

**Quality  
Standards**

# Opioid Prescribing for Acute 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 appropriate prescribing, monitoring, and tapering of opioids to treat acute pain for people 15 years of age and older in all care settings. It does not address opioid prescribing for chronic 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 Chronic Pain* quality standard and *Opioid Use Disorder* quality standard for detailed quality statements related to these topics.

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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.

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](mailto: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 acute pain for people aged 15 years of age and older in all care settings. It does not address opioid prescribing for chronic 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 Chronic Pain* quality standard and *Opioid Use Disorder* quality standard for detailed quality statements related to these topics.

The Opioid Prescribing for Acute 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<sup>1</sup> and intentional poisonings,<sup>2</sup> and suffer a disproportionately higher rate of opioid-related deaths than the general adult population.<sup>3</sup> These higher rates of harm stress the importance of providing guidance on the careful and appropriate prescribing of opioids for acute 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 Acute 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 acute 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 9 quality statements addressing areas identified by Health Quality Ontario's Opioid Prescribing for Acute Pain Quality Standard Advisory Committee as having high potential for improving the quality of care in Ontario for people with acute 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 can be involved in the care of people with acute pain. The term refers to physicians, nurse practitioners, nurses, dentists,

pharmacists, and other health professionals involved in the assessment, monitoring, and treatment of acute pain.

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

## Why This Quality Standard Is Needed

Acute pain is typically a normal, predicted response to surgery, acute illness, trauma, or other injury.<sup>4</sup> It is recent in onset and is a self-limiting process that generally lasts from hours to days or a month after the precipitating event. The duration of acute pain is associated with the time it normally takes for healing to occur.<sup>4</sup>

Acute pain is best treated through a multimodal approach that combines different pharmacological and nonpharmacological therapies. Opioid therapy is one treatment option within this approach, and one that is commonly used: In the first 3 months of 2016 in Ontario, 24% of people who filled a prescription for opioid analgesics received a one-time supply of short-acting medication for a duration of 14 days or less, suggesting the medication was prescribed for acute pain.<sup>5</sup> However, opioids are often prescribed for acute pain conditions when non-opioid treatments would be similarly effective.<sup>6,7</sup>

There are also troubling variations across Ontario in how opioids are prescribed for acute pain. For example, the percentage of new opioid prescriptions issued by surgeons in 2016 that exceeded the recommended

7-day supply varied more than twofold by local health integration network (LHIN) region, ranging from 7.4% to 16.7% (Narcotics Monitoring System, Ministry of Health and Long-Term Care, November 2017). There are also variations in the daily dose of opioids prescribed, with 21% to 42% of new opioid prescriptions from surgeons in Ontario exceeding the recommended dose of 50 mg morphine equivalents across LHIN regions (Narcotics Monitoring System, Ministry of Health and Long-Term Care, November 2017).

The potential benefits of opioid therapy for acute pain are short-term pain control and a quicker return to normal function. The potential harms include the risks of long-term use, addiction, overdose, and death.<sup>6-9</sup> The presence of unused prescribed opioids in the community also poses a safety risk to others and has the potential for diversion.<sup>6,10</sup>

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 acute pain being subjected to opioid-related harms.

## Principles Underpinning This Quality Standard

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

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

People with acute 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 Acute 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)
  - Number of opioid tablets and patches 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 (i.e., people with acute pain) is unavailable.

### How Success Can Be Measured Locally

You may want to assess the quality of care you provide to people with acute 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.

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**

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

## QUALITY STATEMENT 2: **Multimodal Therapies**

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People with acute pain receive multimodal therapy consisting of non-opioid pharmacotherapy with physical and/or psychological interventions, with opioids added only when appropriate.

## QUALITY STATEMENT 3: **Opioid Dose and Duration**

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

## QUALITY STATEMENT 4: **Information on Benefits and Harms of Opioid Use and Shared Decision-Making**

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People with acute pain and their families and caregivers receive information about the potential benefits and harms of opioid therapy, safe storage, and safe disposal of unused medication at the times of both prescribing and dispensing.

## QUALITY STATEMENT 5: **Acute Pain in People Who Regularly Take Opioids**

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

## QUALITY STATEMENT 6: **Acute Pain in People With Opioid Use Disorder**

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

**QUALITY STATEMENT 7:**  
**Prescription Monitoring Systems**

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

**QUALITY STATEMENT 8:**  
**Tapering and Discontinuation**

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

**QUALITY STATEMENT 9:**  
**Health Care Professional Education**

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

# Comprehensive Assessment

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

## Background

For people with acute pain, health care professionals should perform a comprehensive assessment that includes a history and physical examination to determine appropriate acute pain management depending on the diagnosis.<sup>6</sup> Health care professionals should document the type and source of pain, the effects of the pain on function and quality of life, and other co-existing factors. If applicable, previous responses to postoperative

treatment should be considered to guide pain management after surgery or other procedures.<sup>8</sup> People with untreated or undertreated mental health conditions should be offered concurrent mental health care.<sup>4</sup> With standardized processes and procedures, comprehensive assessments can be completed quickly in settings such as emergency departments or walk-in clinics.

**BACKGROUND CONTINUED**

People with acute pain should be assessed for any history of physical dependence or tolerance to opioids, as well as any active or previous substance use disorders because these may be associated with increased opioid requirements, delayed recovery after surgery, and increased risks of harm.<sup>8</sup> The presence of risk factors for opioid use disorder may influence the choice of medication, follow-up, monitoring, and tapering protocols after surgical procedures.<sup>8</sup> Clinicians should also assess the use of other substances that may affect pain management, such as benzodiazepines, cocaine, alcohol, and other psychoactive substances.<sup>8</sup>

In cases where co-existing chronic diseases cause recurrent episodes of acute pain, existing pain management plans and current or past use of opioids should be considered in the care plan for acute pain.

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**Sources:** American Pain Society, 2016<sup>8</sup> | Institute for Clinical Systems Improvement, 2016<sup>4</sup>

## What This Quality Statement Means

### For Patients

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

### For Clinicians

Perform a comprehensive assessment (see definition) for people with acute pain who are taking or for whom you are considering prescribing opioids.

### For Health Services

Ensure systems, processes, and resources are in place to allow clinicians to perform comprehensive assessments of people with acute 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.

## Quality Indicators

### Process Indicator

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

- Denominator: total number of people with acute pain who were prescribed an opioid
- 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

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#### **Comprehensive assessment**

When opioids are prescribed, a comprehensive assessment includes all of the following<sup>6,8</sup>:

- 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
- Past and current substance use disorders
- Past pain management and coping strategies

## Multimodal Therapies

**People with acute pain receive multimodal therapy consisting of non-opioid pharmacotherapy with physical and/or psychological interventions, with opioids added only when appropriate.**

### Background

Most acute pain in primary care, dental, and postoperative settings can be successfully treated with a multimodal therapeutic approach consisting of a combination of non-opioid pharmacotherapy and nonpharmacological interventions. The use of a non-opioid-based multimodal approach compared with a primarily opioid-based approach improves pain control and reduces overall opioid consumption and adverse effects.<sup>8,9</sup> Not all people

undergoing surgery require opioids postoperatively; therefore, a multimodal pain management plan should be developed before the procedure. Regarding people experiencing significant postoperative pain requiring opioid therapy, parenteral opioids should be avoided in those who are able to take medication orally because their use may be associated with a greater risk of long-term opioid use and opioid-related harms.<sup>8</sup>

**BACKGROUND CONTINUED**

Acetaminophen and/or nonsteroidal anti-inflammatory drugs (NSAIDs) reduce opioid consumption when used as part of a multimodal approach to therapy<sup>8,9</sup> and are effective as first-line analgesia for many types of acute pain in people without contraindications. Other pharmacological or nonpharmacological therapies and techniques may be considered based on the pain assessment and diagnosis. To help people prepare for surgery, painful medical procedures, or postsurgical pain, health care professionals may consider the use of pre-emptive analgesia or psychological interventions, such as cognitive behavioural therapy, guided imagery, and other relaxation techniques, as part of a multimodal approach; however, it is unclear which techniques are most effective.<sup>8,9</sup>

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**Sources:** American Pain Society, 2016<sup>8</sup> | Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, 2015<sup>9</sup>



## What This Quality Statement Means

### For Patients

Your health care professional should offer you a variety of ways to manage your pain, including different kinds of physical therapies and medications, depending on the cause of your pain. You should be offered opioids only when other types of treatment are unable to manage your pain.

### For Clinicians

Offer people with acute pain multimodal therapy based on the clinical diagnosis. Offer opioids only when necessary to provide adequate pain relief, and include them as part of a multimodal approach. If the person can tolerate oral medications, oral opioids are preferred over parenteral opioids.

### For Health Services

Ensure that systems, resources, and training are available to allow health care professionals to deliver multimodal therapy for acute pain. Ensure that people with acute pain have equitable access to these therapies and the ability to access timely follow-up for acute pain that does not resolve.

## DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

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### Multimodal therapy

Multimodal therapy is the use of a combination of different analgesic medications, interventional techniques, and/or nonpharmacological interventions that target different mechanisms of action in the peripheral or central nervous system.<sup>8</sup>

### Non-opioid pharmacotherapy

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

### Nonpharmacological therapies

There are a broad range of nonpharmacological therapies that may be used to manage acute pain. The efficacy of each therapy may vary by type or cause of pain.

Examples of self-management interventions include the following:

- Heat
- Ice
- Massage
- Stretching
- Rest

## Quality Indicators

### Process Indicators

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

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

#### Percentage of people with acute pain prescribed an opioid who received physical or psychological interventions or non-opioid pharmacotherapy (acetaminophen and/or nonsteroidal anti-inflammatory drugs) as first-line treatment prior to being prescribed an opioid

- Denominator: total number of people with acute 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 physical or psychological interventions or non-opioid pharmacotherapy as first-line treatment prior to being prescribed an opioid
- Data source: local data collection

#### Percentage of people with acute pain newly started on opioid therapy

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

### DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

#### Nonpharmacological therapies (continued)

Examples of nonpharmacological interventions provided by a health care professional include the following:

- Acupuncture
- Bracing or wrapping
- Spinal manipulation
- Passive physical therapy
- Positioning
- Splints
- Transcutaneous electrical nerve stimulation (TENS)

Psychological therapies include the following:

- Self-management programs (in-person or online)
- Interventions provided by health care professionals, including cognitive behavioural therapy, guided imagery, hypnosis, and relaxation techniques.<sup>8</sup> Some of these modalities should be engaged prior to surgery or a painful medical procedure<sup>8</sup>

Interventional treatments, such as therapeutic injections, are percutaneous or minor surgical procedures targeting specific anatomical structures identified as sources of pain.<sup>9</sup>

## Opioid Dose and Duration

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

### Background

For people in an outpatient or primary care setting who have not consumed opioids recently, opioids prescribed for acute pain should be prescribed for only short-term use at the lowest effective dose.

Opioid use for acute pain is associated with a risk of long-term opioid use; factors associated with the sharpest increase in long-term use include an initial 10-day supply, more than 5 days of use, and a second prescription or refill.<sup>7,9,11</sup>

The maximum daily oral dose recommended for people with acute pain who do not regularly take opioids, based on risk of overdose or death, is a dose equivalent to 50 mg of morphine.<sup>6,7</sup>

Expert opinion suggests a duration of 3 days

or less is sufficient in most cases of acute pain seen in primary care.<sup>7</sup> Methadone, fentanyl or buprenorphine patches, and extended-release versions of other oral opioids are not recommended for the treatment of acute pain because of their increased risk of harm owing to longer half-lives and longer duration of action.<sup>4,7</sup> Physical dependence is an expected physiologic response in people exposed to opioids for more than a few days; therefore, lowering the number and potency of doses prescribed should minimize the need to taper opioids to prevent withdrawal symptoms and reduce the quantity of prescribed opioids available for diversion in the community.<sup>7</sup>

**BACKGROUND CONTINUED**

One reason postoperative prescriptions are often written for 7 days or longer is that it can be difficult to estimate the duration of opioids required.<sup>9</sup> However, clinicians should not prescribe additional doses to patients “just in case” pain continues for longer than expected.<sup>7,9</sup> Prescribing for a duration of more than 7 days, or providing a refill or second prescription, has been associated with approximately double the likelihood of continued use 1 year later.<sup>11</sup> Only in rare or exceptional cases is a supply of opioids for more than 7 days appropriate. If a longer duration of prescription is warranted, health care professionals may consider the use of a partial refill after 7 days if acute pain continues.

If acute pain continues for longer than expected, health care professionals should reassess the person to confirm or revise the initial diagnosis and adjust the pain management plan.<sup>7</sup> If pain persists, health care professionals should consider other conditions, including opioid use disorder, and consult with other relevant health care professionals involved in the treatment of the person's pain.<sup>4,7</sup>

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**Sources:** Advisory committee consensus | American College of Occupational and Environmental Medicine, 2014<sup>6</sup> | Centers for Disease Control and Prevention, 2016<sup>7</sup>

## What This Quality Statement Means

### For Patients

If you are prescribed opioids, your health care professional should prescribe the lowest dose and lowest strength that will work for you. If you are seeing your family doctor, dentist, or nurse practitioner outside the hospital, in most cases, your prescription should be for 3 days or less. More severe acute pain, such as pain from major surgery, may require a longer prescription, but usually not more than 7 days. Your health care professional should monitor your pain and help you to stop taking opioids when your pain is reduced.

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

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

### For Health Services

Ensure that policies and protocols are developed and implemented to encourage low-dose and limited-duration opioid prescriptions for acute pain. Ensure timely follow-up is available to people with acute pain continuing past 7 days.

## Quality Indicators

### Process Indicators

#### **Percentage of people with acute pain prescribed an opioid who were prescribed an initial dose greater than 50 mg morphine equivalents per day**

- Denominator: total number of people with acute 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 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 acute pain prescribed an opioid who are prescribed no more than a 3-day supply**

- Denominator: total number of people with acute pain who are prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator whose prescription is for no more than a 3-day supply
- Data sources: local data collection or linked administrative databases, including the Narcotics Monitoring System

## QUALITY INDICATORS CONTINUED

**Percentage of people with acute pain prescribed an opioid who are prescribed more than a 7-day supply**

- Denominator: total number of people with acute pain who are prescribed an opioid and did not have an opioid prescription in the previous 6 months
- Numerator: number of people in the denominator whose prescription is for more than a 7-day supply
- Data sources: local data collection or linked administrative databases, including the Narcotics Monitoring System

**Percentage of people with acute pain prescribed an opioid whose prescription is for an extended-release opioid**

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

## Information on Benefits and Harms of Opioid Use and Shared Decision-Making

People with acute pain and their families and caregivers receive information about the potential benefits and harms of opioid therapy, safe storage, and safe disposal of unused medication at the times of both prescribing and dispensing.

### Background

Health care professionals should provide patient- and family-centred, individually tailored education, including information on treatment options for the management of acute pain, to allow people with acute pain and their

families and caregivers, as appropriate, to participate in shared decision-making. Health care professionals should also document the plan for pain management.<sup>8</sup>

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**Source:** American Pain Society, 2016<sup>8</sup>



## What This Quality Statement Means

### For Patients

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

### For Clinicians

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

### For Health Services

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

## DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

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### Information

Information should be provided to people with acute pain during in-person visits verbally and via printed or multimedia formats. This information should include, at a minimum, content related to the following<sup>4,8,9</sup>:

Pain management:

- Goals for pain management
- Alternative non-opioid pharmacotherapy and nonpharmacological therapies for acute pain, including their effects, risks, and costs

Opioid prescribing:

- Instructions to take prescribed medications only as needed to relieve severe acute pain
- The signs and symptoms of physical dependence and withdrawal
- A plan for tapering opioids when pain resolves
- A plan for when to follow up with a primary care provider if pain does not resolve

## Quality Indicators

### Process Indicators

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

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

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

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

### DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

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#### Information (continued)

Reducing potential harms of opioids:

- Associated risk factors for opioid use disorder and for overdose and death (e.g., mental health comorbidities, current or past substance use disorder, co-prescribed central nervous system depressants or other sedative hypnotics)
- Possible adverse effects of opioid therapy for acute pain, including the risk of falls, impaired driving, and occupational hazards
- How to recognize and respond to an opioid overdose
- The risk of short-term opioid use leading to long-term use
- The safe storage and disposal of opioids to prevent harms to others and to prevent diversion in the community

## QUALITY INDICATORS CONTINUED

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

- Denominator: total number of people with acute pain who are prescribed an opioid
- Numerator: number of people in the denominator who report that their health care professional always or often involves them as much as they want in decisions about their care and treatment for acute pain
- Data source: local data collection
- 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)<sup>13</sup>

**DEFINITIONS USED WITHIN THIS QUALITY STATEMENT**

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**Shared decision-making**

Shared decision-making is a collaborative process that allows people with acute pain and their health care professionals to make decisions together. The health care professional is responsible for the following<sup>12</sup>:

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

## Acute Pain in People Who Regularly Take Opioids

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

### Background

People with acute pain who have developed a tolerance to opioids as a result of long-term use (via a prescription for chronic pain, opioid agonist therapy, or non-medical use) may have significantly higher opioid requirements and may need different doses to manage acute pain than those who have not taken opioids recently.<sup>9</sup> Assessment and management should focus on effective analgesia, the use of strategies that may reduce the effects of opioid tolerance or opioid-induced hyperalgesia, and the prevention of withdrawal.<sup>9</sup> Usual opioid

doses should be maintained where possible, or appropriate substitutions should be made during acute-pain events.<sup>9</sup>

Health care professionals should work closely with other treating health care professionals and specialist teams as required, including the person's original opioid prescriber whenever possible. If relevant, they should perform appropriate discharge planning after hospitalization to ensure continuity of care in the long term.<sup>9</sup>

**BACKGROUND CONTINUED**

Some people experience exacerbations of chronic diseases that cause acute pain (e.g., sickle cell disease). Health care professionals should follow disease-specific clinical guidelines to improve pain control and patient satisfaction for people with these conditions.<sup>9</sup> People with chronic conditions may benefit from having a pain management plan, whether or not they take opioids regularly. In cases of exacerbations that cause acute pain, people with chronic diseases often require the rapid administration of oral or intravenous opioids (e.g., in the emergency department). Opioids should be prescribed carefully, as people with these conditions are still at risk of developing opioid use disorder.<sup>2</sup>

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**Source:** Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, 2015<sup>9</sup>

## What This Quality Statement Means

### For Patients

If you are already taking opioids (perhaps because of chronic pain) and you are now experiencing acute pain, the health care professional providing care for your acute pain should communicate with the health care professional who has prescribed your current opioid prescription. They should work together to make changes to your regular opioid prescription or care plan, if needed, to make sure your pain is managed safely and effectively.

### For Clinicians

Consider the risk of long-term opioid use and tolerance when prescribing opioids for acute pain. Wherever possible, communicate and coordinate care with the clinicians prescribing the person's long-term opioids, and create a plan to taper to the original dose.

### For Health Services

Ensure that systems and tools are available to help health care professionals coordinate care for people with acute pain who regularly take opioids. Facilities where surgery is performed should provide clinicians and patients with access to a pain specialist to help manage inadequately controlled postoperative pain or the care of people who are at high risk of inadequately controlled postoperative pain because of ongoing opioid use.<sup>8</sup>

## Quality Indicators

### Process Indicators

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

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

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

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

# Acute Pain in People With Opioid Use Disorder

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

## Background

If a person is taking prescribed buprenorphine/naloxone or methadone, whenever possible these medications should be continued during acute-pain events. If acute pain is poorly managed, participation in opioid agonist therapy programs may decrease.<sup>9</sup> Any changes to a care plan for opioid use disorder should be discussed with both the patient and the health care professionals involved in the person's care. Doses of buprenorphine/naloxone may need to be reduced to treat acute pain with additional

opioid therapy. Methadone doses can be divided and given every 8 to 12 hours to provide better acute pain relief.<sup>9</sup> Any changes to opioid agonist therapy doses should be communicated to the original prescriber.

People with past opioid use disorder should discuss their values and preferences for treating acute pain with opioids with their health care professionals. Other non-opioid therapies may be considered as part of a multimodal approach.



**BACKGROUND CONTINUED**

Knowledge of effective treatment for acute pain in people with a current substance use disorder is limited and complicated by factors including<sup>9</sup>:

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

Wherever possible, health care professionals should consult with the person's primary care provider. They may also need to consult with an addictions or pain specialist to coordinate care for people with opioid use disorder who are experiencing acute pain.

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**Source:** Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine, 2015<sup>9</sup>

## What This Quality Statement Means

### For Patients

If you take buprenorphine/naloxone or methadone for opioid use disorder (which includes opioid addiction), continue to take this medication during times when you are being treated for acute pain.

### For Clinicians

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

### For Health Services

Ensure that people with opioid use disorder have access to continued opioid agonist therapy during acute-pain events. Ensure that structures are in place for health care professionals treating acute pain to communicate with opioid agonist therapy prescribers.

## Quality Indicators

### Process Indicator

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

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

### DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

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#### 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.

## Prescription Monitoring Systems

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

### Background

When possible, health care professionals should check the prescription history of a person with acute pain before prescribing or dispensing opioids. Prescription history can inform the management of acute pain by identifying past or current exposure to opioids, which may affect opioid tolerance,<sup>4</sup> and by alerting health care professionals to the total morphine equivalents

of multiple prescriptions or the increased risks for overdose or death posed by combining opioids with other prescribed controlled substances such as benzodiazepines.<sup>4,7</sup> The use of prescription monitoring systems also allows health care professionals to identify multiple prescriptions and other behaviours associated with diversion.

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**Source:** Institute for Clinical Systems Improvement, 2016<sup>4</sup>

## What This Quality Statement Means

### For Patients

To make sure you receive the safest 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.

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

### For Clinicians

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

### For Health Services

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

## DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

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### Diversion

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

### Prescription monitoring system

A prescription monitoring system is an electronic database that collects information on controlled prescription drugs prescribed by health care professionals and dispensed by pharmacies. In Ontario, the Narcotics Monitoring System (NMS) is the central database available to enable reviews of monitored drug prescribing and dispensing activities and to alert prescribers and pharmacists to potential instances of polypharmacy and double-doctoring.<sup>14</sup>

## Quality Indicators

### Process Indicator

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

- Denominator: total number of people with acute pain who were prescribed an opioid
- Numerator: number of people in the denominator whose prescription history was reviewed at the time an opioid was prescribed
- 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

# Tapering and Discontinuation

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

## Background

Tapering and discontinuing opioid therapy for acute pain should begin when severe pain has ceased and function has returned.<sup>6</sup> Most people treated for acute pain should generally not require tapering, but they should be aware of the signs and symptoms of withdrawal, as some degree of physical dependence may have developed.<sup>6</sup> At the initial prescription, health care professionals should work with their patients to create a plan for discontinuing opioids as the acute pain resolves and discuss the appropriate disposal of unused opioids.<sup>8</sup>

Reducing the daily dose by about 20% to 25% can reduce the possibility of experiencing withdrawal.<sup>8</sup>

People with acute pain treated with opioids at

high doses and/or for longer durations may benefit from a period of slower tapering over 5 to 7 days, or longer if necessary.<sup>6</sup> Discontinuing all pain medication is generally indicated, but transitioning to either a nonsteroidal anti-inflammatory drug or acetaminophen can be done when necessary.<sup>6</sup> Continue other non-opioid therapies for any ongoing acute pain management.

Health care professionals should work with people who have been on long-term opioid therapy prior to their acute-pain episode to develop a plan to taper to their baseline dose following the acute-pain episode.<sup>8</sup>

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**Sources:** American College of Occupational and Environmental Medicine, 2014<sup>6</sup> | American Pain Society, 2016<sup>8</sup>

## What This Quality Statement Means

### For Patients

If you take opioids for more than a week and then cut down or stop quickly, you may experience uncomfortable physical symptoms such as trouble sleeping, muscle aches, diarrhea, upset stomach, and vomiting. If you experience any of these symptoms or have trouble stopping your medication, your health care professional will work with you to make a plan to help you cut down and stop taking opioids safely.

### For Clinicians

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

### For Health Services

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

## DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

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### Opioid withdrawal

Withdrawal symptoms occur when there is a reduction or cessation of opioid use following regular use. Common withdrawal symptoms include the following<sup>15</sup>:

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

### Physical dependence

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

## Quality Indicators

### Process Indicators

**Percentage of people prescribed an opioid for acute pain with documentation of receiving information on the potential for physical dependence and symptoms of withdrawal prior to receiving their prescription (aligned with indicator for Quality Statement 4)**

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

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

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



## Health Care Professional Education

Health care professionals have the knowledge and skills to appropriately assess and treat acute pain using a 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 treatment for acute 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.

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**Source:** Advisory committee consensus

## What This Quality Statement Means

### For Patients

Your health care professional should understand how to assess and treat acute pain using different approaches, including different kinds of medications, physical therapies, and psychological therapies. If they prescribe opioids, they should know how to monitor your opioid use, and they should help you lower your dose and stop taking opioids when the time is right.

### For Clinicians

Stay current with the evidence-based knowledge and skills needed to appropriately assess and treat acute pain using a multimodal approach; appropriately prescribe, monitor, taper, and discontinue opioids and other medications indicated for acute pain; 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 acute pain using a multimodal 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 acute pain using a multimodal approach and to prescribe, monitor, taper, and discontinue opioids**

- Data source: provincial/regional data collection

## DEFINITIONS USED WITHIN THIS QUALITY STATEMENT

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### Multimodal approach

A multimodal approach to pain management is the use of a combination of different analgesic medications, interventional techniques, and nonpharmacological interventions that target different mechanisms of action in the peripheral or central nervous system.<sup>8</sup>

# Acknowledgements

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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.



## Looking for more information?

Visit our website at [hqontario.ca](http://hqontario.ca) and contact us at [qualitystandards@hqontario.ca](mailto:qualitystandards@hqontario.ca) if you have any questions or feedback about this guide.

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