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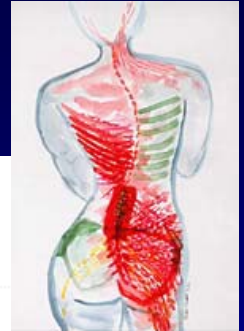
*Faculty of Medicine*

  
**NOVA SCOTIA**

**Health**



**Capital Health**



# **How to Improve Access to Services for Chronic Pain Using a Collaborative Model**

## **The Development of Nova Scotia Chronic Pain Services**

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Collaborative Care Network**

# Situation in NS (pre- 2006):

- Growing number of complaints to DoH from patients and professionals about long wait lists at the Pain Management Unit in Capital Health
- In Fall of 2005, the Acute & Tertiary Care Branch commissioned a report, *Review of Pain Management Services in Nova Scotia*.
- The Report:
  - A patchwork of chronic pain services in the province
  - Wait times of approximately 16 months in Cape Breton and up to 5 years at the Pain Management Unit in Halifax
  - Lack of trained professionals and poorly organized services

# Development of an Action Plan

- Working Group formed in January 2006 to develop an Action Plan for an integrated approach to chronic pain management

## **Road Map of Action Plan:**

- **Priorities** - Levels of care, Access, HHR, Education, Standards
- **Four levels of care** - Prevention/Early Intervention/Community, Primary Care, Secondary Care, Tertiary Care
- **Enablers** - Appropriate payment, Resources (human, capital, operating), Core maps

# Recommendations

- 1) **A Chronic Pain Model** for N.S.– a model for delivery of comprehensive pain services in N.S.
- 2) **Prevention**– working with the DHPP on chronic disease prevention for chronic pain
- 3) **Self-Management**– liaise with existing programs
- 4) **Triage**– development and implementation of expanded triage tools
- 5) **Senior Administration Support**– gain support of senior administrator for the enhancing chronic pain services

# Recommendations

- 6) **Telehealth**— exploration of a consultation service for community physicians
- 7) **Communication**— better coordination through a seamless system
- 8) **Common Wait List**— exploration of one list for patient care
- 9) **Post-Secondary Education**—support for expansion of undergraduate and post-graduate pain programs
- 10) **Education & Training**— assistance for CME for all health professions

# Recommendations

- 11) **HR and Remuneration**– supply of health care providers, appropriate payment models for physicians caring for patients with chronic pain
- 12) **Navigation**– care pathways through the system to help providers and patients
- 13) **Best Practices**– support best practice guidelines for chronic pain treatment in the province
- 14) **Promote and Support Research**– recognizing the importance of research for chronic pain

# Recommendations

- 15) **Transition**– improved facilitation of patients moving between levels of the system, including transition between IWK and CDHA
- 16) **Liaison with WCB**– maximize outcome opportunities with the WCB
- 17) **Evaluation**– use common measurement to evaluate the provincial pain programs

# Chronic Pain Model for NS

- Funding of \$1M annually announced 2006 for the implementation of the Chronic Pain Model
- Implementation highlights five action items
  - Establish an Implementation Committee and recruit an Implementation Coordinator
  - Establish Primary Services in three districts
  - Establish Secondary Services in two districts
  - Enhance existing Secondary and Tertiary Services
  - Address Self Management/Education for Primary Care Providers

# Establish New Primary and Secondary Services

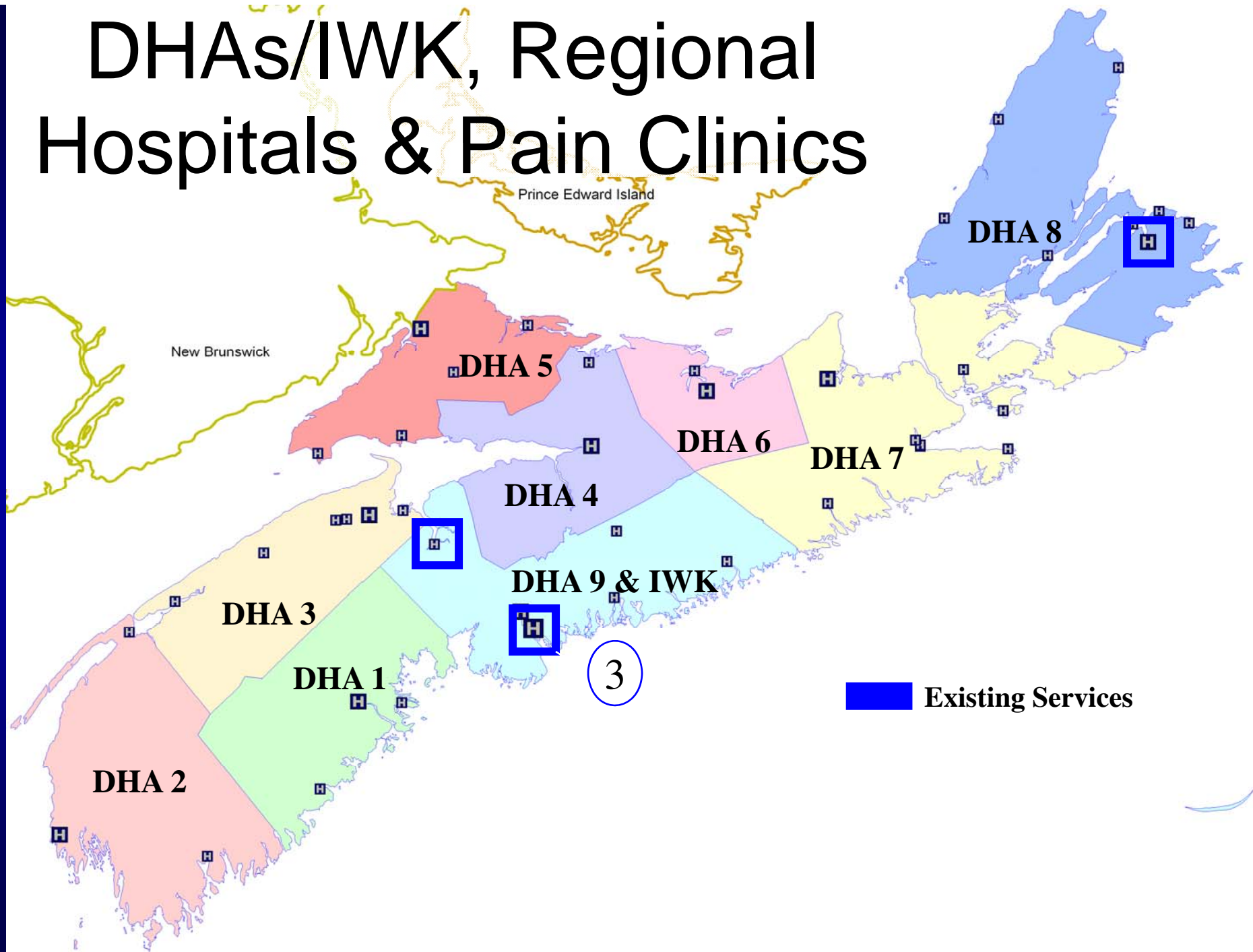
Primary services operate 1 day/week with access to:

- Family physician with interest/training in pain management
- Physiotherapist and/or Occupational Therapist,
- Case Manager
- Administrative support
- \* Psychology/Psychiatry Services

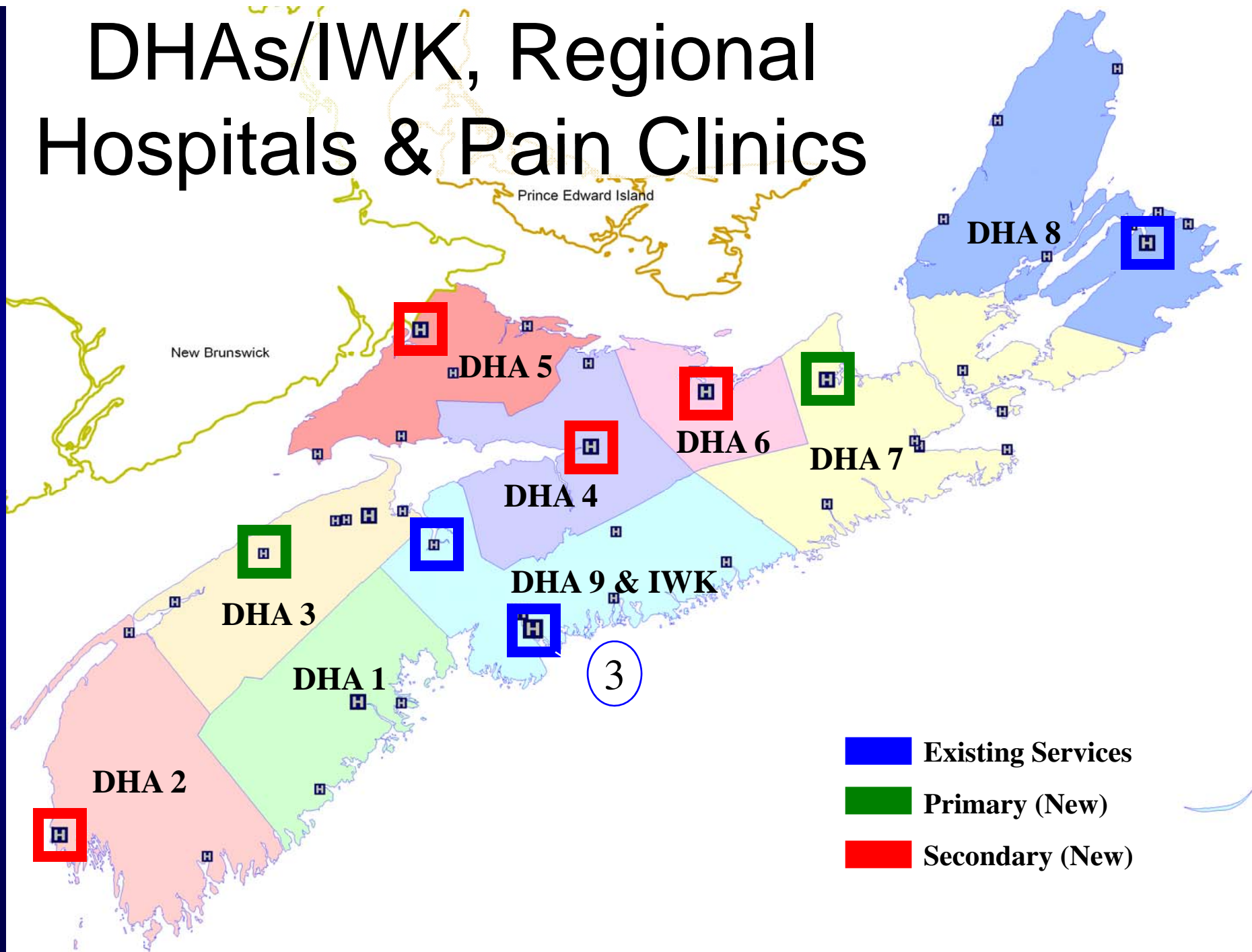
Secondary services operate 1-2 days/week with access to:

- Physician with interest/training in pain management
- Access to anesthesiologist
- Psychiatrist or Psychologist
- Physiotherapist and/or Occupational Therapist
- Case Manager
- Administrative support

# DHAs/IWK, Regional Hospitals & Pain Clinics



# DHAs/IWK, Regional Hospitals & Pain Clinics



# Self Management

## **Original focus:**

- Establish linkage to the CDM strategy to provide access to Self Management opportunities provincially

## **Current focus:**

- All sites have SM programs based on the program offered at the PMU
- Creating collaborations among clinic teams to share knowledge & experiences
- Considering a standardized chronic pain SM program that could be offered through Primary Health Care clinics to increase program availability

# Educational Initiatives

- Annual Multidisciplinary Educational Conference
- DHA specific Pain Educational opportunities
- Dalhousie University - increase pain management education in Health Professions

# Provincial Approaches

- Standardized processes for
  - Referral
  - Triage
  - Assessment including: Medical, Psycho-social, Functional
- Coordinated provincial referral process
- Wait list validation and redistribution project
  - Contact and ensure patient still requires services
  - Offer a transfer to a new clinic if appropriate services available

# Educational Initiative for Primary Care Physicians

- 3-day Intensive Training program through the PMU at Capital Health for physicians affiliated with pain services
- Nova Scotia Chronic Pain Collaborative Care Network (NSCPCCN) Pilot

# Evaluation

- To assess if new model indicates positive change in patient/referring Primary Care Physician experience
- To validate the multi-disciplinary model
- To determine any areas for improvement and develop recommendations for future services based on evaluation results

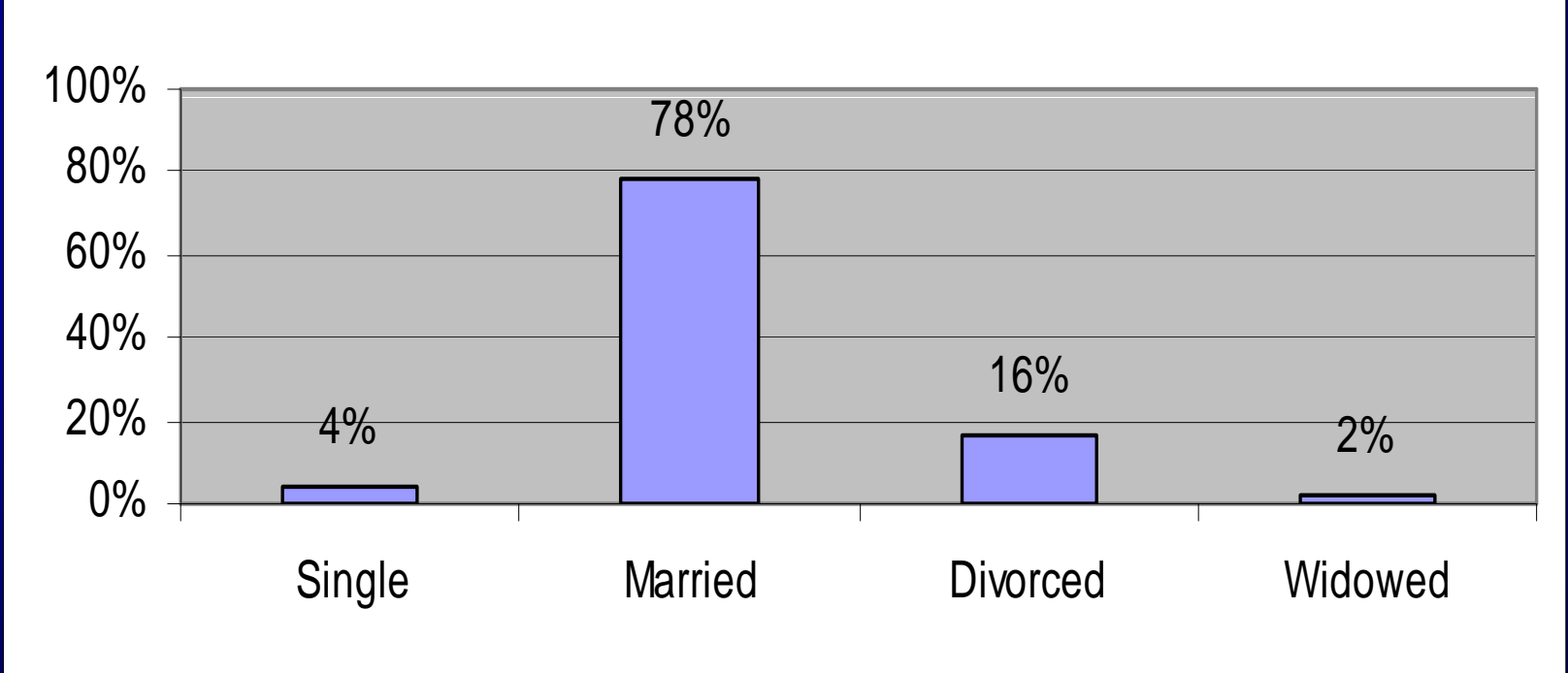
# Evaluation

- Evaluation Period - September 15, 2008 to February 15, 2009
- Sample Size – 54 patients
  - Yarmouth -13
  - Berwick-14
  - Truro - 16
  - GASHA -11
- Outcomes measures
  - Demographics\*
  - Clinical Outcomes
  - Satisfaction\*
  - Wait Times

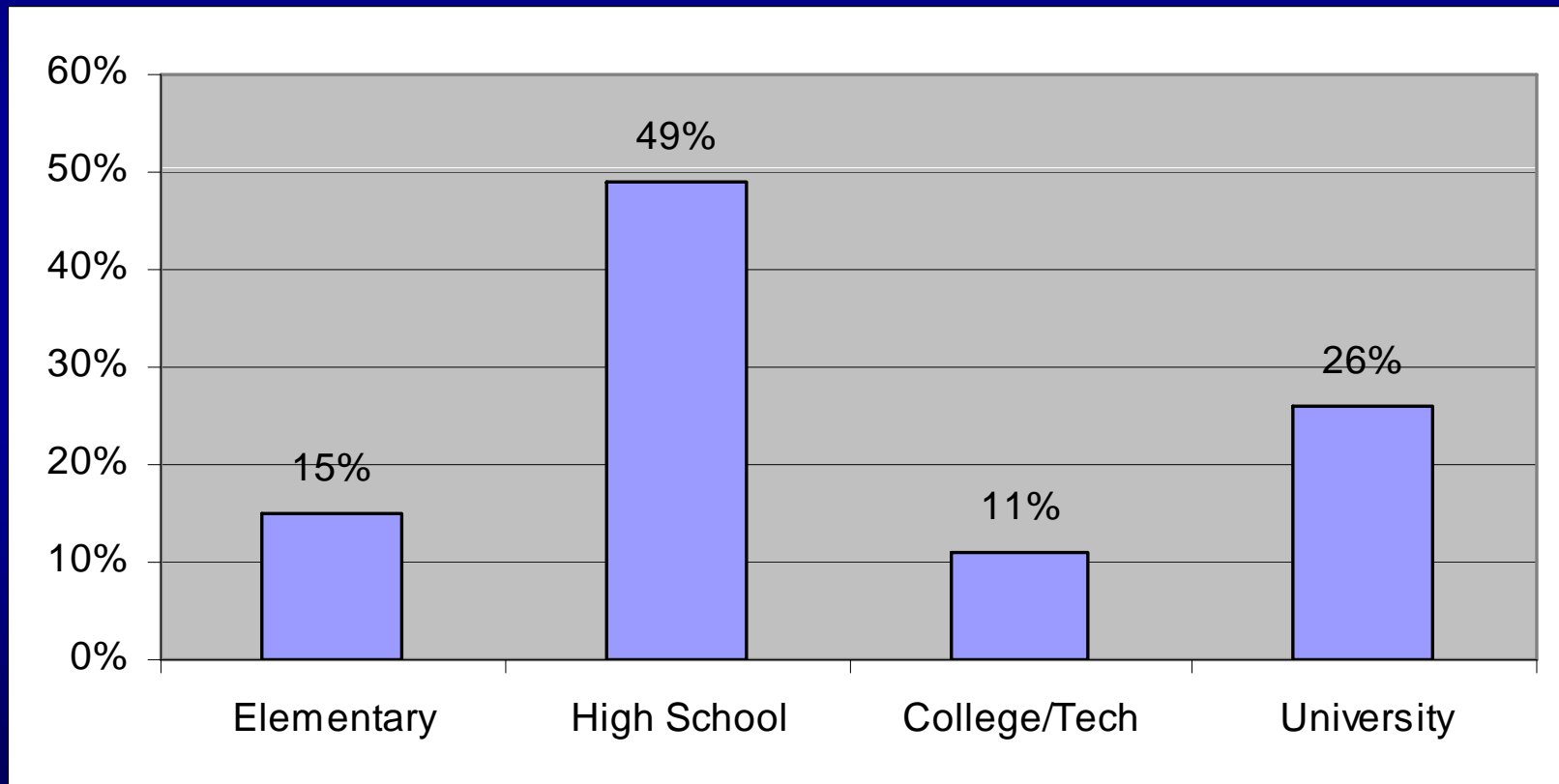
# Demographics

- Average Age
  - 49 years (range = 26 to 85)
- Gender
  - Males - 50%,
  - Female - 50%

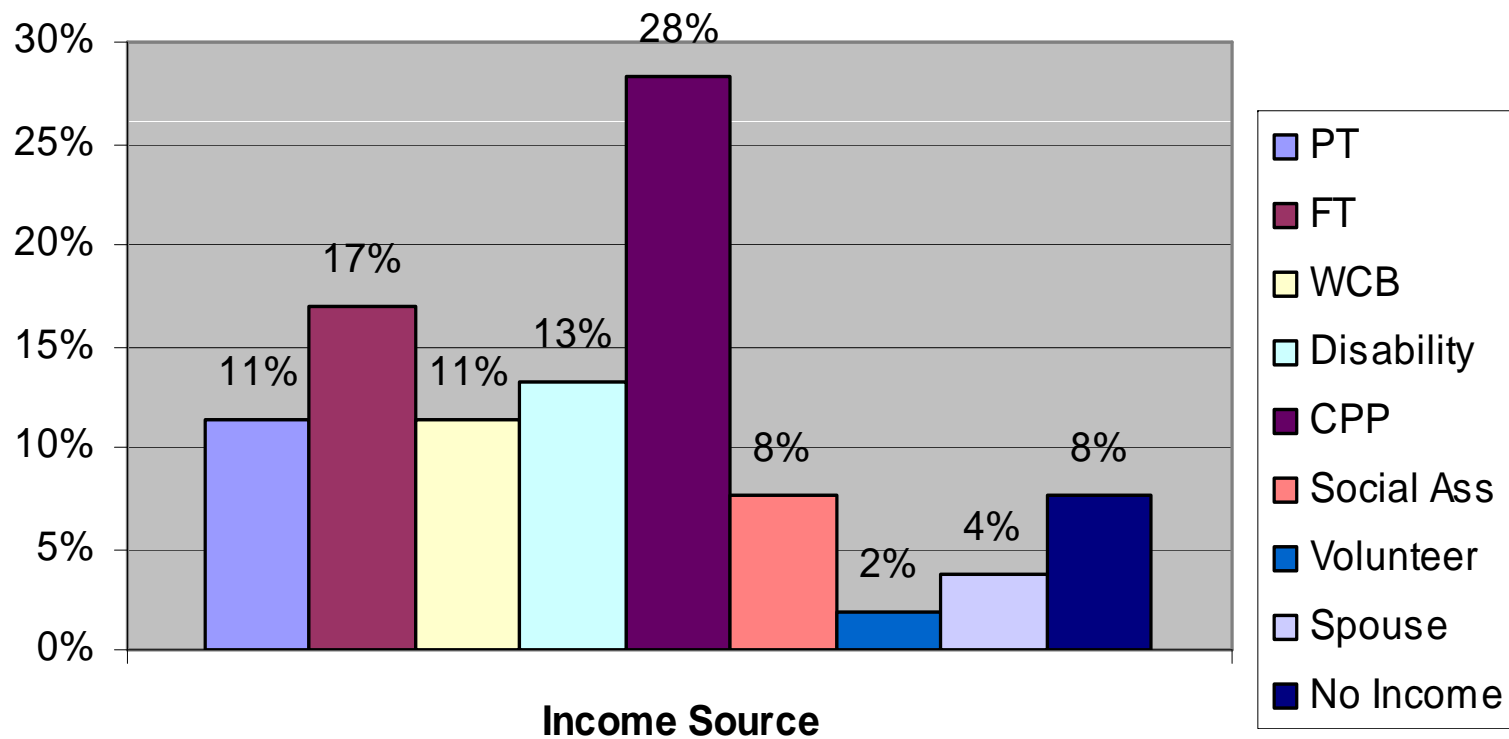
# Marital Status



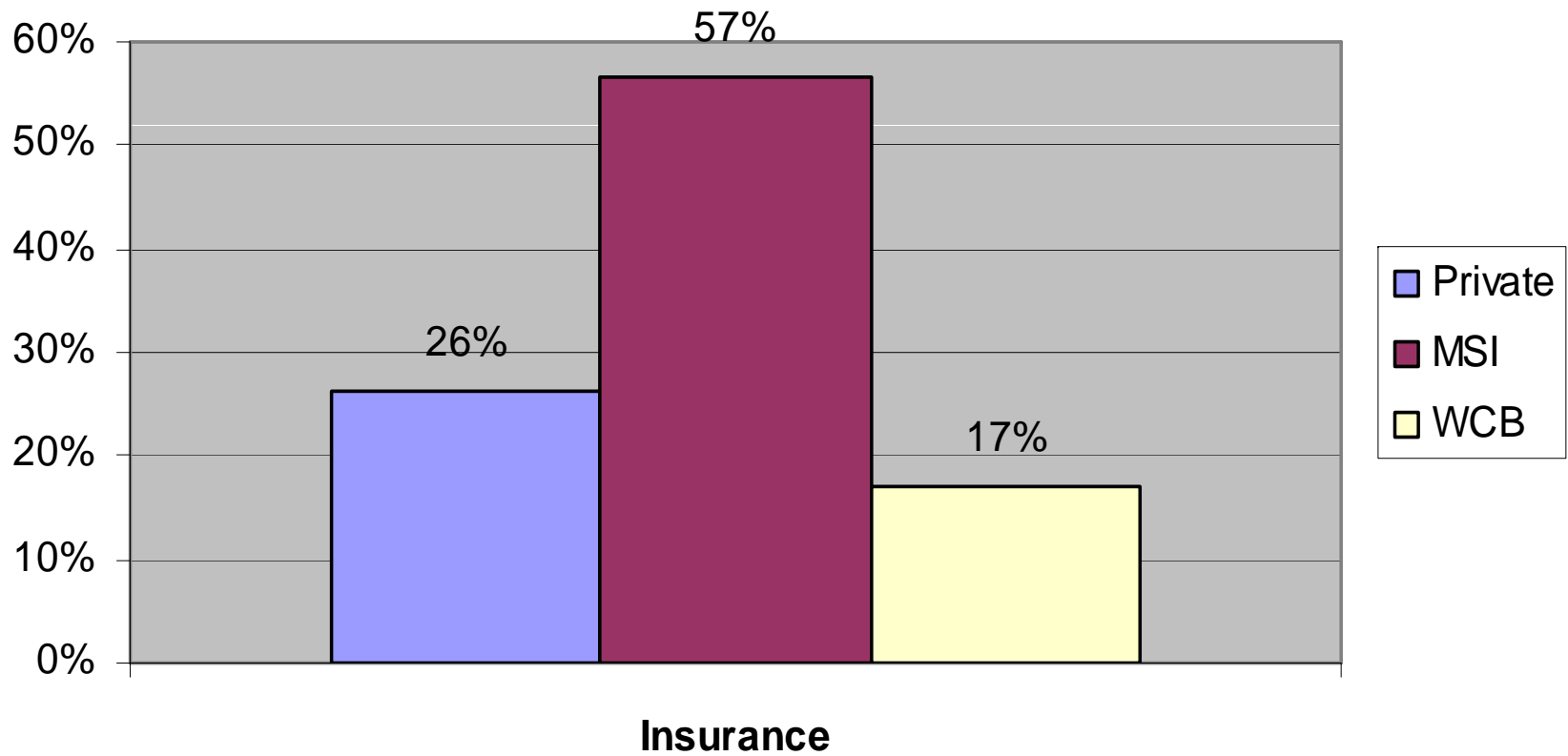
# Educational Level



# Income Sources



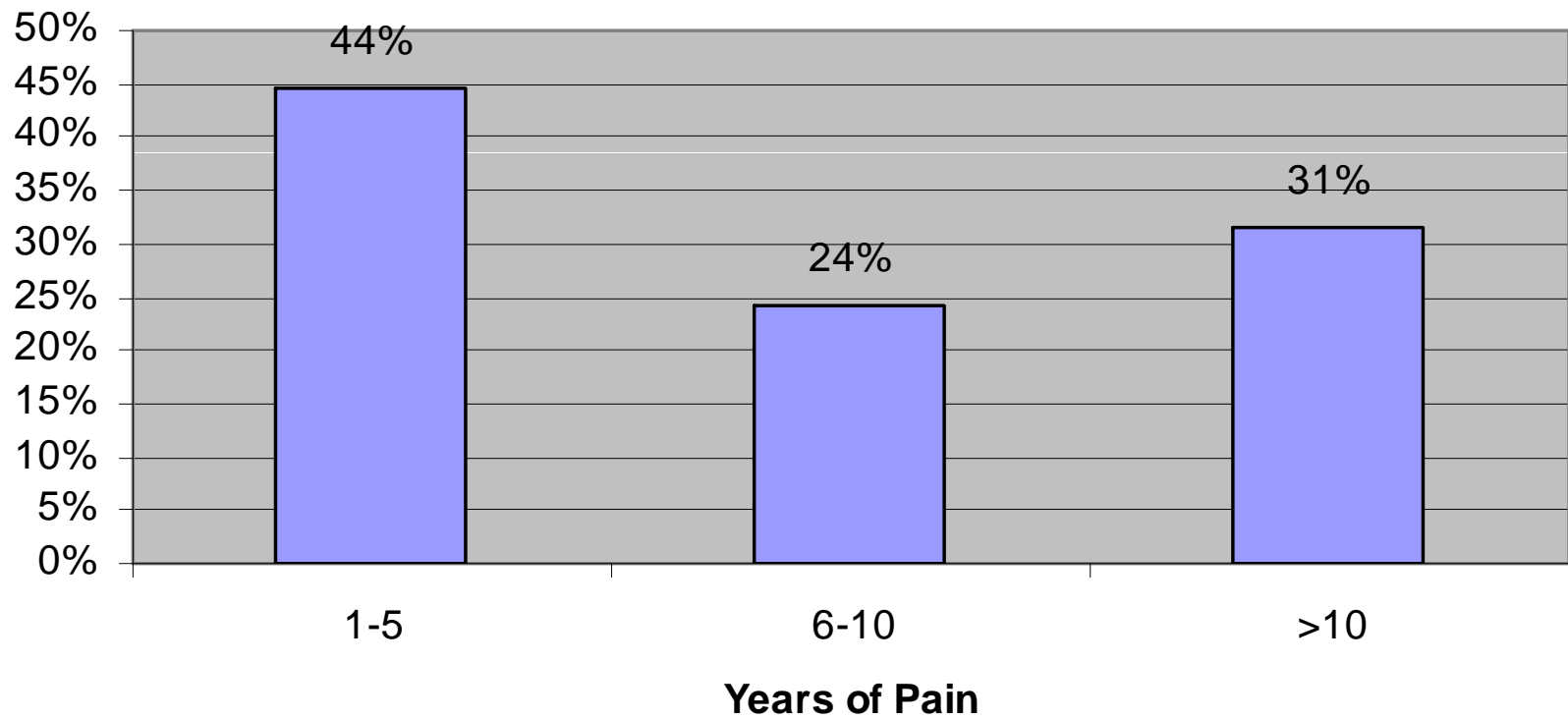
# Insurance Coverage



# Pain Profile

- Average # of specialist seen prior to referral to pain clinics: 4 – 5
- Number of physician referring to pain clinics: 46
- Average Pain Intensity: 7.1 (range 5 -9)
- Patient with Mental Health issues: 67 %
- Patient No shows rate: 13%
- Patients Discharge from Pain Services: 11%

# Average years of Pain



# SM Recommendation

- Patients referred to SM after interdisciplinary assessment: 59%
- Barriers to attending SM
  - Family Obligations
  - Unable to Travel
  - Financial considerations
  - Working

# Patient Satisfaction (N=15)

- Indicated close to home services as positive
  - Agreed or strongly agreed – 12
- Access to the pain clinic helped treating CP problem
  - Agreed or Strongly Agreed -15

# Patient Satisfaction

- Services received helped them live better with chronic pain
  - Agreed or Strongly Agreed-13
- Pain clinic plan was communicated and followed by referring MD
  - Agreed or Strongly Agreed-8

# Patients Comments

- Services could be improved by:
  - Open more often (9)
  - Access to services too late, too long wait (6)
  - Hard to Travel-(pts from SS)(7)
  - Better communication of plan with PCP-(5)

# Patient Comments

- About the pain clinic:
  - Very Good (13)
  - Impressed with the team-they knew what they were doing (10)
  - Positive Environment-they were very open (9)
  - I don't like all the talking stuff (1)

# Patient Comments

- More Information about:
  - Medication and side-effects (6)
  - Sleep Issues (7)
  - How to talk to/deal with employers (3)
  - What these clinics are about before you come (5)

# Patient Comments

- Other Resources to help with my chronic pain condition:
  - Community supports-pools, exercise (5)
  - SM closer to home or transportation (4)
  - Easier access to recommended medications and services (7)

# Physician Satisfaction (pending)

- Satisfaction Survey Questions
  - CP Practice Demographics (3 questions)
  - Impact of CP on practice (6)
  - Impact of CP on HC resources (5)
  - CP and Medication management (5)
  - Resource needs (3)
  - CP educational support (2)

# Lessons Learned

- SM during clinic hours decreases time available for assessments
- No Shows may be reduced with consistent orientation programs
- High rates of mental health issues
- Care-plans & Discharge Planning necessary
- Lack of CP mgt knowledge among community care providers
- Inequity of access to ancillary care providers based on insurance coverage
- Transition Processes

# Next steps

- Move from Implementation committee  
⇒ organizational structure that includes
  - Central coordinator and medical director
  - Medical advisory committee
- Appropriate IT solutions to support coordinated referral system and the network
- Support the new sites
- Support the mentorship network
- Develop standardized guidelines
- Get interdisciplinary education module into medical and health professions curricula

# Action Plan Roadmap:

## **Common Themes:**

- access, education, standards, outcomes, Senior Administrative support, HR

## **Enablers:**

- Payment systems, supply/demand, resources, common standards, communication, core maps

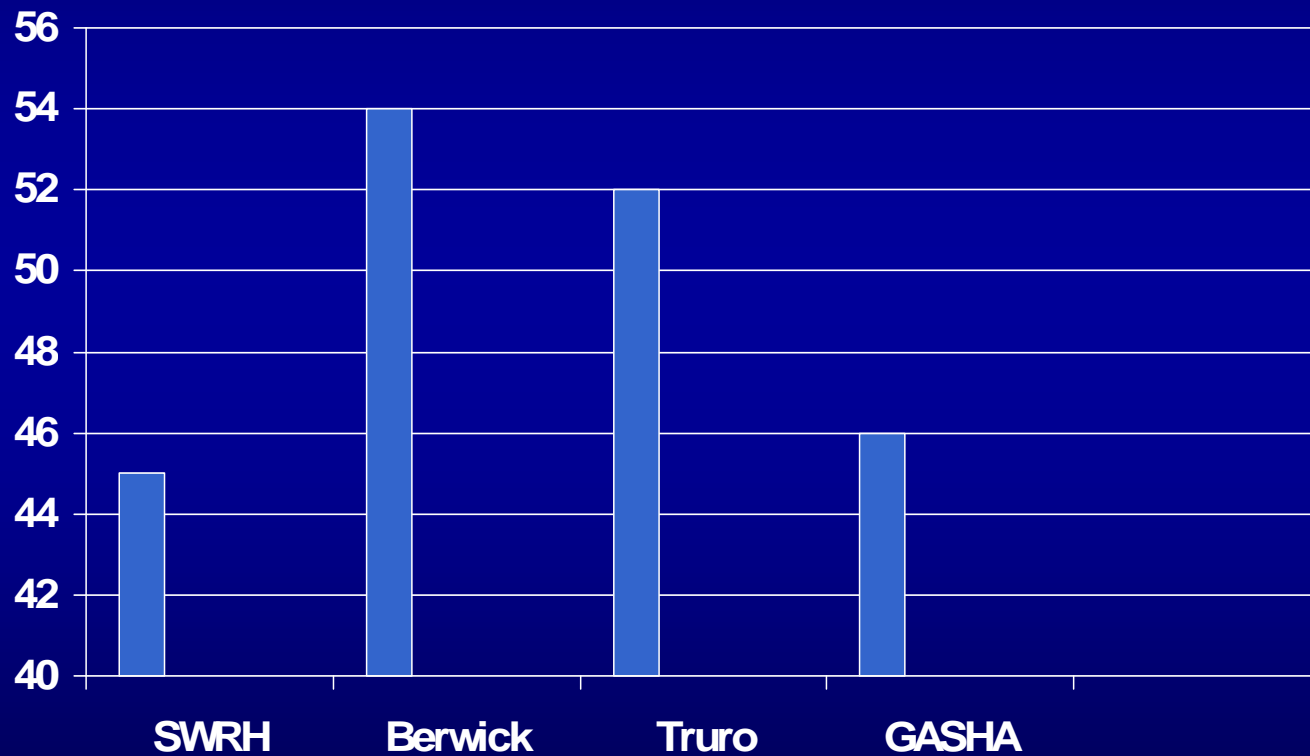
## **Success factors:**

- Return to productive life, access to education, two-way communication, close to home, improved outcomes, monitor/evaluate, efficient, supply/demand balance

# Other recommendations addressed:

- Self management
- Triage
- Senior administrative support
- Communication
- “Coordinated” wait list
- Education and Training
- Remuneration
- Best practices
- Evaluation

# NSCPS Demographic Profile (Average Age)



# NSCPS Demographic Profile (Gender)

