



## Shared Care Final Project Report

<b>Project Title</b>	Chronic Pain Shared Care “Enhancing Patient Access to Chronic Pain Services” (SCC3478)
<b>Physician leads</b>	Dr. Huy Nguyen, Family Physician Lead Dr. Alyssa Hodgson, Anesthesiologist, Specialist Lead
<b>Project lead</b>	Cindy Young
<b>Date of Submission</b>	August 28, 2023



## EXECUTIVE SUMMARY

### Background

Chronic pain is a complex health issue that spans across multiple disciplines and poses challenges for both providers and patients. The Fraser Northwest (FNW) Chronic Pain Shared Care project identified the need to strengthen access to care, increase family physician's awareness of available resources for patients, and support patients without a family doctor on high dose opioids for chronic non-cancer pain. A collaborative, multidisciplinary approach was taken and a diverse group of stakeholders were engaged to provide valuable perspectives and feedback on the project's implementation.

### Project Objectives

The main objectives of the Chronic Pain Shared Care project is to:

1. Increase primary care providers awareness of free/low cost support available for their patients. This includes patient self-management, exercise and movement, pain clinics, specialist clinics, support groups and networks, and educational workshops.
2. Create a referral algorithm/care pathway for providers to increase awareness of available services and direct them to "best practices" evidence for managing chronic pain
3. Develop educational workshops to increase primary care provider's, RNs in Practices and MHSU Clinicians skills and knowledge in navigating chronic pain services
4. Pilot a collaborative approach to opioid prescribing for chronic pain patients

### Project Outcomes

Increased confidence and satisfaction by primary care providers in supporting their chronic pain patients

- Increased understanding by primary care practitioners of how to manage patients with chronic pain, including demonstrating an awareness of available services to support chronic pain patients
- Primary care provider feels supported and both primary care provider and specialist sees merit and satisfaction with the collaborative approach to opioid prescribing

Improved patient care, health outcomes and effect on system costs

- Patient feels well enabled with resources, feels supported and confident with a collaborative pain management plan. Has individual self-management skills, knowledge and awareness of available resources



# TEMPLATES AND FORMS

## Conclusion

The FNW Chronic Pain Shared Care project increased awareness of the complexities of chronic pain by conducting a comprehensive environmental scan to gain valuable insights into the challenges and gaps that exist in the healthcare system. As the project progressed, it became clear that the problems were more complex than anticipated and certain project activities faced barriers. Despite these challenges, the passionate and determined group of stakeholders worked to advocate for system level changes at both regional and provincial levels to create more awareness and demand for chronic pain services. This project provides a foundation for future improvements and initiatives related to chronic pain and has identified many next steps in hopes of keeping the momentum to spread the work that has been done.

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## INTRODUCTION

The Fraser Northwest Division of Family Practice (FNW DoFP) encompasses family physicians in New Westminster, Coquitlam, Port Coquitlam, Port Moody, Anmore and Belcarra representing the traditional catchment area of the Royal Columbian and Eagle Ridge Hospitals. Together, members and division staff work to improve patient access to local primary care, increase local physicians' influence on health care delivery and policy, and provide professional support for physicians.

The FNW Chronic Pain Shared Care project started to strengthen access to care, increase family physician's awareness of available resources for patients, and support patients without a family doctor on high dose opioids for chronic non-cancer pain. Untreated or poorly managed chronic pain restricts activities of daily living, increases the likelihood of developing complex conditions with associated comorbidities, such as anxiety, depression and substance use disorder. Chronic Pain patients are also impacted by stigma, lack of chronic pain supports and services, costs of allied health treatment options, lack of coordination of care and have difficulties with opioid prescribing.

### **Problem Statement:**

Lack of streamlined approach to chronic pain (diagnosis, treatment, management), leading to frustration for both patients and providers within the Fraser Northwest region.

### **Aim Statement:**

Increase the confidence and satisfaction of FNW family physicians managing chronic pain patients by increasing awareness of chronic pain services and resources.

## PROJECT OBJECTIVES

The objectives of the FNW Chronic Pain Shared Care project were to:

1. Increase primary care providers awareness of free/low cost support available for their patients. This includes patient self-management, exercise and movement, pain clinics, specialist clinics, support groups and networks, and educational workshops.
2. Create a referral algorithm/care pathway for providers to increase awareness of available services and direct them to "best practices" evidence for managing chronic pain
3. Develop educational workshops to increase primary care provider's, RNs in Practices and MHSU Clinicians skills and knowledge in navigating chronic pain services.
4. Coordinate with Practice Support Program (PSP) to deliver chronic pain learning modules with local family physicians as the leads.
5. Spread awareness of BC ECHO for Chronic Pain to connect family physicians to specialists for knowledge and resources.
6. Explore the opportunity for chronic pain specific group medical visits.
7. Pilot a collaborative model to opioid prescribing for patients on high dose opioids for chronic non-cancer pain.



## TARGET POPULATION

The target population for this project included primary care providers, anaesthesiologists, allied health professionals such as RNs in Practices, MHSU Clinicians, office staff such as MOAs, practice managers and chronic pain patients and caregivers in the Fraser Northwest communities.

## ENGAGEMENT STRATEGY

Physicians that showed interest in participating and driving this project joined to contribute to the planning and implementation of the project. Additional non-physician stakeholders and guests were invited to participate and share their knowledge, expertise and experiences. Due to the overlap of chronic pain concerns with other health conditions, the group echoed the need for a multidisciplinary approach to manage and support patients with complex pain. A diverse number of providers across all fields of medicine were engaged which helped to ensure the spread of information reached a larger network.

Name	Role	Primary Practice Location
<b>Physician Engagements</b>		
Dr. Huy Nguyen	Family Physician Lead	New Westminster
Dr. Alyssa Hodgson	Anaesthesiologist, Specialist Lead	New Westminster
Dr. John Koehn	Addiction Medicine Physician	New Westminster
Dr. Lalji Halai	Family Physician	Burnaby
Dr. Tracy Monk	Family Physician	Burnaby
Dr. Martha Koehn	Emergency Medicine Physician	New Westminster
Dr. Stephen Barron	Retired Family Physician	Port Coquitlam
Dr. Nazila Soltani	Family Physician	Coquitlam
Dr. Janel Casey	Psychiatrist, Head of Psychiatry (RCH)	New Westminster
Dr. Ramak Shadmani	Family Physician	Coquitlam
Dr. Dean Burrill (Guest)	Anesthesiologist	Delta
Dr. Andrew Best (Guest)	Radiologist	New Westminster
Dr. Tony Tran (Guest)	Anesthesiologist	New Westminster
Dr. Jill Osborn (Guest)	Medical Lead, St. Pauls Complex Pain Clinic	Vancouver



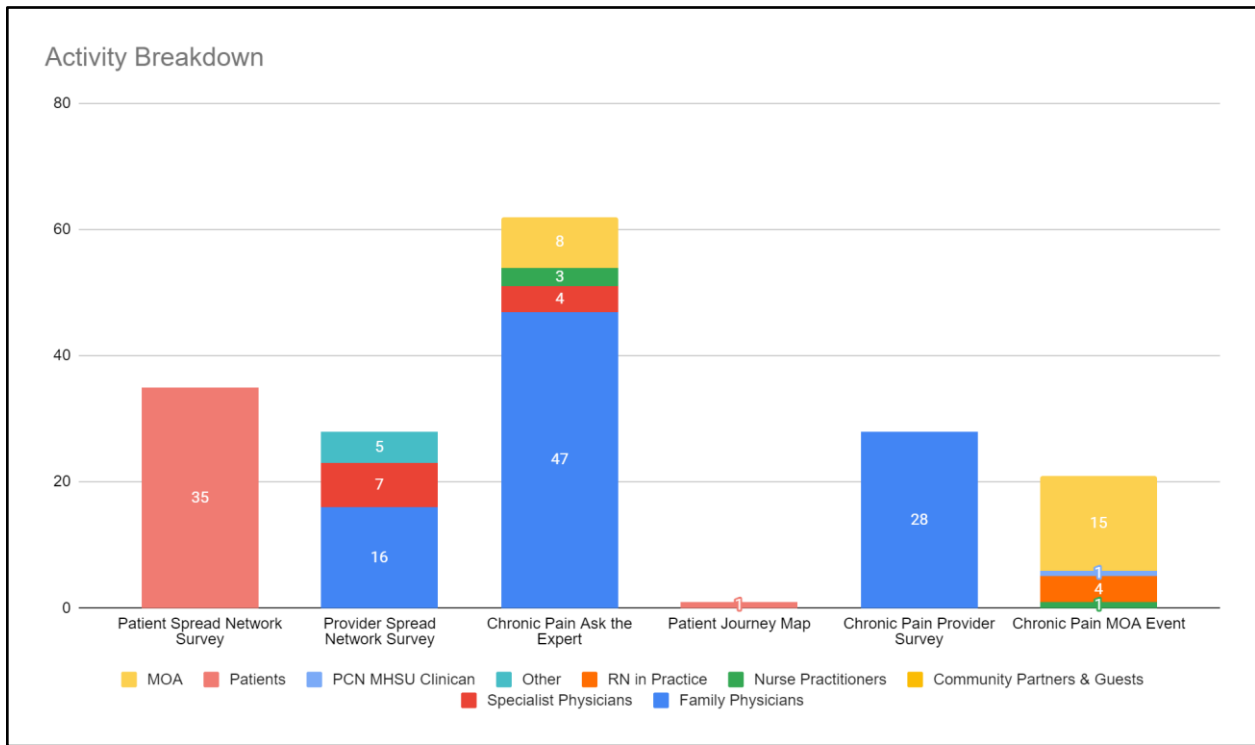
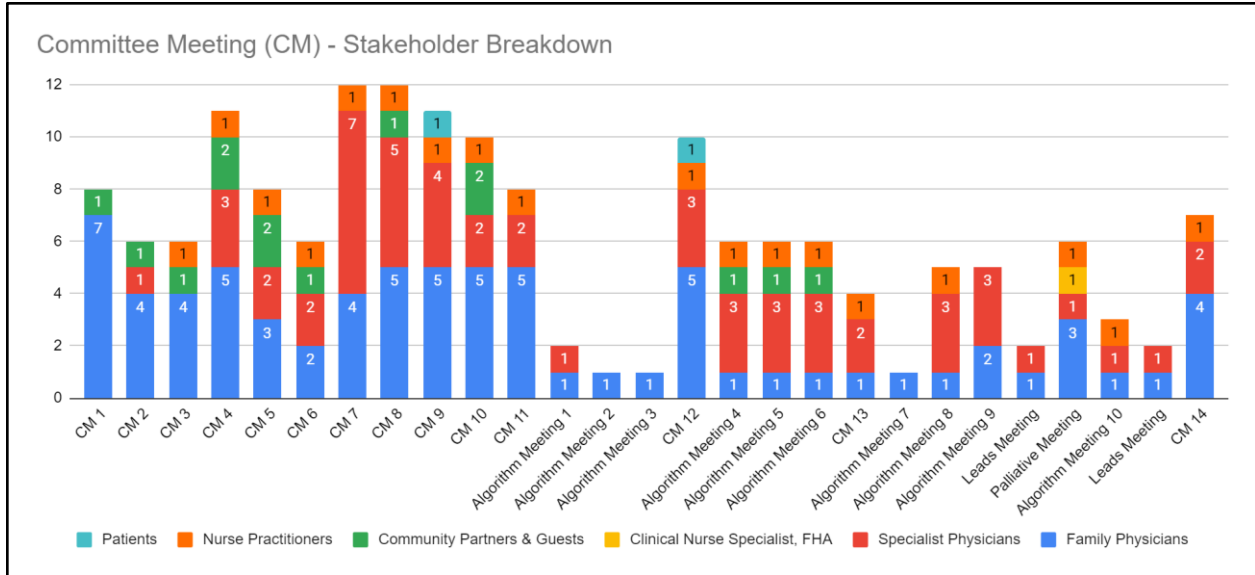
# TEMPLATES AND FORMS

Dr. Aaron Rizzardo (Guest)	Internal Medicine, St. Pauls Complex Pain Clinic	Vancouver
Dr, Mike Butterfield (Guest)	Psychiatrist, St. Pauls Complex Pain Clinic	Vancouver
Dr. Vishal Varshney (Guest)	Anesthesiologist, St. Pauls Complex Pain Clinic	Vancouver
Dr. Amir Bharmal (Guest)	Medical Director for Communicable Disease and Harm Reduction	Vancouver
<b>Non-Physician Engagements</b>		
Brenda Poulton	Clinical Pain Lead, Nurse Practitioner, FHA	Fraser Health Authority (FHA)
Denyse Houde	Director, Clinical Operations, FHA	FHA
Walid Chahline	Director, Mental Health and Substance Use, FHA	FHA
Wendy Magnusson	Director, Clinical Operations, FHA	FHA
Debbie Halyk	Patient Partner	
Dorota Hedzelek (Guest)	Pain BC	BC
Claire Doherty (Guest)	Leader, Virtual Health, Providence Health	Providence Health Authority

A breakdown of stakeholder engagement and involvement in committee meetings and project activities are graphed below. Throughout the project’s duration, a total of 14 committee meetings, 10 sub-committee meetings and 2 physician lead meetings were held to discuss, plan and implement the project activities. Larger exploratory meetings in the beginning of the project were needed to ensure a detailed understanding of the chronic pain landscape and were used for information and solution sharing. Core committee members provided valuable feedback and direction on project activities while other stakeholders and guests were invited to share information about relevant chronic pain services and initiatives which helped to inform the committee of the broader chronic pain landscape.



# TEMPLATES AND FORMS





## DATA COLLECTION ACTIVITIES

The evaluation approach was conducted through a mixed-methods design (i.e. collection of both qualitative and quantitative data). Quantitative data was collected from FHA analytic data and program administrative records. Qualitative data was collected from surveys and interviews with physicians, specialists, stakeholders, patients, and program administrators. The data collected has a developmental lens that focuses on continuous quality improvement and links back to the overall Shared Care goals.

## RESULTS / DATA MATRIX

The purpose of this project's evaluation was to align and support the overall Shared Care goal which is to provide coordinated, continuous and comprehensive patient care in a way that fits the local context and community needs specific to the FNW. The evaluation objectives and questions link directly back to the overall FNW project aim statement. Implementing evaluation measures throughout this initiative supports real-time data collection and clear identification of when progress markers have been attained or when adjustments need to be made to existing measures. The evaluation program's main purpose is to support the cyclical quality improvement processes focusing on the PDSA cycle which supports the implementation, identifies opportunities for improvement, and allows for ongoing feedback between and amongst PCN stakeholders.

The work of this project and its subsequent evaluation are to focus and improve the following key attributes:

- Shared Care Project Goals
- PMH Attributes
- PCN Attributes
- Quadruple Aim

The evaluation has two main objectives and their subsequent evaluation questions below:

1. To evaluate the effectiveness of the Chronic Pain Shared Care Initiative in the Fraser Northwest community
  - a. To what extent does the program contribute to increased communication flow among family physicians and specialists/community programs providing chronic pain resources?
  - b. To what extent does the program contribute to improved patient care?
  - c. To what extent does the program contribute to improved health outcomes for patients seeking care for their chronic pain?
  - d. To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?
2. To identify areas for quality improvement and document lessons learned
  - a. What were the unanticipated outcomes of the proposed strategies?





## PROJECT ACTIVITIES & DELIVERABLES

### **Understanding Resources and Services Available**

From the provider and patient surveys, the committee identified an overarching theme which was to enhance patient access to chronic pain services. An environmental scan of all the chronic pain resources in the community was first conducted to get a better understanding of the chronic pain landscape. From committee meetings, the group learned that the The Pain Hub program at FHA is one of few chronic pain resources in the community. The 8 week program helps patients to build self-management skills in managing their chronic pain. The program was originally launched to target a specific patient population but upon further feedback and discussion with committee members, the committee advocated and helped to expand the eligibility criteria to benefit a greater number of patients. The surveys indicated that there were gaps in knowledge from providers and patients in knowing what free to low cost resources exist.

To increase awareness of resources available, information was shared through various mechanisms, including the division's newsletters, on Pathways, through educational events and committee meetings. An "Ask the Expert" on Chronic Pain was hosted in person on Feb 5, 2020 and was geared towards primary care providers. The presentation included recommendations for interventional pain procedures, practical workflow recommendations from a family physician, and sharing of existing resources and newly launched resources such as the FHA Pain Hub and BC ECHO for Chronic Pain. A total of 67 people attended this workshop including anaesthesiologists, primary care providers and MOAs.

Stemming from that event, the group thought it was important to spread awareness of BC ECHO for Chronic Pain, which hosts free monthly educational sessions for healthcare providers with case study presentations about chronic pain and which builds networking connections for practitioners through a community of practice approach. The overall goal was to connect local family physicians and specialists to this network to improve care delivery for chronic pain patients. Primary care providers were encouraged to attend these sessions through marketing in newsletters and through the Chronic Pain Ask the Expert event. Attendee data showed a small number of physicians from the FNW region attending the sessions with a greater number of allied health professionals attending. This highlights the limited capacity of physicians and suggests the potential for allied health professionals with chronic pain training to remove some burden from primary care providers.

An educational engagement event on October 18, 2022 was geared towards MOAs and allied health practitioners (Registered Nurses in Practice and PCN MHSU Clinicians). As MOAs and allied health practitioners are often involved in the referral process in helping patients navigate services, it was important to include this group so they are better equipped with the information that patients could benefit from. Information about patient self-management resources, exercises, pain clinics, specialist clinics and support groups were shared. A total of 23 people attended this workshop.

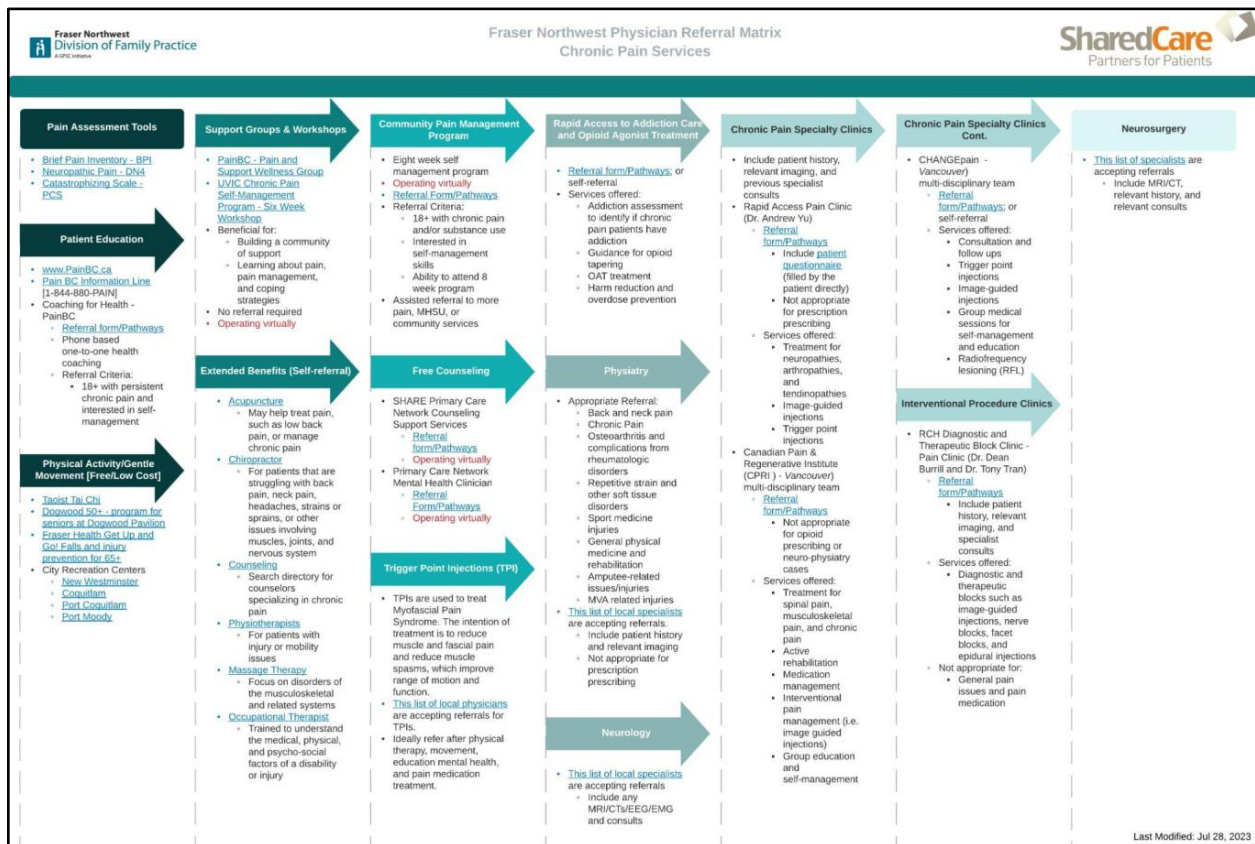


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## Resource Creation

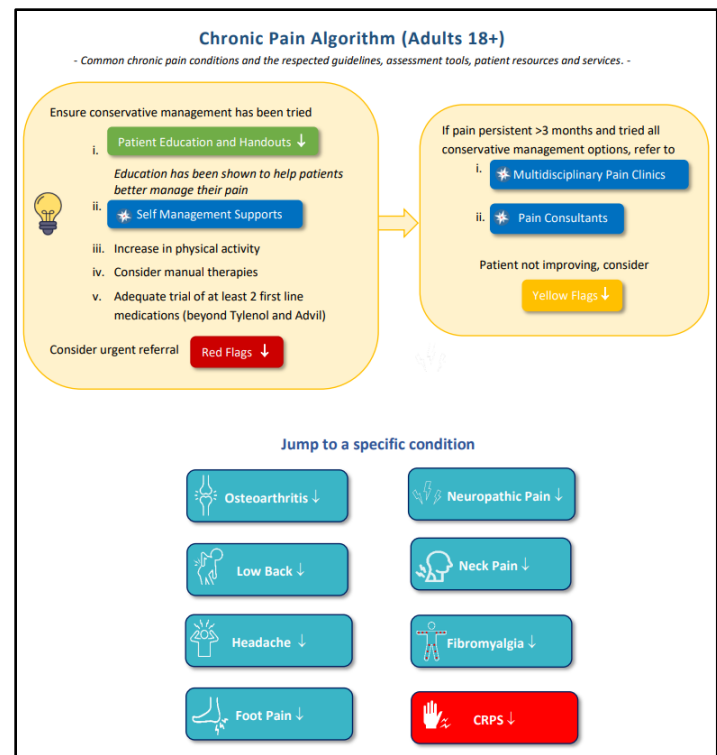
When looking at the treatment pathway, patients and providers tend to rely heavily on neurosurgeons to make a diagnosis and determine treatment pathways for chronic neck and back pain. A majority of patients with chronic neck and back pain will wait months for a consultation, only to find out that they are not surgical candidates. This leads to frustrations from patients and decreased quality of life. The average wait time to access a neurosurgery consult was 18-36 months in 2018 and at the time of writing this report in 2023, the average wait time is now 3 years or more. It was identified that there was an opportunity to educate primary care providers to use existing guidelines to determine whether back and neck pain warrants a surgical consultation and to try conservative treatment options to help patients manage their pain before proceeding with a referral to neurosurgery. As the group had already identified a sizable amount of project activities, it was not within the scope of the project to further involve neurosurgeons. The committee suggested involving neurosurgeons in a separate project in the future.

Using information from the environmental scan, a referral algorithm for providers and patients to visualize the available treatment options was created. However, after reflecting about the patient experience and engaging with other chronic pain experts across the field, it was determined that this linear approach to care was not realistic for many patients. [Click here](#) to view the full resource (see appendix 1).





The committee decided a more comprehensive approach was needed and established a sub-committee working group to create an interactive resource based on the most common chronic pain conditions seen in primary care. The Chronic Pain Care Pathway resource is a practice support tool for primary care providers which focuses on key treatment guidelines and recommendations while highlighting free to low cost resources. It contains links to assessment tools, guidelines, patient resources and community services. The group also consulted with the physicians at the St. Pauls Pain Clinic to determine consensus on best practice guidelines in regards to interventional pain procedures. The resource was created using the Pathways infrastructure, meaning all resources can be found on Pathways for more information. Providers can also utilize the function available on Pathways to email resources directly to patients.



The resource is currently posted on the Pathways website. [Click here](#) to view the full resource (see appendix 2).

## Collaborative Model to Opioid Prescribing for Chronic Pain Patients

Another challenge that was voiced by committee members was seeing longitudinal primary care providers being hesitant to take on patients with high dose opioids for chronic non-cancer pain. A family doctor who was retiring had managed a couple of patients on high dose opioids over the years and was concerned about their care after retirement. These patients' care was going to be taken over by a new to practice physician, however, most new to practice physicians are uncomfortable with opioid prescribing due to fears surrounding scrutiny from the College. Providers also have a lack of knowledge, skills, and support, including available clinical time, to manage complex chronic pain patients. The retiring family doctor hoped that there would be more support for the new physician and hence, the committee decided a collaborative approach to opioid prescribing was needed.

The pilot included an anaesthesiologist, psychiatrist and addiction medicine physician who saw patients to ensure there was a coordinated plan to recommend to the family doctor. The intended goal was to reduce opioid dosages within the College guidelines, support the family physician in patient care, improve patients quality of life and decrease potential adverse effects of high dose opioids. The growing activities related to this pilot with the growing interest and commitment from the physicians logically led to the formation of a new Shared Care project. Please see the evaluation section for more information. An additional report is being prepared with the project's findings, evaluation and next steps.



## LESSONS LEARNED

### **What Worked Well:**

This project had diverse stakeholders involved and all committee members remained engaged throughout the lifespan of the project. Having stakeholders who knew about resources and initiatives of chronic pain at a local, regional and provincial level allowed for increased awareness and for some physicians to provide their input. For example, physicians from this project provided feedback on the development of an upcoming rapid access clinic for low back pain across the region. The committee was also careful about not duplicating efforts across other Shared Care projects or other initiatives across the province. The group's intention in creating the Chronic Pain Care Pathway was to be able to create something that was practical and would benefit a larger group of providers outside of the local community to prevent silos in sharing of information.

Perspectives were considered from all providers and relationships were enhanced as a result. The collective voices from committee members around chronic pain concerns voiced in committee meetings received attention at local department or leadership meetings. This project has seen physicians feeling more empowered in advocating and influencing regional and provincial level conversations around chronic pain.

Through this project, the group also piloted a Collaborative Model to Opioid Prescribing which led to the creation of a new Shared Care Project.

### **Remaining Gaps and Lessons Learned**

Some unforeseeable unintended consequences that came up were due to the pandemic. Local family physicians were interested in leading the PSP Chronic Pain learning modules but due to the pandemic and restructuring of PSP, this was not feasible. The group also discussed the opportunity for group medical visits for chronic pain, unfortunately this was not achievable with the reduction of in person visits during the pandemic.

Another identified challenge is that there is a lack of coordinated services across the region and province. Chronic pain does not have a "home" or specialty in FHA and lacks ownership. This project helped to bring awareness that managing chronic pain patients at a primary care level is difficult without access to locally available services and a multidisciplinary team. The physicians identified the need for more pain initiatives locally and regionally. For example, preventative services and transitional pain clinics which proactively look at preventing acute pain from being chronic pain do not exist in the community, despite being available in other health authorities. Interventional pain procedures are also lacking as patients in the FNW region access care in Surrey with an average wait time of 6-9 months and no coordination between individuals across the health authority providing interventional pain services. Some services are simply not available at a systemic level in FHA. For example, lidocaine and ketamine infusions can be helpful in treating chronic neuropathic pain, but these modalities are not readily available in FHA. Patients who wish to pursue these treatment options must pay privately at private facilities, with the odd exception. St. Paul's pain clinic does offer ketamine and lidocaine infusions, but



access to that clinic is restricted to patients within Vancouver Coastal Health Authority (VCH) or on a case by case basis.

As there were many identified challenges and ideas, it was difficult for the committee to narrow down top priorities. Some of the topics and solutions reflected issues at a larger systems level which led the project activities being too large in scope. For example, creation of the Chronic Pain Care Pathway resource took much more time than anticipated due to the complexities and the lack of clear consensus around chronic pain management across specialists. Consequently, the project did not have enough time to complete the remaining engagement activity to spread the Chronic Pain Care Pathway resource to the community. The group is actively engaging with two organizations in stewarding the Chronic Pain Care Pathway resource over for sustainability and spread. Pain BC and Pain Care BC have expressed interest in this work and ongoing efforts are being made to leverage their scope and vast network. Pain BC is a well known resource in the province and Pain Care BC, a new Health Improvement Network (HIN) at PHSA aims to improve quality and coordination of pain services across BC.

These challenges show the need for more buy-in from HA and provincial partners for larger system level change and consistent sharing of feedback and lessons learned. A coordinated approach with continued opportunities and collaboration among community primary care providers and chronic pain providers is needed to address gaps, improve communication and coordination of care. As well, to support ongoing learning, knowledge and information sharing opportunities to increase awareness of chronic pain services is needed (i.e. for new providers who join the community or to refresh existing provider's awareness).

From patient and provider feedback, we know that social inequities exist in accessing care. Treatments and supports that help patients with managing their chronic pain are costly and not covered by public funding (such as physiotherapist, massage and counselling). Gathering continuous patient feedback and measuring direct impact to patient care is important to ensure efforts are addressing patient's needs.

## NEXT STEPS

The project will utilize the broad stakeholder engagement as an advantage moving forward for continued spread. The committee members involved in this project expressed interest in spreading this work with their vast networks and hope to present to the larger Shared Care network. As mentioned above, conversations with organizations such as Pain BC and PHSA's Pain Care BC network to sustain the Chronic Pain Care Pathways resource on a provincial level is ongoing. It is the desire of the committee that the resource become an up to date roadmap to help primary care providers deliver high quality care to their patients with chronic pain within the primary care home, thereby decreasing over-reliance on tertiary pain care services and/or neurosurgeons. The division will continue with spread efforts as well by disseminating the resource with primary care providers through various communication channels, such as through the weekly FNW newsletter, on Pathways, the Division's Dispatch newsletter and through Shared Care newsletters. Additionally, maintaining engagement of these passionate stakeholders is needed to advocate and address chronic pain challenges that affect the healthcare



## TEMPLATES AND FORMS

system. Ongoing provider education across disciplines about chronic pain to develop skills and confidence is needed to improve provider satisfaction and patient care.





# TEMPLATES AND FORMS



## EVALUATION FRAMEWORK & DATA MATRIX

IHI Modified Triple Aim	Anticipated Outcome	Data Source(s)	Results
<p><b>Provider Experience:</b> To what extent does the program contribute increased confidence and satisfaction by primary care providers in supporting their chronic pain patients</p>	<p>Primary care provider feels supported and both primary care provider and specialist sees merit and satisfaction with model of care and experience</p> <p>Increase confidence in opioid prescribing for new providers who accept attachment of orphaned patients on opioids</p> <p>Opioid dosage reduction within College guidelines, guided by benefit of equal or improved function</p>	<p>Program documentation</p> <p>Family physician satisfaction survey</p> <p>Specialists satisfaction survey</p> <p>MHSU program documentation</p>	<p>This project began out of the need to have a streamlined approach for chronic pain diagnosis by increasing confidence and satisfaction of FNW family physicians in managing their chronic pain patients.</p> <p>An interview conducted with a family physician identified 3 key themes related to chronic pain patients on high dose opioids (included below). Based on the complexity of providing care for these patients and the lack of support available, this physician transitioned out of family practice.</p> <p><b>Theme 1 - uncomfortable/uneasiness with pain medicine (high dose opioid prescribing)</b></p> <p><b>Theme 2 - access to specialist support / collaborative model for pain management and opioid prescribing is limited</b></p> <ul style="list-style-type: none"> <li>• A family physician took an unattached patient who was palliative and required pain medicine, ongoing management, and high dose opioid prescribing</li> <li>• Referred to a palliative specialist for assistance. However, the referral was rejected. The patient was expected to be managed in the primary care setting.</li> </ul> <p><b>Theme 3 - CPSBC expectations vs. patient/family caregiver expectations do not align</b></p> <ul style="list-style-type: none"> <li>• Physician’s personal reflection – “why do family physicians feel uncomfortable with opioid prescribing?”</li> </ul>



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Increased understanding of available services depending on where chronic pain patients are at in healthcare needs

- *In 2015, after 14 years of practice, this family physician had a panel of about 3000 patients. During this time, a friend was leaving Canada, who had a panel of 4-5000 patients. This family physician took these patients and subsequently, the prescribing pattern*
- *went up 3-4x as previous, which flagged the College*
- *Professional and personal consequences:*
  - *Feelings of being 'stuck' between College and very angry/demanding patients*
  - *This family physician cared very deeply about the patient's well-being and genuinely wanted patients to leave the office feeling good. As well, Dr. X did not wish to belong on the wrong side of College*
  - *As a result, the physician transitioned out of solo-family practice and spent the year transitioning their patients.*

It's important to highlight that stories such as these from providers were heard and an opportunity was identified resulting in the development of the Collaborative Model to Opioid Prescribing Shared Care project. The new to practice family physician who was taking on the panel of patients from the retiring family physician indicated that they felt supported having recommendations from the specialists who assessed the patients on high dose opioids. As mentioned above, an additional report is being prepared with the project's findings, evaluation and next steps.

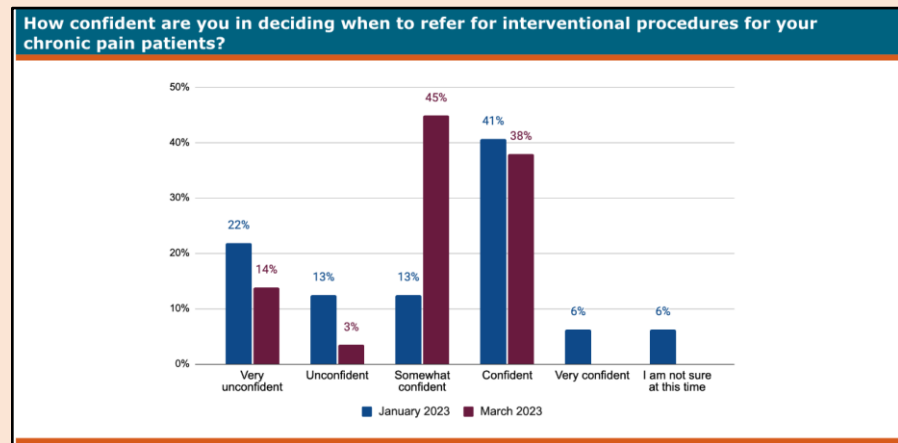
FNW primary care providers were surveyed in both January and March 2023 and it was identified that there continues to be variation in confidence





# TEMPLATES AND FORMS

amongst primary care providers in knowing when to refer their chronic pain patients:



Confidence in knowing where to refer patients was highlighted as a challenge for Primary Care Providers and indicates a continued opportunity for support as it relates to the outcomes identified within this project.

**What challenges do you have regarding the interventional procedures for your chronic pain patients?**

**Raw responses**

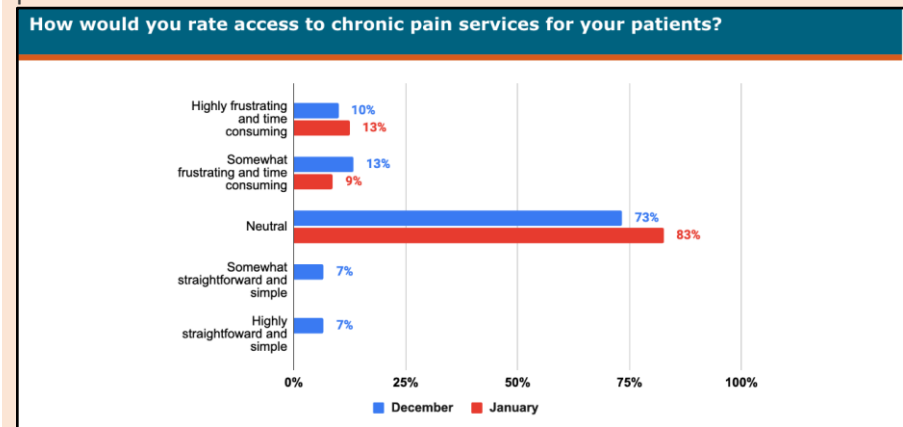
- access
- Dunno
- equipment - time consuming
- Finding the right specialist, wait times
- Haven't made any
- long wait times - excessive x4
- "Sometimes gets disadvantageous when done long term. Sometimes do not get relief.
- "Sometimes possible complications/adverse events from these"
- "sometimes procedures are recommended but I am asked to write orders or request specialized imaging this is suboptimal as not my area of expertise and was reason they were sent onward to specialist as such, specialist should be responsible for orders and interpretations of specialized tests or response to procedures"
- Sometimes there are long wait times or perhaps the treatment doesn't help their pain, the patients get very hopeless and upset.
- Unsure
- "Very long wait time for chronic pain clinics
- benefits are often short-term /marginal"
- Wait times
- wait times. Pt not always able to pay for procedures
- Wait times. Effectiveness
- When Patients would like to continue their Narcotics only
- **"New"** I let the specialist who will do the procedure decide
- **"New"** Long waits. Not sure who can get it done in timely manner.
- **"New"** "Most interventions aren't covered. Neither are the effects permanent solutions. Sometimes leaves patients sometimes feeling like they have gone around in circles"
- **"New"** Nil major challenges/ None x2
- **"New"** not enough knowledge
- **"New"** Not knowing which are offered in which community, when to refer
- **"New"** Not sure where to refer
- **"New"** referrals rejected
- **"New"** There's always a slightly long wait time
- **"New"** They need a longitudinal provider to be accepted for care. Many clinics decline unattached patients.
- **"New"** wait times, what's available, and whether it would be suitable



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In January 2022, through a similar feedback mechanism, providers further shared their satisfaction towards accessibility of chronic pain services for their patients:

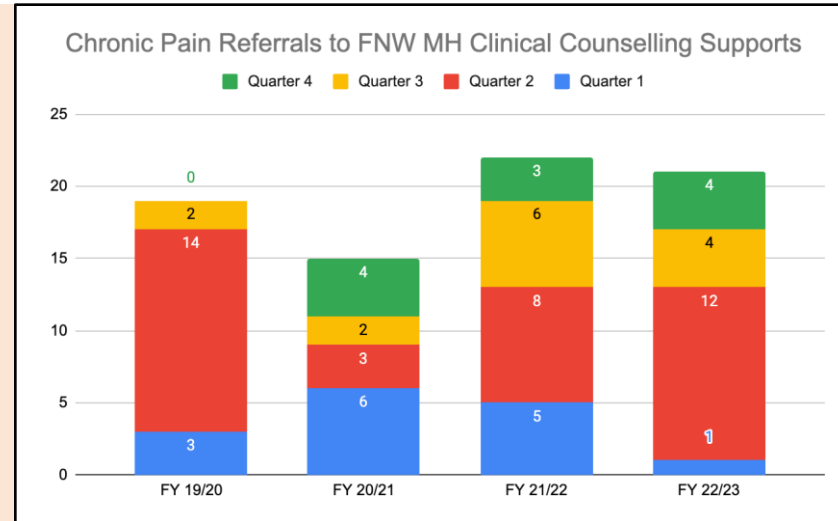


This feedback further illustrates the continued need from providers to know how to support their chronic pain patients and how to navigate the system to ensure coordination and continuity of care exist for patients.

Short term mental health supports for patients with mild-moderate chronic pain mental health concerns have been introduced and data below reflects referral volumes to these services from FNW primary care providers for patients citing the reason for referral is chronic pain related.



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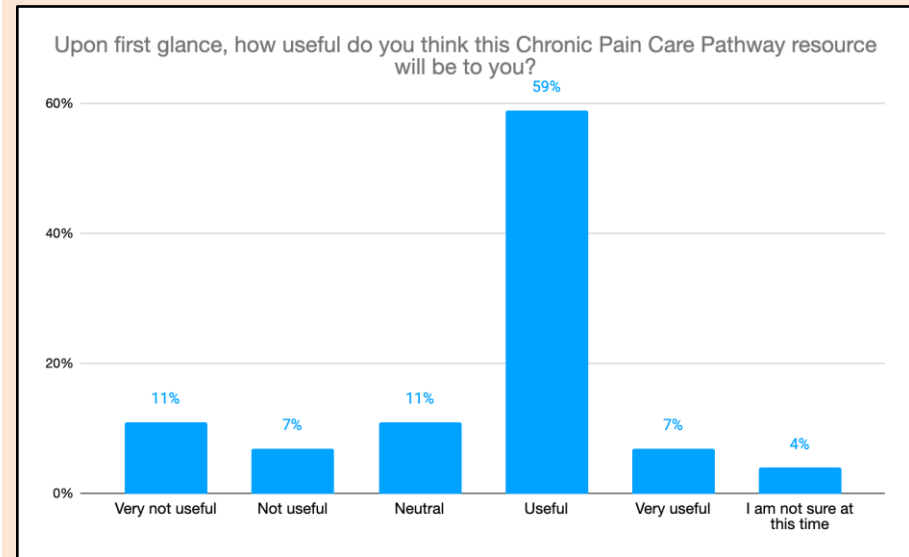
In July 2023, a feedback survey was distributed to clinicians and allied health to understand the provider experience of using the Chronic Pain Care Pathways tool.

The survey results regarding how participants currently find information about chronic pain resources and services reveal a mix of responses, with some expressing dissatisfaction with the available resources and others mentioning the usefulness of the Care Pathway resource. This suggests that the Chronic Pain Care Pathway could potentially address the inadequacy of existing resources and provide valuable support to primary care providers and specialists.

This feedback shows that at first glance, a majority of participants believe that this Care Pathway resource will be useful in their practice.



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Providers shared situations they can see themselves using the care pathway:

- *"To review effective interventions/medications for conditions e.g. neuropathic pain to review appropriate imaging studies based on the patient's presentation to find educational material/resources for those patients whom are open to or capable of reviewing them/participating in them."*
- *"Patients who approach walk-in clinic looking for opioids."*
- *"With our opioid dependent, functioning, chronic pain patients."*

These responses highlight that healthcare providers perceive that utilizing the Care Pathway enhances their self-assurance and competencies in managing patients with chronic pain.



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			<p>Gaps identified by the survey included:</p> <ul style="list-style-type: none"> <li>• Creating a Medical Office Assistant (MOA) and nurse-friendly pathway to assist with administrative work when managing complex chronic pain patients to help distribute some of the burden physicians feel when treating chronic pain patients.</li> <li>• <i>“MOA and nurse-friendly pathway would help offload some admin work from family physicians when treating chronic pain complex patients.”</i></li> </ul> <p>The length of the Care Pathway document, owing to the complexities of chronic pain, might deter providers due to the time it takes to navigate through it.</p> <ul style="list-style-type: none"> <li>• <i>“Is there a way to make it more concise without losing too much pertinent information.”</i></li> <li>• <i>“When and where clinic is busy as the pathway would look overwhelming due to the sheer number of pages - information overload for busy practices.”</i></li> </ul> <p>The feedback survey conducted in July 2023 highlighted a mixed response from providers regarding the current availability of chronic pain resources and services. However, participants expressed optimism about the potential of the Chronic Pain Care Pathway to address existing inadequacies and provide valuable support to primary care providers and specialists. The survey indicated that many providers found the Care Pathway resource useful upon first glance, showcasing its potential benefits for managing patients with chronic pain. Nevertheless, providers also emphasized the need for improvements, such as creating more concise and user-friendly pathways to enhance its overall usability and impact.</p>
<p><b>Patient Experience: To what extent</b></p>	<p>Pain is lessened over time and equal or greater function with opioid dose reduction</p>	<p>Patient satisfaction surveys</p> <p>Patient Journey Mapping</p>	<p>Understanding the patient experience can be best articulated through storytelling. One story was shared by a patient identified the impacts of fragmented care they received and the need for collaboration amongst all health care providers supporting the patient’s journey:</p>



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does the program contribute to improved patient care?

Patient feels well enabled with resources, feels supported and confident with a collaborative pain management plan. Has individual self-management skills, knowledge and awareness of available resources

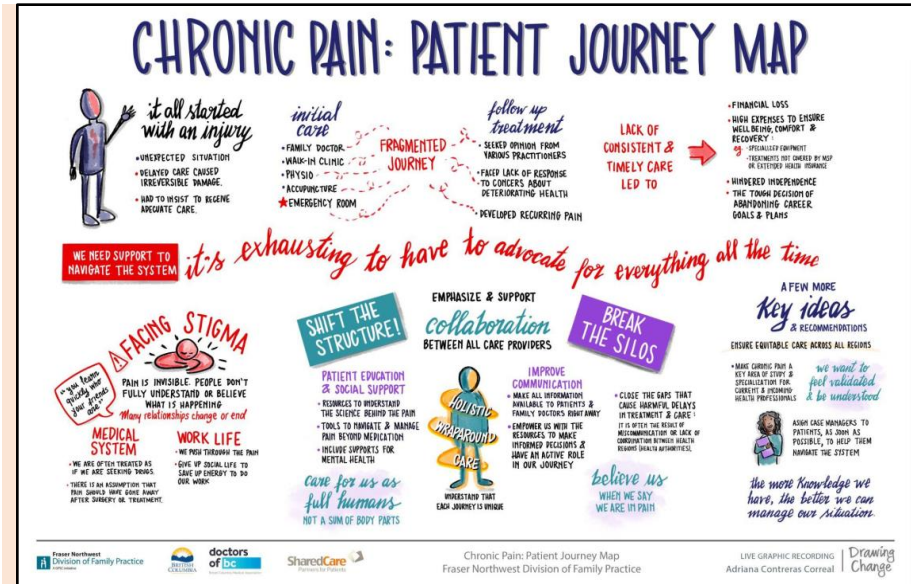
Increase attachment to a longitudinal primary care provider by a meaningful rate

Patient experience and satisfaction regarding access to services and coordination of health care

Family physician satisfaction survey

Encounter code data (MSP)

MHSU program documentation



(see appendix 3)

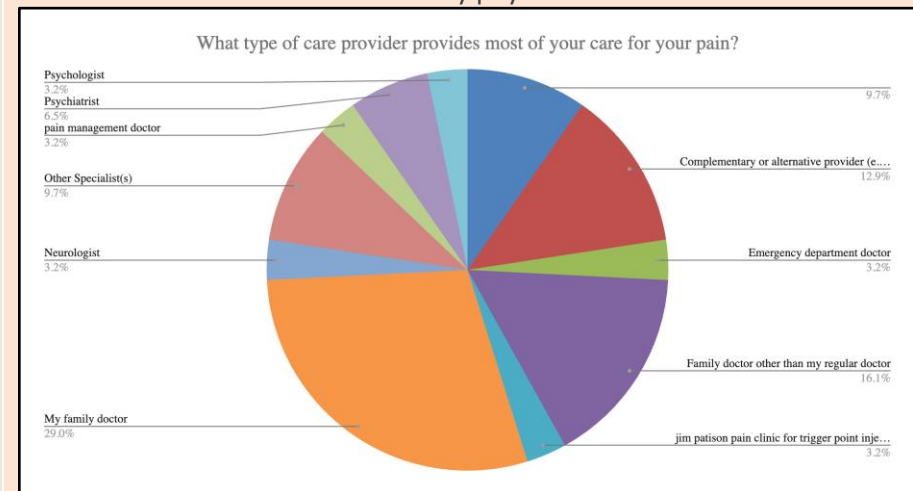
As mentioned above, the Opioid Prescribing project was initiated to address the difficulties in managing patients on high dose opioids within primary care. A total of 4 patients participated in this pilot. Anecdotal feedback from the physicians involved indicated that the patients appreciated the education around opioids and perspectives on how chronic pain can be linked to different areas of medicine. Specialists indicated that patients were more open to lowering their opioid dosages and are not afraid of trying anymore. One patient enrolled in the Pain Hub program at FHA and was happy to have social connection and a reminder of the tools to help manage their pain. Although patients did not reduce their opioid dosages, the family physician received a taper plan and recommendations from the specialists involved.



## TEMPLATES AND FORMS

Member feedback identified a high need around support for patients with chronic non-cancer pain who are struggling with connecting with a care provider. Additional complexities emerged when retirements of physicians who have been supporting these patients along their journey. Although data isn't available to identify how this emerging project has impacted - and lessened pain for patients - this unintentional outcome is a key highlight around the importance of fostering systems of collaboration and consultation amongst the providers to identify needs and improvement mechanisms to develop coordinated support.

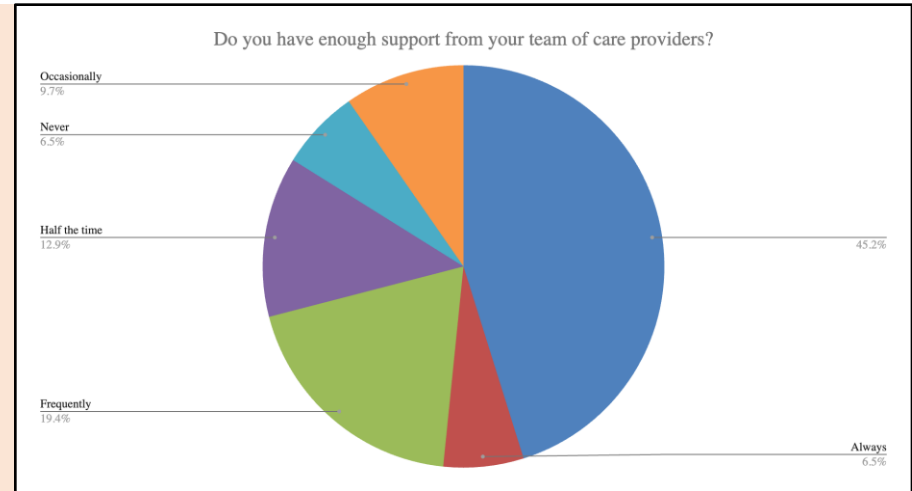
A gap in data for this project is fulsome patient and community feedback regarding chronic pain. In 2020, patients responded that the majority source of their care remains with their family physician:



Patients also indicated a variation in feelings of support from their care providers with a majority of respondents not providing feedback relating to this question:



# TEMPLATES AND FORMS



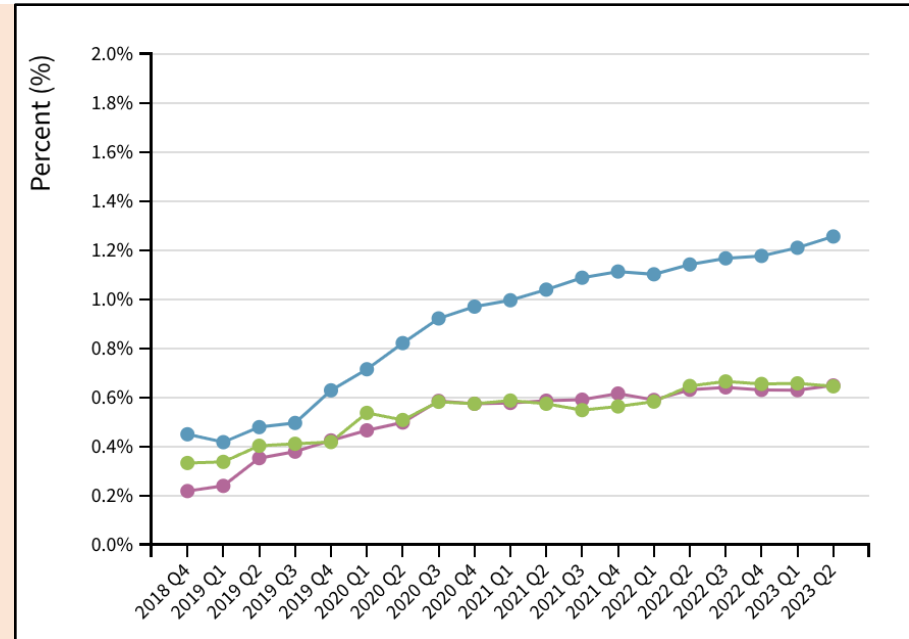
Aggregated community level patient data pulled from the Health Data Coalition (HDC) platform does indicate an increasing prevalence of chronic pain in patients, this indicates an upward trend over the last 5 years:

Legend	Data Source	Ratio	Data as of
	British Columbia	31892 / 2537887 (1.26%)	2023 Q2
	Fraser Health Authority	6348 / 977177 (0.65%)	2023 Q2
	Fraser Northwest	1378 / 213261 (0.65%)	2023 Q2

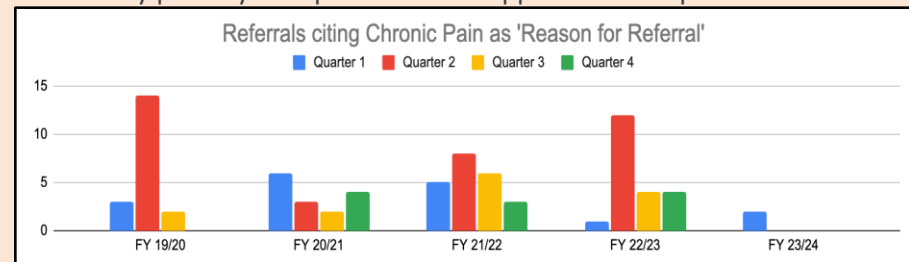




# TEMPLATES AND FORMS



Referrals to mild-moderate counselling supports through the FNW Primary Care Network contracted agency and the establishment of clinical counselling PCN MHSU resources within FHA have also seen increases in referrals from community primary care providers for support for their patients:





# TEMPLATES AND FORMS



			<p>As mentioned above, the Pain Hub program is one of few chronic pain services available in the region. Below are the yearly referral numbers:</p> <ul style="list-style-type: none"> <li>● 2019: 50</li> <li>● 2020: 50 (started virtual programming in spring due to COVID-19)</li> <li>● 2021: 55</li> <li>● 2022: 60</li> <li>● 2023 as of July 1: 60</li> </ul> <p>Reported average retention rate of patients completing the program is about 65-70%. One client feedback interview indicated that the patient found the program helpful in learning more about pain and how to actively manage their pain through nutrition and exercise. Referral volumes show that this program could be more actively utilized among providers and patients in the community, a closer look at how this program could be better adapted to meet the needs of patients is needed.</p> <p>Continued patient and community engagement is an opportunity that will be integrated into the FNW Division structure moving beyond this project's close date as there continues to be feedback from physicians and the community around the need for chronic pain support.</p>
<p><b>Health Outcomes:</b> To what extent does the program contribute to improved health outcomes for patients seeking</p>	<p>Pain is lessened over time and equal or greater function with opioid dose reduction</p> <p>Patient feels well enabled with resources, feels supported and confident with a</p>	<p>Program documentation</p> <p>Encounter code data (MSP)</p> <p>Patient Survey</p> <p>Community program data</p>	<p>Utilization of HDC amongst FNW clinics continued to increase over the last 3 years with the enablement over aggregated data sharing across EMRs enabling physicians and clinics to proactively look at their panel and identify an aggregated view of the complexities of their patient panel. Aggregated community level patient data pulled from HDC does indicate an increasing prevalence of chronic pain patients prescribed opioid medication in the past year, this indicates an upward trend over the last 5 years:</p>



# TEMPLATES AND FORMS

care for their chronic pain?

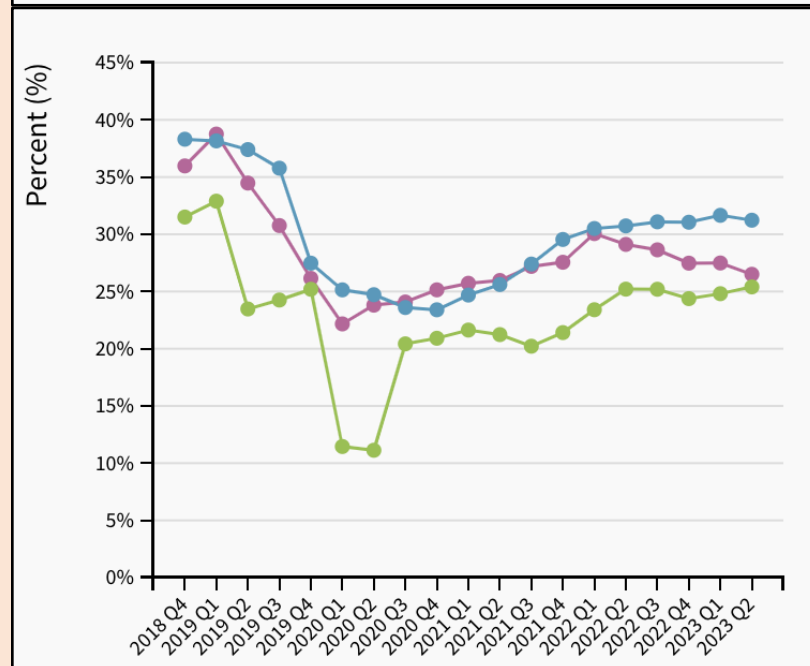
collaborative pain management plan.  
Has individual self-management skills, knowledge and awareness of available resources

Increase attachment to a longitudinal primary care provider by a meaningful rate

Physician survey  
MHSU program documentation  
Patient Journey Mapping

The percentage of active patients with chronic pain (based on the problem list) that have had a coded prescription for an opioid in the past year as recorded in the EMR.

Legend	Data Source	Ratio	Data as of
■	British Columbia	9117 / 29193 (31%)	2023 Q2
■	Fraser Health Authority	1304 / 4920 (27%)	2023 Q2
■	Fraser Northwest	236 / 929 (25%)	2023 Q2



Although rates within the FNW are still trending below the average of the province and the Fraser Health region, there remains a slight upwards trend. This upwards trend does align with the rising prevalence of patients with chronic pain (noted in the earlier section) and it can be assumed that patients are accessing their primary care provider for ongoing medication management needs.



# TEMPLATES AND FORMS



			<p>A gap in data remains around tracking changes in attachment for these patients. Currently, there is no community level data that tracks patients who identify as having chronic pain and to measure an increase or decrease in rate of attachment.</p>
<p><b>System Costs: To what extent did the program contribute to a change in health care utilization and what effect did it have on system costs?</b></p>	<p>Opioid dosage reduction within College guidelines, guided by benefit of equal or improved function</p> <p>Patient feels well enabled with resources, feels supported and confident with a collaborative pain management plan. Has individual self-management skills, knowledge and awareness of available resources</p> <p>Increase attachment to a longitudinal primary care provider by a meaningful rate</p>	<p>FHA program data</p> <p>Patient survey and/or interview</p> <p>Encounter Code (MSP)</p> <p>MoH MSP encounter code</p>	<p>Throughout this project, it emerged that there was limited data to accurately measure, track and report on the impact that this project has had on the health care system costs. That being said, it's important to highlight the change in prescribing/diagnostics documented through HDC as this does indicate there has been an increase in system utilization and likely system costs; however, a fulsome analysis is not available at the time of writing this report. The utilization of medication prescribing within the FNW has grown to 25% of active patients with chronic pain (shown in the graph in the earlier section) which is still lower than the provincial rates.</p> <p>An education event was delivered to FNW allied health and PMH practice staff in 2022. 90% of attendees found this session valuable in expanding their knowledge of the available resources, timely access, and pathways for referrals for patients with chronic pain concerns:</p>



# TEMPLATES AND FORMS



	<p>Increase confidence in opioid prescribing for new providers who accept attachment of orphaned patients on opioids</p> <p>Patient experience and satisfaction regarding access to services and coordination of health care</p>		<div data-bbox="1016 289 1908 789"> <p><b>MOA Chronic Pain Event   Event Evaluation</b></p> <p># of Registrations: 31 # Attended: 23 # Survey Responses: 19</p> <p>Attendees noted that they had a better understanding of the available resources within the community, felt confident educating patients with available resources as it relates to chronic pain management and generally applying the tools into practice</p> <p>Strongly Disagree (1) ————— 3.0 ————— Strongly Agree (4)</p> <p><b>What do you consider your role to be?</b></p> <p>PCN MHSU Clinician 12% Registered Nurse In Practice 12% Office Manager 41% MOA 35%</p> <p><b>Key Takeaways</b></p> <ul style="list-style-type: none"> <li>Attendees reported that this session provided them with a number of resources and an overview of community programs as it relates to pain management.</li> <li>Attendees recognized that there are many resources that they were not aware of prior to attending today's event.</li> <li>Attendees have a better understanding of where resources are located.</li> <li>Attendees noted the need and benefit in receiving Naloxone training, especially in the event of an emergency and to better serve patients.</li> </ul> <p>On a scale of 0 to 10, how valuable did you find today's session? 90% Avg. 9.0</p> <p>October 18, 2022</p> </div> <p>(see appendix 4)</p> <p>Although not directly related to changes in system costs, increased awareness and knowledge of available resources does indicate changes in understanding of available resources and an unintentional outcome in this knowledge may better support chronic pain patients navigating resources directly supporting their needs as opposed to unnecessary visits to acute (i.e. visits to ED for chronic pain needs).</p> <p>A continued gap that has been highlighted in previous sections is limited data to indicate changes in attachment for these patients. Currently, there is no community level data that tracks patients who identify as having chronic pain and to measure an increase or decrease in rate of attachment.</p>
<p><b>Sustainability &amp; Spread: What were the unanticipated</b></p>	<p>Sustainability of project</p>	<p>Program documentation</p>	<p>As mentioned above, there has also been an increase in wait times to the current neurosurgeons in the FNW communities. Out of 5 Neurosurgeons, 3 are not currently advertising wait times or accepting new referrals and the other 2 have seen an increase in referral wait times from 18 months in 2014</p>



# TEMPLATES AND FORMS



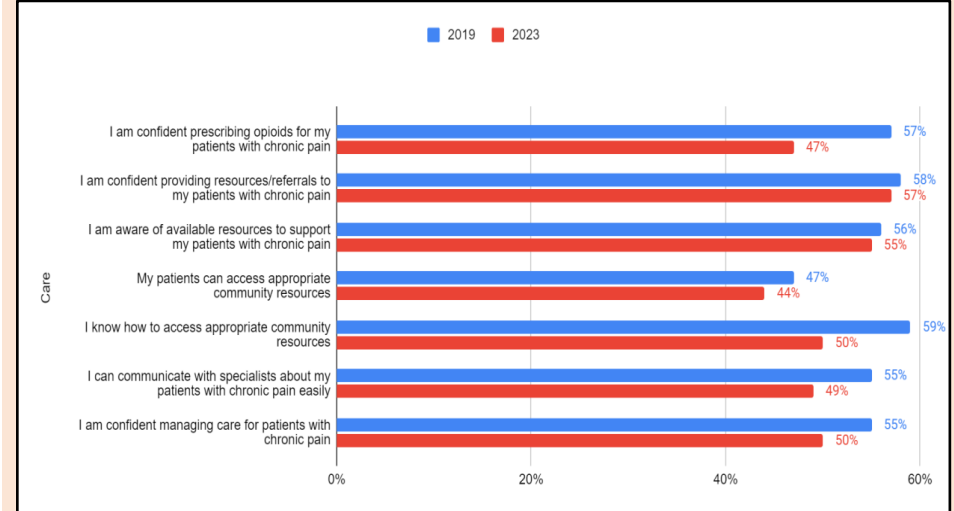
outcomes of the proposed strategies?

Survey/interview feedback (patient, family physician, specialist)

Patient Journey Mapping

and 2018 and to approximately 3 years or more at the time of writing this report. This indicates an ongoing need as well as opportunity for further exploration of support with this speciality and FNW Primary Care Providers.

To compare the 2019 spread network survey responses, a survey in 2023 was conducted to see how primary care providers and RNs felt about providing care for their chronic pain patients. Although RNs did not participate in the survey in 2019, the responses in 2023 still show the gaps in knowledge, skills and resources that are still present.



(see appendix 5)

As part of the close out activities for this project, the Division team led a close out focus group interview where committee members were asked successes, challenges, remaining gaps, and proudest moments. Focusing in this section specifically around the successes and remaining gaps, feedback noted:

**Successes:**



# TEMPLATES AND FORMS

- *“Great to have networking with specialists and pain stakeholders. A key milestone - the patient experience and the path they go through to access resources was a success”*
- *“Part of the landscape is the complex and chaoticness of pain. Great to create a resource such as this. There will be good clarity for local and provincial physicians. We have created something extremely valuable for the new provincial agency to work with”*

### Remaining Gaps

- *“Should have had pain specialists on the table to see how we can expedite or better yet equip family physicians with tools to manage subacute and chronic pain. If we can connect and develop a stream of communication to just text or call pain specialists, this will help with the referral process.”*
- *“Pain hubs and self management do offer some help but it is not enough and it is not an ongoing model of support. They are still difficult and do not exist. There are not enough pain specialists in the field. We do not have quaternary pain care. These are hindrances for patients in our area.”*
- *“Don’t have transitional pain clinics like other health authorities (prevent acute pain from being chronic pain)”*
- *“Social inequities, multi tiered system - patients cannot afford the supports that would be helpful to them (counselling, physio).”*

### Sustainability

- *“For sustainability - education and sessions to show family physicians and nurse practitioners on how to manage and access available resources plus having such sessions regularly so it is sustainable would be the way to go as resources change over time”*
- *“We have had such broad stakeholder engagement. At the end of the day we did see pain BC and specialists. There is not one single group that can sustain this. It is best when we have lots of people involved so we can fill the gaps. Moving forward maintaining engagement of*



## TEMPLATES AND FORMS



			<p><i>these different stakeholders, a couple of family doctors and specialists aren't going to work. "</i></p> <p>A key lesson learned around the scope of this project and successful implementation and sustainability does highlight the need for buy-in from HA partners in order to incorporate resources into the larger system for the cohesion and coordination of care between community providers and the acute system.</p> <p>Creating resources such as care pathways does require ongoing upkeep and updating and may be unsustainable within the current shared care model. As mentioned above, early work is underway to identify transition strategies of this resource to be built into the provincial landscape with Pain Care BC.</p>
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\***Shared Measures** were not implemented at the time of this project creation/implementation





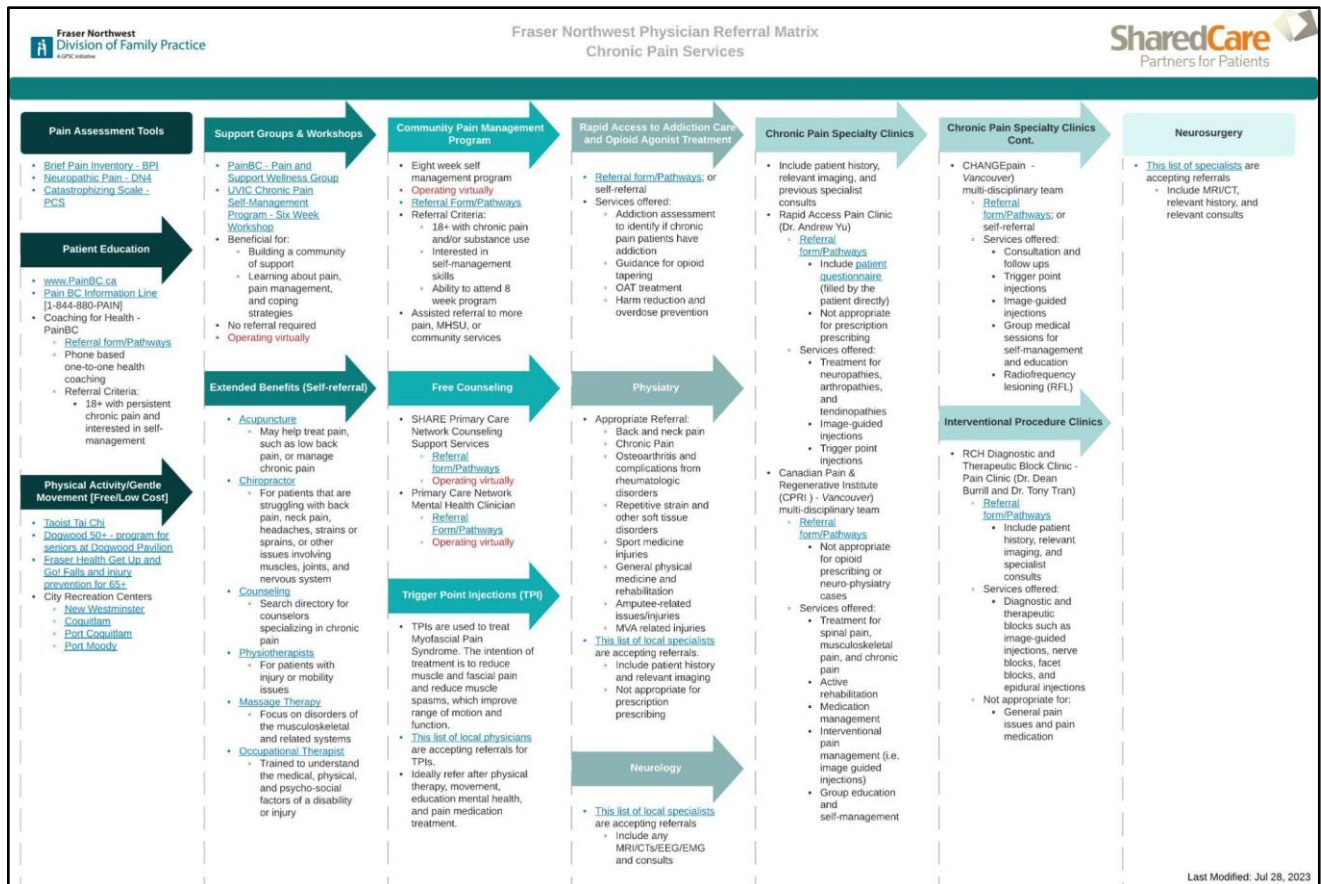
# TEMPLATES AND FORMS

## APPENDICES

- Appendices of relevant documents that would be helpful for the audience.
- Provider testimonials, patient impact stories, and quotations including the [Physician Lead End of Project Survey](#)
- Include PDF copies and links to all resources created during the project.

### Appendix 1 : Chronic Pain Physician Referral Matrix

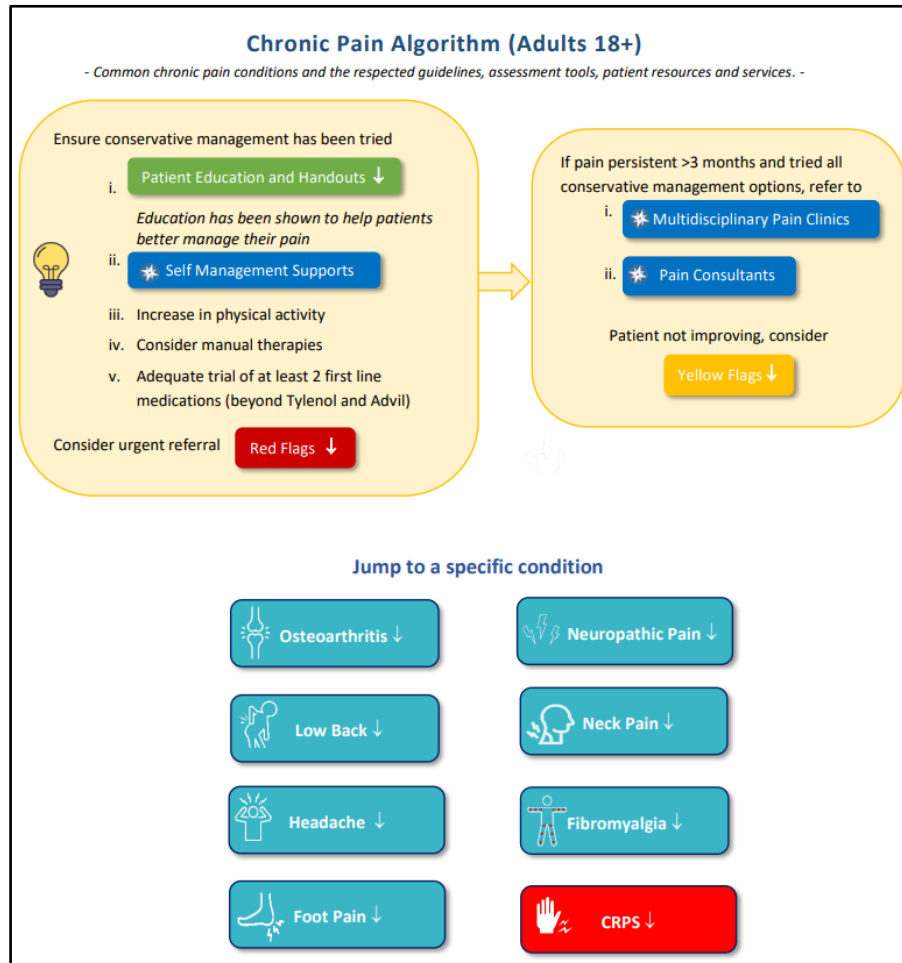
[Click here](#) to view the full resource.





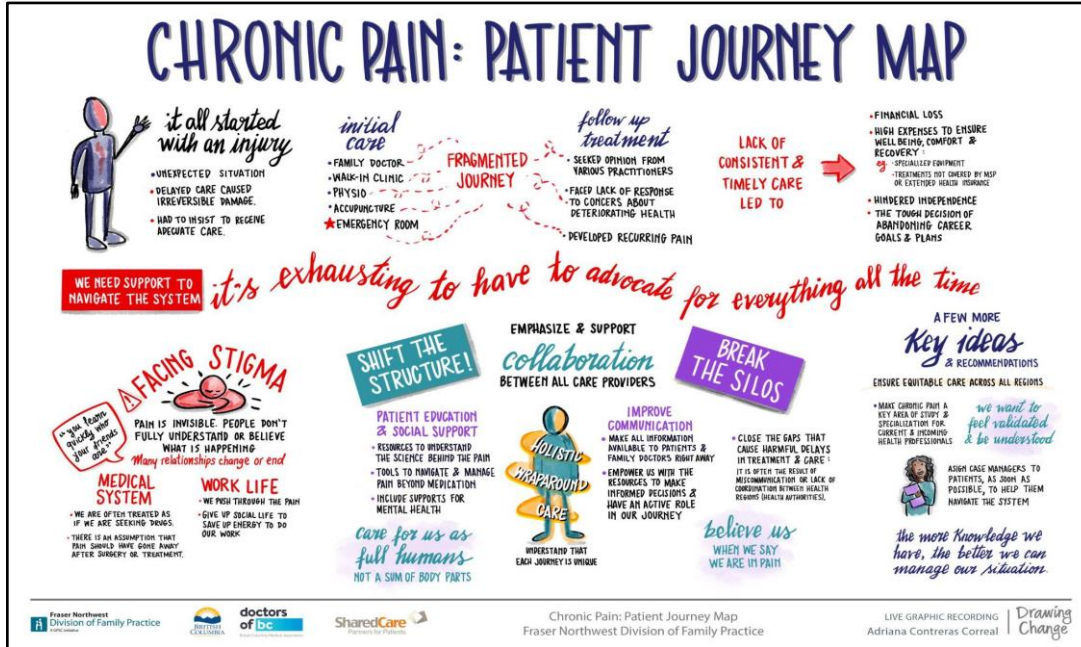
## Appendix 2 : Chronic Pain Care Pathway

[Click here](#) to view the full resource.

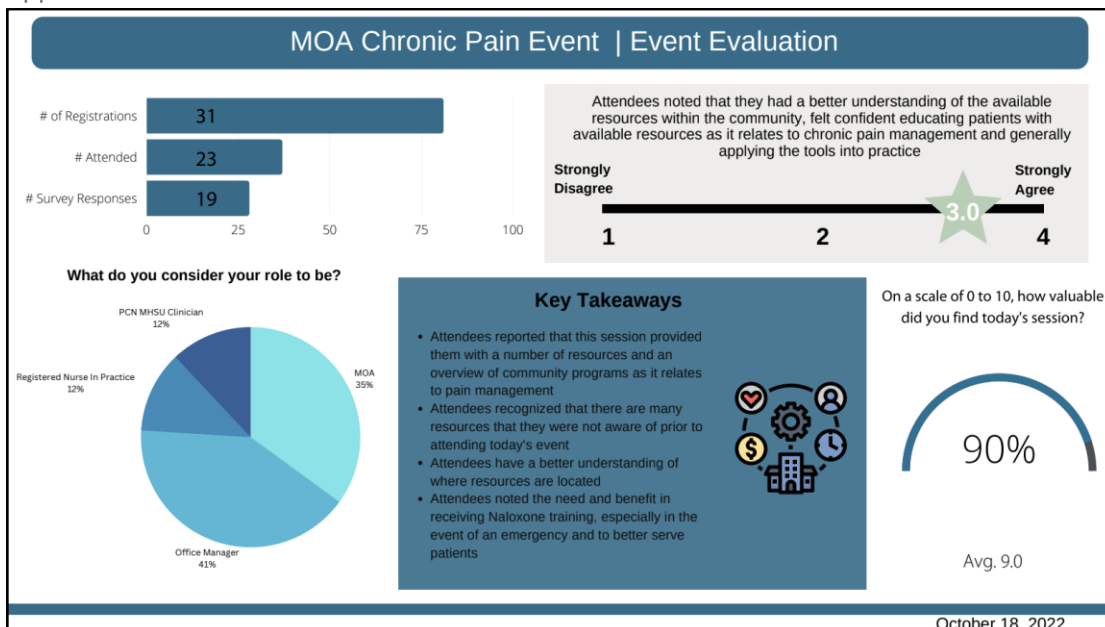




## Appendix 3 : Patient Journey Map



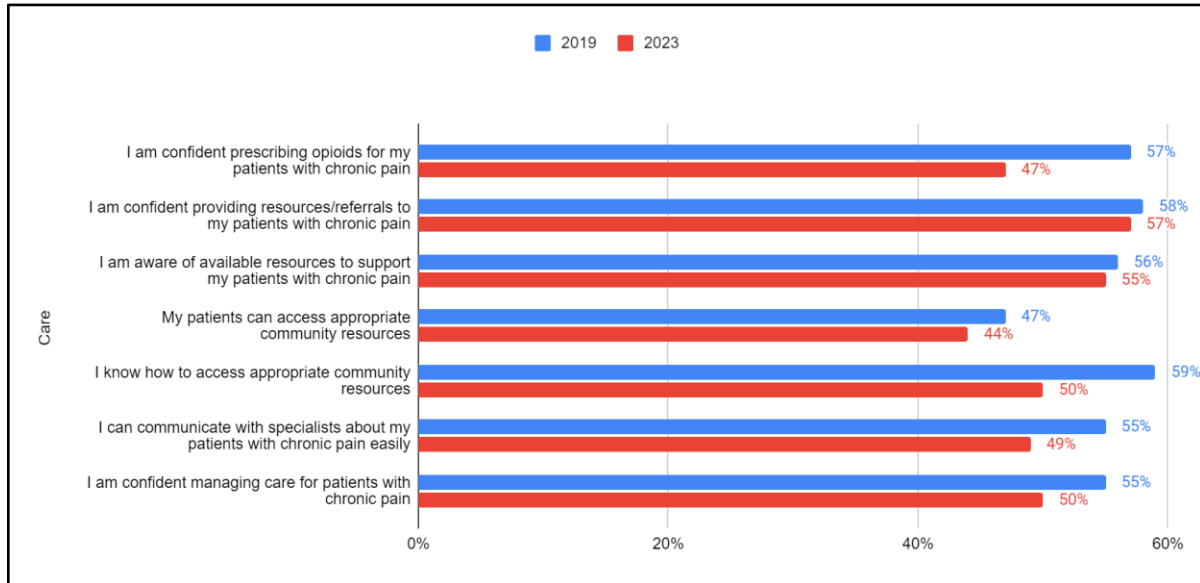
## Appendix 4 : Chronic Pain Event Evaluation





## Appendix 5: Comparative responses in 2019 and 2023 from clinicians

“Thinking about providing care to patients with chronic pain, on a scale of 1-5 how strongly do you agree with...”



## Appendix 6: Physician Lead End of Project Survey

