Quality Standards

Opioid Prescribing for Chronic Pain

Care for People 15 Years of Age and Older

Health Quality Ontario

Let's make our health system healthier

Summary

This quality standard provides guidance on the prescribing, monitoring, and tapering of opioids to treat chronic pain for people 15 years of age and older in all care settings. It does not address opioid prescribing for acute pain or end-of-life care, nor does it address the management of opioid use disorder in depth. Please refer to Health Quality Ontario's *Opioid Prescribing for Acute Pain* quality standard and *Opioid Use Disorder* quality standard for detailed quality statements related to these topics.

Table of Contents

About Quality Standards 1

How to Use Quality Standards 1

About This Quality Standard 2

- Scope of This Quality Standard 2
- Terminology Used in This Quality Standard 2
- Why This Quality Standard Is Needed 3
- Principles Underpinning This Quality Standard 4
- How Success Can Be Measured 5

Quality Statements in Brief 6

Quality Statement 1: Comprehensive Assessment 8

Quality Statement 2: Setting Goals for Pain Management and Function 11

Quality Statement 3: First-Line Treatment With Non-opioid Therapies 14

Quality Statement 4: Shared Decision-Making and Information on the Potential Benefits and Harms of Opioids for Chronic Pain 18

Quality Statement 5: Initiating a Trial of Opioids for Chronic Pain 23

Quality Statement 6: Co-prescribing Opioids and Benzodiazepines 28

Quality Statement 7: Opioid Use Disorder 31

Quality Statement 8: Prescription Monitoring Systems 34

Quality Statement 9: Tapering and Discontinuation 37

Quality Statement 10: Health Care Professional Education 41

TABLE OF CONTENTS CONTINUED

Acknowledgements	43
References	45
About Health Quality Ontario	47

About Quality Standards

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

Quality standards are concise sets of statements that will:

- Help 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.

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

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

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

About This Quality Standard

Scope of This Quality Standard

This quality standard provides guidance on the prescribing, monitoring, and tapering of opioids to treat chronic pain for people 15 years of age and older in all care settings. It does not address opioid prescribing for acute pain or end-of-life care, nor does it address the management of opioid use disorder in depth. Please refer to Health Quality Ontario's *Opioid Prescribing for Acute Pain* quality standard and *Opioid Use Disorder* quality standard for detailed quality statements related to these topics.

The Opioid Prescribing for Chronic Pain Quality Standard Advisory Committee agreed that it is important to include adolescents between 15 and 17 years of age in the scope of this quality standard because of the increased risk of harm opioids pose to this population. Adolescents report higher rates of nonmedical opioid use[1] and intentional poisonings,[2] and suffer a disproportionately higher rate of opioid-related deaths than the general adult population.[3] These higher rates of harm stress the importance of providing guidance on the careful and appropriate prescribing of opioids for chronic pain in youth.

While the scope of this quality standard includes adolescents between 15 and 17 years of age, it should be noted that the statements in this standard are based on guidelines whose evidence is derived primarily from studies conducted on adult (aged 18 years and older) populations. Health Quality Ontario's Opioid Prescribing for Chronic Pain Quality Standard Advisory Committee members agreed that the guidance in this quality standard is equally relevant and applicable to people between 15 and 17 years of age. However, health care professionals should take into account that specialized skills and expertise may be required when providing treatment for special populations, including adolescents with chronic pain for whom opioid therapy has been prescribed or is being considered. If treatment of this or other special populations is beyond a health care professional's expertise, the health care professional should consult or work with a health care professional with appropriate expertise.

This quality standard includes 10 quality statements addressing areas identified by Health Quality Ontario's Opioid Prescribing for Chronic Pain Quality Standard Advisory Committee as having high potential for improving the quality of care in Ontario for people with chronic pain who have been prescribed or are considering opioids.

Terminology Used in This Quality Standard

In this quality standard, the term "health care professional" is used to acknowledge the wide variety of providers who may be involved in the care of people with chronic pain. The term refers to physicians, nurse practitioners, nurses, dentists, pharmacists, and other allied health professionals involved in the assessment, monitoring, and treatment of chronic pain.

The term "prescriber" refers to physicians, nurse practitioners, and dentists who are authorized to prescribe opioids.

Why This Quality Standard Is Needed

Chronic pain is often defined as pain that lasts longer than 3 months or past the time of normal tissue healing,[4,5] and has been estimated to affect 1 in 5 Canadians.[6] In Ontario, opioids are often prescribed to manage chronic pain, but opioid therapy can present a considerable risk of harm for what may be only a short-term benefit for some people. Over the past two decades, Ontario has witnessed a dramatic rise in the rate of opioid prescribing and concurrent rapid increases in the number of opioid-related deaths, hospitalizations, and emergency department visits, as well as an increase in the prevalence of opioid use disorder.[7] In 2015/16, more than 9 million opioid prescriptions were written in Ontario, and 1.94 million Ontarians were dispensed opioids.[8] This rate of opioid consumption is very high by global standards: Canada has the highest rate of opioid prescribing when measured by morphine equivalents dispensed, and the second-highest per capita rate of opioid prescribing in defined daily doses.[4] In Ontario, the rate of prescriptions of stronger opioids, particularly hydromorphone, has also increased substantially over the last few years.[8,9] Finally, there is a remarkable level of unexplained regional variation in the use of opioids across Ontario, with the percentage of people prescribed opioids for pain ranging from 11% to 18% across local health integration network (LHIN) regions.[8]

Current clinical practice guidelines do not recommend opioids as a first-line therapy for chronic pain.[4,5,10] Evidence suggests that a multimodal combination of non-opioid therapies, delivered through a multidisciplinary approach, can often be as effective as opioids in managing chronic pain while presenting far less risk of harm.[4] People with chronic pain should have access to appropriate treatment options that are selected with their health care professionals through a shared decision-making process. This process should include a discussion of the expected benefits and potential harms of both opioid and non-opioid therapies. Critically, the complexities of chronic pain require a biopsychosocial approach to treatment. However, many Ontario health care professionals caring for people with chronic pain —particularly in primary care settings—do not have ready access to other types of services or specialists needed to implement a multidisciplinary approach, such as psychologists, addiction specialists, physiotherapists, and other health professionals.[10]

While opioids may be an appropriate option for treating chronic pain in some circumstances, many people in Ontario are being prescribed high doses, defined here as the equivalent of 90 mg of morphine per day or more. In 2016, the percentage of new opioid prescriptions started at a dose of 90 mg morphine equivalents or more varied between 2.0% and 4.6% across LHIN regions. High doses of opioids are associated with an increased risk of overdose, particularly when combined with other substances such as benzodiazepines or alcohol.[5] Patients taking high doses should be supported by their health care professionals to engage in shared decision-making and should receive continuous care during any trials of tapering or discontinuation of opioid therapy.

Appropriate opioid prescribing practices—including dose reduction and discontinuation—combined with an understanding of patient preferences and values, can help reduce the risk of people with chronic pain being subjected to opioid-related harms. Family physicians and nurse practitioners practising in primary care play a crucial role in supporting effective chronic pain management for patients. Primary care providers should be supported to develop skills to initiate the tapering and discontinuation of opioids for chronic pain, as well as to identify and treat opioid use disorder.

Principles Underpinning This Quality Standard

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

People with chronic pain who have been prescribed or are considering opioid therapy should receive services that are respectful of their rights and dignity and that promote shared decision-making.

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

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

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

How Success Can Be Measured

The Opioid Prescribing for 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 provincially and locally.

How Success Can Be Measured Provincially

- Rate of opioid-related deaths
- Urgent hospital use:
  - Rate of opioid-related emergency department visits
  - Rate of opioid-related hospital admissions
- Prescribing:
  - Rate of people prescribed opioid therapy (proxy measure)
  - Rate of opioid prescriptions dispensed (proxy measure)

Proxy indicators are measures that approximate the intended indicator. In this case, the proxy indicators use data from a broader cohort (e.g., the population of Ontario), since data on the specific cohort of interest are unavailable (i.e., people with chronic pain).

How Success Can Be Measured Locally

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

- Percentage of people with chronic pain with improved quality of life
- Percentage of people with chronic pain with improved functional outcomes
- Percentage of people with chronic pain who experience reduced pain
- Percentage of people who are prescribed opioids for chronic pain and subsequently develop opioid use disorder

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

Quality Statements in Brief

QUALITY STATEMENT 1:
Comprehensive Assessment

People with chronic pain receive a comprehensive assessment, including consideration of their functional status and social determinants of health.

QUALITY STATEMENT 2:
Setting Goals for Pain Management and Function

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

QUALITY STATEMENT 3:
First-Line Treatment With Non-opioid Therapies

People with chronic pain receive an individualized and multidisciplinary approach to their care. They are offered non-opioid pharmacotherapy and nonpharmacological therapies as first-line treatment.

QUALITY STATEMENT 4:
Shared Decision-Making and Information on the Potential Benefits and Harms of Opioids for Chronic Pain

People with chronic pain, and their families and caregivers, receive information about the potential benefits and harms of opioid therapy for chronic pain at the time of both prescribing and dispensing so that they can participate in shared decision-making.

QUALITY STATEMENT 5:
Initiating a Trial of Opioids for Chronic Pain

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

If opioids are initiated, the trial starts at the lowest effective dose, preferably below 50 mg morphine equivalents per day. Titrating over time to a dose of less than 90 mg morphine equivalents per day may be warranted in selected cases in which people are willing to accept a higher risk of harm for improved pain relief.

QUALITY STATEMENT 6: **Co-prescribing Opioids and Benzodiazepines**

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

QUALITY STATEMENT 7: **Opioid Use Disorder**

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

QUALITY STATEMENT 8: **Prescription Monitoring Systems**

Health care professionals who prescribe or dispense opioids have access to a real-time prescription monitoring system at the point of care. Prescription history is checked when opioids are prescribed and dispensed and every 3 to 6 months during long-term use, or more frequently if there are concerns regarding duplicate prescriptions, potentially harmful medication interactions, or diversion.

QUALITY STATEMENT 9: **Tapering and Discontinuation**

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

QUALITY STATEMENT 10: **Health Care Professional Education**

Health care professionals have the knowledge and skills to appropriately assess and treat chronic pain using a multidisciplinary, multimodal approach; appropriately prescribe, monitor, taper, and discontinue opioids; and recognize and treat opioid use disorder.

1

Comprehensive Assessment

People with chronic pain receive a comprehensive assessment, including consideration of their functional status and social determinants of health.

Background

Prior to considering opioid therapy, health care professionals caring for people with chronic pain should consider relevant physical and/or psychological diagnoses and document an assessment of the person's health history and comorbidities, using validated tools to assess functional status, quality of life, and pain.[10,11,12] Alternative or adapted assessment tools should be used for people who cannot self-report.

A person's access to resources plays a large role in their ability to receive health care, engage in healthy lifestyle behaviours, and participate in chronic pain management plans. Therefore, clinicians should also examine socioeconomic factors in a person's life, including the social determinants of health, as part of a comprehensive assessment.

Sources: American College of Occupational and Environmental Medicine, 2014[12] | American Society of Interventional Pain Physicians, 2012[11] | Institute for Clinical Systems Improvement, 2016[10]

What This Quality Statement Means

For Patients

Your health care professional should ask you about your pain, your health, your ability to function at work and at home, and any other issues that may be affecting your health.

For Clinicians

Conduct a comprehensive assessment (see definition) for people with chronic pain who are taking or for whom you are considering prescribing opioids. This assessment should include 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. This includes providing the time required to perform a comprehensive assessment, including history, and ensuring access to assessment tools and, where available, electronic medical histories and patient records.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Comprehensive assessment

A comprehensive assessment includes an assessment of the following[10-12]:

- The pain condition: anatomical site and frequency and severity of pain
- Any other medical conditions
- Psychosocial history, including history of trauma
- Mental health status
- Medication and substance use history
- Functional status
- Sleep patterns
- Past and current substance use disorders
- Past pain management and coping strategies

Functional status

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

Quality Indicators

Process Indicator

Percentage of people with chronic pain prescribed an opioid who received a comprehensive assessment (see definition) prior to being prescribed opioid therapy

- Denominator: total number of people with chronic pain who were prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who received a comprehensive assessment (see definition) prior to being prescribed opioid therapy
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Social determinants of health

The social determinants of health are factors that affect the ability of a person to access or receive high-quality health care, creating unfair and avoidable differences in health status.[13] The social determinants of health include, but are not limited to, the following[10]:

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

2

Setting Goals for Pain Management and Function

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

Background

Health care professionals should work in partnership with people with chronic pain to establish realistic, specific, and measurable goals that focus on pain management, functional improvement, improvement in ability to perform activities of daily living, and any other improvements in quality of life that are important to the person with chronic pain.[10,11] Family members should also be encouraged to be involved in the development of management goals. The goal of both opioid and non-opioid therapies for chronic pain will rarely be the total elimination of pain, but rather a meaningful reduction in pain intensity and/or a significant improvement in other patient-defined functional indicators, such as returning to social activities or employment.[5,10,11]

Management goals should also consider the side effects of therapies for chronic pain and, wherever possible, minimize potential harms. Health care professionals should consider the potential impacts of physical dependence or inter-dose withdrawal from opioids on pain intensity and function when assessing progress toward pain management goals.

Sources: American Society of Interventional Pain Physicians, 2012[11] | Centers for Disease Control and Prevention, 2016[5] | Institute for Clinical Systems Improvement, 2016[10]

What This Quality Statement Means

For Patients

Your health care professional should work with you to set goals for managing your pain. This conversation should focus on goals that matter to you, including reducing your pain and improving your ability to function at work and at home.

For Clinicians

Work with people with chronic pain to set realistic, specific, measurable goals for improvement in pain and function, and evaluate these goals regularly. If you have initiated an opioid prescription, see the person with chronic pain for follow-up within 28 days.

For Health Services

Ensure resources and tools are available to allow clinicians to follow up with people prescribed opioids for chronic pain within 28 days and to evaluate management goals regularly.

Quality Indicators

Process Indicators

Percentage of people with chronic pain prescribed an opioid who have documented goals for pain management, functional improvement, and quality-of-life improvement

- Denominator: total number of people with chronic pain who were prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator with documented goals for pain management, functional improvement, and quality-of-life improvement
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Regular evaluation of goals

Management goals for pain and function should be documented and monitored over time. After initiating an opioid prescription, a health care professional should see the person with chronic pain for follow-up within 28 days.[4] Progress toward goals should then be reassessed every 3 months.

Percentage of people with chronic pain prescribed an opioid who were seen by the prescribing health care professional within 28 days of receiving an opioid prescription

- Denominator: total number of people with chronic pain who were prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who were seen by the prescribing health care professional within 28 days of receiving an opioid prescription
- Data sources: local data collection or linked administrative databases, including the Narcotics Monitoring System and the Ontario Health Insurance Plan (OHIP) Claims Database

Percentage of people with chronic pain prescribed an opioid whose documented goals for pain management, functional improvement, and quality-of-life improvement were reviewed within 3 months of initiating an opioid prescription

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

Outcome Indicator

Percentage of people with chronic pain prescribed an opioid who experienced improved functional outcomes within 3 months of initiating an opioid prescription

- Denominator: total number of people with chronic pain who were prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator with documentation of improvement in functional outcomes within 3 months of initiating an opioid prescription
- Data sources: local data collection, Activities of Daily Living (ADL) Hierarchy Scale, Resident Assessment Instrument–Home Care (RAI-HC; for home care), Resident Assessment Instrument–Minimum Data Set (RAI-MDS; for long-term care)

3

First-Line Treatment With Non-opioid Therapies

People with chronic pain receive an individualized and multidisciplinary approach to their care. They are offered non-opioid pharmacotherapy and nonpharmacological therapies as first-line treatment.

Background

First-line therapy for chronic pain should be an individualized combination of non-opioid pharmacotherapy and nonpharmacological therapies, rather than a trial of opioids.[4] For many people, non-opioid pharmacotherapy is at least as effective as opioids for managing chronic pain and improving function and does not carry the opioid-associated risks of addiction or overdose.[5,12]

Multimodal and multidisciplinary therapies can help reduce pain and improve function more effectively than single modalities.[5] The best therapies for a particular person depend on many factors, including their diagnosis and management goals. Passive modalities, such as massage or spinal manipulation, provide short-term pain relief and potential medium-term benefit with a minimal risk of harm, but should be recommended and implemented only as a complement to an active physical therapy or exercise program.[10] Non-opioid pharmacotherapy should be initiated with the goal of increasing function and restoring a person's overall quality of life, not just providing pain relief.[10]

BACKGROUND CONTINUED

The time and financial commitments required to access some non-opioid therapies can create barriers to access for some people with chronic pain, perpetuating health inequities. To increase access to these therapies where they exist, health care professionals should be aware of resources for low- or no-cost non-opioid therapies and self-management programs for chronic pain in their community.

Sources: Centers for Disease Control and Prevention, 2016[5] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[4] | Institute for Clinical Systems Improvement, 2016[10]

What This Quality Statement Means

For Patients

A combination of physical therapies, psychological therapies, and non-opioid medications is the first choice for treating chronic pain. Your health care professional should offer you different combinations of these therapies before offering opioids.

For Clinicians

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

For Health Services

Ensure that systems, resources, and training are available to allow health care professionals to deliver multidisciplinary, multimodal chronic pain management therapies to reduce the use of opioids, and ensure that people with chronic pain have equitable access to these therapies.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Multidisciplinary approach

A multidisciplinary approach involves a team of two or more different types of health care professional; for example, physicians, nurses, pharmacists, psychologists, physiotherapists, and other allied health care professionals.

Multimodal therapy

Multimodal therapy is the use of a combination of different types of non-opioid pharmacotherapies and nonpharmacological therapies to treat pain and improve function.

Non-opioid pharmacotherapy[10]

Examples of non-opioid pharmacological therapies include the following:

- Acetaminophen
- Nonsteroidal anti-inflammatory drugs
- Anticonvulsants, such as gabapentin and pregabalin
- Antidepressants, such as amitriptyline, nortriptyline, and duloxetine
- Medical cannabis (however, evidence on benefits and harms is limited)

Quality Indicators

Process Indicator

Percentage of people with chronic pain prescribed an opioid who received non-opioid pharmacotherapy and/or nonpharmacological therapies as first-line treatment prior to starting opioid therapy

- Denominator: total number of people with chronic pain who were prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who received non-opioid pharmacotherapy and/or nonpharmacological therapies prior to starting opioid therapy
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Nonpharmacological therapies[10]

There are a broad range of nonpharmacological therapies that may be used to manage chronic pain, typically grouped into the categories of physical interventions and psychological therapies. The efficacy of each therapy may vary by type or cause of pain.

Physical interventions include the following:

- Active physical interventions, such as floor exercise, exercise on special equipment, and aquatic therapy
- Passive physical interventions, such as spinal manipulation, passive physical therapy, and massage

Psychological therapies include the following:

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

Interventional treatments, such as therapeutic injections, are percutaneous or minor surgical procedures targeting specific anatomical structures identified as possible sources of pain.[10,11] Interventional treatments may be appropriate for people with chronic pain who have not received sufficient benefit from other non-opioid pharmacotherapy and nonpharmacological therapies.[10,11]

4

Shared Decision-Making and Information on the Potential Benefits and Harms of Opioids for Chronic Pain

People with chronic pain, and their families and caregivers, receive information about the potential benefits and harms of opioid therapy for chronic pain at the time of both prescribing and dispensing so that they can participate in shared decision-making.

Background

Health care professionals should engage people with chronic pain in shared decision-making, including a consideration of the person's management goals, preferences, and values, to determine the best treatment strategy for each person. The potential harms associated with opioids prescribed for chronic pain include constipation, nausea and vomiting, cognitive changes, hypogonadism, physical dependence, opioid use disorder, nonfatal unintentional overdose, and death.[4] If a person with chronic pain is considering opioids, health care professionals should provide information on the following[5,10]:

- The potential benefits and harms of opioid therapy and alternative treatments
- The responsibilities of the person with chronic pain, the prescriber, and the pharmacist
- A monitoring schedule to reassess progress toward goals for pain management and function every 3 months

BACKGROUND CONTINUED

Clinicians should also recommend laxatives to people being prescribed opioids for chronic pain.

The use of screening tools for opioid use disorder and other substance use disorders is suggested; however, clinical judgment is of paramount importance, as no screening tool is sufficiently accurate to be used as the sole method of identifying substance use disorders. Clinicians should discuss the symptoms of opioid use disorder and overdose with people considering opioids for chronic pain.[5,10-12] Clinicians may consider offering co-prescribed naloxone when prescribing opioids for chronic pain, although evidence on the benefits of this practice has not yet been established.[4]

Sources: American College of Occupational and Environmental Medicine, 2014[12] | American Society of Interventional Pain Physicians, 2012[11] | Centers for Disease Control and Prevention, 2016[5] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[4] | Institute for Clinical Systems Improvement, 2016[10]

What This Quality Statement Means

For Patients

Your health care professional should explain the potential benefits and harms of opioid medications for chronic pain so that you can make decisions about your care together. If you have family involved in your care, they should also receive this information. Potential harms of opioid medications include becoming dependent on the medication, uncomfortable physical symptoms when you stop taking the medication, addiction, and overdose.

For Clinicians

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

For Health Services

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

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Information

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

- The potential benefits and harms of opioid therapy for chronic pain
- Alternative non-opioid therapies for chronic pain, their benefits and harms, and their costs
- The types of health care professionals who may be involved in multimodal, multidisciplinary therapy for chronic pain
- The risks and symptoms of physical dependence and withdrawal
- Factors that increase the risk of opioid use disorder, nonfatal overdose, and death
- The safe storage and disposal of opioids to prevent diversion and reduce safety risks in the community
- How to recognize and respond to an opioid overdose

Quality Indicators

Process Indicators

Percentage of people with chronic pain prescribed an opioid who received information about the benefits and harms of opioid therapy prior to being prescribed opioid therapy

- Denominator: total number of people with chronic pain who were prescribed an opioid
- Numerator: number of people in the denominator with documentation of receiving information about the benefits and harms of opioid therapy prior to being prescribed opioid therapy
- Data source: local data collection

Percentage of people with chronic pain prescribed an opioid who received information about the benefits and harms of opioid therapy prior to being dispensed an opioid

- Denominator: total number of people with chronic pain who were dispensed an opioid
- Numerator: number of people in the denominator with documentation of receiving information about the benefits and harms of opioid therapy prior to being dispensed an opioid
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Shared decision-making

Shared decision-making is a collaborative process that allows people with chronic pain, their families and caregivers, and health care professionals to make decisions together. The health care professional is responsible for the following[14]:

- Inviting the person with chronic pain to participate in the decision-making process
- Presenting pain management options
- Providing information on the potential benefits and harms of each pain management option
- Helping people evaluate pain management options based on their values and preferences
- Facilitating deliberation and decision-making
- Helping implement decisions
- Offering and incorporating decision-making tools such as decision aids

QUALITY INDICATORS CONTINUED

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

- Denominator: total number of people with chronic pain who were prescribed an opioid
- Numerator: number of people in the denominator who reported that their health care professional always or often involves them as much as they want in decisions about their care and treatment
- Data source: local data collection
- Sample survey question: "When you see your care provider or someone else in their office, how often do they involve you as much as you want in decisions about your care and treatment?" (Response options: Always, Often, Sometimes, Rarely, Never, It depends on who I see and/or what I am there for, Not using or on any treatments/not applicable, Don't know, Refused)[15]

5

Initiating a Trial of Opioids for Chronic Pain

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

If opioids are initiated, the trial starts at the lowest effective dose, preferably below 50 mg morphine equivalents per day. Titrating over time to a dose of less than 90 mg morphine equivalents per day may be warranted in selected cases in which people are willing to accept a higher risk of harm for improved pain relief.

Background

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

Because there is evidence of a dose–response relationship for overdose and death related to opioid use, if a trial of opioids is warranted, it should start at the lowest effective dose and be titrated as needed, preferably less than 50 mg morphine equivalents per day. In selected cases in which a higher dose is required for effective pain management and the person with chronic pain has discussed the increased risk of overdose and death with their health care professional, the dose may be titrated up to 90 mg morphine equivalents per day.[4,11] If considering titrating to a high dose of 90 mg morphine equivalents per day or more, a referral to a colleague for a second opinion may be warranted before making a decision.[4] People beginning opioid therapy should be assessed within 28 days of initiation to evaluate benefits and harms, and stable doses should be re-evaluated every 3 months.[4,10]

If opioids are prescribed, opioid therapy should be combined in a multimodal approach with non-opioid pharmacotherapy and nonpharmacological therapies for chronic pain (see Quality Statement 3).[12]

Sources: American College of Occupational and Environmental Medicine, 2014[12] | American Society of Interventional Pain Physicians, 2012[11] | Centers for Disease Control and Prevention, 2016[5] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[4] | Institute for Clinical Systems Improvement, 2016[10]

What This Quality Statement Means

For Patients

Before you start taking opioids, you should know about the potential risks of opioids. If you currently have a drug or alcohol addiction or if you did in the past, or if you currently have a mental health condition, the risk of becoming addicted to opioids or overdosing is higher. Your health care professional should discuss these risks with you.

If you and your health care professional decide that treatment with opioids is right for you, your starting dose should be as low as possible to improve your pain and ability to function. Your health care professional should monitor your use of opioids carefully and help you stay on the lowest possible dose.

When your pharmacist gives you opioids, they should explain to you how to safely store your medication and how to safely dispose of any unused medication you no longer need.

For Clinicians

Prescribe opioids for chronic pain only after other multimodal therapies have been attempted without adequate improvement in pain and function, after you have discussed the potential harms of and alternatives to opioids with the person with chronic pain, and if the person has no absolute contraindications to opioids. For people with relative contraindications, discuss the potential risks they pose.

Initiate opioid therapy at the lowest effective dose, ideally less than 50 mg morphine equivalents per day. Titrate over time to a dose of between 50 and 90 mg morphine equivalents per day only when necessary and only after ensuring the person with chronic pain is aware of the potential harms and is willing to accept a higher risk of harm for improved pain relief.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Adequate improvement in pain and function

Adequate improvement in pain and function occurs when a person with chronic pain is moving toward or meeting their goals for pain management and function (see Quality Statement 2). Clinically meaningful improvement should be focused on function and quality of life. Because there is no clear consensus on patient-important thresholds for pain relief, a number of options may be considered, such as an appreciable reduction in baseline pain (e.g., 20%, 30%, or 50%); reaching a desired pain state, such as “no worse than mild pain”; or a combination of the two.[5,16]

Contraindications

Absolute contraindications

Long-term opioid therapy should not be prescribed for chronic pain to people:

- With an active substance use disorder, including alcohol use disorder[4,12]
- Who are giving or selling their medication to others
- With a confirmed allergy to opioid agents

WHAT THIS QUALITY STATEMENT MEANS CONTINUED

For Health Services

Develop and adopt protocols and policies to assist prescribers to educate patients on the potential harms associated with opioids through a shared decision-making process and to initiate and monitor a trial of opioids for chronic pain. Put processes in place to help people with chronic pain access non-opioid and nonpharmacological therapies.

Quality Indicators

Process Indicators

Percentage of people with chronic pain prescribed an opioid who received non-opioid pharmacotherapy and/or nonpharmacological therapies prior to starting opioid therapy (aligned with an indicator for Quality Statement 3)

- Denominator: total number of people with chronic pain who were prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who received non-opioid pharmacotherapy and/or nonpharmacological therapies prior to starting opioid therapy
- Data source: local data collection

Percentage of people with chronic pain prescribed an opioid with documentation of receiving information about the benefits and harms of opioid therapy prior to starting opioid therapy (aligned with an indicator for Quality Statement 4)

- Denominator: total number of people with chronic pain who are prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator with documentation of receiving information about the benefits and harms of opioid therapy prior to starting opioid therapy
- Data source: local data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Contraindications (continued)

Relative contraindications

Additional caution should be applied when considering prescribing opioids for chronic pain for people:

- With a history of substance use disorder[4]
- With an active mental health disorder that is not stabilized; for example, mood disorders, such as anxiety or depression, or post-traumatic stress disorder[4]
- Who perform safety-sensitive jobs[12]
- Who are pregnant
- With chronic obstructive pulmonary disease (COPD) or sleep apnea
- Taking any other co-prescribed medications that increase the risk of overdose and death when combined with opioids[11]

If contraindications present after long-term opioid therapy has been initiated, health care professionals should not abruptly taper or discontinue opioids.

QUALITY INDICATORS CONTINUED

Percentage of people with chronic pain prescribed an opioid at an initial dose of greater than 50 mg morphine equivalents per day

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

Percentage of people with chronic pain starting opioid therapy who were seen by the prescribing health care professional within 28 days of receiving an opioid prescription (aligned with an indicator for Quality Statement 2)

- Denominator: total number of people with chronic pain who were initiated on opioid therapy and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who were seen by the prescribing health care professional within 28 days of receiving an opioid prescription
- Data sources: local data collection or linked administrative databases, including the Narcotics Monitoring System and the OHIP Claims Database

Percentage of people with chronic pain starting opioid therapy who were evaluated by the prescribing health care professional every 3 months while on opioid therapy

- Denominator: total number of people with chronic pain who were initiated on opioid therapy and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator who were evaluated by the prescribing health care professional every 3 months while on opioid therapy
- Data sources: local data collection or linked administrative databases, including the Narcotics Monitoring System and the OHIP Claims Database

6

Co-prescribing Opioids and Benzodiazepines

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

Background

Clinicians should not initiate a trial of opioids when benzodiazepines, other sedative hypnotics, or any central nervous system depressants are already being prescribed. These drugs can cause central nervous system depression and decreased respiratory drive and, when combined with opioids, may put people at greater risk of overdose and death.[4,10]

Before prescribing opioids, prescribers should check for concurrently prescribed controlled substances, both by asking the person with chronic pain and by checking a prescription monitoring system. If a person with chronic pain is taking a benzodiazepine and a trial of opioids is still indicated, a taper of the benzodiazepine should be considered first. In the rare circumstance in which a clinician and a person with chronic pain choose to proceed with concurrent treatment with both an opioid and a benzodiazepine, both the opioid and the benzodiazepine should be prescribed at the lowest effective dose, and the potential harms of this treatment combination should be documented and discussed before treatment is initiated.

BACKGROUND CONTINUED

In these situations, people with chronic pain should be closely monitored for adverse effects such as drowsiness or confusion. If such symptoms occur, one or both drugs should be discontinued. Health care professionals may also consider co-prescribing naloxone for people taking both an opioid and a benzodiazepine.

People taking opioids for chronic pain who also require treatment for anxiety should be offered psychotherapy, an antidepressant, and/or a drug other than a benzodiazepine to treat their anxiety.[5]

Sources: Advisory committee consensus | Centers for Disease Control and Prevention, 2016[5]

What This Quality Statement Means

For Patients

Whenever possible, you should not take opioids and benzodiazepines at the same time. Benzodiazepines include medications like alprazolam, diazepam, and lorazepam. Taking opioids and benzodiazepines together can cause serious breathing problems.

For Clinicians

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

For Health Services

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

Quality Indicators

Process Indicator

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

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

7

Opioid Use Disorder

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

Background

The development of opioid use disorder is a risk associated with long-term opioid therapy for chronic pain. Clinicians concerned about a person with chronic pain developing opioid use disorder based on the person's concerns, symptoms, or behaviours; findings in a prescription monitoring system; or the use of a risk-screening tool should have a discussion with the person about their opioid use in an open and nonjudgmental way and provide an opportunity for the person to disclose any concerns or problems related to opioid use.[5] Clinicians should assess for the presence of opioid use disorder based on criteria from the current edition of the *Diagnostic and Statistical Manual* (DSM).[17]

People with concurrent chronic pain and untreated opioid use disorder should be offered opioid agonist therapy with either buprenorphine/naloxone or methadone.[5] People with concurrent chronic pain and opioid use disorder or another active substance use disorder should receive optimized non-opioid multidisciplinary pain management. Clinicians should continue to offer non-opioid therapies for chronic pain and consider consulting a pain or addiction specialist as needed.[5]

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

Sources: Centers for Disease Control and Prevention, 2016[5] | Health Quality Ontario, forthcoming[18]

What This Quality Statement Means

For Patients

There is a risk of becoming addicted to opioids. If you are taking your opioids more often or in higher doses than prescribed, or if you feel that opioids are having a negative impact on your life, talk with your health care professional. Your health care professional should not judge you. They should treat you with care and respect.

For Clinicians

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

For Health Services

Ensure systems and resources are in place to allow health care professionals to screen people at risk of opioid use disorder. Ensure pathways are in place that allow people diagnosed with opioid use disorder to access respectful, nonjudgmental, evidence-based treatment within 3 days of diagnosis. For further details, please refer to Health Quality Ontario's *Opioid Use Disorder* quality standard.

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Opioid agonist therapy

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

Quality Indicators

Process Indicator

Percentage of people prescribed an opioid for the treatment of chronic pain diagnosed with opioid use disorder who received opioid agonist therapy within 3 days of diagnosis (aligned with Quality Statement 7 of the Opioid Use Disorder quality standard)

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

Structural Indicator

Local availability of access to opioid agonist therapy (aligned with Quality Statement 7 of the Opioid Use Disorder quality standard)

- Data sources: local data collection, ConnexOntario

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Opioid use disorder

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* defines opioid use disorder as "a problematic pattern of opioid use leading to clinically significant impairment or distress, occurring within a 12-month period." The Manual lists 11 symptoms of opioid use disorder. The presence of 2 to 3 symptoms indicates mild opioid use disorder; 4 to 5 symptoms indicates moderate opioid use disorder; and 6 or more symptoms indicates severe opioid use disorder.[17]

8

Prescription Monitoring Systems

Health care professionals who prescribe or dispense opioids have access to a real-time prescription monitoring system at the point of care. Prescription history is checked when opioids are prescribed and dispensed and every 3 to 6 months during long-term use, or more frequently if there are concerns regarding duplicate prescriptions, potentially harmful medication interactions, or diversion.

Background

Prescription monitoring systems allow health care professionals to identify patterns of opioid and other monitored drug prescribing and to reduce the potential for opioid diversion and polypharmacy.[11] Before prescribing or dispensing an opioid, clinicians should check the prescription history of a person with chronic pain to determine whether they are receiving doses or combinations of controlled substances that are associated with an increased risk of overdose and death, including the co-prescribing of benzodiazepines or other sedatives.[5] A person's prescription history should be reviewed at the initiation of opioid therapy, if the dose is increased, and every 3 to 6 months for long-term stable doses. A person's prescription history should be checked more frequently if there are concerns regarding the potential for substance use disorder, overdose, diversion, indeterminate pain disorder, or prescriptions being obtained from more than one prescriber.[5,10,11]

Sources: American Society of Interventional Pain Physicians, 2012[11] | Centers for Disease Control and Prevention, 2016[5] | Institute for Clinical Systems Improvement, 2016[10]

What This Quality Statement Means

For Patients

To make sure you get the safest, most effective treatment, your health care professional and pharmacist should check your prescription history before prescribing or giving you opioids. They do this to see if you have recently been given opioids or other medications that are dangerous to take with opioids.

For Clinicians

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

For Health Services

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

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Prescription monitoring system

A prescription monitoring system is an electronic database that collects information on controlled prescription drugs prescribed by health care professionals and dispensed by pharmacies. In Ontario, the Narcotics Monitoring System (NMS) is the central database available to enable reviews of monitored drug prescribing and dispensing activities and to alert prescribers and pharmacists to potential instances of polypharmacy and double-doctoring.[19]

Quality Indicators

Process Indicators

Percentage of people with chronic pain prescribed an opioid whose prescription history was reviewed at the time an opioid was prescribed

- Denominator: total number of people with chronic pain who were prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator whose prescription history was reviewed at the time an opioid was prescribed
- Data source: local data collection

Percentage of people with chronic pain prescribed an opioid whose prescription history was assessed at least every 6 months

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

Structural Indicator

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

- Data source: provincial/regional data collection

9

Tapering and Discontinuation

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

Background

Tapering should be offered to all people on long-term opioid therapy every 3 to 6 months,[5,10] especially to those on doses of 90 mg morphine equivalents per day or more.[4,12] Health care professionals should discuss the potential benefits and harms of opioid tapering and work with people with chronic pain to taper to the lowest effective dose or to taper to discontinuation in situations in which patients[5,12]:

- Are not experiencing improvements in pain or function
- Are not adhering to their prescribed dose
- Have aberrant drug screening results
- Are experiencing adverse effects
- Are prescribed both opioids and benzodiazepines
- Request a dose reduction or discontinuation

People taking both benzodiazepines and opioids require tapering to reduce the risk of overdose and death.[5] The concurrent tapering of both drugs is preferred, but it may be more practical to taper one drug at a time depending on adverse effects and risk of harm.

BACKGROUND CONTINUED

During tapering, other non-opioid therapies for chronic pain should be offered with frequent follow-up.[10] Gradual dose reductions of 5% to 10% every 2 to 4 weeks with frequent follow-up is the preferred method of tapering for most people.[4] Health care professionals should work with patients to individualize the tapering strategy for each person's unique needs and, where appropriate, offer referrals to addiction medicine, psychiatry, or other multidisciplinary programs that provide care for people taking high doses of opioids, those who have previously experienced withdrawal, and those who have complex comorbidities.[10,12] As there are cost and availability issues associated with formal multidisciplinary opioid reduction programs, clinicians should endeavour to offer an alternative coordinated multidisciplinary collaboration that includes several health care professionals.[4]

Some people might experience an increase in pain or a decrease in function that lasts more than 1 month after a dose is tapered. In such cases, tapering may be paused or stopped.[4]

Sources: American College of Occupational and Environmental Medicine, 2014[12] | Centers for Disease Control and Prevention, 2016[5] | Guideline for Opioid Therapy and Chronic Noncancer Pain, 2017[4] | Institute for Clinical Systems Improvement, 2016[10]

What This Quality Statement Means

For Patients

Your health care professional should talk with you about cutting down or stopping your opioid medication when:

- You have been taking opioids for 3 months or longer
- Your pain is not getting better
- You are having problematic side effects
- You are on a high dose of opioids
- You want to cut down or stop taking opioids

Cutting down or stopping your opioid medication may have benefits for you, including lowering your risk of overdose and improving your pain.

But, cutting down or stopping opioids can be difficult. Your health care professional should work with you to make this decision together. If you cut down or stop too quickly, you may experience uncomfortable physical symptoms such as trouble sleeping, muscle aches, diarrhea, upset stomach, and vomiting. Your health care professional will work with you to make a plan to help you cut down or stop taking opioids safely. When you are cutting down, you might find it helpful to try other ways to manage your pain, like physical therapies, psychological therapies, or cultural or spiritual practices that are important to you.

For Clinicians

For people on long-term opioid therapy, discuss opioid tapering and offer tapering to discontinuation every 3 to 6 months. Strongly encourage tapering to people who:

- have been prescribed a dose of 90 mg morphine equivalents or more per day
- are not experiencing adequate improvement in pain and function
- are experiencing problematic side effects
- have been prescribed both opioids and benzodiazepines

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Multidisciplinary opioid reduction program

Formal multidisciplinary opioid reduction programs and coordinated multidisciplinary collaborations consist of treatment provided by several health professionals. Possibilities include, but are not limited to, primary care physicians, nurses, pharmacists, physical therapists, chiropractors, kinesiologists, occupational therapists, psychiatrists, and psychologists.[4]

Adverse effects

Possible adverse effects of opioid therapy include cognitive impairment, constipation, depression, falls, hypogonadism, nausea and vomiting, opioid-induced hyperalgesia, sleep apnea, unintentional overdose, opioid use disorder, and death.[4,5,12]

WHAT THIS QUALITY STATEMENT MEANS CONTINUED

For Health Services

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

Quality Indicators

Process Indicators

Percentage of people with chronic pain who were offered a trial of tapering every 6 months while on opioids

- Denominator: total number of people with chronic pain who were prescribed an opioid
- Numerator: number of people in the denominator who were offered a trial of tapering to a lower dose every 6 months while taking an opioid
- Data sources: linked administrative databases, including the Narcotics Monitoring System

Percentage of people with chronic pain prescribed an opioid dose of ≥ 90 mg morphine equivalents per day who received a trial of tapering to a lower dose

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

10

Health Care Professional Education

Health care professionals have the knowledge and skills to appropriately assess and treat chronic pain using a multidisciplinary, multimodal approach; appropriately prescribe, monitor, taper, and discontinue opioids; and recognize and treat opioid use disorder.

Background

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

Source: Advisory committee consensus

What This Quality Statement Means

For Patients

Your health care professional should understand how to assess and treat chronic pain using different approaches, including non-opioid medications, physical interventions, and psychological therapies. They should know how to appropriately prescribe opioids and monitor your opioid use, and they should help you lower your dose and stop taking opioids when the time is right. They should also know how to recognize when opioids might be having a negative impact on your life and how to treat opioid use disorder.

For Clinicians

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

For Health Services

Ensure that health care professionals have access to evidence-based, unbiased educational opportunities that provide information on how to assess and treat chronic pain using a multimodal, multidisciplinary approach; appropriately prescribe, monitor, taper, and discontinue opioids; and recognize and treat opioid use disorder.

Quality Indicators

Structural Indicator

Local availability of physicians, nurse practitioners, and dentists with the knowledge and skills to assess and treat chronic pain using a multidisciplinary, multimodal approach and to prescribe, monitor, taper, and discontinue opioids

- Data source: provincial/regional data collection

DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

Multidisciplinary, multimodal approach

A multidisciplinary, multimodal approach to pain management involves a combination of therapies, including non-opioid pharmacotherapy and nonpharmacological therapies (i.e., active and passive physical interventions, psychological therapies, and self-management programs) provided by a team of different types of health care professionals.

Acknowledgements

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

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About Health Quality Ontario

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

Who We Are

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

What We Do

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

Why It Matters

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

Quality Standards

Looking for more information?

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

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ISBN 978-1-4868-1409-1 (Print)
ISBN 978-1-4868-1419-0 (PDF)
© Queen's Printer for Ontario, 2018

Ontario
Health Quality Ontario