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.\footnote{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.\footnote{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).

Section 1: Baseline and Ongoing Assessment

- Start with a thorough baseline assessment, which may need to be completed over more than one visit.\footnote{1}
  - Begin to develop a rapport with the patient to encourage trust and information sharing.

Management options

- Select non-pharmacological and/or pharmacological therapies.
  - Based on the assessment, identify treatments that you and your patient feel comfortable starting.

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.

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

<table>
<thead>
<tr>
<th>Assessment Parameter</th>
<th>Factors to consider&lt;br&gt;&lt;sup&gt;2,3,5&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain Condition</strong></td>
<td>□ Identify pain diagnoses, e.g., OA, FM or NP&lt;br&gt;□ If suspected Complex Regional Pain Syndrome (CRPS)&lt;sup&gt;i&lt;/sup&gt;, consider urgent referral&lt;br&gt;□ Assess biomedical yellow flags (see below)&lt;br&gt;□ Pain: Brief Pain Inventory (BPI)&lt;sup&gt;iii&lt;/sup&gt;&lt;br&gt;• Intensity&lt;br&gt;• Exacerbating and alleviating factors&lt;br&gt;• Character&lt;br&gt;• Systemic symptoms&lt;br&gt;• Duration&lt;br&gt;□ Past investigations/consultations&lt;br&gt;□ Response to current/past treatments (consider whether trial was long enough to evaluate efficacy/side effects)&lt;br&gt;□ Past medical history&lt;br&gt;□ Current medications (including prescription, non-prescription, and natural products)</td>
</tr>
<tr>
<td><strong>Functional and Social History</strong></td>
<td>□ Assess functional status and impairment (e.g., BPI)&lt;br&gt;□ Psychosocial history: living arrangements, family/social support, family obligations, work status, sleep, relationships&lt;br&gt;□ Assess social yellow flags (see table below)</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
<td>□ Current and past psychiatric history (e.g., depression PHQ-9&lt;sup&gt;iii&lt;/sup&gt;, anxiety GAD-7&lt;sup&gt;iii&lt;/sup&gt;, PTSD)&lt;br&gt;□ Family psychiatric history&lt;br&gt;□ Assess psychological yellow flags (see table below)</td>
</tr>
<tr>
<td><strong>Substance Use History &amp; Opioid Risk Assessment</strong></td>
<td>□ Review history of substance use, abuse, and addiction (start with family history then personal history):&lt;br&gt;□ Alcohol, cannabis, prescription medications, illicit drugs&lt;br&gt;□ Attendance at an addiction treatment program&lt;br&gt;□ 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&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Physical Examination</strong></td>
<td>□ Document relevant physical examination based on diagnosed pain condition(s)</td>
</tr>
</tbody>
</table>

#### YELLOW FLAGS<sup>1</sup>

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.<sup>7</sup>

### 2. Ongoing Assessment

<table>
<thead>
<tr>
<th>Assessment Elements</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Identify new pain, related symptoms or significant change</td>
<td>Physical examination as indicated</td>
</tr>
<tr>
<td>□ Adherence to treatment</td>
<td>n/a</td>
</tr>
<tr>
<td>□ Adverse event related to treatment</td>
<td>n/a</td>
</tr>
<tr>
<td>□ Treatment(s) effect on:&lt;br&gt;• Pain&lt;br&gt;• Function&lt;br&gt;• Quality of life&lt;br&gt;• Mood&lt;br&gt;• Social function</td>
<td>Assess and document using:&lt;br&gt;• Narrative assessment&lt;br&gt;• Validated tools (e.g., BPI)&lt;br&gt;Note: 30% improvement is meaningful for pain and function&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>□ Progress towards patient goals (SMART goals: Specific, Measurable, Agreed-upon, Realistic, Time-based)</td>
<td>Examples&lt;br&gt;• Taking walks/walking dog&lt;br&gt;• Attending family/social events&lt;br&gt;• Returning to part-time work&lt;br&gt;• Participating in recreational activities&lt;br&gt;See Table 3 below for list of behaviours</td>
</tr>
<tr>
<td>□ If on opioids, monitor for:&lt;br&gt;• Aberrant drug-related behaviours&lt;br&gt;• Clinical features of opioid use disorder (see below)&lt;br&gt;□ Use urine drug testing as indicated</td>
<td></td>
</tr>
<tr>
<td>□ In patients with current or past substance use disorder (SUD), monitor for destabilization of disease</td>
<td>Monitor for aberrant use of prescribed medications</td>
</tr>
</tbody>
</table>

### 3. Clinical Features of Opioid Use Disorder (OUD)<sup>6</sup>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altering the route of delivery</td>
<td>• Injecting, biting or crushing oral formulations</td>
</tr>
<tr>
<td>Accessing opioids from other sources</td>
<td>• Taking the drug from friends or relatives&lt;br&gt;• Purchasing the drug from the ‘street’&lt;br&gt;• Double-doctoring</td>
</tr>
<tr>
<td>Unsanctioned use</td>
<td>• Multiple unauthorized dose escalations&lt;br&gt;• Binge use rather than scheduled use</td>
</tr>
<tr>
<td>Drug seeking</td>
<td>• Recurrent prescription losses&lt;br&gt;• Aggressive complaining about the need for higher doses&lt;br&gt;• Harassing medical office staff for faxed scripts or ‘fit-in’ appointments&lt;br&gt;• Nothing else ‘works’</td>
</tr>
<tr>
<td>Repeated withdrawal symptoms</td>
<td>• Marked dysphoria, myalgia, GI symptoms, cravings</td>
</tr>
<tr>
<td>Accompanying conditions</td>
<td>• Currently addicted to alcohol, cocaine, cannabis, or other drugs&lt;br&gt;• Underlying mood or anxiety disorders are not responsive to treatment</td>
</tr>
<tr>
<td>Social features</td>
<td>• Deteriorating or poor social function&lt;br&gt;• Concern expressed by family members</td>
</tr>
<tr>
<td>Views on the opioid medication</td>
<td>• Sometimes acknowledges being addicted&lt;br&gt;• Strong resistance to tapering or switching opioids&lt;br&gt;• May admit to mood-leveling effect&lt;br&gt;• May acknowledge distressing withdrawal symptoms</td>
</tr>
</tbody>
</table>
Non-pharmacological treatments should be considered for all patients with CNCP. 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; however, even a smaller improvement may be meaningful to the patient.

Talking Points
If patients are reluctant to try physical activity/exercise therapy:
- Try the Elicit-Provide-Elicit technique

**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
  - 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
  - Minimal goal: 30 min of exercise 5 days a week
  - Add in other activities as tolerated

- **C) Evaluate**
  - Measure benefits at 8 or more weeks
  - Use BPI to evaluate effect on pain, function and quality of life

### Self-Management Programs
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
  - 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
  - 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

### 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:
    - 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

- **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
Non-opioid medications, in combination with non-pharmacological therapies, are the preferred treatment for CNCP. 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

### A) Initiate
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 antidepresants)
- Discuss potential side effects/risk (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.¹²
- 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
- 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
- Evaluate effects on pain, function, mood and set goals
- Use pain and function assessment scales:¹⁵
  - Brief Pain Inventory (BPI)¹²
- Consider trialling two or three drugs in succession from the same class if one is ineffective¹
- 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 drug¹ (see table on p6 for tapering instructions)

### Drug Table

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Drug</th>
<th>Pain types¹</th>
</tr>
</thead>
<tbody>
<tr>
<td>General</td>
<td>Acetaminophen</td>
<td>Osteoarthritis (hip or knee)</td>
</tr>
<tr>
<td>Nonsteroidal anti-inflammatory drugs (NSAIDs)</td>
<td></td>
<td>Low back pain</td>
</tr>
<tr>
<td>Anti-convulsants</td>
<td>Carbamazepine</td>
<td>1st-line for trigeminal neuralgia (may also be used for general neuropathic pain)</td>
</tr>
<tr>
<td></td>
<td>Gabapentin</td>
<td>Neuropathic pain</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Amitriptyline or gabapentin are usually the first choice)</td>
</tr>
<tr>
<td></td>
<td>Pregabalin</td>
<td>If amitriptyline or gabapentin are not effective/tolerated, pregabalin may be used as an alternative for neuropathic pain or fibromyalgia</td>
</tr>
<tr>
<td>Anti-depressants</td>
<td>Amitriptyline (nortriptiline or imipramine may be used if amitriptyline not effective)¹</td>
<td>Neuropathic pain (Amitriptyline or gabapentin are usually the first choice)</td>
</tr>
<tr>
<td></td>
<td>Duloxetine</td>
<td>Neuropathic pain due to diabetes, fibromyalgia, or osteoarthritis</td>
</tr>
<tr>
<td></td>
<td>Fluoxetine</td>
<td>Fibromyalgia</td>
</tr>
<tr>
<td>Topical</td>
<td>Topical NSAIDs</td>
<td>Musculoskeletal pain¹ and osteoarthritis¹⁷</td>
</tr>
<tr>
<td></td>
<td>Topical rubifacients</td>
<td>Musculoskeletal pain (if other drug treatments are not effective)</td>
</tr>
</tbody>
</table>

* Cannabinoids are not equivalent in effectiveness to anti-depressants or anti-convulsants¹⁸

Cannabinoid forms that can be considered for neuropathic pain:¹⁸
- Synthetic tetrahydrocannabinol (nabilone)
- Nabiximols
- Dried cannabis (vaporizer or edible product)
Section 4: Opioid Medications

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.

### 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 (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\(^6\) to gauge potential risk.\(^2,14\) 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.\(^2\)
- Titrates 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.\(^2,1\)
- 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

#### 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.\(^2,13,21\)
**Section 4: Opioid Medications**

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

**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.*

**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.

<table>
<thead>
<tr>
<th>Type of Referral</th>
<th>Consider when:*</th>
<th>Intervention Management:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to Psychological Therapy</td>
<td>• Patient has moderate to high levels of distress</td>
<td>• Interventional procedures can provide short-term relief of pain, though some interventions are associated with rare but significant adverse outcomes (e.g., stroke, death)</td>
</tr>
<tr>
<td></td>
<td>• Patient has difficulty adjusting to a life with pain</td>
<td>• Consider the following procedures for the specified conditions:</td>
</tr>
<tr>
<td></td>
<td>• Patient is struggling to change their behaviour and maintain normal activities</td>
<td>• Lumbar or cervical epidurals in hospital-based centres (e.g., spinal stenosis, discogenic pain +/- radicular pain)</td>
</tr>
<tr>
<td></td>
<td>• Referral to specialist pain service</td>
<td>• Facet joint injections, medial branch blocks (e.g., facet joint pain)</td>
</tr>
<tr>
<td>Referral to Pain Specialist Service</td>
<td>• Treatment failure after trial of 4 drugs for neuropathic pain</td>
<td>• Radiofrequency nerve ablation (e.g., facet and sacroiliac joint pain)</td>
</tr>
<tr>
<td>(may include interventional management)</td>
<td>• Opioid dose is greater than 90 MME</td>
<td>• Spinal cord stimulators (e.g., low back and associated limb-based pain in failed back surgery)</td>
</tr>
<tr>
<td></td>
<td>• Inadequate response to non-specialist management</td>
<td>• Trigger point injections (e.g., myofascial pain syndromes)</td>
</tr>
<tr>
<td>Multidisciplinary Pain Management Program</td>
<td>• Patient has poor functional capacity</td>
<td></td>
</tr>
<tr>
<td>Features:</td>
<td>• Patient has moderate to high levels of distress</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient has social and occupational problems related to pain</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient has failed to benefit from other, less comprehensive therapies</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Patient prefers self-management rather than a medical approach</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• If referring patient for CRPS, urgent consultation and management required</td>
<td></td>
</tr>
</tbody>
</table>

*Consider using the following resources to support complex cases:*
- Medical Mentoring for Addictions and Pain (MMAP)
- Project ECHO
- eConsult
- Toronto Academic Pain Medicine Institute (TAPMI) [ix]
- The Inter-professional Spine Assessment and Education Clinics (ISAEC)

*See a listing of resources in your LHN 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.

<table>
<thead>
<tr>
<th>Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

#### Assessment

**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.) |
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<tbody>
<tr>
<td>Nov 8, 2016</td>
<td>8</td>
<td>5 daily walks, ~5mins</td>
<td>6</td>
<td>Therapy: n/a</td>
<td>Frequency: n/a</td>
<td>Duration: n/a</td>
<td>Naproxen</td>
<td>Dosing: 220mg, twice daily</td>
<td>A/E: none</td>
<td>Adherence: patient takes medication daily</td>
<td>Dosing: n/a</td>
<td>A/E: n/a</td>
<td>Adherence: n/a</td>
<td>Aberrant Behaviours: n/a</td>
<td>Follow up in 3-4 weeks</td>
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<tr>
<td>Activity: Yoga</td>
<td>Frequency: weekly</td>
<td>Duration: 1hr</td>
<td>Therapy: n/a</td>
<td>Frequency: n/a</td>
<td>Duration: n/a</td>
<td>Dosing: n/a</td>
<td>A/E: n/a</td>
<td>Adherence: n/a</td>
<td>Aberrant Behaviours: n/a</td>
<td>Follow up in 3-4 weeks</td>
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#### Referral

- [ ] Specialist
- [ ] Multi-disciplinary clinic
- [ ] Interventional procedure

#### Medications Trialled

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#### Notes/Comments

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#### Notes

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Supporting Material*

[i] Complex Regional Pain Syndrome (CRPS)

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

[iii] PHQ-9

[iv] GAD-7

[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

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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

[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


https://www.nhms.org/sites/default/files/Pdfs/Urine-DrugTestingguide.pdf

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Patient Resources

[xxx] Centers for Disease Control and Prevention (CDC) - Prescription opioids: What you need to know

[xxxii] Mcmaster University: Messages for patients taking opioids
http://www.evanshealthlab.com/opioids/

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

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

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

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

[xxxvii] My Opioid Manager (Book and App)
http://prc.canadianpaincoalition.ca/en/myopioidmanagerbook.html

[xxxviii] Understanding Pain in less than 5 minutes, and what to do about it!
https://www.youtube.com/watch?v=C_3ph939rVj

[xxxix] Institute for Safe Medication Practices (ISMP) Canada Opioid Stewardship
https://www.ismp-canada.org/opioid_stewardship/

[xx] The Art of Pain Management

[xxi] Self-Management of Chronic Pain
http://www.cirpd.org/PainManagement/WhatIsChronicPain/Pages/Sealf-Management.aspx#selfmanage

[xxii] Webinar - Intro to Mindfulness for Chronic Pain (5 part series)
http://www.cirpd.org/Webinars/Pages/Webinar.aspx?wbID=27

[xxv] Webinar - Yoga for people in pain (5 part series)
http://www.cirpd.org/Webinars/Pages/Webinar.aspx?wbID=21

[xxvi] MoodGym - online CBT program
https://moodgym.anu.edu.au/welcome

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

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*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.
References


This Tool was developed as part of the Knowledge Translation in Primary Care Initiative, led by Centre for Effective Practice with collaboration from the Ontario College of Family Physicians and the Nurse Practitioners’ Association of Ontario. Clinical leadership for the development of the tool was provided by Dr. Arun Radhakrishnan, MSc, MD, CM CCFP and was subject to external review by health care providers and other relevant stakeholders. This Tool was funded by the Government of Ontario as part of the Knowledge Translation in Primary Care Initiative.

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