Centre for Effective Practice

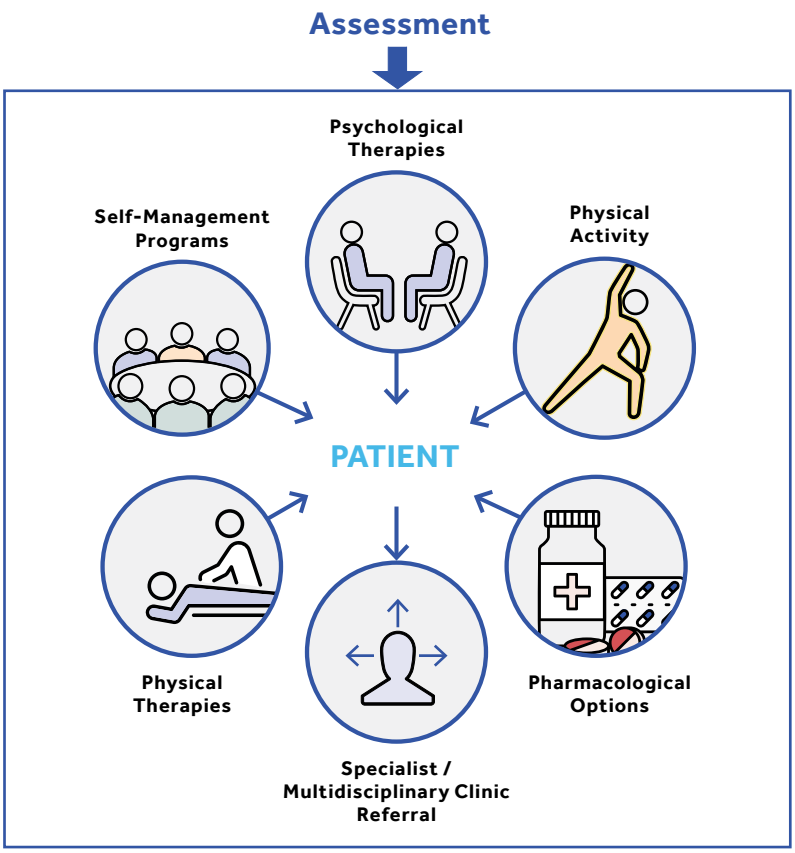
Management of Chronic Non Cancer Pain

Introduction

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

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

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



General Approach

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

Step 1

Assessment

Start with a thorough baseline assessment, which may need to be completed over more than one visit.[1]

- Begin to develop a rapport with the patient to encourage trust and information sharing.

Section 1: Baseline and Ongoing Assessment

Step 2

Management options

Select non-pharmacological and/or pharmacological therapies.

Based on the assessment, identify treatments that you and your patient feel comfortable starting.

Section 2: Non-Pharmacological Therapies

Section 3: Non-Opioid Medications

Section 4: Opioid Medications

Step 3

Initiate, adapt & evaluate

Use the Patient Record and Treatment Plan to help initiate, adapt and evaluate treatments.

Details on individual therapies can be found in **Sections 2-4 and in the Appendix**

Step 4

Refer as appropriate

Consider referral to a specialist or multidisciplinary clinic.

Section 5: Intervention Management and Referral

Section 1: Baseline and Ongoing Assessment

The guides for assessment outlined below are to help develop and monitor a treatment plan for patients with CNCP. **They are not designed to diagnose specific CNCP conditions.** During an assessment, work to develop a rapport with the patient to establish trust and encourage sharing of information. Consider completing a thorough baseline assessment in the following patients:

- Patients with a new diagnosis of CNCP, patients who are new to your practice with a diagnosis of CNCP, and patients currently in your practice with a diagnosis of CNCP.

1. Baseline Assessment

Assessment Parameter	Factors to consider[2,3,5]
Pain Condition	☐ Identify pain diagnoses, e.g., OA, FM or NP ☐ If suspected Complex Regional Pain Syndrome (CRPS)[i], consider urgent referral ☐ Assess biomedical yellow flags (see table below) ☐ Pain: Brief Pain Inventory (BPI)[ii]: • Intensity • Exacerbating and alleviating factors • Character • Systemic symptoms • Duration ☐ Past investigations/consultations ☐ Response to current/past treatments (consider whether trial was long enough to evaluate efficacy/side effects) ☐ Past medical history ☐ Current medications (including prescription, non-prescription, and natural products)
Functional and Social History	☐ Assess functional status and impairment (e.g., BPI) ☐ Psychosocial history: living arrangements, family/social support, family obligations, work status, sleep, relationships ☐ Assess social yellow flags (see table below)
Mental Health	☐ Current and past psychiatric history (e.g., depression PHQ-9[iii], anxiety GAD-7[iv], PTSD) ☐ Family psychiatric history ☐ Assess psychological yellow flags (see table below)
Substance Use History & Opioid Risk Assessment	☐ Review history of substance use, abuse, and addiction (start with family history then personal history): ☐ Alcohol, cannabis, prescription medications, illicit drugs ☐ Attendance at an addiction treatment program ☐ If on opioids, review for the presence of any opioid use disorder features. May use Opioid Risk Tool[v], however, it has insufficient accuracy for risk stratification[2,6] ☐ Use urine drug testing before starting opioid therapy. Consider annual urine drug testing (or more often, as appropriate) for the use of opioid medication and/or illicit drugs[2]
Physical Examination	☐ Document relevant physical examination based on diagnosed pain condition(s)

YELLOW FLAGS[1]

Assess the following to identify patients with CNCP who are at risk for poor outcomes:

Biomedical	• Severe pain or increased disability at presentation • Previous significant pain episodes • Multiple site pain • Non-organic signs • Iatrogenic factors
Psychological	• Belief that pain indicates harm • Expectation that passive rather than active treatments are most helpful • Fear-avoidance behaviour • Catastrophic thinking • Poor problem-solving ability • Passive coping strategies • Atypical health beliefs • Psychosomatic perceptions • High levels of distress
Social	• Low expectations of return to work • Lack of confidence in performing work activities • Heavier workload • Low levels of control over rate of workload • Poor work relationships • Social dysfunction/isolation • Medico-legal issues

Patients at higher risk of poor outcomes may require closer follow-up and greater emphasis on a diversified non-pharmacological and pharmacological, multi-modal approach to treatment.[7]

2. Ongoing Assessment

Assessment Elements	Comments
☐ Identify new pain, related symptoms or significant change	Physical examination as indicated
☐ Adherence to treatment	n/a
☐ Adverse event related to treatment	n/a
☐ Treatment(s) effect on: • Pain • Function • Quality of life • Mood • Social function	Assess and document using: • Narrative assessment • Validated tools (e.g., BPI) Note: 30% improvement is meaningful for pain and function[2]
☐ Progress towards patient goals (SMART goals: Specific, Measurable, Agreed-upon, Realistic, Time-based)	Examples • Taking walks/walking dog • Attending family/social events • Returning to part-time work • Participating in recreational activities
☐ If on opioids, monitor for: • Aberrant drug-related behaviours • Clinical features of opioid use disorder (see below) ☐ Use urine drug testing as indicated	**See Table 3** below for list of behaviours
☐ In patients with current or past substance use disorder (SUD), monitor for destabilization of disease	Monitor for aberrant use of prescribed medications

3. Clinical Features of Opioid Use Disorder (OUD)[8]

Indicator	Examples
Altering the route of delivery	• Injecting, biting or crushing oral formulations
Accessing opioids from other sources	• Taking the drug from friends or relatives • Purchasing the drug from the 'street' • Double-doctoring
Unsanctioned use	• Multiple unauthorized dose escalations • Binge use rather than scheduled use
Drug seeking	• Recurrent prescription losses • Aggressive complaining about the need for higher doses • Harassing medical office staff for faxed scripts or 'fit-in' appointments • Nothing else 'works'
Repeated withdrawal symptoms	• Marked dysphoria, myalgia, GI symptoms, cravings
Accompanying conditions	• Currently addicted to alcohol, cocaine, cannabis, or other drugs • Underlying mood or anxiety disorders are not responsive to treatment
Social features	• Deteriorating or poor social function • Concern expressed by family members
Views on the opioid medication	• Sometimes acknowledges being addicted • Strong resistance to tapering or switching opioids • May admit to mood-leveling effect • May acknowledge distressing withdrawal symptoms

Non-pharmacological treatments should be considered for all patients with CNCP.[1] Choose treatments that you and the patient feel comfortable with and then initiate, adapt, and evaluate the treatment plan (use motivational interviewing techniques, as appropriate).

When determining the benefit of a therapy, an improvement of 30% in pain and function scores is considered clinically meaningful;[2] however, even a smaller improvement may be meaningful to the patient.

Talking Points[9,10]

If patients are reluctant to try physical activity/ exercise therapy:

Try the Elicit-Provide-Elicit technique

Elicit the patient's thoughts/feelings:
"How do you feel about trying some exercise therapy for your pain?"

Provide information (a common patient concern is that exercise therapy will increase pain):
"If I understand correctly, you are concerned that physical activity will increase your pain. Interestingly, it actually tends to do the opposite; physical activity can be an effective way of decreasing pain."

Elicit the patient's opinion:
"What do you think about this?"

Non-pharmacological treatments:

Physical Activity

Examples of pain conditions indicated for: FM, LBP, headache, OA

A) Initiate

- Recommend general activity and exercise therapies, as appropriate
- Recommend combined home and group physical activities to help increase activity levels
- Pick a low impact physical activity, such as walking, pilates, Tai Chi, yoga or aquatic therapy (see **Appendix A**)
- Start low and go slow (e.g., 5 min every other day) and aim for a moderate level of intensity of activity[2,11]
- Consider referral to a physiotherapist if more intensive support is required

B) Adapt

- Improve adherence to home physical activity by encouraging graded activity
- Encourage graded activity – add 10 min every 3-4 weeks[12]
- Minimal goal: 30 min of exercise 5 days a week[2,13]
- Add in other activities as tolerated

C) Evaluate

- Measure benefits at 8 or more weeks[13]
- Use BPI to evaluate effect on pain, function and quality of life
- If benefits are not identified, try other activity types and continue to counsel about the value of exercise and activity

Self-Management Programs[14]

Examples of pain conditions indicated for: FM, LBP, headache, OA, neck pain, rheumatoid arthritis, NP

A) Initiate

- A self-management program should be considered to complement other therapies patients have initiated[1]
- Identify a self-management program that best suits the patient's need (see **Supporting Material & Resources** section)

B) Adapt

- Encourage patients to continue to use strategies learned from the program

C) Evaluate

After program completion:
- Use tools like BPI to evaluate effect on pain, function and quality of life

Psychological Therapies

Examples of pain conditions indicated for: FM, LBP, headache, OA, neck pain, rheumatoid arthritis, NP

A) Initiate

- Cognitive behavioural therapy (CBT) should be considered for the treatment of patients with chronic pain[1]
- Particularly valuable for those with co-morbid depression and/ or anxiety

Start with one of the following psychological therapies:
- CBT, Mindfulness Based Intervention (MBI), Acceptance Commitment Therapy (ACT) or Respondent Behavioural Therapy (see **Appendix A**)
- Consider referral to a psychotherapist, social worker, occupational therapist and/or other mental health professional if more intensive support is required

B) Adapt

- Encourage patients to continue to use strategies learned from therapies

C) Evaluate

- Use tools like BPI, PHQ-9 to evaluate effect on pain, function and quality of life
- Add other types of therapies as appropriate (see **Appendix A**)
- Rarely, may exacerbate some underlying mental illnesses

Physical Therapies

Examples of pain conditions indicated for: LBP, neck pain, NP

A) Initiate

- Consider any of the following for short-term relief of pain:[1]
  - Manual therapy
  - TENS
  - Low level laser therapy

Consider referral to a physiotherapist, chiropractor or osteopath, as appropriate

B) Adapt

- Encourage patients to participate in 8 therapy sessions over 4-6 weeks[14]

C) Evaluate

- Follow up after completion of 8 sessions
- Use BPI to evaluate effect on pain, function and quality of life

See a list of patient resources in the Supporting Materials section:

- Online videos & webinars
- Physical activity resources
- Online tools and programs
- Patient networks, communities and support groups

See a listing of resources in your LHIN

thewellhealth.ca/cncp

Section 3: Non-Opioid Medications

Non-opioid medications, in combination with non-pharmacological therapies, are the preferred treatment for CNCP.[1]
Choose a treatment that you and the patient feel comfortable with and then initiate, adapt, and evaluate the treatment plan.

See **Appendix B** for details on evidence, benefits and harms.

Most patients have either a good response (an improvement of 30% in pain and function scores is considered clinically meaningful) or have no response.[2]

**Start with ONE medication and evaluate.
Use a sequential manner (versus parallel) to trial a second medication, if needed. Minimize polypharmacy as much as possible.**

A) Initiate[1]

Select one medication from the table based on patient's pain type and professional judgment of risks/benefits.

- Agree with patient on goals (pain reduction, improved function/ mood, other)
- Agree on length of initial trial (usually 2 weeks at optimum dose, up to 4 weeks for antidepressants)
- Discuss potential side effects/risks (see **Appendix B**)
- Be aware of concomitant over-the-counter treatments and advise accordingly.
- Where possible, avoid concomitant sedative and hypnotic medications; be aware of concomitant alcohol use and counsel that there is an increased risk of overdose if alcohol and opioids are used together[1,2]
- Start at recommended dose

Tip: Some antidepressants can have a role for neuropathic pain, as well as for nociceptive pain, such as osteoarthritis

See **Appendix B** for details on evidence, benefits/harms, and dosing.

B) Titrate[1]

- Adjust, as needed, up to an effective dose, unless limited by side effects. Do not exceed the maximum dose.
- Minimize polypharmacy as much as possible.

See **Appendix B** for details on dosing and titration.

C) Evaluate[15]

- Evaluate effects on pain, function, mood and set goals
- Use pain and function assessment scales:[15]
  - Brief Pain Inventory (BPI)[ii]

- **Consider trialling two or three drugs in succession from the same class if one is ineffective[1]**
- **Avoid co-prescribing two drugs from the same class**
- **Due to safety risks associated with use of oral NSAIDs, use conservative dosing for the shortest possible duration consistent with approved prescribing limits[16]**

Regularly review ongoing value of each medication. If drug does not produce a meaningful improvement, stop or taper drug[1] (see **table on p6 for tapering instructions**)

Drug Class	Drug	Pain types[1]
General	Acetaminophen	Osteoarthritis (hip or knee)
	Nonsteroidal anti-inflammatory drugs (NSAIDs)	Low back pain
Anti-convulsants	Carbamazepine	1st-line for trigeminal neuralgia (may also be used for general neuropathic pain)
	Gabapentin	Neuropathic pain (Amitriptyline or gabapentin are usually the first choice)
	Pregabalin	If amitriptyline or gabapentin are not effective/tolerated, pregabalin may be used as an alternative for neuropathic pain or fibromyalgia
Anti-depressants	Amitriptyline (nortriptyline or imipramine may be used if amitriptyline not effective)[1]	Neuropathic pain (Amitriptyline or gabapentin are usually the first choice)
	Duloxetine	Neuropathic pain due to diabetes, fibromyalgia, or osteoarthritis
	Fluoxetine	Fibromyalgia
Topical	Topical NSAIDs	Musculoskeletal pain[1] and osteoarthritis[17]
	Topical rubifacients	Musculoskeletal pain (if other drug treatments are not effective)

- **Cannabinoids are not equivalent in effectiveness to anti-depressants or anti-convulsants[18]**

Cannabinoid forms that can be considered for neuropathic pain:[18]

- Synthetic tetrahydrocannabinol (nabilone)
- Nabiximols
- Dried cannabis (vaporizer or edible product)

Opioid medications are not the preferred treatment for CNCP but may be considered in selected patients. If opioids are used, they should be combined with non-pharmacological treatments and non-opioid medications as appropriate.[2]

See **Appendix C** for details on evidence, benefits and harms.

Talking Points

Patient wants opioids but they are not clinically appropriate.

Try the Elicit-Provide-Elicit technique

Elicit how patient feels they would benefit from an opioid:
"You mentioned you would like to try an opioid. How are you hoping it will help you?"

Provide information that addresses the patient's concerns:
"If it's all right, I can give you more information about opioids and how they work for pain. Opioids may seem like they are very strong and effective drugs for pain; however, they are not effective for all types of pain. When opioids are effective, your pain may be reduced by about 1or 2 points on a scale from 0 to 10 and you may notice a small improvement in your ability to function.[1] They also come with risks, and sometimes this means that opioids are not a safe and effective approach for pain relief. We may find that other approaches and medications could work better for you."[3]

Elicit the patient's thoughts:
"How do you feel about trying some non-opioid options? What do you think makes sense for you right now?"

A) Initiate[1,19]

Before trying opioids, it is not necessary to sequentially "fail" non-pharmacological or non-opioid pharmacological therapies, though it is important to weigh expected benefits and risks of therapy[2] (see **Appendix C**). There is no high quality evidence showing that opioids improve pain or function with long term use.

1. Patient Selection:

- Opioids should be reserved for patients that meet the following criteria:
  - A biomedical pain diagnosis, with evidence for an indication of opioids. Currently, there is limited evidence for the use of opioids in FM and headaches (see **Appendix C**).
  - Non-opioid treatments have been trialled or are being trialled concurrently.
  - Pain is severe enough to interfere with daily function.
  - Patients with a low risk of opioid use disorder. Patients with a high risk (active substance use disorder) may require further consultation with an addictions expert.
- May use the Opioid Risk Tool[v] to gauge potential risk.[2,6] Supplement with a history identifying high risk factors such as:
  - Current anxiety, depression, PTSD
  - Current or past history of problematic substance use (e.g., alcohol, opioids, cannabis)

2. Opioid Selection:

- Start with weak opioids (e.g. tramadol, codeine)
- Potent opioids are second line (e.g., morphine, oxycodone, hydromorphone, fentanyl, methadone)

3. Opioid Initiation:

- Set goals with patient (pain reduction, improved function/mood)
- Discuss the short-term benefits and potential side effects/risks, such as potential loss of efficacy over time (see **Appendix C**)
- Avoid prescription of sedative and hypnotic medication when possible
- Be aware of concomitant use of alcohol and over the counter medications
- Agree on duration of an opioid trial (e.g., typically 2 weeks at optimal dose)
- For patients on opioids over 90 morphine milligram equivalents (MME) or patients on opioids with a potential risk for overdose (i.e., past/active/evolving opioid use disorder or concurrent benzodiazepine use), encourage the patient to obtain take home naloxone (kit or intranasal spray) from their pharmacist[2]
- Before starting opioids, discuss an "exit strategy" for how opioids will be discontinued if they do not produce benefits that outweigh risks[2]

B) Titrate[1,19]

Start with immediate-release opioids instead of sustained-release or long-acting opioids. Do not use long-acting opioids unless the patient has severe, continuous pain and has been taking immediate-release opioids daily for at least 1 week.[2]

- Titrate oral opioids until efficacious* (an improvement in function and/or pain of 2 points on a 10-point scale).[19,20]
- Most patients respond to doses in the range of 0-50 MME. As the dose increases, the risk of overdose, addiction, falls, motor vehicle accidents and sleep apnea increase as well.
- Opioids have a medium effect on pain (10-20% reduction) and a small effect on function (<10% change): function can improve even when pain is still present.[2,5]
- Use the lowest effective dose - aim to keep the dose under 90 MME. If a larger dose is required, consider obtaining a second opinion.[2,19]

*See below on the watchful dose and Appendix C for details on dosing.

C) Evaluate[15]

For conditions where opioids may be effective, establish realistic expectations:[2]

- After titration, evaluate benefits and risks of continued therapy at least every 3 months[2]
- If drug does not produce a meaningful improvement, discontinue/taper
- If opioids are inappropriately used, the risk of overdose, hypogonadism, sleep disorders or respiratory function can worsen.

Recommendations in the above tables have been developed in part from a consensus of expert opinion.

WATCHFUL DOSE: Recent guidelines recommend reassessing the benefit/risk of doses ≥50 MME/day and to "avoid or justify increasing dosage" at doses ≥90 MME/day.[2,19,21]

Section 4: Opioid Medications

Tapering Opioids	How to taper[6]	Tapering Pearls
Indications to taper and discontinue opioids: • Insufficient analgesia, insufficient effect on function, or a failed opioid trial • Significant side effects (e.g., sedation, fatigue, depression, sleep apnea, falls, motor vehicle accidents, testosterone suppression) • Suspected opioid use disorder • High opioid dose (well above 90 MME), even if no obvious side effects are present Explain to the patient that tapering often improves pain, mood and function.	• Opioids should never be abruptly stopped, as it may trigger unauthorized use and is an increased risk for overdose • There are many protocols for an opioid taper – the following is an example: 1. Decrease dose by 10% of total daily dose, every 1-2 weeks or monthly. Continue until one-third of the original dose is reached. 2. When one-third of the original dose is reached, decrease dose by 5% every 2-4 weeks. 3. A taper may be paused for a period of time to help the patient adjust.	• In patients who have been on opioids for years a slower taper is more likely to be successful • Taper more cautiously during pregnancy and/or seek out expert consultation – acute withdrawal increases the risk of premature labour and spontaneous abortion • Avoid sedative-hypnotic medications, especially benzodiazepines, during the taper[22] • Optimize non-opioid management of pain and provide psychosocial support for anxiety related to the taper • Some patients may begin to manifest an OUD during the taper. Arrange for appropriate treatment and consider naloxone use.

Strategies to Prevent Opioid Use Disorder (OUD)

1. Identify high risk patients: individuals with current anxiety, depression, PTSD; individuals with current or past history of problematic alcohol or drug use.
2. Do not prescribe opioids to patients at high risk for OUD unless they have a biomedical pain condition affecting function, and have failed at all first-line non opioid treatments. Do not prescribe for fibromyalgia or simple low back pain.
3. Take a baseline urine drug sample. Do not prescribe opioids if cocaine or non-authorized drugs are present.
4. Dispense small amounts frequently – weekly, twice weekly, daily if necessary; especially if patient runs out early.
5. Set the maintenance dose at the lowest possible dose – in most cases, it should be no more than 50 MME.
6. Avoid any drug that is commonly misused in the community (e.g., hydromorphone, fentanyl, oxycodone).
7. If patient shows clinical features of OUD, refer for methadone or buprenorphine treatment. Prescribe buprenorphine yourself if specialized addiction clinic is not available or acceptable to the patient.

Note: *Continuing to prescribe opioids in the face of opioid addiction may put the patient at risk of harm. However, stopping or refusing to prescribe opioids can also cause harm, such as severe withdrawal symptoms or driving the patient to obtain opioids from the street. It is important to mitigate these risks by finding a safe way to reduce and manage opioid use.*

Naloxone

Advise patients at high risk of an opioid overdose (i.e., on opioids over 90 MME; active opioid use disorder; using illicit opioids or concurrent benzodiazepine use) to obtain take home naloxone (kit or intranasal spray) from their pharmacist (consider also communicating with pharmacist directly).[2]

Section 5: Intervention Management & Referral

Ensure that all necessary and relevant information, as required by the clinic or specialist, is included when initiating a referral.

Type of Referral	Consider when:[1]
Referral to Psychological Therapy	• Patient has moderate to high levels of distress • Patient has difficulty adjusting to a life with pain • Patient is struggling to change their behaviour and maintain normal activities • Referral to specialist pain service

Referral to Pain Specialist Service (may include interventional management)	• Treatment failure after trial of 4 drugs for neuropathic pain
	• Opioid dose is greater than 90 MME[2]
	• Inadequate response to non-specialist management
	Intervention Management:
	• Interventional procedures can provide short-term relief of pain, though some interventions are associated with rare but significant adverse outcomes (e.g., stroke, death)
	• Consider the following procedures for the specified conditions:
	  • Lumbar or cervical epidurals in hospital-based centres (e.g., spinal stenosis, discogenic pain +/- radicular pain)
	  • Facet joint injections, medial branch blocks (e.g., facet joint pain)
	  • Radiofrequency nerve ablation (e.g., facet and sacroiliac joint pain)
	  • Spinal cord stimulators (e.g., low back and associated limb-based pain in failed back surgery)
	  • Trigger point injections (e.g., myofascial pain syndromes)

Multidisciplinary Pain Management Program Features: • Rehabilitation and exercise therapy • Patient education • Vocational therapy • Medical management	• Patient has poor functional capacity • Patient has moderate to high levels of distress • Patient has social and occupational problems related to pain • Patient has failed to benefit from other, less comprehensive therapies • Patient prefers self-management rather than a medical approach • If referring patient for CRPS, urgent consultation and management required

Consider using the following resources to support complex cases:

- Medical Mentoring for Addictions and Pain (MMAP)[vi]
- Project ECHO[vii]
- eConsult[viii]
- Toronto Academic Pain Medicine Institute (TAPMI)[ix]
- The Inter-professional Spine Assessment and Education Clinics (ISAEC)[x]

See a listing of resources in your LHIN
thewellhealth.ca/cncp

Patient Record and Treatment Plan

This table is designed to help providers document the 'agreed-on' plan that can be filed in a patient's chart and referred to during subsequent visits to follow up and continue discussion.

Name: ______________________ Date of Birth: ______________________

	Assessment				Treatment Plan (note frequency and duration of therapy; adverse reactions; adherence)				
Date	**Pain** *(BPI scores for 3 domains, 0-10)*	**Function** *(BPI score, 0-10)*	**General Activity** *(BPI score, 0-10)*	**Mood** *(PHQ-9 depression score, 0-20 or higher; GAD-7 anxiety score, 0-21)*	**Physical Activity** *(e.g., yoga, Tai chi, aqua therapy, pilates, physical activity)* ***Frequency*** ***Duration***	**Self-Management / Psychological Therapy** *(e.g., self-management program, CBT, MBI)* ***Frequency*** ***Duration***	**Non-opioid medications** • ***Regimen*** • ***Adverse Reactions*** • ***Adherence***	**Opioid medications** • ***Dosing*** • ***Adverse Effects (A/E)*** • ***Adherence*** • ***Aberrant Behaviours***	**Monitor & Follow-Up** *(e.g., include notes on time frame for follow-up and issues to discuss at next visit, etc.)*
Nov 8, 2016	*8* *7* *7*		*5 daily walks, ~5mins*	*6*	*Activity: Yoga* *Frequency: weekly* *Duration: 1hr*	*Therapy: n/a* *Frequency: n/a* *Duration: n/a*	*Naproxen* *Dosing: 220mg, twice daily* *A/E: none* *Adherence: patient takes medication daily*	*Dosing: n/a* *A/E: n/a* *Adherence: n/a* *Aberrant Behaviours: n/a*	*Follow up in 3-4 weeks*
					Activity: Frequency: Duration:	Therapy: Frequency: Duration:	Dosing: A/E: Adherence:	Dosing: A/E: Adherence: Aberrant Behaviours:	
					Activity: Frequency: Duration:	Therapy: Frequency: Duration:	Dosing: A/E: Adherence:	Dosing: A/E: Adherence: Aberrant Behaviours:	
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Referral
☐ Specialist ☐ Multi-disciplinary clinic ☐ Interventional procedure

Medications Trialled	Notes/Comments

Notes

Supporting Material*

[i] **Complex Regional Pain Syndrome (CRPS)**
Bruehl, S. Complex regional pain syndrome. BMJ. 2015;351.
http://rsds.org/wp-content/uploads/2014/12/CRPS-bruehl.pdf

[ii] **Brief Pain Inventory (BPI)**
http://nationalpaincentre.mcmaster.ca/documents/brief_pain_inventory.pdf

[iii] **PHQ-9**
http://www.ubcmood.ca/sad/PHQ-9.pdf

[iv] **GAD-7**
http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

[v] **Opioid Risk Tool**
http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b02.html

[vi] **Medical Mentoring for Addictions and Pain (MMAP)**
http://ocfp.on.ca/cpd/collaborative-networks/mmap

[vii] **Project ECHO**
http://www.echoontario.ca/Echo-Clinic/Chronic-Pain/Curriculum.aspx

[viii] **eConsult (OTN Hub)**
https://otnhub.ca/patient-care/

[ix] **Toronto Academic Pain Medicine Institute (TAPMI)**
http://www.womenscollegehospital.ca/Education-and-Training/tapmi

[x] **The Inter-professional Spine Assessment and Education Clinics (ISAEC)**
http://www.isaec.org/refer-to-isaec.html

Additional supporting materials and resources that may be useful for providers and patients:

Provider Resources

[xi] **CORE Neck and Headache tool**
https://thewellhealth.ca/neckheadpain/

[xii] **CORE Back Pain tool**
https://thewellhealth.ca/low-back-pain/

[xiii] **RxFiles Opioid Tapering template**
http://www.rxfiles.ca/rxfiles/uploads/documents/opioid-taper-template.pdf

[xiv] **CFP Family Physician Summary of Canadian Opioid Guidelines**
http://www.cfp.ca/content/57/11/1257.full.pdf+html

[xv] **SBIRT (Screening, Brief Intervention, and Referral to Treatment)**
http://www.samhsa.gov/sbirt

[xvi] **McMaster Health Sciences: Practice toolkit**
http://nationalpaincentre.mcmaster.ca/documents/practicetoolkit.pdf

[xvii] **College of Physicians and Surgeons of Ontario (CPSO). Practice Partner: When and how to taper opioids.**
https://www.cpso.on.ca/uploadedFiles/members/resources/Opioid-Tapering-Protocols_Dial-I_2012.pdf

[xix] **Centres for Disease Control. Pocket Guide: Tapering opioids for chronic pain.**
https://www.cdc.gov/drugoverdose/pdf/clinical_pocket_guide_tapering-a.pdf

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http://www.open-pharmacy-research.ca/evidence-based-deprescribing-algorithm-for-benzodiazepines/

[xxi] **RxFiles. Urine Drug Screening – Frequently Asked Questions.**
http://www.rxfiles.ca/rxfiles/uploads/documents/Urine-Drug-Screening-UDS-QandA.pdf

[xxii] **Opioid Risk: Urine Drug Testing Guide.**
https://www.nhms.org/sites/default/files/Pdfs/UrineDrugTestingguide.pdf

Patient Resources

[xxiii] **Centers for Disease Control and Prevention (CDC) - Prescription opioids: What you need to know**
http://www.cdc.gov/drugoverdose/pdf/aha-patient-opioid-factsheet-a.pdf

[xxiv] **McMaster University: Messages for patients taking opioids**
http://nationalpaincentre.mcmaster.ca/opioid/cgop_b_app_b04.html

[xxv] **The Pain Toolkit**
http://www.paintoolkit.org/resources/videos

[xxvi] **RNAO Fact sheets: Helping people manage their pain**
http://rnao.ca/bpg/guidelines/fact-sheets/helping-you-manage-your-pain

[xxvii] **Mike Evans - Best Advice for People Taking Opioid Medication**
http://www.evanshealthlab.com/opioids/

[xxviii] **The Arthritis Society of Canada: Managing Chronic Pain**
https://arthritis.ca/manage-arthritis/living-well-with-arthritis/managing-chronic-pain

[xxiv] **My Opioid Manager (Book and App)**
http://prc.canadianpaincoalition.ca/en/my_opioid_manager_book.html

[xxv] **Understanding Pain in less than 5 minutes, and what to do about it!**
https://www.youtube.com/watch?v=C_3phB93rvI

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https://www.ismp-canada.org/opioid_stewardship/

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http://prc.canadianpaincoalition.ca/en/

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http://www.cirpd.org/Webinars/Pages/Webinar.aspx?wbID=24

[xxxv] **Webinar - Yoga for people in pain (5 part series)**
http://www.cirpd.org/Webinars/Pages/Webinar.aspx?wbID=16

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https://moodgym.anu.edu.au/welcome

[xxxvii] **Canadian Mental Health Association (CMHA)**
http://cmha-yr.on.ca/

*These supporting materials are hosted by external organizations and as such, the accuracy and accessibility of their links are not guaranteed. CEP will make every effort to keep these links up to date.

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