Quality Standards

Opioid Prescribing for Acute Pain

Care for People 15 Years of Age and Older

August 2017

Health Quality Ontario

Let's make our health system healthier

Ontario
Health Quality Ontario

Summary

This quality standard addresses care for people 15 years of age and older with acute pain who have been prescribed or are considering opioids. The scope of this quality standard applies to all care settings. This quality standard provides guidance on the appropriate prescribing of opioids for acute pain, including optimizing the use of multimodal therapies, and reducing the harms associated with prescribed opioids. It does not address opioid prescribing for chronic pain or end-of-life care, nor does it address the management of opioid use disorder. See Health Quality Ontario's *Opioid Prescribing for Chronic Pain* quality standard for quality statements related to chronic pain and *Opioid Use Disorder* quality standard for detailed quality statements related to the diagnosis and management of opioid use disorder.

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About Quality Standards

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

Quality standards are concise sets of statements that will:

- Help patients, residents, families, and caregivers know what to ask for in their care
- Help health care professionals 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 patients

The statements in this quality standard do not override the responsibility of health care professionals to make decisions with patients, after considering each patient's unique circumstances.

How to Use Quality Standards

Quality standards inform clinicians and organizations about what high-quality health care looks like. 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 process, structure, 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 addresses care for people 15 years of age and older with acute pain who have been prescribed or are considering opioids. The scope of this quality standard applies to all care settings. This quality standard provides guidance on the appropriate prescribing of opioids for acute pain, including optimizing the use of multimodal therapies and reducing the harms associated with prescribed opioids. It does not address opioid prescribing for chronic pain or end-of-life care, nor does it address the management of opioid use disorder.
See Health Quality Ontario's *Opioid Prescribing for Chronic Pain* quality standard for quality statements related to chronic pain and *Opioid Use Disorder* quality standard for detailed quality statements related to the diagnosis and management of opioid use disorder.

Why This Quality Standard Is Needed

Acute pain is typically a normal, predicted response to surgery, acute illness, trauma, or other injury.[1] It is recent in onset and is a self-limiting process that generally lasts days to a month after the precipitating event. The duration of acute pain is associated with the time it normally takes for healing to occur.[1]

As part of a multimodal approach to treating acute pain, opioid therapy is one treatment option. In the first three months of 2016 in Ontario, 24% of people who filled a prescription for opioid analgesics received a one-time supply of short-acting medication for a duration of 14 days or less suggesting the medication was prescribed for acute pain.[2] However, opioids are often prescribed for acute pain conditions when nonopioid treatments would also be effective.[3,4]

The potential benefits of opioid therapy for acute pain are short-term pain control and a quicker return to normal function. The potential harms include the risks of long-term use, addiction, overdose, and death.[3-6] The presence of unused prescribed opioids in the community also poses a safety risk to others and has the potential for diversion.[3]

Appropriate opioid prescribing practices, with an understanding of patient preferences and values, can help reduce the risk of people with acute pain developing opioid use disorder and experiencing other opioid-related harms.

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

Principles Underpinning This Quality Standard

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

People with acute pain who have been prescribed or are considering opioid therapy should receive services that are respectful of their rights and dignity and that promote self-determination.

People with acute pain are provided services that are respectful of their gender, sexual orientation, socioeconomic status, housing, age, background (including self-identified cultural, ethnic, and religious background), and disability.

A high-quality health system is one that provides good access, experience, and outcomes for all Ontarians, no matter where they live, what they have, or who they are.

How We Will Measure Our Success

A limited number of overarching goals are set for this quality standard; these have been mapped to performance indicators to measure the success of this quality standard as a whole:

- Prescribing:
    - Rate of people with acute pain prescribed opioid therapy
    - Rate of opioid prescriptions dispensed for acute pain
    - Number of opioid tablets and patches dispensed for acute pain
- Rate of opioid-related deaths
- Urgent hospital use:
    - Rate of opioid-related emergency department visits
    - Rate of opioid-related hospital admissions

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

Quality Statements in Brief

QUALITY STATEMENT 1:
Comprehensive Assessment
People with acute pain considering opioid therapy receive a comprehensive assessment to guide pain management.

QUALITY STATEMENT 2:
Multimodal Therapies
People with acute pain receive multimodal therapy consisting of nonopioid pharmacotherapy and nonpharmacological interventions, with opioids added only when appropriate.

QUALITY STATEMENT 3:
Opioid Dosage and Duration
When opioids are prescribed for acute pain, people receive the lowest effective dose of the least potent immediate-release opioid. A duration of 3 days or less is often sufficient. A duration of more than 7 days is rarely indicated.

QUALITY STATEMENT 4:
Information on Harms of Opioid Use and Shared Decision-Making
People with acute pain, and their families and caregivers as appropriate, receive information about the potential benefits and harms of opioid therapy at the time of both prescribing and dispensing.

QUALITY STATEMENT 5:
Acute Pain in People Who Regularly Take Opioids
People with acute pain who regularly take opioids receive care from a health care professional or team with expertise in pain management. Any short-term increase in opioids to treat acute pain is accompanied by a plan to taper to the previous dosage.

QUALITY STATEMENT 6:
Acute Pain in People With Opioid Use Disorder
People taking buprenorphine/naloxone or methadone for the treatment of opioid use disorder continue their medication during acute-pain events whenever possible.

QUALITY STATEMENT 7:
Prescription Monitoring Systems
Health care professionals who prescribe or dispense opioids have access to a real-time prescription monitoring system at the point of care. Prescription history is checked when opioids are prescribed and dispensed to avoid duplicate prescriptions, potentially harmful medication interactions, and diversion.

QUALITY STATEMENT 8:
Tapering and Discontinuation
People prescribed opioids for acute pain are aware of the potential for experiencing physical dependence and symptoms of withdrawal and have a plan for tapering and discontinuation.

QUALITY STATEMENT 9:
Health Care Professional Education
Health care professionals have the knowledge and skills to assess and treat acute pain using a multimodal approach and to prescribe, monitor, taper, and discontinue opioids.

Quality Statement 1: Comprehensive Assessment

People with acute pain considering opioid therapy receive a comprehensive assessment to guide pain management.

Background

For people with acute pain, health care professionals should perform a comprehensive assessment that includes a history and physical examination to determine appropriate acute pain management depending on the diagnosis.[3] Health care professionals should document the type of pain, the effects of the pain on function and quality of life, and other co-existing factors. If applicable, previous responses to postoperative treatment should be considered to guide pain management after surgery or other procedures.[5] People with untreated or undertreated mental health conditions should be offered appropriate mental health care.[1]

A history of physical dependence or tolerance to opioids and past or active substance use disorders should be assessed because they may be associated with increased opioid requirements, as well as delayed recovery after surgery and increased risks of harm.[5] The presence of risk factors for opioid use disorder may influence the choice of medication, follow-up, monitoring, and tapering protocols after surgical procedures.[5] In cases where co-existing chronic diseases cause recurrent episodes of acute pain, existing pain management plans and current or past use of opioids should be considered in the care plan for acute pain. Clinicians should also assess the use of other substances such as benzodiazepines, cocaine, alcohol, or other psychoactive substances, which may affect pain management.[5]

Sources: American Pain Society, 2017[5] | Institute for Clinical Systems Improvement, 2016[1]

Definitions Used Within This Quality Statement

Comprehensive assessment
A comprehensive assessment consists of a physical examination and functional assessment and the documentation of symptoms, medical and psychiatric comorbidities, concomitant medications, history of chronic pain, substance use, and previous postoperative treatment regimens and responses if applicable.[3,5]

What This Quality Statement Means

For Patients
Before prescribing opioids, your health care professional should give you a physical examination and ask about your physical and mental health, your medical history, any other medications you are taking, and how you responded to treatment for pain in the past.

For Clinicians
Perform a standardized comprehensive assessment (see definition) for people who present with acute pain.

For Health Services
Ensure systems, processes, and resources are in place to assist clinicians with the comprehensive assessment of people with acute pain. This includes providing the time required to perform a comprehensive assessment, including history, and ensuring access to assessment tools.

Quality Indicators

Process Indicator

Percentage of people with acute pain who receive a comprehensive assessment prior to being prescribed opioid therapy

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator who receive a comprehensive assessment prior to being prescribed opioid therapy for acute pain
- Data source: local data collection

Quality Statement 2: Multimodal Therapies

People with acute pain receive multimodal therapy consisting of nonopioid pharmacotherapy and nonpharmacological interventions, with opioids added only when appropriate.

Background

Most acute pain can be successfully treated with a multimodal therapeutic approach consisting of nonopioid pharmacotherapy and nonpharmacological interventions. The use of a nonopioid-based multimodal approach compared with a primarily opioid-based approach improves pain control and reduces overall opioid consumption and adverse effects.[5,6] Not all people undergoing surgery require opioids postoperatively; therefore, a multimodal pain management plan should be developed before the procedure. For postoperative pain, systemic opioids should be avoided in people able to take medication orally because they may be associated with long-term opioid use and opioid-related harms.[5]

Acetaminophen and/or nonselective nonsteroidal anti-inflammatory drugs reduce opioid consumption as part of a multimodal approach to therapy[5,6] and are effective as first-line analgesia for many types of acute pain in people without contraindications. Other pharmacological or nonpharmacological therapies and techniques should be used based on the pain assessment and diagnosis. Health care professionals should also consider the use of cognitive behavioural interventions such as guided imagery, hypnosis, and other relaxation techniques as part of a multimodal approach to postoperative pain; however, it is unclear which technique is most effective.[5]

Sources: American Pain Society, 2016[5] | Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, 2015[6]

Definitions Used Within This Quality Statement

Multimodal therapy
Multimodal therapy is the use of a variety of analgesic medications and interventional techniques that target different mechanisms of action in the peripheral and/or central nervous system. It may also include nonpharmacological interventions.[5]

Nonopioid pharmacotherapy
Nonopioid pharmacotherapy includes, but is not limited to, acetaminophen, non-steroidal anti-inflammatory drugs, gabapentin, pregabalin, serotonin–norepinephrine reuptake inhibitors, and tricyclic antidepressants.

Nonpharmacological therapies
Nonpharmacological therapies to treat acute pain include physical therapies, cognitive behavioural modalities, and interventional techniques. The efficacy of each may vary by pain diagnosis.
Examples of physical therapies include the following:

- Acupuncture
- Bracing or wrapping
- Chiropractic
- Heat
- Ice

- Massage
- Physical therapy
- Positioning
- Splints
- Stretching
- Transcutaneous electrical nerve stimulation (TENS)

Examples of cognitive behavioural techniques include guided imagery, hypnosis, and other relaxation techniques.[5]

What This Quality Statement Means

For Patients
You should be offered a variety of ways to manage your pain, including different kinds of medications, physical therapies, and psychological therapies, depending on the cause of your pain. You should be offered opioids only when other types of treatment are unable to manage your pain.

For Clinicians
Offer people with acute pain multimodal therapy based on the clinical diagnosis. Offer opioids only when necessary to provide adequate pain relief, and include them as part of a multimodal approach.

For Health Services
Ensure that resources, training, and interdisciplinary health care professionals are available to provide multimodal therapy for acute pain, and ensure that people with acute pain have equitable access to these therapies in their local areas.

Quality Indicators

Process Indicators

Percentage of people with acute pain whose pain is managed using a multimodal approach

- Denominator: total number of people with acute pain
- Numerator: number of people in the denominator who receive nonopioid and/or nonpharmacological therapies to manage their acute pain
- Data source: local data collection

Percentage of people with acute pain who receive nonopioid pharmacotherapy (acetaminophen and/or nonsteroidal anti-inflammatory drugs) as first-line treatment prior to being prescribed opioid therapy

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator who receive nonopioid pharmacotherapy as first-line treatment prior to being prescribed opioid therapy
- Data source: local data collection

Percentage of people with acute pain who are newly started on opioid therapy

- Denominator: total number of people with acute pain who did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who are prescribed an opioid
- Data sources: local data collection and linked administrative databases, including the Narcotics Monitoring System

Quality Statement 3: Opioid Dosage and Duration

When opioids are prescribed for acute pain, people receive the lowest effective dose of the least potent immediate-release opioid. A duration of 3 days or less is often sufficient. A duration of more than 7 days is rarely indicated.

Background

For people in an outpatient setting or primary care who have not been exposed to opioids recently, opioids should be prescribed for acute pain only for short-term use and only at the lowest effective dose. Opioid use for acute pain is associated with the development of long-term opioid use; factors associated with the sharpest increase in long-term opioid use after an initial prescription include an initial 10-day supply, more than 5 days of use, and a second prescription or refill.[4,6,7]

The maximum daily oral dose recommended for people with acute pain who do not regularly take opioids, based on risk of overdose or death, is 50 mg of morphine per day, or the equivalent dose of another opioid.[3,4] Expert opinion suggests a duration of 3 days or less is sufficient in most cases of acute pain seen in primary care.[4] Methadone, fentanyl patches, and extended-release versions of opioids, such as oxycodone, oxymorphone, and morphine, are not recommended for the treatment of acute pain because of the increased risk of harm owing to their longer half-lives and longer duration of action.[1,4] Physical dependence is an expected physiologic response in people exposed to opioids for more than a few days; therefore, lowering the number and potency of doses prescribed should minimize the need to taper opioids to prevent withdrawal symptoms and the number of unused pills available for diversion in the community.[4]

One reasons why prescriptions are often written for 7 days or longer is because it can be difficult to estimate postoperative opioid requirements.[6] However, clinicians should not prescribe additional doses to patients "just in case" pain continues for longer than expected.[4,6] Only in rare cases is a supply of opioids of more than 7 days appropriate. However, even in such cases, clinicians should exercise caution. Health care professionals should be aware that prescribing for a duration of more than 7 days or providing a refill or second prescription is associated with approximately double the likelihood of continued use 1 year later.[7]

If acute pain continues for longer than expected, health care professionals should reassess the person to confirm or revise the initial diagnosis and adjust the pain management plan.[4] If pain persists, health care professionals should consider other conditions, including opioid use disorder, and follow-up with other relevant health care professionals involved in the treatment of the person's pain.[1,4]

Sources: American College of Occupational and Environmental Medicine, 2014[3] | Centers for Disease Control and Prevention, 2016[4]

What This Quality Statement Means

For Patients
If opioids are prescribed for your acute pain, your prescription should be for the lowest dose and lowest strength that will work. In most cases, your prescription should be for 3 days or less.

For Clinicians
For acute pain, prescribe the lowest effective dose of the least potent immediate-release opioid. A duration of 3 days or less is often sufficient; more than 7 days is rarely indicated.

For Health Services
Ensure that policies and protocols are developed and implemented to encourage low-dose and limited-duration opioid prescriptions for acute pain.

Quality Indicators

Process Indicators

Percentage of people with acute pain who are prescribed an opioid with an initial dose that does not exceed 50 mg morphine equivalents per day

- Denominator: total number of people with acute pain who are prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who are prescribed an initial dose of less than or equal to 50 mg morphine equivalents per day
- Data sources: local data collection and linked administrative databases, including the Narcotics Monitoring System

Percentage of people with acute pain who are prescribed no more than a 3-day supply of opioids

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator whose prescription is for no more than a 3-day supply
- Data sources: local data collection and linked administrative databases, including the Narcotics Monitoring System

90th percentile number of days' supply of opioids prescribed to people with acute pain

- Data sources: local data collection and linked administrative databases, including the Narcotics Monitoring System

Percentage of people with acute pain whose opioid prescription is for a short-acting opioid

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator whose prescription is for a short-acting opioid
- Data sources: local data collection and linked administrative databases, including the Narcotics Monitoring System

Quality Statement 4: Information on Harms of Opioid Use and Shared Decision-Making

People with acute pain, and their families and caregivers as appropriate, receive information about the potential benefits and harms of opioid therapy at the time of both prescribing and dispensing.

Background

Health care professionals should provide patient- and family-centred, individually tailored education, including information on treatment options for the management of acute postoperative pain to allow people with acute pain and their caregivers to participate in shared decision-making. Health care professionals should also document the plan for pain management.[5] Providing education about postoperative pain may result in reduced pain, less opioid use, and less health care resource use.[6]

Sources: American Pain Society, 2016[5] | Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, 2015[6]

Definitions Used Within This Quality Statement

Information
Information should be provided to people with acute pain during in-person visits verbally and via printed or multimedia formats. This information should include, at a minimum, content related to the following[1,5,6]:

- The pain management plan and goals for pain management
- Alternative nonopioid pharmacotherapy and nonpharmacological therapies for acute pain, including their costs
- Associated risk factors for opioid use disorder and for overdose and death (e.g., psychiatric comorbidities, current or past substance use disorder, co-prescribed central nervous system depressants)
- Instructions to take prescribed medications only as needed to relieve severe acute pain
- Possible adverse effects of opioid therapy for acute pain, including risk of falls and impaired driving
- How to recognize and respond to an opioid overdose
- The risk of short-term opioid use leading to long-term use
- The signs and symptoms of physical dependence and withdrawal
- A plan for tapering opioids when pain resolves
- A plan for when to follow up with a primary care provider if pain does not resolve
- The safe storage and disposal of opioids to prevent diversion in the community

Shared decision-making
Shared decision-making is a collaborative process that allows people with acute pain and their health care professionals to make decisions together. The health care professional is responsible for the following[8]:

- Inviting the person to participate in the conversation and decision-making
- Presenting pain management options
- Providing information on the benefits and risks of each pain management option

- Helping people evaluate pain management options based on their values and preferences
- Facilitating deliberation and decision-making
- Helping implement decisions
- Incorporating decision-making tools such as decision aids

What This Quality Statement Means

For Patients
Your health care professional should explain the potential benefits and harms of opioid therapy for acute pain so that you can make decisions about your care together. If you have family or others involved in your care, they should also receive this information. Potential harms of opioid therapy include addiction and overdose.

For Clinicians
Provide people with acute pain, and their families and caregivers as appropriate, with information verbally and via printed or multimedia formats on the potential benefits and harms of opioid therapy in an accessible format.

For Health Services
Ensure that evidence-based, unbiased information is available in a variety of formats for people with acute pain. Provide an environment that allows clinicians to have conversations about various therapy options with people with acute pain, families, and caregivers.

Quality Indicators

Process Indicators

Percentage of people with acute pain with documentation of receiving information about the potential benefits and harms of opioid therapy at the time an opioid is prescribed

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator with documentation of receiving information about the potential benefits and harms of opioid therapy at the time an opioid is prescribed
- Data source: local data collection

Percentage of people with acute pain with documentation of receiving information about the potential benefits and harms of opioid therapy at the time an opioid is dispensed

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator with documentation of receiving information about the potential benefits and harms of opioid therapy at the time an opioid is dispensed
- Data source: local data collection

Percentage of people with acute pain who are prescribed an opioid that report that their health care professional always or often involves them as much as they want in decisions about their care and treatment for acute pain

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator who report that their health care professional always or often involves them as much as they want in decisions about their care and treatment for acute pain
- Data source: local data collection

Quality Statement 5: Acute Pain in People Who Regularly Take Opioids

People with acute pain who regularly take opioids receive care from a health care professional or team with expertise in pain management. Any short-term increase in opioids to treat acute pain is accompanied by a plan to taper to the previous dosage.

Background

People with acute pain who have developed a tolerance to opioids as a result of long-term use may have significantly higher opioid requirements and may need different dosages to manage acute pain than those who have not taken opioids recently.[6] Assessment and management should focus on effective analgesia, the use of strategies that may reduce the effects of opioid tolerance or opioid-induced hyperalgesia, and the prevention of withdrawal.[6] Usual opioid doses should be maintained where possible, or appropriate substitutions should be made during acute-pain events.[6] Health care professionals should work closely with other treating health care professionals and specialist teams as required and if relevant perform appropriate discharge planning after hospitalization to ensure continuity of care in the long term.[6]

Some people experience exacerbations of chronic diseases that cause acute pain (e.g., sickle cell disease). Health care professionals should follow disease-specific clinical guidelines to improve pain control and patient satisfaction for people with these conditions.[6] People with these conditions may benefit from having a pain management plan, whether or not they take opioids regularly. In cases of exacerbations that cause acute pain, people with chronic diseases often require the rapid administration of oral or intravenous opioids (e.g., in the emergency department). Opioids should still be prescribed carefully, as people with these conditions are still at risk of developing opioid use disorder.[2]

Source: Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, 2015[6]

What This Quality Statement Means

For Patients
If you are already taking opioids (perhaps because of chronic pain) and you are now experiencing acute pain, your dose should be adjusted to treat the acute pain, and your health care professional should discuss the benefits and risks of this dose adjustment with you. Your health care professional should also work with you to make a plan to safely return to your regular dose when the acute pain is over.

For Clinicians
Consider the risk of long-term opioid use and tolerance when prescribing opioids for acute pain. Coordinate care with primary care professionals prescribing long-term opioids, and create plan to taper to the original dose.

For Health Services
Ensure that systems and tools are available to help health care professionals coordinate care for people with acute pain who regularly take opioids. Facilities where surgery is performed should provide clinicians and patients with access to a pain specialist to help manage inadequately controlled postoperative pain or the care of people who are at high risk of inadequately controlled postoperative pain because of ongoing opioid use.[5]

Quality Indicators

Process Indicators

Percentage of people with acute pain who regularly take opioids who receive care from a health care professional or team with expertise in pain management

- Denominator: total number of people with acute pain who regularly take opioids
- Numerator: number of people in the denominator who receive care from a health care professional or team with expertise in pain management
- Data source: local data collection

Percentage of people with acute pain who regularly take opioids who have a documented plan to taper to their original dose following a dose increase to treat acute pain

- Denominator: total number of people with acute pain who regularly take opioids who receive a dose increase to treat acute pain
- Numerator: number of people in the denominator who have a documented plan to taper to their original dose
- Data source: local data collection

Quality Statement 6: Acute Pain in People With Opioid Use Disorder

People taking buprenorphine/naloxone or methadone for the treatment of opioid use disorder continue their medication during acute-pain events whenever possible.

If a person is taking prescribed buprenorphine/naloxone or methadone, whenever possible these drugs should be continued during acute-pain events. If acute pain is poorly managed, participation in opioid maintenance therapy programs may decrease.[6] Doses of buprenorphine/naloxone may need to be reduced in order to treat acute pain with additional opioid therapy. Methadone doses can be divided and given every 8 to 12 hours to provide better acute pain relief.[6]

Knowledge of effective treatment for acute pain in people with a current substance use disorder is limited and complicated by the following factors[6]:

- The psychological, social, and behavioural characteristics associated with substance use disorders
- The concurrent use of other drugs or alcohol
- Medications being used to assist with drug withdrawal and relapse prevention
- Complications of drug use including organ impairment and infectious diseases
- The increased risk of traumatic injury
- The presence of drug tolerance, physical dependence, or withdrawal

Health care professionals may need to consult with an addictions or pain specialist to coordinate care for people with opioid use disorder who are experiencing acute pain.

Source: Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, 2015[6]

Definitions Used Within This Quality Statement

Opioid agonist therapy
Opioid agonist therapy is the medical provision of opioid agonists in a strictly regulated environment with the goal of improving health outcomes and minimizing harms. The opioid agonists used are either buprenorphine/naloxone or methadone. Opioid agonist therapy eliminates the cycle of intoxication and withdrawal, reduces opioid cravings, and blocks the effects of other opioids. Opioid agonist therapy does not have a well-defined timeline. Some people can be tapered to discontinuation after a period of stability, whereas others may need to continue indefinitely. The length of treatment depends on the person, their social stability, the presence of concurrent mental health and/or substance use disorders, and the severity of their opioid dependence.

What This Quality Statement Means

For Patients
If you take buprenorphine/naloxone or methadone for opioid addiction, you should continue to take this medication during times when you are being treated for acute pain.

For Clinicians
Work with other clinicians to provide effective acute-pain management for people with opioid use disorder while maintaining opioid agonist therapy regimens whenever possible.

For Health Services
Ensure that people with opioid use disorder have access to prescribed opioid agonist therapy during acute-pain events.

Quality Indicators

Process Indicator

Percentage of people on opioid agonist therapy with acute pain who continue taking opioid agonist therapy

- Denominator: total number of people with acute pain who were taking opioid agonist therapy prior to the acute-pain event
- Numerator: number of people in the denominator who continue taking opioid agonist therapy during the acute-pain event
- Data sources: local data collection and linked administrative databases, including the Narcotics Monitoring System

Quality Statement 7: Prescription Monitoring Systems

Health care professionals who prescribe or dispense opioids have access to a real-time prescription monitoring system at the point of care. Prescription history is checked when opioids are prescribed and dispensed to avoid duplicate prescriptions, potentially harmful medication interactions, and diversion.

Background

Whenever it is available, health care professionals should check the prescription history of a person with acute pain before prescribing or dispensing opioids. Prescription history can inform the management of acute pain by identifying past or current exposure to opioids, which may affect opioid tolerance,[1] and by alerting health care professionals to the total morphine equivalents of multiple prescriptions or the increased risks for overdose or death posed by combining opioids with other prescribed controlled substances such as benzodiazepines.[1,4] The use of prescription monitoring systems also allows health care professionals to identify multiple prescriptions and other behaviours associated with diversion.

Source: Institute for Clinical Systems Improvement, 2016[1]

Definitions Used Within This Quality Statement

Diversion
Diversion is the transfer of prescribed opioids from the person for whom they were prescribed to another person for illicit use.

Prescription monitoring system
A prescription monitoring system is an electronic database that collects information on controlled prescription drugs prescribed by health care professionals and dispensed by pharmacies. In Ontario, the Narcotics Monitoring System (NMS) is the central database available to enable reviews of monitored drug prescribing and dispensing activities and to alert prescribers and dispensers to potential instances of polypharmacy and double-doctoring.[9]

What This Quality Statement Means

For Patients
To make sure you receive the safest, most effective treatment, your health care professional and pharmacist will check your prescription history before prescribing or dispensing opioids. They do this to see if you have recently been given opioids or other medications that are dangerous to combine with opioids, such as benzodiazepines (for example, alprazolam, diazepam, or lorazepam).

For Clinicians
Check the prescription history of people with acute pain for duplicate prescriptions, potentially harmful medication interactions, and indications of possible diversion behaviour before you prescribe or dispense opioids.

For Health Services
Ensure that opioid prescribers and dispensers have access to a real-time prescription monitoring system at the point of care.

Quality Indicators

Process Indicator

Percentage of people with acute pain whose prescription history is reviewed at the time an opioid is prescribed

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator whose prescription history was reviewed at the time an opioid is prescribed
- Data source: local data collection

Structural Indicator

Availability of a prescription monitoring system to provide health care professionals who prescribe and dispense opioids with real-time prescription information at the point of care

- Data source: provincial/regional data collection

Quality Statement 8: Tapering and Discontinuation

People prescribed opioids for acute pain are aware of the potential for experiencing physical dependence and symptoms of withdrawal and have a plan for tapering and discontinuation.

Background

Tapering and discontinuing opioid therapy for acute pain should begin when severe pain has ceased and function has returned.[3] Most people treated for acute pain should generally not require tapering, but they should be aware of the signs and symptoms of withdrawal, as some degree of physical dependence may have developed.[3] At the initial prescription, health care professionals should work with their patients to create a plan for discontinuing opioids as the acute pain resolves and discuss the appropriate disposal of unused opioids.[5]

People with acute pain treated with opioids at high doses and/or for long durations may benefit from a period of tapering over 5 to 7 days or longer if necessary.[3] Reducing the daily dose by approximately 20% to 25% per day can reduce the possibility of experiencing withdrawal.[5] Discontinuing all pain medication is generally indicated, but transitioning to either a nonsteroidal anti-inflammatory drug or acetaminophen can be done when necessary.[3]

Health care professionals should work with people who have been on long-term opioid therapy prior to their acute-pain episode to develop a plan taper to their baseline dose following the acute-pain episode.[5]

Sources: American College of Occupational and Environmental Medicine, 2014[3] | American Pain Society, 2016[5]

Definitions Used Within This Quality Statement

Opioid withdrawal
Withdrawal symptoms occur when there is a reduction or cessation of opioid use following regular use. Common withdrawal symptoms include the following[10]:

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

Physical dependence
Physical dependence is a physical condition caused by the use of opioids in which a sudden or gradual reduction or cessation of drug use causes unpleasant physical symptoms.

What This Quality Statement Means

For Patients
If you take opioids for more than a few days and then cut down or stop quickly, you may experience uncomfortable physical symptoms such as diarrhea, insomnia, muscle aches, nausea, and vomiting. Your health care professional will work with you to develop a plan to minimize uncomfortable symptoms when reducing and stopping your use of opioids.

For Clinicians
Ensure people with acute pain who have been prescribed opioids are aware of the potential for developing physical dependence and are aware of the symptoms of withdrawal. Work with your patient to develop a plan to taper and discontinue opioid therapy when functional recovery is achieved.

For Health Services
Ensure health care professionals have the tools they need to discuss and plan for opioid tapering and discontinuation after acute pain resolves.

Quality Indicators

Process Indicators

Percentage of people prescribed an opioid for acute pain with documentation of receiving information on the potential for physical dependence and symptoms of withdrawal prior to receiving their prescription

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator with documentation of receiving information on the potential for physical dependence and symptom withdrawal prior to receiving their prescription
- Data source: local data collection

Percentage of people prescribed an opioid for acute pain with documentation of a plan for discontinuing the opioid

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator with documentation of a plan for discontinuing the opioid
- Data source: local data collection

Quality Statement 9: Health Care Professional Education

Health care professionals have the knowledge and skills to assess and treat acute pain using a multimodal approach and to prescribe, monitor, taper, and discontinue opioids.

Background

Health care professionals, students, and learners should be provided with evidence-based, unbiased interprofessional educational opportunities to improve their ability to provide multimodal treatment for acute pain and reduce the harms associated with opioid prescribing. Barriers and facilitators to aligning opioid prescribing practices with current best evidence should be determined, and supports for prescribers to change practice when indicated should be implemented.

Source: Advisory committee consensus

Definitions Used Within This Quality Statement

Multimodal approach
A multimodal approach to pain management is the use of a variety of analgesic medications and techniques that target different mechanisms of action in the peripheral and/or central nervous system. It may also include nonpharmacological interventions.[5]

What This Quality Statement Means

For Patients
Your health care professional should understand how to treat acute pain using different approaches, including different kinds of medications, physical therapies, and psychological therapies.

For Clinicians
Stay current with the evidence-based knowledge and skills needed to appropriately assess and treat acute pain using a multimodal approach and to appropriately prescribe, monitor, taper, and discontinue opioids.

For Health Services
Ensure that health care professionals have access to evidence-based, unbiased educational opportunities that provide information on how to assess and treat acute pain using a multimodal approach and appropriately prescribe, monitor, taper, and discontinue opioids.

Quality Indicator

Structural Indicator

Local availability of health care professionals with the knowledge and skills to assess and treat acute pain using a multimodal approach and to prescribe, monitor, taper, and discontinue opioids

- Data source: provincial/regional data collection

Acknowledgements

Advisory Committee

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

Jason Busse (co-chair)
Department of Anesthesia,
McMaster University

Bjug Borgundvaag (co-chair)
Mount Sinai Hospital

Fiona Campbell
Hospital for Sick Children

Claudette Chase
Sioux Lookout First Nations Health Authority

Hance Clarke
Toronto General Hospital,
University Health Network

Judie Craig
Lived Experience Advisor

Alexandru Mera
Etobicoke General Hospital

David Mock
Wasser Pain Management Centre,
Mount Sinai Hospital, and the Royal College of Dental Surgeons

Monakshi Sawhney
Queen's University, Hotel Dieu Hospital,
and North York General Hospital

We also thank the *Opioid Prescribing for Chronic Pain* Quality Standard Advisory Committee for providing feedback on 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 this 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 voices 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, there is 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.

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 TBA (Print)
ISBN TBA (PDF)

Ontario
Health Quality Ontario