Quality Standards

Opioid Prescribing for Chronic Pain

Care for People 15 Years of Age and Older

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DRAFT

Health Quality Ontario

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Summary

This quality standard addresses care for people 15 years of age and older with chronic 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 chronic pain, including optimizing the use of nonopioid therapies as preferred first-line treatments, and reducing the harms associated with prescribed opioids. It does not address opioid prescribing for acute pain or end-of-life care, nor does it address the management of opioid use disorder. See Health Quality Ontario's *Opioid Prescribing for Acute Pain* quality standard for quality statements related to acute 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 chronic 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 chronic pain, including optimizing the use of nonopioid therapies as preferred first-line treatments and reducing the harms associated with prescribed opioids. It does not address opioid prescribing for acute pain or end-of-life care, nor does it address the management of opioid use disorder. See Health Quality Ontario's *Opioid Prescribing for Acute Pain* quality standard for quality statements related to acute 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

Chronic pain is often defined as pain that lasts longer than 3 months or past the time of normal tissue healing.[1,2] It is estimated to affect 1 in 5 Canadians.[3] Despite their considerable risk of harms, opioids are often prescribed to manage chronic pain. Over the past two decades, Ontario has witnessed a dramatic rise in the rate of opioid prescribing and concurrent rapid increases in opioid-related deaths, hospitalizations, and emergency department visits, as well as an increased prevalence of opioid use disorder.[4] In fiscal year 2015–2016, more than 9 million opioid prescriptions were written in Ontario, and 1.94 million Ontarians were dispensed opioids.[5] The rate of people being prescribed stronger opioids, particularly hydromorphone, has also increased substantially over the last few years.[5,6]

Current clinical practice guidelines do not recommend opioids as a first-line therapy for chronic pain.[1,2,7] Evidence suggests that a multimodal combination of nonopioid therapies, delivered through a multidisciplinary approach, can often be as effective as opioids in managing chronic pain while presenting far less risk of harm.[1] People with chronic pain should have access to appropriate treatment options that are selected with their health care professionals through a shared decision-making process. This process should include a discussion of the expected benefits and potential harms of both opioid and nonopioid therapies. Critically, the complexities of chronic pain require a biopsychosocial approach to treatment. However, many Ontario health care professionals caring for people with chronic pain—particularly in primary care settings—do not have ready access to other types of services or specialists needed to implement a multidisciplinary approach, such as psychologists, addiction specialists, physical therapists, and chiropractors.[7]

Many people with chronic pain in Ontario who are currently taking opioids are being prescribed high doses, defined here as more than the equivalent of 90 mg of morphine per day. Such doses are associated with an increased risk of overdose, particularly when combined with other substances such as benzodiazepines or alcohol.

Appropriate opioid prescribing practices, including dose reduction and discontinuation, with an understanding of patient preferences and values, can help reduce the risk of people with chronic pain being subjected to opioid-related harms. Family physicians and nurse practitioners practising in primary care are critical to effective chronic pain management for patients. It is important that they are supported to develop skills to initiate the tapering or discontinuation of opioids for chronic pain, as well as to identify and treat opioid use disorder.

In addition to this quality standard, Health Quality Ontario has developed two other quality standards related to opioids: *Opioid Prescribing for Acute 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 chronic 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 chronic 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:

- Percentage of people with chronic pain with improved quality of life
- Percentage of people with chronic pain with improved functional outcomes
- Percentage of people with chronic pain who experience reduced pain
- Prescribing:
    - Rate of people with chronic pain prescribed opioid therapy
    - Rate of opioid prescriptions dispensed for chronic pain
- Percentage of people who are prescribed opioids for chronic pain and subsequently develop opioid use disorder
- 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 this quality 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 chronic pain for whom opioids are being considered or are currently being prescribed receive a comprehensive assessment, including consideration of functional status and social determinants of health.

QUALITY STATEMENT 2:
Setting Goals for Pain Relief and Function
People with chronic pain set goals for pain relief and functional improvement in partnership with their health care professionals. These goals are evaluated regularly.

QUALITY STATEMENT 3:
First-Line Treatment With Nonopioid Therapies
People with chronic pain receive a multimodal combination of nonopioid pharmacotherapy and nonpharmacological therapies as first-line treatment. These therapies are ideally delivered through a multidisciplinary approach.

QUALITY STATEMENT 4:
Information on Harms of Opioid Use and Shared Decision-Making
People with chronic 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 so that they can participate in shared decision-making.

QUALITY STATEMENT 5:
Initiating Opioids for Chronic Pain
People with chronic pain begin opioid therapy only after other multimodal therapies have been tried without adequate improvement in pain and function, and they either have no contraindications or have discussed any relative contraindications with their health care professional.

If opioids are initiated, the trial starts at the lowest effective dose, preferably not to exceed 50 mg morphine equivalents per day. A higher dose of up to, but not exceeding, 90 mg morphine equivalents per day may be warranted in cases where people are willing to accept a higher risk of harm for improved pain relief.

QUALITY STATEMENT 6:
Co-prescribing Opioids and Benzodiazepines
People with chronic pain are not prescribed opioids and benzodiazepines at the same time.

QUALITY STATEMENT 7:
Opioid Use Disorder
People prescribed opioids for chronic pain who are subsequently diagnosed with opioid use disorder have access to opioid agonist therapy.

QUALITY STATEMENT 8:
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 initiated and every 3 to 6 months during long-term use, or more frequently if there are concerns regarding avoiding duplicate prescriptions, potentially harmful medication interactions, and diversion.

QUALITY STATEMENT 9:
Tapering and Discontinuation
People with chronic pain on long-term opioid therapy, especially those taking 90 mg morphine equivalents or more per day, are periodically offered a trial of tapering to a lower dosage or tapering to discontinuation.

QUALITY STATEMENT 10:
Health Care Professional Education
Health care professionals have the knowledge and skills to appropriately assess and treat chronic pain using a multidisciplinary, multimodal approach and to appropriately prescribe, monitor, taper, and discontinue opioids.

Quality Statement 1: Comprehensive Assessment

People with chronic pain for whom opioids are being considered or are currently being prescribed receive a comprehensive assessment, including consideration of functional status and social determinants of health.

Background

Prior to considering opioid therapy, health care professionals caring for people with chronic pain should establish appropriate physical and psychological diagnoses and document a full assessment of the person's health history and comorbidities, using validated tools to assess functional status, quality of life, and pain.[7,8,9] A person's access to resources plays a large role in their ability to receive health care, engage in healthy lifestyle behaviours, and participate in chronic pain management plans. Therefore, clinicians should also examine socioeconomic factors as part of a comprehensive assessment.

Sources: American College of Occupational and Environmental Medicine, 2014[9] | American Society of Interventional Pain Physicians, 2012[8] | Institute for Clinical Systems Improvement, 2016[7]

Definitions Used Within This Quality Statement

Comprehensive assessment
A comprehensive assessment includes an assessment of the following[7-9]:

- The pain condition
- Any other medical conditions
- Psychosocial history, including history of trauma
- Mental health status
- Medication and substance use history
- Functional status
- Sleep patterns
- Past and current substance use disorder

Functional status
Functional status is a person's ability to perform activities of daily living, work, play, and socialization. Assessment of functional status is preferably performed using a validated measure.

Social determinants of health
The social determinants of health include, but are not limited to, the following[7]:

- Education
- Employment
- Family and social support
- Geographic location
- Housing
- Income
- Transportation and access to care

What This Quality Statement Means

For Patients
If you are taking opioids or considering taking opioids, your health care professional should ask you about your pain, your health, your ability to function at work and at home, and any other issues that may be affecting your health.

For Clinicians
Conduct a comprehensive assessment (see definition) for people with chronic pain who are taking or considering opioids that includes consideration of functional status and social determinants of health.

For Health Services
Ensure systems, processes, and resources are in place to assist clinicians with the comprehensive assessment of people with chronic 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 chronic pain dispensed an opioid who receive a comprehensive assessment prior to being prescribed opioid therapy

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

Quality Statement 2: Setting Goals for Pain Relief and Function

People with chronic pain set goals for pain relief and functional improvement in partnership with their health care professionals. These goals are evaluated regularly.

Background

Health care professionals should work in partnership with people with chronic pain to establish realistic, specific, and measurable goals that focus on pain relief, functional improvement, and quality of life.[7,8] Family members should also be encouraged to be involved in the development of management goals. The goal of both opioid and nonopioid therapies for chronic pain should rarely be the total elimination of pain, but rather a reduction of pain intensity by at least 30% and/or a significant improvement in other patient-defined functional indicators for success such as return to social activities or employment.[2,7,8] Management goals should also consider the side effects of therapies for chronic pain and, wherever possible, minimize any potential harms. Other functional or social outcomes that are important to the person with chronic pain should also be addressed, including employment status, improvement in activities of daily living, and any other improvements in quality of life as defined by the person with chronic pain.

Sources: American Society of Interventional Pain Physicians, 2012[8] | Centers for Disease Control and Prevention, 2016[2] | Institute for Clinical Systems Improvement, 2016[7]

Definitions Used Within This Quality Statement

Regular evaluation of goals
Management goals should be documented and monitored over time. After initiating an opioid prescription, health care professionals should see the person with chronic pain for follow-up within 28 days.[1] Progress toward management goals should then be reassessed within 2 to 3 months.

What This Quality Statement Means

For Patients
Your health care professional should work with you to set goals for managing your pain. The conversation about goals should focus on what matters to you, including reducing your pain, improving your ability to function at work and at home, and other goals that you feel are important.

For Clinicians
Work with people with chronic pain to set realistic, specific, measurable goals for improvement in pain and function.

For Health Services
Ensure tools are available to clinicians to document management goals and evaluate them regularly.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who have documented management goals for pain relief, functional improvement, and quality of life

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who have documented management goals for pain relief, functional improvement, and quality of life
- Data source: local data collection

Percentage of people with chronic pain whose documented management goals for pain relief, functional improvement, and quality of life are reviewed within 2 to 3 months after initiating an opioid prescription

- Denominator: total number of people with chronic pain who are prescribed an opioid, did not have an opioid prescription in the previous 6 months, and have documented management goals for pain relief, functional improvement, and quality of life
- Numerator: number of people in the denominator whose management goals are reviewed and assessed for progress within 2 to 3 months after initiating an opioid prescription
- Data source: local data collection

Outcome Indicator

Percentage of people with chronic pain who achieve a reduction in pain intensity from baseline of at least 30% within 3 months after initiating an opioid prescription

- Denominator: total number of people with chronic 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 achieve a reduction in pain intensity from baseline of at least 30% according to a numeric rating scale or visual analog scale within 3 months after initiating an opioid prescription
- Data source: local data collection

Quality Statement 3: First-Line Treatment With Nonopioid Therapies

People with chronic pain receive a multimodal combination of nonopioid pharmacotherapy and nonpharmacological therapies as first-line treatment. These therapies are ideally delivered through a multidisciplinary approach.

Background

First-line therapy for chronic pain should be an individualized combination of nonopioid pharmacotherapy and nonpharmacological therapies, rather than a trial of opioids.[1] For many people, nonopioid pharmacotherapy is at least as effective as opioids for managing chronic pain and does not carry the opioid-associated risks of addiction or overdose.[2,9]

Multimodal and multidisciplinary therapies can help reduce pain and improve function more effectively than single modalities.[2] The best therapies for a particular person depend on many factors, including their diagnosis and management goals. Passive modalities, such as massage or spinal manipulation, provide short-term pain relief and potential medium-term benefit with a minimal risk of harm but should be recommended and implemented only as a complement to an active physical therapy or exercise program.[7] Nonopioid pharmacotherapy should be initiated with the goal of increasing function and restoring a person's overall quality of life, not just providing pain relief.[7]

Nonopioid therapies that require time and/or financial commitments can result in health inequity for people with chronic pain. To increase access to these therapies where they exist, health care professionals should endeavour to be aware of resources for low- or no-cost nonopioid therapies and self-management programs for chronic pain in their community.

Sources: Centers for Disease Control and Prevention, 2016[2] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[1] | Institute for Clinical Systems Improvement, 2016[7]

Definitions Used Within This Quality Statement

Multidisciplinary approach
A multidisciplinary approach involves a team of two or more different types of health care professional; for example, physicians, nurses, pharmacists, mental health professionals, physical therapists, chiropractors, and other professionals.

Multimodal therapies
Multimodal therapies are a combination of nonopioid pharmacotherapy and nonpharmacological therapies to treat pain and improve function.

Nonopioid pharmacotherapy[7]
Examples of nonopioid pharmacological therapies include the following:

- Acetaminophen
- Nonsteroidal anti-inflammatory drugs
- Anticonvulsants, such as gabapentin, pregabalin
- Antidepressants, such as amitriptyline, nortriptyline, duloxetine
- Medical cannabis

Nonpharmacological therapies[7]
Physical therapies and psychological therapies are two examples of a broad range of nonpharmacological therapies that may be used to manage chronic pain. The efficacy of each therapy may vary by pain diagnosis.

Examples of physical therapies include the following:

- Exercise
- Active physical therapy
- Passive modalities, such as spinal manipulation, passive physical therapy, and massage

Examples of psychological therapies include the following:

- Self-management programs (in-person or online)
- Psychotherapy (e.g., cognitive behavioural therapy)
- Mindfulness-based stress reduction

Interventional treatments, such as diagnostic and therapeutic injections, are percutaneous or minor surgical procedures targeting specific anatomical structures identified as possible sources of pain.[7,8] Interventional treatments may be appropriate for people with chronic pain who have not received sufficient benefit from other nonopioid pharmacotherapy and nonpharmacological therapies.[7,8]

What This Quality Statement Means

For Patients
A combination of physical therapies, psychological therapies, and nonopioid medications is the first choice for treating chronic pain. Your health care professional should offer you these therapies before offering opioids.

For Clinicians
Offer people with chronic pain a multimodal combination of nonopioid pharmacotherapy and nonpharmacological therapies as first-line treatment. Tailor these therapies to the needs of the person based on their management goals and locally available resources.

For Health Services
Ensure that systems, resources, and training are available to deliver multidisciplinary, multimodal chronic pain management therapies to reduce the use of opioids, and ensure that people with chronic pain have equitable access to these therapies in their local areas.

Quality Indicators

Process Indicator

Percentage of people with chronic pain who receive nonopioid pharmacotherapy and/or nonpharmacological therapies as first-line treatment prior to starting opioid therapy

- Denominator: total number of people with chronic 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 receive nonopioid pharmacotherapy and/or nonpharmacological therapies prior to starting opioid therapy
- Data source: local data collection

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

People with chronic 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 so that they can participate in shared decision-making.

Background

The potential harms associated with opioids prescribed for chronic pain include constipation, nausea and vomiting, cognitive changes, hypogonadism, physical dependence, opioid use disorder, nonfatal unintentional overdose, and death.[1] If a person with chronic pain is considering opioids, clinicians should provide information on the potential benefits and harms of opioid therapy and other alternative treatments; the responsibilities of the person with chronic pain, the prescriber, and the dispenser; and a monitoring schedule to reassess progress toward goals for pain and function.[2,7]

The use of screening tools for opioid use disorder and other substance use disorders is suggested; however, clinical judgment is of paramount importance, as no screening tool is sufficiently accurate to be used as the sole method of substance use disorder diagnosis. Clinicians should discuss the symptoms of opioid use disorder and overdose with people considering opioids for chronic pain.[2,7-9] Some experts have suggested that clinicians consider offering co-prescribed naloxone when prescribing opioids for chronic pain when a person is at an increased risk of overdose, for example owing to a history of overdose or substance use disorder, being prescribed a high dosage of between 50 and 100 mg morphine equivalents per day, or concurrent benzodiazepine use.[2,7] However, although the benefits of naloxone for people with opioid use disorder have been established, the Canadian *Guideline for Opioid Therapy and Chronic Noncancer Pain* reports not having found evidence to support the co-prescribing of naloxone to reduce fatal overdose, all-cause mortality, or opioid-related hospitalization in people prescribed opioids for chronic pain.[1] Clinicians should also recommend laxatives to people being prescribed opioids for chronic pain.

Health care professionals should engage people with chronic pain in shared decision-making, including a consideration of the person's management goals, preferences, and values, in order to determine the best treatment strategy for each person with chronic pain.

Sources: American College of Occupational and Environmental Medicine , 2014[9] | American Society of Interventional Pain Physicians, 2012[8] | Centers for Disease Control and Prevention, 2016[2] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[1] | Institute for Clinical Systems Improvement, 2016[7]

Definitions Used Within This Quality Statement

Information

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

- The benefits and harms of opioid therapy for chronic pain
- Alternative nonopioid therapies for chronic pain and their costs

- The types of health care professionals involved in multimodal and multidisciplinary therapy for chronic pain
- Factors that increase the risk of addiction, nonfatal overdose, and death
- The safe storage and disposal of opioids to prevent diversion and reduce safety risks in the community
- How to recognize and respond to an opioid overdose

Shared decision-making
Shared decision-making is a collaborative process that allows people with chronic pain, their families and caregivers, and health care professionals to make decisions together. The health care professional is responsible for the following[10]:

- 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 and other nonopioid therapies for chronic 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 chronic pain, and their families and caregivers as appropriate, with information on the potential benefits and harms of opioid therapy in an accessible format before initiating a trial of opioids.

For Health Services

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

Quality Indicators

Process Indicators

Percentage of people with chronic pain with documentation of receiving information about the benefits and harms of opioid therapy prior to starting opioid therapy

- Denominator: total number of people with chronic 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 with documentation of receiving information about the benefits and harms of opioid therapy prior to starting opioid therapy
- Data source: local data collection

Percentage of people with chronic pain prescribed an opioid 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 pain

- Denominator: total number of people with chronic 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 report that their health care professional always or often involves them as much as they want in decisions about their care and treatment
- Data source: local data collection

Quality Statement 5: Initiating Opioids for Chronic Pain

People with chronic pain begin opioid therapy only after other multimodal therapies have been tried without adequate improvement in pain and function, and they either have no contraindications or have discussed any relative contraindications with their health care professional.

If opioids are initiated, the trial starts at the lowest effective dose, preferably not to exceed 50 mg morphine equivalents per day. A higher dose of up to, but not exceeding, 90 mg morphine equivalents per day may be warranted in cases where people are willing to accept a higher risk of harm for improved pain relief.

Background

Given the significant risk of harms involved, opioid therapy for people with chronic pain should be considered only after other multimodal therapies have yielded inadequate improvement in pain and function and after people with chronic pain have had a documented, informed discussion of potential harms with their health care professionals. Additional caution should be applied when considering prescribing opioids for people with relative contraindications to opioids, such as a history of mental illness or substance use disorder.

Because there is evidence of a dose–response relationship for nonfatal overdose and death related to opioid use, if a trial of opioids is warranted, it should start at the lowest effective dose, not exceeding 50 mg morphine equivalents per day. In rare cases where a higher dose is required for effective pain relief, the dose should not exceed 90 mg morphine equivalents per day, and the person with chronic pain should be made aware of the increased risk of overdose and death.[1,8] People beginning opioid therapy should be assessed within 28 days to evaluate benefits and harms, and stable doses should be re-evaluated every 3 months.[1,7]

Opioid therapy should be combined with nonopioid pharmacotherapy and nonpharmacological therapies (see statement 3).[9]

Sources: American College of Occupational and Environmental Medicine, 2014[9] | American Society of Interventional Pain Physicians, 2012[8] | Centers for Disease Control and Prevention, 2016[2] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[1] | Institute for Clinical Systems Improvement, 2016[7]

Definitions Used Within This Quality Statement

Contraindications

Absolute contraindications

- Long-term opioids for chronic pain are not recommended for people with an active substance use disorder[1,9]
- Active diversion of controlled substances

Relative contraindications
Additional caution should be applied when considering prescribing opioids for chronic pain for people with any of the following:

- A history of substance use disorder[1]
- An active psychiatric disorder that is not stabilized; for example, mood disorders such as anxiety or depression or post-traumatic stress disorder[1]
- People who perform safety-sensitive jobs[9]
- Pregnancy
- Contraindications to prescribed opioid use including, but not limited to, the following:
    - Chronic obstructive pulmonary disease
    - Co-prescribed medications that increase the risk of overdose and death when combined with opioids of drugs and that are capable of inducing life-limiting drug interactions
    - Concomitant use of other central nervous system depressants[8]
    - Confirmed allergy to opioid agents
    - Sleep apnea

What This Quality Statement Means

For Patients
Before you start taking opioids, you should know about the potential risks of opioids. If you currently have a drug or alcohol addiction, you should not take opioids for chronic pain. If you had a drug or alcohol addiction in the past, or if you currently have a mental illness, the risks of harm from opioids are higher, and you should discuss these risks with your health care professional.

If taking an opioid poses an acceptable risk, your starting dose of should be as low as possible to improve your pain and ability to function.

For Clinicians
Prescribe opioids for chronic pain only after other multimodal therapies have been tried without adequate improvement in pain and function; after you have made people with chronic pain aware of the potential harms of and alternatives to opioids; and if there are no contraindications. For people with relative contraindications, discuss the potential risks they pose. Initiate opioid therapy at the lowest effective dose, preferably not exceeding 50 mg morphine equivalents per day. In rare cases where a higher dose is required for effective pain relief, the dose is not to exceed 90 mg morphine equivalents per day, and the person with chronic pain must be made aware of the increased risk of overdose and death.

For Health Services
Develop and adopt protocols and policies to limit the prescribing of opioids for chronic pain to cases where other multimodal therapies have been tried without adequate improvement in pain and function, where patients are aware of the potential harms of and alternatives to opioids, and where there are no contraindications.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who receive nonopioid pharmacotherapy and/or nonpharmacological therapies as first-line treatment prior to starting opioid therapy

- Denominator: total number of people with chronic 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 receive nonopioid pharmacotherapy and/or nonpharmacological therapies as first-line treatment prior to starting opioid therapy
- Data source: local data collection

Percentage of people with chronic pain with documentation of receiving information about the benefits and harms of opioid therapy prior to starting opioid therapy

- Denominator: total number of people with chronic 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 with documentation of receiving information about the benefits and harms of opioid therapy prior to starting opioid therapy
- Data source: local data collection

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

- Denominator: total number of people with chronic 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 were 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 chronic pain initiated on opioid therapy who have a visit with the prescribing health care professional within 28 days of when the opioid prescription was dispensed

- Denominator: total number of people with chronic 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 have a visit with the prescribing health care professional within 28 days of when the opioid prescription was dispensed
- Data source: local data collection and linked administrative data, including the Narcotics Monitoring System and the Ontario Health Insurance Plan Claims Database

Percentage of people with chronic pain on a stable dose of opioids who are evaluated by the prescribing health care professional every 3 months

- Denominator: total number of people with chronic pain on a stable dose of opioids
- Numerator: number of people in the denominator who are evaluated by the prescribing health care professional every 3 months
- Data source: local data collection and linked administrative data, including the Narcotics Monitoring System and the Ontario Health Insurance Plan Claims Database

Quality Statement 6: Co-prescribing Opioids and Benzodiazepines

People with chronic pain are not prescribed opioids and benzodiazepines at the same time.

Background

Clinicians should not prescribe opioids and benzodiazepines concurrently, as both drugs cause central nervous system depression and can decrease respiratory drive. This guidance also applies to any other drug that is a central nervous system depressant. The concurrent use of opioids and central nervous depressants may put people at greater risks for overdose and death.[1,7]

Opioid prescribers should check prescription monitoring systems for controlled substances being prescribed concurrently by other clinicians. In the rare circumstance in which a clinician and person with chronic pain choose to proceed with the concurrent treatment of an opioid and a benzodiazepine, both the opioid and benzodiazepine should be prescribed at the lowest effective dose, and the potential harms of this treatment combination should be documented before treatment is initiated. Patients should also be closely monitored for adverse effects such as drowsiness or confusion, and if these symptoms occur, one or both drugs should be discontinued.

People prescribed opioids for chronic pain who also require treatment for anxiety should be offered psychotherapy, antidepressants, and/or drugs other than benzodiazepines.[2] Health care professionals may consider co-prescribing naloxone for people taking both opioids and benzodiazepines.

Sources: Advisory committee consensus | Centers for Disease Control and Prevention, 2016[2]

What This Quality Statement Means

For Patients
Whenever possible, you should not take opioids and benzodiazepines (for example, alprazolam, diazepam, or lorazepam) at the same. When taken together, these medications may increase your risks of overdose and death.

For Clinicians
Avoid concurrently prescribing opioids and benzodiazepines whenever possible. Ask about any current opioid or benzodiazepine use before initiating a new prescription for chronic pain or anxiety, and check a prescription monitoring system.

For Health Services
Ensure that tools are available to clinicians to monitor and prevent the concurrent prescribing of opioids and benzodiazepines.

Quality Indicators

Process Indicator

Percentage of people with chronic pain dispensed an opioid and a benzodiazepine

- Denominator: total number of people with chronic pain dispensed an opioid within a 6-month period
- Numerator: number of people in the denominator who are dispensed a benzodiazepine within the same 6-month period
- Data sources: linked administrative databases, including the Narcotics Monitoring System

Quality Statement 7: Opioid Use Disorder

People prescribed opioids for chronic pain who are subsequently diagnosed with opioid use disorder have access to opioid agonist therapy.

Background

The development of opioid use disorder is a risk associated with long-term opioid therapy for chronic pain. Clinicians who are concerned about a person with chronic pain developing opioid use disorder based on the person's concerns or behaviours, findings in a prescription monitoring system, or the use of other risk-screening tools should have a discussion with the person, and in an open and nonjudgmental way, provide an opportunity for the person to disclose related concerns or problems related to opioid use.[2] Clinicians should assess for the presence of opioid use disorder based on criteria from the current edition of the *Diagnostic and Statistical Manual* (DSM).[11]

People with concurrent chronic pain and untreated opioid use disorder should be offered opioid agonist therapy with either buprenorphine/naloxone or methadone.[2] People with concurrent chronic pain and opioid use disorder or another active substance use disorder should receive ongoing pain management that maximizes benefits relative to risks.[2] To provide optimized pain management, clinicians should continue to offer nonopioid therapies for chronic pain and consider consulting a pain or addiction specialist as needed.[2]

For quality statements related to the diagnosis, management, and monitoring of opioid use disorder, please see Health Quality Ontario's *Opioid Use Disorder* quality standard.

Sources: Centers for Disease Control and Prevention, 2016[2] | Health Quality Ontario, forthcoming[12]

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.

Opioid use disorder
The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* defines opioid use disorder as "a problematic pattern of opioid use leading to clinically significant impairment or distress, occurring within a 12-month period." The Manual lists 11 symptoms of opioid use disorder. The presence of 2 to 3 symptoms indicates mild opioid use disorder; 4 to 5 symptoms indicates moderate opioid use disorder; and 6 or more symptoms signifies severe opioid use disorder.[11]

What This Quality Statement Means

For Patients
There is a risk of becoming addicted to opioids. If opioids are having a negative impact on your life or putting you at risk of harm, talk to your health care professional.

For Clinicians
Assess people for opioid use disorder based on current DSM criteria. If you diagnose opioid use disorder in a person taking opioids for chronic pain, ensure that they have access to opioid agonist therapy within 3 days of diagnosis.

For Health Services
Systems and resources should be in place to allow for care providers to screen all those at risk of opioid use disorder. Once opioid use disorder is identified, pathways should be in place such that access to respectful, nonjudgmental, evidence-based treatment may begin within 3 days of diagnosis.

Quality Indicators

Process Indicator

Percentage of people prescribed an opioid for the treatment of chronic pain who are diagnosed with opioid use disorder and receive opioid agonist therapy within 3 days of diagnosis

- Denominator: total number of people prescribed an opioid for chronic pain and diagnosed with opioid use disorder
- Numerator: number of people in the denominator who receive opioid agonist therapy within 3 days of diagnosis
- Data sources: local data collection and linked administrative databases, including the Narcotics Monitoring System

Structural Indicator

Local availability of access to opioid agonist therapy

- Data sources: local data collection, ConnexOntario

Quality Statement 8: 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 initiated and every 3 to 6 months during long-term use, or more frequently if there are concerns regarding avoiding duplicate prescriptions, potentially harmful medication interactions, and diversion.

Background

Prescription monitoring systems allow health care professionals to identify patterns of opioid prescribing and reduce the potential for opioid diversion and polypharmacy.[8] Clinicians should check the prescription history of a person with chronic pain to determine whether they are receiving doses or combinations of controlled substances that are associated with an increased risk of overdose and death, including the co-prescribing of benzodiazepines or other sedatives.[2] A person's prescription history should be reviewed at the initiation of opioid therapy, if the dose is increased, and every 3 to 6 months for long-term stable doses. A person's prescription history should be checked more frequently if there are concerns regarding the potential for substance use disorder, overdose, diversion, indeterminate pain disorder, or prescriptions being obtained from more than one prescriber.[2,7,8]

Sources: American Society of Interventional Pain Physicians, 2012[8] | Centers for Disease Control and Prevention, 2016[2] | Institute for Clinical Systems Improvement, 2016[7]

Definitions Used Within This Quality Statement

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.[13]

What This Quality Statement Means

For Patients
To make sure you receive the safest 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).
They should check your prescription history before prescribing or dispensing opioids for the first time and every 3 to 6 months after that. If you or your health care professional have any concerns, your prescription history should be checked more often.

For Clinicians
Use a prescription monitoring system at the point of care to check your patients' prescription history when opioids are initiated and every 3 to 6 months during long-term use. Check more frequently if you have concerns regarding the potential for substance use disorder, overdose, diversion, indeterminate pain disorder, or prescriptions being obtained from more than one prescriber.

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 Indicators

Percentage of people with chronic pain whose prescription history is reviewed prior to being prescribed opioid therapy

- Denominator: total number of people with chronic 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 whose prescription history was reviewed prior to being prescribed opioid therapy
- Data source: local data collection

Percentage of people with chronic pain whose prescription history is assessed at least every 6 months

- Denominator: total number of people with chronic pain who have been on opioid therapy for at least 6 months
- Numerator: number of people in the denominator whose prescription history is assessed at least every 6 months
- Data source: local data collection

Structural Indicator

Availability of a prescription monitoring system to provide health care professionals with real-time prescription information at the point of care

- Data source: provincial/regional data collection

Quality Statement 9: Tapering and Discontinuation

People with chronic pain on long-term opioid therapy, especially those taking 90 mg morphine equivalents or more per day, are periodically offered a trial of tapering to a lower dosage or tapering to discontinuation.

Background

Tapering should be offered to all people on long-term opioid therapy every 3 to 6 months,[2,7] especially to those on dosages of 90 mg morphine equivalents per day or more.[1,9] Health care professionals should work with people with chronic pain receiving opioid therapy to taper to the lowest effective dose or to taper to discontinuation in situations in which patients[2,9]:

- Are experiencing no improvement in pain or functional gain
- Are not adhering to their prescribed dose
- Have aberrant drug screening results
- Are experiencing adverse effects
- Request a dose reduction or discontinuation

People receiving both benzodiazepines and opioids require tapering to reduce the risk of overdose and death.[2] The concurrent tapering of both drugs is preferred, but it may be more practical to taper one drug at a time depending on adverse effects and risk of harm.

During tapering, other nonopioid therapies for chronic pain should be offered with frequent follow-up.[7] Gradual dose reductions of 5% to 10% of the dose every 2 to 4 weeks with frequent physician follow-up is the preferred method of tapering for most people.[1] Clinicians should individualize the tapering strategy for each person’s unique needs and, where appropriate, offer referrals to addiction medicine, psychiatry, or other multidisciplinary programs that provide care for people taking high doses of opioids, those who have previously experienced withdrawal, and those who have complex comorbidities.[7,9] As there are cost and availability issues associated with formal multidisciplinary opioid reduction programs, clinicians should endeavour to offer an alternative coordinated multidisciplinary collaboration that includes several health care professionals whom physicians can access according to their availability.[1]

Some people might experience an increase in pain or a decrease in function that lasts more than 1 month after a dose is tapered. In such cases, tapering may be paused or stopped.[1]

Sources: American College of Occupational and Environmental Medicine, 2014[9] | Centers for Disease Control and Prevention, 2016[2] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[1] | Institute for Clinical Systems Improvement, 2016[7]

Definitions Used Within This Quality Statement

Multidisciplinary opioid reduction program
Formal multidisciplinary opioid reduction programs and coordinated multidisciplinary collaborations consist of treatment provided by several health professionals. Possibilities include, but are not limited to, primary care physicians, nurses, pharmacists, physical therapists, chiropractors, kinesiologists, occupational therapists, psychiatrists, and psychologists.[1]

Adverse effects
Possible adverse effects of opioid therapy include cognitive impairment, constipation, depression, falls, hypogonadism, opioid-induced hyperalgesia, sleep apnea, unintentional overdose, and opioid use disorder.[2,9]

What This Quality Statement Means

For Patients
Your health care professional should talk to you about reducing your opioid dose or stopping opioid therapy if:

- You have been taking opioids for 3 to 6 months or longer
- Your pain is not improving
- You are having problematic side effects
- You are on a high dose of opioids
- You want to reduce your dose or stop taking opioids

It is dangerous to abruptly stop taking opioids. If you reduce your dose or stop taking opioids, it is important to work with your health care professional to make sure this happens safely.

For Clinicians
Offer opioid tapering, with the possibility of tapering to discontinuation, every 3 to 6 months to people with chronic pain who are on continued opioid therapy. Strongly encourage tapering to people who have been prescribed a dose of 90 mg morphine equivalents or more per day and to people taking both opioids and benzodiazepines.

For Health Services
Develop opioid tapering protocols and ensure health care professionals have the knowledge and skills needed to taper and discontinue opioid therapy safely.

Quality Indicators

Process Indicator

Percentage of people with chronic pain prescribed ≥ 90 mg morphine equivalents per day who receive a trial of tapering

- Denominator: total number of people with chronic pain prescribed ≥ 90 mg morphine equivalents per day
- Numerator: number of people in the denominator who receive a trial of tapering to a lower dose or tapering to discontinuation
- Data sources: linked administrative databases, including the Narcotics Monitoring System

Quality Statement 10: Health Care Professional Education

Health care professionals have the knowledge and skills to appropriately assess and treat chronic pain using a multidisciplinary, multimodal approach and to appropriately 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, multidisciplinary treatment of chronic pain and to 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

Multidisciplinary, multimodal approach
A multidisciplinary, multimodal approach involves a combination of therapies (i.e., nonopioid pharmacotherapy and nonpharmacological therapies) provided by a team of different types of health care professionals that may include physicians, nurses, pharmacists, mental health professionals, physical therapists, chiropractors, and others.

What This Quality Statement Means

For Patients
Your health care professional should understand how to assess and treat chronic pain using different approaches, including physical therapies, psychological therapies, and nonopioid medications. Your health care professional should monitor your use of opioids carefully and help you to reduce your dose or stop taking opioids safely when the time is right.

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

Quality Indicators

Structural Indicator

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

- Data source: provincial/regional data collection

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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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