QUALITY STANDARDS

Low Back Pain

Care for Adults With Acute Low Back Pain

2025 UPDATE

Ontario Health

Scope of This Quality Standard

This quality standard addresses care for adults aged 16 years and older who have a first episode of acute low back pain, or who have recurrent episodes of acute low back pain that last less than 12 weeks. The quality standard addresses mechanical low back pain with or without associated leg symptoms,[1,2] such as radiculopathy caused by compression of a spinal nerve root (a pinched nerve) and neurogenic claudication (painful cramping or weakness in the legs with walking or standing).

Although it applies to care in all settings, this quality standard focuses on primary care and community-based care that can be provided by an interprofessional health care team. It includes the assessment of acute low back pain with or without leg symptoms, assessment of risk factors to prevent chronic low back pain, and management (including pharmacological and additional nonpharmacological interventions) of acute low back pain with or without leg symptoms, as well as physical activity, education, self-management, and psychosocial support for people with acute low back pain. This quality standard includes referral to nonsurgical and surgical specialty health care teams for patients who require additional medical care for their low back pain, but it excludes information on specialty-based interventions.

This quality standard does not address the management of chronic low back pain (lasting more than 12 weeks). Other quality standards addressing chronic pain and pain management include *Chronic Pain*[3] and *Opioid Prescribing for Chronic Pain*.[4] This quality standard excludes low back pain in pregnancy; and the diagnosis and treatment of specific causes of low back pain, such as inflammatory conditions (e.g., ankylosing spondylitis), infections (e.g., discitis, osteomyelitis, epidural abscess), fracture, neoplasm, and metabolic bone disease (e.g., osteoporosis, osteomalacia, Paget's disease), nonspinal causes of back pain (e.g., from the abdomen, kidney, ovary, pelvis, bladder), chronic pain syndromes,[5] and surgical interventions (e.g., fusion and disc replacement, discectomy, laminectomy).[2]

What Is a Quality Standard?

Quality standards outline what high-quality care looks like for conditions or processes where there are large variations in how care is delivered, or where there are gaps between the care provided in Ontario and the care patients should receive. They:

- Help patients, families, and care partners know what to ask for in their care
- Help clinicians 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

Quality standards and their accompanying patient guides are developed by Ontario Health, in collaboration with clinicians, patients, and care partners across Ontario.

For more information, contact QualityStandards@OntarioHealth.ca

Quality Statements to Improve Care: Summary

These quality statements describe what high-quality care looks like for adults 16 years of age and older with acute low back pain.

Quality Statement 1: Clinical Assessment

People with symptoms of acute low back pain who seek primary care receive a prompt comprehensive assessment to inform diagnosis and assess for risk factors for developing chronic low back pain.

Quality Statement 2: Diagnostic Imaging

People with acute low back pain do not receive diagnostic imaging tests unless they present with red flags that suggest serious pathological disease.

Quality Statement 3: Patient Education and Self-Management

People with acute low back pain are offered education and ongoing support for self-management that is tailored to their individual needs and abilities.

Quality Statement 4: Maintaining Usual Activity

People with acute low back pain are encouraged to stay physically active by continuing to perform activities of daily living, with modification if required to maintain or improve mobility and function.

Quality Statement 5: Psychosocial Information and Support

People with acute low back pain who have psychosocial barriers to recovery (yellow flags) identified during their comprehensive assessment are offered further information and support to manage the identified barriers.

Quality Statement 6: Pharmacological Therapies

People with acute low back pain whose symptoms do not adequately improve with physical activity, education, reassurance, and self-management support are offered information on the risks and benefits of nonopioid analgesics to improve mobility and function.

Quality Statement 7: Additional Nonpharmacological Therapies

People with acute low back pain whose symptoms do not adequately improve with physical activity, education, reassurance, and self-management support are offered information on the risks and benefits of additional nonpharmacological therapies to improve mobility and function.

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Abbreviations List

Abbreviation	Definition
CT	Computed tomography
DAD	Discharge Abstract Database
ED	Emergency department
IV	Intravenous
MRI	Magnetic resonance imaging
NACRS	National Ambulatory Care Reporting System
NMS	Narcotics Monitoring System
NSAIDS	Nonsteroidal anti-inflammatory drugs
OH	Ontario Health
OHIP	Ontario Health Insurance Plan
RPDB	Registered Persons Database

2025 Summary of Updates

In 2025, we completed a review of the evidence to capture new or updated clinical practice guidelines and health technology assessments published since the original release of this quality standard in 2019. This update aligns the quality standard with the most recent clinical evidence and with current practice in Ontario.

Below is a summary of changes to the overall quality standard:

- Updated the links, secondary references, and data sources where applicable
- Updated the formatting to align with current Ontario Health design and branding
- Revised the accompanying resources (e.g., patient guide, placemat, case for improvement slide deck, technical specifications) to reflect changes to the quality standard and align with current Ontario Health design and branding
- Updated A Note on Terminology section to include a definition for clinicians and health care teams applicable for the scope of the quality standard
- Updated the Scope of This Quality Standard section to include the assessment of prognostic risk factors to prevent chronic low back pain, and information about other condition-specific quality standards that address chronic pain and pain management, including those on *Chronic Pain*[3] and *Opioid Prescribing for Chronic Pain*[4]
- Updated the data in the Why This Quality Standard is Needed section and the case for improvement slide deck using most up-to-date analytics data hub (ADH) data – which includes data sources such as Discharge Abstract Database (DAD), Ontario Health Insurance Plan (OHIP), National Ambulatory Care Reporting System (NACRS), Registered Persons Database (RPDB), and Narcotics Monitoring System (NMS)
- Updated terminology throughout where applicable, including:
  - Caregiver is changed to care partner
  - Health provider or health care professionals is changed to clinicians and/or health care teams

Below is a summary of changes to specific quality statements:

- Quality statement 1:
  - Updated the quality statement to include assessment of risk factors for developing chronic low back pain
  - Updated the definition of red flags to include suspected cancer in the tumor category and spondyloarthritis, ankylosing spondylitis, non-radiographic axial spondyloarthritis in the inflammation category
  - Included definitions for “symptoms of acute low back pain” and “risk factors for developing chronic low back pain”
  - Updated the audience statements in alignment with revisions to the quality statement

- Quality statement 2:
  - Updated the definition of red flags to include suspected cancer in the tumor category and spondyloarthritis, Ankylosing spondylitis, non-radiographic axial spondyloarthritis in the inflammation category
- Quality statement 3:
  - Updated the quality statement to include considerations for individual needs and abilities
  - Updated the definition of education to include providing education for people with acute low back pain who have yellow flags
  - Updated the audience statements for People With Acute Low Back Pain and Clinicians to align with revisions to the quality statement
- Quality statement 4:
  - Updated the quality statement to emphasize the maintenance and improvement of mobility and function as a goal for maintaining usual activity
  - Updated the definition of modification to include physical activity, activities of daily living, and paid and unpaid work-related duties
  - Included a definition for "maintain or improve mobility and function"
  - Updated the background to include the impact of psychosocial factors on the ability to maintain usual activity
- Quality statement 5:
  - Updated the definition of support to include psychological therapies as an example of factual information clinicians can provide to their patients
  - Added a mention of the *Major Depression*[6] and *Anxiety Disorders*[7] quality standards in the Rationale section for additional information on these conditions
- Quality statement 6:
  - Updated the definition of nonopioid analgesics to include the limited long-term benefits of topicals and recommendations against the use of antiepileptics to manage acute low back pain
- Quality statement 7:
  - Updated the definition of additional nonpharmacological therapies to include clinician-directed exercise
  - Updated the definition of information to include considerations for virtual care

A Note on Terminology

Clinicians: In this quality standard, the term "clinicians" refers to regulated professionals who provide care to patients or clients with acute low back pain. Examples are chiropractors, nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, and social workers.

Health care teams: In this quality standard, the term "health care teams" refers to clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.

Red flags: In this quality standard, the term "red flag" indicates a sign or symptom of a serious underlying pathological disease that may require tests or investigations.[8] Red flag signs or symptoms can be identified as follows[8]:

- **Neurological disorders:** diffuse or substantial motor/sensory loss, progressive neurological deficits, cauda equina syndrome (Note: Acute cauda equina syndrome is a surgical emergency. Symptoms include new bowel or bladder disturbance, including unrecognized fecal incontinence, saddle numbness, lower motor neuron weakness, and distinct loss of saddle/perineal sensation[9])
- **Infection:** fever, history of intravenous (IV) drug use, immunosuppression
- **Fracture:** trauma, osteoporosis risk/fragility fracture
- **Tumour:** history of cancer, unexplained weight loss, significant unexpected night pain, severe fatigue
- **Inflammation:** chronic low back pain for more than 3 months, an age of onset less than 45 years, morning stiffness for more than 30 minutes, improvement with exercise, disproportionate night pain

Yellow flags: In this quality standard, the term "yellow flag" indicates a psychosocial risk factor for developing chronic low back pain.[10] Yellow flags may be identified through the answers to the following questions[10]:

- "Do you think your pain will improve or become worse?"
  - *What to listen for*: a belief that back pain is damaging or potentially severely disabling
- "Do you think you would benefit from activity, movement, or exercise?"
  - *What to listen for*: fear and avoidance of activity or movement

- "How are you coping emotionally with your back pain?"
  - *What to listen for*: a tendency to have a low mood or withdrawal from social interaction
- "What treatments or activities do you think will help you recover?"
  - What to listen for: expectations of passive treatment, rather than expectations that active participation will help

Why This Quality Standard Is Needed

Low back pain is defined as pain localized between the 12th rib and the inferior gluteal folds. Most cases of acute low back pain are "mechanical" or nonspecific, and are characterized by tension, soreness, or stiffness in the low back area.[2,11] Although the source of pain and other symptoms might be attributed to several structures in the back, including discs, facet joints, muscles, and connective tissue,[2] the specific source is often not identifiable.

Worldwide, low back pain causes more disability, activity limitation, and work absenteeism than any other condition.[12,13] An estimated 75% to 85% of adults ages 18 and older (more than 7 in 10) will experience at least 1 episode of acute low back pain in their life.[14,15] Most low back pain episodes improve with initial primary care management, and without further investigations or referral to specialists.[2] Among these, approximately 90% of cases can improve without surgery.[15]

It is important to recognize that the decrease in function and mobility associated with acute low back pain has an impact on the social and economic contexts of people's health, well-being, and quality of life. Evidence shows that people of low socioeconomic status are more likely to experience low back pain as well as receive non-guideline–concordant care such as opioid medication rather than other conservative treatments to manage their acute low back pain than are people of higher socioeconomic status.[16-18] Despite evidence that opioids are not a useful treatment for acute low back pain, back pain is the most common reason physicians prescribe opioids in family medicine and the emergency department.[19] People of low socioeconomic status also have a higher risk of recurrent, persistent low back pain and an overall poorer prognosis.[16,17,20] People with acute low back pain who live in low socioeconomic areas do not have the same access to care as those living in high socioeconomic areas, and are often disadvantaged by their restricted access to health care services.[17,18]

In Canada, about 30% of adults have low back pain that recurs within 6 months of their first episode, and 40% within 1 year.[21] Most people with low back pain can benefit from lifestyle modifications (such as physical activity) and additional interventions (such as pharmacological therapies, heat, manual therapy, and therapeutic exercise).[22] Although consistent recommendations for managing low back pain have been established, there is poor uptake of these recommendations and a lack of consistency in the provision of educational materials and resources to people with low back pain.

Evidence shows that 90% of low back pain is not caused by serious underlying injury or disease that requires magnetic resonance imaging (MRI), computed tomography (CT) scans, medication, surgical referrals, or opioid prescriptions. Between FY 2015 and FY 2019, about 30% of people with low back pain who did not have red flags, which include neurological disorders, infection, fracture, tumour, or inflammation, received diagnostic imaging in Ontario.[14,23] Diagnostic imaging for uncomplicated low back pain without red flags rarely reveals the cause or origin of pain and can expose patients to unnecessary radiation thereby leading to more avoidable tests and surgery.[23] Medical imaging for low back pain is being used more often than necessary.[19,23] Imaging of the lumbar spine accounts for about one-third of all MRI examinations, and the use of diagnostic imaging has grown more rapidly than almost any other type of Canadian health service.[23]

In Ontario, there is considerable regional variation in the use of diagnostic imaging for low back pain; however, the Northern Ontario Health (OH) regions had higher percentages of people receiving any spinal diagnostic imaging within 180 days of visiting a physician or emergency department (ED) for a first episode of acute low back pain than in other OH regions since FY 2019/20. The total cost for spinal imaging, including x-ray examination, CT scanning, and MRI in Ontario was estimated to be $45.8 million in 2002/03, which increased 54% to $70.3 million in 2018/19.[24] Although there have been efforts made to reduce the use of inappropriate spinal imaging, including a Choosing Wisely Canada recommendation against imaging for low back pain unless red flags are present,[25] the percentage of people at or over the age of 16 receiving any spinal imaging including x-ray, MRI, CT, and bone scans, within 180 days of visiting physician or ED for a first episode of acute low back pain increased from 12.4% in FY 2019/20 to 16.8% in FY 2024/25 in Ontario, primarily driven by increased use of x-ray imaging. Meanwhile, the use of other spinal imaging types such as CT, MRI, and bone scans for a first episode of acute low back pain have remained relatively constant since FY 2020/21.

These data highlight many opportunities for improving care for people with acute low back pain in Ontario. Opportunities include decreasing the progression from acute low back pain to chronic low back pain, ensuring timely access to education to help patients manage their symptoms, ensuring access to an appropriate health care team when it is required, decreasing the use of inappropriate imaging for acute low back pain, and decreasing the use of opioids.

Measurement to Support Improvement

The Low Back Pain Quality Standard Advisory Committee identified 6 overarching indicators to monitor the progress being made toward improving care for adults with acute low back pain in Ontario. These indicators are intended for use by those looking to implement the low back pain quality standard, including clinicians working in regional or local roles. Measurement details are available in the technical specifications.

Indicators That Can Be Measured Using Provincial Data

- Percentage of people who seek physician or emergency department care for a first episode of acute low back pain who undergo diagnostic imaging of the spine (x-ray, computed tomography [CT], magnetic resonance imaging [MRI], bone scan) within 90 days and 180 days of the date of the index visit
- Percentage of people who seek physician or emergency department care for a first episode of acute low back pain who are prescribed an opioid medication within 7 days and 90 days of the date of the index visit
- Percentage of people who seek physician or emergency department care for a first episode of acute low back pain who subsequently present to the emergency department for low back pain within 30 days and 90 days of the date of the index visit

Note: To the best of our ability, we excluded red flags from all indicators to attempt to capture only inappropriate diagnostic imaging for low back pain. However, owing to the limitations of administrative data, some red flags could not be excluded. Please see the technical specifications that accompany this quality standard for details of red flag exclusions.

Indicators That Can Be Measured Using Only Local Data

- Percentage of people with acute low back pain who have surgeon or specialist consultations within 90 days of a low back pain diagnosis
- Percentage of people with acute low back pain who report an improvement in their quality of life
- Percentage of people with acute low back pain who rate their interaction with their clinicians as "definitely helping them feel better able to manage their low back pain" (response options: definitely, for the most part, somewhat, not at all)

Quality Statement 1: Clinical Assessment

People with symptoms of acute low back pain who seek primary care receive a prompt comprehensive assessment to inform diagnosis and assess for risk factors for developing chronic low back pain.

Sources: National Institute for Health and Care Excellence, 2020[2] | North American Spine Society, 2020[26] | Toward Optimized Practice, 2015[5]| Veteran's Affairs and Department of Defence, 2022[27]

Definitions

Symptoms of acute low back pain: Mechanical low back pain with or without associated leg symptoms such as radiculopathy caused by compression of a spinal nerve root (a pinched nerve) and neurogenic claudication (painful cramping or weakness in the legs with walking or standing).[1,2]

Primary care: In this quality standard, "primary care" refers to the care provided by a regulated clinician who is responsible for the person's care (e.g., assessment and management) and who the person can access directly without a referral. In the context of acute low back pain management, this usually means a family physician, nurse practitioner, physician assistant, physiotherapist, and/or chiropractor.

Prompt: Primary care clinicians should triage patients with acute low back pain who request appointments to ensure that urgent requests are assessed within 1 to 3 days. This appointment can be with the patient's own primary care clinician or another appropriate interprofessional health care team member.

Comprehensive assessment: A complete and accurate history identifies pertinent elements of the patient's health (e.g., current and past treatment, impact on function at home and work, patient's ability to self-manage their low back pain), when pain occurs (e.g., in the morning, with directions of spinal movement or lifting), and if this is a new episode of acute low back pain or a recurrent episode.

A physical examination and functional assessment should be undertaken by a qualified health care team to identify yellow flags, which are potential psychosocial risk factors for developing chronic pain, and possible red flags.[8,28] Red flags are signs or symptoms of a serious underlying pathological disease that may require tests or investigations.[8] Red flag signs or symptoms can be identified as follows[8]:

- **Neurological disorders:** diffuse or substantial motor/sensory loss, progressive neurological deficits, cauda equina syndrome. (Note: Acute cauda equina syndrome is a surgical emergency. Symptoms include new bowel or bladder disturbance, including fecal incontinence, saddle numbness, lower motor neuron weakness, unrecognized fecal incontinence, and distinct loss of saddle/perineal sensation[9])
- **Infection:** fever, history of IV drug use, immunosuppression

- **Fracture:** trauma, osteoporosis risk/fragility fracture
- **Tumour:** history of cancer, unexplained weight loss, significant unexpected night pain, severe fatigue (suspected cancer)
- **Inflammation (spondyloarthritis):** Ankylosing spondylitis, non-radiographic axial spondyloarthritis, chronic low back pain for more than 3 months, an age of onset less than 45 years, morning stiffness for more than 30 minutes, improvement with exercise, disproportionate night pain

Risk factors for developing chronic low back pain: These risk factors are yellow flags, which may be identified through the answers to the following questions[10]:

- "Do you think your pain will improve or become worse?"
  - What to listen for: a belief that the back pain is damaging or potentially severely disabling
- "Do you think you would benefit from activity, movement, or exercise?"
  - What to listen for: fear and avoidance of activity or movement
- "How are you coping emotionally with your back pain?"
  - What to listen for: a tendency to have a low mood or withdrawal from social interaction
- "What treatments or activities do you think will help you recover?"
  - What to listen for: expectations of passive treatment, rather than expectations that active participation will help

People with acute low back pain who present with yellow flags will benefit from education and reassurance to reduce the risk of chronic illness. If yellow flags persist, additional resources should be considered, including assessment with the Keele STarT Back 9-item tool[8] or the Patient Health Questionnaire for Depression and Anxiety to inform treatment planning (see quality statement 5).[27]

Rationale

Many people with an episode of acute low back pain do not require treatment from a health care team, as the pain usually resolves on its own. People who do seek advice from a primary care clinician should receive a comprehensive assessment using a standardized assessment tool (e.g., Brief Pain Inventory–Short Form, 3-minute Primary Care Low Back Exam, CORE Back Tool) to support clinical decision-making. The tools listed above are examples of commonly used standardized primary care assessments for acute low back pain and may or may not be applicable to all health care disciplines that assess low back pain. A precise anatomical diagnosis is not required to plan effective treatment for people experiencing acute nonspecific low back pain.[5] The most important outcomes to be assessed include pain severity, functional mobility, psychological distress, and health-related quality of life.[2] Assessment should be comprehensive and ongoing (repeated at subsequent visits) to check:[29]

- If symptoms are improving

- If the patient is using nonpharmacological therapies to manage their low back pain
- If factors may be inhibiting the person's recovery that are unrelated to the spine

If a patient's symptoms are not improving, they should follow up with their clinician within 4 weeks of their initial visit.

Imaging is not required and should be ordered only in cases where serious pathological disease is suspected (see quality statement 2). If the patient has unmanageable disabling back or leg pain (i.e., is unable to perform their usual daily activities), if their limitations from back pain are ongoing and substantial, or if their symptoms are worsened by physical activity and exercise, an appropriate referral should be made to a spine-focused clinician.[2,5,29] It is important that interactive, ongoing communication occurs between the primary care clinician, specialist, and person experiencing acute low back pain.[30]

What This Quality Statement Means

For People With Acute Low Back Pain

If you seek primary care for your acute low back pain, your clinician should give you a full health assessment that includes screening for yellow and red flags. A full assessment of your health will help them inform your diagnosis and develop the best management plan, because they will understand your needs, preferences, prognosis, and goals for your care.

For Clinicians

Perform and document a comprehensive assessment that includes screening for yellow and red flags for people with acute low back pain to inform their diagnosis and identify any underlying pathological disease or risk factors for developing chronic low back pain. This assessment should take place early in their episode of acute low back pain and whenever they return to you to discuss their condition. The same approach should be followed for recurrent low back pain.

For Organizations and Health Services Planners

Ensure that clinics and electronic medical records have assessment tools in place that include screening for yellow and red flags to identify any underlying pathological disease or risk factors for developing chronic low back pain in people with acute low back pain so that a comprehensive assessment can be performed early in an episode of acute low back pain.

Quality Indicators: How to Measure Improvement for This Statement

- Number of days from when people with low back pain seek primary care to when they receive a comprehensive assessment from their primary care clinician
- Percentage of people with acute low back pain who are referred to a spine-focused clinician for unmanageable disabling back or leg pain, limitations from back pain that are ongoing and substantial, and/or symptoms that worsen with physical activity and exercise
- Local availability of rapid access clinics for people with acute low back pain

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 2: Diagnostic Imaging

People with acute low back pain do not receive diagnostic imaging tests unless they present with red flags that suggest serious pathological disease.

Sources: National Institute for Health and Care Excellence, 2020[2] | North American Spine Society, 2020[26] | Toward Optimized Practice, 2015[5] | Veteran's Affairs and Department of Defence, 2022[27]

Definitions

Diagnostic imaging: Diagnostic imaging frequently used for low back pain includes CT, MRI, x-ray examination, and bone scan.

Red flag: This indicates the signs or symptoms of a serious underlying pathological disease that may require tests or investigations.[8] Red flag signs or symptoms can be identified as follows[8]:

- **Neurological disorders:** diffuse or substantial motor/sensory loss, progressive neurological deficits, cauda equina syndrome (Note: Acute cauda equina syndrome is a surgical emergency. Symptoms include new bowel or bladder disturbance, saddle numbness, lower motor neuron weakness, unrecognized fecal incontinence, and distinct loss of saddle/perineal sensation[9])
- **Infection:** fever, history of IV drug use, immunosuppression
- **Fracture:** trauma, osteoporosis risk/fragility fracture
- **Tumour:** history of cancer, unexplained weight loss, significant unexpected night pain, severe fatigue (suspected cancer)
- **Inflammation (spondyloarthritis):** Ankylosing spondylitis, non-radiographic axial spondyloarthritis, chronic low back pain for more than 3 months, an age of onset less than 45 years, morning stiffness for more than 30 minutes, improvement with exercise, disproportionate night pain

Rationale

People with acute nonspecific low back pain and no red flags gain no clinical benefit from diagnostic imaging of the spine (x-ray, CT, MRI, bone scan).[1,2] Diagnostic imaging of the low back may also identify age-related changes that may not be the reason for the patient's pain.[21,31] It is common for imaging to identify natural changes that occur in the spine, but these changes occur just as frequently in people with no back pain; no treatment is required for degenerative or "age-related" spine changes.[31] In the absence of red flags, the risks associated with routine diagnostic imaging (unnecessary exposure to radiation[32,33] and lack of specificity of diagnostic imaging[5,33]) generally outweigh the benefits. Diagnostic imaging for people with acute low back pain may lead to unnecessary worry and may generate unnecessary follow-up tests and procedures,[32] and yet imaging results on their own will rarely change the treatment plan.[5]

People with signs or symptoms of serious underlying pathological disease (red flags) benefit from early imaging and should be identified using comprehensive assessment, with further clinical examination by a medical or surgical specialist in low back pain and relevant clinical tests.

What This Quality Statement Means

For People With Acute Low Back Pain

If you have acute low back pain, you do not need an MRI, x-ray, bone scan, or CT scan unless your primary care clinician notices signs of a serious problem or disease. These tests will not explain your symptoms or help in making a diagnosis or a management plan. Decisions about your treatment should be based on your comprehensive assessment and how your symptoms affect your life.

For Clinicians

Do not send patients with acute low back pain for diagnostic imaging unless their symptoms suggest serious underlying pathological disease. If a patient presents with red flags that suggest serious disease, early imaging may confirm or rule out a suspected damaging diagnosis.

For Organizations and Health Services Planners

Ensure that all primary care clinicians have clear policies and processes in place for evaluating acute low back pain through comprehensive assessment without imaging, unless the patient has red flags (serious underlying pathological disease). Health care teams should also monitor the use of imaging for assessing acute low back pain in adults to ensure that it is not being used inappropriately.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people who seek physician or emergency department care for acute low back pain who undergo diagnostic imaging (x-ray, CT scan, MRI, bone scan) of the spine

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 3: Patient Education and Self-Management

People with acute low back pain are offered education and ongoing support for self-management that is tailored to their individual needs and abilities.

Sources: National Institute for Health and Care Excellence, 2020[2] |North American Spine Society, 2020[26] | Toward Optimized Practice, 2015[5] | Veteran's Affairs and Department of Defence, 2022[27]

Definitions

Education: People with acute low back pain should receive the following information, tailored to their individual needs and abilities:

- Back pain is common and usually improves in a short time (typically weeks), but it often recurs
- Low back pain, recurrent or not, usually does not indicate a risk of serious underlying pathological disease (reassure patients as part of the education strategy)
- It is important to remain active and resume normal activities as soon as possible
- Heat can provide greater pain relief when used in combination with exercise
- It is important to take part in physical activity and ensure a healthy lifestyle[29]
- The purpose of pharmacological therapy is for patients to maintain mobility and function while continuing to be physically active
- People with acute low back pain may consider additional nonpharmacological therapies if their symptoms are not improving with physical activity (see quality statement 7)
- People with acute low back pain who present with yellow flags should be provided with education and reassurance to reduce the risk of chronic illness (see quality statement 5)

Ongoing support: A partnership or collaborative working relationship between the health care team, people with acute low back pain, and their support networks to assist with goal setting, overcome barriers to achieving goals, and provide general support and appropriate follow-up when necessary.

Self-management: Self-monitoring of symptoms to identify causes of pain exacerbation, activity pacing, relaxation techniques, communication techniques, and modification of negative self-talk (catastrophizing).[5] Self-management techniques should be tailored to individual needs and abilities to enhance individual skills and confidence in managing acute low back pain.

Rationale

It is important for people with acute low back pain to understand that their symptoms will usually improve and respond to initial care within a short amount of time (typically in weeks). Patient education provides people with information that encourages positive changes in knowledge, beliefs, and behaviour. People with acute low back pain who receive education from a clinician feel less fearful and more in control of their health.[2,5] People with acute low back pain should be offered information on the nature of their symptoms; reassurance about the low risk for serious underlying disease; reminders about the importance of continuing their usual activities and remaining mobile; and guidance on self-managing their current and recurrent symptoms.[9] Self-management involves goal setting to encourage people's self-confidence to manage their pain successfully and increase daily functioning.[5] Empowering patients to take control of their condition by self-managing their symptoms is important to their recovery, and helps them overcome any misconceptions associated with back pain.

Educational materials should be provided in a format that meets the needs and abilities of the individual: for example, printed materials, videos, or multimedia formats.[5,32] Clinicians may choose to use standardized questionnaires and tools to assess how a person manages their low back pain. Recurrence of nonspecific acute low back pain is common; educational materials should describe what to expect in terms of recurrence and how to reduce recurrent low back pain by continuing physical activity and participating in regular exercise.[5,34] Clinicians should be aware that patients might avoid physical activity because they fear it will cause their back pain to recur. If people with acute low back pain seek clinician support, additional education, reassurance, close follow-up, and referral to other clinicians, as required, may promote a return to activity.[5,31]

What This Quality Statement Means

For People With Acute Low Back Pain

Your primary care clinician should offer you information to help you understand your first and/or recurrent episode of acute low back pain and how to manage it. They should help you to understand your pain and make informed decisions about your care, as well as provide you with information and ongoing support based on your needs and abilities. Self-management techniques include self-monitoring of symptoms, pacing activity, implementing relaxation techniques, and modifying negative self-talk.

For Clinicians

Provide education for people with acute low back pain that is responsive to their individual needs and abilities. Information should include all aspects of self-management, including symptom education and strategies for continuing usual activities. Information should be reinforced and expanded upon at subsequent visits. Care partners should be included, if appropriate.

For Organizations and Health Services Planners

Ensure that all health care settings have patient education materials (includes written and electronic tools) available for adults with acute low back pain. Materials should be available in French and other relevant languages and should aim to be culturally appropriate.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with acute low back pain who receive education and ongoing support for self-management
- Percentage of people with acute low back pain who report feeling confident about self-managing their pain

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 4: Maintaining Usual Activity

People with acute low back pain are encouraged to stay physically active by continuing to perform activities of daily living, with modification if required to maintain or improve mobility and function.

Sources: National Institute for Health and Care Excellence, 2020[2] | Toward Optimized Practice, 2015[5]

Definitions

Physically active: Physical activity includes any bodily movement produced by the musculoskeletal system that necessitates energy expenditure, including activities that are done while working, playing, carrying out household chores, caregiving, travelling, and engaging in recreational pursuits.[35] Patients who are recovering from an acute episode of low back pain should be advised that recurrent episodes are common and that remaining physically active and participating in regular exercise may lessen these recurrences.[5,36]

Activities of daily living: Activities of daily living include personal care, continence, toileting, walking, feeding ourselves, work, and leisure.[37] Instrumental activities of daily living include doing housework, preparing meals, shopping, and managing medications.[38]

Modification: Modified physical activities, activities of daily living, and paid and unpaid work-related duties (e.g., modification to work hours, considerations for in-person vs. virtual work) to ensure a safe work environment, given their current health status.[39]

Maintain or improve mobility and function: People with acute low back pain discuss their care goals with their clinician, including how to maintain or enhance their capacity to perform physical activities and activities of daily living, in alignment with their needs and abilities (see quality statements 6 and 7).[2]

Rationale

It is important for people with acute low back pain to remain as active as possible. To reduce the potential for further episodes or recurrence, it is important for patients to remain at least moderately active, especially during and after recovery from an episode of acute low back pain.[5] Staying in bed, prolonged rest, and avoiding physical activity may increase pain and stiffness in the low back.[29] Patients require reassurance that their back pain does not represent ongoing damage to their bones, muscles, or other connective tissues, and that it is safe to continue with normal activities.[28,29]

People with acute low back pain should gradually increase their level of activity by using pacing, which involves modification of behaviour to maintain or improve function, manage symptoms, and reduce recurrence and disability for those experiencing pain.[35] Activity limitation might be required if physical activity causes symptoms to spread (pain or other symptoms radiating to the leg); temporary modifications are often necessary for people to continue to remain active.

People with acute low back pain should move in ways that work best for them to reduce pain and maintain or improve mobility. They should return to work or other life roles quickly, applying strategies that are appropriate to their work environment, using modifications as necessary,[5] and minimizing the risk of prolonged disability.[29] Most people with acute low back pain should be encouraged to return to work with modifications, even if they still feel some back discomfort, because working will not cause further damage to their back.[2,5] The ability to remain physically active and perform daily and work activities may be impacted by psychosocial factors such as fear, anxiety or stress (i.e., yellow flags).[10] People with acute low back pain who present with yellow flags should be provided with education and reassurance to help reduce the risk of chronic illness and be assessed with validated tools to inform treatment planning (see quality statement 5).[27]

What This Quality Statement Means

For People With Acute Low Back Pain

Continue to stay physically active, moving around as much as you can, and try to do a little more each day to stay comfortable and improve how you move and feel. You may need accommodations and modifications to your daily activities, which may include returning to work. Resume your regular activities as soon as your back feels better.

For Clinicians

Encourage your patients with acute low back pain to continue being physically active, moving around within their level of pain tolerance, doing more each day, and returning to work and other life roles as early in their treatment as possible so that they can maintain or improve their mobility and function. Convey the importance of not resting in bed, because bed rest will reduce their overall health and well-being. Once patients feel better, they should resume their regular activities.

For Organizations and Health Services Planners

Ensure that all health care settings have systems, processes, and resources in place for adults with acute low back pain to encourage them to optimize their physical activity and return to work, while minimizing periods of prolonged rest. Ensure that all health care settings have systems and processes in place for people with acute low back pain to receive information on remaining active during an episode of acute low back pain, with appropriate modifications.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with acute low back pain who have documented discussions in their medical record about staying physically active by continuing activities of daily living, with modifications if required to maintain or improve mobility and function
- Percentage of people with acute low back pain who have documented discussions in their medical record about continuing work or returning to work, with appropriate modifications to maintain or improve mobility and function
- Number of days from when people with acute low back pain take a leave of absence from work to when they return to work

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 5: Psychosocial Information and Support

People with acute low back pain who have psychosocial barriers to recovery (yellow flags) identified during their comprehensive assessment are offered further information and support to manage the identified barriers.

Sources: National Institute for Health and Care Excellence, 2020[2] | North American Spine Society, 2020[26] | Toward Optimized Practice, 2015[5]

Definitions

Psychosocial barriers to recovery (yellow flags): A "yellow flag" indicates a psychosocial risk factor for developing chronic low back pain.[10] Patients who present with yellow flags will benefit from education and reassurance to reduce the risk of chronic illness. Patients might also experience barriers to recovery, including fear, financial problems, anger, depression, job dissatisfaction, family issues, and stress.[5] If yellow flags persist, clinicians should consider providing additional resources, including assessment using the Keele STarT Back 9-item tool or the Patient Health Questionnaire for Depression and Anxiety to inform treatment planning.[10,27]

Yellow flags may be identified through the answers to the following questions[10]:

- "Do you think your pain will improve or become worse?"
  - *What to listen for*: a belief that the back pain is damaging or potentially severely disabling
- "Do you think you would benefit from activity, movement, or exercise?"
  - *What to listen for*: fear and avoidance of activity or movement
- "How are you coping emotionally with your back pain?"
  - *What to listen for*: a tendency to have a low mood or withdrawal from social interaction
- "What treatments or activities do you think will help you recover?"
  - *What to listen for*: expectations of passive treatment, rather than expectations that active participation will help

Information: Information about psychosocial barriers should be offered to people with acute low back pain during in-person visits with their clinician, in verbal, printed, or multimedia formats.[5] Patients' needs and goals for improved function and mobility should be discussed.[29]

Support: Factual information that is provided by clinicians to patients that meets the patients' values and preferences (e.g., consider psychological therapies using a cognitive behavioural approach for managing psychological symptoms of acute low back pain). Clinicians should also listen to patients and encourage them to do what is best for them to achieve their care goals.[30]

Rationale

As part of a comprehensive assessment, clinicians should assess patients with acute low back pain for psychosocial risk factors, referred to as yellow flags (see quality statement 1), especially if a patient is not improving. People with psychosocial barriers to recovery may benefit from psychosocial support as a complement to nonpharmacological therapies.[2,40] Programs that include psychosocial support, social and occupational components, and other nonpharmacological interventions are associated with less pain and back-specific disability, as well as with an increased likelihood of returning to work and fewer sick days.[40] People with acute low back pain can access various types of culturally appropriate psychosocial supports, including communication and regular connection with their clinician, education, community support groups, individual counselling, support through employer-sponsored programs, and evidence-based treatment for mood disorders.

For additional information on major depression and anxiety disorders, see Ontario Health's Major Depression[41] and Anxiety Disorders[42] quality standards.

What This Quality Statement Means

For People With Acute Low Back Pain

If you are distressed and struggling to cope with your acute low back pain, tell your health care team so that they can offer you information and support, as well as other nondrug therapies.

For Clinicians

When people with acute low back pain present with yellow flags, offer information and support to manage any psychosocial barriers that could affect their recovery.

For Organizations and Health Services Planners

Ensure that all health care settings have systems, processes, and resources in place so that adults with acute low back pain can receive information and referral to psychosocial support services if needed.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with acute low back pain with identified psychosocial barriers to recovery who report that their clinician has given them information and support to manage their identified psychosocial barriers

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 6: Pharmacological Therapies

People with acute low back pain whose symptoms do not adequately improve with physical activity, education, reassurance, and self-management support are offered information on the risks and benefits of nonopioid analgesics to improve mobility and function.

Sources: American College of Physicians, 2017[36] | National Institute for Health and Care Excellence, 2020[2] | North American Spine Society, 2020[26] | Toward Optimized Practice, 2015[5]| Veteran's Affairs and Department of Defence, 2022[27]

Definitions

Information: Information addressing the benefits and risks associated with pharmacological therapy should be given to people with acute low back pain during in-person visits with their health care team, in verbal, printed, or multimedia formats.[5] Patients' needs and goals for improved function and mobility should be discussed.[29]

Nonopioid analgesics:

- Nonsteroidal anti-inflammatory drugs (NSAIDs) are the first choice of therapy if nonpharmacological therapies do not reduce acute low back pain.[2] They have been shown to have short-term effectiveness in reducing pain severity and improving function
- Skeletal muscle relaxants are used to help manage acute low back pain that does not respond to first-choice therapies.[9,36] These medications have limited benefit and should be prescribed at the lowest effective dose for a limited time (less than 2 weeks) to patients with severe pain and disability who do not respond to nonpharmacological therapies and first-choice analgesics (NSAIDs). The side effects must be considered for each person
- Topicals have limited long term benefits for treatment of low back pain
- Opioids should not be used routinely to treat acute low back pain
- Anti-epileptics (e.g., gabapentinoids) should not be offered for managing low back pain without radiculopathy

Rationale

If a patient's acute low back pain symptoms are not improving with physical activity (see quality statement 4), education, reassurance, and self-management support (see quality statement 3), they

may consider pharmacological therapies to improve function and mobility. Given the nature of acute low back pain and the potential for it to recur, patients should be prescribed medication for only short periods at consistent dosing intervals. People with acute low back pain should continue to remain physically active and maintain nonpharmacological therapies (e.g., education, reassurance, and self-management support) after they start taking medication.

Pharmacological therapy is prescribed for patients with acute low back pain to maintain mobility and function, not primarily to relieve pain. When considering pain-relieving medications, clinicians should take into account risks, benefits, side effects, efficacy, costs, and patients' needs and preferences.[2,36] Patients may be offered a short course of nonsteroidal anti-inflammatory drugs (NSAIDs) to improve function and regain mobility.[36,43] Patients who have contraindications to these medications should not use them.[2,9,29,36] Clinicians should consider other nonopioid analgesics when required (e.g., when people cannot take NSAIDs). Although individual responses vary, many clinical trials have found that acetaminophen is no better than placebo for relieving acute low back pain, improving quality of life, or enhancing sleep quality.[2,36,44]

Opioids should not be used routinely to treat acute low back pain. There is an increase in adverse events when opioids are used as a single intervention, and there are increased risks associated with opioid use, including dependency.[5] In some circumstances, it is reasonable to prescribe opioids at the lowest effective dose for a limited time if patients with severe pain and disability are unresponsive to nonpharmacological therapies and medications.[5,29]

For detailed information about opioid prescribing, please refer to the quality standard *Opioid Prescribing for Acute Pain*.[33]

What This Quality Statement Means

For People With Acute Low Back Pain

If remaining active, receiving education, accepting reassurance, and getting self-management support are not working well enough to control your acute low back pain, your primary care clinician should offer you information on the risks and benefits of pain medication. If you decide to use pain medication, it is important to continue using other nondrug therapies as well. One does not replace the other.

For Clinicians

Offer people with acute low back pain whose symptoms are not improving information on how nonopioid pain-relieving medications may be combined with nonpharmacological therapies to improve function and mobility. Discussions with patients about medications should include an overview of the risks and benefits associated with different options.

For Organizations and Health Services Planners

Ensure that all health care settings have systems, processes, and resources in place so that people with acute low back pain can receive information on the risks and benefits of nonopioid pain-relieving medications.

Quality Indicators: How to Measure Improvement for This Statement

- Percentage of people with acute low back pain whose symptoms are not improving with nonpharmacological therapies (physical activity, education, reassurance, and self-management support) who are given information by their health care team on the risks and benefits of nonopioid analgesics for their acute low back pain
- Percentage of people who seek physician or emergency department care for acute low back pain who are prescribed an opioid medication

Measurement details for these indicators, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Quality Statement 7: Additional Nonpharmacological Therapies

People with acute low back pain whose symptoms do not adequately improve with physical activity, education, reassurance, and self-management support are offered information on the risks and benefits of additional nonpharmacological therapies to improve mobility and function.

Sources: American College of Physicians, 2017[36] | National Institute for Health and Care Excellence, 2020[2]|North American Spine Society, 2020[26] | Veteran's Affairs and Department of Defence, 2022[27]

Definitions

Additional nonpharmacological therapies: Additional therapies that can be used in combination with interventions that should be tried first to maximize effectiveness (including encouraging physical activity, providing education, giving reassurance, and assisting with self-management support). Examples of additional nonpharmacological therapies that should be considered include structured clinician-directed exercise program (e.g., aerobic, aquatic), superficial heat, massage therapy, acupuncture, and manual therapy.

Information: Information addressing the benefits and risks associated with additional nonpharmacological therapies should be given to people with acute low back pain during virtual or in-person visits, as appropriate with their health care team, in verbal, printed, or multimedia formats.[5] Patients' needs and goals for improved function and mobility should be discussed.[29]

Rationale

If a patient's acute low back pain symptoms are not improving with physical activity (see quality statement 4), education, reassurance, and self-management support (see quality statement 3), they may consider heat, manual therapy (with therapeutic exercise), or other additional nonpharmacological therapies to improve function and mobility.[36] These additional therapies have been shown to be more effective when used in combination with physical activity than when used on their own. Manual therapy provides some improvement in patient quality of life and improved function.[2]

What This Quality Statement Means

For People With Acute Low Back Pain

Your health care team should offer you information on nondrug therapies that may work for you, while you continue to be physically active. Using these therapies may help to reduce your pain and discomfort and may improve your overall health and well-being.

For Clinicians

Offer patients information about additional nonpharmacological therapies if their acute low back pain does not adequately resolve with physical activity, education, reassurance, and self-management support.

For Organizations and Health Services Planners

Ensure that all health care settings have systems, processes, and resources in place to provide adults with information on additional nonpharmacological therapies during virtual or in-person visits, as appropriate.

Quality Indicator: How to Measure Improvement for This Statement

- Percentage of people with acute low back pain whose symptoms do not adequately improve with physical activity, education, reassurance, and self-management support who receive 1 or more additional nonpharmacological therapies (see examples of additional nonpharmacological therapies in the definitions that should be considered)

Measurement details for this indicator, as well as overarching indicators to measure improvement for the goals of the entire quality standard, are available in the technical specifications.

Appendix 1: About This Quality Standard

How to Use This Quality Standard

Quality standards inform patients, clinicians, and organizations about what high-quality care looks like for health conditions or processes deemed a priority for quality improvement in Ontario. They are based on the best evidence.

Guidance on how to use quality standards and their associated resources is included below.

For People With Acute Low Back Pain

This quality standard consists of quality statements. These describe what high-quality care looks like for adults 16 years of age and older with acute low back pain.

Within each quality statement, we have included information on what these statements mean for you as a patient.

In addition, you may want to download this accompanying patient guide on low back pain to help you and your family have informed conversations with your clinicians. Inside, you will find information and questions you may want to ask as you work together to make a plan for your care.

For Clinicians and Organizations

The quality statements within this quality standard describe what high-quality care looks like for adults 16 years of age and older with acute low back pain. They are based on the best evidence and designed to help you know what to do to reduce gaps and variations in care.

Many clinicians and organizations are already providing high-quality, evidence-based care. However, there may be elements of your care that can be improved. This quality standard can serve as a resource to help you prioritize and measure improvement efforts.

Tools and resources to support you in your quality improvement efforts accompany each quality standard. These resources include indicators and their definitions, available in the technical specifications. Measurement is key to quality improvement. Collecting and using data when implementing a quality standard can help you assess the quality of care you are delivering and identify gaps in care and areas for improvement.

There are also a number of resources online to help you, including:

- Our patient guide on low back pain, which you can share with patients and families to help them have conversations with you and their other clinicians. Please make the patient guide available where you provide care
- Our measurement resources, including the technical specifications for the indicators in this quality standard, the “case for improvement” slide deck to help you to share why this standard

was created and the data behind it, and our measurement guide containing supplementary information to support the data collection and measurement processes

- Our placemat, which summarizes the quality standard and includes links to helpful resources and tools
- Our *Getting Started Guide*, which includes links to templates and tools to help you put quality standards into practice. This guide shows you how to plan for, implement, and sustain changes in your practice
- Quorum, an online community dedicated to improving the quality of health care across Ontario. This is a place where clinicians can share information and support each other, and it includes tools and resources to help you implement the quality statements within each standard

How the Health Care System Can Support Implementation

As you work to implement this quality standard, there may be times when you find it challenging to provide the care outlined due to system-level barriers or gaps. These challenges have been identified and documented as part of the development of the quality standard, which included extensive consultation with clinicians and lived experience advisors and a careful review of available evidence and existing programs. Many of the levers for system change fall within the purview of Ontario Health, and as such we will continue to work to address these barriers to support the implementation of quality standards. We will also engage and support other provincial partners, including the Ministry of Health or other relevant ministries, on policy-level initiatives to help bridge system-level gaps.

In the meantime, there are many actions you can take on your own, so please read the standard and act where you can.

Appendix 2: Glossary

Term	Definition
Acute low back pain	Low back pain that lasts less than 12 weeks.[2]
Adults	People aged 16 years and older.
Care partner	An unpaid person who provides care and support in a nonprofessional capacity, such as a parent, other family member, friend, or anyone else identified by the person with low back pain. Other terms commonly used to describe this role include “caregiver,” “family caregiver,” “carer,” and “primary caregiver.”
Chronic low back pain	Persistent or recurrent low back pain that lasts longer than 12 weeks and that cannot be consistently attributed to an underlying disease process or structural lesion.[13]
Clinicians	Regulated professionals who provide care to patients or clients. Examples are chiropractors, nurses, nurse practitioners, occupational therapists, pharmacists, physicians, physiotherapists, psychologists, and social workers.
Culturally appropriate care[45]	Care that incorporates cultural or faith traditions, values, and beliefs; is delivered in the person’s preferred language; adapts culture-specific advice; and incorporates the person’s wishes to involve family or community members.
Family	The people closest to a person in terms of knowledge, care, and affection; this may include biological family or family of origin, family through marriage, or family of choice and friends. The person defines their family and who will be involved in their care.
Health care team	Clinicians, as well as people in unregulated professions, such as administrative staff, behavioural support workers, patient transport staff, personal support workers, recreational staff, spiritual care staff, and volunteers.
Primary care	A setting where people receive general health care (e.g., screening, diagnosis, and management) from a clinician who the person can access directly without a referral. This is usually the primary care clinician, family physician, nurse practitioner, or other clinician with the ability to make referrals, request testing, and prescribe medications.
Primary care clinician	A family physician (also called a primary care physician) or nurse practitioner.
Red flags	Signs or symptoms of a serious underlying pathological disease that may require tests or investigations (e.g., tumor, infection, fracture).[8]
Yellow flags	Psychosocial risk factors for developing chronic low back pain (e.g., fear, anxiety).[10]

Appendix 3: Values and Guiding Principles

Values That Are the Foundation of This Quality Standard

This quality standard was created and should be implemented according to the *Patient, Family and Caregiver Declaration of Values for Ontario*. This declaration "is a vision that articulates a path toward patient partnership across the health care system in Ontario. It describes a set of foundational principles that are considered from the perspective of Ontario patients and serves as a guidance document for those involved in our health care system."

These values are:

- Respect and dignity
- Empathy and compassion
- Accountability
- Transparency
- Equity and engagement

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

Guiding Principles

In addition to the above values, this quality standard is guided by the principles outlined below.

Acknowledging the Impact of Colonization

Clinicians should acknowledge and work toward addressing the historical and present-day impacts of colonization in the context of the lives of Indigenous Peoples throughout Canada. This work involves being sensitive to the impacts of intergenerational and present-day traumas and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities, as well as recognizing their strength and resilience. This quality standard uses existing clinical practice guideline sources that may not include culturally appropriate care or acknowledge traditional Indigenous beliefs, practices, and models of care.

Acknowledging the Impact of Racism

Many people in Ontario experience racism and discrimination in their interactions with the health care system, negatively affecting the quality, safety, and effectiveness of the health care they receive.[46,47] Racism refers to systemic discrimination that is deeply embedded in organizational cultures, policies, directives, practices, or procedures; it causes harm by excluding, displacing, marginalizing, and perpetuating unfair barriers and treatment towards Black, Indigenous, South Asian, and other racialized populations.[48] These populations often face profound disparities in accessing and

receiving timely, anti-racist, anti-oppressive, culturally appropriate, and culturally responsive health care.[47,49,50] To advance health equity and achieve better outcomes for all, the harmful effects and impacts of racism and discrimination must be explicitly identified and addressed.[48] Adopting an anti-racist and anti-oppressive approach recognizes the existence of racism and people's intersectional identities; it then actively seeks to identify, reduce, and remove racially inequitable outcomes, power imbalances, and the structures that sustain those inequities.[48]

French Language Services

In Ontario, the *French Language Services Act* guarantees an individual's right to receive services in French from Government of Ontario ministries and agencies in 26 designated areas and at government head offices.[51]

Social Determinants of Health

Homelessness and poverty are 2 examples of economic and social conditions that influence people's health, known as the social determinants of health. Other social determinants of health include employment status and working conditions, race and ethnicity, food security and nutrition, gender, housing, immigration status, social exclusion, and residing in a rural or urban area. Social determinants of health can have strong effects on individual and population health; they play an important role in understanding the root causes of poorer health. People of low socioeconomic status are more likely to experience low back pain, have a higher risk of recurrence, receive non-guideline concordant care, and have limited access to health care services.[16-18] Equitable access to the health system also includes access to culturally safe care. Language, a basic tool for communication, is an essential part of safe care and must be considered throughout a person's health care journey. For example, in predominantly English-speaking settings, services should be actively offered in French and other languages.

Recovery

This quality standard is underpinned by the principle of recovery, as described in the Mental Health Strategy for Canada. Adults with acute low back pain who present with yellow flags experience barriers to recovery, including fear, financial problems, anger, depression, job dissatisfaction, family issues, and stress.[5] Adults with acute low back pain can lead meaningful lives and have a right to services provided in an environment that promotes hope, empowerment, self-determination, and optimism, and that are embedded in the values and practices associated with recovery-oriented care. The concept of recovery refers to "living a satisfying, hopeful, and contributing life, even when there are on-going limitations caused by mental health problems and illnesses."[52] As described in the Mental Health Strategy Canada, "recovery – a process in which people living with mental health problems and mental illnesses are actively engaged in their own journey of well-being – is possible for everyone. Recovery journeys build on individual, family, cultural, and community strengths and can be supported by many types of services, supports, and treatments."[53]

Mental wellness is defined as a balance of the mental, physical, spiritual, and emotional, which is enriched as individuals have purpose in their daily lives, hope for their future, a sense of belonging, and a sense of meaning.[54] These elements of mental wellness are supported by factors such as culture, language, Elders, families, and creation. The First Nations Mental Wellness Continuum

Framework provides an approach that "respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing."[54]

Integrated Care

Adults with acute low back pain should receive care through an integrated team-based approach that facilitates access to interprofessional services from primary care clinicians, nonsurgical and surgical speciality health care teams, and programs in the community, according to the patient's needs over time.[17] Clinicians should work with patients, care partners, and communities to deliver the highest quality of care.[43] Interprofessional collaboration, shared decision-making, coordination of care across different settings within and beyond the health sector, and continuity of care (including follow-up care) are hallmarks of this patient-centred approach.

Trauma-Informed Care

Trauma-informed care is health care that reflects an understanding of trauma, the impact that traumatic experiences can have on human beings, and the potential to traumatize or retraumatize patients when providing them with care.[55,56] A trauma-informed approach does not necessarily involve addressing the trauma directly. Rather, it involves acknowledging that a person may have experienced a previous traumatic event that may contribute to their current health concerns and taking steps to reduce opportunities for traumatization (e.g., using active strategies around consent, attending to individual patient needs, recognizing the inherent power imbalance in clinician–patient relationships, and facilitating greater patient agency and choice in all interactions).[57,58] A trauma-informed approach emphasizes the creation of an environment in which a person can feel comfortable disclosing trauma, and it involves understanding, respecting, and responding to the effects of trauma.[56-58]

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Raj Rampersaud (co-chair)
Spine Surgeon, University Health Network; Professor, Department of Surgery, Division of Orthopaedic Surgery, University of Toronto

Jeanne Bank
Lived Experience Advisor

Karen Clayton-Roberts
Chief Nurse Practitioner, Clinic Director, Belleville Nurse Practitioner Led Clinic

David Dos Santos
Chiropractor, Trillium Health Partners

Caroline Fanti
Physiotherapist and Director, Regional Orthopedic Program, Thunder Bay Regional Health Sciences Centre

John F. Flannery
Medical Director, Musculoskeletal & Multisystem Rehab Program, University Health Network—Toronto Rehab

Simon French
Associate Professor, School of Rehabilitation Therapy, Faculty of Health Sciences, Queen's University

Deborah Kopansky-Giles
Chiropractor, St Michael's Hospital Family Health Team; Professor, Graduate Education and Research, Canadian Memorial Chiropractic College

Jordan Miller
Physiotherapist, Assistant Professor, School of Rehabilitation Therapy, Queen's University

Ravinder Ohson
Family Physician, Associate Clinical Professor, Department of Family Medicine, McMaster University

John Riva
Chiropractor, Assistant Clinical Professor, Department of Family Medicine, McMaster University

Scott Shallow
Family Medicine Physician, Queen's University

Barbara Sklar
Lived Experience Advisor

Paul Taenzer
Psychologist, Independent Practice

Jenny Tang
Lived Experience Advisor

Eugene Wai
Spinal Surgeon, The Ottawa Hospital; Associate Professor, Department of Surgery, University of Ottawa

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About Us

We are an agency created by the Government of Ontario to connect, coordinate, and modernize our province's health care system. We work with partners, providers, and patients to make the health system more efficient so everyone in Ontario has an opportunity for better health and well-being.

Equity, Inclusion, Diversity, and Anti-Racism

Ontario Health is committed to advancing equity, inclusion and diversity and addressing racism in the health care system. As part of this work, Ontario Health has developed an *Equity, Inclusion, Diversity and Anti-Racism Framework*, which builds on existing legislated commitments and relationships and recognizes the need for an intersectional approach.

Unlike the notion of equality, equity is not about sameness of treatment. It denotes fairness and justice in process and in results. Equitable outcomes often require differential treatment and resource redistribution to achieve a level playing field among all individuals and communities. This requires recognizing and addressing barriers to opportunities for all to thrive in our society.

For more information about Ontario Health, visit OntarioHealth.ca

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Ontario Health
500–525 University Avenue
Toronto, Ontario
M5G 2L3

Toll Free: 1-877-280-8538
TTY: 1-800-855-0511
Email: QualityStandards@OntarioHealth.ca
Website: hqontario.ca

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