Quality Standards

Opioid Use Disorder

Care for People 16 Years of Age and Older

Health Quality Ontario

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Health Quality Ontario

Summary

This quality standard addresses care for people 16 years of age and older (including those who are pregnant) who have or are suspected of having opioid use disorder. The scope of this quality standard applies to all services and care settings, including long-term care homes, mental health settings, remote nursing stations, and correctional facilities, in all geographic regions of the province.

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About Quality Standards

Health Quality Ontario, in collaboration with clinical experts, people with lived experience, and caregivers across the province, is developing quality standards for Ontario.

Quality standards are concise sets of statements that will:

- Help people and their families to know what to ask for in their care
- Help care providers know what care they should be offering, based on evidence and expert consensus
- Help health care organizations measure, assess, and improve their performance in caring for people

The statements in this quality standard do not override the responsibility of care providers to make decisions with individuals, after considering each person's unique circumstances.

How to Use Quality Standards

Quality standards inform care providers and organizations about what high-quality health care looks like for aspects of care that have been deemed a priority for quality improvement in the province. They are based on the best available evidence.

They also include indicators to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps and areas for improvement. These indicators measure processes, structures, and outcomes.

In addition, tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard.

For more information on how to use quality standards, contact **qualitystandards@hqontario.ca**.

About This Quality Standard

Scope of This Quality Standard

This quality standard focuses on care for people 16 years of age and older (including those who are pregnant) who have or are suspected of having opioid use disorder. The scope of the standard covers all services and settings, including nursing homes, mental health settings, remote nursing stations, and correctional facilities, in all geographic regions of the province.

While the scope of this quality standard includes adolescents aged 16 and 17 years and people who are pregnant, it should be noted that the statements in this standard are based on guidelines whose evidence is derived primarily from studies conducted on adult (aged 18 years and older), nonpregnant populations with moderate to severe opioid use disorder. Health Quality Ontario's Opioid Use Disorder Quality Standard Advisory Committee members agreed that the guidance in this quality standard is also relevant and applicable to people with opioid use disorder who are 16 and 17 years of age and to people who are pregnant. However, care providers should take into account that specialized skills and expertise may be required when providing treatment for special populations, including youth with opioid use disorder, those who use opioids intermittently or on a nondaily basis, and those with opioid use disorder who are pregnant. If treatment of these or other special populations is beyond a care provider's expertise, the provider should consult or work with a care provider with appropriate expertise.

This quality standard includes 11 quality statements and 1 emerging practice statement addressing areas identified by Health Quality Ontario's Opioid Use Disorder Quality Standard Advisory Committee as having high potential for improving the quality of care in Ontario for people with opioid use disorder.

Terminology Used in This Quality Standard

In this quality standard, "family" refers to family members, friends, or supportive people not necessarily related to the person with opioid use disorder. The person with opioid use disorder must give appropriate consent to share personal information, including medical information, with their family.

The term "care provider" is used to acknowledge the wide variety of providers that can be involved in the care of people with opioid use disorder. The term includes both regulated health care professionals, such as nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, social workers, and speech-language pathologists, and unregulated health care providers, such as peer support workers and volunteer providers. Our choice to use "care provider" does not diminish or negate other terms that a person may prefer.

"Opioid use disorder" is defined as "a problematic pattern of opioid use leading to clinically significant impairment or distress, occurring within a 12-month period." The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) describes 11 symptoms of opioid use disorder.

The term "diagnosis" refers to the use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) by physicians, psychologists, or nurse practitioners to determine if someone has opioid use disorder. Formal diagnosis is a requirement for initiating opioid agonist therapy; however, formal diagnosis is not, and should not be, a requirement to access other services. People often seek help for an addiction on the basis of self-identification, or a need for care may be identified by a care provider who administers assessments but who cannot formally diagnose a substance use disorder. Therefore, this quality standard uses the term "identified" to refer to situations in which a person has been assessed as having suspected opioid use disorder but has not received a formal diagnosis.

"Opioid agonist therapy" is defined as the provision of an opioid agonist (typically a long-acting formulation) as part of a treatment program. Opioid agonist therapy eliminates the cycle of intoxication and withdrawal, reduces opioid cravings, and blocks the effect of other opioids. People with opioid use disorder who are stabilized on opioid agonist therapy are considered to be in recovery and typically experience a significant improvement in health and social function. They would have uncomfortable symptoms if they were suddenly to discontinue opioid agonist therapy, but they are no longer considered to have an active substance use disorder. In Ontario, opioid agonist therapy must be prescribed by a physician or nurse practitioner.

Why This Quality Standard Is Needed

People with opioid use disorder have a mortality rate more than 10 times that of the general population.[1] Fatal overdoses are a significant cause of mortality for people with opioid use disorder, and the rate of fatal overdoses has been rising rapidly in Ontario. According to statistics from the Office of the Chief Coroner for Ontario, the rate of opioid overdose–related deaths increased by 285% between 1991 and 2015.[2] Opioids have become one of the leading causes of death among younger adults in Ontario: In 2010, nearly 1 in every 8 deaths among 25- to 34-year-olds was related to opioid use.[3] Opioids also disproportionately affect those involved with the justice system: 1 in every 10 drug overdose deaths in adults occurs within 1 year of release from a correctional facility.[4] In addition to the high risk of overdose, people with opioid use disorder are also at higher risk for death from a variety of other causes, including cardiovascular conditions and infectious diseases.[1]

There are many opportunities to improve health outcomes and the quality of care for Ontarians with opioid use disorder. Many people with opioid use disorder report being unable to access the care they need.[5] There are also regional variations in the availability of opioid agonist therapy—the first-line treatment for opioid use disorder—with significantly less provision in rural and remote locations than in urban centres.[6] Some treatment facilities also prohibit the use of this evidence-based therapy: Roughly 1 in 4 residential addiction treatment programs in Ontario do not allow people to take opioid agonist therapy while participating in their programs (ConnexOntario.ca, May 2017).

Even when people are able to access opioid agonist therapy in Ontario, they do not always receive evidence-based care for other health needs. For example, people receiving methadone therapy in Ontario are significantly less likely to be screened for cervical, breast, and colorectal cancer, and those with diabetes are less likely to receive diabetes monitoring than the general population.[7]

There is an urgent need to address the opioid crisis in Ontario, and a crucial part of achieving this goal is addressing gaps in the quality of care for people with opioid use disorder across the province. Based on evidence and expert consensus, the 11 quality statements that make up this quality standard provide guidance on high-quality care for opioid use disorder, with accompanying indicators to help care providers and organizations monitor and improve the quality of care they provide.

In addition to this quality standard, Health Quality Ontario has developed two further quality standards related to opioids: *Opioid Prescribing for Acute Pain* and *Opioid Prescribing for Chronic Pain*.

Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect and equity.

People with opioid use disorder should receive services that are respectful of their rights and dignity and that promote shared decision-making. They should be given the same care and be treated with the same degree of respect and privacy as any other person.

People with opioid use disorder should be provided services that are respectful of their gender, sexual orientation, socioeconomic status, housing, age, background (including self-identified cultural, linguistic, ethnic, and religious backgrounds), and disability. Equitable access to the health system also includes access to culturally safe care. Language, a basic tool for communication, is an essential part of safe care and needs to be considered throughout a person's health care journey. For example, in predominantly Anglophone settings, services should be actively offered in French and other languages.

Care providers should be aware of the historical context of the lives of Canada's Indigenous peoples and be sensitive to the impacts of intergenerational trauma and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities.

Although not completely understood, addiction appears to be associated with psychological and social factors, particularly adverse childhood experiences such as neglect and abuse.

Care for people with opioid use disorder should be guided by a trauma-informed approach. With this approach, it is not necessary for the person to disclose their trauma; rather, this approach acknowledges how common trauma is among people who use substances and seeks to connect those interested in treatment with appropriate trauma services.

People with opioid use disorder benefit from care provided by a care provider or care team with the knowledge, skill, and judgment to provide evidence-based treatment for opioid use disorder while also receiving care that addresses all of their primary health care needs.

A high-quality health system is one that provides appropriate access, experience, and outcomes for everyone in Ontario no matter where they live, what they have, or who they are.

How Success Can Be Measured

The Opioid Use Disorder Quality Standard Advisory Committee identified a small number of overarching goals for this quality standard. These have been mapped to indicators that may be used to assess quality of care provincially and locally.

How Success Can Be Measured Provincially

- Rate of opioid-related deaths
- Urgent hospital use:
  - Rate of opioid-related emergency department visits
  - Rate of opioid-related hospital admissions
- Percentage of primary care providers (family physicians and primary care nurse practitioners) who have prescribed opioid agonist therapy in the last year
- Percentage of community pharmacies providing opioid agonist therapy services in the past year

How Success Can Be Measured Locally

You may want to assess the quality of care you provide to people with opioid use disorder. You may also want to monitor your own quality improvement efforts. It may be possible to do this using your own clinical records, or you might need to collect additional data. We recommend the following list of potential indicators, some of which cannot be measured provincially using currently available data sources:

- Percentage of people receiving treatment for opioid use disorder who reported improved quality of life
- Percentage of people receiving treatment for opioid use disorder who reported improved functional outcomes, including the following:
  - Return to work and/or work retention
  - Social functioning
  - Physical functioning
- 12-month treatment retention rate for people treated for opioid use disorder

In addition, each quality statement within this quality standard is accompanied by one or more indicators. These indicators are intended to guide the measurement of quality improvement efforts related to the implementation of the statement.

Quality Statements in Brief

QUALITY STATEMENT 1:
Identifying and Diagnosing Opioid Use Disorder

People at risk of opioid use disorder are asked about their opioid use and are further assessed, as appropriate.

QUALITY STATEMENT 2:
Comprehensive Assessment and Collaborative Care Plan

People diagnosed with or identified as having opioid use disorder have a comprehensive assessment and a care plan developed in collaboration with their care providers.

QUALITY STATEMENT 3:
Addressing Physical Health, Mental Health, Additional Addiction Treatment Needs, and Social Needs

People with opioid use disorder have integrated, concurrent, culturally safe management of their physical health, mental health, additional addiction treatment needs, and social needs.

QUALITY STATEMENT 4:
Information to Participate in Care

People with opioid use disorder are provided with information to enable them to participate in their care. If their family is involved, they are also provided with this information.

QUALITY STATEMENT 5:
Opioid Agonist Therapy as First-Line Treatment

People with opioid use disorder are informed that treatment that includes opioid agonist therapy is safer and more effective than treatments that do not include opioid agonist therapy.

QUALITY STATEMENT 6:
Access to Opioid Agonist Therapy

People diagnosed with or identified as having opioid use disorder have access to opioid agonist therapy as soon as possible, within a maximum of 3 days.

QUALITY STATEMENT 7:
Treatment of Opioid Withdrawal Symptoms

People with opioid use disorder who are in moderate or severe withdrawal from opioids are offered relief of their symptoms with buprenorphine/naloxone within 2 hours.

QUALITY STATEMENT 8:
Access to Take-Home Naloxone and to Overdose Education

People with opioid use disorder and their families have immediate access to take-home naloxone and to overdose education.

QUALITY STATEMENT 9:
Tapering Off of Opioid Agonist Therapy

People who have achieved sustained stability on opioid agonist therapy who wish to taper off are supported in a collaborative slow taper if clinically appropriate.

QUALITY STATEMENT 10:
Concurrent Mental Health Disorders

People with opioid use disorder who also have a mental health disorder are offered concurrent treatment for their mental health disorder.

QUALITY STATEMENT 11:
Harm Reduction

People who use opioids have same-day access to harm reduction services. A comprehensive harm reduction approach includes education, safe supplies, infectious disease testing, vaccinations, appropriate referrals, and supervised consumption services.

1

Identifying and Diagnosing Opioid Use Disorder

People at risk of opioid use disorder are asked about their opioid use and are further assessed, as appropriate.

Background

There is no evidence supporting universal screening for opioid use disorder.[8] However, people with selected characteristics that put them at higher risk for opioid use disorder (see definition) should be asked, with sensitivity and respect, about their opioid use.[8] If a person states that they are using opioids, their care provider should engage them in a discussion regarding the type of opioid they are using, the method of administration, the frequency of administration, and the quantity of opioids they use.[8] If it is possible that a person's opioid use is causing them significant impairment or distress, the person should be assessed for opioid use disorder via the most current *Diagnostic and Statistical Manual of Mental Disorders* criteria.[9]

Source: National Institute for Health and Care Excellence, 2008[8]

What This Quality Statement Means

For People With Opioid Use Disorder

If you or your care provider are worried that opioids are having a negative impact on your life, the first step is to talk with your care provider about your opioid use. These opioids might be ones you are using recreationally or ones that were prescribed to you. Your care provider should ask you how you take opioids, how often you take them, and what amount you are taking. Your care provider should not judge you and should treat you with care and respect. The purpose of this conversation is to help you get better, not to get you in trouble.

For Care Providers

People at risk of opioid use disorder should be screened and, if necessary, provided with a more thorough assessment for a possible diagnosis of opioid use disorder.

For Health Services

Systems and resources should be in place to allow care providers to screen all those at risk of opioid use disorder.

Quality Indicators

Process Indicator

Percentage of people at risk of opioid use disorder who are asked about their opioid use

- Denominator: total number of people identified as having a characteristic that puts them at risk of opioid use disorder (see definition)
- Numerator: number of people in the denominator who are asked about their opioid use (type of opioid they are using, method of administration, frequency of administration, and quantity being used)
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

People at risk of opioid use disorder

Characteristics that put people at higher risk for opioid use disorder and that suggest they may be candidates for screening include the following:

- Receive care in or have a history of involvement with the criminal justice system
- Receive care in a mental health setting
- Have been prescribed long-term opioid therapy for chronic pain (see the quality standard *Opioid Prescribing for Chronic Pain*)
- Present with symptoms that suggest the possibility of opioid use disorder; for example, medical complications related to injection drug use (e.g., skin infections, abscesses, endocarditis, premature valve disease)
- Have alcohol use disorder
- Have substance use disorder
- Have experienced psychological trauma and/or adverse childhood experiences, including intergenerational trauma[10]

2

Comprehensive Assessment and Collaborative Care Plan

People diagnosed with or identified as having opioid use disorder have a comprehensive assessment and a care plan developed in collaboration with their care providers.

Background

For people with opioid use disorder and their care providers, a comprehensive assessment and care plan help to identify complications of opioid use and other physical, social, and mental health concerns.[11] Care providers should give evidence-based information to the person about their condition, and they should assess their goals to determine the most appropriate expertise needed to provide them with comprehensive care.[8] The care plan should be reassessed regularly until the person's goals are met.[12]

Sources: National Institute for Health and Care Excellence, 2008[8] | Registered Nurses' Association of Ontario, 2015[12]

What This Quality Statement Means

For People With Opioid Use Disorder

If you are diagnosed with or identified as having opioid use disorder, and if you are ready to make a change, your care provider will do an assessment with you. They should ask about things like your use of opioids and any other drugs or alcohol, your physical health, your mental health, and other concerns you may have. After doing this assessment, your care provider should work with you to make a care plan that addresses all of your needs. If you choose, your family can also help you make your care plan.

For Care Providers

If a person is diagnosed with or identified as having opioid use disorder, and if the person agrees, perform a comprehensive assessment and complete a care plan with the person as soon as possible. Continue to reassess the person during subsequent visits, and adjust the plan accordingly until the goals of the plan are met.

For Health Services

Ensure systems, processes, and resources are in place to allow care providers to perform comprehensive assessments and create care plans for people diagnosed with or identified as having opioid use disorder. This includes providing the time required for care providers to conduct comprehensive assessments and ensuring access to the resources necessary to develop and maintain or adjust care plans.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Comprehensive assessment

A comprehensive assessment should address, at a minimum, the following items:

- The person's goals for treatment
- Opioid use and overdose risk
- Physical health status and medical conditions, including chronic pain
- Mental health (see Quality Statement 10)
- Other substance use (e.g., alcohol, benzodiazepines, tobacco)
- Potential infections resulting from drug use
- Socioeconomic information
- Trauma screen*
- Family history of substance use and mental health disorders*
- Resilience and strengths*
- Biological testing (e.g., urine drug screens)*

** Secondary care providers (e.g., cardiologists, infectious disease specialists) are not expected to complete the entire comprehensive assessment. The asterisk indicates items that can be deferred as long as the secondary care provider refers the person to another provider who will complete the assessment. In urgent care settings, completion of the entire comprehensive assessment may need to be deferred until acute issues are addressed.*

Quality Indicators

Process Indicators

Percentage of people diagnosed with or identified as having opioid use disorder who have a comprehensive assessment

- Denominator: total number of people diagnosed with or identified as having opioid use disorder
- Numerator: number of people in the denominator who have a comprehensive assessment
- Data source: local data collection

Percentage of people diagnosed with or identified as having opioid use disorder who have a comprehensive assessment and a care plan

- Denominator: total number of people diagnosed with or identified as having opioid use disorder who have a comprehensive assessment
- Numerator: number of people in the denominator who have a care plan
- Data source: local data collection

Percentage of people diagnosed with or identified as having opioid use disorder who have a care plan who developed their care plan in collaboration with their care provider

- Denominator: total number of people diagnosed with or identified as having opioid use disorder who have a care plan
- Numerator: number of people in the denominator who developed their care plan in collaboration with their care provider
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Care plan

When establishing a care plan with a person with opioid use disorder, care providers should aim to address the following[8,11]:

- Management of the person's opioid use disorder, including the following:
  - Same-day access to harm reduction services (see Quality Statement 11)
  - Access to ongoing treatment within 3 days
  - Access to take-home naloxone and to overdose education
  - Access to treatment for other current substance use (e.g., use of alcohol, benzodiazepines, tobacco)
  - Housing and occupational needs
  - Income support
  - Connection with a primary care provider
  - Psychological and pharmacological treatments for concurrent mental health disorders (see Quality Statement 10)

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Addressing Physical Health, Mental Health, Additional Addiction Treatment Needs, and Social Needs

People with opioid use disorder have integrated, concurrent, culturally safe management of their physical health, mental health, additional addiction treatment needs, and social needs.

Background

It is important that people with opioid use disorder be provided with nonjudgmental, culturally supportive care that extends beyond addressing their opioid use disorder.[11]

Those providing treatment with either buprenorphine/naloxone or methadone in specialized clinic settings should ensure that people receiving opioid agonist therapy also have their physical health, mental health, additional addiction treatment needs, and social needs addressed concurrently either in the specialized clinic or via other care providers. Care providers in specialized clinic settings should encourage and support a transition to primary care providers for those receiving ongoing treatment with buprenorphine/naloxone to ensure they receive comprehensive primary care.

BACKGROUND CONTINUED

In addition to physical health, mental health, and additional addiction treatment needs, the social needs of people with opioid use disorder, including housing and income support, should be addressed. Stress-management strategies and tools for preventing relapse should be discussed.[13] Where appropriate, referrals to health and social services, such as peer-support groups, cultural supports, and vocational and skills training, should be provided.[11]

Source: Advisory committee consensus

What This Quality Statement Means

For People With Opioid Use Disorder

There may be more than one care provider helping you manage your opioid use disorder. Often, your family doctor or nurse practitioner can provide at least part of your treatment, including buprenorphine/naloxone. If you need additional help, they can connect you with other care providers who can help you with other physical health, mental health, or additional addiction treatment needs you may have. They can also connect you with people who can help with things like finding housing, a job, or financial support.

For Care Providers

Provide support and referrals to address the person's physical health, mental health, additional addiction treatment needs, and social needs. If you are unable to provide these on site, you are responsible for facilitating access to them elsewhere. Offer applicable referrals for peer-support groups, cultural supports, and vocational and skills training supports.

For Health Services

Ensure systems, processes, and resources are in place to allow care providers to manage the physical health, mental health, additional addiction treatment needs, and social needs of people with opioid use disorder. This includes ensuring care providers have the time and resources required to provide counselling and comprehensive physical and mental health care to people with opioid use disorder. Pathways should be in place to facilitate referrals to health and social services when appropriate.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder who have a regular primary care provider

- Denominator: total number of people with opioid use disorder
- Numerator: number of people in the denominator who have a regular primary care provider
- Data sources: local data collection, administrative data

Structural Indicator

Local availability of spots in comprehensive addiction management programs that provide culturally safe care for people with opioid use disorder and address physical health, mental health, additional addiction treatment needs, and social needs

- Data source: local data collection

4

Information to Participate in Care

People with opioid use disorder are provided with information to enable them to participate in their care. If their family is involved, they are also provided with this information.

Background

High-quality care involves a partnership between care providers and the person with opioid use disorder.[11] Care providers bring their expertise, and the person with opioid use disorder brings their knowledge of the impact that opioid use disorder has on their life, as well as their goals, values, and preferences. Information about opioid use disorder can improve the ability of people and their families to navigate the health system and optimize their use of appropriate resources.

Source: Advisory committee consensus

What This Quality Statement Means

For People With Opioid Use Disorder

Your care provider should give you information about opioid use disorder. They should tell you about all of your treatment and harm reduction options and the different care providers who might be involved in your care. This information should be given to you in a variety of ways, including verbally, written down, or in a video. If you choose to have family involved in your care, and you give your permission to share information with them, they should also be given this information. You should be involved in all decisions made about your care.

For Care Providers

Provide evidence-based information that is tailored to meet the person's learning needs in a format and at times that are most appropriate for them. When family are involved in the person's care, and if the person consents, include family as much as possible in discussions and decision-making.

For Health Services

Ensure that appropriate educational resources are available for care providers to use with people with opioid use disorder. These resources should be available in written and multimedia formats and translated when necessary.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Information

Information about opioid use disorder should be provided throughout the care continuum verbally and/or in a printed or multimedia format. This information should include, at minimum, content related to the following:

- Diagnosis
- Elements of the care plan (see Quality Statement 2)
- Care providers involved in implementing the care plan
- How to recognize and respond to a potential opioid overdose (see Quality Statement 8)
- Information about available treatment options and harm reduction services (see Quality Statement 11) that includes evidence-based information about the objectives, duration, benefits, risks, costs, and potential side effects associated with treatment and harm reduction strategies

Quality Indicators

Process Indicators

Percentage of people with opioid use disorder who report receiving information (see definition) from their care provider for themselves, and their family as appropriate, to enable participation in their care

- Denominator: total number of people with opioid use disorder
- Numerator: number of people in the denominator who report receiving information (see definition) from their care provider for themselves, and their family as appropriate, to enable participation in their care
- Data source: local data collection

Percentage of people with opioid use disorder who report that their care provider involves them as much as they want in decisions about their care

- Denominator: total number of people with opioid use disorder
- Numerator: number of people in the denominator who report that their care provider involves them as much as they want in decisions about their care
- Data source: local data collection
- Sample survey question: "When you see your care provider or someone else in their office, how often do they involve you as much as you want in decisions about your care and treatment?" (Response options: Always, Often, Sometimes, Rarely, Never, It depends on who I see and/or what I am there for, Not using or on any treatments/not applicable, Don't know, Refused)[14]

5

Opioid Agonist Therapy as First-Line Treatment

People with opioid use disorder are informed that treatment that includes opioid agonist therapy is safer and more effective than treatments that do not include opioid agonist therapy.

Background

People with opioid use disorder who are treated with opioid agonist therapy have better retention in addiction treatment, less use of addictive substances, improved health and social functioning, and lower rates of mortality than those who do not receive opioid agonist therapy as part of their treatment.[15-17] Most people who stop taking opioids without first being stabilized on opioid agonist therapy will relapse.[13] Relapse is particularly dangerous because a person who has stopped taking opioids has a reduced tolerance and is therefore at an increased risk of overdose and death.[13] Use of opioid agonist therapy is particularly important for pregnant people, for whom the benefits of therapy far outweigh the potential risks of neonatal abstinence syndrome, which is a time-limited and treatable condition.[18]

People with opioid use disorder who decline opioid agonist therapy should be offered a supervised, slow opioid agonist taper using either buprenorphine/naloxone or methadone, lasting longer than 1 month.[13] They should also be offered concurrent psychosocial treatment, support, and monitoring for at least 6 months.[19,20]

All people who are considering immediate opioid cessation or who have stopped taking opioids should be counselled on the risks of overdose owing to a reduction in their opioid tolerance. They should also be provided with take-home naloxone and taught how to administer it and how to recognize and respond to emergencies.[21]

Sources: Advisory committee consensus | British Columbia Centre on Substance Use, 2017[13]

What This Quality Statement Means

For People With Opioid Use Disorder

When you and your care provider work on your care plan, your care provider should explain the different types of treatment available to you. No matter where you seek treatment, you should be offered a treatment called opioid agonist therapy. This is sometimes called maintenance therapy. This treatment makes your care plan safer and more effective.

If you and your care provider have discussed your treatment options for opioid use disorder, and you understand that a treatment that includes opioid agonist therapy is safer and more effective than treatments that do not include opioid agonist therapy, but you decide that opioid agonist therapy is not right for you, then your care provider should offer you a supervised, slow opioid agonist taper. Your care provider will put you on methadone or buprenorphine/naloxone and slowly lower the dose of your medication over a minimum of 1 month. This is done to prevent you from feeling sick, which happens when you stop taking opioids quickly. Your care provider should also offer you regular counselling and support while you lower your dose and for 6 months after that.

For Care Providers

Inform people with opioid use disorder that incorporating opioid agonist therapy into their care plan is recommended. However, treatment is ultimately the person's decision; if they opt to forgo stabilization and opioid agonist therapy, their decision must be respected. If they decline opioid agonist therapy, inform them of the harms associated with immediate opioid cessation, and encourage a slow taper with buprenorphine/naloxone or methadone. Provide them with take-home naloxone, instructions on overdose prevention, and contact information for harm reduction services. If family is involved in the person's care, and if the person consents, the family should also be provided with take-home naloxone, instructions on overdose prevention, and contact information for harm reduction services.

WHAT THIS QUALITY STATEMENT MEANS CONTINUED

For Health Services

Ensure systems, processes, and resources are in place to ensure that accurate, evidence-based information on treatment options is provided to all people with opioid use disorder and their families as appropriate. This includes the information that treatment that includes opioid agonist therapy is safer and more effective than treatments that do not include opioid agonist therapy.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder who are informed that treatment that includes opioid agonist therapy is safer and more effective than treatments that do not include opioid agonist therapy

- Denominator: total number of people with opioid use disorder
- Numerator: number of people in the denominator who report being told that treatment that includes opioid agonist therapy is safer and more effective than treatments that do not include opioid agonist therapy
- Data source: local data collection

6

Access to Opioid Agonist Therapy

People diagnosed with or identified as having opioid use disorder have access to opioid agonist therapy as soon as possible, within a maximum of 3 days.

Background

Following the identification of suspected opioid use disorder, it is important to rapidly initiate a formal diagnosis. A diagnosis is required to start opioid agonist therapy and can be made by a physician, psychologist, or nurse practitioner, although only physicians and nurse practitioners can prescribe opioid agonist therapy. For people with opioid use disorder who are pregnant, it is particularly important that they are started on opioid agonist therapy as soon as possible.[18]

Prescribers must complete a full assessment to determine if opioid agonist therapy is appropriate for a particular person. If it is decided that opioid agonist therapy is appropriate, and if the person with opioid use disorder chooses to receive opioid agonist therapy, prescribers should recommend either buprenorphine/naloxone or methadone.[16,17,22,23] Individual characteristics, preferences, and ease of accessibility to treatment should be considered when choosing between opioid agonist therapies. Buprenorphine/naloxone should be the treatment of choice in most cases, as it is a safer medication and more easily accessible than methadone in rural and remote locations.[13] For example, pregnant people with opioid use disorder living in remote communities are often unable to access methadone in their home community and must move to a community that does offer it to receive treatment.

BACKGROUND CONTINUED

Initiating and maintaining opioid agonist therapy with buprenorphine/naloxone or methadone can be done in primary care, integrated care (primary care and addiction care), or specialized clinic settings.

All addiction treatment services and addiction care providers should facilitate the continued use of opioid agonist therapy for those currently receiving this treatment and facilitate access to it for those requesting initiation. If a person receiving opioid agonist therapy enters an inpatient facility (e.g., a hospital or residential addiction treatment program) or a correctional facility, their opioid agonist therapy should be continued without disruption. The last dose of opioid agonist therapy should be verified, and appropriate adjustments should be made to the dose if there have been missed doses.

Sources: Advisory committee consensus (time frame) | British Columbia Centre on Substance Use, 2017[13] | Centre for Addiction and Mental Health, 2011[22]

What This Quality Statement Means

For People With Opioid Use Disorder

Opioid agonist therapy reduces cravings for opioids and blocks the effects of other opioids. Because of this, it makes your care plan safer and more effective. There are two medications used for opioid agonist therapy. One is a combination of buprenorphine and naloxone, which is also called Suboxone. The other is methadone. Your care provider should talk with you about the differences between these two medications to help you make the best choice for you.

You should be given opioid agonist therapy within 3 days of being diagnosed with or identified as having opioid use disorder, no matter where you first ask for treatment or where you receive treatment.

If you are already taking opioid agonist therapy and you go into a hospital, a residential addiction treatment program, or a correctional facility, your treatment should be continued without stopping at any time.

For Care Providers

If the person you are treating agrees to opioid agonist therapy, start them on buprenorphine/naloxone or methadone as soon as possible. Buprenorphine/naloxone should be the treatment of choice in most cases, especially if methadone is not locally available and requires extensive travel for the person to obtain. If you are unable to prescribe opioid agonist therapy, refer the person to a care provider or organization that can initiate treatment within no more than 3 days.

For Health Services

Ensure systems, processes, and policies are in place to allow people to receive opioid agonist therapy within 3 days of identification or diagnosis regardless of where they present for treatment (whether hospital, residential addiction treatment facility, or correctional facility). No one with opioid use disorder receiving opioid agonist therapy should be refused access to any type of treatment (including inpatient addiction services). If an organization is unable to provide opioid agonist therapy (e.g., if no physicians or nurse practitioners are available), the organization should partner with an organization or clinician able to provide on-site access to opioid agonist therapy.

Quality Indicators

Process Indicator

Percentage of people diagnosed with or identified as having opioid use disorder who receive opioid agonist therapy within 3 days

- Denominator: total number of people diagnosed with or identified as having opioid use disorder
- Numerator: number of people in the denominator who are offered opioid agonist therapy within 3 days of diagnosis or identification
- Data source: local data collection

Structural Indicator

Local availability of access to opioid agonist therapy

- Data sources: ConnexOntario, Ministry of Health and Long-Term Care

7

Treatment of Opioid Withdrawal Symptoms

People with opioid use disorder who are in moderate or severe withdrawal from opioids are offered relief of their symptoms with buprenorphine/naloxone within 2 hours.

Background

People with opioid use disorder who do not use opioids for an extended period of time may experience serious and painful physical withdrawal symptoms that should be treated as soon as possible. Buprenorphine/naloxone has been shown to be more effective than clonidine or lofexidine in improving symptoms of withdrawal and is associated with fewer side effects.[24] However, buprenorphine/naloxone may precipitate withdrawal in people who have recently used opioids; therefore, withdrawal symptoms should be of moderate to severe intensity before buprenorphine/naloxone is given.[13,22]

Once acute withdrawal has been treated, care providers should focus on addressing the person's long-term treatment and harm reduction goals and refer them to appropriate resources as necessary. If a person opts for opioid agonist therapy, bridging treatment with buprenorphine/naloxone should be offered until their follow-up appointment, which should occur within 3 days.

Source: Advisory committee consensus

What This Quality Statement Means

For People With Opioid Use Disorder

If you are feeling sick because you have not had opioids for a while, you might be experiencing withdrawal. You can go to your care provider to get help to feel better. If your care provider says that you are experiencing moderate or severe withdrawal, they should make sure you get medication within 2 hours to help you feel better. Once you are feeling better, your care provider should talk with you about different ways to manage your opioid use disorder and ways to reduce your risk of harm.

For Care Providers

If a person presents with moderate or severe symptoms of opioid withdrawal, offer treatment within 2 hours of presentation. If buprenorphine/naloxone is not available through an on-site process, a patient-specific prescription can be written and filled in the community for witnessed ingestion on site or at the pharmacy. Buprenorphine/naloxone is the suggested first-line treatment for withdrawal symptoms.

Once the acute withdrawal has been treated, discuss the person's goals for long-term treatment and harm reduction, and refer them to appropriate resources as necessary. If they opt for opioid agonist therapy, offer them bridging treatment with buprenorphine/naloxone to use until their follow-up appointment, which should occur within 3 days.

For Health Services

Ensure systems, processes, and resources are in place to allow care providers to provide people with opioid use disorder immediate access to treatment for opioid withdrawal. This includes having policies in place to enable care providers to give buprenorphine/naloxone quickly to relieve opioid withdrawal symptoms and to refer patients to the appropriate resources following symptom control.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Moderate or severe withdrawal

Withdrawal symptoms occur when a person has either been administered an opioid antagonist (i.e., naloxone) or there is a reduction or cessation of opioid use following regular use. Common withdrawal symptoms include the following[9]:

- Diarrhea
- Dysphoric mood
- Insomnia
- Irritability
- Lacrimation or rhinorrhea
- Muscle aches
- Nausea or vomiting
- Piloerection
- Pupillary dilation
- Restlessness
- Sweating
- Yawning

The Clinical Opiate Withdrawal Scale can be used to assess the severity of withdrawal symptoms. Points are attributed to symptom severity, with a total score of 5 to 12 indicating mild withdrawal, 13 to 24 indicating moderate withdrawal, 25 to 36 indicating moderately severe withdrawal, and more than 36 indicating severe withdrawal.[25]

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder in moderate or severe withdrawal who receive buprenorphine/naloxone within 2 hours of presentation

- Denominator: total number of people with opioid use disorder in moderate or severe withdrawal
- Numerator: number of people in the denominator who receive buprenorphine/naloxone within 2 hours of presentation
- Data source: local data collection

8

Access to Take-Home Naloxone and to Overdose Education

People with opioid use disorder and their families have immediate access to take-home naloxone and to overdose education.

Background

People with opioid use disorder, their families, and people being released from a correctional facility are more likely than the general population to experience or witness an opioid overdose.[21] People with opioid use disorder being released from correctional facilities are at particularly high risk of overdose owing to their reduced opioid tolerance.[4]

All people with opioid use disorder, and their families as appropriate, and all people being released from correctional facilities should be offered take-home naloxone. People should be taught how to administer naloxone and how to recognize and respond to a potential opioid overdose. When deciding which administration type of take-home naloxone to offer, consider the formulations available, the individual's administration skills, and the setting.[21]

Sources: British Columbia Centre on Substance Use, 2017[13] | World Health Organization, 2014[21]

What This Quality Statement Means

For People With Opioid Use Disorder

Naloxone is a drug that helps reverse the effects of an opioid overdose long enough for you to get to the hospital. Your care provider should give you naloxone to take home, and they should teach you how to use it in case you or someone you know has an opioid overdose. If your family is involved in your care, your care provider should also give them naloxone to take home and explain how to use it in case they need to give it to you in an emergency.

For Care Providers

Provide people with opioid use disorder, and their families as appropriate, with take-home naloxone and instructions on how to administer the medication and how to respond in the case of a potential opioid overdose.

For Health Services

Ensure systems, processes, and resources are in place so that all people with opioid use disorder, and their families as appropriate, and all people being released from correctional facilities have access to take-home naloxone, are taught how to use it, and are provided with overdose education, regardless of where the person presents.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Access to take-home naloxone

Care providers working in all settings, including community clinics and services, pharmacies, hospitals, inpatient addiction programs, mental health care facilities, and correctional facilities, should provide people with take-home naloxone. They should also provide information on how to use naloxone and how to recognize and respond to a potential opioid overdose.

Overdose education

Overdose education should be provided to people when they are given take-home naloxone. In the case of a potential opioid overdose, if a person does not respond to stimulation, it is important to take the following steps:

1. Call 911 to request emergency assistance
2. Perform chest compressions
3. Administer naloxone (may need to be repeated)
4. Stay with the person until help arrives

Quality Indicators

Process Indicators

Percentage of people with opioid use disorder and their families who receive take-home naloxone, education on how to use it, and overdose education

- Denominator: total number of people with opioid use disorder
- Numerator: number of people in the denominator and/or their families who receive take-home naloxone, education on how to use it, and overdose education
- Data source: local data collection

Percentage of people with opioid use disorder who receive take-home naloxone and overdose education when released from a correctional facility

- Denominator: total number of people with opioid use disorder released from a correctional facility
- Numerator: number of people in the denominator who receive take-home naloxone and overdose education when released
- Data source: local data collection

Structural Indicator

Local access to take-home naloxone and overdose education for people with opioid use disorder and their families

- Data source: local data collection

9

Tapering Off of Opioid Agonist Therapy

People who have achieved sustained stability on opioid agonist therapy who wish to taper off are supported in a collaborative slow taper if clinically appropriate.

Background

Stability in treatment is attained once a person with opioid use disorder is functioning well on an optimal dose of opioid agonist therapy. An optimal dose is one that allows a person to be free of opioid withdrawal symptoms and cravings for the full 24-hour dosing interval without experiencing intoxication or sedation from the medication.[13]

Once stability is achieved, the frequency of a person's routine visits with a care provider for opioid agonist therapy should be reassessed. Care providers should consider the balance between safety and the potential burden that the visits have on the person's quality of life.[22]

Following a period of sustained stability, some people may want to taper off of opioid agonist therapy. The ideal duration of stability before tapering off depends on the duration and severity of a person's opioid use disorder and instability. For example, those with a long history of opioid use may require a longer period of regular opioid agonist therapy before tapering than those with a shorter history of opioid use. Tapering may not be appropriate for some people, and such individuals should be encouraged to continue their opioid agonist therapy indefinitely.[13,22] However, if a person insists on tapering against medical advice, care providers should respect this request and initiate a taper.

BACKGROUND CONTINUED

Prior to initiating a collaborative slow taper, all people, even those who have been stable for many years, should be counselled on the risks of overdose owing to reduced tolerance, provided with naloxone, and taught how to administer naloxone and how to recognize and respond to emergencies.[21]

For people who would like to stop methadone, but who are not ready to discontinue opioid agonist therapy, providers should offer a switch to buprenorphine/naloxone. Buprenorphine/naloxone is safer, can be prescribed in primary care settings, is available in more rural and remote locations, and may be easier to taper to discontinuation.[13,22] If this switch is beyond the scope of practice or expertise, the prescriber should consult with a care provider who has the appropriate expertise.

Source: British Columbia Centre on Substance Use, 2017[13]

What This Quality Statement Means

For People With Opioid Use Disorder

If you are on opioid agonist therapy and you are feeling better, you or your care provider may suggest slowly lowering the dose of your medication over time. This is called tapering, and the goal is to eventually stop your opioid agonist therapy. Tapering may be considered when:

- You feel comfortable with the dose you are on
- Your health and social functioning have gotten better and stayed better for 1 year or more
- You want to stop taking opioid agonist therapy
- You have adequate supports available, like friends, family, or a peer support group

Tapering is not a good option for everyone. The tapering process is different for each person, depending on how long opioids have been negatively impacting your life and how severe your opioid use disorder is.

If tapering your opioid agonist therapy would likely not be a good option for you, your care provider may recommend continuing with your regular opioid agonist therapy. However, you always have the right to taper your opioid agonist therapy if you want to.

For Care Providers

When a person wishes to stop opioid agonist therapy, and if clinically appropriate, support them in a collaborative slow taper of opioid agonist therapy to discontinuation.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Collaborative slow taper

A collaborative slow taper is a period of about 12 months or longer during which a person works with their care provider to establish an appropriate rate for tapering.[13] The person being treated has the right to stop tapering or reduce the rate of tapering at any point.

Clinically appropriate

Determining clinical appropriateness for tapering off of opioid agonist therapy includes considering the many factors that may reduce the risk of relapse following the taper; for example, duration of stability, duration of abstinence from substance use, absence of current or untreated psychiatric comorbidities, and the presence of strong supportive social networks.

WHAT THIS QUALITY STATEMENT MEANS CONTINUED

For Health Services

Ensure supports are in place to allow people on opioid agonist therapy to achieve improved mental health and social functioning. This will help people gain stability and provide an environment in which a collaborative slow taper to discontinuation is possible for appropriate people.

Quality Indicators

Process Indicators

Percentage of people who have achieved sustained stability on opioid agonist therapy who wish to discontinue opioid agonist therapy when it is clinically appropriate who are undergoing a taper off of their opioid agonist therapy

- Denominator: total number of people with opioid use disorder who have achieved sustained stability who wish to discontinue opioid agonist therapy when it is clinically appropriate
- Numerator: number of people in the denominator who are undergoing a taper off of their opioid agonist therapy
- Data source: local data collection

Percentage of people who have decided to taper off of their opioid agonist therapy who are supported in a collaborative slow taper

- Denominator: total number of people with opioid use disorder who have decided to taper off of their opioid agonist therapy
- Numerator: number of people in the denominator who are supported in a collaborative slow taper (see definition)
- Data source: local data collection

10

Concurrent Mental Health Disorders

People with opioid use disorder who also have a mental health disorder are offered concurrent treatment for their mental health disorder.

Background

Individuals, families, and communities affected by opioid use disorder face high rates of concurrent mental illness.[8] Management of opioid use disorder should always include a mental health assessment and, if appropriate, treatment and referral for concurrent mental health disorders (see also Quality Statements 2 and 3).

Source: National Institute for Health and Care Excellence, 2008[8]

What This Quality Statement Means

For People With Opioid Use Disorder

If you have opioid use disorder and a mental health disorder, like depression or anxiety, your care provider should offer or arrange for treatment of both your opioid use disorder and your mental health disorder at the same time.

For Care Providers

If the person you are treating for opioid use disorder also has a mental health disorder, you should facilitate concurrent treatment for their mental health disorder.

For Health Services

Ensure systems, processes, and policies are in place to allow people receiving treatment for opioid use disorder to receive concurrent treatment for mental health disorders.

Quality Indicators

Process Indicator

Percentage of people with opioid use disorder and a mental health disorder who receive concurrent treatment for their mental health disorder

- Denominator: total number of people with opioid use disorder and a mental health disorder
- Numerator: number of people in the denominator who receive concurrent treatment for their mental health disorder
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Mental health disorder

Examples of common mental health disorders include major depressive disorder, generalized anxiety disorder, and post-traumatic stress disorder.

Treatment for mental health disorders

Detailed guidance on effective treatments for mental health disorders is available in other guidance sources, including Health Quality Ontario's *Major Depression* quality standard.

11

Harm Reduction

People who use opioids have same-day access to harm reduction services. A comprehensive harm reduction approach includes education, safe supplies, infectious disease testing, vaccinations, appropriate referrals, and supervised consumption services.

Background

Harm reduction strategies are practices, programs, and policies that aim to reduce the adverse health, social, and economic consequences of substance use without requiring a person to abstain from substance use.[12] Care providers and treatment programs for opioid use disorder should be guided by a harm reduction approach that enables immediate access to education and same-day access to harm reduction services as necessary.

Sources: Advisory committee consensus (same-day access) | British Columbia Centre on Substance Use, 2017[13] | National Institute for Health and Care Excellence, 2008[8] | Registered Nurses' Association of Ontario, 2015[12]

What This Quality Statement Means

For People With Opioid Use Disorder

Your care provider may talk with you about harm reduction. Harm reduction strategies are ways to reduce your chances of getting an infection, having an overdose, or dying from using opioids. They include:

- Information about how to be as safe as possible while taking opioids
- Access to safe supplies, like sterile needles and alcohol swabs
- Vaccinations for preventable illnesses like hepatitis B
- Tests for infections like human immunodeficiency virus (HIV), hepatitis B, and hepatitis C
- Referrals to other health care services you might want or need

Not everyone will want or need these services, but if you do, you should be able to get them the same day you ask for them.

For Care Providers

Offer all people who use opioids information on harm reduction. Offer people safe supplies if requested, or refer them to a location that provides safe supplies if they are not on hand. Where appropriate, encourage infectious disease testing and vaccinations. For those testing positive for infectious diseases, arrange timely referrals to appropriate medical care. For those likely to benefit from supervised consumption services, provide information on these services and offer to facilitate access to them.

For Health Services

Ensure systems, processes, and resources are in place to allow all people who use opioids immediate access to harm reduction education and same-day access to harm reduction services either on site or via referral.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Education

Information gaps should be assessed, and, if needed, education should be offered to people with opioid use disorder on how to reduce the risk of the following[26]:

- Acquiring HIV, hepatitis B, hepatitis C, and other pathogens
- Drug poisoning
- Soft-tissue injuries
- Other harms associated with drug consumption

Safe supplies

Safe supplies should be offered for the use of opioids and other substances, including the following: glass stems, screens, mouthpieces, push sticks, foil, meth pipes, needles and syringes, cookers, filters, ascorbic acid, sterile water, alcohol swabs, tourniquets, safe disposal containers, and condoms.[26]

Infectious disease testing

The need for testing for infections should be assessed and, when appropriate, should be offered for HIV, hepatitis B, hepatitis C, sexually transmitted infections, and tuberculosis.[8,26,27]

Quality Indicators

Process Indicator

Percentage of people who use opioids who reported receiving harm reduction services within 24 hours of request

- Denominator: total number of people who use opioids who requested harm reduction services
- Numerator: number of people in the denominator who reported receiving harm reduction services within 24 hours
- Data source: local data collection

Structural Indicator

Local availability of same-day access to harm reduction services

- Data source: Ministry of Health and Long-Term Care

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Vaccinations

The need for vaccinations should be assessed, and, when appropriate, vaccinations should be offered. Vaccinations to consider include those for diphtheria, hepatitis A, hepatitis B, influenza, pneumococcal pneumonia, and tetanus.[8,26,27]

Appropriate referrals

Assess people for the need for referrals for HIV and hepatitis C treatment, other substance use concerns, and housing services.[27]

Supervised consumption services

Supervised consumption services are spaces designated exempt from the Controlled Drugs and Substances Act.[28] In these spaces, people can consume illicit drugs in a safe, supportive, hygienic environment under the supervision of staff who can intervene in the event of an overdose or other adverse event. Staff can also offer assessment and education and encourage engagement with or provide referrals to other health or treatment services.

Emerging Practice Statement: Pharmacological Treatment Options for People With Opioid Use Disorder and Treatment Options for Adolescents

What Is an Emerging Practice Statement?

An emerging practice statement describes an area for quality improvement that has been prioritized by the advisory committee but for which there is insufficient or inconsistent evidence in the guidelines used in the development of the quality statements. An emerging practice statement acknowledges that there is a need for evidence-based guidance to be developed in an area but that the evidence base in this area is still emerging.

Rationale

Additional Opioid Agonist Therapy Options

For people with opioid use disorder who have been offered traditional opioid agonist therapy (both buprenorphine/naloxone and methadone) and had suboptimal results, or who do not wish to take these treatments, there may be added value in considering other opioids within the context of a harm reduction framework. This could include prescribed oral opioids, prescribed injection opioids, or supervised consumption of non-prescription opioids.

Opioid Antagonist Therapy

For people with opioid use disorder who are no longer taking opioids (including opioid agonist therapy), opioid antagonists such as naltrexone may assist in preventing relapse to opioid use. Novel delivery systems, including extended-release formulations and long-acting implants, show more promise than the oral naltrexone currently available in Canada.[13]

Treatment Options for People Under 16 Years of Age

The guidelines used to develop this quality standard were based on studies conducted with adult populations. This quality standard may be of benefit to adolescents with moderate or severe opioid use disorder, but there is insufficient evidence to be sure what high-quality care looks like for this age group.

Acknowledgements

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Health Quality Ontario thanks the following people for their generous, voluntary contributions of time and expertise to help create this quality standard:

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About Health Quality Ontario

Health Quality Ontario is the provincial advisor on the quality of health care. We are motivated by a single-minded purpose: Better health for all Ontarians.

Who We Are

We are a scientifically rigorous group with diverse areas of expertise. We strive for complete objectivity, and look at things from a vantage point that allows us to see the forest and the trees. We work in partnership with health care providers and organizations across the system, and engage with patients themselves, to help initiate substantial and sustainable change to the province's complex health system.

What We Do

We define the meaning of quality as it pertains to health care, and provide strategic advice so all the parts of the system can improve. We also analyze virtually all aspects of Ontario's health care. This includes looking at the overall health of Ontarians, how well different areas of the system are working together, and most importantly, patient experience. We then produce comprehensive, objective reports based on data, facts and the voice of patients, caregivers, and those who work each day in the health system. As well, we make recommendations on how to improve care using the best evidence. Finally, we support large-scale quality improvements—by working with our partners to facilitate ways for health care providers to learn from each other and share innovative approaches.

Why It Matters

We recognize that, as a system, we have much to be proud of, but also that it often falls short of being the best it can be. Plus certain vulnerable segments of the population are not receiving acceptable levels of attention. Our intent at Health Quality Ontario is to continuously improve the quality of health care in this province regardless of who you are or where you live. We are driven by the desire to make the system better, and by the inarguable fact that better has no limit.

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Quality Standards

Looking for more information?

Visit our website at **hqontario.ca** and contact us at **qualitystandards@hqontario.ca** if you have any questions or feedback about this guide.

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ISBN 978-1-4868-1405-3 (Print)
ISBN 978-1-4868-1415-2 (PDF)

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