Team Based Approaches to Chronic Pain Management: Opioid Stewardship

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Objectives

1. Recognize where the Opioids Clinical Primer fits in the suite of supports known as Ontario Pain Management Resources (OPMR)
2. Describe key strategies for reducing the risks of opioids in the management of chronic non-cancer pain
3. Identify the benefits of a team based approach to opioid stewardship

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What is the Opioids Clinical Primer?

"The Tiered CPD Model will include minimum training requirement for all opioid prescribers and dispensers, with additional training and supports based on provider and community needs."

EXCELLENCE IN CARE ACROSS ONTARIO

QUALITY IMPROVEMENT PLANS

QUORUM

QUALITY IMPROVEMENT IN ACTION

PRACTICE REPORTS

- Primary Care
- Long-Term Care
- Orthopaedic Surgery
- Hospital Performance Series Reports
- MyPractice: General Medicine
- Partnered Supports for Helping Patients Manage Pain

E-LEARNING AND EVENTS

Ontario Pain Management Resources

A Partnership to Help Clinicians Support their Patients

Helping patients manage pain is complex. To help navigate this challenging landscape and support health care providers across the health system, Health Quality Ontario and organizations across the province offer a coordinated program of supports to help family doctors, nurse practitioners and other primary care clinicians manage their patients' pain, including the appropriate use of opioids.

The following provides a one-stop summary of available pain management supports.

Guidelines and Standards

Six Courses

1. **Opioid Use Disorder in Primary Care: Principles of Assessment and Management**
2. **Managing Patients with Opioid Use Disorder in Primary Care with Buprenorphine**
3. **Safer Opioid Prescribing Strategies**
4. ***Mental Health, Chronic Pain, and Substance Use: Addressing the Connections***
5. ***Strategies for Managing Chronic Pain: Moving Beyond Opioids***
6. ***Treating Opioid Use Disorder: Initiating Buprenorphine in Primary Care, ED and Inpatient Settings***

***coming soon**

Assess Your Knowledge

1. You have been prescribing oxycocet 2 tablets QID to a 50 year old male for back pain for about 8 years. You have recently become concerned that he may be misusing his medication. He has asked for a couple of early refills, and his last urine sample showed codeine as well as oxycodone, but you haven't had a chance to see him since the result came in.

You receive a call from his pharmacy: they have received your renewal as well as a prescription for acetaminophen with codeine from another physician.

What is the most appropriate option at this point in time?

a. Change his dose to long-acting oxycodone so his dose will last longer
b. Rotate to another opioid because his pain is not being managed
c. Cancel the prescription and discharge him from your practice
d. Have his medications dispensed twice weekly until you can see him again to determine next steps

2. Which of the following factors increases the risk of opioid related death?

a. Doses above 50 mg
b. Concurrent prescriptions for pregabalin
c. Alcohol use
d. All of the above

3. True or False? Naloxone is an opioid antagonist (blocker) that can temporarily reverse the effects of an opioid overdose. A prescription is required to obtain naloxone from a pharmacy.

a. True.
b. False.

4. A patient new to you has chronic neuropathic pain related to a complex ankle fracture. She has not had relief with acetaminophen and OTC NSAIDs. She has no active substance use or mental health issues. Are opioids appropriate based on the information provided?

a. Yes
b. No

5. According to the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain all patients on doses of opioids greater than 90MME/D (mg morphine equivalents/day) should have their doses tapered and potentially discontinued.

a. True
b. False

Why Are We in an Opioid Crisis?

Multiple complex factors, including:

- High prevalence of chronic pain in the general population
- Prescribing practices
- Changes in the illicit drug supply
- Psychological, social and biological risk factors that increase the risk of addictions
- Inadequate access to treatment for substance use and mental health disorders, couple with stigma

Prescribing Practices

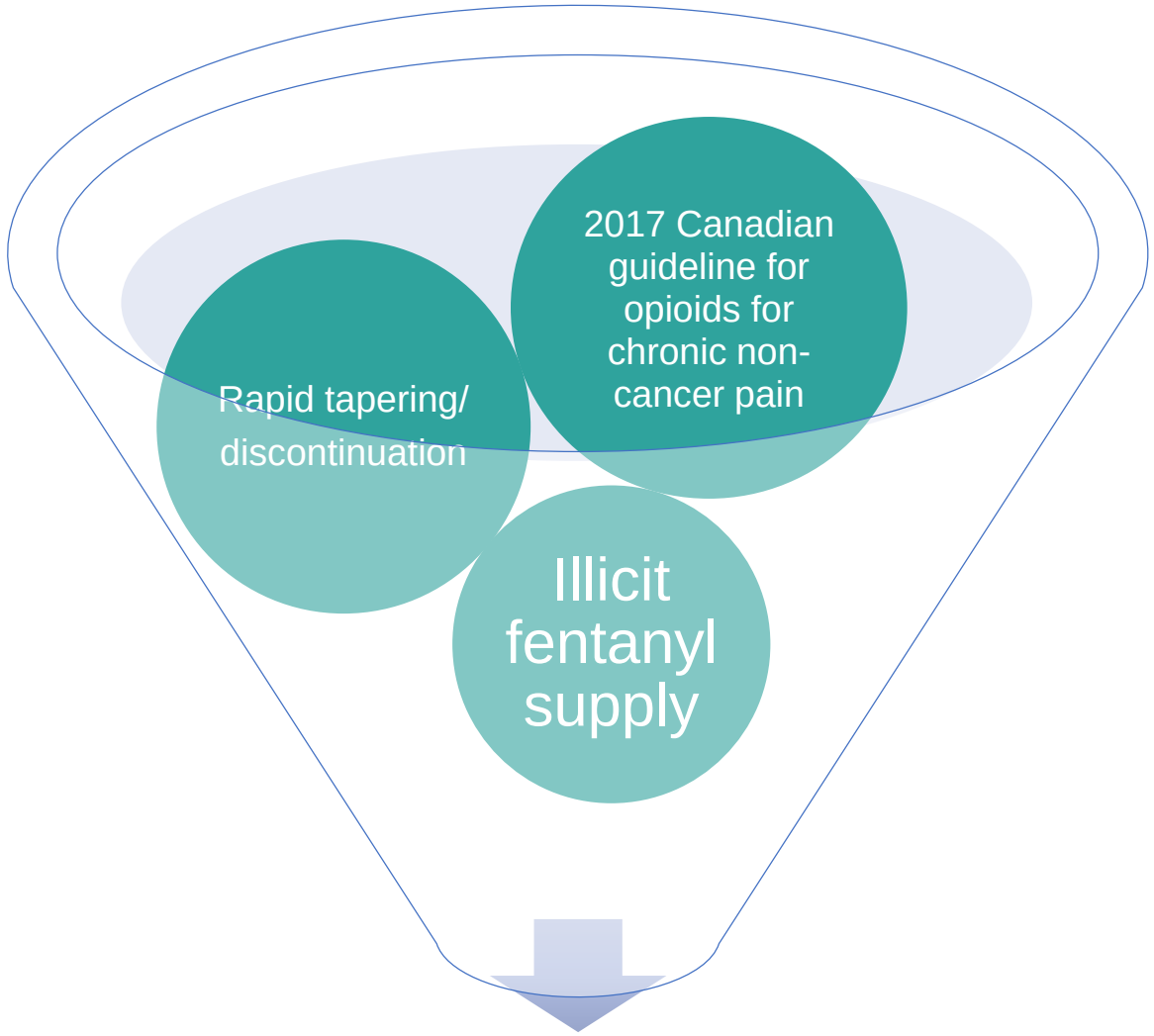
- 20% of the population has chronic pain
- Risk of opioids was historically underestimated
  - 5.5% of patients with no pre-existing substance use or psychiatric disorder develop addiction to opioids prescribed for chronic pain
  - 9% of patients with active substance use issues develop addiction to opioids in the context of prescriptions for chronic pain
- Risks of de-prescribing

Withdrawal and the Illicit Drug Supply

- Abrupt cessation of opioids leads to withdrawal symptoms
- Withdrawal symptoms can cause patients to seek opioids from non-medical sources
- The risk of harm from non-medical sources is high because:
  - Opioid tolerance is lost within days
  - Street opioids often contain fentanyl powder
  - Ultra-high potency of fentanyl puts both naïve and experienced users at risk of overdose

In 2017 over 60% of street drug samples tested positive for fentanyl

Context


2017 Canadian guideline for opioids for chronic non-cancer pain
Rapid tapering/ discontinuation
Illicit fentanyl supply
Overdose crisis

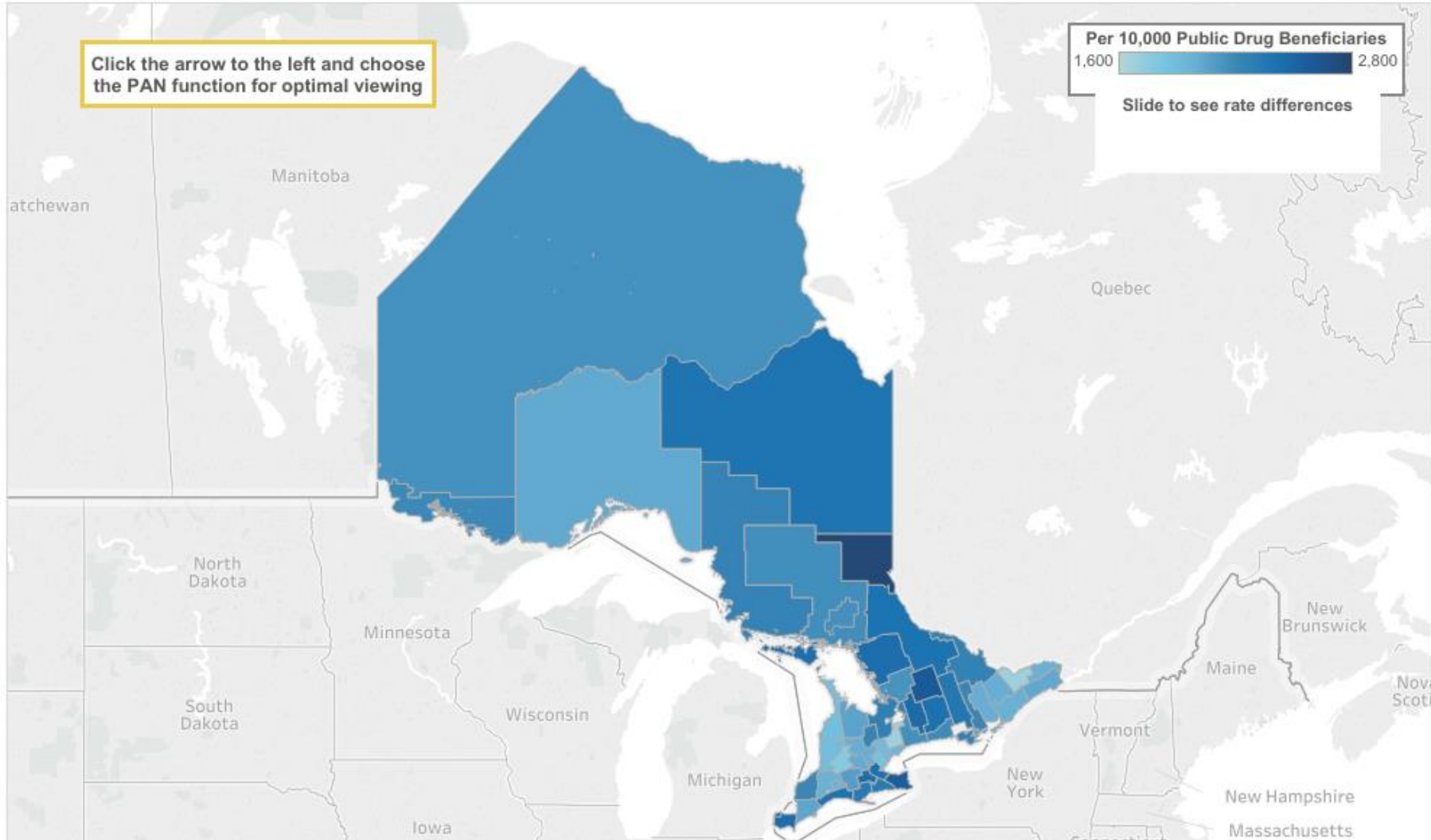
ODPRN ONTARIO DRUG POLICY RESEARCH NETWORK

Ontario Prescription Opioid Tool

Rates of Opioid Use and Related Adverse Events in Ontario by County

Rate of Opioid Users in 2015	Rate of Opioid Maintenance Therapy Users in 2015	Rate of Opioid-Related Emergency Department Visits in 2014	Rate of Opioid-Related Hospital Admissions in 2014	Annualized Rate of Opioid-Related Deaths Over 5 Years (2009-2013)

Rate of Opioid Users in 2015



Geographic area
Ontario

Indicator
Opioids for Pain (Individuals)

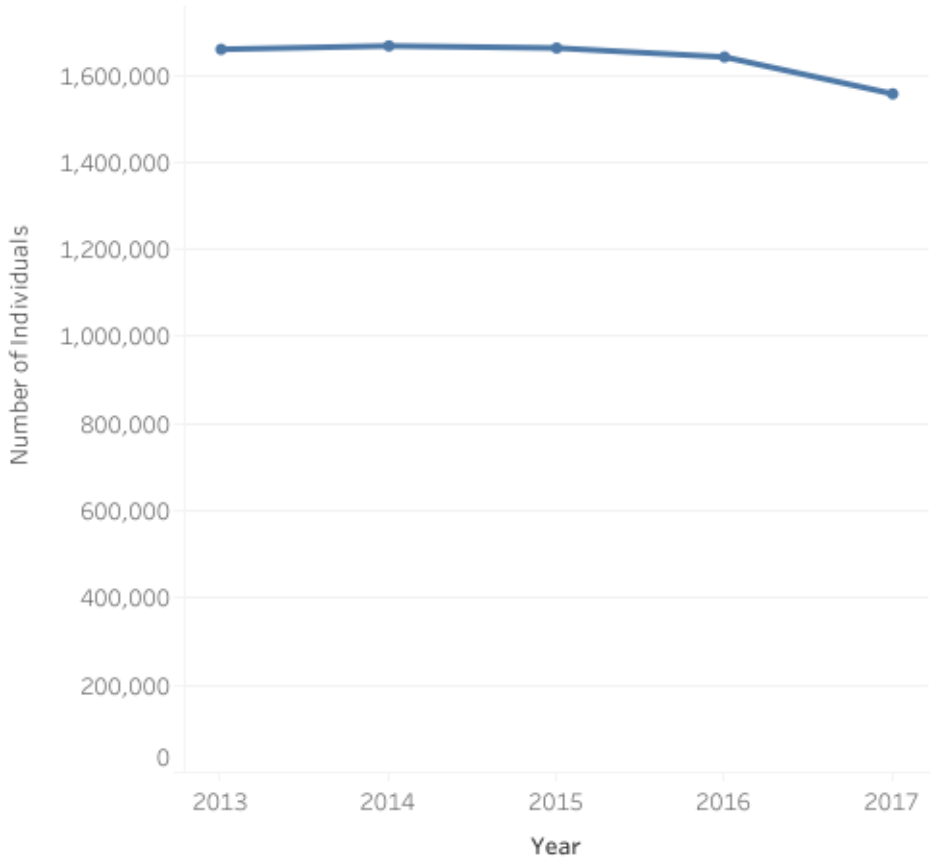
Graph by
(•) Count
( ) Rate

Show data
Multiple values

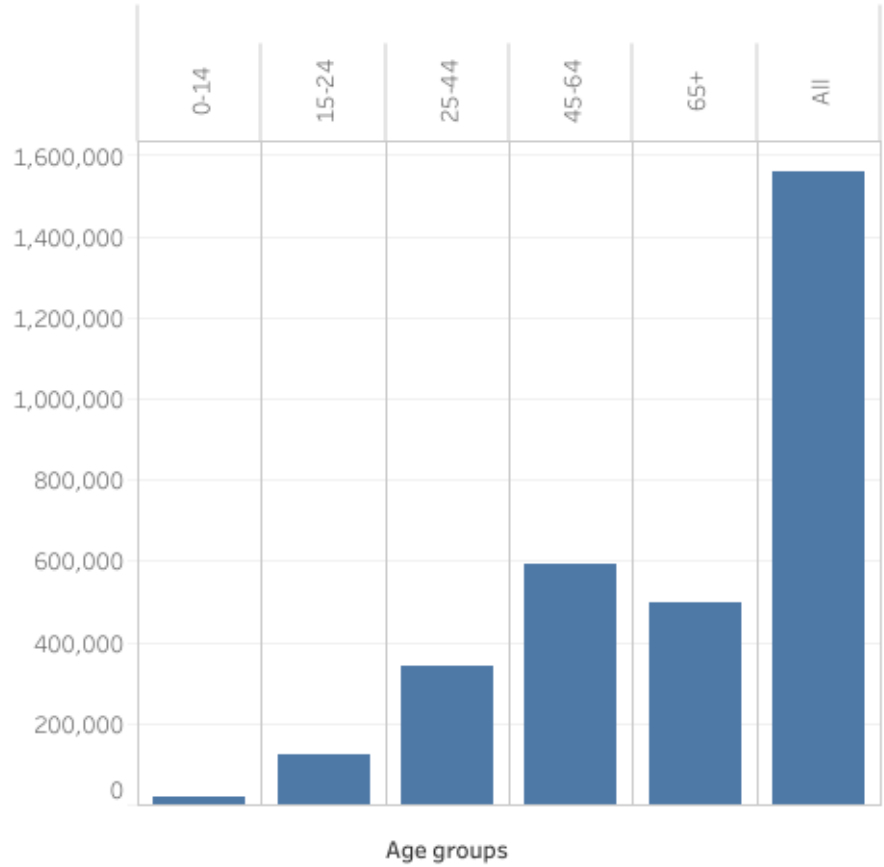
Sex
All

Count of Opioids for Pain (Individuals) in Ontario

Over Time by Age Group: All

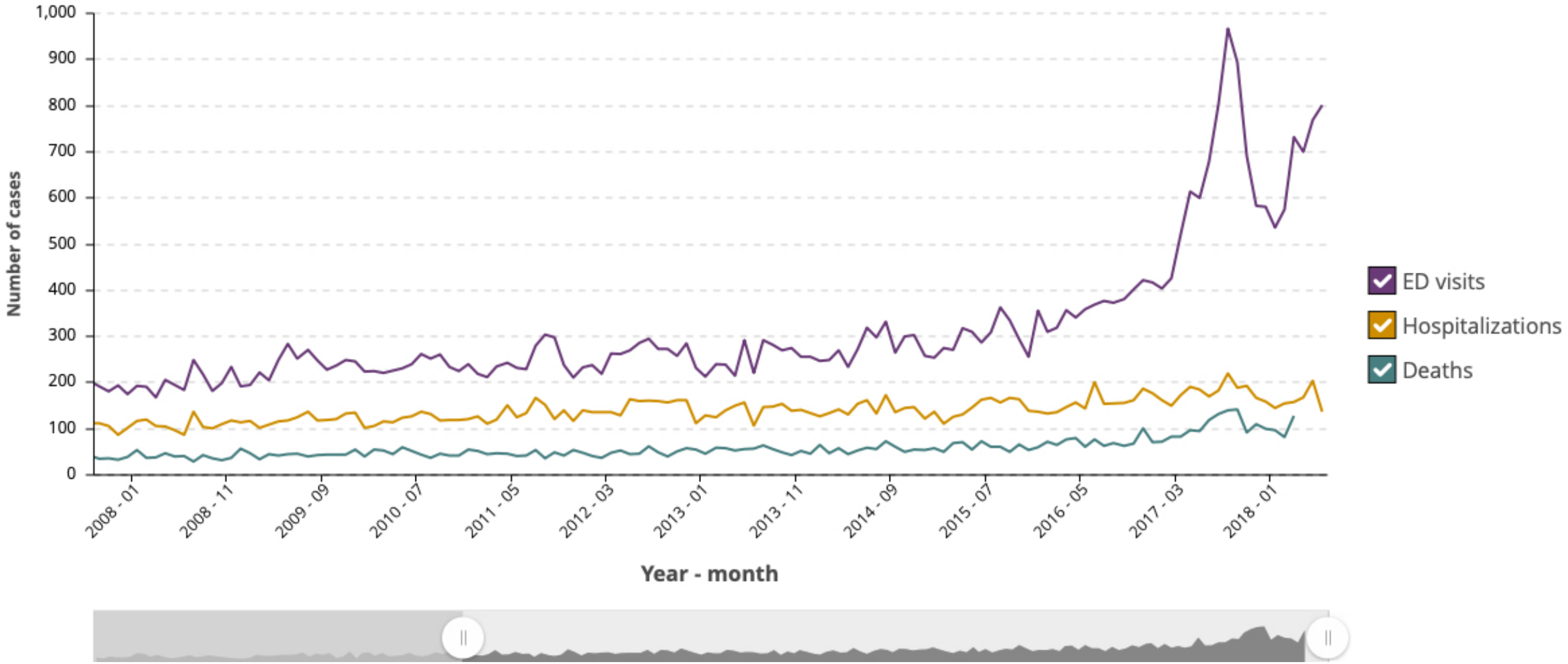


Age Groups by Year: 2017

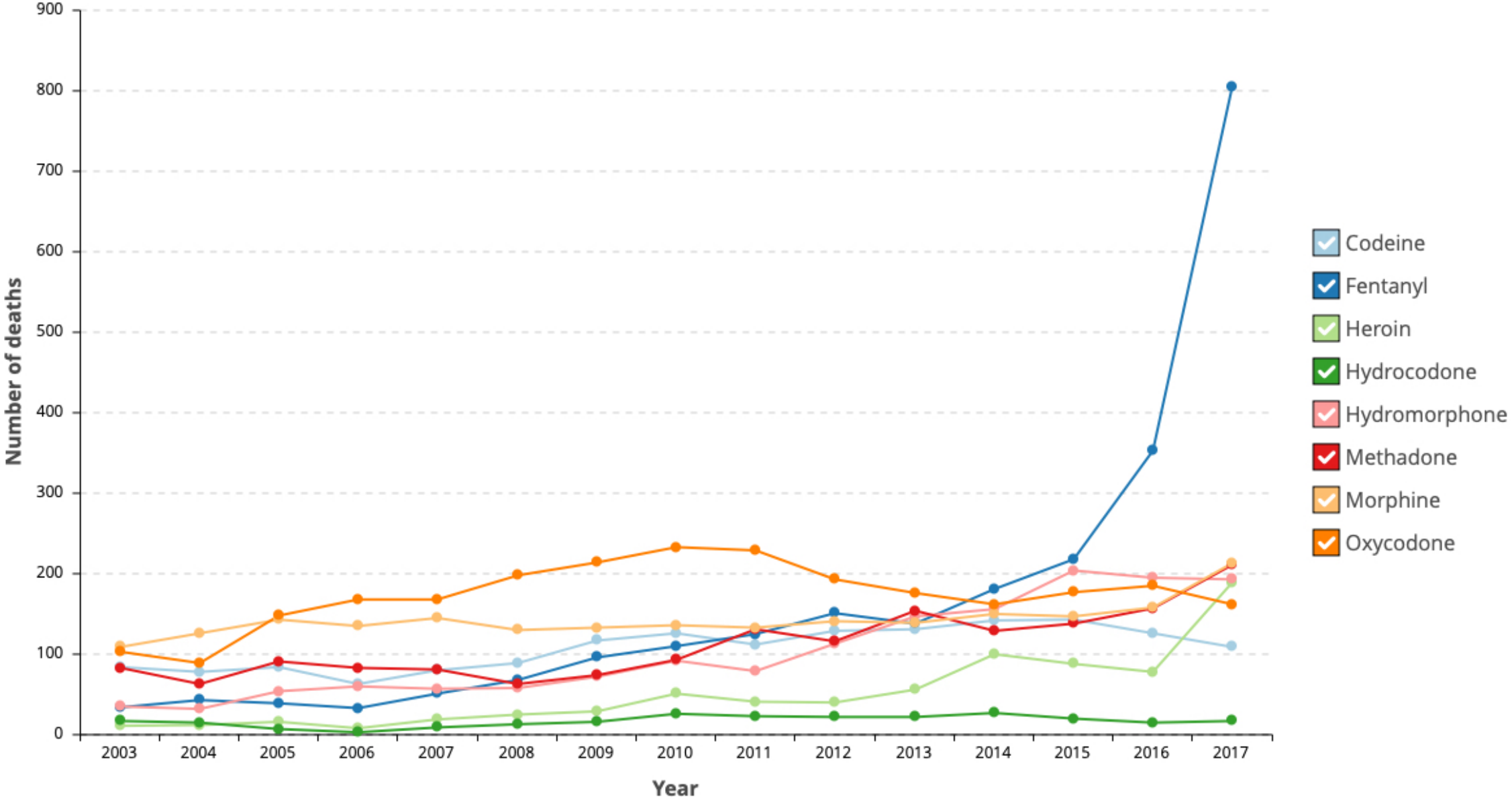


Notes:
1) LHIN/PHU is based on the individual's location of residence.
2) * In accordance with ICES' commitments in data sharing agreements, a number of approaches have been taken to ensure no reporting of small cells. These are summarized in the technical appendix.

Cases of opioid-related morbidity and mortality, Ontario, 2003 - 01 – 2018 - 06



Type of opioid present at death, Ontario, 2003 – 2017



Direct links: Prescribing and Harms

89%	• Prescription in the year before death (Dhalla 2009) • 56% in month before death
91%	• Prescribed opioids after non-fatal overdose (Larochelle 2016)
59%	• First exposed by prescribing – among those with heroin or nonmedical prescription opioid use (Butler 2016)
37%	• Prescription source before addiction treatment (Sproule 2009)
Up to 1/3	• Develop addiction in chronic opioid therapy (Juurlink 2012)
3x	• Risk of opioid-related mortality on 200mg/d vs. <20mg/d (Gomes 2011)
48%	• Sedative prescription 30d before opioid death (Fulton-Kehoe 2015)

Dr. Pamela Leece, Dr. Mel Kahan, Understanding the fentanyl crisis in Canada: A public health lens. Public Health Ontario Ground Rounds. May 24, 2016.

Opioid Related Harms

- Sleep apnea
- Depression/dysphoria
- Severe constipation
- Hypogonadism
- Fractures
- Hyperalgesia
- Withdrawal-mediated pain

The 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain

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Recommendation 1: When considering therapy for patients with chronic non-cancer pain

Strong Recommendation

We recommend optimization of non-opioid pharmacotherapy and non-pharmacological therapy, rather than a trial of opioids

Recommendation 2: For patients with chronic noncancer pain, without current or past substance use disorder and without other active psychiatric disorders, who have persistent problematic pain despite optimized nonopioid therapy

Weak Recommendation

We suggest adding a trial of opioids rather than continued therapy without opioids.

Recommendations 6 and 7: For patients with chronic noncancer pain who are beginning long term opioid therapy

Strong Recommendation

Recommendation 6: We recommend restricting the prescribed dose to less 90mg morphine equivalents daily rather than no upper limit or a higher limit on dosing

Some patients may gain important benefit at a dose of more than 90mg morphine equivalents daily. Referral to a colleague for a second opinion regarding the possibility of increasing the dose to more than 90mg morphine equivalents daily may therefore be warranted in some individuals.

Recommendation 8: For patients with chronic noncancer pain who are currently using opioids, and have persistent problematic pain and/or problematic adverse effects

Weak Recommendation

We suggest rotation to other opioids rather than keeping the opioid the same

Rotation in such patients may be done in parallel with, and as a way of facilitating, dose reduction

Recommendation 9: For patients with chronic noncancer pain who are currently using 90mg morphine equivalents of opioids per day or more

Weak Recommendation

We suggest tapering opioids to the lowest effective dose, potentially including discontinuation, rather than making no change in opioid therapy.

Some patients are likely to experience significant increase in pain or decrease in function that persists for more than one month after a small dose reduction; tapering may be paused and potentially abandoned in such patients.

Clinical Dilemmas

- Should all patients on opioids be tapered?
- Should all patients on doses >90 MME/D be tapered?
- What should I do with a patient who seems to be doing well on their current regimen?
- Should I avoid starting any patients on opioids for chronic pain?
- How can I manage chronic pain more effectively?

Case 1: Betty

- 80yo with severe osteoarthritis of the shoulders and hands
- Diverticulitis, anxiety
- Lives alone
- Drives
- Medications:
  - Acetaminophen with codeine 30mg; 2 TID
  - Ramipril
  - Lorazepam 1mg BID prn
  - Zopiclone 7.5mg qhs for sleep

Case 2: Dave

- 50 year old former police officer on disability for chronic back pain following a work-related motor vehicle crash
- Lives with his partner and their combined 4 kids, ages 10-22
- Medication:
  - OxyNeo 30mg BID + oxycocet 2 TID prn
  - Duloxetine 60mg OD
  - Pregabalin 300mg BID
  - Ramipril
  - Atorvastatin
  - Pantoprazole

Case 3: Tamara

- 36yo heavy equipment operator with migraines, endometriosis and severe dysmenorrhea.
- Medications:
  - Progesterone only BCP
  - Cyklokapron
  - Sertraline

Strategies for Opioid Stewardship

- Patient Education
- Opioid Agreements
- Managing prescriptions safely
- Calculating dose in MME/D
- Assessing benefit vs risks of opioids
- Planning a taper

Team Roles

- MD
- RN/NP
- Pharmacist
- Physiotherapist
- Social Worker
- Dietician
- Support Staff
- QI team

Patient Education

- Side effects, evidence for harms vs benefits, tolerance
- Risks of sedation
- Caution about driving while doses are being initiated or titrated
- Caution re risks with BZDs, gabapentinoids and “z-drugs”
- Advise against combining alcohol and opioids
- Explain phenomenon of loss of tolerance

Opioid Agreements

- Helps to clarify expectations
- Structures a process of informed consent
- Outlines responsibilities and boundaries for both patients and prescribers
- Is NOT a contract, is NOT required by the CPSO
- Written- signed by clinician and patient, copy for patient and chart
- Verbal – should be documented in patient’s chart

Opioid Agreement – Typical Inclusions

- Patients will receive opioid prescriptions from one prescriber
- Patients will inform their other providers of their medication
- Patients will not give their medication to anyone else nor receive someone else’s medication
- Medication will be stored safely
- Opioid prescriptions will not be replaced if they are lost or stolen
- Prescription renewals will require an in-person assessment
- Urine drug screens may be requested as a means of monitoring treatment

Safe Storage

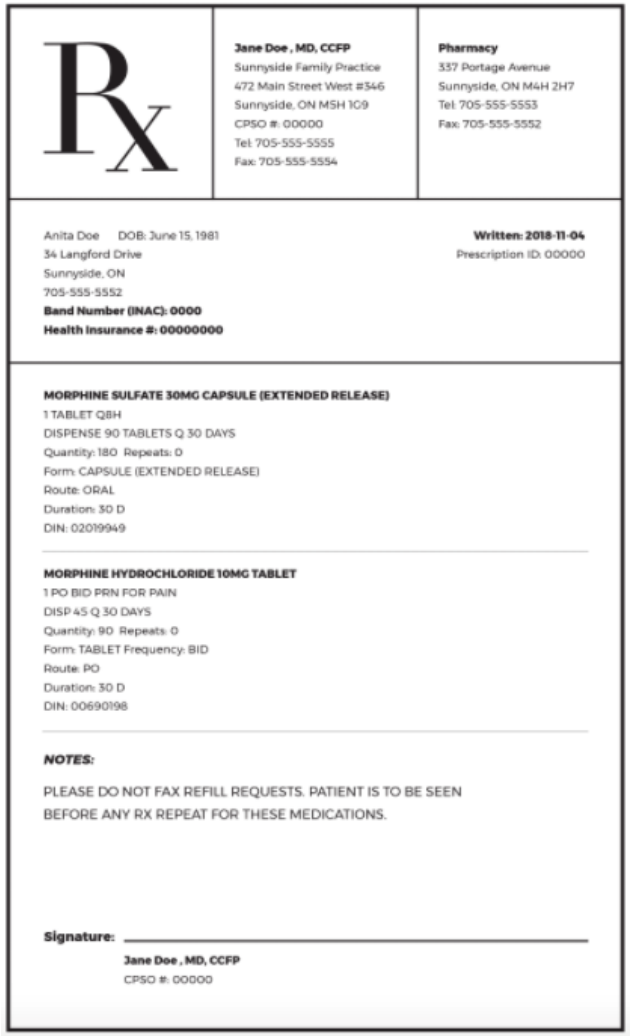
- Out of sight and out of reach
- Locking device (e.g. locked toolbox, key kept separately)
- Return unused medications to the pharmacy
- All patch formulations should be managed with a patch return policy

Appropriate Quantities and Dispensing Intervals

- No more than 14 days at a time when medications are being titrated
- Maximum 28-30 days of medication at a time for patients
  - On stable doses
  - With no concerning behaviours
  - With reassessments every 3 months
- More frequent dispensing for patients with concerning behaviour patterns, e.g. q1-2 weeks (or even q1-2 days)
- Consider blister packs

Writing Prescriptions Safely

- Start date
- End date?
- Dose in mg and tablets
- Dispensing intervals
- Faxed to pharmacy
- Reminder to advise the patient to book a follow-up appointment rather than fax renewal request
- Advise MD if patient appears sedated



Rx

Jane Doe , MD, CCFP
Sunnyside Family Practice
472 Main Street West #346
Sunnyside, ON M5H 1G9
CPSO #: 00000
Tel: 705-555-5555
Fax: 705-555-5554

Pharmacy
337 Portage Avenue
Sunnyside, ON M4H 2H7
Tel: 705-555-5553
Fax: 705-555-5552

Anita Doe DOB: June 15, 1981
34 Langford Drive
Sunnyside, ON
705-555-5552
Band Number (INAC): 0000
Health Insurance #: 00000000

Written: 2018-11-04
Prescription ID: 00000

MORPHINE SULFATE 30MG CAPSULE (EXTENDED RELEASE)
1 TABLET Q8H
DISPENSE 90 TABLETS Q 30 DAYS
Quantity: 180 Repeats: 0
Form: CAPSULE (EXTENDED RELEASE)
Route: ORAL
Duration: 30 D
DIN: 02019949

MORPHINE HYDROCHLORIDE 10MG TABLET
1 PO BID PRN FOR PAIN
DISP 45 Q 30 DAYS
Quantity: 90 Repeats: 0
Form: TABLET Frequency: BID
Route: PO
Duration: 30 D
DIN: 00690198

NOTES:

PLEASE DO NOT FAX REFILL REQUESTS. PATIENT IS TO BE SEEN BEFORE ANY RX REPEAT FOR THESE MEDICATIONS.

Signature: _____

Jane Doe , MD, CCFP
CPSO #: 00000

Managing Requests for Prescription Repeats

- *In general*, a prescription should last until the next booked appointment
- Patients should be aware of office policy
- Are staff consistent with office policy?
- What are additional considerations?
  - Previous requests for renewals?
  - Risk of destabilization if medication is not renewed?

Strategies for Managing Prescription Requests

- *Ideally,* appointment for assessment before renewal/refusal
- *Alternatives:*
  - Set an appointment date and extend just until that date
  - Dispense in smaller quantities
  - Remind the patient of office policy; explain that if an exception is being made, they should not expect that in future
  - Communicate with the pharmacy; request that they advise patients to book an appointment rather than faxing a request
  - Have a strategy in place for when the prescriber is out of the office
  - Will others in the office renew the prescription to bridge the gap?
  - Will they require an office visit?

Communicating with Other Health Professionals

- Pharmacists
  - Assistance checking the Narcotics Monitoring System/Digital Health Drug Repository
  - HQO suggests that prescription history be checked at the initiation of opioid therapy and every 3-6 months for people on long-term stable doses, more often if there are concerns about problematic substance use or multiple prescribers
  - Assistance with checking interactions/additive risks
- Other Prescribers
  - Communicate if an opioid prescription has been prescribed
  - Who will be responsible for monitoring/renewing that medication?
  - Are there risks of interactions with other medications?

Communicating with Other Health Professionals

- Pharmacist
- Other prescribers

Note: The Digital Health Drug Repository (DHDR) is a new way for providers to view information about their patients' dispensed opioid and controlled medications. DHDR can be accessed via the Connecting Ontario or Clinical Connect viewers or the OneAccess Portal.

Information Available to Health Care Providers

Publicly funded drugs

Monitored drugs

Viewable Drug Information

Publicly funded pharmacy services

Viewable Pharmacy Service Information

Over 5 years of information about all monitored drugs (narcotics and controlled substances), regardless of payor, when the approved identification used was a valid Ontario Health Number.

Available information in the DHDR

Calculating Morphine Equivalencies

Opioids*	To convert to oral morphine equivalent, multiply by:	To convert from oral morphine, multiply by:	50 MED equivalent dose	90 MED equivalent dose
Oral preparations (mg/d)				
Codeine	0.15 (0.1-0.2)	6.67	334 mg/d	600 mg/d
Hydromorphone	5.0	0.2	10 mg/d	18 mg/d
Morphine	1.0	1	50 mg/d	90 mg/d
Oxycodone	1.5	0.667	33 mg/d	60 mg/d
Tapentadol	0.3-0.4	2.5-3.33	160	300
Tramadol	0.1-0.2	6	300	540**
Transdermal fentanyl	60 – 134 mg morphine = 25 mcg/h 135 – 179 mg = 37 mcg/h 180 – 224 mg = 50 mcg/h 225 – 269 mg = 62 mcg/h 270 – 314 mg = 75 mcg/h 315 – 359 mg = 87 mcg/h 360 – 404 mg = 100 mcg/h			

Assessing Benefits vs Risks of Opioids

- Assess benefit for function, not just pain (e.g. BPI or history, not just pain scale)
- Review other medications that may increase risks (e.g. benzodiazepines, higher dose gabapentinoids, “z-drugs”)
- Assess side effects (constipation, sweats, fatigue, depression, weight gain, low libido, sleep apnea, hyperalgesia)
- Assess for problematic use/opioid use disorder
- Screen for other problematic substance use
- Screen for mood and anxiety disorders

Planning a Taper

Tapering works best when it's voluntary; engaging the patient is important.

A successful taper typically involves:

- motivational interviewing
- goal setting
- frequent visits
- communication with pharmacist,
- optimizing non-opioid and non-pharmacologic interventions

Case 1: Betty

- 80yo with severe osteoarthritis of the shoulders and hands
- Diverticulitis, anxiety
- Lives alone
- Drives
- Medications:
  - Acetaminophen with codeine 30mg; 2 TID
  - Ramipril
  - Lorazepam 1mg BID prn
  - Zopiclone 7.5mg qhs for sleep

Considerations for Betty

- Dose: 180mg codeine = approximately 30mg morphine
- Risks/Adverse Effects:
  - Constipation
  - 2 sedating medications
- Benefits
  - Has been taking codeine for so long she can’t tell.
  - Manages her ADL independently
- Problematic use?
  - No early refills, never sees other physicians

Considerations for Betty

- Strategies
  - Could try to decrease codeine gradually e.g. tablets with 20mg instead of 30?
  - *Consider “deprescribing” for her BZD/zopiclone; explore alternative medication and non-medication approaches
  - May benefit from assessment by social work, physiotherapist, dietician
  - Review risks re driving, alcohol, prescription renewals, storage and self-management

Case 2: Dave

- 50 year old former police officer on disability for chronic back pain following a work-related motor vehicle crash
- Lives with his partner and their combined 4 kids, ages 10-22
- Medication:
  - OxyNeo 30mg BID + oxycocet 2 TID prn
  - Duloxetine 60mg OD
  - Pregabalin 300mg BID
  - Ramipril
  - Atorvastatin
  - Pantoprazole

Considerations for Dave

- Dose: 80mg oxycodone = 135mg morphine /day
- Risks/Adverse Effects:
  - dose>90mg in association with high-dose pregabalin
  - Drinks 2-4 drinks daily
  - Low libido, low energy, weight gain
- Benefits
  - Rates his pain 5/10 but not doing very much. Mood low.
- Problematic Use?
  - Requests for early refills once for travel only; no reports of aberrant use
  - Check of DHDR shows that he hasn’t filled prescriptions from any other doctors

Considerations for Dave

- Strategies
  - Appropriate for a taper based on risks vs benefits
  - Use CEP/Rx Files tools to map goals, dose reductions and reassessments
  - Locked box
  - Will need regular appointments – benefit of team
  - “Prescribe” naloxone

Case 3: Tamara

- 36yo heavy equipment operator with migraines, endometriosis and severe dysmenorrhea.
- Medications:
  - Progesterone only BCP
  - Cyklokapron
  - Sertraline

Considerations for Tamara

Would you start her on an opioid?

- Optimize non-opioid medications
- Screen for current and past problematic substance use
- Screen for mood and anxiety disorders
- Consider whether her condition is one that is helped by opioids
- What would goals of therapy be?
- If you did start her, at what doses?

Team Roles

- MD
- RN/NP
- Pharmacist
- Physiotherapist
- Social Worker
- Dietician
- Support Staff
- QI team

Tools/Strategies to Improve Opioid Stewardship

- EMR queries, e.g.:
  - MME/d>50,>90,>200 MME/D
  - opioids with BZDs/sedative hypnotics and pregabalin/gabapentin
- Practice tools e.g.:
  - Centre for Effective Practice Opioids for Chronic Non-Cancer Pain Tool
  - morphine equivalence calculator
- Screening tools, e.g.
  - Substance use screeners
  - GAD-7, PHQ-9
  - Brief Pain Inventory
- Patient handouts

Team Practices to Improve Chronic Management & Opioid Stewardship

- Clear process for handling prescription renewals
- Ensure all prescriptions are done in the EMR
- Physio assessment of all patients with chronic pain
- Pharmacist assessment of all patients on long-term opioids, or opioids with sedating
- Ensure appointments and prescriptions are synced
- Check-lists to ensure patients have been linked to self-management programs
- Maintain list of patient oriented resources
- Team leader for coordination

Team Goals?

- Reduce rates of co-prescribing of opioids and sedating medications ✓
- Reduce rates of faxed prescription renewal requests ✓
- Target individuals at higher risk of opioid related adverse effects ✓
- Increase number of patients with an opioid agreement on file ✓
- Use Brief Pain Inventory (BPI) scores as a measure of effective pain management rather than pain scores ✓
- Discuss naloxone with all patients on opioids ✓
- For patients with opioid use disorder, offer/arrange treatment with opioid agonist therapy ✓
- Reduce overall MME/D dosages ☒

Key Messages

- There is no “safe” dose of opioids
- Stopping opioids rapidly puts patients at risk
- Caution re overlapping opioids and sedating medications is essential
- Safer prescribing and dispensing strategies should be used for all patients – universal precautions
- Naloxone can be recommended for all patients on opioids
- Team based approaches can reduce the risks of opioid prescribing and improve outcomes for patients with chronic pain

Naloxone Kits

Should be offered to:

- Every patient on higher dose opioids
- Every patient who uses street opioids
- Patients who may have an opioid use disorder
- Patients who use opioids and alcohol and/or benzodiazepines
- Family members/friends of those with problematic opioid use

1. You have been prescribing oxycocet 2 tablets QID to a 50 year old male for back pain for about 8 years. You have recently become concerned that he may be misusing his medication. He has asked for a couple of early refills, and his last urine sample showed codeine as well as oxycodone, but you haven't had a chance to see him since the result came in.

You receive a call from his pharmacy: they have received your renewal as well as a prescription for acetaminophen with codeine from another physician.

What is the most appropriate option at this point in time?

a. Change his dose to long-acting oxycodone so his dose will last longer.
b. Rotate to another opioid because his pain is not being managed.
c. Cancel the prescription and discharge him from your practice.
d. Have his medications dispensed twice weekly until you can see him again to determine next steps.

2. Which of the following factors increases the risk of opioid related death?

a. Doses above 50 mg
b. Concurrent prescriptions for pregabalin
c. Alcohol use
d. All of the above

3. True or False? Naloxone is an opioid antagonist (blocker) that can temporarily reverse the effects of an opioid overdose. A prescription is required to obtain naloxone from a pharmacy.

a. True
b. False

4. A patient new to you has chronic neuropathic pain related to a complex ankle fracture. She has not had relief with acetaminophen and OTC NSAIDs. She has no active substance use or mental health issues. Are opioids appropriate based on the information provided?

a. Yes
b. No

5. According to the 2017 Canadian Guideline for Opioids for Chronic Non-Cancer Pain all patients on doses of opioids greater than 90MME/D (mg morphine equivalents/day) should have their doses tapered and potentially discontinued.

a. True
b. False

Weak recommendation: suggest tapering to the lowest effective dose rather than making no change in opioid therapy

OPIOIDS CLINICAL PRIMER

Safer Opioid Prescribing Strategies ★★★★★

Understand your role in minimizing opioid-related harms through patient education and safe prescribing and dispensing practices. Learn how to assess patients on opioids for adverse effects, and when and how to taper and switch opioids. Select patients who are likely to benefit from opioids and are at a lower risk of harm.

60%

Continue this course | Return to program home

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Resources and References Safer Prescribing Practices.pdf download

Questions?