

Quality Standards



Chronic Pain

Care for Adults, Adolescents, and Children

DRAFT

Summary

This quality standard addresses care for people with chronic pain lasting longer than 3 months, and where any signs of serious underlying pathology (i.e., “red flags,” such as cancer, infection, or fracture) or other treatable conditions requiring medical or surgical management have been ruled out. It addresses care for adults, adolescents, and children, but excludes infants. It applies to care for chronic pain delivered in outpatient settings, including primary care, community pain clinics, and interprofessional pain programs. This quality standard does not specifically address headache, pain from active cancer, or pain experienced during end of life. See Health Quality Ontario’s quality standards [Palliative Care](#) and [Opioid Prescribing for Chronic Pain](#) for quality statements related to palliative care and the use of opioids for chronic pain.

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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 for aspects of care that have been deemed a priority for quality improvement in the province. They are based on the best available evidence.

Tools and resources to support clinicians and organizations in their quality improvement efforts accompany each quality standard. One of these resources is an inventory of indicator definitions to help clinicians and organizations assess the quality of care they are delivering, and to identify gaps in care and areas for improvement. These indicator definitions can be used to assess processes, structures, and outcomes. It is not mandatory to use or collect data when using a quality standard to improve care. The indicator definitions are provided to support quality improvement efforts; clinicians and organizations may choose indicators to measure based on local priorities and local data availability.

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 with chronic pain lasting longer than 3 months, and where any signs of serious underlying pathology (i.e., “red flags,” such as cancer, infection, or fracture) or other treatable conditions requiring medical or surgical management have been ruled out. It addresses care for adults, adolescents, and children, but excludes infants. It applies to care for chronic pain delivered in outpatient settings, including primary care, community pain clinics, and interprofessional pain programs. This quality standard does not specifically address headache, pain from active cancer, or pain experienced during end of life. See Health Quality Ontario’s quality standards [Palliative Care](#) and [Opioid Prescribing for Chronic Pain](#) for quality statements related to palliative care and the use of opioids for chronic pain.

Terminology Used in This Quality Standard

This quality standard defines “interprofessional care” as care provided by professionals working as a group to provide comprehensive evidence-informed services. Their working environment is participatory, collaborative, and coordinated. The goals for pain management and function are aligned with the goals of the person being treated. Interprofessional collaboration, shared decision-making, coordination of care, and continuity of care (including follow-up care) are hallmarks of this patient-centred approach. Collaborative practice in health care “occurs when multiple health care workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers, and communities to deliver the highest quality of care across settings.”¹

Why This Quality Standard Is Needed

This quality standard uses the commonly accepted definition of “chronic pain” as pain that typically lasts longer than 3 months or that continues past the time of normal tissue healing.^{2,3} Some common examples of chronic pain include musculoskeletal, neuropathic, and postsurgical pain,² but chronic pain is also associated with many other underlying conditions.^{2,3} Chronic pain can also be considered a disease in itself when the underlying cause is unknown but the pain has a significant impact on a person’s physical, emotional, and psychological well-being, with detrimental effects on the person’s functional, social, and economic status, and quality of life.⁴ People with chronic pain may also experience mood disorders, sleep disturbances, and impaired social interactions.²

Chronic pain is common and can significantly affect quality of life, including the ability to work or attend school. Some estimates suggest that as many as one in five Canadians live with chronic pain.⁵ About one-half of people with chronic pain report experiencing the condition for more than 10 years.⁶

Studies show that people with chronic pain have a health-related quality of life similar to individuals with heart disease or chronic obstructive pulmonary disease.⁷ In Ontario, the average annual extra cost of chronic pain to the health care system is estimated to be 51% more than for a matched person with similar morbidity and demographic characteristics but without chronic pain.⁸

Chronic pain can be challenging to assess and manage because of the variety of underlying conditions, the relative lack of effective treatments, and the different ways people are affected. A

treatment that works well for one person may not work well for another. Effective treatment requires a personalized and equitable approach to care.³ The challenge is to determine when and where to use different treatments for the best long-term outcomes.³ Even in cases where pain cannot be eliminated, evidence-based interventions can significantly improve a person's quality of life, mood, and function.³

People with chronic pain achieve the best outcomes when they are treated through a multimodal and interprofessional approach designed to improve function and quality of life.² Health care professionals should work together and closely with the person with chronic pain and their family to promote their health and well-being and provide support for their self-management.⁵

While most people with chronic pain are able to receive their care from their primary care provider, some will also require periodic access to an interprofessional pain program or to specialist care.³ Access to specialized pain care varies across Ontario. In some places, there are no pain specialists, and some pain management interventions might not be available or affordable for everyone.⁵

Principles Underpinning This Quality Standard

This quality standard is underpinned by the principles of respect and equity. People with chronic pain should receive services that are respectful of their rights and dignity and that promote shared decision-making and self-management.

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

Health care providers should be aware of the historical context of the lives of Indigenous Peoples throughout Canada and be sensitive to the impacts of intergenerational trauma and the physical, mental, emotional, and social harms experienced by Indigenous people, families, and communities.

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

Patient Guide

The [patient guide](#) on chronic pain can help patients and families have conversations with their health care provider. Inside, patients will find questions they may want to ask as they work together to make a plan for their care.

Clinicians and health services should make patient guides available in settings where people receive care.

How Success Can Be Measured

The Chronic Pain Quality Standard Advisory Committee identified a small number of overarching goals for this quality standard. These have been mapped to indicators that may be used to assess quality of care. No provincially measurable indicators of success were identified because, currently, provincial data sources on chronic pain care are limited, as is the ability to identify people with chronic pain. As data sources or methods are developed to accurately identify people with chronic pain, the provincial measures of success for this standard will be reconsidered.

How Success Can Be Measured Locally

Providers may want to monitor their own quality improvement efforts and assess the quality of care they provide to people with chronic pain. It may be possible to do this using their own clinical records, or they might need to collect additional data. We recommend that health care providers consider using the following indicators to measure the quality of care patients are receiving; these indicators cannot be measured provincially using currently available data sources:

- Percentage of people with chronic pain who receive non-opioid pharmacotherapy as first-line pharmacological treatment for pain
- Percentage of people with chronic pain who experience an improved quality of life
- Percentage of people with chronic pain who experience improved functional status

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

To assess the equitable delivery of care, the statement-specific indicators and the overall indicators can be stratified by patient or caregiver socioeconomic and demographic characteristics, such as income, education, language, age, sex, and gender.

Quality Statements in Brief

Quality Statement 1: Comprehensive Assessment

People with chronic pain receive a comprehensive assessment that includes consideration of functional status and the social determinants of health.

Quality Statement 2: Setting Goals for Pain Management and Function

People with chronic pain set goals for pain management and improved function. They regularly evaluate these goals with their health care professionals.

Quality Statement 3: Supported Self-Management and Education

People with chronic pain are offered education and are encouraged and supported to access self-management resources or programs as part of a long-term management strategy.

Quality Statement 4: Physical Activity

People with chronic pain are encouraged and supported to engage in regular physical activity.

Quality Statement 5: Physically Based Interventions

People with chronic pain are encouraged and supported to engage in physically based interventions.

Quality Statement 6: Therapeutic Exercise

People with chronic pain are encouraged and supported to engage in therapeutic exercise.

Quality Statement 7: Pharmacotherapy

People with chronic pain are offered non-opioid pharmacotherapies and/or non-pharmacological therapies as first-line treatment for chronic pain. Medications are regularly reviewed for effectiveness in meeting goals for pain management and improved function.

Quality Statement 8: Psychologically Based Interventions

People with chronic pain are offered psychological assessment and appropriate psychologically based interventions.

Quality Statement 9: Psychosocial Supports

People with chronic pain, their families, and their caregivers are offered psychosocial supports that consider their emotional, social, cultural, cognitive, accessibility, or spiritual needs. Psychosocial supports may include traditional knowledge, medicines, and healing practices for chronic pain, where appropriate.

Quality Statement 10: Interventional Management of Chronic Pain

People with chronic pain are offered interventional management, when clinically indicated, in combination with other strategies and interventions as part of an interprofessional approach to chronic pain management.

Quality Statement 11: Access and Referral to an Interprofessional Chronic Pain Program

People whose quality of life is significantly impacted by their chronic pain are referred by their primary care provider to an interprofessional pain program. They are seen for a first appointment within 3 months of referral.

Quality Statement 12: Transitions and Coordination of Care

People with chronic pain receive timely and collaborative care during and after health care transitions.

Quality Statement 1: Comprehensive Assessment

People with chronic pain receive a comprehensive assessment that includes consideration of functional status and social determinants of health.

Background

People with chronic pain should receive an assessment that considers relevant physical, psychological, and social factors. A compassionate and person-centred approach to assessment that considers individual patient experiences and needs increases the chances of successful management of chronic pain by creating a supportive therapeutic environment.³ Health care professionals should use validated tools to assess functional status, quality of life, psychological distress, and pain.^{2,3} Alternative or adapted assessment tools should be used for people who cannot self-report.⁵ Assessments do not necessarily need to be finalized in one visit or by the same health care professional, but should be completed in a coordinated way. The person's health history and concurrent health issues should also be documented and addressed.

Access to resources plays a large role in each person's ability to access health care, engage in healthy lifestyle behaviours, and participate in chronic pain management plans. Therefore, the assessment should also consider socioeconomic factors, including the social determinants of health. The socioeconomic assessment should be repeated whenever there are new concerns or significant changes in the person's clinical scenario.

Sources: Institute for Clinical Systems Improvement, 2016² | Registered Nurses Association of Ontario, 2013⁵ | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Comprehensive assessment

A comprehensive assessment should include^{2,3,5}:

- Description of the pain condition: the history, source, quality (i.e., neuropathic, nociceptive, centrally mediated, or mixed), anatomical site, and radiation of the pain, as well as its frequency and severity⁹
- Signs of serious underlying pathology (i.e., "red flags," such as cancer, infection, or fracture) or other treatable conditions requiring medical or surgical management
- Medication use and effectiveness for pain and function
- Functional status, or attendance at school for children and youth
- Sleep patterns
- Past and current mental health status, including a history of trauma or post-traumatic stress disorder (PTSD)
- Food security, nutritional status, or deficiencies
- Psychosocial history and issues (i.e., "yellow flags," such as the person's attitudes and beliefs, emotions, behaviours, and family and workplace factors)
- Past and current substance use; a family history of substance use
- Family history of chronic pain
- Past pain management and coping strategies and their effects

- Beliefs, knowledge, and level of understanding of pain and pain management
- Assessment of cognitive status, frailty, and impairment (physical or cognitive)
- Physical examination

Family members can be an important contributor to the assessment of pain for those with conditions where self-reporting is difficult.

Functional status

Functional status refers to a person's ability to perform activities of daily living, including work, play, and socialization. Examples include being able to attend school, participating in personal hygiene, driving, and managing medications. The assessment of functional status should be performed using a validated assessment tool; for example, the Brief Pain Inventory.

Social determinants of health

The social determinants of health are factors that affect a person's ability to access or receive high-quality health care; these can create unfair and avoidable differences in health status.⁹ The social determinants of health include, but are not limited to²:

- Culture
- Language
- Early child development
- Education
- Employment
- Ethnicity
- Family and social support
- Geographic location
- Housing
- Income
- Transportation and access to health care facilities

What This Quality Statement Means

For People With Chronic Pain

Your health care professional should ask you about your pain, your health, your ability to sleep and rest, your ability to function at work or school 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. This assessment should include the consideration of functional status and social determinants of health. Use alternative or adapted assessment tools to assess people who cannot self-report pain or functional status.

For Health Services

Ensure systems, processes, and resources are in place to allow clinicians to perform comprehensive assessments of people with chronic pain. These include providing the time required to perform a comprehensive assessment, including history, and ensuring access to assessment tools, electronic medical histories, and patient records.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who receive a comprehensive assessment (see definition)

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who receive a comprehensive assessment
- Data source: local data collection

Number of days between when people report chronic pain symptoms and when they have a completed comprehensive assessment

- Calculation: can be measured as mean, median, or distribution of the wait time (in days) between when people report chronic pain symptoms and when they have a completed comprehensive assessment
- Data source: local data collection

Quality Statement 2: Setting Goals for Pain Management and Function

People with chronic pain are encouraged to set goals for pain management and improved function. They regularly evaluate these goals with their health care professionals.

Background

Chronic pain can rarely be eliminated. Therapy will usually be designed to achieve a meaningful reduction in pain intensity and/or a significant improvement in other patient-defined functional indicators, such as returning to social activities, employment, or school.² Goals should be patient-driven and focus on things that are important to the person with chronic pain.² Health care professionals should work in partnership with people who report chronic pain to set specific, measurable, achievable, relevant, and time-limited (SMART) goals that may include:

- Pain management
- Activities of daily living
- Sleep
- Mental health

These goals should be based on the comprehensive assessment⁵ (see quality statement 1) and set using a shared decision-making process.² Health care professionals can promote and support engagement and pacing during daily activities when working towards goals. Goals should be documented in a collaborative care plan and shared with the person's family and/or caregivers, peer leaders, if applicable, and any other involved health care professionals.²

Referral to an interprofessional pain program should be considered if goals are not being met, if the person's pain is not adequately controlled, or when specific therapies or assessments are being considered that are beyond the scope of a person's regular health care provider³ (see quality statement 11).

Sources: Institute for Clinical Systems Improvement, 2016² | Registered Nurses Association of Ontario, 2013⁵

Definitions Used Within This Quality Statement

Evaluate regularly

Management goals for pain and function should be documented and monitored over time. Progress toward goals should be reassessed at least every 3 months, or more frequently, based on the nature of the specific goals developed.

What This Quality Statement Means

For People With Chronic Pain

Have conversations with your health care professionals to set goals for managing your pain and improving your quality of life. Discuss goals that matter to you, including reducing your pain and improving your ability to function at work, at school, or at home.

For Clinicians

Work with people with chronic pain to set SMART goals for pain management and improved function, and regularly evaluate these goals together.

For Health Services

Ensure resources and tools are available to allow clinicians to follow up with people with chronic pain to evaluate management goals regularly together.

Quality Indicators

Process Indicator

Percentage of people with chronic pain who have documented goals for pain management and functional improvement

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who have documented goals for:
 - Pain management
 - Functional improvement
- Data source: local data collection

Quality Statement 3: Supported Self-Management and Education

People with chronic pain are offered education and are encouraged and supported to access self-management resources or programs as part of a long-term management strategy.

Background

Self-management encourages people with chronic pain to gain the skills, information, and confidence to manage their physical and emotional health. It may increase their quality of life and impact their use of health care services.¹⁰ Health care professionals can provide education on physical and psychological self-management strategies, such as self-massage, stretching, simple home-based strengthening exercises, posture, graded activities, sleep hygiene, breathing, relaxation, meditation, and diet. Self-management and education are complements to other therapies for chronic pain and are not meant as replacements.³

Sources: Registered Nurses Association of Ontario, 2013⁵ | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Education

Education can be provided in a variety of forms, including in person, written, or online. It may be provided by a health care professional, trained peer educator, or other trained person. Education should include evidence-based information on^{2,3,11}:

- The pain condition
- Pain mechanisms, pathologies, and the processes of healthy normal functioning
- The physiology of pain, including differences between acute and chronic pain
- The psychology of pain, including fear and avoidance, stress, and depression
- The benefits of physical activity and exercise
- Recommended physical, psychological, pharmacological, and self-management interventions and strategies
- Healthy eating, nutrition, and weight management
- The risks of substance use, including cigarettes, alcohol, and opioids
- The management of other concurrent chronic conditions
- Evidence of potential benefits and harms for all therapies for chronic pain, where they exist

Self-management

Self-management programs (such as the Self-Management Ontario program) are distinct from education and can be individual or group based. They may involve interactions between a participant and a facilitator. Self-management empowers people and their families to take a central role in managing their chronic pain and improving their quality of life. It may increase their confidence in their ability to manage symptoms and communicate effectively with their health care providers.¹⁰ Self-management skills include goal setting, breathing, activity pacing, exercise, self-regulation, and problem-solving.

What This Quality Statement Means

For People With Chronic Pain

You and your family should be offered education on chronic pain and information on self-management programs for chronic pain in your community. Self-management groups and programs can connect you with other people with chronic pain and help you develop goal-setting and coping skills.

For Clinicians

Provide education to people with chronic pain and their families, and encourage them to access self-management resources or programs as part of a long-term pain-management strategy. Be aware of programs and resources available in your local community.

For Health Services

Ensure education materials (written, online, or other) and self-management programs are available and accessible to people with chronic pain.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who receive education on chronic pain

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who receive education on chronic pain
- Data source: local data collection

Percentage of people with chronic pain who access self-management resources or programs

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who access self-management resources or programs
- Data source: local data collection

Outcome Indicator

Percentage of people who report feeling better able to cope with their pain after receiving education or after accessing self-management programs

- Denominator: total number of people with chronic pain who receive education or who access a self-management program
- Numerator: number of people in the denominator who feel better able to cope with their pain
- Data source: local data collection

Quality Statement 4: Physical Activity

People with chronic pain are encouraged and supported to engage in regular physical activity.

Background

For people with chronic pain who have stopped physical activity, health care professionals should encourage activity and provide education on its benefits, while considering any potential exacerbation of underlying or undiagnosed musculoskeletal injury or cardiovascular or neurologic disease.² People with chronic pain can use pacing and awareness of their response to different physical activities to guide their self-management plans and goals for pain and function. Health care professionals should address fears of worsening pain and, if appropriate, offer a graded approach to regular physical activity that gradually increases over time.

Daily physical activity is recommended, including moderate to vigorous aerobic activity, in intervals of 10 minutes or more, based on the person's overall health status and abilities.¹²⁻¹⁴ Moderate activity causes adults to sweat a little and breathe harder; examples are brisk walking or biking. Vigorous activity causes adults to sweat and be out of breath; examples are faster-paced walking or carrying heavy loads such as a backpack or groceries. Physical activities should be tailored to a person's goals for functional improvement and improved quality of life.

For information specific to osteoarthritis of the hip, knee, or hand, see Health Quality Ontario's [Osteoarthritis](#) quality standard.

Source: Institute for Clinical Systems Improvement, 2016²

Definitions Used Within This Quality Statement

Physical activity

Any activity that involves bodily movement, done as part of leisure, recreation, work, play, active transportation, or household tasks. It is different from therapeutic exercise, which is a type of physical activity that is planned, structured, repetitive, and designed to improve or maintain one or more components of physical fitness.²

What This Quality Statement Means

For People With Chronic Pain

Daily physical activity can reduce pain and improve function. Your health care professional can help you decide what activities might work best for you.

For Clinicians

Encourage and support people with chronic pain to stay active in everyday life. Offering a graded approach to physical activity may help alleviate fears around worsening pain.

For Health Services

Create programs and resources that encourage and promote physical activity and meet the needs of people with chronic pain.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who receive information from their health care professional about engaging in regular physical activity

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who receive information from their health care professional about engaging in regular physical activity
- Data source: local data collection

Percentage of people with chronic pain who report participating in daily physical activity

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who report participating in daily physical activity
- Data source: local data collection

Quality Statement 5: Physically Based Interventions

People with chronic pain are encouraged and supported to engage in physically based interventions.

Background

Physically based interventions can provide short-term relief from chronic pain. The efficacy of each intervention may vary by type or source of pain. There is little to no high-quality evidence to guide people with chronic pain and their health care professionals on the effectiveness of one type of physically based intervention compared with another. The potential benefits of being physically active, as well as the benefits and harms of physically based interventions, should be discussed together.²

Information and education on accessing and using physically based interventions should be included as part of self-management programs. The time and financial commitments required to access physically based interventions can be barriers, perpetuating health inequities. Health care professionals should offer information on physically based interventions and support people with chronic pain in accessing interventions that meet their needs as part of their plans for self-management.¹⁵ Health care professionals should be aware of low- or no-cost programs for chronic pain in their community.

Sources: American College of Physicians, 2017¹⁵ | Institute for Clinical Systems Improvement, 2016² | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Physically based interventions

These include manual therapies and hands-on treatments, such as manipulation and mobilization, that are applied to the person with chronic pain by a health care professional.^{2,3} Physically based interventions as a treatment option in the management of chronic pain are practised by a variety of health care professionals including, but not limited to, physiotherapists, chiropractors, occupational therapists, and massage therapists.

Types of physically based interventions to be considered in the management of chronic pain include^{2,3,15}:

- Manual therapy for short-term relief of pain in chronic low back pain
- Transcutaneous electrical nerve stimulation (TENS) for chronic pain. Either low- or high-frequency TENS can be used
- Low-level laser therapy for chronic low back pain
- Breathing activities

Other interventions to consider include postural correction, walking aides, and environmental changes to the home or worksite.

What This Quality Statement Means

For People With Chronic Pain

Manual therapies can reduce pain in the short term. Talk with your health care professional to determine what physically based interventions might benefit you based on your goals and condition.

For Clinicians

Work with people with chronic pain to determine a plan for physically based interventions to be trialled based on the unique needs of the person in the context of their chronic pain.

For Health Services

Ensure people with chronic pain have access to physically based interventions.

Quality Indicators

Process Indicator

Percentage of people with chronic pain who receive physically based interventions for chronic pain

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who receive physically based interventions for chronic pain
- Data source: local data collection

Quality Statement 6: Therapeutic Exercise

People with chronic pain are encouraged and supported to engage in therapeutic exercise.

Background

Therapeutic exercise in addition to physical activity is recommended in the management of chronic pain.³ Exercise can improve pain symptoms and increase a person's ability to function. It can also improve their overall sense of well-being. Some people may experience exacerbation of their pain or new onset of pain during or after exercise. Assuming appropriate technique and intensity, no specific exercise has been shown to give greater benefits. The optimum frequency has not been determined.²

Recommended approaches to help people with chronic pain start and continue exercising include supervised exercise sessions, individualized exercises in group settings, and the provision of a combined group and home exercise program.³ Progression of exercise may be accomplished through graded exposure with the opportunity for reassessment with a qualified health care professional. Health care professionals should offer information on therapeutic exercise and be aware of resources for low- or no-cost programs for chronic pain in their community.¹⁵

For osteoarthritis of the hip or knee, specific progressive neuromuscular training, muscle strengthening, and aerobic exercise of sufficient frequency and intensity to maintain or improve joint health and physical fitness is recommended. For more information, see Health Quality Ontario's [Osteoarthritis](#) quality standard.

Sources: American College of Physicians, 2017¹⁵ | Institute for Clinical Systems Improvement, 2016² | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Therapeutic exercise

Exercise as a therapeutic intervention is defined as a structured, repetitive, physical activity designed to improve or maintain physical fitness and maintain or increase range of motion. It is recommended or prescribed by a health care professional and can be facilitated or implemented by another trained person.²

What This Quality Statement Means

For People With Chronic Pain

Exercise can reduce your pain and improve your mood. Talk with your health care professional about exercises that might help you based on your goals and condition.

For Clinicians

Work with people with chronic pain to determine a plan for therapeutic exercise to be trialed based on the unique needs of the person in the context of their chronic pain.

For Health Services

Ensure people with chronic pain have access to therapeutic exercise programs and providers.

Quality Indicators

Process Indicator

Percentage of people with chronic pain who participate in therapeutic exercise

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who participate in therapeutic exercise
- Data source: local data collection

Quality Statement 7: Pharmacotherapy

People with chronic pain are offered non-opioid pharmacotherapies as first-line treatment for chronic pain. Medications are regularly reviewed for effectiveness in meeting goals for pain management and improved function.

Background

Pharmacotherapy should be initiated with the goals of providing pain relief and also increasing function and restoring a person's overall quality of life.² Pharmacotherapy should be offered along with other non-pharmacological strategies and interventions. The goals, expected outcomes, and potential benefits and harms of pharmacotherapies, along with benefits and harms of other treatment options, should be discussed with the person with chronic pain as part of the shared decision-making process.⁵ In selecting pain-relieving medication, a stepped approach should be used that takes into consideration risks, side effects, efficacy, costs to the patient, and the person's needs and preferences.

Studies show that for many people with chronic pain, non-opioid pharmacotherapies such as nonsteroidal anti-inflammatory drugs (NSAIDs) are at least as effective as opioids for managing pain and improving function; in addition, they do not carry the risks of addiction, tolerance, and overdose that are associated with opioids.^{16,17} If NSAIDs are offered, the risks of cardiovascular and gastrointestinal harms should be discussed, especially for older people. Combination therapies should be considered for people with neuropathic pain.

People with chronic pain should begin a trial of opioid pharmacotherapy only after other multimodal therapies have been tried without adequate improvement in pain and function. See Health Quality Ontario's quality standard [Opioid Prescribing for Chronic Pain](#) for more detailed information on prescribing opioids for chronic pain.

For osteoarthritis of the hip, knee, or hand, use a stepped approach to pharmacotherapy. For more information, see Health Quality Ontario's [Osteoarthritis](#) quality standard.

Medications for chronic pain should be reviewed regularly and assessed for their effectiveness in managing pain and improving function to support their continued use. Medications should be reviewed more frequently when they are being changed, or when the pain or underlying concurrent diagnoses change.³ Use of other currently prescribed medications, alcohol, smoking, substances, over-the-counter medications, vitamins, minerals, and other supplements should be documented and any potential interactions discussed.

Since depression and anxiety commonly accompany chronic pain, people with chronic pain should be assessed for depression and anxiety. When necessary, they should be diagnosed and treated, including treatment with psychotherapy and antidepressant therapy for people with major depression.³ For more information, see Health Quality Ontario's [Major Depression](#) quality standard.

Sources: Institute for Clinical Systems Improvement, 2016² | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Non-opioid pharmacotherapy

Non-opioid medications for chronic pain include several types of medications. Non-opioid medications to consider for the management of chronic pain include the following³:

NSAIDs

- For chronic non-specific low back pain. Cardiovascular and gastrointestinal risks need to be taken into account when prescribing any non-steroidal anti-inflammatory drug

Anticonvulsants

- Gabapentin for neuropathic pain
- Pregabalin for fibromyalgia, and for neuropathic pain if other first- and second-line pharmacological treatments have failed
- Carbamazepine for neuropathic pain. Potential harms should be discussed
- Flexible dosing may improve tolerability. Failure to respond after an appropriate dose for several weeks should result in trial of a different compound

Antidepressants

- Tricyclic antidepressants (such as amitriptyline, nortriptyline, or imipramine) should *not* be used for chronic low back pain
- Amitriptyline for fibromyalgia and neuropathic pain (excluding neuropathic pain related to human immunodeficiency virus [HIV])
- Duloxetine for fibromyalgia or osteoarthritis, and for diabetic neuropathic pain if other first- or second-line pharmacological treatments have failed
- Fluoxetine for fibromyalgia
- If one tricyclic antidepressant causes unacceptable side effects, it is appropriate to try a different one
- Optimised antidepressant therapy for chronic pain with moderate depression

Acetaminophen

- Uncertain effectiveness for chronic low back pain¹⁸

Topicals

- Topical NSAIDs for chronic pain due to musculoskeletal conditions, particularly in patients who cannot tolerate oral NSAIDs
- Topical capsaicin patches (8%) for peripheral neuropathic pain when first-line pharmacological treatments have been ineffective or are not tolerated
- Topical lidocaine for postherpetic neuralgia if first-line pharmacological treatments have been ineffective
- Topical rubefacients (substances that dilate capillaries and increase blood circulation) for musculoskeletal conditions if other pharmacological treatments have been ineffective

Cannabinoids (including cannabis)

- Further research is needed to assess both short- and long-term benefits and harms of cannabinoids used for the management of chronic pain²
- Consider medical cannabinoids for chronic neuropathic pain after reasonable trials of other therapies have not been effective¹⁹

What This Quality Statement Means

For People With Chronic Pain

Talk with your health care provider to determine if medications may benefit you, based on your goals and condition. Regularly discuss your medications with your health care professional. Let them know whether your medications are improving your pain and function, or if you are having any side effects.

For Clinicians

Offer people with chronic pain a combination of non-opioid medications along with non-drug therapies as first-line treatment. Review medications regularly for effectiveness in meeting the person's goals for pain management and improved function. A guide for primary care providers to aid in prescribing medications for chronic pain is available in the Management of Chronic Non-Cancer Pain tool.²⁰

For Health Services

Develop and adopt protocols and policies to assist prescribers and pharmacists to provide education to people with chronic pain on the potential benefits and harms associated with pharmacotherapy. Use shared decision-making processes and tools to help people evaluate the potential benefits and harms of pharmacotherapies for chronic pain.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who receive non-opioid pharmacotherapy as first-line pharmacological treatment for chronic pain

- Denominator: total number of people with chronic pain who are prescribed pharmacotherapy to control their pain
- Numerator: number of people in the denominator who receive non-opioid pharmacotherapy as first-line pharmacological treatment
- Data source: local data collection

Percentage of people with chronic pain who receive pharmacological treatment to control their pain whose medications are reviewed for effectiveness in pain management and meeting goals

- Denominator: total number of people with chronic pain who receive pharmacological treatment to control their pain
- Numerator: number of people in the denominator whose medications are reviewed for effectiveness in pain management and meeting goals
- Data source: local data collection

Quality Statement 8: Psychologically Based Interventions

People with chronic pain are offered psychological assessment and appropriate psychologically based interventions.

Background

The perception of pain and the impacts on quality of life that arise from it are linked to a person's emotional, cognitive, and social functioning.³ Living with chronic pain can affect a person's mental health and their response to treatment.³ For children and adolescents with mixed chronic pain conditions, psychologically based interventions are associated with reduced pain intensity, along with reduced disability immediately following treatment and up to 12 months later.² Psychologically based interventions for chronic pain are used to reduce pain, increase coping skills, and improve quality of life.³ Mental health issues such as depression, anxiety, post-traumatic stress disorder (PTSD), and substance use disorder should be treated concurrently with chronic pain.

Barriers to access, including wait times for funded services and costs for non-funded services, should be considered. Health care professionals should be aware of low- or no-cost psychological services available in their community, including interprofessional teams and online options.

Sources: Institute for Clinical Systems Improvement, 2016² | Registered Nurses Association of Ontario, 2013⁵ | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Psychological assessment

Assessment should include a discussion about ability to cope with chronic pain symptoms and any impacts on mood and mental health. Assessment should also be offered for the diagnosis of depression or anxiety. For more information on assessment and diagnosis of major depression, see Health Quality Ontario's [Major Depression](#) quality standard. For more information on assessment and diagnosis of anxiety, see Health Quality Ontario's [Anxiety Disorders](#) quality standard.

Psychologically based interventions

Psychologically based interventions to consider for chronic pain include the following^{2,3}:

- Acceptance and commitment therapy
- Cognitive behavioural therapy
- Dialectical behavioural therapy
- Mindfulness-based interventions
- Progressive relaxation or electromyographic biofeedback

The efficacy of each type of therapy can vary by mechanisms of pain and the person's other characteristics, such as mental health status.

Health care professionals providing psychologically based interventions should have training and knowledge in both the intervention and chronic pain as a condition.

What This Quality Statement Means

For People With Chronic Pain

Your primary care professional should ask you about your mood and mental health. They should discuss approaches to coping with chronic pain and improving your quality of life that include psychological services such as mindfulness, counselling, or therapy. You should be offered resources available in your community that are appropriate for you.

For Clinicians

Assess people with chronic pain for the need for psychologically based interventions. Offer psychologically based interventions, directly or through referral, to people with chronic pain to help increase their coping skills and improve their quality of life. Use tools such as the Brief Pain Inventory ([BPI](#)) or Patient Health Questionnaire ([PHQ-9](#)) to evaluate the effects of psychologically based interventions on pain, function, and quality of life.²⁰

For Health Services

Ensure psychologically based interventions are available and accessible for people with chronic pain.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who receive psychological assessment

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who receive psychological assessment
- Data source: local data collection

Percentage of people with chronic pain who receive appropriate psychologically based interventions

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who receive appropriate psychologically based interventions
- Data source: local data collection

Quality Statement 9: Psychosocial Supports

People with chronic pain, their families, and their caregivers are offered psychosocial supports that consider their emotional, social, cultural, cognitive, accessibility, or spiritual needs. Psychosocial supports may include traditional knowledge, medicines, and healing practices for chronic pain, where appropriate.

Background

Each person with chronic pain will experience and report pain in a manner unique to them. Comprehensive approaches to chronic pain management consider the psychosocial, spiritual, and cultural contexts in which the pain is experienced.^{3,5} Person-centred interventions for chronic pain may include recreation, social interaction, and religious or spiritual counselling, or working with a social worker, occupational therapist, or other professional on concrete issues such as housing, employment, or income.⁵ Emotional supports can give people a sense of purpose and provide important coping mechanisms. Having a sense of purpose can provide a distraction from chronic pain, a sense of being needed, and a feeling of productivity; these may help the person to feel more in control of their life and wellness.

Health care professionals should also recognize the value of Indigenous healing practices and use them in the treatment of Indigenous people in collaboration with Indigenous healers and Elders, where requested by the person with chronic pain.²¹

Sources: Registered Nurses Association of Ontario, 2013⁵ | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Accessibility needs

Accessibility involves considering and addressing the needs people have that will allow them to be fully included and have access to full participation in all recommended health care therapies. Accessibility needs include physical, developmental, intellectual, learning, visual, auditory, and emotional supports and services to make a health care environment or treatment accessible. Where appropriate, it may also include access to language interpretation services.

Cultural needs

Cultural needs relate to the beliefs and preferences that come from one's social and ethnic identities. Cultural needs may be related to linguistic needs, health beliefs and behaviours, traditions, rituals, or cultural barriers to accessing health care.

Psychosocial support

Psychosocial support involves developmentally and age-appropriate care related to a person's state of mental, emotional, social, cultural, and spiritual well-being. It can also include cognitive therapies or strategies such as those related to memory, attention, executive functioning, or fatigue.

Social needs

Social needs relate to a person's relationships with their family, community, and network (friends, acquaintances, and coworkers). Social needs may relate to family structure and location; family dynamics; communication; social and cultural networks; perceived social support; work and school settings; finances; sexuality; intimacy; living arrangements; caregiver

availability; medical decision-making; access to transportation, medications, equipment, and nutrition; community resources; or legal issues.

Spiritual needs

Spiritual needs relate to “the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred.”²² Spiritual needs may include religious practices or philosophical reflection.

What This Quality Statement Means

For People With Chronic Pain

Your health care professional should ask you, your family, and your caregivers about your mental, emotional, social, cultural, and spiritual well-being. These needs should be discussed and addressed as part of your care for chronic pain and according to your wishes, values, and goals for pain management and function.

For Clinicians

Ensure that the overall psychosocial well-being of people with chronic pain, their families, and their caregivers is assessed, and that their needs are incorporated into the care plan. Make referrals to support services where appropriate.

For Health Services

Ensure that resources are available for health care professionals to assess and meet the psychosocial needs of people with chronic pain, their families, and their caregivers.

Quality Indicators

Process Indicator

Percentage of people with chronic pain who receive psychosocial supports

- Denominator: total number of people with chronic pain
- Numerator: number of people in the denominator who receive psychosocial supports
- Data source: local data collection

Quality Statement 10: Interventional Management of Chronic Pain

People with chronic pain are offered interventional management, when clinically indicated, in combination with other strategies and interventions as part of an interprofessional approach to chronic pain management.

Background

Diagnosing or treating pain by injecting medications and/or by implanting devices directly into the body, using interventional techniques, is an option for relief of chronic pain that is not reasonably improved through pharmacological and nonpharmacological therapies. Guidance for the indications, duration, or frequency for interventional techniques is limited, and there are rare but serious harms associated with interventional procedures.²³ These treatments are less frequently indicated for children.

Interventional techniques may help by improving participation in other non-pharmacological therapies and in physical activity. Interventional techniques should be monitored closely for effectiveness in improving pain and function. Clinicians and people with chronic pain should determine together what reduction in pain scores and improvement in function are considered clinically meaningful and indicate reasonable improvement as a basis for continuing treatment.³ More research is needed to determine the appropriateness of individual procedures and the comparative effectiveness with other therapies for chronic pain.

Health care professionals offering interventional techniques should have the appropriate skills and knowledge to offer them. They should be able to discuss the available evidence on effectiveness and the potential benefits and harms of interventional procedures, as compared with other non-invasive therapies for chronic pain. They should engage in shared decision-making with people with chronic pain, their families, and their caregivers. In Ontario, health care professionals offering interventional techniques must have this scope of practice designation from the College of Physicians and Surgeons of Ontario or be in a recognized training program.

Sources: Advisory committee consensus | Neuropathic Pain Special Interest Group, 2013²³

Definitions Used Within This Quality Statement

Other strategies and interventions

May include, but are not limited to strategies and interventions discussed in other quality statements:

- Statement 3: Supported Self-Management and Education
- Statement 4: Physical Activity
- Statement 5: Physically Based Interventions
- Statement 6: Therapeutic Exercise
- Statement 7: Pharmacotherapy
- Statement 8: Psychologically Based Interventions
- Statement 9: Psychosocial Supports

Interventional management

Interventional pain management involves diagnosing or treating pain by injecting medications and/or using radiofrequency lesioning or pulsed treatment with an implanted device at sites identified as or suspected to be the mechanism of pain or the location where the pain is felt.^{2,24}

The College of Physicians and Surgeons of Ontario defines the interventional pain procedures that are appropriately performed in interventional clinics in Ontario.²⁴ These procedures are listed under broad categories, including:

- Cranial nerve blocks/deep nerve blocks of the head and neck
- Neuraxial blocks (including spinal cord stimulation)
- Peripheral nerve blocks
- Plexus blocks
- Sympathetic nerve blocks
- Intravenous infusions
- Joint blocks
- Neuroablative blocks (radiofrequency ablation)

Injections into tissues that are superficial and easily accessible (e.g., tendon, muscle, peripheral joints) may also be offered, such as trigger point and botulinum toxin (Botox) injections.

Interventional management should be discontinued if there are not sufficient improvements in pain and function.

What This Quality Statement Means

For People With Chronic Pain

You may be offered interventional management (injections or an implanted device) for your chronic pain, depending on the type of pain you have. Discuss these techniques with your doctor and talk about how effective they might be and the potential risks involved.

For Clinicians

Consider interventional management on a trial basis for people with chronic pain when there is not sufficient progress toward the goals for pain management and function. Engage in shared decision-making with the person, along with their family and caregiver. Include information on effectiveness and potential benefits as well as harms, and compare these with the benefits and harms of other therapies and strategies. Discontinue interventional management if there are not sufficient improvements in pain and function.

For Health Services

Ensure that interventional management is available when clinically indicated as part of an interprofessional approach to managing chronic pain.

Quality Indicators

Process Indicator

Percentage of people with chronic pain receiving interventional management who receive interventional management as part of an approach that includes other pain management strategies and interventions

- Denominator: total number of people with chronic pain who receive interventional management
- Numerator: number of people in the denominator who receive interventional management as part of an approach that includes other pain management strategies and interventions
- Data source: local data collection

Quality Statement 11: Access and Referral to an Interprofessional Chronic Pain Program

People whose quality of life is significantly impacted by their chronic pain are referred by their primary care provider to an interprofessional pain program. They are seen for a first appointment within 3 months of referral.

Background

People who have not experienced sufficient improvement in pain and function from multimodal therapies,¹¹ or who have poor function, moderate to high levels of distress, or social and occupational problems related to pain, may be considered for an interprofessional chronic pain program.¹¹ Some people may benefit from a more intensive interprofessional pain program early in their treatment.

Age, literacy, and perceived motivation should not be barriers to referral.¹¹ Common barriers to participation in interprofessional chronic pain programs include unmanaged mental health conditions, active substance use disorders, post-traumatic stress disorder (PTSD) symptoms, and severe disability. People with these conditions may need additional assistance in overcoming health inequities.¹¹ Specialized pain programs should consider management of concurrent disorders and access to substance use disorder treatment and mental health care, where appropriate. Approaches to pain management and functional improvement provided through interprofessional chronic pain programs may support long-term opioid therapy tapering.

Chronic pain programs, where appropriate, should work with the person with chronic pain to develop a plan for return to work, school, or functional role. To be effective, education and self-management tools developed in interprofessional chronic pain programs should be applied on an ongoing basis after a person completes the program. Participants in interprofessional chronic pain programs should be supported in returning to primary care and maintaining their goals for pain management and function.

Sources: British Pain Society, 2013¹¹ | Scottish Intercollegiate Guidelines Network, 2013³

Definitions Used Within This Quality Statement

Interprofessional chronic pain program

Interprofessional chronic pain programs¹¹ use a variety of methods to achieve the following: reductions in pain, physical disability, and emotional distress, while enhancing quality of life, improving function, improving self-management, and optimizing the use of health care resources. Pain management strategies are applied flexibly and may include pharmacotherapies, physical and psychologically based interventions, physical activity, therapeutic exercise, education, and techniques for self-management. Shared decision-making, goal setting, identifying and managing barriers to activity, and practising specific practical and psychological skills are used to produce sustainable positive changes in pain and function.

Pain programs are time limited. A return to primary care is coordinated to support the continuity of care. Short- and long-term outcomes are evaluated. Interprofessional pain programs can be offered in a variety of settings, including hospitals and community-based clinics, and through telemedicine.

What This Quality Statement Means

For People With Chronic Pain

If your quality of life is significantly impacted by your chronic pain, you may be referred to a pain program where you could get treatment from different types of health care providers who have expertise with pain. You should receive a first appointment within 3 months of referral.

For Primary Care Providers

Refer people with chronic pain whose quality of life is negatively impacted by their pain, or whose goals for pain and function are not being met, or who have not benefitted from other multimodal therapies to an interprofessional chronic pain program that is accessible to them.

For Health Services

Ensure the availability of interprofessional pain programs and timely access to a first appointment within 3 months for people with chronic pain. Interprofessional pain programs may be located in a variety of settings, including hospitals and community-based clinics, or delivered virtually through telemedicine or other technologies.

Quality Indicators

Process Indicators

Percentage of people with chronic pain whose quality of life is significantly impacted by their chronic pain who are referred to an interprofessional chronic pain program

- Denominator: total number of people with chronic pain whose quality of life is significantly impacted by their chronic pain
- Numerator: number of people in the denominator who are referred to an interprofessional chronic pain program
- Data source: local data collection

Percentage of people with chronic pain who have been referred to an interprofessional chronic pain program who had their first contact with the program within 3 months after referral

- Denominator: total number of people with chronic pain who have been referred to an interprofessional chronic pain program
- Numerator: number of people who had their first contact with an interprofessional chronic pain program within 3 months after referral
- Data source: local data collection

Structural Indicator

Local availability of interprofessional chronic pain programs

- Data source: local data collection

Quality Statement 12: Transitions and Coordination of Care

People with chronic pain receive timely and collaborative care during and after health care transitions.

Background

Models of care for chronic pain should support collaborative care for effective transitions between providers or settings, such as the sharing of information between primary care and specialists, and between youth and adult care.⁵ Interprofessional care teams may include team members outside of the health care system or health facility. Assistance with other determinants of health, such as income, housing, or employment, may be part of the collaborative care plan. Information sharing between team members (with the person's consent) and identifying which health care professional is most responsible for helping the patient manage their pain is important.

The collaborative care plan should detail the care the person should receive during and after their transition, and should include the person's preferred communication methods. Use of technology, such as secure text messaging, secure email, patient portals, or telehealth, may improve communication.²

Youth with chronic pain who are transitioning to adult care services should receive a comprehensive health summary at the time of referral. Services included under "transfer of care to adult services" include monitoring of the person's attachment to adult services; attendance at adult appointments in an expected timeframe; ongoing communication between pediatric, primary, and adult providers; and shared responsibility for the management of lapses in care.²⁵ Similarly, people with chronic pain transitioning from an interprofessional pain program back to primary care should have a collaborative care plan for long-term management.

Sources: Canadian Association of Pediatric Health Centres, 2016²⁵ | Institute for Clinical Systems Improvement, 2016² | Registered Nurses Association of Ontario, 2013⁵

Definitions Used Within This Quality Statement

Collaborative care

An interprofessional, team-based approach that includes the person with chronic pain and their family or caregiver as team members, as well as other specialty consultation support as needed. Collaborative care includes²:

- Dedicated staff to coordinate, support, and educate patients
- Methods for reliable and systematic patient follow-up
- Consistent use of evidence-based treatment practices
- Communication between providers
- A detailed written plan that helps team members understand the care expected and monitor adherence to quality care

What This Quality Statement Means

For People With Chronic Pain

When you change care settings or health care providers, your care team should work with you to make sure that important information about your care plan, your goals for pain management and function, and your medications travels with you.

For Clinicians

Ensure that people moving between care settings or health care providers experience coordinated and seamless transitions. This includes facilitating communication between settings and other related processes. Ensure that a collaborative care plan that supports continuity of care is developed and distributed to all care team members.

For Health Services

Ensure that systems, processes, and resources are in place to facilitate communication and information-sharing between health care providers and care settings during transitions.

Quality Indicators

Process Indicators

Percentage of people with chronic pain who transition from one health care provider or setting to another who have a documented collaborative care plan

- Denominator: total number of people with chronic pain who transition from one health care provider or setting to another
- Numerator: number of people in the denominator who have a documented collaborative care plan
- Data source: local data collection

Percentage of adolescents with chronic pain transitioning to adult care services who receive a comprehensive health summary at the time of referral

- Denominator: total number of adolescents with chronic pain who transition to adult care services
- Numerator: number of people in the denominator who receive a comprehensive health summary at the time of referral
- Data source: local data collection

Outcome Indicators

Percentage of people with chronic pain who transition from one health care provider or setting to another who are satisfied with their transition

- Denominator: total number of people with chronic pain who transition from one health care provider or setting to another
- Numerator: number of people in the denominator who are satisfied with their transition
- Data source: local data collection

Percentage of people with chronic pain who transition from one health care provider or setting to another who report that there was good communication between their health care providers

- Denominator: total number of people with chronic pain who transition from one health care provider or setting to another
- Numerator: number of people in the denominator who report that there was good communication between their health care providers
- Data source: local data collection
- Note: An example of a validated survey question that can be used to inform your local data collection is available in the Canadian Patient Experiences Survey, Canadian Institute for Health Information: “Do you feel that there was good communication about your care between doctors, nurses, and other staff?” (Response options: “Never, Sometimes, Usually, Always”)²⁶

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About Health Quality Ontario

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