Interior Health's Chronic Pain Strategy

Recommendations and Actions for Consideration

Prepared by: Interior Health Planning and Strategic Services

Reviewed and Approved by: Interior Health's Pain Strategy Steering Committee

Date: November 12, 2012

Interior Health

Contents

Pain Strategy Steering Committee Members 1

Executive Summary 2

Background 4

Scope and Underlying Principles 5

Demand for Chronic Pain Services 7

Current Services and Utilization 8

Stakeholder Perspectives 10

A Framework for a Strategy 12

- Service / Care 12
- Education 16
- Knowledge and Information 17
- Funding, Policy, Governance, and Administration 18

Summarizing the Problem 18

Proposed Recommendations and Actions 19

Conclusion 24

Appendix A: Map of Interior Health 25

Appendix B: Pain Strategy Steering Committee Terms of Reference 26

Appendix C: Inventory of IH Pain Services – Synopsis of Results 29

- Addendum – Kamloops Pain Services 32

Appendix D: Stakeholder Interview Summary 36

Appendix E: Interior Health Pain Strategy Physician Survey Results 37

Appendix F: Patient Focus Group Summary 40

Appendix G: IH Pain Service Administrative Roles and Responsibilities 42

Pain Strategy Steering Committee Members

Dr. Alan Stewart (Co-Chair)	Senior Medical Director Community and Residential Services
Karen Omelchuk (Co-Chair)	Corporate Director Health System Planning
Amanda Parks	Coordinator Health System Planning
Darlene Arsenault	Program Director Primary Care and Chronic Disease Management
Dr. Rob Baker	General Practitioner / Thompson Division of Family Practice
Alternate: Dr. Shirley Sze	
Denise Chartrand	Director Peri-Operative Services Royal Inland Hospital
Peter Du Toit	Acute Area Director, Thompson Cariboo Shuswap
Valerie Hruschak	Social Worker, Mental Health and Substance Use Services
Dr. Stephen Jefferys	Anaesthesiologist, Kelowna General Hospital
Dr. Duncan Laidlow	Medical Director Tertiary Rehabilitation, Kelowna General Hospital
Tracy MacDonald	Health Service Administrator, Kelowna General Hospital
Dr. Mandy Manak	General Practitioner / Thompson Division of Family Practice
Dr. Walter VanRietschoten	General Practitioner / East Kootenay Division of Family Practice
Dr. Wendy Wickstrom	General Practitioner / Central Okanagan Division of Family Practice

Executive Summary

In the spring of 2012, Interior Health's Senior Executive Team identified the need to develop a comprehensive strategy for the provision of chronic non-malignant pain services for adults. A multi-disciplinary Steering Committee was established to advise on and facilitate the development of the Strategy.

Key elements of the project approach included developing underlying guiding principles, a well defined physician engagement plan, obtaining input from patients, a literature review, site visits, interviews, developing an IH inventory of services, and a broad stakeholder planning day, and identifying a service delivery framework around which to develop recommendations and specific actions.

In summary, within IH, the burden of pain on Interior Health is large and growing.

- It is currently estimated that 135,000 adults in IH aged 20+ experience moderate to severe chronic pain and these resulted in an estimated 81,000 unscheduled ED visits in 2011.
- Annually approximately 81,000 unscheduled ED visits are a result of chronic pain.
- Between 2,400- 3,900 individuals living in residential permanent beds in IH are estimated to experience persistent pain.
- It is estimated that 3,700 IH staff experience moderate to severe chronic pain which is likely contributing significantly to absenteeism and lost productivity.
- The rate of death from prescription opiods (commonly used to treat chronic pain), is two times higher than the rest of BC.

At an individual level, the impact of chronic pain on the quality of life and well being of patients and their families is profound and cannot be easily quantified. While pockets of excellent work across Interior Health to address the problem are occurring, a comprehensive coordinated chronic pain management system does not exist and care is all too often delayed, disorganized, inaccessible, or ineffective.

To strengthen systems of care for chronic pain, the literature defines key elements of a tiered / networked service delivery framework, or the Stepped Model of Care. Within the model, there is a need for higher level interventional procedures; however as with other chronic diseases, emphasis should be placed on building capacity at the community level and primary care levels.

A total of 7 recommendations and 22 actions are presented in the Strategy including:

1. Improve access by enhancing existing resources and establishing new services to create a comprehensive, coordinated, multidisciplinary network of pain services across Interior Health.
2. Initiate effective education strategies for patients, families, the general public, physicians and providers on the nature of chronic pain the disease, treatment and management approaches, and on the availability of resources in communities and across the health authority.
3. Focus on prevention and early intervention including improving the management of acute pain associated with surgery, trauma, and other conditions to minimize the risk of progression to chronic pain.
4. Where appropriate, integrate chronic pain services with mental health and substance use service delivery and implement best practice, guideline driven care.

5. Establish the appropriate leadership and provide the required resources to establish and coordinate an Interior Health Chronic Pain Service.
6. Establish and use a quality improvement and evaluation framework to monitor and improve the delivery of services and measure expected outcomes to ensure accountability and sustainability.
7. Strengthen research capacity in the field of chronic pain.

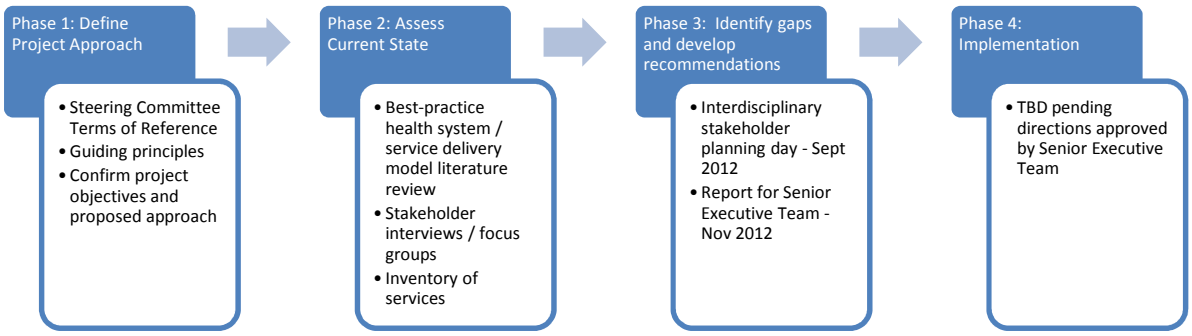
The development of the IH Chronic Pain Strategy has been a major point of engagement with staff and physicians. It has also generated much interest across the province from health authorities and Pain BC who have provided knowledge and guidance along the way. Successful implementation of recommendations provides an opportunity to effectively provide quality health services for individuals with chronic pain, and be recognized provincially and nationally as a leader in service design and the translation of strategy to action.

Background

Interior Health is mandated to plan, deliver, monitor, and report on publicly funded health services for people that live within health authority boundaries (Appendix A). Its Senior Executive Team (SET) identified the need to develop a comprehensive pain strategy to ensure pain management services provided are integrated, responsive, and meeting the health needs of both individuals and the population. The Executive Sponsor leading the development of the Pain Strategy is the VP Allied Health and Planning & Strategic Services. The project is being co-led by Interior Health's Allied Health and Planning & Strategic Services and Medicine and Quality portfolios. A Pain Strategy Steering Committee (PSSC) was established in April 2012 to guide the project. Terms of Reference for the Committee are included in Appendix B.

The Steering Committee's goal for the project is to work with partners and stakeholders to develop a comprehensive strategy for the provision of chronic non-malignant pain services for adults that live within Interior Health. The final Strategy will be presented to Interior Health's SET in November 2012.

The project is proceeding in a phased approach as outlined below, noting that Phase 4: Implementation is beyond the scope of the Steering Committee. Phase 4 will proceed pending directions approved by SET.



This document is a the final Interior Health Chronic Pain Strategy developed through Phases one through three. The Strategy presents a synthesis of information gathered from:

- 30 stakeholder interviews
- Three patient focus groups and an online patient survey
- An online physician survey of 56 members of Interior Health Divisions of Family Practice
- Both peer-reviewed and grey literature
- The development of an Interior Health pain services inventory
- Site visits and interviews with other BC Health Authorities
- Ongoing engagement with Pain BC
- Steering Committee input and final approval

Scope and Underlying Principles

The scope of IH's Chronic Pain Strategy is chronic non-malignant pain in adults. The definitions of which are presented below.

- **Pain** is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.[1]

- **Chronic Pain** is pain that persists beyond the expected period of healing. Generally speaking, chronic pain is pain that lasts more than three months, however this timeframe is somewhat arbitrary and it is not possible to generalize this timeframe across the entire population. Chronic pain can be intermittent (occurs in a pattern) or persistent (lasting more than 12 hours daily) and can be considered a disease itself.[2] Although improvement may be possible, for many patients cure may be unlikely[3] and treatment focuses on pain management.

- In contrast, **Acute Pain** is pain of sudden onset that is expected to last a short time. It usually can be linked to a specific event, injury, or illness.[4] Acute pain is usually transitory, lasting only until the noxious stimulus is removed or the underlying damage or pathology is healed.

- **Malignant** conditions tend to produce death or deterioration.[5] **Non-malignant** conditions are those that do not tend to result in death or deterioration.

It is recognized that chronic pain has a distinct pathology and can be a disease itself. As with other chronic diseases, improving systems, supports and services for individuals requiring pain management is an imperative. To help guide the development of recommendations to improve services, the Steering Committee identified underlying principles to inform its work. These principles were adapted from a variety of sources[6] and are presented in the box on the following page.

[1] Merskey, H. & Bogduk, N. (1994). Part III: Pain Terms, A Current List with Definitions and Notes on Usage. Classification of Chronic Pain, 2nd Edition. International Association for the Study of Pain. Task Force on Taxonomy, IASP Press. Seattle, WA.
[2] Canadian Pain Society website. www.canadianpainsociety.ca
[3] Institute of Medicine. (2011). Relieving pain in America: A blue print for transforming prevention, care, education, and research. http://www.nap.edu/catalog.php?record_id=13172
[4] Institute of Medicine. (2011). Relieving pain in America: A blue print for transforming prevention, care, education, and research. http://www.nap.edu/catalog.php?record_id=13172
[5] Merriam-Webster Medline Plus Medical Dictionary http://www.merriam-webster.com/medlineplus/malignant
[6] Interior Health's *Charting the Course* (2012), Pain BC's Strategic Plan 2012, and the Institute of Medicine's *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011) and previous Steering Committee discussions including the presentation made at the June 6th meeting.

Chronic Pain Strategy – Underlying Principles

1. **Patient and Family Centeredness**
    - As we develop chronic pain programs and deliver care, we will partner with patients and their families to consider their needs, values and preferences.
    - The effectiveness of pain treatments depends greatly on the strength of the clinician-patient relationship*;* pain treatment is never about the clinician's intervention alone.

2. **Quality and Safety**
    - Care will reflect the diversity of the population and the individuality of the client's needs, experiences, cultural and religious values, preferences and beliefs.
    - It is known that pain results from a combination of biological, psychological, and social factors; given this, in most cases inter-disciplinary assessment and treatment is the optimum model.
    - It is recognized that opioid drugs can be safe and effective when used as prescribed and appropriately monitored; patients must be carefully screened and treated if needed for mental health and substance use disorders.

3. **Equitable Access**
    - A chronic pain system of care should minimize access disparities which can exist depending on where one lives and whether or not one has extended medical coverage.

4. **Prevention and Early Intervention**
    - Every effort should be made to achieve both primary prevention of pain (e.g., in surgery from a broken hip) and secondary prevention (of the transition from acute to chronic state) through early intervention.
    - Efforts will be made to re-direct resources upstream to address pain problems at the earliest possible point in the patient's journey.
    - Many features of the problem of pain lend themselves to public health and community based approaches.

5. **Integration Across the Continuum**
    - Pain services will be coordinated and seamless across the health care continuum.

6. **Evidence-Based**
    - Innovation to improve outcomes for patients will be encouraged.
    - Research and surveillance information will enable the planning of services.
    - Continuous evaluation and monitoring will enable improved program delivery and patient outcomes.

7. **Sustainability**
    - Sustainable programs and supports can be achieved through the dedication of appropriate resources and the redesign of existing services.

Demand for Chronic Pain Services

There is a large demand for chronic pain services in the province of British Columbia. The most recent population-based data identified on the burden of chronic pain in the province comes from a random telephone survey conducted in 2007/08[7] which indicated that the prevalence in the province for moderate to severe chronic pain in adults (18 and older) was 22.5%. Data collected by Statistics Canada as part of the Canadian Community Health Survey reported that in BC in 2008 the prevalence of pain or discomfort that prevents activities among those 35 to 44 years of age was 10.2%.[8]

Uncontrolled pain continues to be the single most common cause of disability amongst working-age adults in Canada. Sixty percent of people with chronic pain eventually lose their job, suffer loss of income or will have a reduction in responsibilities as a result of their pain. For those who are still employed, it is anticipated that they will have a mean number of 28.5 lost-work days per year.[9]

The incidence of chronic pain in the elderly is of particular concern. It is estimated that persistent pain affects 50-80% of the individuals that live in residential facilities in Australia.[10] Residents often experience co-morbidities such as dementia, may face ageist attitudes, and are often denied services available for the broader population.[11]

When the above rates are translated to the IH population, it is estimated that:

- **135,000 adults in IH experience moderate to severe chronic pain** (aged 20+)
- **By 2021, this number will increase to 150,000 adults** (aged 20+)
- Between **2,400 – 3,900[12] individuals living in residential permanent beds within IH experience persistent pain**

The burden of chronic pain on the health system is great. Chronic pain costs society more than cancer, heart disease and HIV combined.[13] Those with chronic pain are five times as likely to utilize health care services and 58% percent of them experienced symptoms of depression or anxiety, co-morbidities that can increase the utilization of health care resources.[14] For organizations, the prevalence of chronic pain within the workforce is also a concern. In Australia in 2006, it was estimated that individuals with pain lost on average 16.4 work days/year[15] (this estimate includes both days off and lost productivity).

The Canadian Institute for Health Information (CIHI) estimates that chronic pain is the third most prevalent chronic condition managed by primary care practitioners in Canada and that back pain is the sixth most common problem for emergency department visits. Approximately 21% of all of BC's emergency department visits have been estimated to be related to chronic pain.[16]

---

[7] Taenzer P, Jovey R, Schopflocher D. (2009). Chronic Pain in Canada – Prevalence and Consequences.
[8] Statistics Canada. CANISM Table 105-0501: Health indicator profile, annual estimates, by age group and sex, Canada, provinces, territories, health regions (2007 boundaries) and peer groups, occasional. Canadian Community Health Survey.
[9] Statistics Canada. Housing, Family and Social Statistics Division. A Profile of Disability in Canada. Statistics Canada. 89-577- XIE, 1-24.2001.
[10] Parmelee PA, Smith B and Kat IR. (2010). Pain complaints ad cognitive status among elderly institution residents. J Am Geriatr Soc 41:517-522.
[11] Pain Australia. (2001). *National Pain Strategy: Pain Management for All Australians*. The National Pain Summit Initiative.
[12] Calculated as 50-80% (Parmelee 2012) of total number of permanent residential beds within IH. Total number of permanent beds as of June 30, 2012 is 4923. Source: Information Management and Support. Report prepared by Nathalie Ammaturo for HCC Directors.
[13] Pain BC. Strategic Plan 2010-2013. Changing pain. Changing minds.
[14] Sipkoff M. (2003). Health plans need to take control. Managed Care. Issue 10. http://www.managedcaremag.com/archives/0310/0310.pain.html
[15] MBF Foundation in collaboration with University of Sydney Pain Management Research Institute. (Nov 2007). The high price of pain: The economic impact of persistent pain in Australia.
[16] Gould (2007). As quoted in Fraser Health Authorities Chronic Pain Business Case. June 18, 2008. V 2.0

Again, when the above rates are translated to Interior Health, it is estimated that:

- In 2011/12 **over 81,000 unscheduled emergency department visits**[17] across IH are a result of individuals with **chronic pain.**
- Individuals with chronic pain are high-users of IH's health care services and **significant drivers of demand (cost)** across the continuum
- **78,300 adults within the health authority experience symptoms of depression or anxiety**[18] in addition to their experience of moderate to severe chronic pain (aged 20+)
- **3,700 of Interior Health's staff** experience moderate to severe chronic pain. This is likely contributing to the number of work days lost per year, as well as sick and overtime rates.

A common treatment for chronic pain is the prescription of natural opium alkaloids or "pain killers". These drugs are highly prescribed, and recently identified by CIHI as one of the top ten drugs with the highest rate of use among seniors on public drug programs.[19]

The management of non-illicit, non-methadone opioids in Interior Health is of particular concern. In the October 2012 Medical Health Update, Interior Health's Medical Health Officers noted that approximately **21 prescription opioid overdose deaths per year occur within IH.**[20] This rate is comparable to that of BC residents killed in any given year in motor vehicle accidents involving alcohol. The rate of these overdose deaths in IH is almost twice that of the rest of BC. Further to this, it was found that **82% of these overdose cases have a documented source of chronic pain**.

The statistics clearly paint a picture of the overwhelmingly negative impact of chronic pain on individuals, communities, and the broader health system.

Current Services and Utilization

In Interior Health, pain management services are fragmented and lack coordination. It is safe to say that despite the need, there is no comprehensive pain service for the health authority and that demand is largely unmet.

Chronic pain care is provided by a wide variety of organizations and groups including:

- Family practitioners in their office environments (including those licensed to prescribe methadone for pain).
- Specialist physicians (anaesthesiologist, radiologist, physiatrist) providing services in hospital and private clinics.
- Other private practice health professionals including physiotherapists, massage therapists, psychologists, social workers, complementary alternative medicine providers, and others.

[17] Calculated as 21% of total unscheduled ED visits in 2011. Data Source for total ED visits: Admissions Universe: MIS/GL. Author: Robin Blanchard, Strategic Information Analyst. Nathalie Ammaturo, Statistics Analyst. Date Prepared: Sept 10, 2012.
[18] Calculated as 58% of estimated number of adults within IH estimated to experience moderate to severe chronic pain.
[19] Canadian Institute for Health Information. (2012). A Snapshot of Health Care in Canada as Demonstrated by Top 10 Lists, 2011. In selected provinces.
[20] MHO Update. Alert for Physicians/Pharmacists. Prescription opioid overdose deaths of persons with chronic pain in the Interior Health region. October 9, 2012. http://www.interiorhealth.ca/AboutUs/MediaCentre/PublicationsNewsletters/Pages/default.aspx.

- Physicians in IH facilities (including anaesthetists, radiologists, and family practitioners) are providing interventional pain management services and a few independent programs have evolved in the Community Integration portfolio.
- Patient and provider education is given by external organizations including the University of Victoria's Centre for Aging and the Arthritis Society. Additionally, non-profits offer Web Based Resources including the Canadian Pain Society and Pain BC.

To better assess the current availability and state of services in Interior Health, feedback from leadership teams across Interior Health was collected to compile an inventory of IH chronic pain management services. As far as can be ascertained, there are no Interior Health multi-disciplinary teams that provide a whole person, bio-psycho-social model of chronic pain care that meet the International Association for the Study of Pain (IASP) best practice standard and aligns with best practices either in facility or community environments. Results of this inventory are presented in Appendix C, but at a high level it reveals:

- The most commonly cited service within Interior Health is that provided at Kelowna General Hospital (KGH). At present this is primarily an anaesthetist with complex pain expertise that provides nerve blocks guided by either ultra-sound or fluoroscopy and other pain management consultative services as able. Access to fluoroscopy equipment can be limited.
- In Kamloops, a core group of practitioners is providing chronic pain services. Recognizing the need to coordinate and integrate these services, the Thompson Division of Family Practice formed a Chronic Pain Committee. This multidisciplinary working group is proposing the creation of a care continuum that includes tertiary chronic pain management capacity in Kamloops.[23] It is envisioned this will involve a centre with a number of primary care providers that devote time to chronic pain management with ready access to specialists who have expertise in chronic pain management.
- In addition to the services provided at Kelowna and Kamloops, pain services are reported at other sites including Vernon Jubilee, Penticton Regional, and Trail Regional Hospitals. However, as with Kelowna and Kamloops, they do not offer a comprehensive coordinated multidisciplinary approach to assessment, care, treatment and education.
- Having said that, there are some groups, teams and services moving towards this approach:
  - The KGH Occupational Rehab Program, a service is limited to ICBC and WCB clients.
  - Community Services at Vernon Jubilee Hospital which support an outpatient chronic pain team.
  - Chronic pain self-management group education series in Kelowna for clients within the Mental Health and Substance Use program.
  - Community nursing in Sparwood with expertise and education in pain management offering one on one client support for pain management.
- In addition to the above, private non-IH services are available. Of note:
  - The Maple Tree Clinic in Salmon Arm houses 2 general practitioners offering pain services to clients. Physicians are co-located with other pain management services including a psychologist, physiotherapist, and orthotics specialist.
  - The Welcome Back Clinic MRI and Pain Management Centre in Kamloops offers clients advanced pain management services including diagnostics and interventions as well as access to allied health professionals.

[23] Thompson Tertiary Chronic Pain Centre Business Case. First iteration for discussion purposes. October 29th, 2012. Prepared by the Thompson Region Division of Family Practice.

Marked disparities in access exist across IH and arise based on geography and whether or not individuals have extended medical coverage to access private practice health professionals. In terms of geography – some communities have some type of chronic pain management services while others do not, the links between communities are fragmented or non-existent, and communication between services varies and is not systematic often depending on "who knows who". In terms of extended medical – those with coverage are able to access private providers, however many without extended coverage cannot.

As a result of the way data is coded or captured and because of the fragmented nature of the service, it is hard to obtain a picture of the true utilization of services. It is however safe to say that:

- Waitlists exist to access services.
- Wait times are significant and the current availability and organization of services is not enough to meet demand.

Stakeholder Perspectives

Internal and external stakeholder input was obtained to inform the development of recommendations. Interviews, an online survey to the Divisions of Family Practice, patient focus groups and an online patient survey were all conducted to determine perspectives on the current state, gaps in services, and needed improvements. The following section outlines the approach and results for each of these channels of information and also identifies common themes.

Stakeholder Interviews

Thirty interviews were conducted with both internal and external stakeholders including family physicians, specialists, mental health staff, nurses, physiotherapists, administrators, and more. Appendix D outlines key interview findings. The most commonly mentioned gaps and areas for improvement included:

- Waitlists and a lack of access to services.
- The lack of coordinated comprehensive pain services across IH; the lack of a true system of care
- The need for education and training.
- High costs to patients – patients without extended medical coverage often cannot afford to access other disciplines such as physiotherapy or massage.

Division of Family Practice Physician Survey

To obtain physician input, an online survey was circulated through the Divisions of Family Practice. A total of 56 online surveys were completed with participation from four of the Divisions of Family Practice – Central Okanagan, Shuswap / North Okanagan, East Kootenay, and Thompson.[24] Key findings is presented in Appendix E.

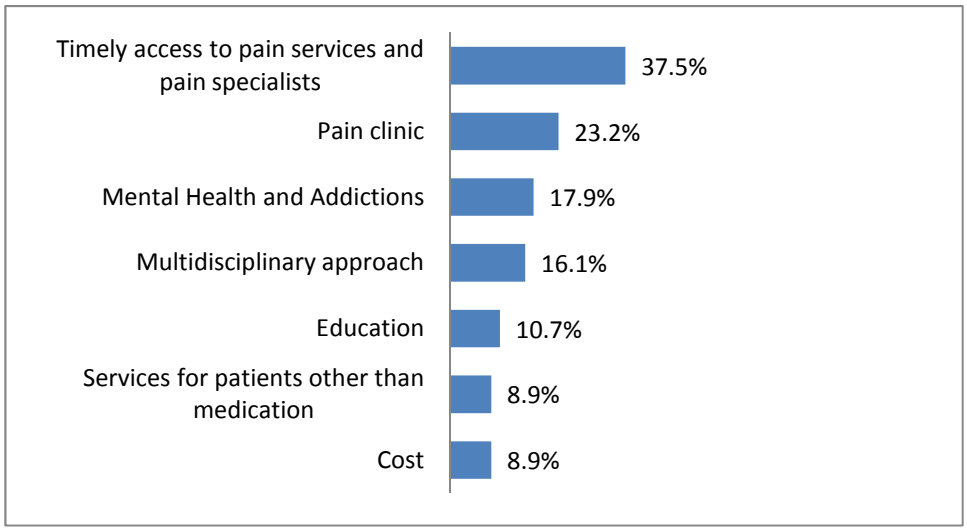
In summary, the survey revealed most of respondents offered non-opioid analgesic drugs and adjuvant analgesic drugs to chronic pain patients. Similarly, the majority of respondents refer to other physicians for interventional and diagnostic treatments and to other health providers for multidisciplinary services including physiotherapy, massage therapy, acupuncture, and chiropractic services among others.

[24] The Kootenay Boundary DFP conducted their own survey earlier this year. Findings were similar to those obtained through this survey process.

When asked about the gaps in services and areas needing improvement, physicians noted common themes for both questions commenting on:

- The lack of services in general and the absence of a true pain clinic for which to refer.
- For services that do exist, there are long wait times and inequitable access.
- Inadequate supply of specialists and individuals with pain expertise to support the entire health authority, be it to provide intermittent consultation and support to family physicians, or to provide more complex interventions.

In terms of the most important improvements, the figure below outlines areas cited by respondents.



Of note:

- More than one-third identified the need for improved timely access to pain services and pain specialists (37.5%).
- Almost one quarter (23.2%) identified the need for pain clinic/s.
- Another frequently mentioned area for improvement was the ability to access ongoing mental health support and psychiatric care that specializes in pain and addictions (17.9%).
- The importance of education for both professionals and patients as well as a multidisciplinary approach to pain management was highlighted.
- Physicians also identified the need to offer patients more than just prescriptions for their chronic pain as well as the additional cost to patients to access allied health professionals to help them with their pain.

Patient Focus Groups and Online Survey

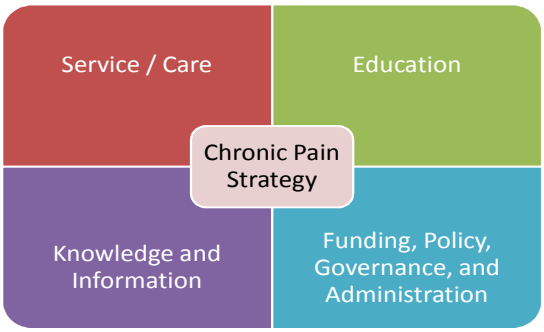
In partnership with the Patient Voices Network, Interior Health conducted 3 focus groups and an online survey for patients with chronic pain. A total of 18 patients and family members participated. Major themes identified included:

- The need for more information and list of resources available to patients with chronic pain.
- The important role of the GP in accessing information and referral to other health professionals.
- The need for multidisciplinary assessment and treatment.
- A desire to have a holistic approach to pain management that addresses the mental health and well being of the patient as well as the physical aspects of their pain.

Common Themes
Encouragingly, many of the comments and responses from the physician survey and patient focus groups align with what was heard in the stakeholder interviews and the literature. **Increased education and knowledge, access to services, lack of services, and system coordination are priorities for action.**

A Framework for a Strategy

As part of the project approach, a peer-reviewed and grey literature search was completed to identify best practices in chronic pain management at a systems level. Based on literature results, the Steering Committee determined the following four overarching categories around which to conceptualize an ideal pain management system:



The following sections describe some ideal characteristics within each of these four categories.

Service / Care

This category captures all of the elements and concepts related to direct patient care, including the standards and guidelines that inform that care. Within this category and as articulated in the principles developed for the IH Pain Strategy, it is recognized that chronic pain can be a chronic disease in its own right. And as a chronic disease, the ideal care delivery model for chronic pain is aligned with those for other chronic conditions. It is recognized that within the population there will be broader demand for prevention, promotion, and first point of contact primary care. These are the services that should be widely available. Coordination and referral to higher levels of care will occur as needed. A smaller proportion of the population requires specialty care and as the level of specialty increases, it is generally accepted that services should be clustered to ensure safety, quality, sustainability, and efficiency.

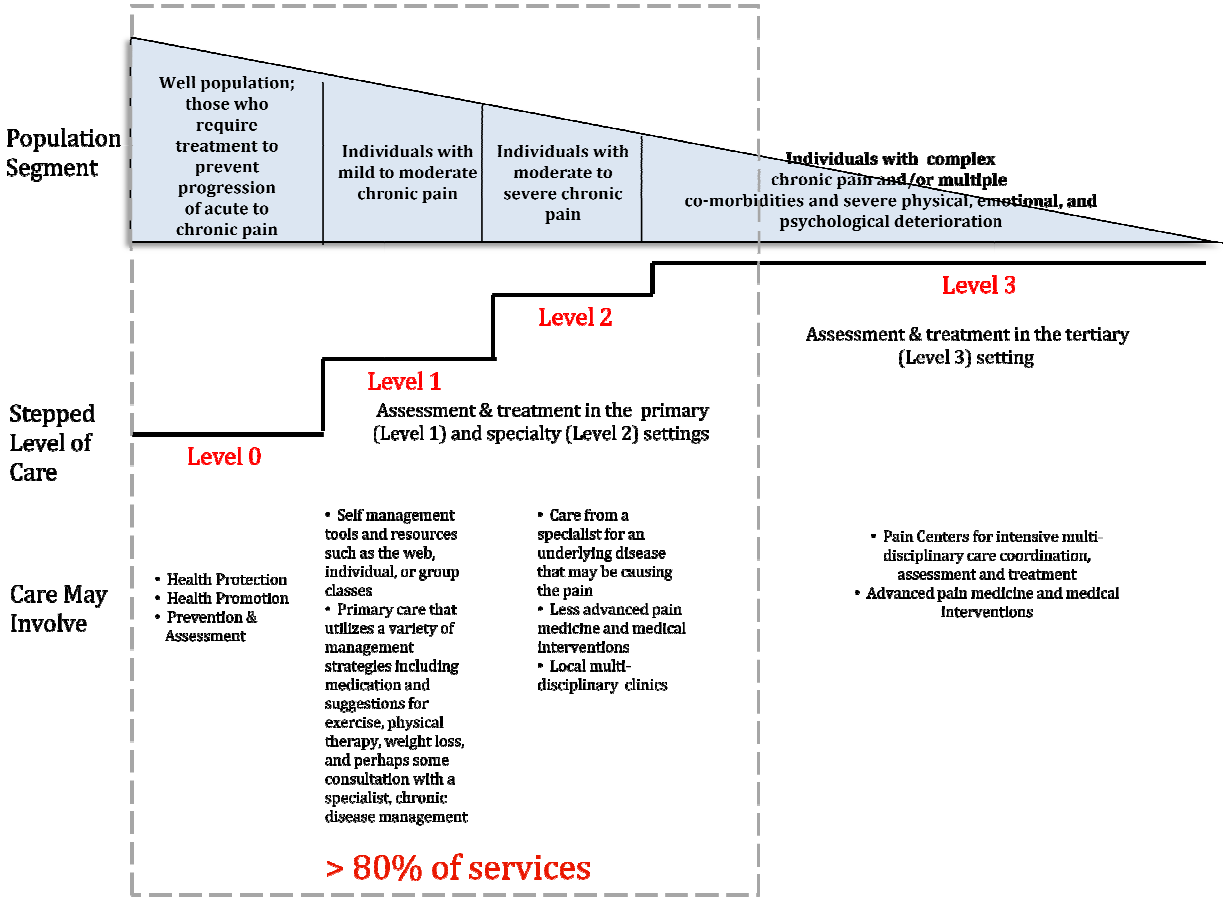
Accreditation Canada currently does not have a specific Pain Standard, however within the scope of the IH Pain Strategy, the provision of pain services aligns most closely with Populations with Chronic Conditions Standard 4.3[25] which states:

> "The organization has chronic disease self-management programs for clients with chronic conditions. The guideline for this standard emphasizes the importance of self-management approaches to cope with physical and emotional symptoms such as pain (among others)."

[23] http://www.accreditation.ca/en/content.aspx?pageid=54

Strategies for chronic diseases are often framed around the health care continuum: staying healthy, treating illness, living with disease, and coping with end of life. Within pain management literature and practice, this continuum, or elements of this continuum are often referred to as the Stepped Care Model. Several models were reviewed and adapted to develop the IH Pain Strategy Stepped Care Model which is the foundation around which Service / Care recommendations were developed.[26]

IH Pain Strategy Stepped Care Model



As illustrated in the model, the majority of pain management and treatment services (greater than 80%) should be provided within Levels 0-2. This is where demand is the greatest and a focus here can prevent escalation to more intense or complex Level 3 services.

Across the steps, treatment approaches can include the following:[27]

- Medications
- Regional anaesthetic interventions / surgery

[26] Sources reviewed included material from: Fraser Health Authority, Pain BC documents, Department of Veterans Affairs VHA Directive 2009-053 Pain Management October 2009, Institute of Medicine *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research* (2011), McMaster Evidence Brief *Supporting Chronic Pain Management Across Provincial and Territorial Health Systems in Canada*

[27] The Institute of Medicine. (2011). *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research.*

- Psychological therapies
- Rehabilitative / physical therapy, and
- Complimentary Alternative Therapy (CAM)

In **Level 0**, the focus is on health protection, health promotion, and prevention and assessment for the entire population. This includes public health strategies including coordination across the public and private sector, ongoing strategies to increase public awareness of chronic pain, and focus on self management.[28] The assessment and identification of patients at risk of progressing to chronic pain is also an important part of the pain management system as early recognition can be a preventative strategy for decreasing the prevalence of chronic pain.[29]

Level 1 of the Stepped Care Model focuses on self management tools and resources and primary care strategies. These services are offered across the system by a variety of health care providers and require support and education for physicians and health care providers working with patients with chronic pain.

Characteristics of an effective Level 1 service include:[30]

- a competent primary care workforce
- family and patient education programs
- collaboration with mental health teams
- self management programs (either face to face or online)
- and various support programs

Patients with more complex needs or urgent care needs should be triaged to Level 2 or 3 to allow Level 1 practitioners to focus on the less complex larger number of patients. [31]

Moving to **Level 2** of the model, patients with moderate to severe chronic pain will benefit from accessing local multi-disciplinary clinics with care from a specialist and a team of health care providers providing less advanced pain medicine and medical interventions.

In addition to the characteristics of the Pain Clinic described by the International Association for the Study of Pain (IASP) described below, this level of services can include:[32]

- pharmacological interventions
- physical therapy
- psychological treatment (CBT or family counselling)
- patient education
- vocational counselling
- and in some cases surgery or other non-pharmacological modalities

More complex patients are triaged to these Level 2 services and may be referred from GPs, non-pain specialists, or other primary care centres. These services can be offered in hospital ambulatory care settings or in community settings.[33]

[28] The Institute of Medicine. (2011). Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research.
[29] Pain Australia. (2001). National Pain Strategy: Pain Management for All Australians. The National Pain Summit Initiative.
[30] Department of Veterans Affairs. (2009). VHA Directive: Pain Management. Veterans Health Administration, Washington, DC.
[31] Pain Australia. (2001). National Pain Strategy: Pain Management for All Australians. The National Pain Summit Initiative.
[32] Alberta Heritage Foundation for Medical Research. (2003). Multidisciplinary Pain Programs for Chronic Pain: Evidence from Systematic Reviews. HTA 30: Series A Health Technology Assessment.
[33] Pain Australia. (2001). National Pain Strategy: Pain Management for All Australians. The National Pain Summit Initiative.

Advanced pain medicine and medical interventions are used for patients with complex long-standing pain problems in **Level 3** services. Advanced pain medicine diagnostics and pain rehabilitation programs are used for patients that have previously failed other less intensive interventions, have higher rates of opioid dependence and higher prevalence of surgery. These patients often have more functional impairment, greater levels of emotional problems, more constant pain, and have been seen by a wide range of health care professionals leading to increased health care utilization.[34]

At this tertiary care level, pain specialists work in a multidisciplinary team within a major hospital and deal with the most complex chronic pain. These teams also play an important role in the education, training, and research for the pain services of the region.[35]

The International Association for the Study of Pain (IASP)[36] has developed recommendations to guide the establishment and maintenance of pain treatment services. It defines pain centers, pain clinics, and pain practice. Regardless of the type of service – centers, clinics, or practices – across all there is substantial evidence for the effectiveness of multidisciplinary treatment for chronic pain problems.

Pain Centers are distinguished from Pain Clinics in that they include educational and research activities. They are ideally affiliated with education or research institutions. Beyond this distinction, both Pain Centers and Pain Clinics should:

- Have clinical staff from a wide variety of medical and other health care disciplines. All providers should be appropriately qualified and licensed and knowledgeable about the contributions of biological, psychological and social/environmental factors to pain problems.
- Be able to treat any type of pain problem, with some type of a system to obtain consultation as needed from physicians not included in the staff (noting that consultation may be off-site). That is, coordinate and refer to higher levels of care as needed.
- Co-locate clinicians in a space that enables communication on a frequent and scheduled basis about patients and their treatment as well as administrative and clinical policies, procedures, and guidelines.
- Deliver guideline driven, evidence based care.
- Assess and treat patients in a multi-disciplinary fashion and involve specialists as needed.
- Focus on both pain and/or pain management and also on improving the patient's physical, psychological, work and social role functioning.
- As standard practice, collect and use data on outcomes (including pain intensity, psychological distress, function and quality of life) of the patients evaluated and treated, and engage in continuous quality improvement.

The Australia Chronic Pain Strategy emphasizes the importance of higher levels of care (Level 2,3) being provided in a time-limited manner and that patients after receiving these services should return to the local community level for ongoing services and support for self-management of their chronic pain. Level 2 and 3 services have highly skilled providers who offer comprehensive and expert assessment and treatment during a defined period of time for the patient.

---

[34] Alberta Heritage Foundation for Medical Research. (2003). Multidisciplinary Pain Programs for Chronic Pain: Evidence from Systematic Reviews. HTA 30: Series A Health Technology Assessment.
[35] Pain Australia. (2001). National Pain Strategy: Pain Management for All Australians. The National Pain Summit Initiative.
[36] International Association for the Study of Pain Task Force on Wait-Time Summary and Recommendations. Online Available: **http://www.iasp-pain.org/Content/NavigationMenu/GeneralResourceLinks/Guidelines2/default.htm**

A network of care or "hub and spoke" model with a whole systems view can help ensure coordination across levels. Within the system and the individual services within it, wait time targets should be met and other clinical guidelines followed (for example, guidelines on the safe and effective use of opioids, or treatment of specific pain conditions). A regional referral and triage process is recommended. Triage benchmarks and wait time targets exist and can vary anywhere from immediately for acute painful conditions up to six months depending on the level of urgency and the guideline.[37] Not only are links to higher levels of care important, but coordination and smooth transfer back to communities are needed.

Across all levels, pain support groups play a valuable role.

Determining the service capacity required to meet population health needs within this framework is still very much experimental. Research in the design of pain management systems is evolving, and currently practice is often driven by provider behaviour. It has been suggested that the ideal approach is to build capacity with a whole systems, coordinated, integrated lens, and then evaluate the effectiveness and modify accordingly.

Education

The Canadian Pain Coalition states that "Effective interactions of Canadians in pain with their health care systems are flawed because of misunderstandings about the nature of chronic pain across the board, and the appropriate care required."[38] There is agreement that a well functioning pain system has effective education strategies in place for providers, patients and their families, and the general public.

Specifically patients, their families and the public will:

- Understand the nature of chronic pain.
- Be aware of individual and community actions to prevent injuries, minimize risk, and be mobilized to take action.
- Where appropriate, shift their view from "cure" to "cope". Often when individuals are not prepared to accept a diagnosis, they continue to search for answers they find acceptable increasing the burden on the health system. In many cases there must be a shift to accept the existence of chronic pain and recognition that a healthy lifestyle is still possible.
- Recognize the role individuals must play in the self-management of their disease.
- Know where to go for appropriate services.

Health professionals will:

- Encourage preventative actions.
- Recognize warning signs, initiate timely and appropriate treatment, seek and have access to speciality consultation and support when necessary.
- Understand the disease itself including the multiple causes and effects of pain, the range of treatments available, and the need to consider chronic pain as a biopsychosocial disorder.
- Deliver care informed by practice guidelines that recommend particular management options. There is no standard "approach" to chronic pain management given the highly individualized approach to care each person requires and the beliefs that different providers and patients have about the effectiveness of management options. For example there are differing beliefs about

[37] Considers International Association for the Study of Pain and Canada Wait Times Alliance guidelines.
[38] *The Status of Pain in Canada – moving toward a Canadian Pain Strategy.* Recommended by the Canadian Pain Coalition, *The National Voices of People with Pain*. Brief for the Parliamentary Committee on Palliative and Compassionate Care. October 19, 2010.

the effectiveness of psychological treatments such as cognitive behavioural therapy or on the use of opioids to control pain. Knowledge and support to deliver guideline based care is critical.
- Know where to refer clients for appropriate services.

Knowledge and Information

This category refers to the collection, sharing, and use of knowledge and information to design, implement, monitor, and improve pain services. It includes research, evaluation, quality improvement, and surveillance activities as well as Information Management and Information Technology (IMIT) capabilities. Within this category, ideal pain management systems are characterized by the following:

- Easily sharing information across providers and care levels to ensure effective, efficient, appropriate care and continuity.
- Standard data and information collection tools and templates across the system that enable quantification and analysis of: what services are offered, where, by whom, how frequently, and at what cost; over and under-utilization of services and medication; quality improvement metrics that are supported by an embedded quality improvement framework.
- The utilization of technology including the electronic medical record and Telehealth.

The routine tracking of patient outcomes is a key part of the development of improved pain services. Measurement should not only assess "relief of pain" but also progress towards attaining more functional goals as well as:[39]

- reduced overdependence on drugs and other treatment modalities
- symptomatic improvement and reduced subjective pain intensity
- regained independence
- mastering coping techniques and self-management skills
- restoring the ability to function productively and satisfyingly
- decreased inappropriate use of the health care system

An essential part of pain services is ongoing monitoring and evaluation of effectiveness and efficiency of the system of pain services. Several studies in recent years have attempted to show the economic impact and cost savings of implementing multidisciplinary teams for pain management.

A review in 2006[40] clearly demonstrates that comprehensive pain programs offer the most efficacious and cost effective, evidence-based treatment for persons with chronic pain, however there are still many gaps in the literature for cost effectiveness of chronic pain treatments.[41]

Multiple visits to emergency can be an effect of inadequate treatment, lack of an adequate diagnosis and GP follow up, as well as lack of knowledge and resources for chronic pain management. Along with a multidisciplinary approach, a network of primary care providers in the community, education and resources for patients and their families, and a well functioning triage and referral system will all contribute to reduced visits to the emergency departments, more effective chronic pain management, and shifting care to the community. It is imperative in the implementation of pain services to monitor

[39] Alberta Heritage Foundation for Medical Research. (2003). Multidisciplinary Pain Programs for Chronic Pain: Evidence from Systematic Reviews. HTA 30: Series A Health Technology Assessment.
[40] Gatchel, R.J., Okifuji, A. (2006). Evidence Based Scientific Data Documenting the Treatment and Cost-Effectiveness of Comprehensive Pain Programs for Chronic Non-malignant Pain. *The Journal of Pain*, Vol 7, No 11: pp 779-793.
[41] MBF Foundation in collaboration with University of Sydney Pain Management Research Institute. (Nov 2007). The high price of pain: The economic impact of persistent pain in Australia.

and measure these intended outcomes and impacts on the health system. The use of a model for outcomes measures such as the 'triple aim model' could be used to measure outcomes looking at improving per capita costs and efficiency of the health care system (decrease ED visits, decreased opiate use, etc.), improved provider experience, and improved individual experience and outcomes.

Funding, Policy, Governance, and Administration

Leadership to oversee the pain management and treatment system as well as the daily operations of teams and programs is crucial. Further points to consider include:

- Establishing alternate compensation mechanisms or fee schedules for physicians that consider the time and demands associated with primary and secondary prevention, treatment, management and rehabilitation. Current financial arrangements encourage some forms of care (e.g. injections) over others (e.g. counselling and monitoring).
- Engaging the most cost-effective providers and providing "tiered" support from (as well as referrals to) higher levels.
- Exploring options to provide quality, cost-effective programs. For example, group sessions, community partnerships (e.g. with private practitioners, local non-profits, community recreation groups, etc.), or contracting out services.
- Establishing a central coordinating hub to analyze data about treatment patterns and outcomes, disseminate resources and tools to patients and providers, link to educational / research institutions, monitor improvement efforts, facilitate continuing professional development.
- Engaging people that experience pain as an integral part of the planning and design of services.

Summarizing the Problem

Within IH, the burden of pain on Interior Health is large and growing.

- It is currently estimated that 135,000 adults in IH aged 20+ experience moderate to severe chronic pain and these resulted in an estimated 81,000 unscheduled ED visits in 2011.
- Annually approximately 81,000 unscheduled ED visits are a result of chronic pain.
- Between 2,400- 3,900 individuals living in residential permanent beds in IH are estimated to experience persistent pain.
- It is estimated that 3,700 IH staff experience moderate to severe chronic pain which is likely contributing significantly to absenteeism and lost productivity.
- The rate of death from prescription opiods (commonly used to treat chronic pain), is two times higher than the rest of BC.

At an individual level, the impact of chronic pain on the quality of life and well being of patients and their families is profound and cannot be easily quantified.

While pockets of excellent work across Interior Health to address the problem are occurring, a comprehensive coordinated chronic pain management system does not exist and care is all too often delayed, disorganized, inaccessible, or ineffective.

Proposed Recommendations and Actions

Recommendation 1:
Improve access by enhancing existing resources and establishing new services to create a comprehensive, coordinated, multidisciplinary network of pain services across Interior Health.

It is important to note that there are no guidelines to inform the specific levels of service required to meet the health needs of the population for chronic pain. As a guide, Vancouver Island Health Authority (VIHA) is used as a comparator. VIHA has approximately the same population as Interior Health and somewhat similar rural / urban mix. To support the population it has two tertiary sites with Level 3 Pain Clinics (Nanaimo and Royal Jubilee Hospitals). The VIHA model was built with a focus on tertiary interventional services. VIHA's secondary and community (Level 2 and Level 1) services are evolving and do not as readily provide a guide in terms of capacity required to meet health needs. As identified in the principles for the development of this Strategy, many of the features of the problem of chronic pain lend themselves to public health and community based approaches. There is a need for higher level interventional procedures; however emphasis should be placed on building capacity at the community level and supporting Levels 0-2 on the Stepped Model of Care.

Action 1.1:
Enhance existing services in Kelowna and Kamloops to establish multi-disciplinary Level 3 Pain Clinics that align with the International Association for the Study of Pain's criteria for Pain Treatment Services.[42]

While the emphasis of the chronic pain service delivery model will be shifting care more locally to communities, these clinics will be the central "hubs" in Interior Health's network of chronic pain services. They will provide advanced Level 3 interventions for the entire health authority. It is envisioned that the multi-disciplinary teams in these communities will also provide lower levels of chronic pain management services (e.g. Level 2) within their catchments. Further work however needs to occur to determine locations and linkages of services on a community by community basis.

Services at Level 3 clinics will be provided from 8:00am – 4:00pm Monday to Friday. The staffing model will include:

- 3.00 physicians with pain management expertise, typically anaesthetists or GPs with additional training. It is envisioned that physicians will be compensated through a blend of fee for service and sessional funding. In addition, 1.0 FTE of total Level 3 physician complement (6.00 with two Level 3 sites) will be dedicated to medical oversight of the pain program acting as a Medical Co-Lead. Funding for the Medical Co-lead will be through Interior Health's operating budget.
- 1.0 Nurse Practitioner
- 1.0 RN or LPN
- 1.0 Physiotherapy
- 0.50 Occupational Therapy

[42] Recommendations for Pain Treatment Services. International Association for the Study of Pain. http://www.iasp-pain.org/AM/Template.cfm?Section=Pain_Treatment_Facilities&Template=/CM/HTMLDisplay.cfm&ContentID=9218

- 0.50 Social Work or Psychology
- 0.40 Pharmacy
- 0.20 Dietitian
- 1.00 Clerk / Receptionist
- 1.00 Diagnostic Imaging Technologist

The Level 3 Pain Services will have access to C-arm fluoroscopy units during hours of operation to assess and treat patients within the program.

As the Pain Clinics and IH Pain Service evolves, in partnership with Radiology Services, work will be undertaken to clearly identify the patients and interventions that will be provided by the Pain Clinics and those that will be provided by Radiology. As capacity permits, and again as IH Pain Services evolve, appropriate services for individuals within facilities experiencing acute pain will be explored.

Action 1.2:
In a phased approach, establish Level 2 multidisciplinary pain clinics across Interior Health.

Level 2 Clinics will be phased in as follows:

- Year 1 – Salmon Arm and Castlegar
- Year 2 - Penticton and Cranbrook
- Year 3 – Williams Lake

These locations were chosen and phased in this manner by considering population density, geographic coverage across the region and readiness for implementation including current level of service, interest, and expertise in the provision of chronic pain services.

Level 2 clinics will operate 4 days per week and have a similar staffing model as the Level 3 sites. Physicians will be compensated through a blended fee for service sessional funding model**.**

As per best practices, less advanced fluoroscopy guided interventions will be provided within the local acute care facility. A more thorough review of existing resources in Level 2 communities is required to determine the ideal clinic location noting that preliminary opportunities have been identified. Further opportunities to integrate within existing services in Community Integrated Health Services will need to be explored to identify areas for cost savings, innovative approaches, and improved access for patients. Innovative partnerships with local recreation facilities and existing community resources will also be explored. Dedicated dollars to support lease arrangements will be set aside.

Action 1.3
Develop and implement standardized referral form, intake and triage process, use of shared electronic system for providers, and discharge criteria that will be implemented across all sites.

This action is essential to ensure a well-functioning system. Existing forms and criteria to support this have been collected.

Action 1.4
Ensure existing and newly established chronic pain services address health inequities, especially for excluded, vulnerable, and marginalized populations.

Recognizing special populations have inherent inequities in access and services, the IH Chronic Pain Service will work collaboratively to address inequities by supporting access to chronic pain services across the region. Strategies should focus on improving care for populations disproportionately affected by and undertreated for pain.

Recommendation #2:
Initiate effective education strategies for patients, families, the general public, physicians and providers on the nature of chronic pain the disease, treatment and management approaches, and on the availability of resources in communities and across the health authority.

Action: 2.1:
Within existing infrastructure, offer Practice Support Program (PSP) for Chronic Pain to family physicians.

Note: This Pain PSP module is currently being developed provincially.

Action 2.2:
Considering the materials and information in the PSP module and other evidence based pain education materials, develop a robust education strategy for front line providers in both acute and community settings on chronic pain and chronic pain services.

This strategy will consider website, social media, printed material, in-person training sessions, partnerships with existing educational activities, and will utilize existing knowledge coordinators / professional practice educators. A scan of existing tools and resources used by patients by community will be completed and building on existing resources, a comprehensive education strategy will be implemented to increase patient and provider access to culturally and linguistically appropriate information[43].

Action 2.3:
Liaise with the RACE (Rapid Access to Consultative Expertise) initiative (led by GPSC Shared Care Committee and Providence Health) and develop a strategy to support Interior Health providers through this network.

Action 2.4:
Incorporate self-management classes / group workshops and resources into the care process including building partnerships with existing self management / group programs in the region.

[43] An application for Acceleration funding for a Knowledge Coordinator to support this action was submitted in October 2012.

Action 2.5:
Develop and make available a more comprehensive list of pain management resources (provincial, health authority wide, and by community) for patients and providers.

Action 2.6:
Assess viability to support community physicians and health care providers with Telehealth by linking them to higher levels of care within the network.

Recommendation #3:
Focus on prevention and early intervention including improving the management of acute pain associated with surgery, trauma, and other conditions to minimize the risk of progression to chronic pain.

Action 3.1:
Partner with Chronic Disease Management and Prevention / Promotion portfolios to identify chronic pain risk factors. Develop and implement prevention and promotion strategies aligning with Ministry of Health priorities.

Action 3.2:
Conduct a more thorough assessment of the management of acute pain to develop appropriate strategies to ensure evidence based care, minimize the progression to a chronic condition, and integrate acute and chronic pain service delivery as appropriate.

Recommendation #4:
Where appropriate, integrate chronic pain services with mental health and substance use service delivery and implement best practice, guideline driven care.

Action 4.1:
As part of the education strategy at the primary care level, roll out and monitor the use of the Canadian Guidelines for Safe and Effective Use of Opioids including screening for mental health and substance use needs in chronic pain patients.

Action 4.2:
Conduct a more thorough review of existing mental health and substance use services to identify opportunities to integrate education approaches and service delivery.

Recommendation #5:
Establish the appropriate leadership and provide the required resources to establish and coordinate an Interior Health Chronic Pain Service.

Action 5.1:
Identify the Senior Executive Sponsor for the IH Pain Service who will be accountable for the outcomes of the Interior Health Pain Service.

Action 5.2:
Hire leadership to support the implementation of recommendations.

This includes an administrative lead situated appropriately in the organization to move forward with the implementation of recommendations, a Medical Co-lead position, Project Coordinator / Clinical Lead, and an IMIT analyst to implement recommendations and actions of the Chronic Pain Strategy. Responsibilities of these individuals are presented in Appendix H.

Action 5.3:
Transition the Pain Strategy Steering Committee to an advisory committee for the IH Pain Service.

The purpose of this advisory committee will be to facilitate the implementation of these recommendations and establishment of the IH Pain Service. This includes advising on the development of more tactical, operational plans.

Action 5.4:
Investigate and pursue external partnership and funding opportunities including the Arthritis Foundation, the Vancouver Foundation, and the Ministry of Health.

Recommendation #6:
Establish and use a quality improvement and evaluation framework to monitor and improve the delivery of services and measure expected outcomes to ensure accountability and sustainability.

Action 6.1
Develop the evaluation framework at both the clinical delivery level and for the IH Pain Service itself.

Action 6.2
Ensure relevant data to support service delivery and program evaluation is collected including clinical outcomes and health care utilization data.

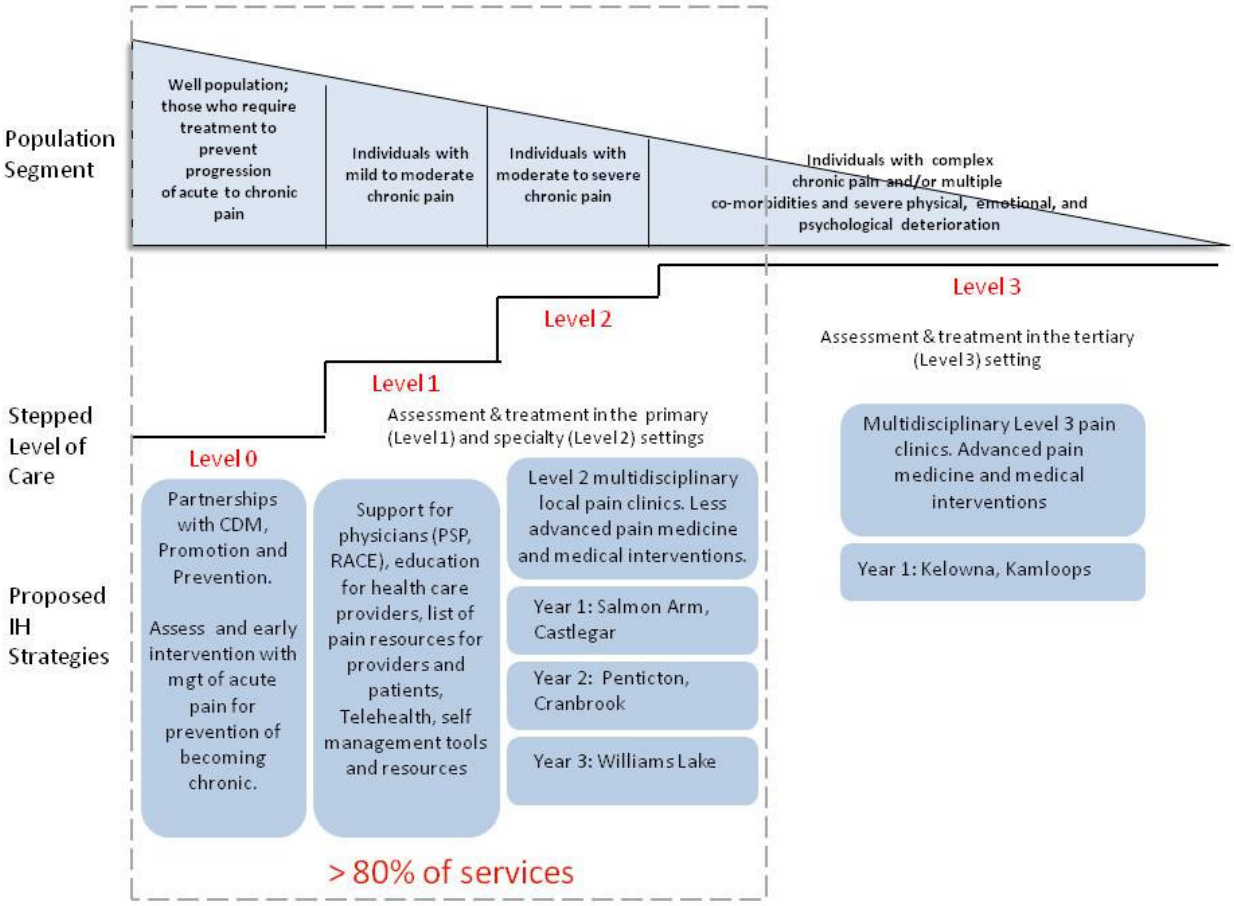
Action 6.3
Implement an evaluation of clinical care / outcomes and evaluate the broader Pain Service.

Recommendation #7:
Strengthen research capacity in the field of chronic pain.

Action : 7.1
Partner with academic researchers and facilities to enhance the evidence base for chronic pain services and strengthen research capacity with the health authority.

The figure on the following page links the above action items to the Stepped Model of Care for IH.

IH Chronic Pain Strategy Recommendations for the Stepped Care Model

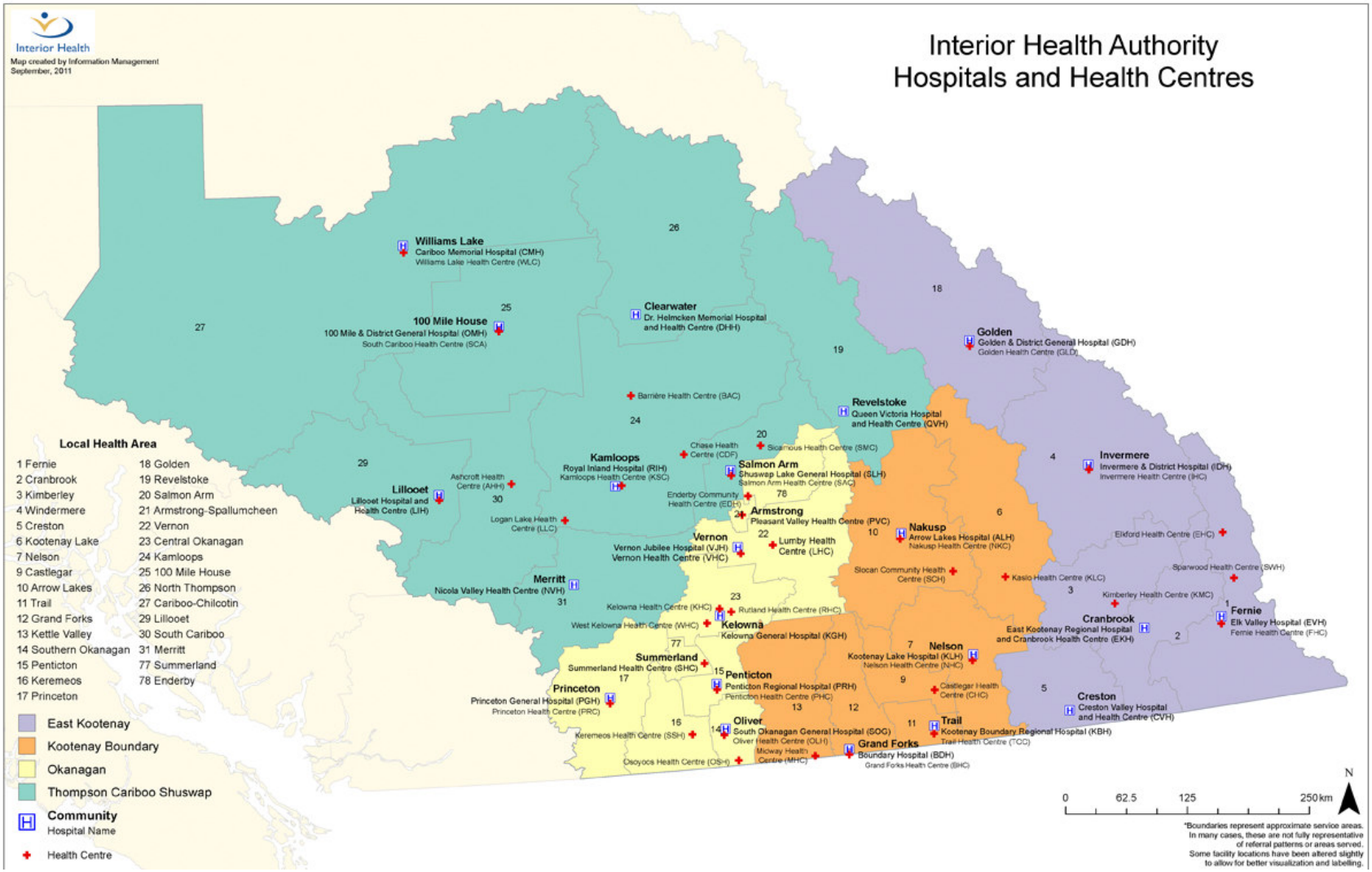


Conclusion

Chronic pain can be truly devastating for individuals and families afflicted with the disease. Its burden on the health system is great and as with other complex chronic conditions, improving systems of care warrants priority attention. Care providers that work in this area are passionate and committed to the work they undertake, which is often isolated, uncoordinated and under-resourced. The scope of the IH Chronic Pain Strategy focuses on improving services for adults with chronic non-malignant pain, but in addition to acute pain, future areas of work in this area include cancer, palliative, and pediatric pain.

This Strategy, developed through a highly consultative process that included both physicians, other health providers, and individuals suffering from chronic pain presents recommendations and actions to strengthen service delivery to support clinicians and care providers to effectively meet the health service needs of individuals with chronic pain and ensure the provision of quality, sustainable care both now and into the future.

Appendix A: Map of Interior Health



Appendix B: Pain Strategy Steering Committee Terms of Reference

PREAMBLE

Pain is a major health concern in Canada. Individuals who experience and suffer from pain have the need for both integrated and coordinated care in the community with their primary health care team, and with specialists in the acute settings. Interior Health covers a large geographic area and there is a need to ensure the pain management services provided are meeting the health needs of populations that live within these boundaries. Toward this end, the Senior Executive Team (SET) has identified the need to develop a comprehensive strategy for the provision of **chronic non-malignant pain** services for the clients of the region.

I. PURPOSE

The Pain Strategy Steering Committee (PSSC) will advise on and facilitate the development of a comprehensive pain strategy for Interior Health including making final recommendations to SET.

II. COMMON TERMS

Pain: an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage[44].

Acute Pain: pain of sudden onset that is expected to last a short time. It usually can be linked to a specific event, injury, or illness[45]. Acute pain is usually transitory, lasting only until the noxious stimulus is removed or the underlying damage or pathology is healed.

Chronic Pain: pain that persists beyond the expected period of healing. Generally speaking, chronic pain is pain that lasts more than three months, however this timeframe is somewhat arbitrary and it is not possible to generalize this timeframe across the entire population. Chronic pain can be intermittent (occurs in a pattern) or persistent (lasting more than 12 hours daily) and can be considered a disease itself .[46] Although improvement may be possible, for many patients cure may be unlikely[47] and treatment focuses on pain management.

Malignant: tending to produce death or deterioration[48]

III. SPECIFIC DUTIES AND RESPONSIBILITIES

The PSSC will consider the entire care continuum of pain services but its initial priority area of focus will be on chronic non-malignant pain in the adult population. Within this scope it will:

[44] Merskey, H. & Bogduk, N. (1994). Part III: Pain Terms, A Current List with Definitions and Notes on Usage. Classification of Chronic Pain, 2nd Edition. International Association for the Study of Pain. Task Force on Taxonomy, IASP Press. Seattle, WA.
[45] Institute of Medicine. (2011). Relieving pain in America: A blue print for transforming prevention, care, education, and research. http://www.nap.edu/catalog.php?record_id=13172
[46] Canadian Pain Society website. www.canadianpainsociety.ca
[47] Institute of Medicine. (2011). Relieving pain in America: A blue print for transforming prevention, care, education, and research. http://www.nap.edu/catalog.php?record_id=13172
[48] Merriam-Webster Medline Plus Medical Dictionary http://www.merriam-webster.com/medlineplus/malignant

- Provide guidance and direction on the development of a collaborative project plan for the IH Pain Strategy including but not limited to:
  - Confirming project goals and objectives, planning principles, and project scope
  - Advise on appropriate stakeholders to involve in the project including: family physicians, patients, allied health professionals, health administrators, front line staff, and external organizations as appropriate
  - Advise on exemplar organizations for further investigation and direction as required on the service delivery model literature review
  - Advise on key elements required in for an inventory of services
- Assist with the implementation of the project plan (i.e. up to submissions of final recommendations to Interior Health's Senior Executive Team) including but not limited to:
  - Ensuring above mentioned stakeholders are engaged and involved in the process
  - Providing both administrative and clinical expertise in the gathering and synthesis of information and in the development of strategic recommendations (may include advising on interview questions, facilitating site visits, participating in site visits, reviewing inventory of services, population need / utilization, and best practices to develop preliminary recommendations, participating in a broader stakeholder planning session, modifying recommendations based on stakeholder planning day input, etc.)
  - Identify resource implications for proposed strategies
- Review and provide input into final Pain Strategy prior to submission to IH's SET
- Ensures key project deliverables are met within required timelines – the target deadline for the Strategy to be presented to SET is the fall of 2012
- Shares and communicates information to their respective stakeholders / portfolios / colleagues on the work of the PSSC the progress of the Pain Strategy

IV. COMPOSITION AND OPERATIONS

A. Membership

- Members are asked to participate at the request of their respective Vice Presidents or at the request of the Chair(s). Membership will include individuals from both clinical and administrative perspectives with consideration of the following:
  - Physician/s with pain management expertise
  - Clinical psychologist or social worker with pain management expertise
  - Family physician/s with interest and experience in pain management
  - A RN or Nurse Practitioners involved in pain management
  - Administrative representatives with interest / experience in pain management from the Tertiary, Acute, and Community Integration portfolios
  - Karen Omelchuk – Director Health System Planning (Co- Chair)
  - Dr. Alan Stewart – Senior Medical Director Community and Residential (Co-Chair)
  - Amanda Parks – Coordinator Health System Planning
- Attempts will be made to balance members across IH's geography, sites, and portfolios

B. Term

One year.

C. Accountability

The PSSC is accountable to the project Executive Sponsor - Vice President Planning & Strategic Services.

D. Authority

The PSSC is an advisory committee to the Vice President Planning and Strategic Services.

E. Meeting Frequency and Administration

- Meetings will occur approximately every 4 weeks or at the call of the Chair.
- Staff support, preparation and circulation of agendas, minutes and background information will be provided by Planning and Strategic Services.
- Meeting minutes will be circulated to all members in a timely manner.
- Members will submit agenda items to the Chair in advance of the meeting.

F. Quorum

- A majority of members must be present to achieve quorum.
- All members will be voting members.
- The intent is to make decisions by consensus, however when consensus cannot be reached, majority will rule.

V. COMMITTEE AND TEAM LINKAGES

- Interior Health portfolio leadership teams
- Divisions of Family Practice / Inter-Division Strategic Council
- Interior Health Integrated Care Coordination Committee

VI. KEY REFERENCE DOCUMENTS

The committee's work will be guided by the following key documents:

- Interior Health's Strategy Map
- Interior Health's *Charting the Course: Planning Principles and Considerations for Change*

Appendix C: Inventory of IH Pain Services – Synopsis of Results

Survey Methodology

- A web link to an electronic survey was sent via email to Senior Leadership teams across the clinical & community portfolios
- In some instances, duplicate responses for the same service/program were received. These responses were compiled into single responses where evident.
- The survey was open from July 6th to July 27th, 2012
- A total of 55 responses were received
- A total of 17 responses were fully or significantly completed
- The majority of responses (88%) identified the pain program/service as an IH service (n=15)

Results

This section highlights the key results of the pain services inventory survey.

Result #1: Pain related services offered by location

The table below summarizes the responses received for the pain services inventory survey. The results are presented by program/service name and then by the city/community where the services are provided.

Table 1: Summary of the Pain Services by Location

Program/ Service Name	City/ Community	Involves a multi-disciplinary team	Provides Medications	Provides Interventional/ Diagnostic Treatments	Provides Psychological therapies	Provides Rehabilitative therapies	Provides Physical therapies	Provides Complimentary Alternative Medicine
IH Renal Program	IH Wide	x	x		x	x		
Pool Maintenance exercise program	Kelowna					x		
KGH Occupational Rehab Program (*restricted to WCB and ICBC clients)	Kelowna	x				x	x	
KGH Pain Clinic	Kelowna		x	x				
Residential Services	West Kelowna	x	x				x	x
Residential Services	Vernon	x	x (If GP prescribed)			x		x
VJH Pain Clinic	Vernon		x	x				

Program/ Service Name	City/ Community	Involves a multi-disciplinary team	Provides Medications	Provides Interventional/ Diagnostic Treatments	Provides Psychological therapies	Provides Rehabilitative therapies	Provides Physical therapies	Provides Complimentary Alternative Medicine
PRH Pain Management Clinic	Penticton		x	x				
Residential Services	South Okanagan Residential	x	x			x		x
Community Mental Health & Substance Use	Kamloops	x	x		x	x	x	x
Independent practice	Salmon arm		x	x	x		x	
Shuswap Pain Services	Salmon Arm	x	**Not indicated/provided**					
Diagnostic Imaging (Nelson)	Nelson			x				
KBRH pain clinic	Trail		x	x				
Diagnostic Imaging (Trail)	Trail			x				
Sparwood Primary Care Centre Pain Service	Sparwood				x			x
Community Nursing	Williams Lake	x			x	x	x	

For the 8 pain services/programs that indicated the involvement of a multidisciplinary team in the assessment, treatment and follow-up of patients, Table 2 (below) provides the further details on the disciplines involved.

Table 2: Breakdown of the disciplines involved in the pain service/program

		Multi Disciplinary Team Members								
Program/ Service Name	**City/ Community**	**Admin Support**	**Nursing (RNs, LPNs, NPs)**	**PT**	**Social Work**	**Occupational Therapist**	**Psychologist**	**Psychiatrist**	**GP**	**Specialist**
IH Renal Program	IH Wide		x	x	x				x	x
Residential Services	Vernon		x	x		x				
KGH Occupational Rehab Program	Kelowna			x		x	x	x	x	
Community Nursing	Williams Lake		x	x		x			x	x
Residential Services	South Okanagan Residential		x	x		x				
Shuswap Pain Services	Salmon Arm	x		x		x	x		x	
Community Mental Health & Substance Use	Kamloops	x	x	x	x	x		x	x	x
Residential Services	West Kelowna		x	x		x			x	

Result #2: Chronic Pain Experts in Interior Health

In addition to the specific pain related services being provided in each of the communities, respondents were also asked to identify chronic pain experts within Interior Health they were aware of. Table 3 below provides the responses that were received.

Table 3: List of Chronic Pain Experts in Interior Health Identified by Respondents

• Community Services in Vernon has an outpatient chronic pain team located at VJH as part of the rehab dept.
• KGH Occupational Rehab Program , Neil Pearson, Penticton Physiotherapist
• There is an anaesthetist in Salmon Arm name?. There are also a handful of family MDs with their methadone RX license but prefer not to be named (for obvious reasons).
• KGH: Drs Jefferys, Etheridge, Van Heerden, Squire, Cleveland, De Wet, Lourens, Trow, Duncan
• Its the Kamloops DFP- can't recall the xact name, but can get it Divisions of Family Practice/Chronic Pain Committee: Dr. Shirley Sze, Dr. Rob Baker, Dr. Lyn MacBeath, Dr. Boris Gimbarzevsky, Dr. Mandy Manak, Dr. Jill Calder, Dr. Krista Bradley, Kerry McLean Small, Ayesha Hussan, Rae Samson
• Pain clinic at KGH; ? link with KGH above? Diane Stockwell at Hospice is available for consultation, Botox treatments via Dr Laidlow
• Dr. Alistair Duncan – location?
• Dr. John Crowther
• Dr Nial Davidson

Result #3: General Comments on Chronic Pain Services

The table below lists the general comments on chronic pain services that were received in the survey.

Table 4: General Comments on Chronic Pain Services

• Presently our chronic pain services are evolving and there are preliminary documents provincially to support future work within this area *[Renal]*.
• Chronic pain conditions are not included in the regular KGH Outpatient Physiotherapy admission criteria. If chronic pain conditions are treated by a given Outpatient Physio department, they are a relative low priority, as all IH outpatient services are directed more to hospital discharges, rather than chronic conditions.
• This program [KGH Occupational Rehab Program] incorporates many proven concepts in chronic pain management. Unfortunately, it is restricted to WCB and ICBC clients, as the program exists solely on the revenue that it brings in.
• Dr.Reid sees the patients and treats the patients with the assistance of an LPN or RN [if] they are available to assist as we don't have a funded program. This clinic is on a Tuesday on his day off, he arranges all DI support if needed. The RN or LPN books his patients and provides follow up if needed. The consults are all sent to Dr.Reid via mail as he doesn't have an office at KBRH as he is a full time anaesthetist *[and]* am unsure who he may [refer] these patients to as he sees the patients on his own if the staff are assisting in another clinic.
• I have often felt 'isolated' for the majority of my career in pain management. I am delighted to see that IH is starting to take a proactive approach in helping people with chronic pain and will help in any way I can.
• No support services including nursing, physio . Lack of hospital time and support for procedures in hospitals which involve equipment usually located in hospitals such as fluoroscopy.
• Would welcome ability to refer complex patients to a multidisciplinary pain management team

Addendum – Kamloops Pain Services

Several health care providers in Kamloops have been meeting as part of a Chronic Pain Committee with support from the Thompson Division of Family Practice. This committee has provided further information on the current pain services in Kamloops.[49] The table below outlines existing practitioners and services for chronic pain management in Kamloops.

Practitioner	Pain Expertise and Services
Dr. Rob Baker Certified addiction medicine and chronic pain management	• Specializing in addiction medicine and chronic pain management including pharmaceutical therapy, minimal to moderate intervention, lidocaine infusion, prolotherapy, and trigger point injections • Family practice with methadone exemption • Certified in addiction medicine (CCSAM, CISAM)
Dr. Brownlee **Neurosurgery**	• Medicine Degree for the University of Calgary • BSC degree at the University of Ontario, MSC from the University of Toronto • Internship through UBC at St. Paul's Hospital in Vancouver, B.C. followed by Neurosurgery Residency training at the University of Calgary • In 1996 he obtained his Fellowship of the Royal College of Physicians and Surgeons • member of the American Board of Neurological Surgeons • Since 1996 to today he has been performing Clinical Practice Neurosurgery at the Royal Inland Hospital in Kamloops, British Columbia.

[49] Thompson Tertiary Chronic Pain Centre Business Case. First iteration for discussion purposes. October 29th, 2012. Prepared by the Thompson Region Division of Family Practice.

Dr. Krista Bradley **Family Medicine**	• RN, BN, MD, MSc, FCFPC • Family physician with specific interest in chronic pain management
Dr. Jill Calder **Physiatry**	• MD, BSR; duly qualified physician licensed to practice medicine in the Province of British Columbia • Fellow of the Royal College of Physicians and Surgeons of Canada in Physical Medicine & Rehabilitation • Clinical Director of Tertiary Rehabilitation Services for Royal Inland Hospital • qualified Electromyographer and member of the Canadian Society of Clinical Neurophysiologists • Medical Degree is from Queen's University (MD, 1986) • degree from the University of British Columbia with dual qualifications in Physiotherapy and Occupational Therapy (BSR, 1982) • Current office practice is heavily weighted towards the assessment and management of chronic pain, chronic neurologic disease, and post-traumatic impairments; Hospital-based practice has been biased towards rehabilitation of acquired brain injury and complicated orthopaedic cases
Karen Cooper	• Community Physiotherapist with 22 years' experience • Post graduate courses in chronic pain • Lead chronic disease management programs as part of our role in Home and Community Care
Dr. Tim Dundas **WorkSafe BC**	• 24 years in full service family practice with CCFP certification • Past 12 years Medical Advisor, WorkSafe BC • Chair of the WorkSafeBC Physician's Liaison Committee, and a member of the WorkSafeBC Physician Education Initiatives Committee, and the PSP MSK Content and Packaging Committee. • Past 12 years studying the assessment and treatment of chronic pain • Particular interest is in the documentation of the assessment and management and course of chronic pain with a focus on the functional outcomes • Interested in promoting the development of models for multi-disciplinary community based chronic pain management that is focussed on cognitive-behavioral approach rather than procedural and pharmacological interventions. The frequency of co-morbidity in this patient population is recognized
Dr. Ruth Farren **Family Medicine**	• BSc MD CCFP • Family practice • Methadone Clinic methadone/suboxone exemption • Palliative care/Hospice • King St MH&SA • General practice
Dr. Boris Gimbarzevsky	• MD, 12 year history of treating chronic pain • ABIM certification with recertification in 2007 • Has taken a number of chronic pain management courses including Pain Champions program in 2008 • Psychiatric interests include eating disorders (and provide medical services to eating disorders clinic) as well as Bipolar disorder – on Eli Lilly advisory boards 2004-2007 • Pursuing Methadone License • half time hospitalist and half time practice at Summit Medical clinic • Pre-med school background in neurophysiology and pharmacology research for 12 years

Dr. Robert Gully **Anesthesiology**	• M.D. from the University of Alberta, FRCP© • Fellowship in anesthesia with experience in epidural and caudal steroid blocks, stellate ganglion blocks, lumbar sympathetic blocks , trigger point injections, prolotherapy, peripheral nerve blocks to treat acute and chronic pain
Ayesha Hassan **Pharmacy**	• BSc (Pharm), ACPR, MSc (Palliative Care) • Clinical Pharmacist, Outpatient Parenteral Therapy (RIH) • Clinical Instructor, Faculty of Pharmaceutical Sciences (UBC) • Certified Facilitator, Chronic Pain Self Management Program (Uvic) • Skilled in chronic pain assessments, medication management (including extemporaneous compounding), specialty infusions (e.g. SC lidocaine, ketamine), CBT for insomnia.
Dr. Michael Kowbel **Anesthesiology**	• Bsc (Physiology), M.D., F.R.C.P.C. © • Anesthetist with Interventional Therapy Training
Dr. Mandy Manak **Addiction Medicine**	• Treatment of chronic pain in patients with concurrent addictive disorders – particularly prescription drug addiction or abuse – and other coexisting mental and personality disorders. • Clinical Director of the Interior Chemical Dependency Office, where medical and behavioural intervention for individuals with prescription medication or other chemical dependencies is offered. • Adjunct treatments include intra-articular and trigger point injections, in-house support groups for opioid dependent chronic pain patients, private counselling services.
Dr. Charles Marke **Psychiatry**	• Psychiatrist with special training in Addiction Medicine • Instigated the development of the Kamloops Outpatient Detox Facility
Dr. Lyn MacBeath **Psychiatry**	• MD, FRCPC, ABAM-certified • Certified in psychiatry (FRCPC) and addiction medicine (ABAM, CCSAM) • Specializing in concurrent psychiatric issues and chronic pain (including addiction) • Committed to collaborative care, group medical visits and the use of Telehealth services to provide optimal multidisciplinary assessment and treatment for patients in urban and rural settings.
Kerry McLean-Small **Public Health**	• Master of Nursing Studies • Past 15 years in MHSU services • Current Clinical Supervisor for Counseling Services • Expertise in Addictions, Mental Health, Concurrent Disorders • Current member of Provincial Advisory Committee for Trauma Informed Practice • Current Community MHSU Project Lead for Trauma & Chronic Pain.
Dr. Ian Mitchell **Emergency**	• FRCP Emergency Medicine • Interest in pain management
Dr. Bruce Newmarch **Family and Emergency Medicine**	• BSc, MD (UBC), CCFP (EM) • Family and emergency medicine focus • Interest in chronic pain management
Dr. Orlando Passerin **Family Medicine**	• Family practice with methadone and suboxone exemptions • Specializing in addiction medicine and chronic pain management • Currently working at the interior chemical dependency office • Actively attend workshops and conferences in addictions and chronic pain.
Dr. Prathap Raghavan **Physical Medicine and Rehab**	• MD, BSR; duly qualified physician licensed to practice medicine in the Province of British Columbia

	• A Fellow of the Royal College of Physicians and Surgeons of Canada in Physical Medicine & Rehabilitation and currently Clinical Director of Tertiary Rehabilitation Services for Royal Inland Hospital; qualified Electromyographer and member of the Canadian Society of Clinical Neurophysiologists • Current office practice is heavily weighted towards the assessment and management of chronic pain, chronic neurologic disease, and post-traumatic impairments; Hospital-based practice has been biased towards rehabilitation of acquired brain injury and complicated orthopaedic cases
Dr. Dave Ritenburg **Addiction and Chronic Pain**	• Addition and Chronic Pain Management • Methadone/Suboxone exemption
Rae Samson **Mental Health/Substance Use**	• MSW • CIHS Manager, Mental Health and Addiction Services
Dr. Shirley Sze **President** **Thompson Region Division of Family Practice**	• BMSc, MD (distinction), CCFP, FCFP • long standing family physician in Kamloops and member of the Palliative Care/Hospice physician team • President of the Thompson Region Division of Family Practice • PSP Champion since the program's inception in 2007 • Presenter at Institute of Healthcare Improvement on topics on Patient Self Management and day long workshop on Patients as Partners • Organizer of a number of Pain Management Conferences for our community • Taken the Pain Management Primer by Dr. Roman Jovey • Member of the Provincial Advisory Committee for the rollout of the GPSC PSP Pain Module • Familiar with intra-articular and trigger point injections

Appendix D: Stakeholder Interview Summary

How can we best capture need / demand for within IH?

- High demand, but need to articulate what the need is – what is the true waitlist for pain services
- What is the volume of people not addressing their pain?
- 25-30% of population have chronic pain but may not accessing services – hard to determine how much service to plan for
- Hard to get data - no billing code for chronic pain

What are the biggest gaps in service for clients in IH experiencing pain?

- long waitlists for specialists at tertiary sites
- patients are often unable to access effective pain services
    - can result in ineffective treatment of their chronic pain in emergency rooms
- lack of coordination for comprehensive chronic pain services
- concern and frustration among GPs to support patients with chronic pain
    - complex nature of chronic pain: physical, emotional, mental
    - problems with prescribing and addictions
    - FFS model doesn't work for chronic pain as it takes a long time for the patient to tell their story
    - lack of education, training, and support for GPs to deal with patients with chronic pain
- lack of education and training for other health professionals
- patients without extended medical coverage often can't access other disciplines (PT/OT/Massage)
- gaps and poor management of acute pain – this can lead to chronic pain
- gaps in cancer pain treatment

What are your top 3 recommendations for improvements?

- multidisciplinary teams including GPs, specialists, psychology, physiotherapy, occupational therapy, pharmacy, nursing, nutrition, and more
- community based resources for pain management including smaller satellite sites for pain management, community based pain clinics, supports such as self management, patient education, and assessment
- equipment at tertiary sites (i.e. C-arm), and linkages of tertiary site to sites in communities
- education and support for GPs including CME, PSP module, practical tools, lists of resources available for patients, strategies for methadone, mentorship network, and telephone consultation to specialists
- coordinated approach to pain services including central intake and triage and building on / linking with existing resources where possible (i.e. IHNs, heart function clinics, chronic disease models, Telehealth, etc
- prevention of acute pain becoming chronic and the use of public health principles in a model for pain management
- other innovative approaches to pain management included: use of recreation facilities for pain services, pain champions in the community, patient navigators, a best practice network, evaluation, clear discharge criteria, group visits, outreach, and a mobile pain unit

Other models / aspects in pain management to consider

- patients learning to see pain from a new perspective – it won't be cured, but can live better with pain
- other funding models including 3rd party payers (ICBC, Worksafe) and industry supports for GP education
- potential role in pain management of Nurse Practitioners and Clinical Nurse Specialists
- link between pain management and addictions

Appendix E: Interior Health Pain Strategy Physician Survey Results

Interior Health is working with partners and stakeholders to develop a comprehensive Pain Strategy for adults with chronic non-malignant pain. As part of assessing the current state and identifying gaps in services, both providers and patients will be involved in a variety of ways including surveys, interviews, focus groups, and committee work.

To inform the Pain Strategy, we conducted an online survey with physicians through the Divisions of Family Practice in the region. The purpose of this survey was to gather information from physicians about services currently being offered to patients with chronic pain and to gain an understanding of the biggest gaps and areas for improvement in services for chronic pain.

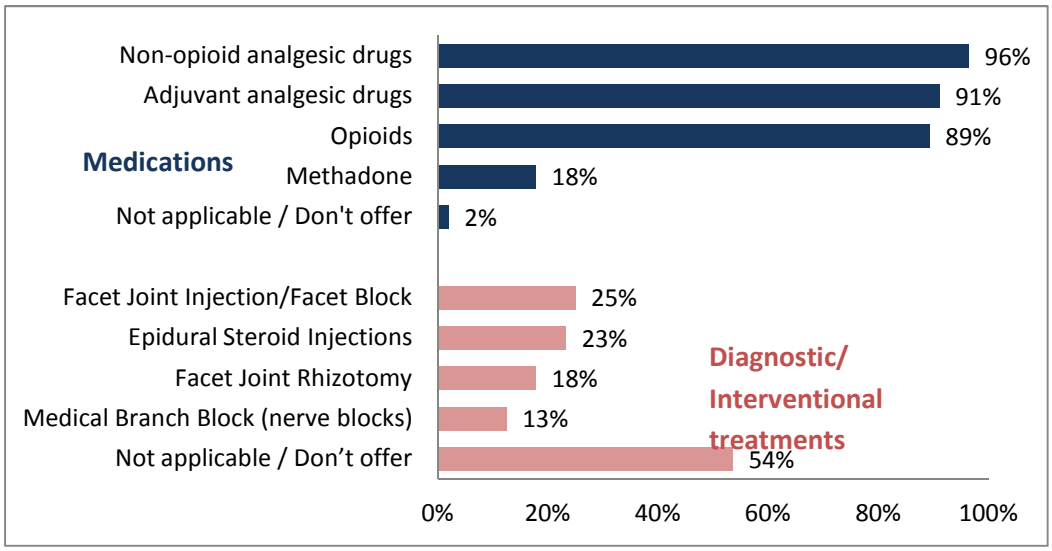
A total of 56 online surveys were completed with participation from 4 Divisions of Family Practice – Central Okanagan, Shuswap/North Okanagan, East Kootenay, and Thompson[50]. Table 1 outlines the percentage of responses and rates from each Division that participated.

Table 1: Response Rates and Percentage by Division of Family Practice

Division	*Percentage of total responses*	*Response rate for Division*
Central Okanagan	*37.5%*	*12.1%*
Shuswap / North Okanagan	*19.6%*	*11.0%*
Thompson	*30.4%*	*14.0%*
East Kootenay	*12.5%*	*10.9%*

CURRENT SERVICES OFFERED

Figure 1 below indicates the percentage of physicians who responded indicating they offer the following medications and interventional/diagnostic treatments to their patients with chronic pain.



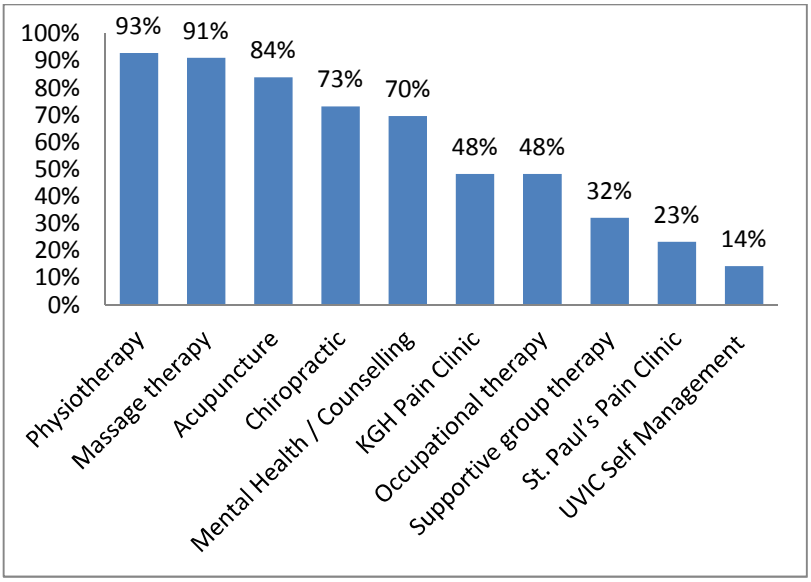
[50] It should be noted that the Kootenay Boundary Division of Family Practice completed their own survey related to chronic pain. The results of that survey have also informed the development of the IH Pain Strategy.

When indicating what other services physicians offer patients with chronic pain, 96% of the physicians who responded refer to other health professionals.

Other Services and Resources

Physicians who responded indicated the following other services and resources they are aware of their patients accessing for chronic pain.

Figure 2: Other services and resources patients access for chronic pain



Gaps and Important Improvements

Survey respondents listed the 3 biggest gaps in services in the Interior region for patients with chronic pain. The major themes arising were:

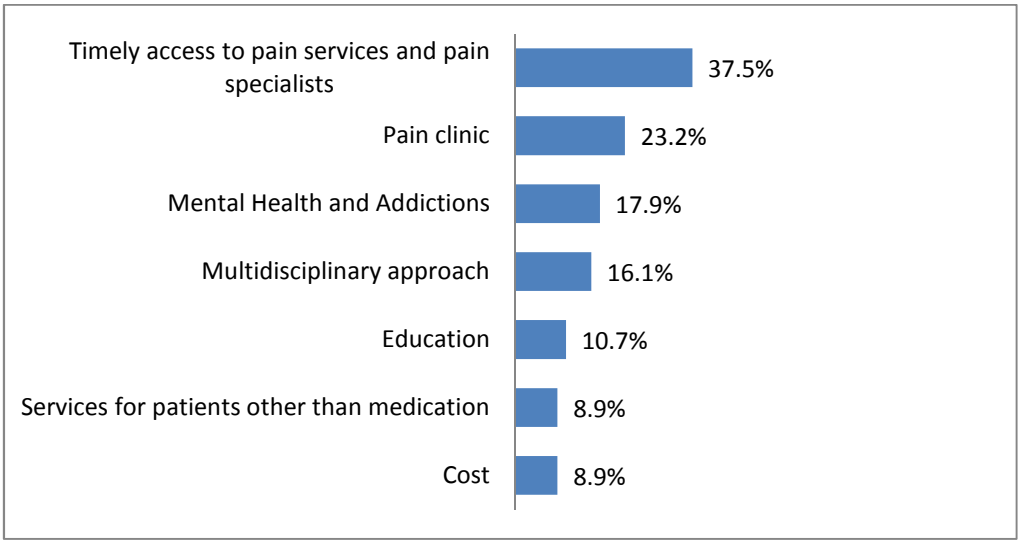
Table 2: Major Themes

Theme	Description
Wait times	The long waitlists to see specialists and to get into pain clinics. Delays in accessing pain services, consults, and operations needed for patients to manage pain.
Access	Access to pain specialists, to diagnostic tools, to interventional pain services, to procedures for pain management.
Pain Clinic	There is no 'pain clinic' for timely, comprehensive pain management including assessment and treatment.
Mental Health	Ability to access counselling, ongoing mental health support, and psychiatric care that specializes in pain and addiction.
Specialists	There is a lack of pain specialists. Need for more expertise in the area and easier/timely access to pain specialists.
Multidisciplinary Approach	No multidisciplinary pain service, program, care team, or approach to pain management.
Prescriptions/ Addictions	Over prescription of narcotics, opioid abuse, dealing with the addiction side of chronic pain, and overall poor monitoring of patients taking opioids.
Geography	Problem with the geographic distance to pain clinic and lack of coordinated services at a local level.

Cost	The cost of allied health services is a barrier for clients.
Other	Lack of coordinated care, GPs having the time to adequately work with these patients, education and access to those knowledgeable about pain management, CME, and education for patients.

Survey responses for both the gaps and improvements needed for pain management highlighted several key themes. Of the themes above, the most responses for important improvements needed were in the following areas:

Figure 3: Most important improvements



Additional Comments and Quotes

In addition to the noted gaps and areas for improvements above, some of the GPs noted the difficulty of working with patients with chronic pain in the Fee for Service setting. They simply don't have the time to spend with these patients who need a more thorough assessment. The are funding issues with medications for patients that aren't covered by Pharmacare. Given than many of these patients are unemployed or low income, the additional cost of allied health services and medications can have a substantial financial burden on these patients.

There are issues with geography and an inequitable impact on rural patients when it comes to accessing services for pain management. Patients in rural communities often don't have access to the same pain services as those in urban sites and having to travel for services can be a large barrier to patients in chronic pain who can't travel.

Notable physician quotes:

"It's very frustrating to try to provide care without appropriate services/support."
"[Pain is] Probably the most neglected area."
"Getting a patient to a pain specialist or clinic is just a dream, I have almost given up trying."
"Patients need more than having more and more narcotics prescribed to them."
"Most patients and physicians tend to under treat pain because they are afraid of addiction."

"Far too many seem to go no further than getting their drugs prescribed. Majority become marginalized, deconditioned and emotionally and socially isolated."

Appendix F: Patient Focus Group Summary

Interior Health is working with partners and stakeholders to develop a comprehensive Pain Strategy for adults with chronic non-malignant pain in the region. As part of assessing the current state and identifying gaps in services for adults with chronic pain, both providers and patients will be involved in a variety of ways including surveys, interviews, focus groups, and committee work.

A key part of assessing current services for adults with chronic pain is to involve patients in the region who have experience chronic pain. The purpose of conducting focus groups with patients and family members in the Interior Region was to gather input about their experiences accessing chronic pain services and what they identify as the critical gaps and areas for improvement for services for patients with chronic pain.

In partnership with the Patient Voices Network, Interior Health conducted 3 focus groups and an online survey for patients in the region. A total of 18 patients participated.

Findings - Major Themes

Major Themes	
Information / Resources	Patients need access to a list of resources available to them as a patient with chronic pain. Similar to other programs in IH, when patients leave the hospital or access another service, they could be given a list of resources of what is available in the community. Patients talked a lot about their lack of knowledge of what services are available in IH and how they did their own research online to find other specialists and health professionals to help manage their pain.
Role of GP	General Practitioners are the gate keepers of information and access to other health professionals for patients. Many patients felt they had to advocate strongly with their GP in order to get referrals to other health professionals. They acknowledge the lack of training and resources available to their GPs and felt this was a key area for improvement. Doctors as well as patients need to be educated and know what resources are available to manage chronic pain. Patients expressed the importance of their GP doing more than just prescribing medications and knowing who to refer patients to when they cannot offer them any more help themselves.
Multidisciplinary Assessment and Treatment	The list of services and health professionals patients have accessed is extensive and includes a broad spectrum of care providers including physiotherapists, occupational therapists, massage therapists, chiropractors, naturopathic doctors, dieticians, psychiatrists, many physician specialists, and more. Patients noted the importance of these disciplines in helping to manage chronic pain and the need for a comprehensive team approach to pain management. Not all patients benefit from the same service, but having a team assessment and the ability to access the services that will work for them at an affordable rate will help the patients manage their pain effectively with the right health care providers.
Holistic Approach	There is a strong link between chronic pain and mental health. Patients had both experiences with co-diagnosis of chronic pain and a mental disorder as well as the emotional and mental health impacts of chronic pain. Health care providers need to acknowledge the link between a patient's physical and mental health and treat the person as a whole. Both the physical and mental health of patients needs to be acknowledged by all care providers and treated and managed in a holistic way. One patient noted that until all of the areas related to the chronic pain are addressed, the cycle of chronic pain will continue.

Experiences and Areas for Improvement

Pain Clinic

"can you imagine if a hospital had all these people available that you're going to deal with, you don't have to go to anyone else"

"If Interior Health could be convinced how important the pain clinic [at KGH] is and provided space and equipment, fewer patient's would clog the Dr's offices and hospital's emergencies."

While there were several comments about the great experiences at the KGH pain clinic, the long waitlist and lack of ongoing visits to the clinic were noted. Patients recommended some kind of pain clinic where they could access the different disciplines on an ongoing basis. A patient advocate or nurse phone line was a suggestion for how patients in the community managing their pain could access additional help when their pain worsened or to find out about other resources available to them.

Mental Health

"[The] psychological effects of unrelenting chronic pain"

"Many patients will receive too much pain relieving medications and end up with severe depression and this is treated with more medications. Many will eventually try suicide to get attention and too many of those succeed."

There were several comments and agreement between patients about the overwhelming impact of chronic pain and the toll it takes on their lives. The emotional trauma caused to them and their loved ones was noted by many of the participants. The issue of suicide and its link to chronic pain was prominent in the conversations and should be acknowledged in a comprehensive system for chronic pain that includes the mental health of the patient.

Understanding Pain

"pain is not obvious, not like having your arm cut off" / "chronic pain is often an invisible condition"

"When I am doing something like talking to my Doctor or like the workshop, I can ignore the pain for a while. But only for so long, and that can give people a wrong impression, because they think that you are ok. Chronic pain saps your energy and you can only keep it up for so long."

Patients expressed the importance of physicians and other health care providers being able to understand pain and listen to the patient's experience of pain. The issue of 'being a good patient' and trying to describe pain to a medical professional conflicts with the feeling of complaining and feeling like a hypochondriac. Patients need someone to listen to their experience of pain and be solution based to help them find what will work for them to help manage their pain. Education about the anatomy and physiology of pain, the appropriate use of medications, and chronic pain and what it is will be important for both patients and health care providers.

Cost

"[You] don't know what's going to work ahead of time so can spend a lot of money trying to find what works"

While patients were in agreement about the need for a multitude of health professionals to be involved in pain management, they recognized the large barrier of cost. They have experienced the additional costs to access allied health professionals, travel for treatments, physical activity programs, and medications. This is unsustainable for patients unemployed or low income and even for those that do work and have benefits. Cost and the travel required for treatment will be key considerations for an effective pain program for the region.

Appendix G: IH Pain Service Administrative Roles and Responsibilities

Administrative Lead – 1.0 FTE

Priority[51]	Responsibilities
1	With Medical Co-Lead, lead the establishment of pain clinics across the health authority. This includes working across portfolios to secure location and equipment, hiring staff, developing policies, procedures, standardized forms, intake and triage processes, discharge criteria, and implementing the service delivery model for the levels in the Stepped Model of Care. (Level 2 and Level 1)
1	Provide oversight on the development and implementation of the education strategy directly supervising the work of the Project Coordinator / Clinical Lead.
1	Develop strong relationships, collaborate and build partnerships with internal and external stakeholders including leadership in Acute Services, Community Integration, Allied Health, Pharmacy, Lab, Diagnostic Imaging, IMIT, Divisions of Family Practice, family physicians, specialist physicians, Interior Health corporate portfolios, Pain BC, other non-profit groups, potential funding partners, and academia to establish the IH Pain Program.
1	Lead the transition of the Pain Strategy Steering Committee to the Pain Program Advisory Committee and continue to act as chair of this committee for the pain program.
1	Investigate and pursue external partnership and funding opportunities including the Arthritis Foundation, the Vancouver Foundation, and the Ministry of Health.
1	Act as the central point of contact and representative for pain management services within the health authority.
2	Working with the medical co-lead and mental health and substance use programs, establish the roll out of the use of the Canadian Guidelines for Safe and Effective use of Opioids and integrate chronic pain services with mental health and substance use service delivery where appropriate.
2	Develop measurement and evaluation framework for the delivery of clinical care and for the Pain Program itself.
2	Partner with Chronic Disease Management and Prevention/Promotion portfolios to develop and implement strategies for the prevention and early intervention of chronic pain. Partner with acute pain management across the health authority to ensure evidence based care, minimize the risk of progression to a chronic condition and integrate acute and chronic pain service delivery as appropriate.
2	Assess Telehealth opportunities.
2	Partner with academic researchers and facilities to enhance the evidence base for chronic pain services and strengthen research capacity within the health authority.

[51] It is acknowledged that all responsibilities must be addressed for a well functioning pain system. Priority refers not to the importance of the responsibility, but rather highlights areas that will first require focus.

Medical Co-Lead – 1.00 FTE

Priority	Responsibilities
1	In partnership with the Program Lead, facilitate the establishment of IH Pain Program.
1	Provide medical leadership and physician oversight of the Pain Program. This includes ensuring quality care by engaging physicians at IH sites to facilitate standardization and the delivery of safe, evidence informed care.
1	Work with the Practice Support Program to ensure implementation of physician education and professional development events.
1	Develop and implement an approach to link and work with the Divisions of Family Practice including involvement in the RACE initiative.
2	Liaise and/or participate in other internal planning committees , groups, etc. as required.
2	Assess ability to support community physicians and health care providers with Telehealth by linking them to higher levels of care within the network.

Project Coordinator / Clinical Lead – 1.00 FTE

Priority	Responsibilities
1	Compile a comprehensive list of pain management resources (provincial, health authority wide, and by community) for patients and providers.
1	Develop and implement an education strategy for front line providers in both acute and community settings on chronic pain and chronic pain services considering multiple communication channels and education approaches and including a scan of existing tools and resources used. Incorporate self-management classes / group workshops and resources into the care process including building partnerships with existing self management / group programs in the region.
1	Support Program Lead and Medical Co-Lead to establish the IH Pain Program.

Data Analyst / IMIT Support – 1.00 FTE (this position will functionally report through Interior Health's Information Management and Support portfolio)

Priority	Responsibilities
1	Develop and ensure standardized data entry processes and a shared electronic system for health care providers across the IH Pain Program.
1	Working with the Program Lead, establish the intake and triage system ensuring functionality across IH sites and services.
1	Establish systems to ensure the relevant data to support service delivery and program evaluation is collected.
1	Prepare reports as required to support planning and quality improvement.
1	Explore opportunities to create pain flag in Meditech