MARATHON
FAMILY HEALTH TEAM

Chronic Pain Program

MFHT Addiction and Chronic Pain Committee

November 19, 2014

MARATHON
FAMILY HEALTH TEAM

Table of Contents

Introduction

Welcome to the MFHT Chronic Pain Program! This is intended to be a general guideline to standardize care as much as possible between different providers. It was created in response to the growing need for direction with regards to the challenging population of patients suffering with chronic pain. These patients present unique challenges including the associated risks of addiction and diversion.

While the management of chronic pain is complex and multi-faceted, this program – through necessity – focuses on the prescribing of opioids. This is unfortunate because the non-opioid options are incredibly important in improving patient outcomes. It is the opioids, however, that consume most of our time and generate most of our questions and concerns.

We have found challenges in transferring existing opioid-prescribing guidelines into our practices. The guidelines are long, have significant grey areas, and for challenging cases recommend referral for pain and addiction services which we don't have available in our remote community.

The program is intended to put knowledge into practice. We use our *Chronic Pain Algorithm* (see *Program Overview*) to provide a visual overview for the management of chronic pain in Marathon. We then reference appendices with relevant forms and information from the medical literature.

The goals of this program are simple: improve and standardize patient care while simplifying the process for physicians. To reiterate, this is intended to be highly practical. This is the second edition and continues to be a work in progress. ***It is written for chronic, non-cancer pain***. Despite our best efforts, there will still be grey areas and we welcome questions and discussion moving forward into future editions. We will update the program as new information arises, and look forward to receiving your feedback along the way.

Sincerely,

MFHT Chronic Pain and Addictions Committee:

Dr. Megen Brunskill, MD, CCFP	mbrunskill@mfht.org
Dr. Nancy Fitch, MD, CCFP	nfitch@mfht.org
Dr. Ryan Patchett-Marble, MD, CCFP	rpatchett@mfht.org
Shelley Heavens, MSW	sheavens@mfht.org
Michele Lajeunesse, Health Promoter	healthpromo@mfht.org
Margaret Cousins, Epidemiologist	mcousins@mfht.org
Elana Armitage, IT	earmitage@mfht.org

Chronic Pain Program Overview

The Chronic Pain Algorithm (below) is intended to be a high-yield overview of the entire program. This appendix will take you through how the program is applied at a macro-level, while the remainder of the appendices will be applied at a micro-level.

The point of the program is to systematically monitor all patients being prescribed opioids for chronic non-cancer, non-palliative pain, and to tailor that level of monitoring to the patient's individual risk. We then use that monitoring (i.e. urine drug screens, aberrant behaviour, etc) to re-stratify patients according to their evolving risk. The program continually adapts to a patient's evolving risk such that we tighten control more and more for those that appear to be at increasing risk, and loosen control for those that appear to be at decreasing risk. For example, someone who is initially low risk but has a random urine drug screen that shows cocaine and heroin will likely be placed into a higher risk monitoring/prescribing system.

Once a patient is identified as having chronic pain, he/she will enter the *Chronic Pain* Algorithm. The patient will then complete the MFHT *Chronic Pain Questionnaire* (*CPQ*) to gather a focused history, and a *Brief Pain Inventory* (*BPI*) to establish a baseline for their pain severity and functional impairment. The patient will complete and hand in these forms *prior* to their initial chronic pain double appointment. This initial appointment is an opportunity to clarify history and diagnoses, perform a focused physical examination, and decide on whether an opioid trial might be indicated as part of the management plan. If opioids are a part of the management strategy then this appointment may be used to discuss Risk Stratification, Treatment Agreements, and expectations regarding monitoring.

Once a patient in the Chronic Pain Algorithm is prescribed opioids, he/she will be subject to monitoring with BPIs and random Urine Drug Screens (UDS). If the patient is part of the high-risk group (SOPP – Structured Opioid Prescribing Program) then there will be scheduled UDS in addition to random UDS. A patient can move to more or less stringent monitoring/management depending on their behaviour (see *Opioid Monitoring Ladder* in Appendix D). It is very difficult to tell if someone being prescribed opioids is misusing it as opposed to taking it for physical pain. The idea with the *Opioid Monitoring Ladder* is that the person's level of risk is changing as new information arises (like the results of a urine drug screen), and the *Opioid Monitoring Ladder* adapts prescribing and monitoring strategies to that evolving risk.

When first prescribed, opioids are on a trial basis. For them to be prescribed on an ongoing basis, it must be shown that they are lowering pain scores by 30% and/or improving function. The BPI can be used to measure these outcomes. In addition, if the patient is to continue to have opioids prescribed then he/she must not demonstrate aberrant behaviour (*Appendix F*). The primary detection method is urine drug screening. While UDS can be very helpful, it is critical to know when to order a UDS, how to interpret them, and what to do with the results. This program aims to be as specific as possible with regards to the capabilities and limitations of UDS (Appendix E).

If a specific opioid is *not* working, then the provider must decide amongst the following options: dose increase, rotation to a different opioid, or tapering of opioids altogether (*Appendix G*).

All of these assessments and results will be entered and retrieved from the *MFHT Chronic Pain Flow Sheet.* The flow sheet was created by the *MFHT CPA Committee* as a "one-stop-shop" for storing and retrieving information related to chronic pain. It is intended to be highly practical and has all of the relevant information organized and compiled.

For further elucidation of the above principles, here are some Frequently Asked Questions:

Which patients have "Chronic Pain"?

One of the challenges is identifying when a patient should be considered "chronic pain" and should enter this algorithm. If the patient has near-constant, non-cancer pain for more than three months, with limited hopes for improvement, then the decision is straightforward. However, there are several common but challenging scenarios for deciding if someone has "chronic pain". A patient who has relapsing and remitting pain, such as mechanical back pain or rheumatoid arthritis, may not be considered chronic pain if flares are infrequent and mild. If flares are severe or frequent, then consider having patient enter the *Chronic Pain Algorithm*.

Another common challenge is the patient who is transitioning from acute pain to chronic pain. For example, a patient who had a total knee arthroplasty requires acute pain management post-operatively. If this pain goes on longer than expected or seems to plateau, then consider having the patient enter the *Chronic Pain Algorithm*.

If someone is being prescribed opioids for pain, even if they don't fit into the above criteria, then consider entering the patient into the algorithm if receiving 30 or more tablets per month for two consecutive months.

What about patients that I have followed for some time who are already on opioids?

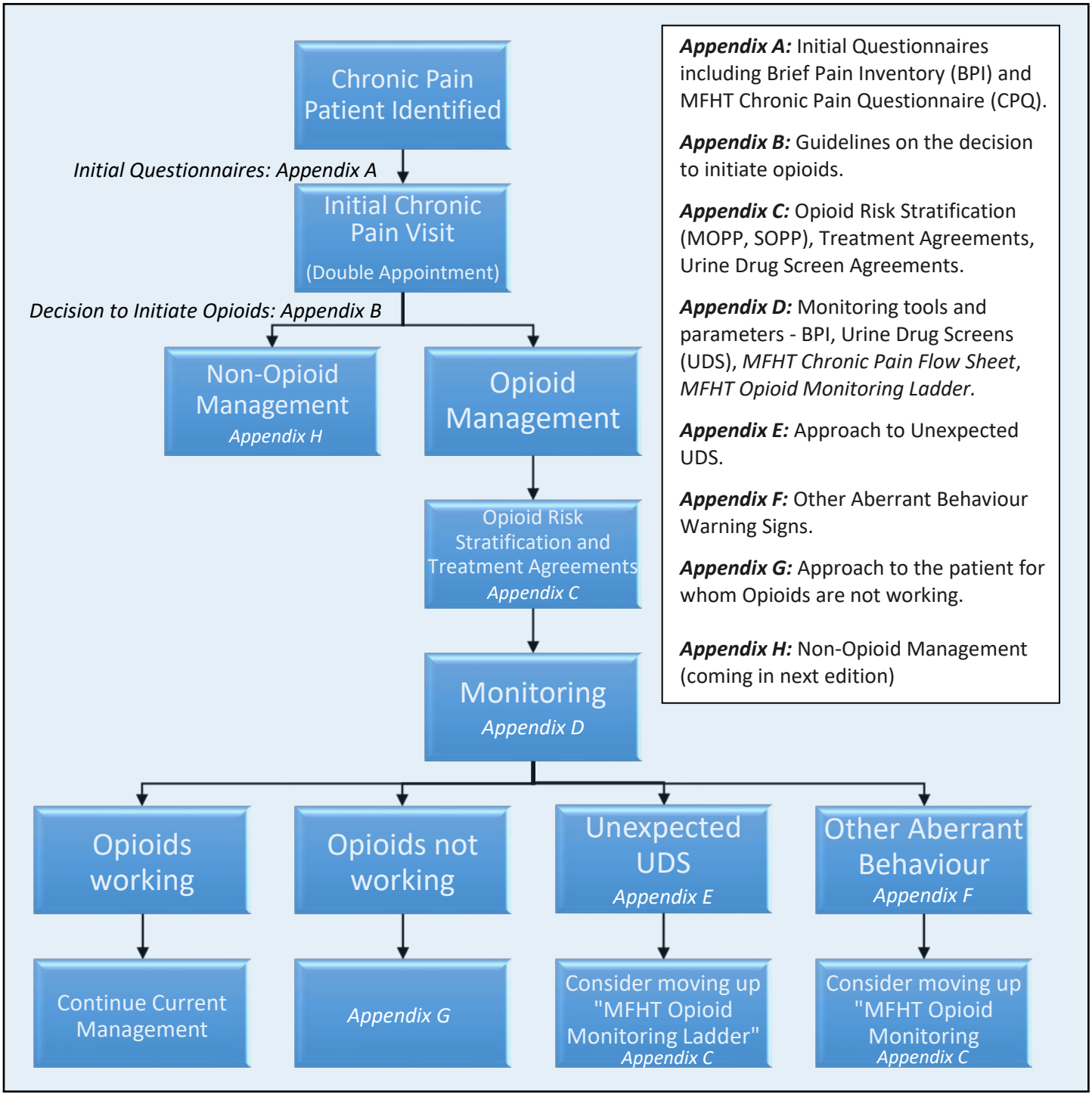
It is still recommended that you consider starting at the top of the algorithm. At minimum, we recommend you start at *Decision to Initiate Opioids* and if patient does not have a strong indication for opioids then you consider tapering and discontinuing them. It is important that we have all of the chronic pain patients at MFHT who are on opioids under *Treatment Agreements*. It is also recommended that you start using the MFHT *Chronic Pain Flow Sheet* as this should make documentation easier and simplify information retrieval for yourself and other providers.

How do I set up the initial appointment?

Send the front-desk a message and ask to book a double apt for chronic pain. Cc the message to Elana. If you are seeing the patient then give them a copy of the *CPQ* and *BPI*. Elana will then confirm with the patient that it has been handed in seven days before the appointment. If it has not been handed in by three days before the appointment then the appointment will be cancelled.

MARATHON FAMILY HEALTH TEAM

Chronic Pain Algorithm



Note: this program is for patients with Chronic *Non-Cancer* Pain

Appendix A: Questionnaires

There are two questionnaires central to the program: the *MFHT Chronic Pain Questionnaire* (*CPQ*), and the *Brief Pain Inventory* (*BPI*).

The *CPQ* was designed by the CPA Committee to collect information relevant to the pain condition in that patient's social context. It is only completed once as a baseline prior to the first double appointment. It was designed by reviewing the literature for relevant information needed for chronic pain and addiction that the patient may self-report. It also has all of the questions needed to complete the *Opioid Risk Tool* as an assessment of a patient's risk.

The *BPI* is a standardized tool which scores a patient's pain and functional impairment. It is used initially and regularly as a means of monitoring the effectiveness of the opioids. This is critical because these are the two main outcome measures to determine if prescription opioids are working. BPIs are therefore the main tool to determine if an opioid is working. Remember however that they are a tool and are not to replace clinical judgement. As part of the Tablet PC Pilot Project, the CPA Committee will be using BPIs which can be completed either in the waiting room on a tablet, or even from home using a secure online survey. Both methods lead to the results going straight into OSCAR with no paper. The Functional Impairment score is calculated automatically using this software.

Note that for the BPI, there are numerous questions but there are only two important numbers to come out of it. The first one is the person's pain score. There are four pain scores reported on the *BPI* so the provider much choose the one to track. If the person has flares, then "worst" pain might be most appropriate. If the person has constant pain, then perhaps the "average" pain might be most appropriate to track. The second number that is important is the functional impairment. This includes adding up the numbers for 9)A-I. Keeping in mind that it is a measure of *impairment*, a higher score indicates worse functionality (maximum impairment 90/90).

The CPQ and BPI are both saved under eDocs in OSCAR:

- *MFHT Chronic Pain Questionnaire*
- *Brief Pain Inventory*

Appendix B: Initiating Opioids

Unfortunately, medical indications for opioids are not black and white. This is because every patient requires weighing the risks and benefits.

A systematic literature review completed in the production of the guidelines for the use of opioids in chronic non-cancer pain[i] showed that:

- Opioids were more effective than placebo for pain and function, irrespective of the type of opioid (strong or weak) or mechanism of pain (nociceptive or neuropathic).
- The effect sizes of opioids over placebo were medium1 for pain and small for function. In other words, opioids work better for pain than for function.
- One opioid (tramadol) was effective for fibromyalgia for pain and function; however there were only two randomized trials, and the effects sizes were small for both pain and function.

Small Effect Size

- Mean difference less than 10% of the scale (e.g., <10mm on a 100 mm VAS).
- ES <0.5.

Medium Effect Size

- Mean difference 10 to 20% of the scale.
- ES from 0.5 to <0.8.

Large Effect Size

- Mean difference >20% of the scale.
- ES ≥ 0.8.

Examples of CNCP with placebo-controlled trials showing efficacy (note: study duration = 3 months max)	**Examples of CNCP that have NOT been studied in placebo-controlled trials**
fibromyalgia (tramadol only)	headache
diabetic neuropathy	irritable bowel syndrome
peripheral neuropathy	chronic pelvic pain
postherpetic neuralgia	TMJ dysfunction

Examples of CNCP with placebo-controlled trials showing efficacy (note: study duration = 3 months max)	Examples of CNCP that have NOT been studied in placebo-controlled trials
phantom limb pain	atypical facial pain
spinal cord injury with pain below the level of the injury	non-cardiac chest pain
lumbar radiculopathy	Lyme disease
osteoarthritis	Whiplash
rheumatoid arthritis	repetitive strain injury
neck pain	

Notes:

1. Nociceptive pain of musculoskeletal origin (e.g., osteoarthritis, low-back pain, neck pain)

Opioids showed only small to moderate benefits for nociceptive pain in improving function and relieving pain[ii]. If opioids are required, patients generally respond to moderate doses. Acetaminophen, NSAIDs and non-pharmacological treatments are often effective for patients with low back pain and other common musculoskeletal problems.

2. Neuropathic pain

Opioids showed only small to moderate benefits for neuropathic pain[iii]. Patients with neuropathic pain may require higher opioid doses, in combination with tricyclic antidepressants[iv] or anticonvulsants[v].

3. Migraine, tension headache, functional GI problems

Opioids are usually not indicated for migraine or tension headaches, or for patients with functional gastro-intestinal problems such as irritable bowel syndrome[vi].

4. Widespread soft tissue pain

The benefit of the weak opioid tramadol for fibromyalgia was small. Other pain-relief options should be considered.

Appendix C: Safe Prescribing Strategies

Safe prescribing is all about ensuring that the opioids are not hurting the patient or someone else. This could happen primarily by the patient taking more than prescribed, using an alternate route (snorting, injecting), using with other dangerous substances, or selling/trading the medications to others.

Safe prescribing involves the initial assessment and then ongoing monitoring. This appendix is intended to provide an overview of initial risk stratification and necessary treatment agreements (sometimes called "contracts"). Ongoing monitoring is discussed in *Appendix D - Monitoring*.

The risks of misuse are assessed initially using the Opioid Risk Tool (ORT) and then moving forward the main strategies include Urine Drug Screens (UDS) and observing for other aberrant behaviour (see *Appendices E* and *F*).

There are essentially two streams to the program – one for high risk patients and one for lower risk patients. The patients that are higher risk have a history or previous behaviour that necessitates stricter monitoring. This stream is termed the Structured Opioid Prescribing Program (SOPP). In contrast, patients with a lower risk of misuse are in the stream with less strict monitoring. This stream with lower-risk, lower-intensity monitoring is the MFHT Opioid Prescribing Program (MOPP).

The first decision you need to make is whether this patient should be in the SOPP or MOPP stream. There are certain features that make the patient automatically enter the SOPP stream:

1) Opioid Risk Tool score ≥ 8
2) Failed Urine Drug Screen previously
3) Physician preference

The two streams are not black-and-white – within each stream there can be higher and lower risk patients depending on individual factors. This is important for monitoring and can be seen in the *Opioid Monitoring Ladder* (*Appendix D*), however the within-stream distinction is not important for the initial treatment agreements. For the purposes of signing treatment agreements, the main distinction you need to make is MOPP vs. SOPP. Practically, the main distinction between MOPP and SOPP is that the SOPP stream has *regular UDS* in addition to random UDS. This regular UDS could be as frequently as two times per week or it could be less often. Within either stream, you can adjust dispensing intervals, require more frequent visits to see you, etc.

Once you have decided MOPP vs SOPP, you must decide if they are low literacy and then complete the appropriate contract. There are two versions for each of MOPP and SOPP – one for average literacy and one for low literacy. They are listed under e-FORMS in OSCAR:

MFHT – C – MOPP Opioid Contract

MFHT – D – MOPP *(low literacy)*

MFHT – K – SOPP Opioid Contract

MFHT – L – SOPP *(low literacy)*

A patient who is initially considered low risk (MOPP) may display concerning behaviour that moves them to higher risk (SOPP), and likewise a higher risk patient may display good behaviour and move to the lower risk stream.

Regardless of which stream patients are in, they must sign the *Urine Drug Screen Agreement*. This ensures that the patient knows what is expected of them with regards to UDS since both streams will intermittently provide random UDS.

To summarize, the documents that you need to complete initially are:

- *Opioid Treatment Agreement* (SOPP vs MOPP, consider low-literacy version)
- *MOPP* or *SOPP Checklist*
- *Urine Drug Screen Agreement*

You should send an OSCAR message to Elana any time a patient is starting/stopping SOPP or MOPP, any time you are moving them from one stream to another, and when you are discontinuing opioids for someone that was in a MOPP/SOPP program. This is very important as Elana will use this to maintain the list which will be used for random urine drug screens and for research and evaluation purposes.

MARATHON
FAMILY HEALTH TEAM

MFHT Opioid Prescribing Program Checklist

Item	Patient Initial	MD Initial
explain that all opioid prescriptions are on a trial basis - if the medication doesn't work it will be stopped - if the medication has significant adverse effects it will be stopped - if the patient displays behaviour concerning for misuse of the medication it will be stopped		
explain that MFHT has a random urine drug screening program that is mandatory for ALL patients on an opioid medication for CHRONIC non-cancer, non-palliative pain		
review the random urine drug screening program - 36 hours to provide sample from time of call - what happens if they have an unexpected result - what happens if they do not provide a sample		
review the risks of opioid medications - all patient develop tolerance - side effects (constipation, dry skin, itching, hypogonadism, sleep apnea, addiction etc.) - no driving unless dose is stable		
early releases are not guaranteed and must have at least 3 business days for processing. Proof of travel may be required		
inform the patient that they accept responsibility for these medications - any lost or stolen medications will not be replaced and the patient agrees to inform the police immediately if medications are lost or stolen		
explain that opioid withdrawal is uncomfortable but not life threatening		
explain the opioid contract - no illicit drugs while on this prescription - no sharing or selling of this medication - this medication is only provided by this physician or a designated physician covering their practice - no refills through the ER		
ensure that the patient has time to ask any questions		

MARATHON
FAMILY HEALTH TEAM

MFHT Structured Opioid Prescribing Program Checklist

Item	Patient Initial	MD Initial
explain the structured opioid prescribing program - regular and random urine drug screens - short dispensing intervals - no early releases for any reason - no replacement of lost or stolen pills		
the patient agrees to regular urine drug screening - if they have expected urine drug screens for a period of 6 months they may be moved out of the high risk program or their intervals may be relaxed		
the patient agrees to bring their pills/patches to all appointments with their family doctor for counts		
the patient understands that if they display behaviour concerning for misuse of their medication it will be stopped or their dispensing interval shortened		
the patient understands that an unexpected result on a urine drug screen will result in their medication being stopped or their dispensing interval shortened		
the patient was given an opportunity to ask questions		

MARATHON
FAMILY HEALTH TEAM

Urine Drug Screen Agreement

Name:_____ DOB (mm/dd/yyyy): _____

This agreement was developed by the MFHT Addiction and Chronic Pain committee for use within the MFHT Opioid Prescribing Program. Urine drug screens provided within this program are your property and will not be duplicated without your consent.

Our Commitment

Even though urine drug screens are a very common part of most medical clinics prescribing opioid pain medicines, we understand that you may want to keep the information that you need this test to yourself. Urine drug screen appointments will look like any other clinic appointment, as much as possible.

You will receive 24 hours notice of your UDS appointment. If you are using a medical van, and if you are concerned that you may be late, you can explain that it is for a UDS, for the health centres are committed to getting you there on time.

Our Urine Drug Screen Protocol is carefully followed by all clinic health care providers, which minimizes any risk of error in handling your urine sample. Your involvement is expected in confirming that the test samples are yours.

Your Commitment

I will treat health care providers with respect.

I understand that if I do not attend my appointment for a urine drug screen, this counts as an unexpected result.

I will not change my urine in any way: This includes

- Bringing in someone else's urine or non-urine product and attempting a switch
- Adding something to my urine
- Taking 'blockers' or other substances with the intent to change my urine result

The Plan

1. **An appointment will be provided via telephone or email with 24hrs notice.**
2. **Failure to attend the appointment results in an 'unexpected result' within the MFHT Opioid Prescribing Program. Your prescribing physician will be notified, and will follow up.**
3. **Come prepared to urinate. Your health care provider will attempt to rebook you later in the day if you cannot, but this may not be possible. If rebooking to another day is required, your physician will be notified that you were unable to urinate, which is an 'unexpected result.'**

I agree to the above

My signature: _____Today's Date: _____

Appendix D: Monitoring

While opioids are beneficial for certain chronic pain conditions, the potential benefit must be weighed against the potential risks. It can be especially difficult to determine this balance prior to initiating a trial with opioids. If you begin prescribing opioids, then monitoring the patient's subsequent behaviour and response to treatment can give you a significant amount of information. This is one of the reasons that monitoring the patient is so important. Good quality monitoring can tell you the benefits (the BPI measures pain and day-to-day function), as well as the risks (UDS, other aberrant behaviour). You can then make an informed decision about the balance between risks and benefits and whether continued opioids are worthwhile.

Benefits:

The benefits of opioids are typically measured using the *Brief Pain Inventory*. It is a short questionnaire that will produce two meaningful numbers: a pain score, and a functional impairment score (see *Appendix A*). These two numbers are important because it is the pain reduction and functional improvement that we gage to be markers of success with opioids. Guidelines recommend either a 30% reduction in pain, or improved function, to show that the medication is providing meaningful benefit.

Risks:

There are numerous monitoring strategies we have that are intended to minimize potential opioid misuse. These safer methods often come with an associated inconvenience for the patient.

There are a few general principles to minimizing risk. First of all, medications are less likely to be diverted or abused if the patient has less available at any given time. This is accomplished through decreasing dispensing intervals (smaller quantities dispensed more frequently) which may even culminate in daily observed dosing such that the patient never has any medications to go home with.

Secondly, misuse is more likely to be detected and extinguished in a system with closer monitoring. If that monitoring system picks up concerns, then the monitoring becomes stricter and it becomes increasingly difficult for patients to engage in concerning behaviour in the future. As the control becomes increasingly strict, the patient moves up the *Opioid Monitoring Ladder* (below) and eventually may have no option but methadone through the OATC, or buprenorphine (Suboxone) maintenance therapy at the MFHT. In addition to catching aberrant behaviour, it is hoped that the monitoring system will prevent aberrant behaviour before it

starts. If patients know that having cocaine in their urine, or losing their prescription, or requesting multiple early refills leads to “red flags” on their chart, and tighter monitoring parameters – then perhaps they will be less likely to present with these issues.

Savage[vii] (2010) has noted that tightened structure of care appears effective in reducing risk behaviours and in identifying those patients in whom opioid therapy may not be effective. She notes that, "*Some specific strategies that have been suggested for higher-risk patients include weekly or more frequent medication release, 24-hour-notice pill counts, and substance abuse education worksheets, referral to pain and substance abuse websites, individual compliance counseling, completion of an opioid compliance checklist and urine drug screens at each visit*."

Urine drug screening

Urine drug screening is the main method for monitoring aberrant behaviour. There is detailed information about how to interpret the results and what to do with that interpretation in *Appendix E – Approach to Unexpected UDS*.

This appendix will focus on describing what urine drug screens are, and their general strengths and limitations.

There are two methods for detecting drugs in the urine – Immunoassay (IA) and Chromatography. Each type is associated with advantages and disadvantages.

	Advantages	Disadvantages
Immunoassay	- fast (done in office) - sensitive - cheap (~$3 each)	- non-specific - those in use now don’t detect synthetic opioids such as fentanyl and hydromorphone - the “BZO” doesn’t pick up clonazepam
Chromatography	- specific (few false positives) - tests dozens of different drugs automatically	- Expensive (covered by OHIP though) - Slow - If you want certain drugs (like psilocybin found in mushrooms), then you have to specifically ask for them

The CPA Committee has decided to take the best of both types of UDS. Any UDS done at the MFHT will have *both* immunoassay and chromatography. Immunoassay has the advantage

of providing a quick result for the most common drugs (cocaine, oxycodone, methadone (EDDP), morphine/codeine and benzodiazepines). That same urine sample is then sent off for chromatography – which although it can take longer to come back, has the advantage of detecting a wide range of drugs that IA cannot. It also may serve as confirmatory testing for IA.

UDS at the MFHT can be either random or scheduled. Random UDS will apply to both MOPP and SOPP streams. 10% of patients will be selected each month to do a random UDS. They will be given notice of the appointment <36h in advance. The CPA committee is in the process of putting together a detailed approach to patients that are either on vacation, or show up late, or for whatever reason do not provide a satisfactory UDS within 36h of being notified.

Opioid Monitoring Ladder

The *Opioid Monitoring Ladder* was created by the *ACP Committee* to make it easy to decide what to do with patients who you feel require stricter (or less strict) monitoring moving forward with their treatment. It also can also be used when deciding on how strict you should be initially depending on their risk factors. If you have information that they are very high risk for misuse, then start near the top, and if they are low risk then start at the bottom.

Generally, if a patient displays concerning behaviour (see *Appendices E* and *F*) then they move up, and if they do not display concerning behaviour then you consider moving down the ladder. Their position on the ladder is intended to be dynamic.

If the concerning behaviour is mild or of questionable significance, then you may even consider it a “strike” and once they have accumulated two or three strikes – you move them up the ladder and make their monitoring stricter.

Chronic Pain Flow Sheet:

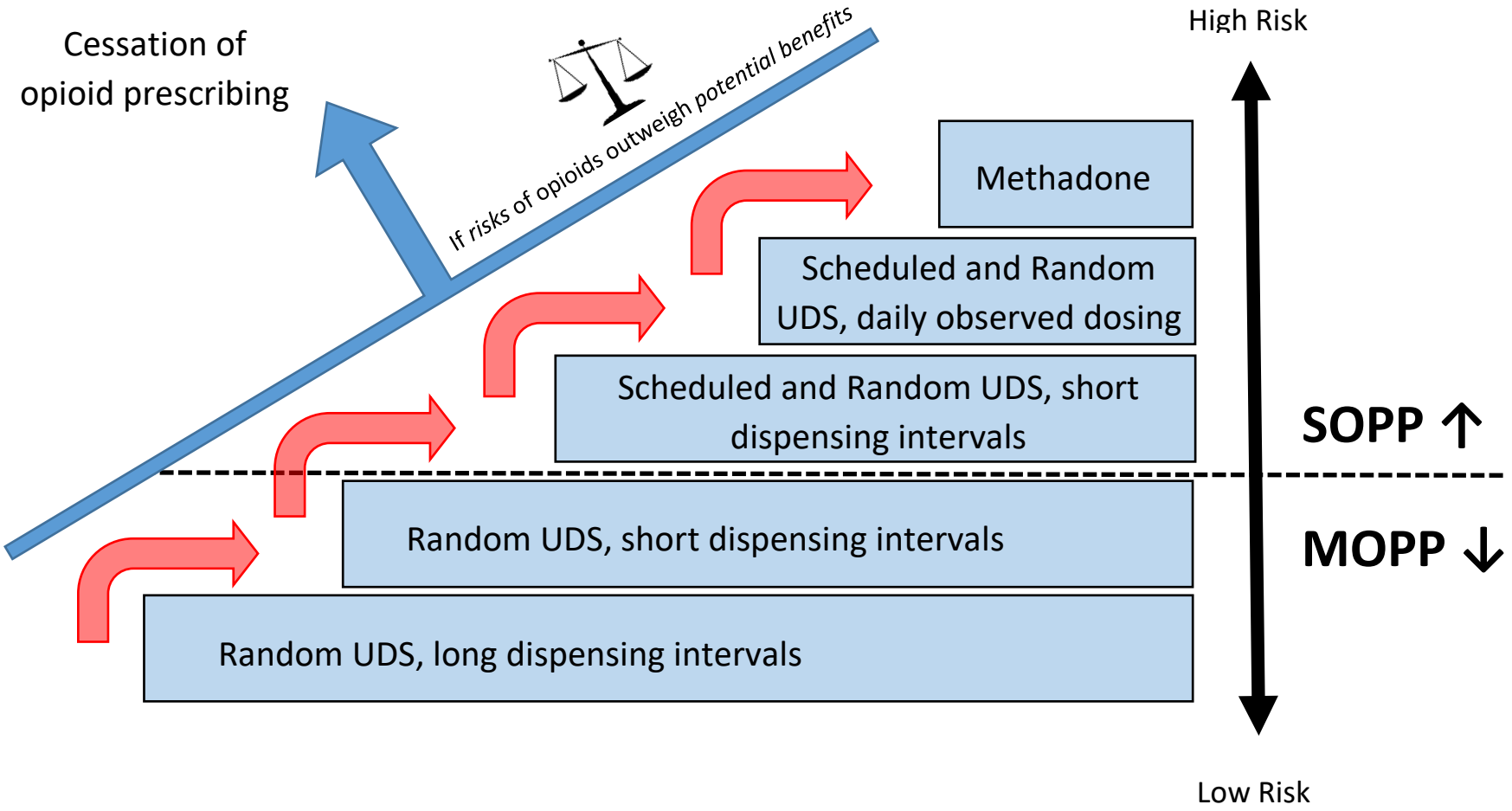
The *Chronic Pain Flow Sheet* is the method of monitoring that brings everything together. You can track the risks and benefits over time including BPI scores and UDS results. You can see all of the relevant *Past Medical History* and *Social History*. It is one of the more creative pieces of the Chronic Pain Program. It is intended to be a highly practical place to both chart new information, and learn everything you need to know about the patient’s history. Without this, it is extremely difficult to find information about these chronic pain patients. Chart notes go back many years – interspersed with other medical issues, numerous UDS, imaging results, early refill requests, etc. The goal of the Flow Sheet is to have it serve as a stand-alone document such that you do not even need to write a note in the regular notes section of OSCAR. Notes should be written directly into the Flow Sheet. The Flow Sheet should be particularly useful when someone is covering paperwork and knows nothing about the

patient. It is a work in progress and the first iteration has yet to be piloted. The *CPA Committee* is looking forward to hearing your feedback and improving the Flow Sheet in the months and years to come.

The start of the Flow Sheet is a brief history of this patient's pain diagnosis and pertinent co-morbidities and social factors which may influence their pain prognosis and course. The next section summarizes all UDS for this patient and actions taken based on the results. The third section is the opioid medication summary. This is where changes to dose, early releases or any aberrant behaviours are documented. This will make it easy to identify trends and allow the physician to ensure safe and effective opioid use. This section will also make it easy for any other provider to gain a quick overview of this patient's treatment plan. The last sections focus on the actual appointments. First there are the SMART goals which are identified with the patient to make it easy to know if the opioid trial is indeed achieving the functional goals set by the patient. Remember these goals needs to be specific, measurable, achievable, relevant and timely. The Flow Sheet then moves on to include the main pillars of chronic pain management. First the BPI score is documented. While you can include the pain score, the interference score is likely a more useful measure of your patient's functioning. The mind section is where you can explore mindfulness, CBT or other cognitive therapies. Movement is where you can explore not only rehabilitative movement like physiotherapy, yoga, swimming, etc. but also the amount of day to day activity that your patients engage in. Self-Management is where you can encourage specific self-management programs or books as well as look at their general self-care (how are they sleeping, are they working towards a healthy weight, etc.). Medications includes opioid and non-opioid medications. Finally, interventions refers to items such as joint injections, trigger points, or other interventional procedures. At the end of this page is where you can keep track of relevant referrals.

MARATHON
FAMILY HEALTH TEAM

MFHT Opioid Monitoring Ladder



The red arrows signify how monitoring parameters may change if aberrant behaviour is displayed. In general, patients should have looser controls for showing good behaviour and tighter controls for aberrant behaviour. The risks and benefits are continually re-evaluated and if at any time the risks outweigh potential benefits, the patient will no longer be offered opioid treatment (medication would typically be tapered and discontinued).

UDS = Urine Drug Screens *SOPP = Structure Opioid Prescribing Program (for higher risk patients)* *MOPP = MFHT Opioid Prescribing Program (for low risk patients)*

MFHT policy: Urine Drug Screen (UDS) testing protocol

Policy#: UDS protocol

Nov 14, 2014 Draft #8

Background: This protocol is for staff use within the Marathon Family Health Team Opioid Prescribing Program. It has been developed by the MFHT Addictions and Chronic Pain committee.

Related MFHT policies: MFHT Opioid Prescribing Program (MOPP)

Structured Opioid Prescribing Program (SOPP)

Required equipment: MOPP UDS screening pt questionnaire, clipboard and pen

MOPP UDS recording sheet

Urine Drug screen kit; thermometer

Urine container with line drawn at 30 cc; Biosample bag

Completed OHIP req, patient label sticker x 3

Location:

- MFHT clinic premises. This protocol will be used by RPNs/RNs/NPs/PAs in booked appointments for RDU screening.

Goals:

To fulfill the MOPP and SOPP guidelines without exposing patients (who may wish to keep private their information of being on prescribed opioids/other narcotics) to barriers or stigma.

Protocol:

- On the 1st workday of the month, the list of randomly selected patients for urine drug screens will be generated. Booking staff will use the list to book the appointments over the month, contacting patients with approximately 36hrs to an appointment. From the first successful contact, some leeway (up to 24h) may be given by booking staff while booking patients, however, it is not acceptable for patients to negotiate a different week. If unable to reach patients, the PRHC and PMHC may be used for support. Inability to contact patients will be messaged to the prescribing physician.
- If a patient on the list arrives late, the front staff person shall check the schedule for the day and contact an available provider to request their unscheduled assistance with the protocol.
- When starting the appointment, the RPN/RN/NP/PA shall:
  - Proceed to their appointed suite
  - Ask the patient to remove all unnecessary outdoor clothing (e.g. hoodie, coat)
  - Request the patient to remove any items from pockets and place them on the exam table

- Request the patient to leave their purse or backpack in the room
- Complete the Patient Questionnaire regarding last dose taken
- Explain what will happen next, while still in the room. Say,
  - "First, you will wash your hands with plenty of soap and water, with the door open.
  - Then, I will hand you the sample container; Urinate up to the line; you can finish urinating in the toilet. Do not flush the toilet. Affix the lid very tightly, and put it in the bag. Come out as soon as possible, as it is critical that I check the temperature. Low temp means it has to be redone.
  - Bring the container out with you and hand it to me; you and I must watch the urine together from this point—it must always remain in both of our sightlines."
- Remain outside the door until sample is complete.
- Take the urine and move with the patient back to the room.

- Following the sample collection, the RPN/RN/PA shall insert and hold the drug screen kit in the urine for 10-15s. Remove the kit and observe the time (requires 5 min before interpretation.) Take the urine temperature; for a sample NOT in the range of 32.2 and 37.7 deg C, discuss the problem with the patient and suggest a repeat sample collection. Record the urine temp on the recording sheet; transcribe the urine drug screen results at 5 min. **Refrain from permitting the patient to see the dip results prior to confirmation that the questionnaire is entirely completed; cover it with your recording sheet.** If the patient does NOT wish to wait for the results, affix a patient label to the kit in the lower right corner, and ask the patient to initial it, to confirm it is their kit. If the patient waits for their results to be transcribed, have them initial the completed reporting form. For the patients who waited, dispose of the kit visibly into a sharps container. For those who did not wait, photograph the initialled kit and note the photo on Elana's camera sheet.
- Following the temp and the dip, the lab container of urine is sealed with a patient sticker, in front of the patient. It is placed in a specimen bag and the req is added (have the patient confirm their name is on the req.) The req should say, "broad spectrum toxicology screen." Tell the pt that this will be sent to the WMGH lab as an OHIP service. There is no need to transfer the urine to a new container.
- Thank the patient and ask if they have any questions; msg questions to the ordering physician, if needed, and promise that the msg will be delivered.
- Scan the Patient questionnaire form and the RDU recording sheet immediately to Elana at the copier machine. If this protocol is being requested in association with a booked physician appointment, take the report to the HCA. Otherwise, to shredding.
- Go back and flush the toilet; look for odd things like urine stained bags in the garbage, etc.
- For patients who cannot urinate, do not exceed the allotted appointed time. If it is possible to offer a repeat appointment later in the day, do so, but if not, explain that as per their Urine Drug Screen Agreement, inability to urinate counts as an unexpected result and their prescribing physician will follow up accordingly.

Appendix E: Unexpected Urine Drug Screens

An important component to prescribing opioids is monitoring for abuse and diversion. Urine drug screening is an essential part of this program. While not perfect – urine drug screens (UDS) can have both false positives and false negatives – they often provide information which will influence ongoing monitoring strategies and management. For an overview of urine drug screening, and its strengths and limitations – see *Appendix D – Monitoring*. It is important when interpreting any test to understand its strengths and limitations. We test urine samples using both IA and chromatography so that if an unexpected result shows up twice then we can be more confident in the result.

This appendix will focus on how to interpret UDS results and how it might affect your management and monitoring strategies moving forward.

When interpreting a UDS, there are two main results that indicate a "failed" UDS – a drug that should be present is *absent*, and a drug that should be absent is *present*. It is essential that when doing a UDS, the patient completes a UDS Self-Report beforehand. This is because if there is an unexpected result, then it is much more difficult to act on without a pre-existing reason. After a patient on oxycodone has a UDS that fails to show oxycodone, he may say that he hadn't taken any the week before since his pain was under control. Self-report questionnaires have been created to address this issue for MOPP and SOPP. Both questionnaires ask specifically about the last time they took the drug they are prescribed. The SOPP questionnaire also asks more targeted questions about other drugs. See below for MOPP and SOPP self-report questionnaires.

If a patient does not have a drug in their urine that they are supposed to have, it is important to keep an open mind. The absence of a drug does not automatically mean that they are diverting. It is common for patients to take their medication too much early in a prescription and run out before their next refill is due. This leads to a negative urine even though they are not diverting. While both diverting and taking all of the medication shortly after a refill are considered aberrant behaviour – the two may be managed differently. If someone is diverting then it is reasonable to discontinue their opioids in short-order. If someone is addicted and consistently taking them more than prescribed, then this person likely needs treatment for addiction (See *Appendix I – The Addicted Patient*). In both cases, it may be reasonable to move towards the top of the *Opioid Monitoring Ladder* because it minimizes the potential harms in either scenario. Remember that patients with addiction

issues often require Opioid Maintenance Therapy as part of their treatment plan. This includes methadone, Suboxone, or on occasion long-acting morphine like Kadian.

The second scenario for a failed UDS is when a patient has a drug in the urine that is not supposed to be there. This is important because if a person is taking other drugs it may point towards addiction (to the prescribed medication and/or an illicit drug in the urine). It is also dangerous to mix opioids with other drugs. Mixing a sedating medication with another sedating medication (another opioid or benzodiazepines) is dangerous, as is mixing sedating medications with stimulants (cocaine). Generally using cannabis with opioids does not add any acute danger and is therefore not considered a failed UDS.

While there is an obvious “pass” and an obvious “fail” - unfortunately UDS results do not always fit into this simplified dichotomy. If a patient fails to show for a UDS appointment, shows up but says he cannot urinate, or the urine does not pass the contamination screen (temperature, creatinine, oxidants, and pH) – then these are also considered an “unexpected result”. Depending on the specific circumstances, you should consider moving them up the *Opioid Monitoring Ladder*. If it’s a minor infraction then consider giving a warning, then after a certain number of warnings – depending on the severity of the infractions – move up the ladder.

MARATHON
FAMILY HEALTH TEAM

MOPP UDS Self-Report (paper questionnaire)

My Name: Today's Date:
Family Doctor:

I am prescribed the following pain medication(s): CIRCLE

morphine / statex / ms contin / kadian
hydromorphone / dilaudid / hydromorph contin
fentanyl
codeine
oxycocet / percocet / oxycodone / oxyneo / endocet
tramacet / tramadol
methadone

My last dose was at: _____h today/yesterday/other_____CIRCLE

Other drugs or medications I have used recently:

Any other information I want my family doctor to know:

_____My signature

MARATHON
FAMILY HEALTH TEAM

SOPP UDS Self-Report (on tablet PC)

All questions refer to both drugs that are prescribed by the doctor and those that are obtained elsewhere.

When was the last time you took any medication containing CODEINE? (Tylenol # 1/2/3 or 4, CodeineContin, etc)

When was the last time you took any medication containing OXYCODONE? (Percocet, Oxycocet, Endocet, Oxyneo, Oxycontin, etc)

When was the last time you took any medication containing MORPHINE? (Statex, MS Contin, Kadian, M-Eslon, Morphine-SR, etc)

When was the last time you took any medication containing HYDROMORPHONE? (Hydromorph Contin, Dilaudid, etc)

When was the last time you took any medication containing FENTANYL? (Duragesic patches, etc)

When was the last time you took any medication containing METHADONE?

Other Prescription Drugs

When was the last time you took any methylphenidate? (Ritalin, Concerta, Biphentin, etc.)

Have you used any benzodiazepines in the last month? (ex: Ativan/lorazepam, Valium/diazepam, clonazepam, alprazolam, oxazepam, temazepam, etc.) No Yes

Street Drugs

When was the last time you used cocaine or crack cocaine? 4 days

- Less than two days
- 3 days
- 4 days
- 5 days
- one week
- two weeks
- three weeks
- one month
- I haven't used in the last month

General

Comments:

Note: this form is for **demonstration purposes** only. Clinical use is not permitted witho ocean License Agreement.
For more information on adopting this form for clinical use, sign up here, or contact us

View Source

Appendix F: Other Warning Signs for Misuse

Unfortunately it can be very difficult to distinguish uncontrolled pain from opioid misuse. We have reviewed the literature and here are some of the factors that may provide warning signs of Opioid Misuse.

Warning Signs of Opioid Misuse (Nicholson & Passik, 2007)

Probably more predictive	Probably less predictive
Selling prescription drugs	Aggressive complaining about need for higher doses
Prescription forgery	Hoarding during periods of reduced symptoms
Stealing or borrowing another patient's drugs	Requesting specific drugs
Injecting oral formulation	Unapproved use of drug to treat another symptom
Obtaining prescription drugs from nonmedical sources	Obtaining similar drugs from other medical sources
Concurrent abuse of related illicit drugs	Reporting psychic effects not intended by the clinician
Unsanctioned close escalations (multiple times)	Unsanctioned dose escalations (1 to 2 times)
Recurrent prescription losses	

Fleming et al.[viii] (2008) conducted a study of 904 chronic pain patients receiving opioid therapy for an average of 6.4 years. Four specific behaviours were strongly associated with substance abuse:

1. Over sedation on purpose
2. Feeling intoxicated
3. Obtaining early refills
4. Increasing the dose of opioids without medical authorization

Common question with potential misuse:

1) **What should I do with early refill requests?**

   Early refill requests *may* be a sign of opioid misuse. Especially if they are repeated and the patient is exhibiting other concerning behaviour. To minimize risks, there are several things you should consider when an early refill is requested. Is the patient's request because they are leaving town for another city? If that city has a pharmacy, then simply have the next refill sent there and filled at the regularly scheduled time (you will need a new prescription since you cannot transfer narcotics). Tell the local pharmacy to not dispense the next refill that was due to prevent any chance of effectively getting the same refill twice.

   If this is not an option, and you are considering releasing the early refill for a patient going out of town, be sure to stipulate on the correspondence with the pharmacy that the next refill should be at the regularly scheduled time. So if the early-release refill is filled at day 11 of a 14-day prescription, then the next refill will be dispensed 17 days later (when it would have been due anyway). If you don't do this, then the pharmacy will dispense the next one two weeks after the early refill was dispensed and effectively the patient will have three extra days of medication.

   If the early refill is because the patient was taking more medications than prescribed, then you should have the discussion with them that this is concerning behaviour. If they need more opioids then they should speak with the physician first before just taking them and running out. If there is no other concerning behaviour then you may consider increasing the dose but if it becomes persistent then you may want to move up the *Opioid Monitoring Ladder*. Similar to other soft concerns, you could also issue a warning, document it in the chart, and then if it happens again consider moving up the *Opioid Monitoring Ladder*. Regardless, if there is an early refill given that it should be documented in the chart under "Ongoing Concerns" or the Chronic Pain Flowsheet if you're using one.

2) **What should I do if I receive a report from the pharmacy or someone else that patient is selling their opioids?**

This is a challenging scenario. It depends on the strength of the evidence. You cannot cut someone off of medications based solely on speculation. If the source is another healthcare professional who has personally seen the behaviour, then ask if he/she will write a letter to support this. If the source would like to remain confidential, then you can write in the chart

that a “source” has written a letter and/or supplied the information, and then in a separate legal folder include more detailed information. Practically, if you were to do this then we would have to speak with the MFHT Executive Director to coordinate as this has not been done to date. The information is stored this way because the patient has access to his chart, but not the legal folder so he could not find out the informant. However, the information would still be there for any authorities if it escalated to the level that specific evidence was required.

Appendix G: Failure of Opioids

It is not uncommon for opioids to fail in accomplishing treatment goals. Generally this is because potential risks have begun to outweigh potential benefits. To reiterate, the benefits are monitored primarily through the trends in the BPI (the outcomes being pain and day-to-day functioning). The risks are monitored primarily through UDS and observing for aberrant behaviour. Note that risks are not limited to just opioid misuse. If the patient is having reduced sex drive, or debilitating constipation, or any of the other side effects – then this of course contributes to risk/harm and may justify labelling the opioid as having "failed".

There are a number of options in dealing with a failed opioid trial. The first question is whether a trial of a different opioid may be warranted. This could be considered if there are specific side effects or a new preferred route of administration. If you are rotating to a different opioid, see the instructions below. If you decide that opioids medications should be stopped altogether then see the tapering protocol below.

If necessary, then here is an example of a cocktail of medications that you can use to help someone in opioid withdrawal:

1) ***Agitation/sweating/restlessness:*** Clonidine 0.1-0.2mg po q6h prn (max 0.6mg per day). Avoid if hypotension
2) ***Pain/aches:*** Tylenol 650mg po q4h prn (max 4g/day for adults), or Advil 400mg po q6h
3) ***Nausea:*** Gravol 50mg po q6h
4) ***Diarrhea:*** Loperamide (Immodium) 4mg po then 2mg po after each loose BM (maximum 16mg/day). Beware of potential abuse of loperamide.
5) ***Muscle cramping:*** Baclofen 5-10mg up to TID

MARATHON FAMILY HEALTH TEAM

Switching Opioid Medications

remember that opioid withdrawal is unpleasant but not life threatening BUT opioid overdose is life threatening so err on the side of underdosing

- Calculate the morphine equivalent dose of the patient's current opioid medication.
- If the MEQ is HIGH the new opioid dose should by 50% of the previous opioid dose. If the MEQ is moderate to low then the new opioid dose should be reduced by 60-75%.
- Reference the MEQ table below for guidance.

Opioid	Equivalent Dose	Conversion to MEQ
Morphine	30	1
Codeine	200	0.15
Oxycodone	20	1.5
Hydromorphone	6	5
Meperidine	300	0.1
Methadone and Tramadol	Dose equivalents unreliable	
Transdermal fentanyl	60-134 mg morphine = 25 mcg/h 135-179 mg morphine = 37 mcg/h 180-224 mg morphine = 50 mcg/h 225-269 mg morphine = 62 mcg/h 270-314 mg morphine = 75 mcg/h 315-359 mg morphine = 87 mcg/h 360-404 mg morphine = 100mcg/h	

- Ensure that your new prescription clearly explains to the pharmacy to cancel any previous opioid prescriptions.
- Ensure that the patient and family members are aware of signs of opioid overdose including: slurred or drawing speech, emotional lability, ataxia, "nodding off" during conversation or activity. Also ensure that they know to contact their prescriber right away if they notice these signs.
- Check in with patient 3 days after starting new opioid to ensure no signs of overdose and that their pain relief is at least comparable to before the switch.

use caution in pregnancy as acute withdrawal can be associated with preterm labour and spontaneous abortion

remember that the following risk factors put patients at higher risk of overdose: elderly, benzodiazepine use, renal or hepatic impairment, COPD, sleep apnea, cognitive impairment

MARATHON
FAMILY HEALTH TEAM

MFHT Opioid Tapering Policy

1. Select taper rate
    a. reduce by 10% of daily dose every day
    b. reduce by 10% of daily dose every week (select this option for patients who are anxious about the taper, psychologically dependent on their medication or if they have co-morbid respiratory or cardiac conditions)
2. Begin Taper
    a. ensure regular visits during the taper to assess for withdrawal symptoms, pain levels and for any positive effects of the taper (improved energy, mood and alertness)
    b. the physician may decide to use urine drug screening to ensure compliance with the taper
3. Once you have reached 1/3 of the original dose reduce the taper to 1/2 of the previous rate.
4. The physician may opt to hold a taper if the patient is having severe withdrawal symptoms. The taper should then resume after this held dose reduction.

** If a patient is unable to complete the taper the physician may decide to continue at the lower dose if the patient's functional status improves and they are compliant to the opioid contract. This is left to the discretion of the individual physician and depends on the original reason for the taper.

Appendix H: Non-Opioid Management

(coming next edition)

Appendix I: The Addicted Patient

(coming next edition)

Appendix J: Other Prescription Narcotics

(coming next edition)

References:

[i] Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. Canada: National Opioid Use Guideline Group (NOUGG); 2010 [cited year month date]. Available from: http://nationalpaincentre.mcmaster.ca/opioid/

[ii] (Furlan 2006, Furlan unpublished 2010, Nuesch 2009)

[iii] (Furlan 2006, Furlan 2009, Eisenberg 2005)

[iv] (Khoromi 2007)

[v] (Gilron 2005)

[vi] (Bigal 2009)

[vii]

[viii]