Opioid Prescribing and Pain Management:

Prescription Monitoring Program Overview and the Management of Acute Low Back Pain

CADTH Evidence Driven.

Conflict of Interest Disclosure and Funding Support

Content Creation: CADTH

Disclosures

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- CADTH Scientific Advice

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- New Brunswick Department of Health
- New Brunswick Medical Society
  - Choosing Wisely New Brunswick

Learning Objectives

- Describe the risks associated with opioid use (including overdose, duration of therapy, and drug combinations).
- Review the objectives of the prescription monitoring program (PMP) and how it can support decision-making at the point of care.
- Examine the appropriate management of acute low back pain in the primary care setting.
- Identify strategies for communicating the risks versus benefits of opioid therapy with patients.

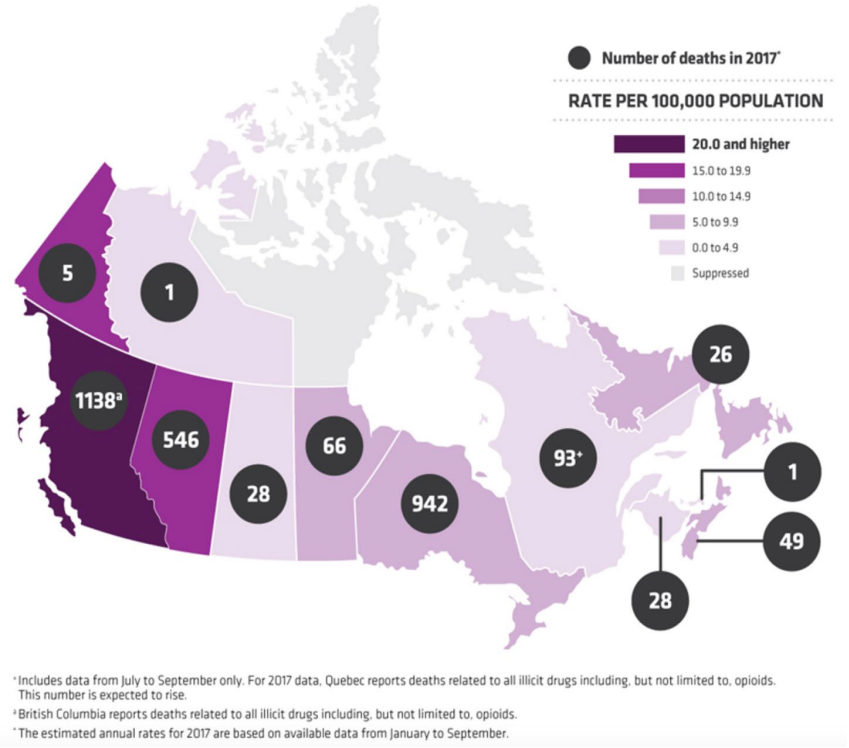
“The roots of what we now call the opioid crisis can be traced back many years to the promotion of opioid prescribing as low-risk, non-addictive, effective treatments for moderate pain.”

— Centre for Addiction and Mental Health (CAMH), 2016

“Opioids are being prescribed too frequently, at overly high doses and quantities, for longer periods of time than medically necessary, and in contexts that are not supported by evidence — all of which can inadvertently lead to misuse, opioid use disorder, and diversion into the community.”

— CAMH Prescription Opioid Policy Framework

Statistics and Regional Differences



*Includes data from July to September only. For 2017 data, Quebec reports deaths related to all illicit drugs including, but not limited to, opioids. This number is expected to rise.
[a]British Columbia reports deaths related to all illicit drugs including, but not limited to, opioids.
*The estimated annual rates for 2017 are based on available data from January to September.

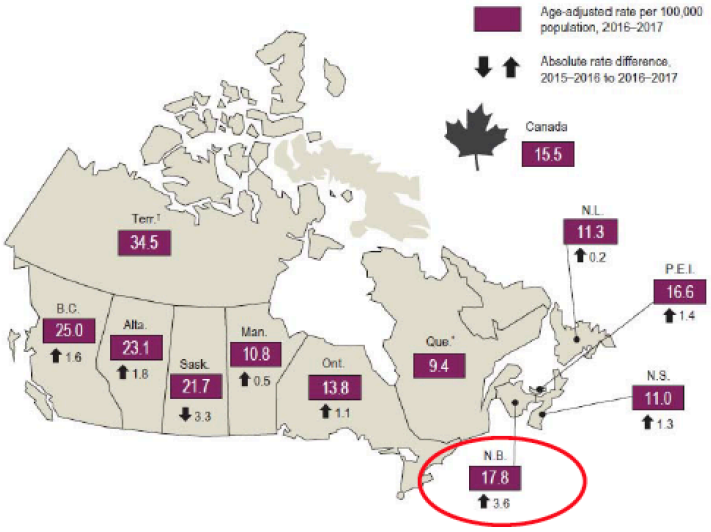
- 2016: 2,946 apparent opioid-related deaths
- Jan. to Sept. 2017: 2,923 apparent opioid-related deaths and counting
- Circles indicate number of deaths per province or territory (rate per 100,000)
- Highest incidence in British Columbia
- Lowest incidences in the territories and Maritimes

Special Advisory Committee on the Epidemic of Opioid Overdoses. National report: Apparent opioid-related deaths in Canada (January 2016 to September 2017). Ottawa: PHAC; March 2018.

Opioid-Related Hospitalizations

- Opioid poisoning hospitalization rate in Canada: 16 per day
- Opioid poisoning hospitalization rate in New Brunswick: 17.8 per 100,000

Opioid poisoning hospitalization rates by province/territory
2016–2017

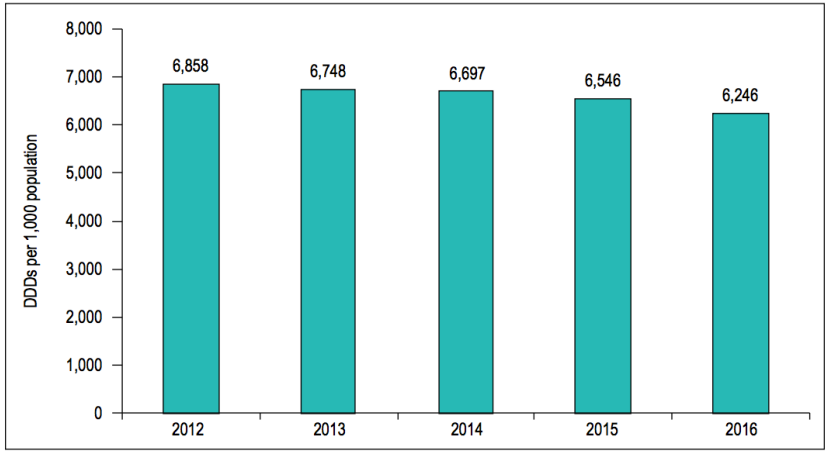


Notes
* Quebec data is from 2015–2016 (the most recent year of data available); therefore, there is no absolute rate difference shown.
† Yukon, Northwest Territories and Nunavut data is grouped due to low volumes. This data should be interpreted with caution. Nunavut data is from 2015–2016 (the most recent year of data available); therefore, there is no absolute rate difference shown.
Source
Hospital Morbidity Database, Canadian Institute for Health Information, published Sept 2017.

Opioid-related harms in Canada. Ottawa: CIHI. 2017.

Canadian Prescribing Trends

Defined Daily Doses Per 1,000 Population for Prescription Opioids, Canada,* 2012 to 2016



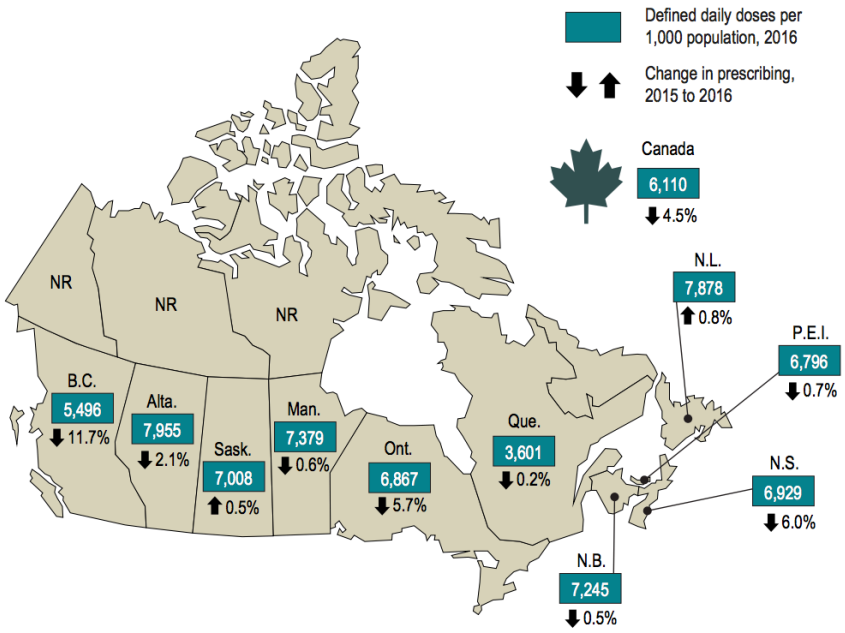
Notes
* Excludes the territories.
DDDs: Defined daily doses.
Excludes injectable and rectal dosage forms, as use in community pharmacy settings is relatively infrequent and the quantity is not always reported accurately.
Crude data by province and year is available in the companion Excel file *Pan-Canadian Trends in Prescription Opioid Dispensing: Data Tables.*
Source
CompuScript, QuintilesIMS Canada Inc.

- Overall number of opioid prescriptions **increased by 2%** (population-adjusted)
- Doses of opioid prescriptions **decreased by 8.9%** (population-adjusted)

Pan-Canadian trends in the prescribing of opioids, 2012 to 2016. Ottawa: CIHI. 2017.

Regional Prescribing Trends Including New Brunswick

Defined Daily Doses Per 1,000 Population for Top Six Opioids, 2016, and Percentage Change From 2015 to 2016, Canada



- New Brunswick: 7,245 defined daily doses per 1,000 population
- New Brunswick: Decrease of 0.5% from 2015 to 2016
- Largest decreases in British Columbia (11.7%) and Nova Scotia (6.0%)

Notes
NR: Not reported.
Excludes injectable and rectal dosage forms, as use in community pharmacy settings is relatively infrequent and the quantity is not always reported accurately.
Crude data by province and year is available in the companion Excel file *Pan-Canadian Trends in Prescription Opioid Dispensing: Data Tables.*
Source
CompuScript, QuintilesIMS Canada Inc.

Pan-Canadian trends in the prescribing of opioids, 2012 to 2016. Ottawa: CIHI. 2017.

Relationship Between Opioid Prescribing and Morbidity/Mortality

A study by Fischer et al. evaluated the relationship between opioid prescribing and associated morbidity/mortality in Ontario, 2005 to 2011.

Conclusion: Prescription opioid analgesic dispensing levels were found to be strongly correlated with mortality and morbidity (treatment) indicators.

Fischer et al. Correlations between prescription opioid analgesic dispensing levels and related mortality and morbidity in Ontario, Canada, 2005-2011. Drug Alcohol Rev. 2014;33(1):19-26.

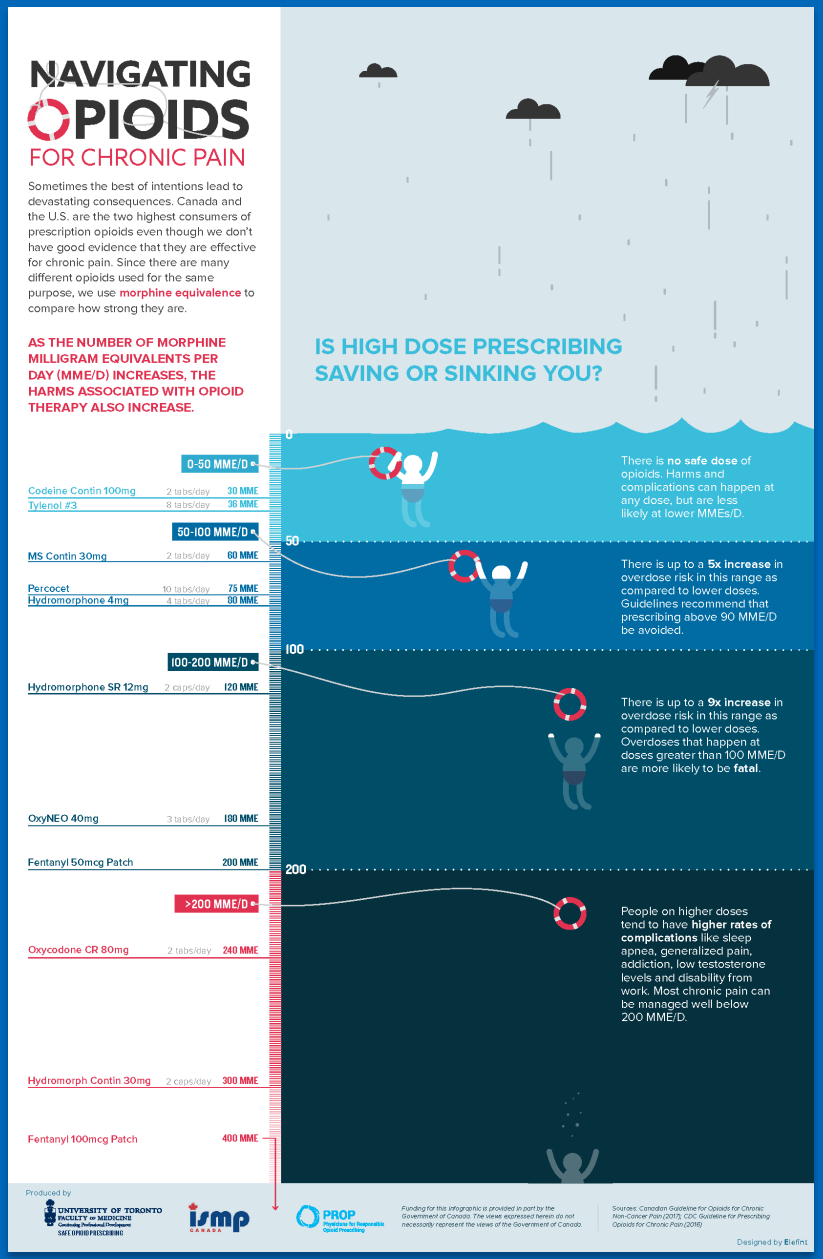
Early Opioid Prescriptions and Long-Term Use

- Studies and information from workers' compensation demonstrate that people who are prescribed opioids early after an injury, or for periods longer than a week, or who receive a second prescription, are more likely to use opioids long-term.[1-4]
- Studies show that the more opioid prescriptions a person receives, the more likely they are to take opioids long-term, at higher doses, and use opioids of higher potency.
    - For example, one study showed that 46% of people who took four prescriptions or more became long-term opioid users.[5]

1. Franklin et al. Early opioid prescription and subsequent disability among workers with back injuries: the Disability Risk Identification Study Cohort. Spine. 2008;33(2):199-204.
2. Mosher et al. Predictors of long-term opioid use after opioid initiation at discharge from medical and surgical hospitalizations. J Hosp Med. 2018;13(4):243-248.
3. Alam et al. Long-term analgesic use after low-risk surgery: a retrospective cohort study. Arch Intern Med. 2012;172(5):425-430.
4. Clarke et al. Rates and risk factors for prolonged opioid use after major surgery: population based cohort study. BMJ. 2014;348:g1251.
5. Deyo et al. Association between initial opioid prescribing patterns and subsequent long-term use among opioid-naïve patients: A statewide retrospective cohort study. J Gen Intern Med. 2017;32(1):21-27.

Navigating Opioids for Chronic Pain

www.ismp-canada.org/download/OpioidStewardship/navigating-opioids-11x17-canada.pdf



Institute for Safe Medication Practices

The Institute for Safe Medication Practices (ISMP) also offers a variety of opioid-prescribing supports and opioid-prescribing tools, including a Prescribing Handout among others, available at: www.ismp-canada.org/opioid_stewardship/

Essential Clinical Skills for Opioid Prescribers

Safer Opioid **PRESCRIBING**

ACUTE PAIN in the Emergency Department or Walk-in Clinic

- **Avoid opioids if possible.**
- Prescribe a small supply of weak opioids (codeine, buprenorphine patch, tramadol) for only 3 days, until patients can see their family doctor.
- Do not prescribe potent opioids (morphine, oxycodone, hydromorphone, fentanyl) for minor pain, e.g., muscle strains.

CHRONIC PAIN: Patient selection

- Reserve opioids for severe pain that impairs daily function (e.g., spinal stenosis, neuropathic pain) that has not responded to an adequate trial of all appropriate non-opioid treatments.
- Do not prescribe for fibromyalgia, headaches, low back or neck pain.
- Get a second opinion before prescribing to patients at high risk for opioid use disorder (younger, have an underlying psychiatric disorder (e.g., anxiety, PTSD) or have current or past problematic substance use).

PATIENT WARNINGS

- Explain tolerance: a safe dose for you can be lethal to a non-tolerant individual.
- Keep opioids away from children and adolescents living at home.
- Do not share opioids with anyone and do not borrow opioids from anyone.
- Do not drink alcohol or take sedating drugs while taking your opioid.
- Be careful about driving for a few days after initiation and dose increases.
- If you have stopped opioids for more than 2-3 days, contact your doctor before resuming – you may need a lower dose.

Inform patients that:

- Long-term effectiveness of opioids is unknown.
- Opioids will be discontinued if they do not significantly improve function and pain, or have complications or problematic side effects.

OPIOID SELECTION AND INITIATION

- Taper and discontinue benzodiazepines when starting opioids.
- Always start with weak opioids first.
- Maximum starting dose 30 mg MED/D.*

* MED/D: *Morphine equivalent dose/day*

30 mg morphine = **20 mg** oxycodone = **6 mg** hydromorphone

Dose Titration:

- Increase by no more than 25% for doses less than 50 mg MED/D, and by no more than 10% for doses more than 50 mg MED/D.
- Most patients respond to doses of less than 50 mg MED/D; get a second opinion if doses above 90 mg MED/D are contemplated.

Elderly:

- Initial opioid dose should be less than 20 mg MED/D, with lower dose increases (5–10 mg MED/D).
- **Avoid transdermal fentanyl.**
- Taper and discontinue benzodiazepines.
- Avoid opioids at night, especially long-acting opioids.

Naloxone: Recommend take-home naloxone for patients who are on greater than 90 mg MED/D, on benzodiazepines, or have a history of respiratory impairment, past overdose, or substance use disorder. Naloxone kits are available for free and without a prescription in many pharmacies.

Opioid **TAPERING**

- **High doses (greater than 90 mg MED/D) are not safe and usually not necessary:** Most pain patients respond to doses of 50 mg MED/D or less. High doses increase the risk of overdose, addiction, motor vehicle collisions, and falls.
- Tapering can improve mood, pain, and function in patients with severe pain despite a high opioid dose.
- **Abrupt cessation of high opioid doses is dangerous:** Patients will seek other sources of opioids to relieve withdrawal. Opioid tolerance is lost within days, putting patients at high risk of overdose.

INDICATIONS FOR OPIOID TAPERING:

- **Opioid failure:** Severe pain and impaired function despite adequate dose.
- **Overdose, fall, or harm risk** (e.g., heavy alcohol use, benzodiazepine use, advancing age or worsening co-morbidities).
- **Opioid complications** (e.g., hyperalgesia, sleep apnea, fatigue, or dysphoria).
- **Suspected opioid use disorder** with patient unwilling to pursue methadone or buprenorphine treatment.

TAPERING PROTOCOL

Opioid formulation: Long-acting preferred (until low dose reached).

Dosing interval: Scheduled doses at constant interval (BID or TID) rather than PRN.

Rate of taper: No more than 10% of total daily dose every 1–2 weeks.

Endpoint of taper: Lowest dose that does not markedly exacerbate pain, at least less than 90 mg MED/D.

Dealing with patient resistance:

- Explain that tapering will improve pain, mood, energy level, and function.
- If patient runs out early, increase dispensing frequency (e.g., daily).

Opioid use disorder with suspected injection, diversion, or street use: Taper quickly (1-3 months) with daily dispensing. Stop prescribing after the taper is completed, even if the patient refuses methadone or buprenorphine treatment.

substanceuse@wchospital.ca

Opioid Wisely

Choosing Wisely – Opioid Wisely

- Central to the campaign are recommendations for when the use of opioids should **not** be first-line therapy.
- Includes informational resources to help patients have informed conversations with health care providers about safe options for managing pain.

Choosing Wisely New Brunswick has identified "Opioid Wisely" as a priority project.

Opioid wisely. Fredericton (NB): New Brunswick Medical Society; 2018.

Prescription Monitoring Programs (PMPs)

A pan-Canadian strategy called "*First Do No Harm: Responding to Canada's Prescription Drug Crisis*" was launched in 2013.

- The use of prescription monitoring programs, or PMPs, is endorsed as one important component of the overall strategy.

Prescription monitoring programs in Canada: Best practice and program review. Ottawa: Canadian Centre on Substance Abuse; 2015.

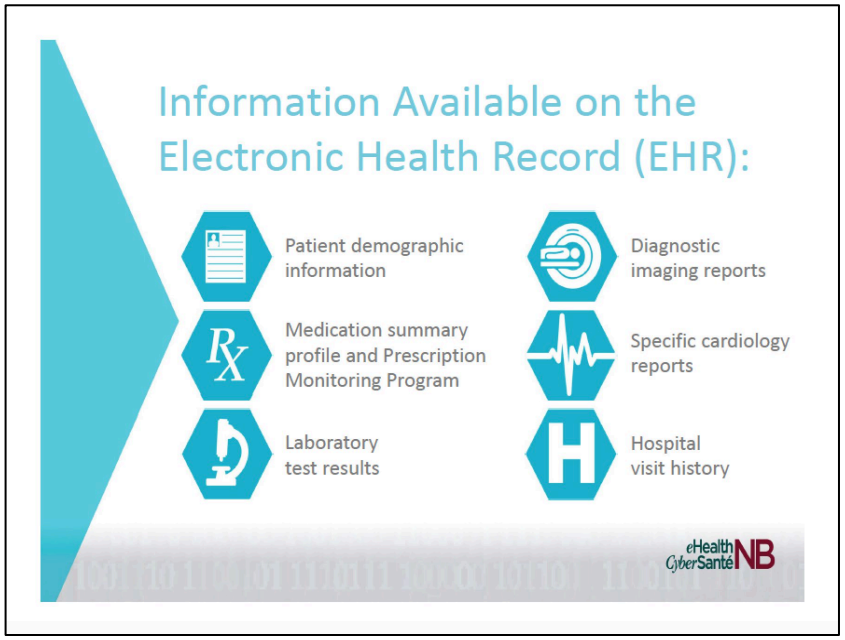
Prescription Monitoring Programs

The purposes of PMPs include:

1. To enhance patient care and assist in the safe use of controlled prescription drugs by monitoring prescription dispensing information.
2. To help reduce the harms resulting from the use of controlled prescription drugs.
3. To assist in reducing the diversion of controlled prescription drugs.

Prescription monitoring programs in Canada: Best practice and program review. Ottawa: Canadian Centre on Substance Abuse; 2015.

The New Brunswick PMP



- Accessed through eHealthNB

eHealth CyberSanté NB

- The full medication summary can be accessed in real time via the Drug Information System, as well as a view of a patient's monitored drug prescriptions (PMP).

Prescription monitoring program and drug information system. Fredericton (NB): Government of New Brunswick; 2018.

The New Brunswick PMP

- Monitored drugs include opioids, stimulants, and central nervous system depressants (e.g., benzodiazepines).
- The electronic health record and PMP make it easier for health care professionals to use a patient's most up-to-date prescription information to make safe, more informed decisions about patient care by:
  - sharing electronic health information among health care practitioners
  - providing a comprehensive medication history (of filled prescriptions) for individual patients
  - helping to prevent duplicate medications
  - identifying drug-related problems.

Prescription monitoring program and drug information system. Fredericton (NB): Government of New Brunswick; 2018.

The New Brunswick PMP

Prescription information available in the PMP includes:

- the name of the drug
- its strength
- the amount prescribed, dispensed, and remaining
- directions for use
- the name of the prescriber
- information on the pharmacy where the prescription was filled.

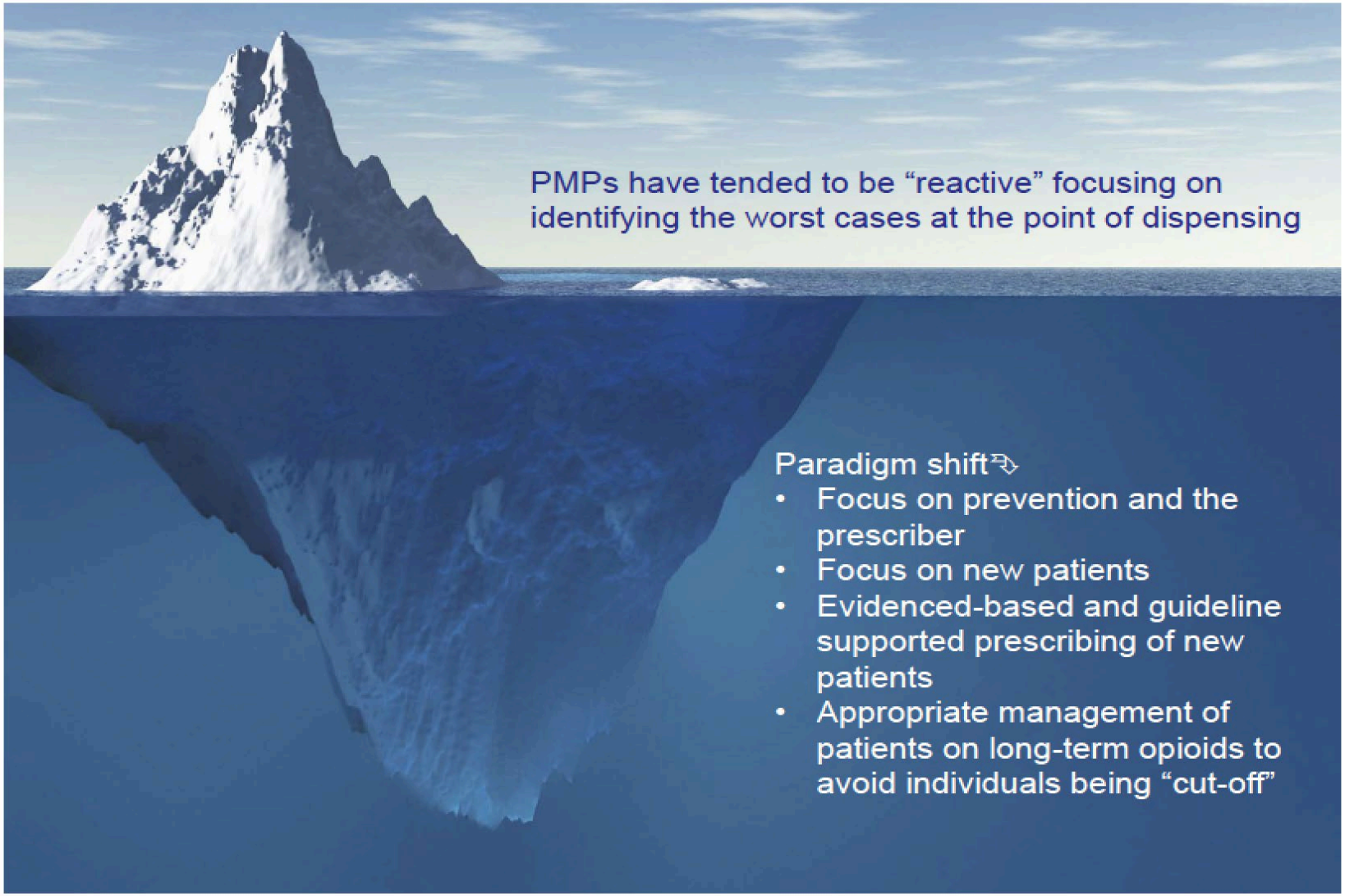
Prescription monitoring program and drug information system. Fredericton (NB): Government of New Brunswick; 2018.

The New Brunswick PMP

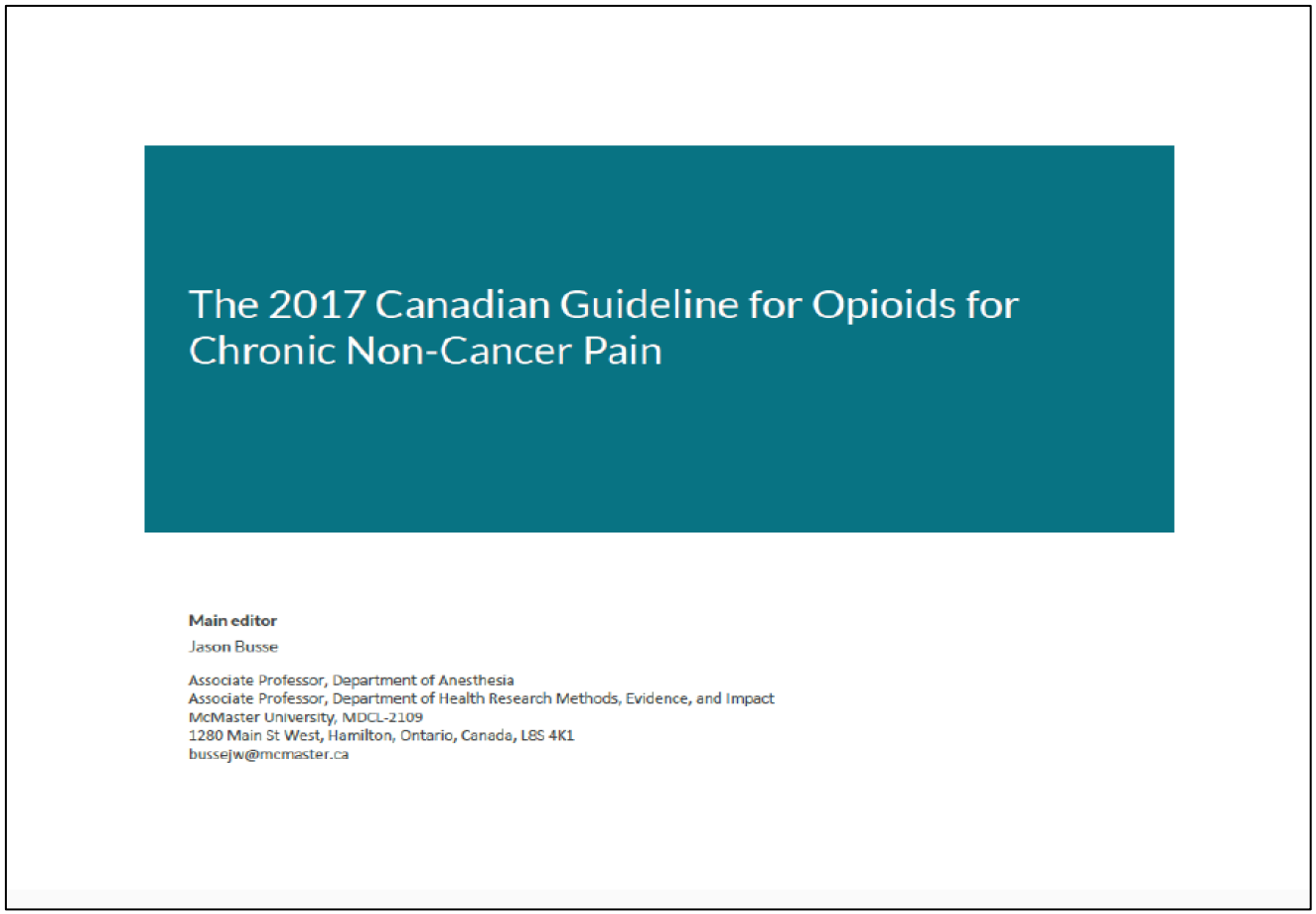
- The New Brunswick PMP can trigger alerts in real time to help identify potential issues such as double-doctoring, prescriptions filled at multiple pharmacies, and high quantities of monitored drugs.
- Additional PMP functionality is being developed with the Electronic Health Record Pharmacy Technical Group and other stakeholders.

Sign up at www.eHealthNB.ca for free access today!

Prescription monitoring program and drug information system. Fredericton (NB): Government of New Brunswick; 2018.


PMPs have tended to be “reactive” focusing on identifying the worst cases at the point of dispensing
Paradigm shift
• Focus on prevention and the prescriber
• Focus on new patients
• Evidenced-based and guideline supported prescribing of new patients
• Appropriate management of patients on long-term opioids to avoid individuals being “cut-off”

New Canadian Guidelines


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

Main editor

Jason Busse

Associate Professor, Department of Anesthesia
Associate Professor, Department of Health Research Methods, Evidence, and Impact
McMaster University, MDCL-2109
1280 Main St West, Hamilton, Ontario, Canada, L8S 4K1
bussejw@mcmaster.ca

Key Guideline Recommendations

When starting opioids:

- **Three (3) or fewer days** usually will be sufficient for most non-traumatic pain not related to major surgery.
- Use immediate-release at lowest effective dose.
- Use precautions for > 50 morphine milligram equivalents (MME)/day.
- Avoid increasing to > 90 MME/day.
- Don’t provide more than is needed for expected duration of pain.
- Avoid opioid and benzodiazepine combination.

Brusse et al. Guideline for opioid therapy and chronic noncancer pain. CMAJ. 2017;189(18):E659-E666.
Dowell et al. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1-49 .
Determining when to initiate or continue opioids for chronic pain. Rothesay (NB): College of Physicians and Surgeons New Brunswick; 2018.

Calculating Morphine Milligram Equivalents (MME)

OPIOID (doses in mg/day except where noted)	**CONVERSION FACTOR**
Codeine	0.15
Fentanyl transdermal (in mcg/hr)	2.4
Hydrocodone	1
Hydromorphone	4
Methadone	
1-20 mg/day	4
21-40 mg/day	8
41-60 mg/day	10
≥ 61-80 mg/day	12
Morphine	1
Oxycodone	1.5
Oxymorphone	3

These dose conversions are estimated and cannot account for all individual differences in genetics and pharmacokinetics.

CDC. Calculating total daily dose of opioids for safer dosage. 2016; https://www.cdc.gov/drugoverdose/pdf/calculating_total_daily_dose-a.pdf

Note: Guideline Recommendations

IMPORTANT

The guideline recommendations described on the previous slide are for chronic, non-cancer pain.

THEY DO NOT APPLY TO ACUTE PAIN, CANCER PAIN, OR PALLIATIVE CARE.

Note also that they are for patients BEGINNING opioid therapy.

Alternative strategies must be used for patients already receiving long-term, high-dose opioid therapy.

Case Introduction: Mr. Ross

John Ross

50-year-old male, presenting with acute lower back pain

Initial Assessment

Start by conducting a full assessment of Mr. Ross, including:

- history
- physical and neurological exam
- evaluation of “red flags”
- evaluation of “yellow flags” (psychosocial risk factors).

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015.

Initial Assessment

History: John Ross, a 50-year-old male, is a previously opioid-naive patient who was prescribed a three-day course of Percocet four days ago in the ER. He is now presenting back to you — his family physician — looking for a second Percocet prescription, as his pain has not resolved and he ran out a day ago.

- Mr. Ross states that the Percocet works well, and he needs a few more days of it to get better.
- He rates his pain a 7 out of 10.
- Mr. Ross is new to your practice, having recently moved from another town in New Brunswick. He is a divorced single male living alone and has no children. He has shared that he is on no other meds and has no other medical conditions. His BMI is 31.

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015

Low Back Pain "Red Flags"

- Features of cauda equina syndrome including sudden or progressive onset of loss of bladder and bowel control, or saddle anesthesia (Emergency)
- Severe worsening of pain, especially at night or lying down (Urgent)
- Significant trauma (Urgent)
- Weight loss, history of cancer, fever (Urgent)
- Use of steroids or intravenous drugs (Urgent)
- Patients older than 50 years (especially older than 65) with first episode of severe back pain (Soon)

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015

Low Back Pain "Red Flags"

If red flags are evident, consider referring the patient for evaluation (including lab tests and imaging, as indicated) and treatment (e.g., ER, relevant specialist, rheumatologist in the case of inflammatory disease, etc.).

EMERGENCY: Referral within hours
URGENT: Referral within 24 to 48 hours
SOON: Referral within weeks

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015.

Low Back Pain "Yellow Flags" Psychosocial Risk Factors

- Belief that pain and activity are harmful
- "Sickness behaviours" (like extended rest)
- Low or negative mood, social withdrawal
- Treatment expectations that do not fit best practices
- Problems with claim and compensation
- History of back pain, time off, other claims
- Problems at work, poor job satisfaction
- Heavy work, unsociable hours (shift work)
- Overprotective family or lack of support

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015

Risks Associated With Prolonged Bed Rest and Return to Work

- Consistent findings show that bed rest is not an effective treatment for acute low back pain but may delay recovery.
- Advice to stay active and to continue ordinary activities results in a faster return to work, less chronic disability, and fewer recurrent problems.

Waddell et al. Systematic reviews of bed rest and advice to stay active for acute low back pain. Br J Gen Pract. 1997;47(423):647-652.
Treating lower back pain: How much bed rest is too much? Toronto: Choosing Wisely Canada; 2018.

Opioid Therapy?

Question: Is opioid therapy the preferred first-line treatment for acute low back pain?

Opioid Therapy?

Answer: No (opioid therapy is not first line).

Reason: Evidence shows that early treatment of acute pain with opioids leads to a higher probability of subsequent opioid prescriptions and opioid dependence without improving pain and recovery outcomes.

If opioids are required for severe acute pain, three days or less is recommended to control the pain while minimizing the potential risks and harms associated with opioid use.

Dowell et al. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.

Preferred Pharmacologic Treatment: Acute Low Back Pain

Rather than opioids, consider:

- NSAIDs
  - Ibuprofen — up to 800 mg t.i.d., maximum of 800 mg q.i.d., or
  - Diclofenac — up to 50 mg b.i.d.
  - Consider proton pump inhibitors if patient > 45 years of age.
  - Topical NSAIDs may be considered for localized pain.
- Acetaminophen — up to 1,000 mg q.i.d.
- Short-course muscle relaxants
  - E.g., cyclobenzaprine, 10 mg to 30 mg/day

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015.
Topical NSAIDs versus opioids for acute musculoskeletal pain: A review of the clinical effectiveness. Ottawa: CADTH; 2017.
Pain management & opioids: Addressing important challenges and introducing a chronic pain & opioids mini-book. Saskatoon (SK): RxFiles, Saskatoon Health Region (SHR); 2017.
Low back pain and sciatica in over 16s: assessment and management. (NICE guideline NG59). London: National Institute for Health and Care Excellence; 2016.

Mr. Ross' Pharmacologic Treatment

- Assume no contraindications to NSAIDs for Mr. Ross.
- Prescribe ibuprofen 800 mg t.i.d. for one week, with the plan to follow up at that time.

Note: Non-pharmacologic treatment is also an important part of the management of acute low back pain.

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015.

Pain Management & Opioids: Addressing important challenges and introducing a chronic pain & opioids mini-book. Saskatoon (SK): RxFiles, Saskatoon Health Region (SHR); 2017.

Mr. Ross' Non-Pharmacologic Treatment

Recommendations for Mr. Ross:

- Stay active.
- Use heat and cold packs for the pain.
- Slowly return to usual activities (including work) as soon as possible.
- Return for a follow-up appointment if the pain worsens or if new symptoms appear.
- Do not stay in bed.

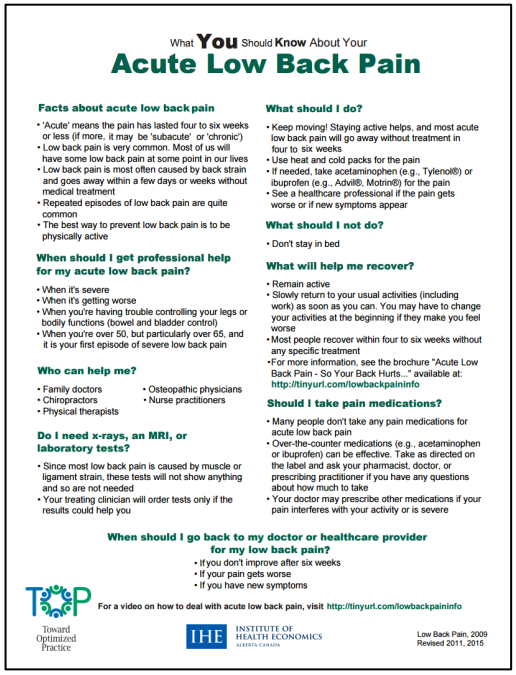
You may also:

- Consider referral to other health care practitioners (physiotherapy, massage, etc.).
- Offer informational resources for Mr. Ross to take home.

A summary of the guideline for the evidence-informed primary care management of low back pain. Edmonton (AB): Toward Optimized Practice; 2015.
Clinically Organized Relevant Exam (CORE) back tool. Toronto: Centre for Effective Practice; 2016.

Patient Resources: Acute Low Back Pain

Patient Handout



What **You** Should **Know** About Your

Acute Low Back Pain

Facts about acute low back pain

- 'Acute' means the pain has lasted four to six weeks or less (if more, it may be 'subacute' or 'chronic')
- Low back pain is very common. Most of us will have some low back pain at some point in our lives
- Low back pain is most often caused by back strain and goes away within a few days or weeks without medical treatment
- Repeated episodes of low back pain are quite common
- The best way to prevent low back pain is to be physically active

When should I get professional help for my acute low back pain?

- When it's severe
- When it's getting worse
- When you're having trouble controlling your legs or bodily functions (bowel and bladder control)
- When you're over 50, but particularly over 65, and it is your first episode of severe low back pain

Who can help me?

- Family doctors
- Chiropractors
- Physical therapists
- Osteopathic physicians
- Nurse practitioners

Do I need x-rays, an MRI, or laboratory tests?

- Since most low back pain is caused by muscle or ligament strain, these tests will not show anything and so are not needed
- Your treating clinician will order tests only if the results could help you

What should I do?

- Keep moving! Staying active helps, and most acute low back pain will go away without treatment in four to six weeks
- Use heat and cold packs for the pain
- If needed, take acetaminophen (e.g., Tylenol®) or ibuprofen (e.g., Advil®, Motrin®) for the pain
- See a healthcare professional if the pain gets worse or if new symptoms appear

What should I not do?

- Don't stay in bed

What will help me recover?

- Remain active
- Slowly return to your usual activities (including work) as soon as you can. You may have to change your activities at the beginning if they make you feel worse
- Most people recover within four to six weeks without any specific treatment
- For more information, see the brochure "Acute Low Back Pain - So Your Back Hurts..." available at: http://tinyurl.com/lowbackpaininfo

Should I take pain medications?

- Many people don't take any pain medications for acute low back pain
- Over-the-counter medications (e.g., acetaminophen or ibuprofen) can be effective. Take as directed on the label and ask your pharmacist, doctor, or prescribing practitioner if you have any questions about how much to take
- Your doctor may prescribe other medications if your pain interferes with your activity or is severe

When should I go back to my doctor or healthcare provider for my low back pain?

- If you don't improve after six weeks
- If your pain gets worse
- If you have new symptoms

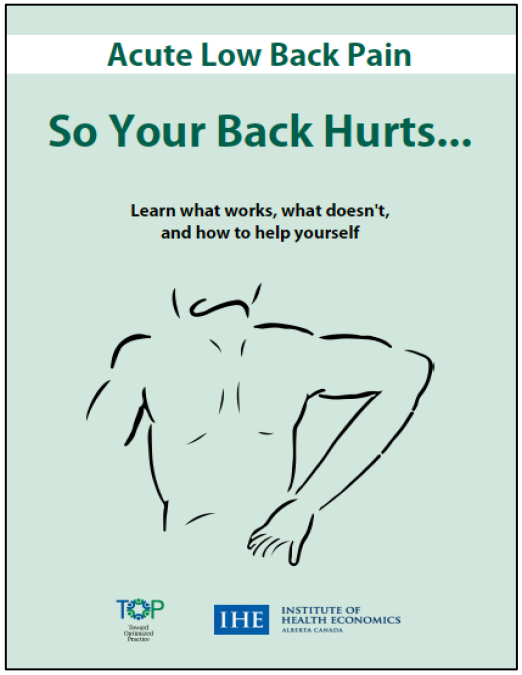
For a video on how to deal with acute low back pain, visit http://tinyurl.com/lowbackpaininfo

Toward Optimized Practice

IHE INSTITUTE OF HEALTH ECONOMICS ALBERTA CANADA

Low Back Pain, 2009
Revised 2011, 2015

Patient Brochure



Acute Low Back Pain

So Your Back Hurts...

Learn what works, what doesn't, and how to help yourself

Toward Optimized Practice

IHE INSTITUTE OF HEALTH ECONOMICS ALBERTA CANADA

What you should know about your acute low back pain. Edmonton (AB): Toward Optimized Practice; 2015.
Acute low back pain: So your back hurts…learn what works, what doesn't, and how to help yourself. Edmonton (AB): Institute of Health Economics; 2015.

What If …

What if the patient was more adamant about receiving another Percocet prescription, stating that the pain had not improved and that he needed at least the same dose of pain medication (if not more) to get through this?

Module 3: Communicating with patients. (CDC guideline for prescribing opioids for chronic pain). Atlanta (GA): Centers for Disease Control and Prevention; 2016.

Difficult Conversations Re Opioid Use

Question: What are some recommended communication strategies to handle difficult conversations with patients regarding opioid use?

Difficult Conversations About Opioid Use

Motivational Interviewing:

- is patient-centred
- is directive
- enhances a patient's intrinsic motivation to change
- explores and helps the patient resolve contradicting feelings or ideas.

Module 3: Communicating with patients. (CDC guideline for prescribing opioids for chronic pain). Atlanta (GA): Centers for Disease Control and Prevention; 2016.

Difficult Conversations About Opioid Use

Motivational Interviewing Principles

1. Express empathy through reflective listening.
2. Explore the discrepancy between patient's goals or values and their current behaviours.
3. Explore with patients all feasible options to manage their pain.
4. Adjust to patient resistance rather than opposing it directly.
5. Support self-efficacy and optimism.

Module 3: Communicating with patients. (CDC guideline for prescribing opioids for chronic pain). Atlanta (GA): Centers for Disease Control and Prevention; 2016.

Getting Back to Mr. Ross…

So this hypothetical, more challenging version of Mr. Ross also mentions in his discussion with you:

- "I was able to sleep on the Percocet and I have trouble sleeping even without the back pain."

Question: What are some additional considerations that would be important for this case?

Additional Considerations

- Check electronic health record (EHR) and PMP data to see what Mr. Ross has been prescribed in the past and what he is being prescribed now.
- Screen for other symptoms and conditions (e.g., sleep disorders, substance use disorders, mental health diagnoses):
  - **Sleep Disorders Questionnaire** (Alberta's Toward Optimized Practice Guidance): /www.topalbertadoctors.org/download/2176/Sleep%20Disorders%20Questionnaire.pdf?_20180427204745
  - **Substance Use Disorder Screening Tools:** e.g., CAGE-AID, CRAFFT
  - **Mental Health Screening Tools:** e.g., PHQ-9, GAD-7

Dowell et al. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.

What You Find Out…

- Mr. Ross' EHR information is accessed, and the PMP screen shows one prescription filled two months ago at a pharmacy in the patient's former home town for a 30-day supply of lorazepam 2 mg q HS, PRN.
- In the process of administering screening questions to Mr. Ross, he explains that he had a close older brother pass away suddenly almost three months ago from a heart attack.
  - He becomes almost tearful when mentioning this.
  - Mr. Ross also explains that he used the lorazepam for about two weeks to try and help with sleep, but then he stopped because he found he would wake up again after a few hours anyway.
  - Upon further inquiry, Mr. Ross shares that the half-empty bottle of lorazepam was in a cupboard at home, and he took one last night when he was desperate and out of the Percocet.

Mr. Ross' Benzodiazepine Prescription

Question: How might this information on the benzodiazepine prescription change your approach with the patient?

Safety Warning

There is a heightened risk of overdose when co-prescribing opioids and benzodiazepines (both are CNS depressants); thus, extra caution is warranted. Clinicians should avoid prescribing opioids and benzodiazepines concurrently, whenever possible.

CDC Guidance: Experts agreed that, although there are circumstances when it might be appropriate to prescribe opioids to a patient receiving benzodiazepines (e.g., severe, acute pain in a patient taking long-term stable, low-dose benzodiazepines therapy, or opioid agonist therapy for a patient with opioid use disorder), clinicians should avoid prescribing opioids and benzodiazepines concurrently, whenever possible.

Brusse et al. Guideline for opioid therapy and chronic noncancer pain. CMAJ. 2017;189(18):E659-E666.

Dowell et al. CDC guideline for prescribing opioids for chronic pain — United States, 2016. MMWR Recomm Rep 2016;65(No. RR-1):1–49.

Drug Safety Communications: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks. Silver Spring (MD): U.S. FDA; Sept 2017.

Policies to prevent harms from the co-prescribing of opioids and central nervous system depressant drugs. Ottawa: CADTH; 2018.

What if There Are Multiple Prescriptions From Multiple Prescribers for Mr. Ross?

Question: How would your approach differ if there is evidence of multiple opioid prescriptions from several prescribers when checking the PMP for Mr. Ross?

What if There Are Multiple Prescriptions From Multiple Prescribers for Mr. Ross?

Answer: It is, of course, concerning when a patient is seeing multiple prescribers with the goal of obtaining more opioid prescriptions.

- This highlights the importance of always checking the PMP before prescribing.
- It is important to have a discussion with the patient, including applying the principles of motivational interviewing discussed earlier and working with the patient to optimize alternative non-opioid and non-pharmacologic pain management strategies.
- Lastly, it is important to screen for opioid use disorder.

Screening for Substance Use Disorders, Mental Health, and/or Sleep Disorders

Question: Given the information Mr. Ross revealed during screening, what would your next steps be?

Screening for Substance Use Disorders, Mental Health, and/or Sleep Disorders

Management Strategy

It is important to further address the patient's grief and risk of possible depression. Set a follow-up appointment to further discuss this.

- Also refer Mr. Ross to a sleep clinic for a formal evaluation.
- Discuss sleep hygiene as an additional strategy.

Thank You!

Questions?