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Prescribing Practices Forum - Steps Towards a National Best-Practice in Prescribing Opioids

Presented by the Michael G. DeGroote National Pain Centre
in partnership with Health Canada
May 15, 2015

L to R: MP David Sweet, Dr. Trevor Theman, Registrar, College of Physicians and Surgeons of Alberta; Minister Ambrose; Dr. Michael Hamilton, Physician Lead and Medication Safety Specialist, Institute for Safe Medication Practices Canada; Dr. Norman Buckley, Director, Michael G. DeGroote National Pain Centre and Professor and Chair, Departmental Anesthesia, McMaster University.

The Problem – Norm Buckley, Director, Michael G. DeGroote National Pain Centre, McMaster University

- Prescription drug abuse is an issue of increasing concern in Canada. In recognition of this, Health Canada recently funded the Michael G. DeGroote National Pain Centre to update the *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*.
- This forum, funded by the Government of Canada and hosted by the Michael G. DeGroote National Pain Centre, brings together regulatory authorities, health professionals, provinces/ territories and experts to identify steps to improve prescribing practices, with the ultimate goal of reducing the abuse of prescription drugs.
- Representatives from medicine, nursing, dentistry, pharmacy, the Canadian Centre for Substance Abuse (CCSA), and the Federation of Medical Regulatory Authorities of Canada (FMRAC) are participating to inform those present on strategies that regulatory agencies are currently implementing to measure the extent of prescription drug abuse, and to mitigate this issue; as well as potential opportunities to share best-practices and to develop a strategies to address the problem.
- It is not acceptable that drugs that are meant to help people become the instruments of harm or injury. Sometimes this harm or injury is a result of:
  - Predictable adverse reactions and effects unknown to the prescriber and patient taking the drug.
  - Unanticipated reactions and effects to the drugs prescribed that end up causing harm.
  - Diversion of prescribed drugs that are sometimes stolen or are intentionally abused.
- We have come to realize that the resolution of prescription drug abuse is a complex problem. Part of the problem is that there is a lack of understanding of the problems related to pain and addiction. Prescription drug misuse can occur with great frequency when social issues are at play.
- Our goal is to bring people together to establish a common ground to implement a strategy that was developed over several years; *First Do No Harm* developed through the Canadian Centre on Substance Abuse.

First Do No Harm: A National Strategy for Prescription Drug Misuse – Robert Eves, Director, Strategic Partnerships and Knowledge Mobilization, Canadian Centre on Substance Abuse (CCSA)

- As Director of Strategic Partnerships and Knowledge Mobilization at the Canadian Centre on Substance Abuse (CCSA), Mr. Eves' portfolio is responsible for creating, building, sustaining, and leveraging effective partnerships to mobilize people, knowledge, and other resources for collective action and change towards shared goals.
- The CCSA was responsible for developing the *First Do No Harm* strategy along with a number of partners and stakeholders from across Canada.
- CCSA brings people together for the shared purpose of addressing issues related to substance abuse.

About CCSA

- CCSA has been working for over twenty-five years with stakeholders across the country to deal with the issue of substance abuse.
- CCSA is Canada's only national agency dedicated to reducing the harms of alcohol and other drugs on society.
- CCSA lives outside of the Ministry; it was created by an Act of Parliament in 1988 and has provided national leadership and advanced knowledge and solutions to address alcohol and other drug-related harms.
- They are uniquely positioned to work collaboratively with all levels of government, and the not-for-profit and private sectors, to make a difference in the lives of Canadians.

Why CCSA's Work Matters

- *Health*: CCSA sees the impact of substance abuse in many areas especially in health where it contributes 60+ diseases such as cancer, heart disease, diabetes, HIV/AIDS.
- *Economics*: Substance abuse costs over $40 billion per year in Canada.
- *Public Safety*: A significant factor in crime, as many as 80% of federal offenders have a history of substance abuse issues.
- Despite this, substance abuse is preventable and treatable, and recovery is a reality for many.

CCSA's National Priorities

- Prior to 2005, CCSA in partnership with Health Canada undertook a series of cross-Canada consultations where those close to the issue of substance abuse were asked "What should the priorities be for the field?"
- In 2005, collaboratively with Health Canada, CCSA released a National Framework for Action. In that framework, prescription drug misuse was identified as one of the top issues. What has taken time is the collective and political will to see action towards a solution.

Prescription Drugs in Canada: Misuse

- 4.8% of Canadians aged 15+ reported non-medical prescription opioid use during the past year (Shield et al., 2013).

Youth

- 2.8% of Canadian students in grades 7–12 reported past-year use of pain relievers to get high.
- Students in grade 12 had the highest rate of non-medical opioid use (16.1%) (Health Canada 2012–2013 Youth Smoking Survey).

First Nations (FN)

- 4.7% FN individuals 18+ living on-reserve or in northern FN communities reported past-year use of opioids without a prescription in 2008–2010 (FNIGC, 2012).
- 1.3% First Nations youth 12–17 reported using opioids without a prescription during the previous 12 months (ACHA, 2013).

Prescription Drugs in Canada: Harms

- Dramatic rise in opioid-related deaths in Ontario from 2004–2011 (Office of Chief Coroner, 2011).
- Rise in ER visit rates in Ontario for opioid-related mental and behavioural disorders from 2008–2009 & 2010–2011 (MOHLTC, 2012).
- In 2010, 12.1% of all deaths among those aged 25–34 years in Ontario was opioid-related; up from 5.5% in 2001 (Gomes et al., 2014).
- Rx opioid-related admissions to Ontario substance use treatment programs doubled from 2004–2009 (Fischer et al., 2010).
- Rx opioids identified as the presenting problem substance by:
  - 10.6% those seeking addiction treatment in Ontario (2005–2006)
  - 18.2% in Ontario (2012–2013) (CAMH, 2013).
- No national-level data is available for prescription drug-related mortality in Canada.

First Do No Harm: Responding to Canada's Prescription Drug Crisis

- In 2012, CCSA called on their stakeholders and partners from across the country to come together and talk about the Canada's prescription drug crisis.
- They knew that there were a lot of people already doing good work, who wanted to do something about this problem, but there was no national level initiative to take it on. CCSA got the initiative going and brought partners together. In March 2013, CCSA released the *First Do No Harm* strategy.
- Forty partners from across the country were represented; who were all willing to act collectively to move the initiative forward; it was Canada's first pan-Canadian strategy.
- The second year of a ten-year strategy (long-term vision) is now complete.
- The first pan-Canadian strategy included 58 recommendations across seven areas: Prevention, education, treatment, monitoring and surveillance, enforcement, legislation and regulations, evaluation and performance measurement.

FDNH and Prescribing Practices

- Work has begun on a number of the strategies and includes:
  - Core competencies for healthcare practitioners (HCPs)
  - Accredited HCP continuing education programming
  - Academic detailing programs
  - Clinical point-of-care, decision-support tools
  - Local and long-distance clinical networks that provide healthcare practitioners with prompt and easily accessible clinical advice and information (This rides throughout the strategy; there is a call for other professionals to have the ability to connect with one another to find out what advice they might get in helping to have better prescribing practices moving forward)
  - Revise healthcare practitioner curricula
  - Evidence-informed guidelines and policies for various clinical settings.
- Throughout the strategy there have been other recommendations that include:
  - Evidence-informed guidelines
  - Validated risk assessment tools
  - Policies that promote appropriate prescribing practices (including regulatory bodies).

- Identify and promote access to network of experts (this is within the education stream but this can run through all the seven streams).
- Establish prescription monitoring programs in all provinces and territories.
- Actively monitor and intervene with members as needed to reduce high-risk prescribing or dispensing practices, in collaboration with prescription monitoring programs.
- Prescribing practices are very strongly represented within the First Do No Harm strategy and this comes from the partners and stakeholders who worked on the strategy with us to make sure that it included the key components of how we were going to address the problem in the first place.

FDNH in Action

- Other great work is happening and CCSA try to make sure that this strategy group is linked into other work that is taking place and vice versa.
- These are other related initiatives:
    - A Federal/Provincial/Territorial working group on prescription drug abuse.
    - A Prescription Drug Abuse Coordinating Committee.
    - Expansion of National Anti-Drug Strategy (NADS) in Speech from the Throne (October 2013) to include prescription drugs.
    - House of Commons Standing Committee on Health (HESA): The role of government in prescription drug abuse in fall–winter 2013–2014 which contained very clear and actionable recommendations.
    - SOCI, Standing Committee on Social Affairs, Science and Technology: Prescription Pharmaceuticals in Canada: Unintended consequences (October 2014).
    - CCSA and Minister Ambrose co-hosted a symposium focused on prescribing.

Priority Projects for 2015-2016

- CCSA is looking to recalibrate their work and become more project-focused within their current limited budget.
- CCSA set aside a small pool of funds to seed a number of projects to move forward.
- A national advisory council meeting took place March 2015 looking at several projects. Of those projects, the following will move forward:
    - High-dose opioid prescribing limits
    - Prescription monitoring programs
    - Common Indicator Minimal Dataset
    - Prescriber risk scoring analysis and reviews
    - Access to buprenorphine in First Nations communities
    - Competencies and continuing education
    - Guidelines for death investigations
    - Overdose and overdose death prevention, including increased access to naloxone
- CCSA welcomes others to join in this work.
- This work is happening in collaboration with partners from across the country. On its own CCSA could not have accomplished a fraction of this work.

Q: What is the source of the statistics for deaths from opioid use?

A: The data was obtained from the Office of the Chief Coroner in 2011.

Q: What is the focus of the high-dose prescribing project?

A: It refers to "watchful dose" and widened risk potential, where limits should be set and what exceptions to the limits should be. 'High-dose' focusses on such things as the watchful dose where you know that you are widening the risk potential for patients after a certain limit. You need to know and understand where those limits should be and when exceptions can be made. This is not to say that we are limiting prescribers entirely; it is just that we have a space where physicians and prescribers can work in. After a limit they would be required to be careful of the watchful dose and be aware of what an exception is. Partially, this project helps to determine what the limits should be and what high dose actually means.

Q: What are your thoughts on the fentanyl patch return or patch exchange programs?

A: We have only just started to delve into this; although our research in the policy division has done a couple of alerts on fentanyl specifically, part of that was to look into our return programs actually showing the ability to tract the level of use. We do not have any actual data at this point to know if that is case, but we do know that there is a really good potential to know to a certain extent, if the patches are ending up in the right hands and if they are coming back. We do not have any data at this point to suggest that it has been an effective approach but on paper and in theory it seems like it should be a step in the right direction. This is one of those unknowns at this point.

Q: Accessing buprenorphine?

A: In Ontario now, there must be AFN approval. As part of CCSA's strategy partnership, CCSA is working with the Assembly of First Nations to ensure that the strategy works with their system of approvals and ensures access to buprenorphine.

Q: In the absence of a national data set, do you have a strategy to address the issue if we do not have a clear picture? Ontario is not same as British Columbia, how do we get better nationwide statistics?

A: CCSA undertook an international search for evidence to inform our current recommendations with evidence that supports each of the recommendations. A great deal of information is from the United States because they have more sophisticated monitoring. As to how we would get there *[in regards to getting a national data set]* is to ensure we have a very strong national surveillance system around prescription monitoring programs and that there are common data sets in order that data can be gathered across the country and compared; as data will not look the same in every jurisdiction. We can also look at all the other substances since we know that the data on those substances will not necessarily look the same in each jurisdiction either. Generally speaking, we will see certain levels of harms across the board and they may manifest slightly differently depending on the jurisdiction and what *[drugs]* are available there. This is being taken up and moving forward as a key priority by Health Canada as well as the strategy groups.

Q: How do we involve patients and consumers in education with respect to those living with the experience of using prescription drugs and the education of the individuals; and those patients' families and communities?

A: This lies within our education stream which is focused on the prescribing professionals and care practitioners. If you look at the prevention stream, it is focused on the communities, the individuals, and the families, making sure they are aware of what they are taking, how it can affect them, and the risks. One organization we are working with is the Institute for Safe Medication Practices (ISMP), and they have projects in this area. CCSA is going to be working collaboratively with them around educating patients and families about what they are taking and the risks associated with the drug(s) they have, in a very easy to understand language.

Q: Patient education should provide patients with information on risks, similar to heroin on first prescribing, and not prescribed without any warnings. Patient information should be accurate information that is industry free – the prescription monitoring program is too late. Multiple intervention points include at the point of prescription, or before the moment of decision; offering alternative routes in combination or separately.
A: We need multiple interventions points starting where the prescription may occur, and even before that. There is a lot of awareness raising that can be done with the public about certain substances one should be aware of; the same we would do with other substances that have a higher risk associated with them. Having this information is most effective at the moment of decision. We want to give patients and families some decision-making tools that allow them to decide on the path they want to take. For the time the drug is being prescribed, we also have in our strategy recommendations for alternate routes that can be offered in combination or completely separately. It is important that there should be multiple points of intervention.

Comment: '*My Opioid Manager'* is a patient resource, with apps for iPhone and android. The '*Opioid Manager'* can help with the point-of-care decision making and opioid monitoring.
http://www.opioidmanager.com/
http://nationalpaincentre.mcmaster.ca/opioidmanager/

Comment: It is important to mention that the National Opioid Guideline Group (NOUGG), which was created by the Federation of Medical Regulatory Authorities of Canada (FMRAC) who created the Canadian opioid guideline, put in place Working Groups. One of those working groups is a knowledge translation group for patients and the public which is led by two patient representatives, Lynn Cooper and Janice Sumpton from the Canadian Pain Coalition. They have worked on creating tools which can be disseminated in doctors' offices or in pharmacies to patients. These are also available on the National Pain Centre website: http://nationalpaincentre.mcmaster.ca/tools

Q: With regard to methadone maintenance programs, should physicians have required or mandated training in the proper use of methadone as an opioid replacement therapy?
A: Ideally, we would like to see the methadone usage in the curriculum as well as other replacement therapy approaches, from undergraduate medical curriculum to continuing medical education. We would like this knowledge to become a curriculum requirement and for there to be standards for all prescribers. This is a part the strategy. We need education and to know how these replacement drugs get into people's hands in the first place.

Comment: There is a lot of data but we need in order that people can take action on the issue being discussed today. We need to be aware that there is more than one variable to consider with these issues, such as the use of alcohol and another prescription drugs. Currently, we can see trends specific to location and where hotspots may be; possibly we can target issues where they are more prevalent. Embedded in the *First Do No Harm* strategy is to understand the issues surrounding the patient before prescribing opioids. We cannot treat each patient the same. Each patient has unique situations that may determine whether they should be prescribed opioids.

Q: How do we make coroner's data relevant to prescribers?
A: We need to target education to multiple variables and trends in "hot spots" and be able to have rapid responses. We need to distinguish between accidental versus intentional overdoses.

How can regulators use their Prescription Monitoring Programs (PMPs) (Saskatchewan) – Doug Spitzig, Pharmacist Manager, Prescription Review Program, College of Physicians and Surgeons of Saskatchewan

How Regulators Use the Prescription Monitoring Program

- The College of Physicians and Surgeons of Saskatchewan (CPSS) use an electronic Patient Information Program (PIP) available at point-of-care.
- The CPSS Prescription Review Program (PRP) monitors for inappropriate prescribing as legislated in bylaws of the CPSS. Drugs identified as having a potential for misuse are added to the database as agreed upon by stakeholders and the college.
- Sets requirements for prescribing and which drugs are included.
- The program is education-based and at arms-length from the regulatory aspects of the college. As it is still under the purview of the college there can be regulatory intervention when education fails; this is rarely needed however.
- The PRP provides education for prescribing practices and alerts prescribers to possible inappropriate usage, e.g. diversion, inappropriate prescribing, double-doctoring.
- Prescribers provide explanation of use including diagnosis and rationale for treatment.

Activities of Prescription Review Program (PRP)

- The PRP primarily provides education to encourage appropriate prescribing practices on current national standards and guidelines; collects information from prescribers and feeds information back to prescribers to help them decide if their behaviour is appropriate.
- This is supported by a de-identified peer-review and interview process, followed by regulatory intervention.
- The CPSS PRP works in collaboration with other agencies, professions, regulators and Health Canada so as not to duplicate work.
- Change is not always the same as a reduction in use; it could be a change in formulation.
- Alert prescribers to possible inappropriate usage of PRP drugs by patients.
- Alert prescribers to possible inappropriate prescribing of PRP drugs i.e. double-doctoring.

- Unsubstantiated reports of possible diversion or illicit use of PRP drugs.
- Require prescribers to provide explanations for their prescribing of PRP drugs including diagnosis, indications for use and medical rationale for prescribing.
- Double-doctoring, early refills on a consistent basis, L/T benzodiazepines.
- Inappropriate pain management according to the *Canadian Guideline for the Safe and Effective use of Opioids for Chronic Non-Cancer Pain.*
- PRP drugs contradicted by *Beers Criteria* for the elderly.
- Make recommendations to a prescriber with respect to prescribing PRP drugs according to current national standards, guidelines and best-practices. Continued inappropriate prescribing/use could result in: De-identified peer reviews → Interview process → regulatory intervention.
- The program has reviewed 400,000 patient profiles.

The program allows for the CPSS regulatory body to address prescription drug misuse collaboratively. The PRP started with twenty-five people and now have over 130 people and organizations:

- Other health professions such as pharmacy, dentistry, and nursing
- Other regulatory medical regulators
- Health Canada agencies – NIHB
- Saskatchewan Health
- Saskatchewan Justice – chief coroner's office
- Law enforcement
- First Nations organizations and communities
- Regional health authorities – methadone program.

CPSS through PRP participated on national initiatives and programs:

- Development of *Canadian Opioid Guideline*
- CCSA national drug strategy – *First Do No Harm*
- CCENDU – provincial coordinator
- Centre for Addiction and Mental Health (CAMH) – research prescribing development.
- Prescription drug misuse – research priority

Challenges:

- Cross border drug shopping
- Limited data, i.e. drug overdose deaths from coroner's office
- Benzo prescribing guidelines.

Q: An Ontario study showed a high degree of variability between lowest and highest opioid prescribers. Is this the same in Saskatchewan? Did the Prescription Monitoring Program help?

A: Yes it did help with regards to volume. Previously two people did 11% of the prescribing; this is no longer occurring. A clinically-based approach allows them to find commonalities, e.g. education; lack of knowledge among MDs on pain management, structured opioid treatment. Cluster 5 recommendations [*Managing opioid misuse and addiction in CNCP patients*] in the *Canadian Opioid Guideline* is one resource that much time is spent on. The problem of combination of benzos and opiates is that physicians do not know how to analyze results,

metabolism pathway charts. The program had to develop the trust of physicians. The PRP are not the 'drug cops' but are there to prevent harms. After all these years (since 2006) a rapport has developed. Calls are regularly received from law enforcement and the CPSS can take it up with the physicians if there is a risk for diversion.

Comment: A physician noted that she had previously worked in Regina and fully endorses the program. The program is remarkable, having the ability to obtain real-time information. She misses the program since moving to Ontario.

Prescription Monitoring Programs - Essential Elements, What is out there now? – Beth Sproule, Advanced Practice Pharmacist/Clinician Scientist, Centre for Addiction and Mental Health (CAMH)

- Prescription Monitoring Programs (PMPs) have an important role to play in promoting the safe use of controlled prescription drugs, to help reduce harms and to assist in reducing diversion.
- PMPs vary in models of administrative oversight, specific drugs targeted for monitoring, methods of data collection, types of interventions, and level of information sharing.
- Work is ongoing to determine the essential elements of an effective program, however several key features have be recommended, for example: including all prescription drugs that have been, or could be, associated with misuse and addiction; make up-to-date, full patient profiles available, confidentially, in real-time to clinicians at point-of-care; be proactive in intervening in potential problematic prescribing; standardizing data collection to facilitate cross jurisdictional monitoring, with robust safeguards to protect patient privacy; and evaluate the impact of the program to detect both intended and unintended consequences.
- In Canada, 10 provinces have or are in planning stages, or have features of PMPs. Each program is unique, and work is underway to share practices.
- There are still many research questions to be investigated to help identify best-practices to guide this work.
- For more information on PMP features, evidence and current Canadian PMPs, see the report "*Prescription Monitoring Programs in Canada: Best Practice and Program Review*" available on the Canadian Centre on Substance Abuse website: http://ccsa.ca/Resource%20Library/CCSA-Prescription-Monitoring-Programs-in-Canada-Report-2015-en.pdf.

Best Practices for PMPs:

1. Need to look at what drugs are being monitored. Are some being missed, e.g. benzos, tramadol? If only some drugs are monitored and not others then abuse shifts to the unmonitored drugs.
2. Data should be available in 'real-time'.
   a. Clinicians must have access to the patient record 'now' and also a 'mandate' to look at it and use the information therein to make clinical decisions.
   b. 'Alerts' feedback on inappropriate combinations of drugs must be 'instant'.
3. The PMP collects information, but what happens to the information? More information helps decision-making.

4. What criteria trigger alerts? What is questionable activity? What flags are used and how are the sensitivity and specificity of these set? What are efficient identifiers to describe outliers?
5. Cross-jurisdictional communication, e.g. across provincial lines. Standardize the collection of information to allow sharing among PMPs; must have robust data security/privacy.
6. Evidence for effectiveness/impact measurement. What works and what does not? A Florida study published May 2015 showed that PMP's have an impact.

Many provinces already have features of PMPs so we can now make great strides. Must focus on criteria for questionable activity, evaluation of specific aspects and be mindful of possible negative consequences such as shifts to other drugs or restricted access to medication.

Q: Are there any province not that are doing a lot well?
A: Saskatchewan is doing an excellent job, and Nova Scotia is doing a long of right things. Alberta is also doing a great deal and has a number of good reports.

Comment: Doug Spitzer acknowledged that there is a challenge with the Prescription Monitoring Program and cross-border drug shopping. There are also concerns around benzodiazepines; guidelines are needed.

Medical Regulators – How do they fit into the picture? Should guidelines be standard? – Trevor Theman MD FRCSC, Registrar, College of Physicians & Surgeons of Alberta

- As chair of FMRAC, Dr. Theman spoke from the regulatory community on behalf of the ten provincial Colleges of Physicians and Surgeons in Canada. Concrete actions for reducing harm from opioid abuse are needed while giving patients access to needed medication. This is largely about reducing the harm arising from the abuse of opioids and other drugs of abuse. There is a great deal of frustration around managing this problem.
- The view from Alberta is that by the time the problems begin to show up to regulators, it means regulations have failed; and to intervene on a bad prescriber it is too late. More upstream interventions are required. They should be multi-pronged with a multi-stakeholder approach, including regulators, professionals, governments, social services, police and training institutions.
- The limiting factor of PMP's is that while it may have a good impact, what if you don't have one?
- What is needed are:
    - PMPs in every province with real-time information. A recent 'data dump' on benzos in Alberta showed they are 1.6 times the volume of opioids
    - To remove privacy barriers to sharing information
    - To measure efforts
    - Resources for members (physicians) including education on maintaining boundaries with patients in psychic distress
    - Guideline on benzos
    - Encouraging government to take action.

- We need to recognize the broader goals to the patients and public we serve. We want patients to receive medications that help them; that have evidence to support their use in treating disease and disability, including the management of chronic pain. We want patients to receive proper management of painful conditions including the use of non-pharmacologic therapies when proper to do so. We want patients who do suffer from addiction to be able to access treatment for their addiction, including access to methadone and buprenorphine. And we want patients who are 'suffering' to be able to access the necessary social supports.
- We have a role to play in ensuring that our physicians prescribe correctly, thoughtfully, and where evidence supports, the use of pharmaceuticals.
- We can intervene with the bad prescriber but by then it is late, patients have been mistreated (some for extended periods of time) and the physician is likely rather entrenched in his/her prescribing habits. As regulators we are rather far downstream; we need more upstream interventions and efforts to reduce the number of poor prescribers we currently see.
- To do so requires a multi-pronged, multi-stakeholder approach.
- Medical Regulatory Authorities can identify high risk prescribers and we can intervene, with the expectation of at least some success. The *Improve* program in Manitoba makes this point, and this is supported by experience in British Columbia, Alberta, Saskatchewan and Quebec. We need to recognize, however, that those jurisdictions can intervene because they have a provincial Prescription Monitoring Program. Unfortunately this is not true for all Canadian jurisdictions, We ALL need better access to better data. This means we need:
    - A PMP in every province with real-time information about all medications with abuse potential (and maybe all medications).
    - Information from police, coroners/medical examiners, pharmacists, poison control etc.
    - Surveillance data (from governments and addiction facilities, etc.).
- We also all need to understand better what works and what does not. That means we have to be willing to measure what we are each doing, and to report on our success or failure.
- We need resources for our members - and, indeed, all health professionals - including information about their practices, education and coaching at all stages of their careers:
    - Especially education on maintaining boundaries
    - How to manage psychic distress, social problems, demanding patients, and mental health issues
    - More evidence-informed guidelines (such as the National Opioid Use Guidelines), e.g. for benzodiazepines.
- We need to reduce privacy barriers so we can share patient and provider-specific information:
    - Between agencies
    - Across borders (e.g. PMPs sharing information across provincial/territorial borders)
    - Between professions
- Dr. Theman is encouraged that the Federal Minister of Health and the provincial/territorial deputy ministers see this as a big problem because it is a big problem. None of us are going to fix it by ourselves, therefore let us make use of the talent, initiative and authority we have to commit to actions that will help address the problem of prescription drug abuse.

Q: Does FMRAC set the standards or does each college set their own opioid standards?
A: FMRAC is a federation, a voice, it has no authority. The question of who set the standards for appropriate prescribing was the reason behind the development of the 2010 *Canadian Guideline for Safe and Effective Use of Opioids for Chronic Non-Cancer Pain*. Exceptions to the recommendations are a challenge to regulators; with disagreement on the expert opinion, one needs to look at individual problems.

Comment: Jeanette Smith (CADTH) reported that CADTH is finalizing an environmental scan of measures and policies due to be released in June. The report will be publicly posted on the CADTH website.
https://www.cadth.ca

Pharmacy Regulators – What is their role? – Anne Resnick, BScPhm, Deputy Registrar, Ontario College of Pharmacy

Role of the Pharmacy Regulator: Assure safe high quality patient care by optimizing practice.

- The pharmacy 'business' (both practitioners and owners or managers) is 'Standards of Practice', recognizing that these are minimum expectations. As a regulator our business is to 'move the mountain' of practice so that more are practicing at a level higher than the usual statistical curve.
- There is a need to change the culture of the pharmacy profession from following orders (filling a prescription as directed) to making rational, evidence-based and defensible decisions in the best interest of the patient. Also, to advocate for systemic change such as electronic systems which will improve patient and public health, and internal change such as use of technology and human resources (regulated technicians) to enable maximal scope of practice.
- Regulators balance a tightrope of specificity of language in legislation so that good practitioners will optimize the health and wellness of their patients, while dangerous/suboptimal practice is recognized and remediated or prevented. The pharmacy regulators job is to identify the latter; the balance must be to risk prevention and proactive harm reduction.
- Their aim to get out of the way of good practitioners while staying conscious of the need for prohibitions, tough messaging, challenge of assumptions.
- The Regulator must demonstrate collaborative, outcome based, patient-centred decision making; several examples of working with partners:
  - Patch-for-Patch (P4P) Fentanyl pilot project has brought together law enforcement, multiple regulators, provincial and local associations.
  - National entry to practice competencies, standards of practice and software management systems.

Stretch Goal:

- Interdisciplinary team assessments (model of methadone assessment in Ontario).

Challenges:

- Legislative change which is out of pharmacy regulators control; electronic access to patient records which is not available; however, practitioners and regulators must always make decisions in the best interest of the patient.
- Challenge of evaluating impact and effectiveness; need for better data and more partners.

Nursing- how are they approaching the situation? – Josette Roussel, RN, MSc, MEd, Senior Nurse Advisor, Practice and Policy, Canadian Nurses Association

- The Canadian Nurses Association (CNA) is the national professional voice for more than 135,000 registered nurses from across the country.
- Registered nurses (RNs) and nurse practitioners' (NPs) priority above all else, is his or her patient's health and well-being. RNs and NPs are present throughout the system, delivering care at the community level, in institutions and in patient's home. They are actively involved in hospitals, clinics, community health centers, senior's centers, nursing stations, and reserves, among others.
- From their experiences in communities and various health-care settings across the country, nurses know full well that prescription drug abuse is a public health and safety issue across Canada.
- Overdoses, family breakdowns, blood-borne infections, drug-related violence and death; are all very real consequences of the issue. However, prescription drugs are necessary for many Canadians and can have important positive effects in their lives. The problem is not a simple one, nor is the solution.
- Prescription drug abuse is a topic that the nursing profession has focused on and the association has had opportunities to bring forth the nursing perspective. CNA endorsed the recommendations of the *First Do No Harm* report from the National Advisory Council on Prescription Drug Misuse and participated in national discussions on prescription drug abuse.

Relapse Rates of Addiction

- One of the issues raised by nurses when it comes to prescription drug abuse is the high relapse rates of addiction treatment programs. Nurses have reported that individuals often need to go through withdrawal and treatment multiple times. Assistance for individuals who relapse must be built into treatment; and access to support programs in the continuum of care is needed as early as possible. Some of the programs or services for prescription drug abuse are not available to a client at the time they really need it. There are significant wait lists for many of these services. Nurses indicate the importance of early detection and referral and the availability of community based programs.
- Examples of services that would be ideal at the community level are: access to supervised injection sites, methadone treatment, outreach workers or needle exchange services. These services also offer a point-of-contact between health care providers and people who use drugs.

Adequate Pain Relief

- Nurses are reporting that the treatment of pain needs to be addressed adequately within the health care system, given it is one of the reasons people will seek prescription drugs in the first place. There are many dimensions related to pain relief, including fear of addiction, unaddressed acute pain that becomes chronic, multiple physical and emotional dimensions, and the need of a team approach and early intervention to prevent addiction. This past year CNA offered its members educational webinars that explored pain assessment and management and what nurses should know in their practice. These are among CNA's most popular webinars.

Promotion of Good Mental Health

- Nurses bring the importance of promoting good mental health throughout the lifespan of a patient or client. Focusing efforts earlier in life is seen as an effective and sustainable way to move towards achieving a healthier population.
- Early childhood intervention program: Examples of such programs nurse led, in-home individual parent training program for first time, at risk parents and their infants exist and demonstrate lasting positive outcomes for both mother and child, improving the short term psychological health of mothers, helping reduce depression, anxiety or stress, improving self-esteem and relationship.

Social Determinates of Health

- Due to the complexity of prescription drug abuse, multifaceted preventive approaches must be developed and implemented. Nurses believe in putting a particular emphasis on prevention and on paying greater attention to the social determinants of health, such as employment and income, food security, education, early childhood development and life skills as a priority. Having a solid foundation in one's life can create some stability; that is a foundational step toward prevention of becoming addicted to prescription drugs.
- Nurses understand very well the concept and value of harm-reduction. Nurses believe that harm reduction, including supervised injection, really is an essential tool in a comprehensive health-care strategy for substance use and addiction. A harm reduction approach supports the delivery of care in a supportive, non-judgemental environment. This approach is closely linked with much needed health and social services, as well as addictions counselling and treatment services. At Vancouver's supervised injection site, *Insite*, has resulted in a 30 per cent increase in the use of detox and long-term addiction treatments. As one element in a comprehensive drug strategy that includes prevention, treatment and enforcement, harm reduction services are essential to addressing the issue of addictions.

Nurse Practitioners and Their Role in Prescribing Drugs

- Nurse practitioners and registered nurses with advanced education and experience are authorized to prescribe medications and certain controlled drugs and substances as defined by the Controlled Drugs and Substances Act. This new authority is progressing at the jurisdictional level and education programs have been developed to prepare NPs for this authority. These programs delivered by universities include: education about provincial and federal regulations related to narcotics and controlled substances; standardized approaches to the assessment of clients for whom narcotics may be prescribed; and evidence-based (Canadian Guidelines for prescribing), systemic approaches and tools for the prescription of narcotics and controlled substances; comprehensive, effective therapeutic treatment

and management options for nurse prescribers, including non-pharmacological alternative modalities; multidisciplinary approaches to care related to clients on narcotics and controlled substances; and addiction, drug tolerance, drug -seeking behavior and drug tapering.

- NP students are rigorously examined to ensure safety to practice in areas of prescribing. Educators worked with both Colleges of Physicians and Pharmacists.
- These programs are important and ensure NPs have the knowledge, skills and abilities for prescribing. Some nurse practitioners are reporting that there is a sense of "anxiety" for prescribing narcotics not by the practitioners but by their employer.
- There have been some reports from NPs of inappropriate prescribing practices. One example is that NPs are seeing "more issues with prescription of antibiotics" and "high number of medications in seniors" in the long-term care sector. The importance of prescribing guidelines and ongoing education has been raised by nurse practitioners.
- Everyone today has a role to play in promoting a healthy Canada - health-care providers, governments, employers, regulators and Canadians. The problem of prescription drug abuse and dependence is a very real one. It is imperative we start working together to advance healthy public policy and to implement strategies at multiple levels of the system to tackle the issues that contribute to prescription drug abuse and dependence.

Comment: In general, there is a lot of anxiety around prescribing opioids. This contributes to the long waiting lists that we see when there are prescribers who will not prescribe pain medication. One-third of pain clinic patients are stable and ready to be discharged to family practice but have no family doctor willing to prescribe opioids due to the anxiety around prescribing. A minimum expected prescribing standard needs to be established.

Template for Action – Norm Buckley

- Dr. Buckley has been involved in the problem of prescription drug abuse since 2010. Since that time he has attended several meetings where law enforcement officers were present who spoke of this same problem – prescribed medications abuse. Other meetings took place with Public Safety Canada and Health Canada and then with the Canadian Centre on Substance Abuse (CCSA). The CCSA took the lead in taking a strategy forward as they had a unique collaborative role with many different groups.
- It was found that a lot of disrupted societies had disproportionately larger issues with drug misuse and drug diversion.
- Examples of solutions were found to be collaborative, ones where law enforcement work with communities (e.g. RCMP working with Elders in Alberta, Elders provided stability in the community; Nova Scotia developed a local plan that brought the entire community together (physicians, law enforcement, pharmacists, emergency doctors) and said what should happen going forward and applied the principles of the *Canadian Opioid Guideline*. They reported good results of much less prescribing, no apparent clinical issues, and patients reporting that they are still being cared for properly).

- It seemed to us in Hamilton that part of the process was that a coherent local strategy to deal with this problem of drug misuse and diversion needed to be developed; in addition to having an overarching national strategy, provincial regulations, and formulary regulations, all which support best practice care. We brought together, with the support of CIHR, a group of people to identify the problem and later on, discuss solutions. There was representation from law enforcement, medicine, First Nations, pharmacists, Ministry of Health, etc. Together we created the *Template for Action*. http://nationalpaincentre.mcmaster.ca/tools.html
- The *Template for Action* is a list of things that each of these groups (physicians, law enforcement, etc.) can do to help with the drug misuse and diversion problem.
- More rapid dissemination of information is needed in regards to what the problems are and what is locally important about drug misuse and diversion.
- The *Template for Action* requires further dissemination, and we need to see how each group should report problems and who each group delivers information to when problems arise.

Q: Where does the role of private and public insurers fit into the template?
A: We would group them in with the Community group. The community group is divided into the three groups (Business, Community Groups, and Schools/Public Health). The Workplace Safety and Insurance Board (WSIB) have a proactive approach in prescribing in many areas and they use guidelines including the *Canadian Opioid Guideline*. Private insurers have used the guideline to some extent. When the guideline first came out requests were received from insurers asking to explain certain parts of the guideline and we responded. Dr. Jason Busse has done a great deal of research with disability insurers, and that is a group we are trying to engage in this process because, at least from the pain standpoint, disability insurers have a huge interest in identifying what is appropriate and optimal care for pain.

Comment: With respect to chronic pain, accessibility and availability of non-pharmacological management can reduce and sometimes even eliminate the necessity for strong opioids or opioids all together.

Response: If we agreed on what constituted best-practice then Ministries could reasonably support other treatments as best-practice. We need to look at the alternatives before starting opioids; what are the best-practices before (e.g. graded activity, core muscle strengthening, anti-inflammatory drugs). A diagnosis must first be made - pain is not a diagnosis. The condition causing the pain must be treated.

Q: In the *Template for Action* under "Government/Narcotics Monitoring Program", the third point is "Make Naloxone available"; can you elaborate on that, and where would you like this to be heading?
A: The current situation is that Naloxone is not widely available. The importance of Naloxone is that it can be used as a rescue measure for people on high dose opioids or with addiction and it can temporize during an early overdose, which would give you time to call first responders. With respect to how can we make Naloxone available; Public Health departments are making it available through programs for patients with identified addiction. Negotiations are underway with Ministries of Health, certainly in Ontario and other provinces, about how to make it available, in what settings, and the appropriate mode of delivery (e.g. preloaded epi-pen or ampules for injection).

Remarks - Honourable Rona Ambrose, Federal Minister of Health

- The Honourable Rona Ambrose, Minister of Health, attended the Prescribing Practices Forum marking an important milestone in the federal government's efforts to work closely with partners to tackle prescription drug abuse.
- The Minister underscored the Government's commitment to fighting prescription drug abuse by announcing federal funding in the amount of nearly $8 million to support 6 projects focused on improving prescriber education and the development of a coordinated national approach for the monitoring and surveillance of prescription drugs. Some of the projects include:
  - McMaster University to update *Canadian Guideline for Safe and Effective Use of Opioids for Non-Cancer Pain* and develop e-tools for prescribers
  - University of Waterloo for developing and implementing a collaborative, web-based education program focused on adherence to opioid guidelines targeting physicians, pharmacists and students in medicine and pharmacy.
  - Canadian Association of Schools of Nursing for developing skills and knowledge competencies and creating electronic teaching resources for nurse practitioners with prescribing rights.
- Prescription drug abuse is a significant public health and safety concern in North America. Drugs like opioids, sedative-hypnotics and stimulants are legal when properly prescribed and have proven therapeutic benefits. However, when prescription drugs are over-prescribed, misused or abused, they also have a high potential for harm such as addiction, withdrawal, injury, and death.
- The Prescribing Practices Forum is one of several ways the Government is supporting initiatives to combat prescription drug abuse. Recent investments include $13.5 million over five years to improve addictions prevention and treatment services for First Nations living on-reserve, and through the Canadian Institutes of Health Research (CIHR) the national research network has expanded aimed at improving the health of Canadians living with substance abuse to include prescription drug abuse.
- Statistics about opioid use, including a 2013 Ontario survey, report that 70% of youths abusing opioids got the drugs at home.
- The Minister acknowledged there are challenges in developing Prescription Monitoring Programs posed by information "silos". To address this, the government has allocated $5 million towards the goal of developing a pan-Canadian PMP, and asking CIHI to create standards and indicators for national PMP data.
- A national approach to prescription drug abuse in First Nations communities will focus on crisis intervention teams that will receive $13 million.
- The Minister acknowledged the world-class Michael G. DeGroote National Pain Centre and the *Canadian Opioid Guideline*, and thanked those present for their leadership which is making a huge difference in tackling this problem, including CCSA and their ongoing projects. She thanked everyone present for their leadership and attention to this public health issue.

Dental prescribing guidelines; what do they say? – David Mock, DDS, PhD, FRCD(C), Professor Emeritus, Oral Pathology/Oral Medicine & Dean Emeritus, Faculty of Dentistry, University of Toronto

- Recognizing that:
    1. The management of pain is an important component of dental practice,
    2. Dentists and dental specialists are significant prescribers of analgesics including opioids (in one US study, 12% of immediate release opioids were prescribed by dentists).
    3. The Royal College of Dental Surgeons of Ontario (RCDSO) struck a working group to develop *Guidelines on the Role of Opioids in the Management of Acute and Chronic Pain in Dental Practice*.
- In addition to the RCDSO team, the working group included members from the College of Physicians and Surgeons of Ontario and the Ontario College of Pharmacists.
- Since acute and postoperative pain is the most common concern of dentists in practice, the document details very specific recommendations for prescription regimes for each of mild, moderate and severe pain including dosages and numbers of tablets prescribed, criteria and cautions regarding repeats.
- The value of non-pharmacological treatment as well as non-opioid analgesics is emphasized but not at the expense of inadequate pain control.
- There is appropriate latitude for clinical judgement on a case-by-case basis.
- This includes an algorithm for the management of acute pain taking the reader through the process when considering the prescription of analgesics, considering the existing or expected level of pain the patient will encounter.
- In the chapter on the management of chronic pain, consideration is separated into those cases of primary orofacial pain versus those of pain disorders originating outside the orofacial complex or as part of a generalized pain disorder.
- Consultation and collaboration with other health care professionals is encouraged, including the primary health care practitioner, particularly when dealing with pain originating outside the orofacial complex.
- The guidelines include advice on assessing risk and dealing with problematic drug-related behaviour.
- Patient education on use, storage and disposal of medication is also discussed.
- Dentists and dental specialists are advised to consult and collaborate with other appropriate health-care practitioners when dealing with high risk patients, including what they might do if inter-professional support is not readily available as is often the case outside of major population centres.
- Appropriate and secure prescription writing practice is reviewed and emphasized.
- Practices for safeguarding drugs stored in a dental office are discussed, including monitoring use and staff education.
- It is expected that the guidelines will be available by the end of 2015 once Royal College approval has been obtained. The guidelines will then be circulated to all members of the RCDSO.

Provincial formulary decisions - How prescriptive should they be? What is their role and goal? - Christine Seager, BScPhm, Senior Manager, Drug Benefits Management, Ontario Public Drug Programs (OPDP), Ministry of Health and Long Term Care

- The goals of the Ontario Public Drug Program (OPDP) have expanded from providing drug coverage to a broader set of five pillars:
    - Improving patient access to medication
    - Ensuring better value for money
    - Promoting appropriate use of medications
    - Investing in innovative health system research / rewarding innovation
    - Strengthening the transparency and accountability in the public drug system.
- Traditionally, provincial drug plans have simply provided coverage for prescription drugs for eligible recipients, such as seniors and people receiving social assistance.
- The Ontario Public Drug Programs provides drug coverage to approximately 30% of Ontario residents (3.8 million eligible recipients). In general, drugs are funded on the Ontario Drug Benefit Formulary or under the Exceptional Access Program (EAP).
- In Ontario, the drugs funded under the Ontario Drug Benefit program are listed as for any typical formulary including open-listed and restricted access drugs.
- Drugs funded on the ODB formulary as “open benefits” may also have “Therapeutic Notes”. “Therapeutic Notes” provide guidance to prescribers on where the product can be used in the most cost-effective manner as advised by the ministry’s expert advisory committee, the CED. Therapeutic notes define appropriate therapy; and therefore, the *expectation* is that both prescribers and dispensers should follow them.
- The second category of drugs on the ODB formulary is “Limited Use” (LU) benefits. Criteria are applied to certain drugs to limit use in specific situations, durations, or for use only after other drugs have been tried first. The “Limited Use” mechanism is an “honour” system. It is a passive restrictive mechanism.
- Most provincial drug plans also use enforced restrictions such as the Exceptional Access Program in Ontario, where the prescriber is required to provide a patient-specific request, often in writing, regarding justification for the use of the drug in question.
- Formulary restrictions are used either to encourage evidence-based prescribing or to contain costs.
- Significant advances in science and medicine have resulted in many drugs becoming available to better manage and treat many diseases. However, at the same time, it is accompanied by the challenges of ensuring the drugs are used appropriately. In the case of opioids, this has been particularly challenging. Balancing access and appropriate utilization is not an easy task.

Ontario Experience with Long-Acting Oxycodone

- Ontario’s experience with the transition from OxyContin to OxyNEO will help to illustrate the impact of formulary restrictions.
- OxyContin was listed on the ODB Formulary around 2000 as a Limited Use benefit, *“For the treatment of chronic pain in patients who cannot tolerate, or have failed treatment with another listed long-acting opioid.”* This was likely primarily a cost-containment decision, intended to allow reimbursement after long-acting morphine. An analysis of ODB claims data showed that the majority of OxyContin

prescribing did not appear to comply with the criteria; 88% of recipients had no prior LA opioid claims; 23% had no prior opioid at all. Similarly, for fentanyl patches which have similar reimbursement criteria, 60% of recipients had no prior LA opioid claims, while 16% of ODB recipients on fentanyl patches had no prior opioid use at all.

- This appears to demonstrate that not only were the LU criteria being ignored by prescribers, the use of fentanyl patches in opioid-naïve patients demonstrates inappropriate prescribing, noting that fentanyl is only indicated and recommended in guidelines as a second-line agent.
- With the transition to OxyNEO, it was decided to reimburse under the EAP with similar criteria as OxyContin, after an adequate trial of at least one other listed long-acting opioid product. The higher 60 mg and 80 mg strengths are not reimbursed, noting that when dosed twice daily it would be close to or exceed the "watchful dose" of 200 mg/day MED recommended in the *Canadian Opioid Guideline*. Each and every request was responded to with a letter that included the rationale for the restricted listing of OxyNEO and references to opioid prescribing guidelines (i.e. *Canadian Opioid Guideline*).
- Restricted access to OxyNEO under the EAP reduced the number of ODB recipients of LA oxycodone by 80%.
- However, the restricted listing of OxyNEO resulted in many prior OxyContin users switching to other less-restricted long-acting and short-acting opioids with the largest increases seen in the utilization of hydromorphone. The <u>overall</u> number of opioid recipients remained essentially unchanged.
- Also, despite the lack of funding of the 60 mg and 80 mg tablets, the related communications and reference to guidelines, there was no impact on high dose prescribing of OxyNEO.
  - Over 40% of OxyNEO recipients received prescriptions exceeding 200 mg MED compared to approximately 13% of recipients of other LA opioids.
  - Based on ODB claims data, the calculated mean dose of OxyNEO exceeded 200 mg MED. This was double the calculated mean MED for other LA opioids.
- Understanding the issues surrounding opioid utilization, abuse and diversion, the Ontario government introduced new regulatory requirements that long acting oxycodone drug products must have abuse deterrent properties to be considered for public funding.

<u>Conclusions and Next Steps in Formulary Restrictions</u>

- Where do we go from here? The Ontario experience with OxyNEO shows that the current passive listing strategies in place intended to influence prescribing or to promote appropriate or cost-effective utilization are largely ineffective while the EAP is considered obstructive and a barrier to patient care, and it is a time-consuming and labour intensive mechanism to scrutinize every request to ensure that the drug is being prescribed according to certain criteria. Even though the restrictive reimbursement process such as EAP could change utilization patterns, it may not necessarily have a positive impact on appropriate use of a drug. Restrictive formulary mechanisms are generally blunt tools. These mechanisms should ideally be combined with other strategies in a multi prong approach, for example:
  - Promoting guidelines and education – what mechanisms can be considered to encourage physicians to prescribe according to published treatment guidelines? How can these be worked into listing or reimbursement criteria? Can the funding of drugs be restricted only to physicians who have completed certain training or educational programs? We know that other jurisdictions such as Washington State have used legislation to enforce standards of practice relating to pain management that all primary care physicians must follow and document.

- Use of prescriber agreements – an agreement or contract with individual prescribers who agree to prescribe certain drugs according to established criteria in order to obtain coverage. For example, British Columbia has a prescribing agreement for Suboxone where it is funded; only the prescriber signs an agreement stating that they will prescribe Suboxone according to the criteria. Could a similar strategy by considered for certain opioid products to exempt prescribers for EAP or LU restrictions?

- To achieve the best balance between access to these medications for patients who legitimately need them for pain management and the prevention of harm and abuse from opioids, collaboration of all the partners in the health-care system is needed.
- Provincial drug plan managers, prescribers and regulatory colleges work together on:
  - Appropriate prescribing working groups
  - Must be done in conjunction with other initiatives such as PMPs, prescriber feedback, educational initiatives (e.g. academic detailing), improved access to addiction and mental health services, etc.

Q: Given the high percentage of prescriptions that are not consistent with the recommendations, what are the barriers that cause this disconnect between recommendations and reality?
A: We don't know why there is such poor compliance with the criteria.

Q: Have you had an opportunity to drill down to learn what the barriers are?
A: Not yet, it is an honor system.

Guidelines – Should they be standards? – Norm Buckley

- Should guidelines become standards is an important issue. Presently, guidelines are suggestions for best-practice. If a prescriber does not have all the information he/she cannot make a good decision.
- The concept of a standard is a legal concept in Tort law meaning that the degree of prudence and caution that should be applied by a reasonable physician is actionable. Should guidelines be more prescriptive; that is, should they be standards for the degree of prudence and caution that should be applied by a reasonable physician?
- In some clinical areas, no expert opinion is needed to distinguish between a guideline and a standard. For example, in anesthesia the presence of the anesthetist is required during delivery of anesthetic and there is no circumstance that the absence will be allowed.
- For appropriate dosage questions, the need for rigorous analytic thought such as that (the late) Dr. David Sackett brought to medicine was apparent to the committee who drafted the first *Canadian Opioid Guideline*.
- The initial recommendations were reviewed by 85 representatives from many disciplines, and used by FMRAC and NOUGG to draft the set of 24 specific recommendations that were agreed upon by 80% of the reviewers.
- The difficult part is deciding what we do in the update process.

Discussion – Concrete actions and next steps for take away

- Dr. Theman noted that standards of practice in Alberta may be prosecuted against. The challenge in the clinical setting is creating non-exceptional standards for what a reasonable physician would do. Education is the most reasonable approach. Managing patient expectations and boundaries is important; physicians need to learn how to manage patients.
- There is poor teaching around chronic pain in undergraduate and postgraduate training programs. We need to teach this topic and guideline recommendations in a more meaningful way before making them standards.
- One participant disagreed with the above statement. The pain specialists ECHO project in Ontario uses mentoring to teach primary care providers how to care for chronic pain patients. The impression is that physicians want standards and boundaries to use as arguments to say "no" to patients and felt that if you make guidelines standards, the best-practices will follow.
- The *Canadian Opioid Guideline* recommendations have guided the CPSO counsel and peer assessors. Although education is lacking it has become a guide; they are becoming standards. The Dental College may find this true over time.
- Guidelines are important to have when matters are not black and white. Education on managing pain is important. Physicians need to use their judgement and document their thinking process.
- The scope of the guideline should be broadened. If we do not identify the problem correctly, our guideline will be lacking. The guideline is important for patients in pain; but is it when the patient is having a problem? We should focus not just on abuse, but also on prevention.
- Lack of education is not due to a lack of courses. There are a number of courses available; however people are not taking them – is it because they are not mandatory? What more can we do on the education side?
- A survey (2010) conducted by Dr. Judy Watt-Watson found that less than 20 hours of undergraduate medical curriculum are devoted to acute or chronic pain. That has changed somewhat; the University of Toronto now has a two-week pain program with an inter-professional context. Western University has added training for residents; now they have close to 80 hours. A project undertaken at McMaster University by Anesthesia residents identified 17 hours of pain education in the undergraduate curriculum. McMaster's problem-based curriculum is harder to analyze by topic but it is perhaps also more responsive and easier to change. It is not good, but it is getting better.
- Nursing is now integrating pain into their program curriculum.
- CPSO is addressing the need to change practice patterns via preceptorships. They have found that teaching works better with mentorship/preceptorships for chronic pain, addiction and mental health.
- Guideline implementation is a challenging issue – if people are not using the guideline it will not be effective. We cannot simply tell someone who is not using it to start; and until we understand this there will be a huge gap. How do we move it more into practice? We have heard that 83% of prescribers are not following guidelines, why the gap between evidence and practice? As Dr. David Sackett once said, "Evidence alone is never enough, we need to build in values and preferences and navigate barriers to implementation".

- The 83% statistics number may show a need to survey professionals about why they do what they do. The Quebec Community Fund Initiative Project will support education and will survey professionals in Quebec.
- Public Health follows the guideline recommendations, but how does a general practitioner manage his/her knowledge base? Some health departments develop a one-pager to help their prescribers.
- Methadone prescribers must follow a combination of standards and guidelines. If the prescriber can explain why they have deviated from the standards that is acceptable.
- Environmental barriers and how far people need to travel must be taken into consideration.
- A blend of standards and guidelines makes sense and should be created for ease of application, not to create barriers. Obtaining endorsement for the 24 recommendations in the 2010 guideline was difficult. Physicians were afraid that the recommendations would become standards. The recommendation that almost did not get endorsed was that for urine drug screening. Physicians stated that they have no way to perform the screening. As a result the final recommendation has weak wording (i.e. “if you do UDS, do it right” as opposed to “if you prescribe opioid you must do UDS”).

Concrete Actions and Next Steps

Q: An important point repeatedly raised is that prescribers need access to information at the point-of-care. Point-of-care information will be through the Prescription Monitoring Program (PMP). There are isolated Prescription Monitoring Program’s (PMP’s) across the country. With respect to point of care information and PMPs, we need to connect people together.
A: Beth Sproule (CAMH) knows a great deal about Prescription Monitoring Programs. Another individual to connect with is Jeannette Smith (CADTH). Jeannette can talk to drug plan managers who have the PMPs for the public formularies and connect them to these managers.

Comment: We need to look at what can be done ethically, legally, and physically with data being mined *[the Prescription Monitoring Data from PMPs and the Pharma net data]* to get a better idea of where we are right now. Then as guidelines and standards roll out, we can evaluate if they are changing practice since we will then have evidence from the data collected through PMPs and Pharma net. Also, it must be decided from the outset what will be measured in order that we have evidence of that change.

Comment: Barbara Moran noted that Health Canada’s intention is to get jurisdictions that do not already have PMP’s, to put them in place. There is a need to figure out what PMP’s collect and who do they share that information with. We must get around any provincial barriers.

Q: Is there anything the Formulary Office can do, but might not have thought of already? Or something you are already doing that we should know about?
A: Glenn McAuley (MOHTLC) reported that they have some draft recommendations -- how can we get physicians to think about what they are doing before they write their first prescription? For example, when using a passive approach by sending letters to individual physicians that applied for OxyNEO, we said to

please refer to the *Canadian Opioid Guideline*. We ended up seeing an increase in the average Oxycodone dose that was prescribed. These letters had little impact on paying attention to guidelines. We need a blend of passive/restrictive methods that encourages physicians to follow guidelines before they write that first prescription. Right now, we can only do this with Ontario Drug Benefit (ODB) recipients. We need to get physicians to document what they do before they write that first prescription and every time the patient comes back to see the physician. We may need to go back and see what other groups can do to enforce some documentation before writing that prescription and other things we would like to see for reimbursement purposes. This needs to come forth more academically and not from government.

Comment: We need more effective dissemination of best-practice tools. Andrea Furlan (UHN) would be an appropriate individual to connect with as she has created educational tools for opioid use.

Comment: We need to clarify how prescription monitoring programs (PMPs) are structured. We have created a network that has representation from governments and our intention is to first try to get jurisdictions that don't have PMPs and to put them into place. We are trying to work with them by mentoring them and helping them identify what some of the best-practices are around a PMP. We also let the jurisdictions know what we think are the best PMPs. We need to know what information these PMPs collect and who gets to see information from PMPs. Privacy barriers need to be taken into consideration.

Q: What does the Canadian Institute for Health Information (CIHI) know about PMP's?
A: CIHI has been asked to work with the provinces/territories, and stakeholders to understand what information is being a collected and what new data to collect. The goal is enhancing the quality of comparable data in the prescription drug abuse area.

Q: What is the probability of getting the diagnosis of pain into CIHI somewhere?
A: Mike Gaucher noted that CIHI has some information but not at the level detail necessary. Most data is related to International Classification of Diseases (ICDs). Chronic pain does not exist as ICD-9 or ICD-10 code.

Comment: Beth Sproule noted that in the *First Do No Harm* strategy there is a monitoring and surveillance implementation team and there is some confusion between a PMP and a national surveillance system. PMP's are a collection of prescription data and are just one part of the problem. A national surveillance programs is broader in scope in that it is information we need about what is actually happening with this problem more broadly and the indicators (e.g. coroner's data, rates of seeking treatment). They are currently conducting research about best practices for PMPs.

Comment: 'Radars' (http://radars.org) is a great system in the United States that we should have in Canada:

- Radars is a surveillance system that connects people by geographic area. When there is a signal in a geographical area such as occurrence of diversion of drugs such as opioids or opioid related deaths above a certain threshold, a team is sent to that region to understand what is going on and to intervene.
- In some specific areas it reduced abuse, diversion, and deaths related to opioid prescribing immensely.
- The program has approximately six different reports.

- The program requires funding. Radars is funded through pharmaceutical companies. Subscriptions keep the program going. By having the subscriptions, companies can get information on their specific product, which meets some of the requirements they have for FDA.
- Radars has been looking to get some form of the program going in Canada, however there has not yet been enough interest. They do have some programs going on in Canada; they started with trying to connect poison centres and some coroner's work, and there is an online survey that is going to be launched soon. There are some pieces in Canada that shows trends.

Comment: In terms of the drug formulary, Minister Ambrose reminded us that we write more prescriptions per capita than any other country in the world; the question becomes "Why?" We also fund more prescriptions for drugs where there is a risk for abuse than any other country in the world. When we talk about best-practices of what might help the government, we were talking about the need for modalities other than opioids to manage chronic non-cancer pain. If we are trying to work in collaboration, it may be wise for our formularies to say that we cannot indefinitely write prescriptions for the next ten years for this patient, but ask about "What else are you doing, and are you looking at a tapering management program over time, etc.?" It is easy to keep writing prescriptions and it is harder to start thinking about other modalities besides the prescription that is automatically paid for by the government.

Comment: Some of the optimal care is not funded by the current health care system in many provinces and that also creates an issue. This is a point of ongoing discussion. There has been a discussion about allocating money in Ontario for multidisciplinary chronic pain care including physiotherapy, counselling, reactivation, etc. This idea lives in different places in different provinces.

Q: Are there any particular takeaways the people at the Institute of Safe Medical Practice (ISMP) have or people you have met that are useful to your mission, or for whose mission you are useful? The ISMP work complements very strongly with what has been talked about today.
A: Mike Hamilton (ISMP), stated that they are one of groups that have been funded as part of the National Anti-Drug Strategy. They are tasked with coming up with ways to make it easier for clinicians to stay within the guidelines. For instance, making sure that the prescription monitoring data gets to the physician at the right time when they are with their patient and are able to use that information. They have also been tasked to make sure that a lot of the work that is done at ISMP gets to the physician when they need it. As a clinician, it is hard using an Electronic Medical Record (EMR) to get the data needed to assist in making the right decision, and knowing what to ask to get an idea of for how long the drugs should be prescribed and the monitoring that is needed. Much information is there but one needs to close one program to access another for the information. We have these tools, these EMRs, and so what functional specifications are needed to get the data to the physician or to the prescriber when the patient is right there. ISMP may need to develop a small tool or a couple of them with a vendor to implement it within the EMR and explore how that works to improve point of care access to information. If anyone has a good idea as to where we can get the information needed when you are about to prescribe something, please connect with ISMP.

Comment: Norm Buckley noted that Dr. Dale Gunter, Department of Family Medicine at McMaster has been working the last two years with OSCAR (http://oscar-emr.com/) which is an Open Source Computer Assisted Record (OSCAR). Their goal has been to create a computer decisions support system which will assist in the

management of chronic pain and direct people towards optimal therapy. It is being rolled out now in the beta testing phase.

Comment: Andrea Furlan, University Health Network, has received funding to create a self-assessment program for physicians prescribing opioids. The program is a knowledge test where physicians can test themselves according to the guideline recommendations and see what they know and identify their own knowledge gaps. A second tool/program they will develop is a practice assessment tool. It is similar to the methadone checklist that physicians must do every year to determine if your practice is conducive and safe for prescribing methadone. Andrea will be developing the same practice assessment tool for physicians prescribing opioids for chronic non-cancer pain.

Comment: The National Pain Centre is initiating the update/revision process of the *Canadian Opioid Guideline*. If there is anything that people would like to see represented in the update that is currently not there, or something requiring more detail, this is your opportunity to let us know and/or participate in the process. Send an email to npc@mcmaster.ca and let us know what you would like to see in the updated guideline.

Comment: Kate Smolina noted that Washington State has worked with multiple stakeholders and seen wonderful results around reduced harms and in a number of metrics that indicate improvements in the situation. Everyone had to be at the table and do their part; and a big change was realized; it is a great model. (A comprehensive approach to address the prescription opioid epidemic in Washington State: milestones and lessons learned**.** Franklin G, et al. Am. J. Public Health 2015 Mar; 105(3):463-9. PMID: 25602880).

Comment: The challenge faced when developing the education piece was that we were starting with the premise that you, the prescriber, are thinking about starting opioids. This is a problem because this is not typically where the patient starts; the patient starts with chronic pain. Somehow we have to incorporate that beginning piece in order that the physician or prescriber does not say opioids are needed straightaway for chronic pain. This piece needs to be added to the guideline.

Comment: Ramesh Zacharias reported that today we have 100% more drivers on the road than in the 1980's, yet the death rate is 50% less. This happened by bringing everyone together (education, insurance, automobile manufactures, regulators, licensing, etc.) redesigning roads, creating graduated licenses, etc. We need to learn from that lesson and take a similar approach in resolving this problem.

Comment: A big problem is the diffusion of responsibility; all stakeholders must work together on this problem to fix it.

Closing Remarks

- Dr. Buckley asked everyone to make the connections with other people initiated today; begin collaborations and tasks working together to resolve the issues around prescription drug abuse.
- Thanks were extended to Health Canada for the funding to update the Canadian Opioid Guideline and sponsor the Prescribing Practices Forum.

Forum Participants	Organization
Speakers	
Ambrose, Rona	Honourable Federal Health Minister
Buckley, Norm	Director, Michael G. DeGroote National Pain Centre, McMaster University
Eves, Robert	Director, Strategic Partnerships, Canadian Centre on Substance Abuse
Mock, David	Faculty of Dentistry, University of Toronto
Resnik, Anne	Ontario College of Pharmacists
Roussell, Josette	Canadian Nurses Association
Seager, Christine	Manager, Drug Benefits Management, MOHTLC
Spitzig, Doug	Pharmacist Manager, Prescription Review Program, CPSS
Sproule, Beth	Centre for Addiction and Mental Health (Prescription Monitoring Programs)
Theman, Trevor	College of Physicians and Surgeons of Alberta
Participants	
Auger, Chris	Ontario Provincial Police
Blake-Evans, Linda	Hamilton Public Health Services
Borg Debono, Victoria	Michael G. DeGroote National Pain Centre, McMaster University
Brasch, Jennifer	Physician, St. Joseph's Hospital, Hamilton
Busse, Jason	Michael G. DeGroote National Pain Centre, McMaster University
Carol, Angela	College of Physicians and Surgeons of Ontario
Champagne, Pierre	Responsible du Programme de suivi administratif, Collège des médecins du Québec
Chan, Winnie	Senior Pharmacist, MOHLTC
Chang, Feng	School of Pharmacy, University of Waterloo
Choy, Herman	ISMP Canada
Couban, Rachel	Michael G. DeGroote National Pain Centre, McMaster University
Epworth, Candace	ISMP Canada
Furlan, Andrea	Toronto Rehab - University Health Network
Gahimbare, Eméry	Senior Program manager, Health Canada
Gardner, Michael	Royal College of Dental Surgeons of Ontario
Gaucher, Michael	Director Pharmaceuticals & Health Workforce Information Services, Canadian Institute for Health Information
Gerace, Rocco	Registrar, College of Physicians & Surgeons of Ontario
Giudace-Tompson, Ada	Advocates for Reform of Prescription Opioids
Goshua, Anna	Michael G. DeGroote National Pain Centre, McMaster University
Hamilton, Michael	Institute for Safe Medication Practices Canada
Hatcher, Lydia	Family Medicine, St. Joseph's Hospital, Hamilton
Hickey, Jim	College of Physicians & Surgeons of Newfoundland & Labrador
Kaushal, Alka	Michael G. DeGroote National Pain Centre, McMaster University
Kluz, Agnes	Physician
Lefebvre, Fleur-Ange	FMRAC
Mahon, Benjamin	Communications and Public Affairs Branch, Health Canada
Makosso Kallyth, Sun	Michael G. DeGroote National Pain Centre, McMaster University
McAuley, Glenn	Lead Pharmacist, EAP Liason & Policy, MOHLTC
Moran, Barbara	Health Canada
Mulla, Sohail	Michael G. DeGroote National Pain Centre, McMaster University
Murphy, Laura	Department of Pharmacy Services, University Health Network, Toronto
Nelson, Mary	Pharmacist, Burlington Family Health Team
Osmond, Jamie	Associate Registrar, College of Physicians & Surgeons of Newfoundland & Labrador
Pierce, Susan	Manager, Pharmacy Policy Development Division, First Nations & Inuit Health Branch, Health Canada
Rehman, Yasir	Michael G. DeGroote National Pain Centre, McMaster University
Sajan, Paul	Manager, Prescription Drug Abuse Program, Canadian Institute for Health Information
Shantharam, Yalnee	Toronto Rehab - University Health Network
Shaw, Karen	Registrar, College of Physicians & Surgeons of Saskatchewan
Smolina, Kate	Population & Health, UBC
Stewart-Patterson, Ivanka	Centre de recherche et d'aide pour narcomanes, Montreal, QC
Tomlinson, Dale	Michael G. DeGroote National Pain Centre, McMaster University
Ulan, Susan	College of Physicians & Surgeons of Alberta
Wang, Li	Michael G. DeGroote National Pain Centre, McMaster University
Weinberg, Erica	Rouge Valley Health System, Scarborough, ON
Zacharias, Ramesh	Medical Director, CPMU, HHS
Ziomek, Anna	Registrar, College of Physicians & Surgeons Manitoba