Role of Interprofessional Health Care Providers in Opioid De-Implementation

Queens' Family Health Team (QFHT) Kingston site

Erin Desmarais, Social Worker
Cynthia Leung, Pharmacist
Abigail Scott, Data & Quality Improvement Analyst

Department of Family Medicine
Delivering the Future of Primary Health Care

Presenter Disclosure

- **Presenters:**

Erin Desmarais, Social Worker

Cynthia Leung, Pharmacist

Abigail Scott, Data & Quality Improvement Analyst

- **Relationships with commercial interests:**

None

Work Environment

QFHT is an academic FHT with clinics in Kingston and Belleville

QFHT Kingston site	QFHT Belleville site
"QFHT" for over 10 years	Joined "QFHT" in 2012
OSCAR EMR* since 2010	OSCAR EMR* since 2013
Everyone (physicians, staff, etc.) is a Queen's University employee	Only allied health "FHT" staff are Queen's University employees
Currently nearly 17,000 patients, 24 MRPs*, 50 resident physicians, 24 nurses, 15 clerks, 1 pharmacist, 2 social workers, 1 dietitian, etc.	Currently 12,000 patients, 19 MRPs*, 12 resident physicians, 8 allied health "FHT" staff

OSCAR is NOT shared

* EMR = Electronic Medical Record
MRP = Most Responsible Provider
(i.e. the patient's "Family Doctor")

2016: New Guidelines

Date: Wed, May 11, 2016 at 8:31 AM
Subject: Opioid guidelines, and patient totals - QI or other project?

HI Abi and Sherri and Karen
I was at a session last night at Pub Health, re Opioid use in chronic pain, its overuse, new guidelines, etc. Multiple presenters from Kieran Moore, PHU, to the police, to folks from our various Pain Clinics, and Street Health and Rupa Patel from North Kingston.
The new CDC guidelines, which will (hopefully) be the goal of the Canadian ones, still being published, are strongly pulled back from our (Canadian) generous 200MME/day to 50MME/day.
http://www.cdc.gov/drugoverdose/prescribing/providers.html

I am wondering if it would be technically possible for you to audit our charts (try with mine?) and be able to have a "total morphine equivalents/day" report for patients. If so, then we could have a list then of who is over, and then could work on plans for decreasing their MME/Day dosing, trying to achieve guideline goals.
Something like this….

Patient ID #	Narcotic 1	Morphine Equivalents	Narcotic 2	Morphine Equivalents	Narcotic 3	Morphine Equivalents	Total Morphine Equivalents	Difference from 50MME/day

June 2016: Report created and tested by a few physicians

Hello

Abi just showed me her newest report that she developed at our request to help MRPs with surveillance of their patients who are on strong opioids to identify patients who are on more than 50MME per day. To my eyes the report look great and clearly have been a lot of work to create so thanks very much to Abi for working on them for the past many weeks.

While reviewing the report of my patients it brought up one point for clarification. From my perspective we should be identifying patients who have been on strong opioids (hydromorphone, oxycodone, morphine and fentanyl) for longer than 6 months. (The report identified patients who were on hydromorph post rib fracture and recent abdo surgery and in my mind this is not the population we are trying to capture). Is this ok with you two?

Once we get the report right we can give it to other MRPs

December 2016 & May 2017: Report given to all QFHT Kingston site MRPs

Dr. Who's Patients who are Prescribed at least 50 MME per Day*

Demo	Age	Opioid	Morphine Milligram Equivalents (MME) per Day	Reason
12468	66	HYDROMORPHONE and DILAUDID	140	Chronic pain syndrome
2346	43	OXYNEO	90	Waiting for surgery (back)
5345	26	MORPHINE	120	Palliative
34589	49	HYDROMORPHONE	60	Post-surgery
29873	76	OXYNEO	85	Leg pain
2794	52	HYDROMORPHONE	160	Back pain
83409	56	OXYNEO	75	Fibromyalgia
23467	84	HYDROMORPHONE	90	Back and leg pain
27408	64	OXYNEO	315	Palliative
37982	35	HYDROMORPHONE and KADIAN	50	Chronic pain

December 9, 2016

* Doses at or above 50 MME/day increase risks for overdose by at least 2x the risk at <20 MME/day

Created by Abi Scott
Please contact her to correct errors

Summer 2017: Opioid Working Group

It's time! QFHT prescribing of opioids for chronic pain Inbox x

Karen Hall Barber <karen.hallbarber@dfm.queensu.ca> 5/30/17
to DFM, Locums, Cohort, geoff.hodgetts

Hello
It's time. QFHT is going to be tackling opioid prescribing for chronic pain.

Thanks to Rupa and Meredith for their terrific presentation today about prescribing opioids.

SHORT VERSION:
. Please let me know if you are interested in participating in a QFHT Opioid Prescribing Working Group. I am hoping to meet several times in June to have something in place in the next few months.
. I'm particularly interested in hearing from locums, residents & people who have more patients above 50meq/day than they are comfortable with.

...

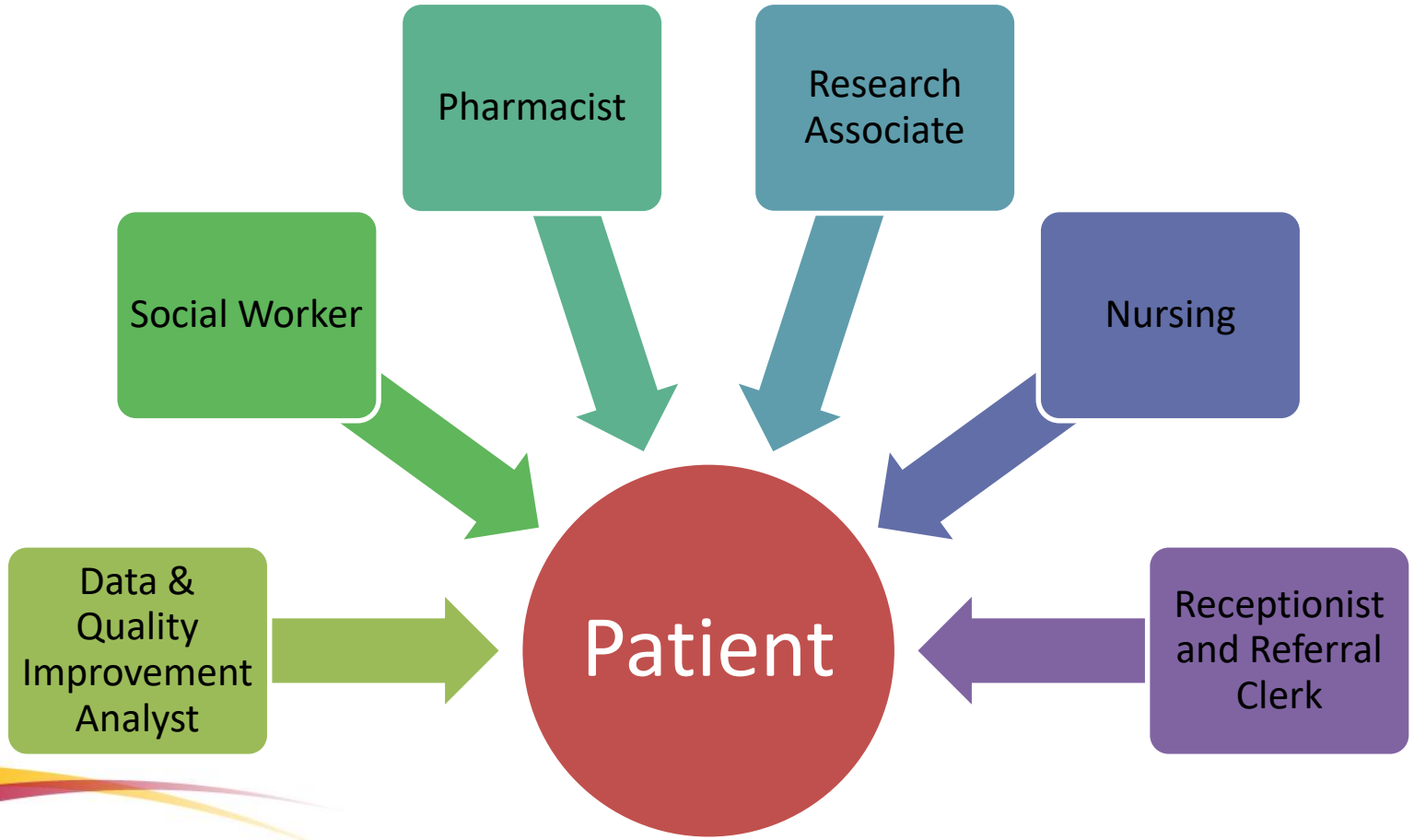
In summary, we must collectively participate in addressing this crisis.
Please let me know if you are interested in helping with this.

October 2017: Safer Opioid Prescribing (SOP) program at QFHT Kingston site

SOP Team:

- Dr. Karen Hall Barber (Physician Lead)
- Jennifer MacDaid (Clinical Program Coordinator)
- Lynn Roberts (Research Associate)
- Cynthia Leung (Pharmacist)
- Erin Desmarais (Social Worker)
- Abi Scott (Data & Quality Improvement Analyst)
- Diane Cross (Executive Director) *gave approval*

Interprofessional Healthcare Providers



Why October 2017? Homework.

Institute for Healthcare Improvement

Virtual Training

Leadership and Organizing for Change

Also, news.

5 people in Kingston area treated for suspected fentanyl overdoses in 2 days

Toronto also saw a spate of overdoses last week, 4 of which were fatal

CBC News Posted: Aug 03, 2017 2:38 PM ET | Last Updated: Aug 03, 2017 2:38 PM ET

opioid-related causes a median of 2.6 years after the first opioid prescription; the proportion was as high as 1 in 32 among patients receiving doses of 200 MME or higher.[5] We know of no other medication routinely used for a nonfatal condition that kills patients so frequently.

The new CDC guideline em-

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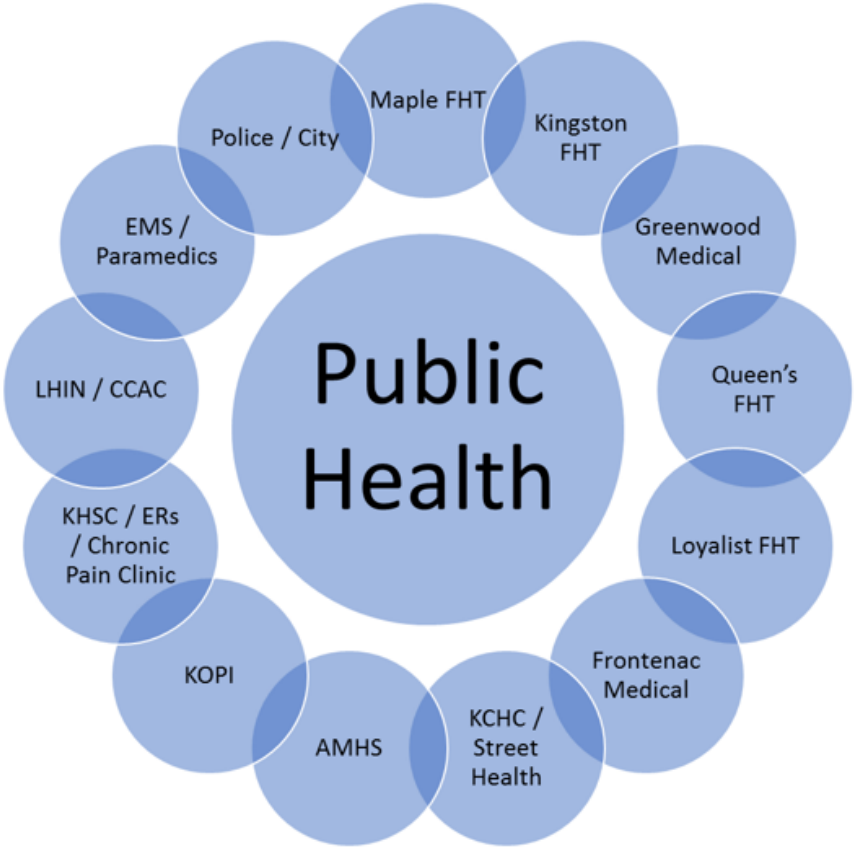
Organizing Sentence

We are organizing all clinical staff at QFHT, their patients, and any external, local organizations or individuals who can support this initiative
to take the first step towards safer opioid prescribing
by effectively tapering the opioid prescriptions of appropriate patients (using multifaceted best practice guidelines)
because opioid prescribing at high doses is too prevalent in our community
by mid-November

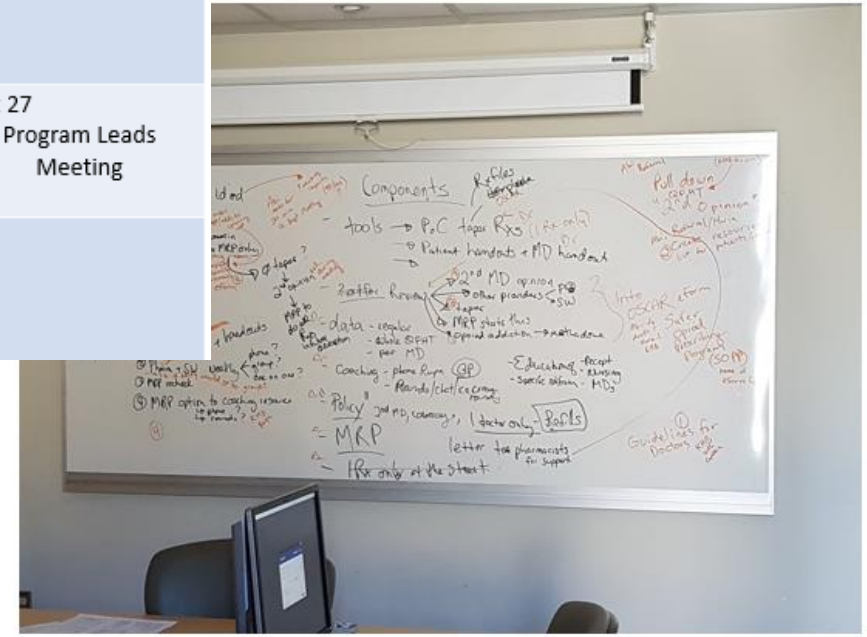
Snowflake Diagram



Project Timeline

Monday	Tuesday	Wednesday	Thursday	Friday
Oct 2 SOP program is created!	Oct 3	Oct 4 Cynthia Leung joins SOP	Oct 5 SE LHIN Primary Care Forum	Oct 6 Shared queries with Public Health
Oct 9 Thanksgiving	Oct 10 eForms added to OSCAR	Oct 11 Kickoff at Department Meeting	Oct 12 Cynthia talks to KOPI	Oct 13 SE LHIN Self Mgmt. Conference
Oct 16 Dr. Dubin's Support Group	Oct 17 Naloxone in QFHT Emergency Bag	Oct 18	Oct 19	Oct 20
Oct 23	Oct 24	Oct 25	Oct 26	Oct 27 Program Leads Meeting
Oct 30 SOP Team Meeting	Oct 31	Nov 1 SOP Rounds & KFLA Primary Care Meeting		

Brainstorming Session



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SOP program aimed to:

- Create awareness around the risks of high doses of opioids, the lack of evidence around efficacy/safety for treating chronic pain, opioid tolerance and diminished effectiveness over time, best practice for chronic use and the risk of addiction and overdose
- Create tools, resources and provide support for both primary care providers and patients during the discussions around, and initiation of safer opioid use
- Complete opioid reviews for patients on doses 90 MME/day or higher, create individualized plans for safer pain management and tapering plans where appropriate

* MME/day = Milligrams of Morphine Equivalents per day

ROLE OF QFHT PHARMACIST IN SAFER OPIOID PRESCRIBING

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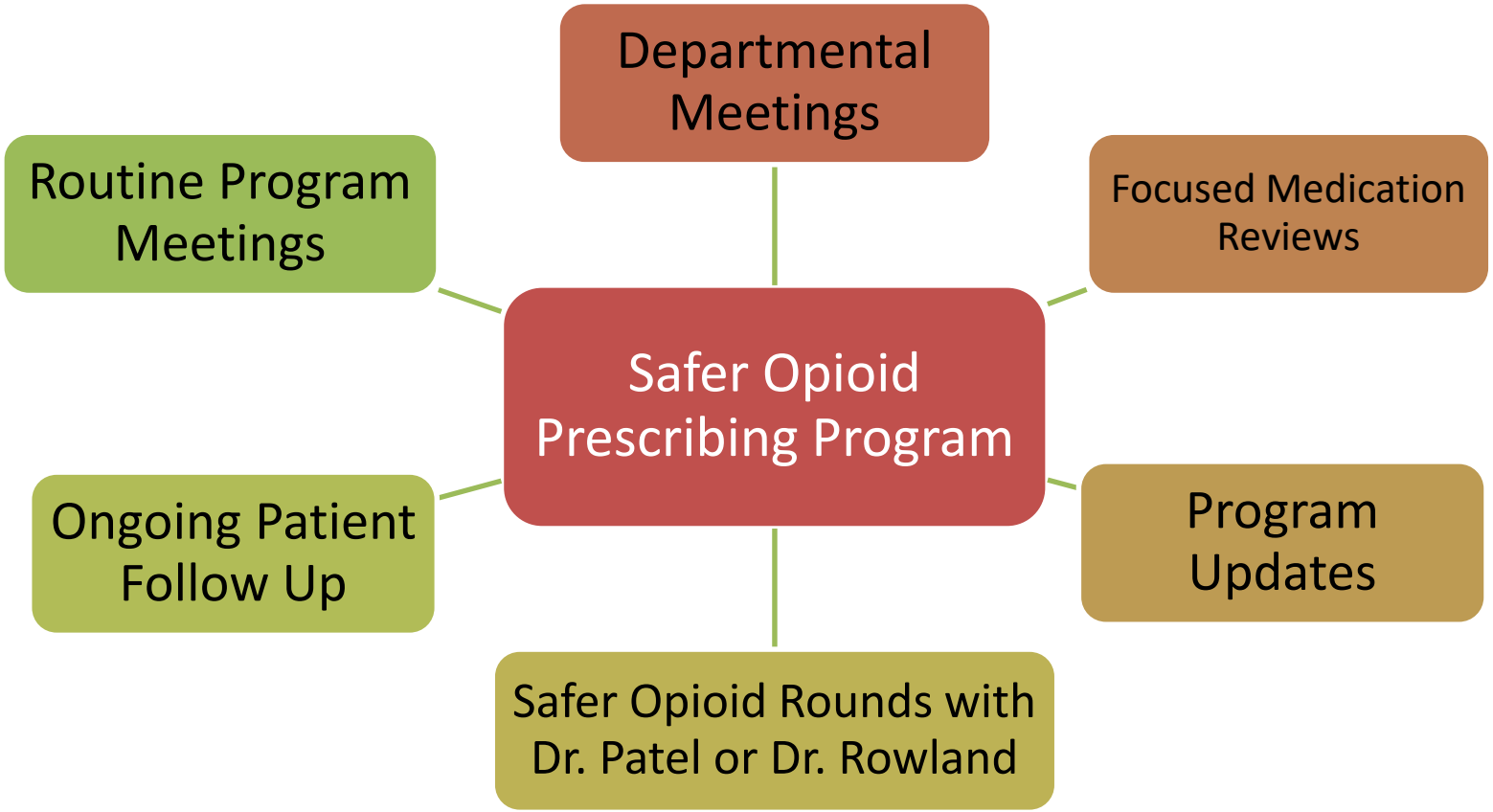
Main Components of Our Program



Faculty Only Rounds

- Peer-to-peer counselling from
  - Dr. R Patel and Dr. M Rowland *
- Case discussions, coaching

* Family Doctors

Role of a Primary Care Pharmacist

- Medication Review with a focus on Opioid Use and Pain Management
  - Calculate MME (Milligram of Morphine Equivalent)
  - Identify risk factors (e.g. Previous History of PTSD, severe depression, concurrent use of benzodiazepines)
  - Calculate the ORT (Opioid Risk Tool) score or ACE (Adverse Childhood Experience) score
  - Propose possible solutions
- Alert social worker / nursing with tapering plan

Support for Opioid Tapering

- Narcotic prescriptions have additional legal requirements (e.g. Patient Identifier, CPSO#)

- Dose Reduction needs to work with existing dosage strengths (e.g. switch to M-Eslon as it comes as 10mg strength is easier to work) as well as limitations with coverage (e.g. high dose opioids have been delisted)

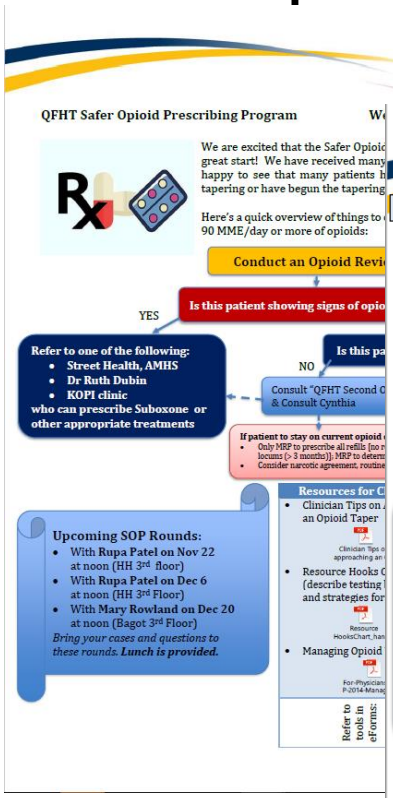
- Questions to consider
  - How fast (e.g. every 2 weeks or every 4 weeks)
  - How much (e.g. reduce by 10%-20% or 10mg with each reduction)
  - How to dispense the supply (e.g. Blister pack, release every 7 day)
  - Any PRN Opioid doses
  - Naloxone Kit?

Ongoing Support with Patients

Pharmacist can support patients who are thinking or going through opioid tapering:

- Help patients to establish realistic goals with pain management and confirm progress
- Identify different options (non-opioid and non drug) to manage pain and related symptoms
- Monitor and manage withdrawal symptoms (e.g. diarrhea, runny nose)
- Develop plan(s) in anticipation of the discussion on opioid
- Refer to Social Work

Safer Opioid Prescribing Program Updates



QFHT Safer Opioid Prescribing Program

We are excited that the Safer Opioid
great start! We have received many
happy to see that many patients h
tapering or have begun the tapering

Here's a quick overview of things to
90 MME/day or more of opioids:

Conduct an Opioid Revi

Is this patient showing signs of opio

YES

Refer to one of the following:
- Street Health, AMHS
- Dr Ruth Dubin
- KOPI clinic

who can prescribe Suboxone or other appropriate treatments

NO

Is this pa

Consult "QFHT Second O
& Consult Cynthia

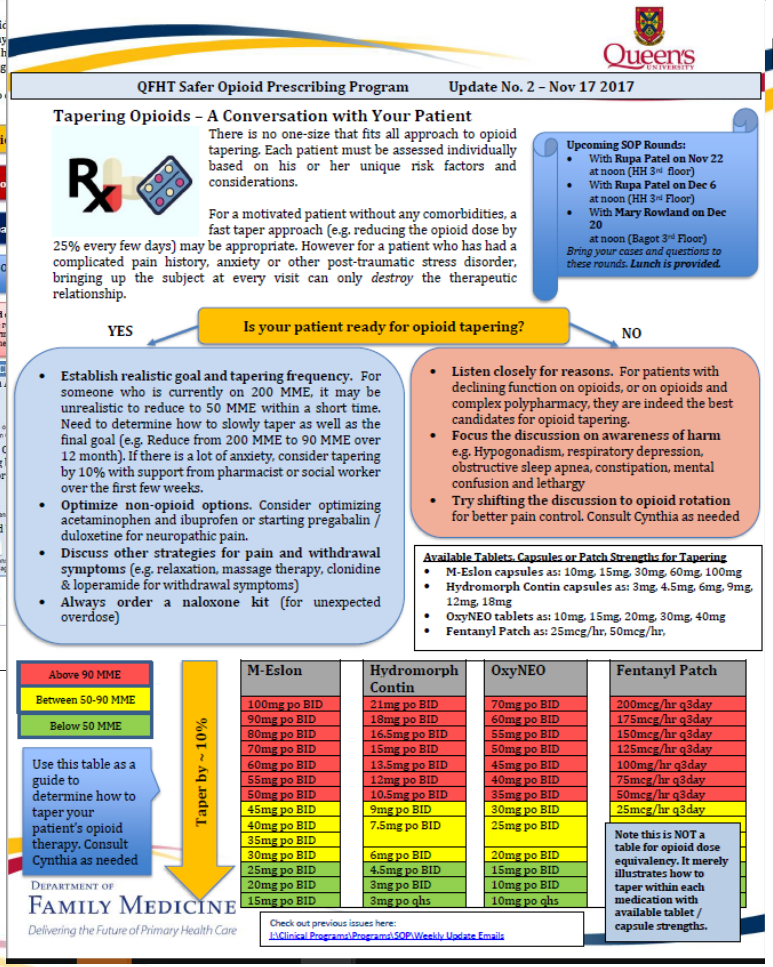
If patient to stay on current opioid
- Only MRP to prescribe all refills [no r
locums (> 3 months)]; MRP to determ
- Consider narcotic agreement, routine

Upcoming SOP Rounds:
- With Rupa Patel on Nov 22 at noon (HH 3rd floor)
- With Rupa Patel on Dec 6 at noon (HH 3rd Floor)
- With Mary Rowland on Dec 20 at noon (Bagot 3rd Floor)

Bring your cases and questions to these rounds. ***Lunch is provided.***

Resources for C
- Clinician Tips on an Opioid Taper
- Resource Hooks C (describe testing and strategies for
- Managing Opioid

Refer to tools in eForms:



QFHT Safer Opioid Prescribing Program Update No. 2 – Nov 17 2017

Tapering Opioids – A Conversation with Your Patient

There is no one-size that fits all approach to opioid tapering. Each patient must be assessed individually based on his or her unique risk factors and considerations.

For a motivated patient without any comorbidities, a fast taper approach (e.g. reducing the opioid dose by 25% every few days) may be appropriate. However for a patient who has had a complicated pain history, anxiety or other post-traumatic stress disorder, bringing up the subject at every visit can only *destroy* the therapeutic relationship.

Upcoming SOP Rounds:
- With Rupa Patel on Nov 22 at noon (HH 3rd floor)
- With Rupa Patel on Dec 6 at noon (HH 3rd Floor)
- With Mary Rowland on Dec 20 at noon (Bagot 3rd Floor)

Bring your cases and questions to these rounds. ***Lunch is provided.***

Is your patient ready for opioid tapering?

YES

- **Establish realistic goal and tapering frequency.** For someone who is currently on 200 MME, it may be unrealistic to reduce to 50 MME within a short time. Need to determine how to slowly taper as well as the final goal (e.g. Reduce from 200 MME to 90 MME over 12 month). If there is a lot of anxiety, consider tapering by 10% with support from pharmacist or social worker over the first few weeks.
- **Optimize non-opioid options.** Consider optimizing acetaminophen and ibuprofen or starting pregabalin / duloxetine for neuropathic pain.
- **Discuss other strategies for pain and withdrawal symptoms** (e.g. relaxation, massage therapy, clonidine & loperamide for withdrawal symptoms)
- **Always order a naloxone kit** (for unexpected overdose)

NO

- **Listen closely for reasons.** For patients with declining function on opioids, or on opioids and complex polypharmacy, they are indeed the best candidates for opioid tapering.
- **Focus the discussion on awareness of harm** e.g. Hypogonadism, respiratory depression, obstructive sleep apnea, constipation, mental confusion and lethargy
- **Try shifting the discussion to opioid rotation** for better pain control. Consult Cynthia as needed

Available Tablets, Capsules or Patch Strengths for Tapering
- **M-Eslon capsules** as: 10mg, 15mg, 30mg, 60mg, 100mg
- **Hydromorph Contin capsules** as: 3mg, 4.5mg, 6mg, 9mg, 12mg, 18mg
- **OxyNEO tablets** as: 10mg, 15mg, 20mg, 30mg, 40mg
- **Fentanyl Patch** as: 25mcg/hr, 50mcg/hr,

Above 90 MME
Between 50-90 MME
Below 50 MME

Use this table as a guide to determine how to taper your patient's opioid therapy. Consult Cynthia as needed

Taper by ~ 10%

M-Eslon	Hydromorph Contin	OxyNEO	Fentanyl Patch
100mg po BID	21mg po BID	70mg po BID	200mcg/hr q3day
90mg po BID	18mg po BID	60mg po BID	175mcg/hr q3day
80mg po BID	16.5mg po BID	55mg po BID	150mcg/hr q3day
70mg po BID	15mg po BID	50mg po BID	125mcg/hr q3day
60mg po BID	13.5mg po BID	45mg po BID	100mg/hr q3day
55mg po BID	12mg po BID	40mg po BID	75mcg/hr q3day
50mg po BID	10.5mg po BID	35mg po BID	50mcg/hr q3day
45mg po BID	9mg po BID	30mg po BID	25mcg/hr q3day
40mg po BID	7.5mg po BID	25mg po BID	
35mg po BID			
30mg po BID	6mg po BID	20mg po BID	
25mg po BID	4.5mg po BID	15mg po BID	
20mg po BID	3mg po BID	10mg po BID	
15mg po BID	3mg po qhs	10mg po qhs	

Note this is NOT a table for opioid dose equivalency. It merely illustrates how to taper within each medication with available tablet / capsule strengths.

Check out previous issues here:
J:\Clinical Programs\Programs\SOP\Weekly Update Emails

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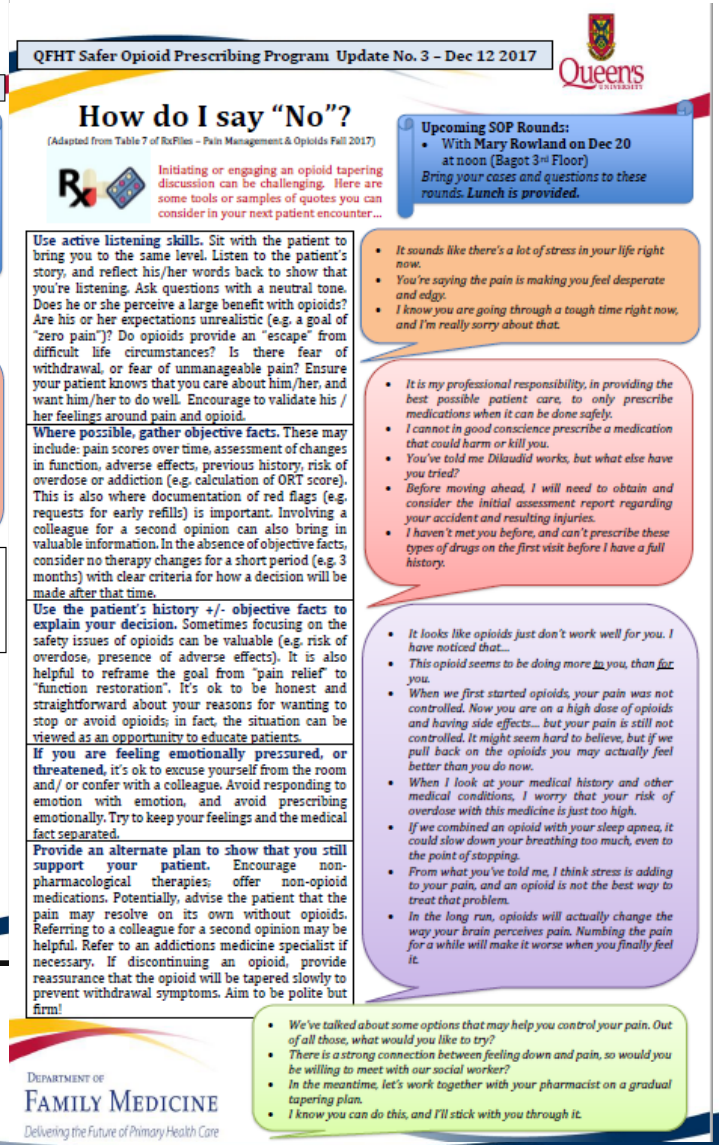

QFHT Safer Opioid Prescribing Program Update No. 3 – Dec 12 2017

How do I say "No"?

(Adapted from Table 7 of RxFiles – Pain Management & Opioids Fall 2017)

Initiating or engaging an opioid tapering discussion can be challenging. Here are some tools or samples of quotes you can consider in your next patient encounter...

Upcoming SOP Rounds:
- With Mary Rowland on Dec 20 at noon (Bagot 3rd Floor)

Bring your cases and questions to these rounds. ***Lunch is provided.***

Use active listening skills. Sit with the patient to bring you to the same level. Listen to the patient's story, and reflect his/her words back to show that you're listening. Ask questions with a neutral tone. Does he or she perceive a large benefit with opioids? Are his or her expectations unrealistic (e.g. a goal of "zero pain")? Do opioids provide an "escape" from difficult life circumstances? Is there fear of withdrawal, or fear of unmanageable pain? Ensure your patient knows that you care about him/her, and want him/her to do well. Encourage to validate his / her feelings around pain and opioid.

- *It sounds like there's a lot of stress in your life right now.*
- *You're saying the pain is making you feel desperate and edgy.*
- *I know you are going through a tough time right now, and I'm really sorry about that.*

Where possible, gather objective facts. These may include: pain scores over time, assessment of changes in function, adverse effects, previous history, risk of overdose or addiction (e.g. calculation of ORT score). This is also where documentation of red flags (e.g. requests for early refills) is important. Involving a colleague for a second opinion can also bring in valuable information. In the absence of objective facts, consider no therapy changes for a short period (e.g. 3 months) with clear criteria for how a decision will be made after that time.

- *It is my professional responsibility, in providing the best possible patient care, to only prescribe medications when it can be done safely.*
- *I cannot in good conscience prescribe a medication that could harm or kill you.*
- *You've told me Dilaudid works, but what else have you tried?*
- *Before moving ahead, I will need to obtain and consider the initial assessment report regarding your accident and resulting injuries.*
- *I haven't met you before, and can't prescribe these types of drugs on the first visit before I have a full history.*

Use the patient's history +/- objective facts to explain your decision. Sometimes focusing on the safety issues of opioids can be valuable (e.g. risk of overdose, presence of adverse effects). It is also helpful to reframe the goal from "pain relief" to "function restoration". It's ok to be honest and straightforward about your reasons for wanting to stop or avoid opioids; in fact, the situation can be viewed as an opportunity to educate patients.

- *It looks like opioids just don't work well for you. I have noticed that...*
- *This opioid seems to be doing more to you, than for you.*
- *When we first started opioids, your pain was not controlled. Now you are on a high dose of opioids and having side effects... but your pain is still not controlled. It might seem hard to believe, but if we pull back on the opioids you may actually feel better than you do now.*
- *When I look at your medical history and other medical conditions, I worry that your risk of overdose with this medicine is just too high.*
- *If we combined an opioid with your sleep apnea, it could slow down your breathing too much, even to the point of stopping.*
- *From what you've told me, I think stress is adding to your pain, and an opioid is not the best way to treat that problem.*
- *In the long run, opioids will actually change the way your brain perceives pain. Numbing the pain for a while will make it worse when you finally feel it.*

If you are feeling emotionally pressured, or threatened, it's ok to excuse yourself from the room and/ or confer with a colleague. Avoid responding to emotion with emotion, and avoid prescribing emotionally. Try to keep your feelings and the medical fact separated.

Provide an alternate plan to show that you still support your patient. Encourage non-pharmacological therapies; offer non-opioid medications. Potentially, advise the patient that the pain may resolve on its own without opioids. Referring to a colleague for a second opinion may be helpful. Refer to an addictions medicine specialist if necessary. If discontinuing an opioid, provide reassurance that the opioid will be tapered slowly to prevent withdrawal symptoms. Aim to be polite but firm!

- *We've talked about some options that may help you control your pain. Out of all those, what would you like to try?*
- *There is a strong connection between feeling down and pain, so would you be willing to meet with our social worker?*
- *In the meantime, let's work together with your pharmacist on a gradual tapering plan.*
- *I know you can do this, and I'll stick with you through it.*

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Sample Opioid Tapering Plans

Dr <Physician Name> Queens Family Health Team

Queens Department of Family Medicine

Date:
To: Community Pharmacist

Address:
Phone:
Fax:

Patient:
Address:

Phone:
Birthdate:
Health Card No:

Dear Pharmacist,

This patient and I have agreed to taper his / her opioid use over the next several weeks. Below is the tapering plan. We hope to collaborate with your pharmacy to ensure there is minimal interruption related to the tapering plan.

Note that this will be the only prescription that will be issued for the duration specified.

Our team will have ongoing follow up with patient for any pain or withdrawal symptoms.

Planned Dates	Fentanyl Patch Regimen	Instruction on Patch Day	Duration	Quantity Required	Qty to dispense q15d
	200mcg/hr every 3 days	4 x 50mcg/hr Patch	30 days	50mcg /hr Patch - 8 boxes of 5 patches (= 40 patches)	50mcg/hr patch 4 boxes of 5 patches (= 20 patches)
					50mcg/hr patch 4 boxes of 5 patches (= 20 patches)
	175mcg/hr every 3 days	3 x 50mcg/hr Patch 1 x 25mcg/hr Patch	30 days	50mcg /hr Patch - 6 boxes of 5 patches (= 30 patches) 25mcg /hr Patch – 2 boxes of 5 patches (= 10 patches)	50mcg/hr patch – 3 boxes of 5 patches (= 15 patches) 25mcg/hr patch – 1 box of 5 patches (= 5 patches)
					50mcg/hr patch – 3 boxes of 5 patches (= 15 patches) 25mcg/hr patch – 1 box of 5 patches (= 5 patches)
	150mcg/hr every 3 days	3 x 50mcg/hr Patch	30 days	50mcg/hr Patch – 6 boxes of 5 patches (= 30 patches)	50mcg/hr patch – 3 boxes of 5 patches (= 15 patches)
					50mcg/hr patch – 3 boxes of 5 patches (= 15 patches)
	125mcg/hr every 3 days	2 x 50mcg/hr Patch 1 x 25mcg/hr Patch	30 days	50mcg/hr Patch – 4 boxes of 5 patches (= 20 patches) 25mcg/hr Patch – 2 boxes of 5 patches (= 10 patches)	50mcg/hr patch – 2 boxes of 5 patches (= 10 patches) 25mcg/hr patch – 1 box of 5 patches (= 5 patches)
					50mcg/hr patch – 2 boxes of 5 patches (= 10 patches) 25mcg/hr patch – 1 box of 5 patches (= 5 patches)
	100mcg/hr every 3 days	2 x 50mcg/hr Patch	30 days	50mcg/hr Patch – 4 boxes of 5 patches (= 20 patches)	50mcg/hr Patch – 2 boxes of 5 patches (= 10 patches)
					50mcg/hr Patch – 2 boxes of 5 patches (= 10 patches)
	75mcg/hr every 3 days	1 x 50mcg/hr Patch 1 x 25mcg/hr Patch	30 days	50mcg/hr patch – 2 boxes of 5 patches (= 10 patches) 25mcg/hr patch – 2 boxes of 5 patches (= 10 patches)	50mcg/hr patch – 1 box of 5 patches (= 5 patches) 25mcg/hr patch – 1 box of 5 patches (= 5 patches)
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	50mcg/hr every 3 days	1 x 50mcg/hr Patch	30 days	50mcg/hr patch – 2 boxes of 5 patches (= 10 patches)	50mcg/hr patch – 1 box of 5 patches (= 5 patches)
					50mcg/hr patch – 1 box of 5 patches (= 5 patches)
	25mcg/hr every 3 days	1 x 25mcg/hr patch	30 days	25mcg/hr patch – 2 boxes of 5 patches (= 10 patches)	25mcg/hr patch – 1 box of 5 patches (= 5 patches)
					25mcg/hr patch – 1 box of 5 patches (= 5 patches)

☐ Dispense a Naloxone Kit and provide necessary training for patient in case of opioid overdose

Signed by: _____ CPSO Number: _____ Date: _____

Dr <Physician Name> Queens Family Health Team

Date:
To: Community Pharmacist

Address:
Phone:
Fax:

Patient:
Address:

Phone:
Birthdate:
Health Card No:

Dear Pharmacist,

This patient and I have agreed to taper his / her opioid use over the next several weeks. Below is the tapering plan. We hope to collaborate with your pharmacy to ensure there is minimal interruption related to the tapering plan.

Note that this will be the only prescription that will be issued for the duration specified.

Our team will have ongoing follow up with patient for any pain or withdrawal symptoms.

Planned Dates	M-Eslon Regimen	Morning Instruction	Evening Instruction	Duration	Quantity Required	Quantity to dispense q2week
	100mg po BID	1 x 100mg cap	1 x 100mg cap	4 wks	100mg x 56 caps	100mg x 28 caps
						100mg x 28 caps
	90mg po BID	1 x 60mg cap 1 x 30mg cap	1 x 60mg cap 1 x 30mg cap	4 wks	60mg x 56 caps 30mg x 56 caps	60mg x 28 caps; 30mg x 28 caps
						60mg x 28 caps; 30mg x 28 caps
	80mg po BID	1 x 60mg cap 2 x 10mg cap	1 x 60mg cap 2 x 10mg cap	4 wks	60mg x 56 caps 10mg x 112 caps	60mg x 28 caps; 10mg x 56 caps
						60mg x 28 caps; 10mg x 56 caps
	70mg po BID	1 x 60mg cap 1 x 10mg cap	1 x 60mg cap 1 x 10mg cap	4 wks	60mg x 56 caps 10mg x 56 caps	60mg x 28 caps; 10mg x 28 caps
						60mg x 28 caps; 10mg x 28 caps
	60mg po BID	1 x 60mg cap	1 x 60mg cap	4 wks	60mg x 56 caps	60mg x 28 caps
						60mg x 28 caps
	55mg po BID	3 x 15mg cap 1 x 10mg cap	3 x 15mg cap 1 x 10mg cap	4 wks	15mg x 168 caps 10mg x 56 caps	15mg x 84 caps; 10mg x 28 caps
						15mg x 84 caps; 10mg x 28 caps
	50mg po BID	1 x 30mg cap 2 x 10mg cap	1 x 30mg cap 2 x 10mg cap	4 wks	30mg x 56 caps 10mg x 112 caps	30mg x 28 caps; 10mg x 56 caps
						30mg x 28 caps; 10mg x 56 caps
	45mg po BID	1 x 30mg cap 1 x 15mg cap	1 x 30mg cap 1 x 15mg cap	4 wks	30mg x 56 caps 15mg x 56 caps	30mg x 28 caps; 15mg x 28 caps
						30mg x 28 caps; 15mg x 28 cap
	40mg po BID	1 x 30mg cap 1 x 10mg cap	1 x 30mg cap 1 x 10mg cap	4 wks	30mg x 56 caps 10mg x 56 caps	30mg x 28 caps; 10mg x 28 caps
						30mg x 28 caps; 10mg x 28 caps
	35mg po BID	1 x 15mg cap 2 x 10mg cap	1 x 15mg cap 2 x 10mg cap	4 wks	15mg x 56 caps 10mg x 112 caps	15mg x 28 caps; 10mg x 56 caps
						15mg x 28 caps; 10mg x 56 caps
	30mg po BID	1 x 30mg cap	1 x 30mg cap	4 wks	30mg x 56 caps	30mg x 28 caps
						30mg x 28 caps
	25mg po BID	1 x 15mg cap 1 x 10mg cap	1 x 15mg cap 1 x 10mg cap	4 wks	15mg x 56 caps 10mg x 56 caps	15mg x 28 caps; 10mg x 28 caps
						15mg x 28 caps; 10mg x 28 caps
	20mg po BID	2 x 10mg cap	2 x 10mg cap	4 wks	10mg x 112 caps	10mg x 56 caps
						10mg x 56 caps
	15mg po BID	1 x 15mg cap	1x 15mg cap	4 wks	15mg x 56 caps	15mg x 28 caps
						15mg x 28 caps

Above MME 90

Between MME 50-90

Below MME 50

☐ Dispense a Naloxone Kit and provide necessary training for patient in case of opioid overdose
☐ Acetaminophen 650mg-100mg q6h prn
☐ Naproxen 375mg po BID prn M: 100
☐ Loperamide 2mg po QID PRN for diarrhea
☐ Clonidine 0.1mg BID for 7 days

Signed by: _____ CPSO Number: _____ Date: _____

Quick Tapering Tool

Above 90 MME

Between 50-90 MME

Below 50 MME

Use this table as a guide to determine how to taper your patient's opioid therapy. Consult Cynthia as needed

Taper by ~ 10%

M-Eslon	Hydromorph Contin	OxyNEO	Fentanyl Patch
100mg po BID	21mg po BID	70mg po BID	200mcg/hr q3day
90mg po BID	18mg po BID	60mg po BID	175mcg/hr q3day
80mg po BID	16.5mg po BID	55mg po BID	150mcg/hr q3day
70mg po BID	15mg po BID	50mg po BID	125mcg/hr q3day
60mg po BID	13.5mg po BID	45mg po BID	100mg/hr q3day
55mg po BID	12mg po BID	40mg po BID	75mcg/hr q3day
50mg po BID	10.5mg po BID	35mg po BID	50mcg/hr q3day
45mg po BID	9mg po BID	30mg po BID	25mcg/hr q3day
40mg po BID	7.5mg po BID	25mg po BID	
35mg po BID			
30mg po BID	6mg po BID	20mg po BID	
25mg po BID	4.5mg po BID	15mg po BID	
20mg po BID	3mg po BID	10mg po BID	
15mg po BID	3mg po qhs	10mg po qhs	

Note this is NOT a table for opioid dose equivalency. It merely illustrates how to taper within each medication with available tablet / capsule strengths.

Check out previous issues here:
I:\Clinical Programs\Programs\SOP\Weekly Update Emails

DEPARTMENT OF FAMILY MEDICINE
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Available Tablets, Capsules or Patch Strengths for Tapering

- M-Eslon capsules as: 10mg, 15mg, 30mg, 60mg, 100mg
- Hydromorph Contin capsules as: 3mg, 4.5mg, 6mg, 9mg, 12mg, 18mg
- OxyNEO tablets as: 10mg, 15mg, 20mg, 30mg, 40mg
- Fentanyl Patch as: 25mcg/hr, 50mcg/hr,

DEPARTMENT OF FAMILY MEDICINE
Delivering the Future of Primary Health Care

Online Resources

Wilderman Medical Clinic

- The internet Cognitive Behavioural Therapy (iCBT) program consists of eight modules of cognitive behavioural therapy and mindfulness practices. For individuals of all ages with chronic pain and symptoms of anxiety and / or depression.

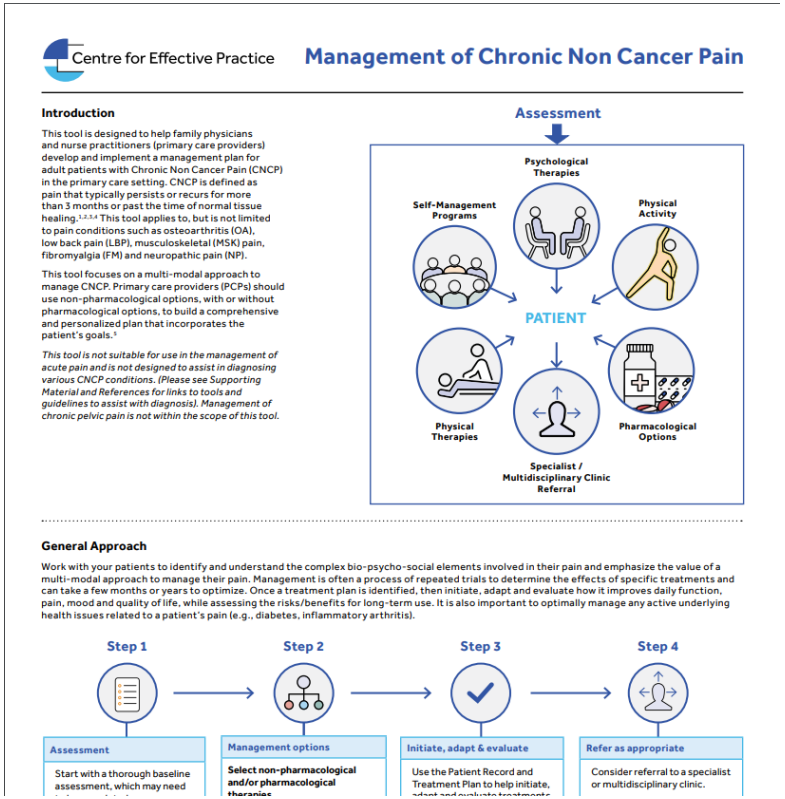
Chronic Disease Self-Management Program

- The Ontario Ministry of Health and Long Term Care Funded the free, evidence-based Stanford University Chronic Disease Self Management Program

Pain BC

- Pain BC has a number of programs and resources for chronic pain management, including coaching for health and tools and resources for self-management

Other Resources



Centre for Effective Practice

Management of Chronic Non Cancer Pain

Introduction

This tool is designed to help family physicians and nurse practitioners (primary care providers) develop and implement a management plan for adult patients with Chronic Non Cancer Pain (CNCP) in the primary care setting. CNCP is defined as pain that typically persists or recurs for more than 3 months or past the time of normal tissue healing.[1,2,3,4] This tool applies to, but is not limited to pain conditions such as osteoarthritis (OA), low back pain (LBP), musculoskeletal (MSK) pain, fibromyalgia (FM) and neuropathic pain (NP).

This tool focuses on a multi-modal approach to manage CNCP. Primary care providers (PCPs) should use non-pharmacological options, with or without pharmacological options, to build a comprehensive and personalized plan that incorporates the patient's goals.[5]

This tool is not suitable for use in the management of acute pain and is not designed to assist in diagnosing various CNCP conditions. (Please see Supporting Material and References for links to tools and guidelines to assist with diagnosis). Management of chronic pelvic pain is not within the scope of this tool.

Assessment

Psychological Therapies

Self-Management Programs

Physical Activity

PATIENT

Physical Therapies

Pharmacological Options

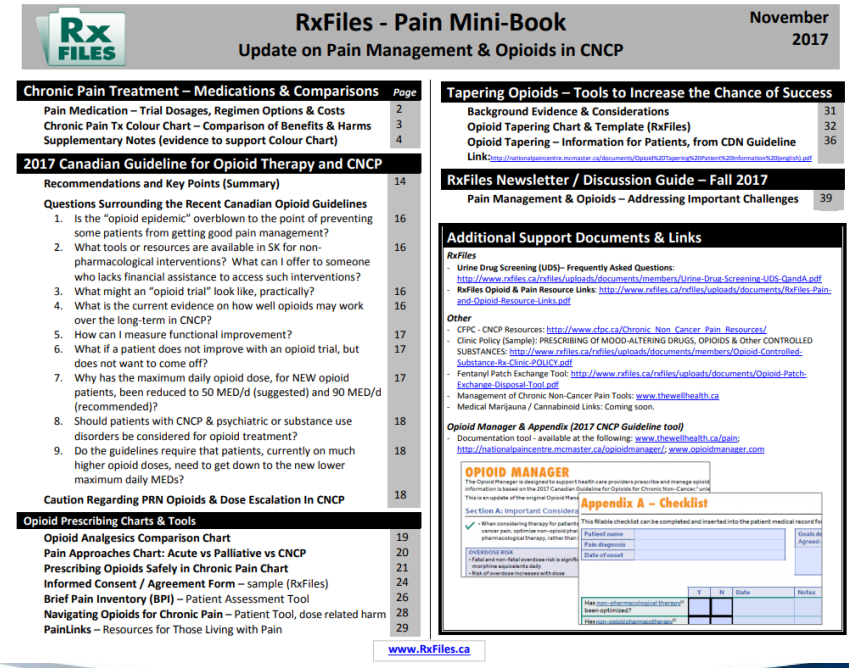
Specialist / Multidisciplinary Clinic Referral

General Approach

Work with your patients to identify and understand the complex bio-psycho-social elements involved in their pain and emphasize the value of a multi-modal approach to manage their pain. Management is often a process of repeated trials to determine the effects of specific treatments and can take a few months or years to optimize. Once a treatment plan is identified, then initiate, adapt and evaluate how it improves daily function, pain, mood and quality of life, while assessing the risks/benefits for long-term use. It is also important to optimally manage any active underlying health issues related to a patient's pain (e.g., diabetes, inflammatory arthritis).

Step 1	Step 2	Step 3	Step 4
Assessment	**Management options**	**Initiate, adapt & evaluate**	**Refer as appropriate**
Start with a thorough baseline assessment, which may need	**Select non-pharmacological and/or pharmacological**	Use the Patient Record and Treatment Plan to help initiate,	Consider referral to a specialist or multidisciplinary clinic.

Centre of Effective Practices (https://thewellhealth.ca/cncp)



RxFiles

RxFiles - Pain Mini-Book

Update on Pain Management & Opioids in CNCP

November 2017

Chronic Pain Treatment – Medications & Comparisons *Page*

2017 Canadian Guideline for Opioid Therapy and CNCP

Opioid Prescribing Charts & Tools

Tapering Opioids – Tools to Increase the Chance of Success

RxFiles Newsletter / Discussion Guide – Fall 2017

Additional Support Documents & Links

RxFiles
- Urine Drug Screening (UDS)– Frequently Asked Questions: http://www.rxfiles.ca/rxfiles/uploads/documents/members/Urine-Drug-Screening-UDS-QandA.pdf
- RxFiles Opioid & Pain Resource Links: http://www.rxfiles.ca/rxfiles/uploads/documents/RxFiles-Pain-and-Opioid-Resource-Links.pdf

Other
- CFPC - CNCP Resources: http://www.cfpc.ca/Chronic_Non_Cancer_Pain_Resources/
- Clinic Policy (Sample): PRESCRIBING OF MOOD-ALTERING DRUGS, OPIOIDS & Other CONTROLLED SUBSTANCES: http://www.rxfiles.ca/rxfiles/uploads/documents/members/Opioid-Controlled-Substance-Rx-Clinic-POLICY.pdf
- Fentanyl Patch Exchange Tool: http://www.rxfiles.ca/rxfiles/uploads/documents/Opioid-Patch-Exchange-Disposal-Tool.pdf
- Management of Chronic Non-Cancer Pain Tools: www.thewellhealth.ca
- Medical Marijauna / Cannabinoid Links: Coming soon.

Opioid Manager & Appendix (2017 CNCP Guideline tool)
- Documentation tool - available at the following: www.thewellhealth.ca/pain; http://nationalpaincentre.mcmaster.ca/opioidmanager/, www.opioidmanager.com

OPIOID MANAGER

Appendix A – Checklist

www.RxFiles.ca

RxFiles – Pain Mini-Book

ROLE OF QFHT SOCIAL WORKER IN SAFER OPIOID PRESCRIBING

Department of
Family Medicine
Delivering the Future of Primary Health Care

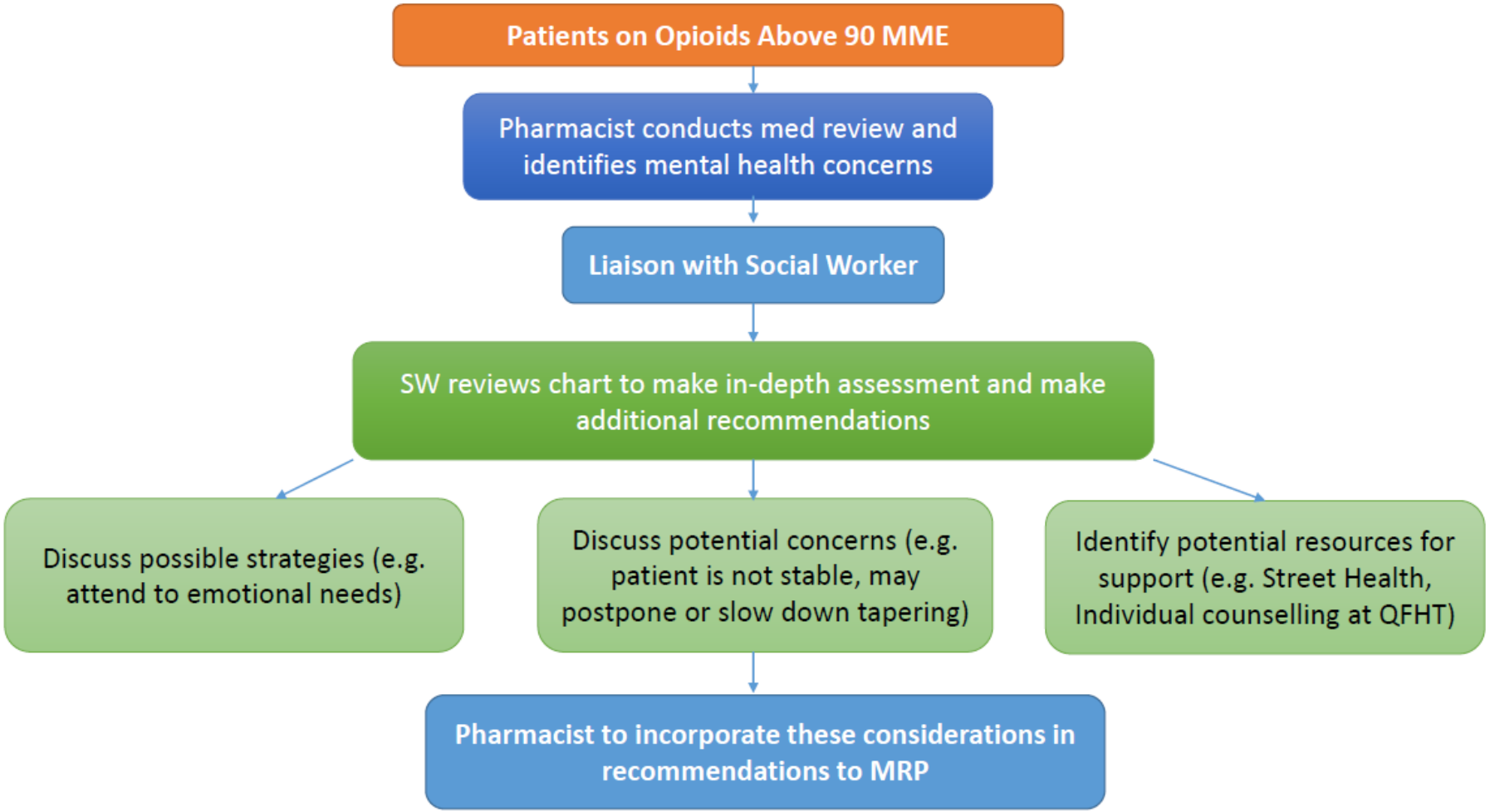
Why involve a social worker?

- Important to involve social worker when a patient is considering tapering opioids.
- Strong link between pain and mental health.
- Our model is to be proactive in looking at these risk factors (even though social worker is not involved directly) so that we can address presenting concerns in a timely manner

My Role

- Joined SOP October, 2017
- Take a “back seat” role
- Assess and intervene from psychosocial perspective

Our Model


Patients on Opioids Above 90 MME
Pharmacist conducts med review and identifies mental health concerns
Liaison with Social Worker
SW reviews chart to make in-depth assessment and make additional recommendations
Discuss possible strategies (e.g. attend to emotional needs)
Discuss potential concerns (e.g. patient is not stable, may postpone or slow down tapering)
Identify potential resources for support (e.g. Street Health, Individual counselling at QFHT)
Pharmacist to incorporate these considerations in recommendations to MRP

My Role

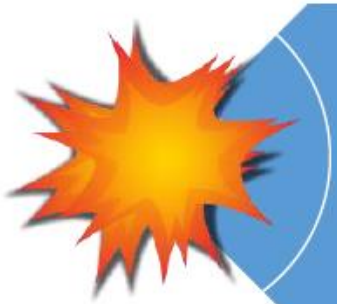
- Reinforcing the same message (SW, Pharm, Doctors etc.)
- Open communication with MRP should concerns be expressed in counselling session.
- Treating the underlying condition or referring to appropriate community resource
- Anxiety Management Strategies- Decatastrophizing

Community Resource Identification

- Liaised with community agencies to identify referral options
- Talked with stakeholders about getting patients access to timely supports in the community- Identified Street Health as point of contact for patients struggling with a taper where we suspect there are addiction issues
- Considered other resources to help address underlying mental health concerns for those not willing/able to taper

Quick Tools for Anxious Patients....

Identifying automatic thoughts and thought distortions



Decatastrophizing

- What are you worried about? What is the worst thing that could happen?
- How likely is this event to happen?
- Has anything this bad ever happened before
- How awful would it be if it did happen?
- If the worst happened, how would I cope

Quick Tools for Managing Pain…

Distractions	Deep Breathing	Progressive Muscle Relaxation	Positive Affirmation Statements
• Can be helpful when pain is high • The key is to pick a healthy distraction	• focuses on slow, patterned abdominal breathing.	• Involves tensing a muscle group for several seconds, and passively focusing on how the tensed muscle feels.	• "I am strong enough to handle this pain."

In Summary…

1. Champion (or group of champions)

2. Proactive support for clinicians and patients involved

3. Consider who on the team is best suited for the task*

4. Involve the whole team and agree on a consistent message

* If you don't have a "full" team, just start small

Thank you! Questions?

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Abi Scott, Data & Quality Improvement Analyst
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Please email us for copies of resources

Questions for each other

- For Abi: How do you generate a report?
- For Cynthia: Any surprises you've found when doing opioid reviews with patients and physicians? (hypothyroidism)
- For Cynthia, Erin: What are we going to recommend when the patient has recurring, transient pain during tapering?

Questions for Discussion

- How would you begin a conversation with a patient on high dose opioids?
- What are some of your strategies to deal with resistance?
- What are some of your ways to engage your patients?