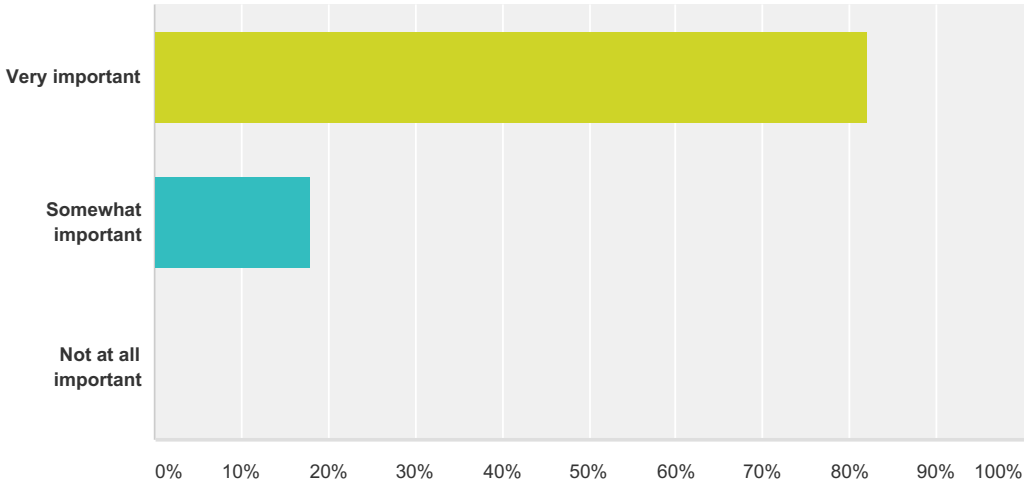
Answered: 28 Skipped: 1



Answer Choices	Responses	
Very welll	**21.43%**	6
Somewhat	**50.00%**	14
Not at all	**28.57%**	8
Total		**28**

Q30 How important to you believe it is for you to be able to identify appropriate and inappropriate patients for methadone therapy (as an analgesic)?

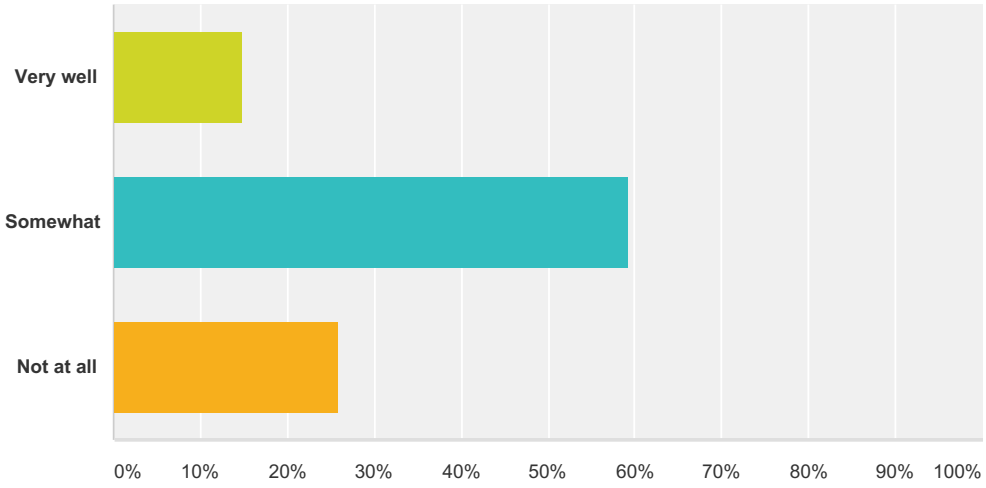
Answered: 28 Skipped: 1



Answer Choices	Responses	
Very important	**82.14%**	23
Somewhat important	**17.86%**	5
Not at all important	**0.00%**	0
Total		**28**

Q31 How skillfully are you able to determine a starting dose of methadone in an opioid-naive patient?

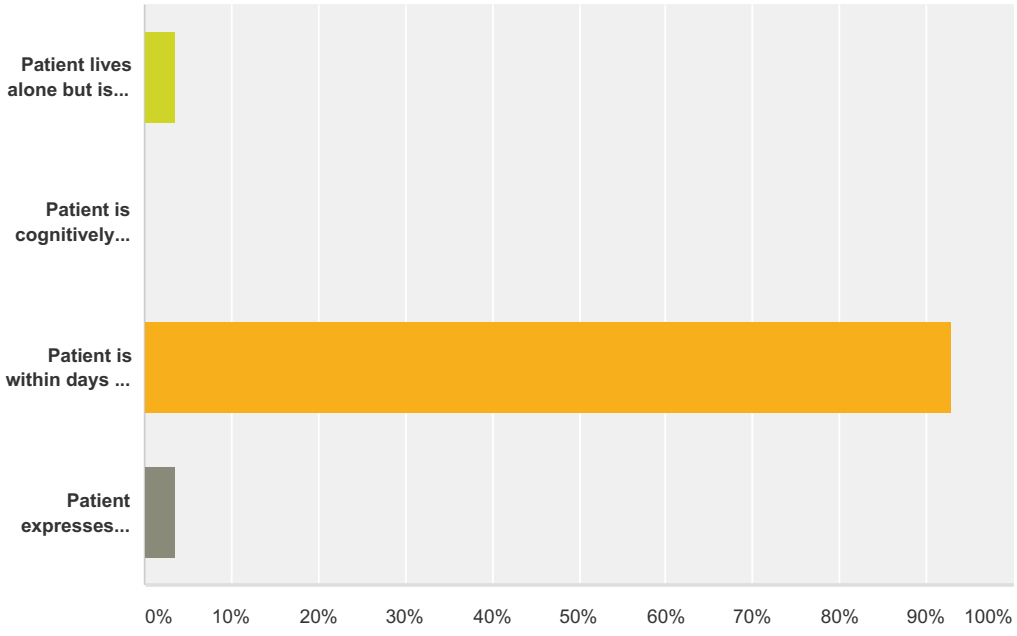
Answered: 27 Skipped: 2



Answer Choices	Responses	
Very well	**14.81%**	4
Somewhat	**59.26%**	16
Not at all	**25.93%**	7
Total		**27**

Q32 Which of the following scenarios is an example of an INAPPROPRIATE candidate for conversion to methadone therapy?

Answered: 28 Skipped: 1



Answer Choices	Responses	
Patient lives alone but is mentally competent	**3.57%**	1
Patient is cognitively impaired but has a competent caregiver	**0.00%**	0
Patient is within days of death	**92.86%**	26
Patient expresses concern that methadone is for "druggies"	**3.57%**	1
Total		**28**

Q33 PR is a 62 year old man with end-stage lung cancer. He is admitted to hospice on OxyContin 40 mg po q12h, and OxyIR 15 mg po q2h (takes about 3 doses per day). His pain control is fairly good but could be a bit better. He is receiving appropriate co-analgesics, and he is not taking any medications that would interact with methadone. What regimen would you recommend if converting to methadone instead of OxyContin, and using morphine instead of oxycodone for breakthrough pain?

Answered: 16 Skipped: 13

#	Responses	Date
1	10 mg q 8 and morphine 20 mg q 2	6/7/2016 5:02 PM
2	methadone 5mg po tid and morphine 15mg po q3h prn	6/7/2016 3:42 PM
3	Methadone 10mg po BID. Morphine 20mg po q2h prn.	6/7/2016 3:32 PM
4	Not sure Methadone 10mg po tid Morphine 20mg q 2hr prn	6/7/2016 1:55 PM
5	Methadone 5 mg q 12	6/7/2016 1:36 PM
6	10 mg moethadone BID Morphine 20 mg q 2 hours prn	6/7/2016 1:20 PM
7	5mg Po q8	6/7/2016 1:07 PM
8	Methadone 5mg po tid and about morphine 20mg po q2h prn pain	6/7/2016 11:00 AM
9	???	6/7/2016 10:56 AM
10	6 mg BID of methadone and 20 mg morphine q2 prn	6/6/2016 6:07 PM
11	5 mg PO BID	6/6/2016 1:21 PM
12	Methadone 5 TID Morphine 5 q 6 prn	6/6/2016 11:16 AM
13	Methadone 20 bid morphine 10 q 3	6/6/2016 11:09 AM
14	5mg po q 12 atc	6/6/2016 11:05 AM
15	Total oxycodone per day: 80 + 45 = 125 converting to PO Morphine equivalent: 125 x 1.5 = 187.5 1:10 factor total daily Methadone need ~ 18.8 mg would directly switch to methadone 5mg Q8H PO /SL ATC. with 30 mg Q3H PRN of morphine PRN PO/SL. half the dose of oxycodone on day 2 DC oxycodone on day 3 after beginning Methadone.	6/6/2016 10:47 AM
16	10mg bid Morphine 20mg	6/6/2016 9:51 AM

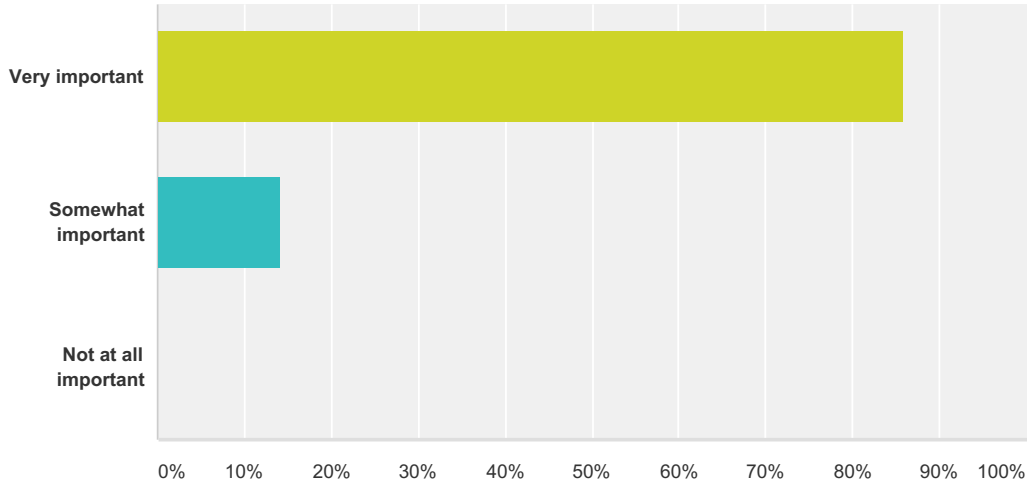
Q34 Aside from the usual opioid-induced adverse effects, risk factors for what potential adverse effect should be assessed prior to starting methadone therapy?

Answered: 19 Skipped: 10

#	Responses	Date
1	?	6/7/2016 5:02 PM
2	Respiratory depression Prolonged QT	6/7/2016 3:50 PM
3	QT interval and cardiac risk	6/7/2016 3:42 PM
4	QT prolongation	6/7/2016 3:32 PM
5	QT prolongation, liver impairment	6/7/2016 2:02 PM
6	QT prolongation	6/7/2016 1:55 PM
7	Qt prolongation	6/7/2016 1:36 PM
8	qt prolongation	6/7/2016 1:20 PM
9	cardiac effects	6/7/2016 1:07 PM
10	Check EKG for QT and QTc intervals	6/7/2016 11:00 AM
11	???	6/7/2016 10:56 AM
12	QT interval	6/7/2016 10:40 AM
13	QT interval assessment	6/6/2016 1:21 PM
14	QTc	6/6/2016 11:16 AM
15	EKG rythmn	6/6/2016 11:09 AM
16	?	6/6/2016 11:05 AM
17	QTc prolongation EKG to rule out QTc prolongation higher cardiac risk seen with baseline QTc >500	6/6/2016 10:47 AM
18	Respiratory status Drug interactions	6/6/2016 9:51 AM
19	edema, liver toxicity	6/6/2016 9:35 AM

Q35 How important do you believe it is for you to be able to determine a starting dose of methadone in an opioid-tolerant patient (e.g., perform a conversion calculation to methadone)?

Answered: 28 Skipped: 1



Answer Choices	Responses	
Very important	**85.71%**	24
Somewhat important	**14.29%**	4
Not at all important	**0.00%**	0
Total		**28**

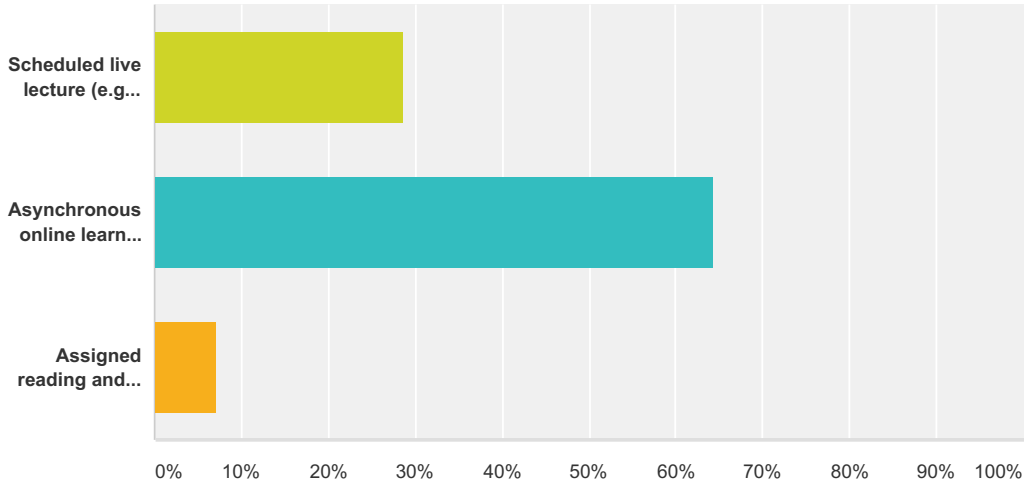
Q36 What barriers, if any, exist to you prescribing and monitoring methadone therapy with confidence and competence (e.g., lack of physical resources, lack of structure/process, information or knowledge deficit, no interest in doing so, no perceived value, etc.).

Answered: 21 Skipped: 8

#	Responses	Date
1	knowledge	6/7/2016 5:02 PM
2	Lack of structure/process, information and knowledge deficit	6/7/2016 3:50 PM
3	none.	6/7/2016 3:32 PM
4	none	6/7/2016 2:18 PM
5	Knowledge deficit and unfamiliarity	6/7/2016 2:02 PM
6	information deficit	6/7/2016 1:55 PM
7	Lack of process Knowledge deficit	6/7/2016 1:36 PM
8	lack of structure/process, comfort level.	6/7/2016 1:20 PM
9	protocol is limits liberal use of methadone in seasons hospice, I see no need to be obligated to consult medical director or pharmacist for each patient.	6/7/2016 1:07 PM
10	I work per diem, so I don't feel comfortable starting/recommending something that I am not closely monitoring myself (eg. daily telephone outreach calls, or a f/u visit within 3-5 days.)	6/7/2016 11:00 AM
11	Education	6/7/2016 10:59 AM
12	information and knowledge deficit	6/7/2016 10:56 AM
13	Knowledge deficit and lac of experience difficulty in availability and pharmacy issues	6/7/2016 10:40 AM
14	lack of knowledge, perceived value by the community	6/7/2016 10:36 AM
15	There are relatively few patients on methadone in our setting and they are typically managed by our MD who is very familiar with methadone.	6/7/2016 8:55 AM
16	None	6/6/2016 1:21 PM
17	None	6/6/2016 11:16 AM
18	Feedback on treatment comes from field RN ?training	6/6/2016 11:09 AM
19	New more training	6/6/2016 11:05 AM
20	all listed above as well some setups primary physician resistance due to discomfort using Methadone	6/6/2016 10:47 AM
21	difficulty in following up daily with home patients on palliative care when starting methadone	6/6/2016 9:35 AM

Q37 How would you prefer to receiving instruction and training in methadone prescribing and monitoring?

Answered: 28 Skipped: 1



Answer Choices	Responses
Scheduled live lecture (e.g., one hour lecture, practice problems) to be conducted at an appointed time that requires your physical presence	**28.57%** 8
Asynchronous online learning (e.g., one hour pre-recorded lecture that includes practice problems with resolution) to be completed as your schedule allows	**64.29%** 18
Assigned reading and practice problems, followed by an in-person assessment	**7.14%** 2
Total	**28**