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Erie St Clair Local Health Integration Network

Regional Chronic Pain Management Model Future Vision (Discussion Paper)

Prepared by the
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Ontario
Erie St. Clair Local Health Integration Network
Réseau local d'intégration des services de santé d'Érié St. Clair

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BACKGROUND AND PREVALANCE

A review of current literature on chronic pain in Canada indicated that the prevalence of chronic moderate to severe pain is significant. In a 2001 Ipsos Reid Survey, twenty-nine percent of 2012 adult Canadians reported chronic non-cancer pain with an average intensity of 6.3 (scale 1-10). The average duration of chronic pain reported was 10.7 years. *(1)* Of the 340 chronic pain patients surveyed in greater detail, less than 10% were treated with a major opioid. This led the authors of this study to conclude that chronic pain was undertreated in Canada. Dr. Mark Awuku, Associate Professor of Pediatrics, Schulich School of Medicine and Dentistry, described the growing problem of managing sickle cell crises in hospital, and other chronic pain conditions in children that are undertreated by area practitioners.

The mean number of days respondents were unable to work because of chronic pain was 9.3. Nearly one half of patients reported great difficulty attending social and family events. The prevalence of pain was greatest in the older age group of $\geq$ 55 years, with 49.1% reporting chronic pain.

A second prevalence study was completed in 2007, demonstrating an overall chronic pain prevalence of 25% (not significantly different). *(2)* The incidence of chronic pain in Ontario was also 25%. Chronic pain patients were noted to visit their doctor for pain on average 3.9 times per year. Those in moderate to severe pain visited their doctor 3.1 to 7 times per year, respectively. While mild improvements were reported in pain control since 2001, the authors noted physicians continued to demonstrate reluctance to prescribe opioids.

Most frequent causes of patient reported, chronic non-cancer pain were arthritis and inflammatory conditions (31%), low back and spinal conditions (21%), injury and postoperative sequelae (13%), headache (11%), neuropathic and neurologic problems (11%). Family physicians surveyed noted chronic back pain as the most common cause of patient reported pain (95%). Of note, due to the limits of the survey, these are not necessarily accurate representations of those with chronic pain in our community.

Chronic Non-Cancer Pain

Illustrated below, is the prevalence of chronic pain in three distinct illnesses, suggesting benefits from a chronic pain program.

Multiple Sclerosis: Prevalence in Canada: 240 per 100,000 *(3)*
Prevalence of MS Pain: 71% *(4)*

Interpretation:

Assuming a population of 672,000 in Erie St. Clair, about 1613 Multiple Sclerosis (MS) patients could benefit from the program. The mean indirect health care cost on our community per MS patient in pain is $2,528 (SD +/- 5695) in 6 months. *(4)* Note, hospitalizations and Emergency Department (ED) visits comprised the majority of costs at $745 per patient in six months. This suggests an annual cost for MS pain management of about $8.16 million dollars in Erie St. Clair, of which $2.4 million is related to hospital and emergency services for pain.

Fibromyalgia: Prevalence in Canada: 4.9% adult females, 1.6% adult men
Majority report significant pain (disease feature)

Interpretation:

Assuming a population of 672,000 in Erie St. Clair, about 16,500 women and 5,400 men could benefit from a regionalized pain clinic. Fibromyalgia is a recognized disease that causes central neuropathic pain. Many patients require lifelong pain control strategies including drug therapy.

Diabetes: Prevalence in Ontario 8.8% (2005, present estimate 10%) *(6)*
Prevalence of Pain (moderate to severe) in Diabetes 57.8% *(7)*

Interpretation:

Assuming a population of 672,000, about 39,000 patients could benefit from a chronic pain program in the Erie St. Clair Local Health Integration (LHIN) region.

In addition, the list of other illnesses associated with chronic pain is extremely long. Most prevalent would be mechanical back pain, neuropathic back pain (sciatica) from disc impingement, osteoarthritis and rheumatoid arthritis, traumatic and non-traumatic brain and spinal cord injury. It is noted that there is no local brain and spinal cord injury program in the Erie St. Clair region. The nearest centre is in London at Parkwood Hospital. These patients require significant and long-term support for pain management and rehabilitation.

In conclusion, based on prevalence studies, 25-29% of Canadians live in chronic non-cancer pain. For Erie St Clair this would equate to approximately 168,000 to 195,000 residents living with chronic non-cancer related pain.

Chronic Pain Among Cancer Survivors

The burden of chronic pain among cancer survivors is becoming more significant. Approximately 62% of cancer patients are cured of their illness. The prevalence of chronic pain is likely to rise among this group. Good quality prevalence studies of pain among cancer survivors are lacking.

Anecdotally, Dr. Christopher Leighton (a member of the Erie St. Clair LHIN Chronic Pain Management Task Group) saw a number of consultations in his pain clinic for patients with chronic post-mastectomy or post-thoracotomy pain. Chronic post-mastectomy pain occurs in nearly half of mastectomy patients, the majority of women rating it as moderate to severe pain. It is protracted over years in about 25% of patients.

Chronic Malignant Pain Among Ambulatory Patients

The Hospice of Windsor and Essex County Inc. has been the central agency in this region over the last three decades, to provide pain and symptom management services to those patients with advanced or metastatic malignancy. Ambulatory care clinics have been offered both at the Windsor Regional Cancer Program and the Hospice, but the demand for such services has always exceeded the capacity. Presently, ambulatory pain clinics at the Windsor Regional Cancer Program are no longer offered. The program is now focused on developing an inpatient palliative care program.

The Hospice of Windsor and Essex County Inc. physicians offer minimal service in the way of ambulatory care for cancer patients who have pain, and do not have advanced disease. Only one pain clinic is offered monthly. The need for ambulatory pain management among cancer patients is significant in Windsor and Essex County.

In considering a regional pain program, an initial SWOT (Strengths, Weaknesses, Opportunities, Threats) analysis was completed by members of the Erie St. Clair LHIN Chronic Pain Management Task Group and found the following:

- **Strengths** for a regional pain program (RPP) include: the need level in our community, existing skilled health care providers (family physicians and specialists, nurse practitioners, registered nurses), support for the need to provide integrated pain management, and the ability to train interested physicians in Windsor.
- **Weaknesses** identified include: the potential burden of this patient group (who may lack family physicians), knowledge lapses of appropriate chronic pain management among regional health care providers (physicians, nurses, pharmacists), lack of hospital-based acute pain services, lack of an existing ambulatory pain clinic, lack of an integrated infrastructure, and funding limitations.
- **Opportunities** include the ability to provide pain management support entirely within our LHIN (reducing patient travel and not relying on other LHINs for service), building partnerships with other facilities/health care organizations (hospitals, hospice, Community Care Access Centre [CCAC] etc.), facilitating patient rehabilitation and early return to employment, building partnerships such as with addiction specialists and a chronic pain program, development of an ambulatory chronic pain program with specialist associations (such as anaesthesia), and the reduction of pain related ED visits and fee-for-service OHIP expenditures.
- **Threats** recognized include, that the chronic pain population in our region is “huge”, the excessive costs associated with pain services provided within a hospital setting, lack of financial incentives for “pain” physicians, and the competition for health care dollars.

DESCRIPTION OF CURRENT SERVICES

Sarnia/Lambton: Two anesthesiologists provide outpatient pain clinics at regional hospitals, and also offer interventional pain procedures. This is not a comprehensive service, does not include psychology or social work support, and appears to focus on interventional treatments (and therefore is cost intensive – funding is entirely hospital based). A patient interest group has requested ambulatory pain clinics (which would include epidural and systemic lidocaine infusions).

Dr. Glenn Maddison and an Erie St. Clair CCAC Nurse Practitioner (NP) provide palliative and end-of-life care in a comprehensive and successful model which includes home visits, ambulatory and inpatient care.

Chatham-Kent:

Chronic pain management can be represented by many different types of therapies and services. The following describes the two aspects of care delivery at the Chatham-Kent Health Alliance (CKHA). The physician lead is Dr. Ramin Safakish, who is a Fellow of the Royal College of Physicians and Surgeons of Canada (FRCPC) in Anaesthesia, Adjunct Professor of Anaesthesia at the University of Western Ontario (UWO) and is an Interventionist Pain Specialist certified in radio frequency therapy for pain management. The care modalities at CKHA are supported by ultrasound and radiology for direct visualization and include diagnostic nerve blocks, therapeutic nerve blocks, epidural and intra-articular cortico-steroid injections and sympathetic nerve blocks. As a result of these interventions, patient outcomes are significantly better than other treatment options; which are well received by patients and explain the high demand for continued service.

Currently, at CKHA there are a significant number of chronic pain patients (approximately 600 patients have been served from January – December 2009) being treated in diagnostic imaging via an intra-articular injection of local anaesthetic and steroid that achieves relief for facet-related pain, but is limited in duration to approximately 6 weeks. This temporary relief leads to the chronicity of patient visits and coupled with new referrals, creates a backlog of patients and waiting lists that extends from 18-24 months.

These patients are referred by a family physician to Dr. Safakish at the Ambulatory Care Clinic at Sydenham Campus. An initial assessment and consultation with Dr. Safakish is completed and the patient is either treated and discharged, or referred for intra-articular injection (procedure completed in diagnostic imaging department – approximately 1 day per week); or referred for radio frequency therapy depending on clinical status.

In the Sydenham Campus setting, an interprofessional team (nurse, clinical nurse specialist, physiotherapist, social worker) participate in the both the assessment phase and immediate treatment phase essential for the excellent outcomes achieved.

These patients are referred from across and beyond Erie St. Clair LHIN as there are no other treatment sites of this type with resulting positive patient outcomes. The patients include hospital employees who were on worker's compensation (WSIB) and have returned to full work duties (approximately 10 CKHA employees). Many of these patients frequented the Emergency Services at CKHA as this was their only referral option and their pain management was drug therapy only. The primary care physicians' response has been overwhelmingly positive as these are traditionally a marginalized patient population where there was no access to treatment modalities that had positive outcomes. The projected case volume is 1500 patient visits annually.

There does not appear to be comprehensive approach to pain management i.e. without NP, social worker, or psychologist; little emphasis on pharmacotherapy is noted.

Dr. Sullivan and Dr. Bryan are leading the development of a palliative care and end-of-life care program. An ambulatory clinic has been established and a NP participates in both outpatient care and home visits.

Windsor-Essex: There is no dedicated ambulatory or interventional chronic pain program.

Dr. Jeff Cohen provides ambulatory pain management (and palliative care) as a component of his human immunodeficiency virus (HIV) practice at Windsor Regional Hospital.

A pain clinic offered by anesthesiologists at Windsor Regional Hospital was closed March 31, 2010. Windsor Regional Hospital (Regional Cancer Program) has declined to reopen an ambulatory pain clinic (once weekly) for cancer patients operated by an oncologist from 2006-2009. A full-time palliative care physician and a nurse practitioner have been hired to develop an inpatient palliative care program at the Metropolitan campus. Dr. Gordon Giddings will start in November, and will also act as the Erie St. Clair Palliative Care Lead for Cancer Care Ontario. Dr. C. Sheehan provides inpatient palliative and end-of-life care at Malden Park (Windsor Western Campus).

The Hospice of Windsor and Essex County Inc. (HWEC) coordinate palliative and end-of-life care referrals. Two physicians (1.5 Full Time Equivalent [FTE] total), Dr. Cargill and Dr. Gall, provide home visits, and occasionally provide inpatient consultations at area hospitals. Additional part-time physicians provide end-of-life care at the Hospice residence. Family medicine residents currently spend a one-month rotation at the HWEC.

Patients debilitated with chronic pain from non-malignant and illnesses are seen by the HWEC physicians. Such patients include those with Multiple Sclerosis or advanced rheumatoid arthritis, for example. About 20% of the referrals to the HWEC are not related to cancer. An outpatient pain and symptom clinic is held once monthly on site. An additional physician may assist in ambulatory care in the fall 2010.

Table 1 – Non-Cancer Referrals to the Hospice of Windsor and Essex County Inc.

	Total Number of Referrals	Number of Non-Cancer Referrals	Percentage of Non-Cancer Referrals
2007	842	192	23%
2008	1050	251	24%
2009	1090	207	19%

Courtesy of Sandra Kroh RN, Director of Patient and Family Services

Hôtel-Dieu Grace Hospital has a dedicated Nurse Practitioner for palliative care and pain assessment. Sharon Allen RN, NP assists health care teams within the hospital, both with patient care and educational initiatives. This practice has been very successful by all accounts.

Dr. Sheila Horen provides palliative and end-of-life care at the Leamington District Memorial Hospital.

MAIN PROBLEMS TO BE ADDRESSED

The main problems to be addressed are listed below:

- Improve access to chronic pain management care throughout the Erie St. Clair LHIN
  - Reduce the need for residents to travel outside of the Erie St. Clair LHIN for treatment by a regionalized pain program
  - Facilitate ease of access for patients (improve navigation), with minimal waiting times
- Improve the quality of chronic pain management throughout the Erie St. Clair LHIN
  - Centralized program with representation in all three counties
  - Multidisciplinary and comprehensive patient-centered approach
  - Education for patients and health care providers about optimal pain management strategies and practices.
  - Enlist interested specialists to participate in a regional pain program, supporting on site physiatry, neurology, anesthesia, and neurosurgery patient consultations
  - Coordinate delivery of an integrated care plan, with CCAC and existing programs (The Hospice of Windsor and Essex County Inc., Methadone program, interventional clinics in Chatham-Kent and Sarnia-Lambton, etc.)
  - Evidence based care, to improve quality of life.
  - Certain prescription medications covered by a limited access program through the LHIN-Ministry of Health and Long-Term Care (MOHLTC)
- Reduce Opioid abuse and dependency
- Improve cost-effectiveness for the delivery of pain management
  - Reduce pain-related ED visits (including opioid seekers) and pain related hospital admissions.
  - Utilize existing resources, infrastructure, and trained professionals where possible to avoid duplication of services.
  - Reduce hospital readmissions within 30 days for patients with “selected” pain related Case Mix Groups (CMGs), such as geriatric patients with chronic pain or diabetes complicated by painful neuropathy.
  - Reduce inappropriate pain related referrals to specialists (e.g. mechanical back pain or sciatica referrals to neurosurgery)
  - Reduce physician visits (urgent care, family physician, specialist) for chronic pain management. NP assessment as the initial point of access.
  - Reduce lost days at work and level of pain-related disability
- Promote physician recruitment
  - Train family physicians (part-time) to provide specialized pain management

- Provide physician incentives to facilitate recruitment and retention.

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VISIONING EXERCISE – A REGIONAL CHRONIC PAIN MANAGEMENT PROGRAM

A "Visioning Exercise" for a Regional Chronic Pain Management Program was completed by the Erie St. Clair LHIN Chronic Pain Management Task Group in June 2010 - common themes are noted below:

- **Overall Vision Over the Next 3-5 Years:**
  - Central referral and triage (assessment) process with coordination of existing services
  - Multidisciplinary and interdisciplinary care, comprehensive team based care
  - Educational services for patients, community, and health care providers
  - Evidence based practices
  - Regionalized care (centered in Windsor) with local ambulatory care teams for Sarnia-Lambton and Chatham-Kent residents

- **Key Patient Populations:**
  - Patients in chronic pain with significant impairment in Activities of Daily Living (ADL), or unable to work
  - Prevalent, difficult to manage chronic pain syndromes:
    - Neuropathic pain, including refractory back pain (sciatic) and failed back surgery sydrome; fibromyalgia; post herpetic neuralgia, diabetic neuropathy, multiple sclerosis
    - Chronic inflammatory pain: rheumatic disease (rheumatoid arthritis, systemic lupus erythematosus (SLE), etc.), vascular disease, advanced osteoarthritis for example.
    - Specialized patient groups: elderly, children, renal dialysis patients, opioid dependent patients
    - Conflict over the coverage of cancer patients is noted.

- **Functional Changes in the System:**
  - Coordination of referrals, triage (assessments)
  - Reduction in waiting times for pain management services
  - Reduction in patient travel
  - Coordinated access to addiction services
  - Coordinated patient records (electronic)
  - Decreased ED visits
  - Improved patient navigation
  - Reduced admissions
  - Improved pain control, quality of life, lessen disability

PRINCIPLES OF A REGIONAL CHRONIC PAIN PROGRAM

The ideal program would be:

- **Comprehensive** – Inclusive of all patients with refractory chronic pain (eventually), except those who are suitable for palliative care. Acute and chronic pain would also be appropriate, especially for interventional procedures.

- **Holistic and Patient-Centred** – Regard the patient as a multidimensional person and address pain management from a "total pain" concept, in which one would address the medical, psychological, social work, nursing, and spiritual care needs of the individual. Psychology and social work support would support those individuals with a history of substance abuse or alcohol addiction.

- **Integrative and Community Based** – The scope should eventually be broadened to encompass all residents, including those unable to travel to an ambulatory clinic. Integration with the Hospice of Windsor and Essex County Inc. may avoid duplicate coverage of similar patient groups (with chronic illness and pain) and allow coordination of care.

- **Multi and Interdisciplinary** – True "pain specialists" are extremely rare. The "home base" should include: part-time Family Practitioners with additional training in pain management, and Nurse Practitioners. Depending on the program size, an additional nurse may be required. A Psychologist and a Social Worker, Occupational Therapy and Physiotherapy support, Physician Specialists, clinics with a Pain Specialist, Anesthesia, Interventional Radiology, Rehabilitation Medicine, Oncologist/Pain Specialist, Palliative Care Physician, Psychiatry, Addiction Medicine Specialist, Neurosurgeon, Neurologist.

- **A Leader in Community Education** – Regional continuing medical education programs, in cooperation with the Schulich School of Medicine and Dentistry (SSMD), should aim to provide opportunities to discuss current concepts in chronic pain management and the appropriate use of opioids, gabapentoids, anticonvulsants etc. The regional pain program would serve as an exceptional training opportunity for SSMD undergraduate medical students and post-graduate residents.

MAIN GOALS OF A REGIONAL CHRONIC PAIN PROGRAM

- **Patient Oriented:**

  - Provide adequate pain control to improve quality of life, lessen suffering, facilitate rehabilitation, increase level of function, permit a return to employment and those activities which provide enjoyment and self fulfillment. Ongoing monitoring of patient satisfaction, pain and quality of life inventories, and self-reported visits to other clinicians for pain issues will help to confirm this goal.
  - To reduce the total time required for an individual patient to obtain adequate pain control (by reducing the number of patient visits to family physician, specialist visits, and ED visits).

- **Community Oriented:**
  - To reduce travel for patients presently being referred to London for pain management.
  - As a corollary, to reduce waiting lists for pain related visits to regional tertiary level pain specialists. (Dr. Dwight Moulin, Pain Specialist at the London Health Sciences Centre, has a 6-month wait for non-cancer pain patients and a 3-month wait for cancer patients).
  - To reduce area emergency department wait times by reducing ambulatory patient visits for acute or chronic pain exacerbations.
  - To reduce the inappropriate use opioids in our community related to poor pain control resources.
  - To act as a pain education resource for patients, physicians, nurses, pharmacists, and the Erie St. Clair CCAC. The chronic pain program will provide medical students, postgraduate medical residents, and nursing students a unique and exceptional learning experience. Onsite training will be provided for physicians and nurses new to the program. Continuing medical education activities will be developed for regional physicians in collaboration with the Schulich School of Medicine and Dentistry.

- **Health Economic Oriented:**
  - To reduce ambulatory visits to area emergency departments for pain exacerbations from chronic illness.
  - To reduce hospital admissions for pain exacerbations related to chronic illness.
  - To reduce hospital readmissions, within 30 days, for certain CMGs with chronic pain (e.g. elderly, diabetes)
  - To reduce OHIP fee-for-service expenditures on chronic pain patients, through better pain management, and both physician and patient education.
  - To reduce the number of sick days taken, and to lessen the level of disability related to undertreated pain i.e. to effect the global costs of disability.

CLIENT GROUPS TO BE SERVED BY A REGIONAL CHRONIC PAIN PROGRAM

The following is a comprehensive listing of "ideally" who the program should be serving. The coverage could be introduced in a "phased-in" approach, and also integrated with other regional programs.

- **Neuropathic Pain:**
  - Brain and spinal cord injury patients (traumatic and non-traumatic)
  - Demyelinating Disease – Multiple Sclerosis (technically falls under item a.)
  - Diabetic pain (e.g. peripheral neuropathy)
  - HIV-related pain
  - Refractory neuropathic back and neck pain (failed back surgical syndrome, sciatica, spinal stenosis, severe degenerative disc disease, etc.)
  - Neuropathic orofacial pain (e.g. Trigeminal neuralgia)
  - Fibromyalgia
  - Chronic pain syndromes in cancer survivors

- Chronic pain syndromes in cancer patients with a life expectancy > 1 year (potential overlap with Hospice)

- **Chronic Inflammatory Pain (Nociceptive or Mixed Nociceptive/Neuropathic)–**
  - Chronic rheumatoid arthritis
  - Severe osteoarthritis (refractory pain)
  - Collagen vascular disease (SLE, Ankylosing Spondylitis, etc.)
  - Vascular disease – Ischemic limb, mesenteric angina etc.
  - Renal dialysis patients
  - Chronic pelvic pain (women) – endometriosis, pelvic inflammatory disease (PID)

- **Pediatric Population:**
  - Sickle cell disease (growing prevalence in our community)
  - Chronic pain among cancer patients (disease and treatment related)
  - Juvenile arthritis
  - Chronic headaches (unknown cause)

- **Geriatric population**

- **Considerations for Selecting Priority Populations :**
  - The most prevalent conditions, to reduce pain and suffering among the greatest number in our community (e.g. diabetic neuropathy, fibromyalgia)
  - Conditions of greatest economic burden to our LHIN presently, through ED visits and hospital readmissions
  - Orphaned patients – those with chronic painful illnesses and with limited access to appropriate specialists e.g. rheumatic disease, multiple sclerosis, brain and spinal cord injuries (traumatic and non-traumatic), ambulatory cancer patients

SERVICE TO BE PROVIDED BY A REGIONAL CHRONIC PAIN PROGRAM

Services would be evidence based (Canadian Pain Society endorsed, for example), or held in high regard by a profession such that it is considered a standard of care (*Note: items in italics would be offered offsite, via referral)*:

- **Interventional (describe):**
  - peripheral nerve blocks, epidural (+/- intrathecal) anaesthesia, lidocaine infusions, *vertebroplasty, balloon kyphoplasty*, *implanted spinal cord stimulators*

- **Pharmacologic Therapy:**
  - Anti-inflammatory medication (e.g. NSAIDS), synthetic opioids (e.g. Tramadol), controlled release and immediate release opioids including methadone, anticonvulsants, tricyclic antidepressants, gabapentoids, Serotonin-Norepinephrine Reuptake Inhibitors (SNRI) antidepressants, cannabinoids.. *Coverage of some prescription medication costs could be covered by a LHIN special access program (e.g. coverage of gabapentin, duloxetine, controlled release opioids)*

- **Rehabilitation Therapies:**
  - Physiotherapy, Occupational Therapy, Psychology (liaise with addiction specialists)

- **Complementary Therapies: "Wellness Strategies",**
  - Acupuncture, massage therapy, touch therapy, others, possibly liaise with Hospice programs

- **Self-Management:**
  - Cognitive behavioral therapy (via dedicated psychologist), relaxation exercises, biofeedback, group education and support sessions,

- **Educational/Teaching**:
  - Patient and community oriented education sessions
  - Undergraduate medical student and postgraduate family resident teaching -- Schulich residents to participate in pain program
  - Continuing medical education role in collaboration with the Schulich School of Medicine and Dentistry – regular symposia, citywide "pain" rounds, lectures

- **Telemedicine Patient Consultations**:
  - Clinics with NP/physician or specialists in Windsor supporting Sarnia-Lambton and Chatham-Kent
  - Weekly videoconference patient case conferences, open to regional practitioners

PROPOSED FUNCTIONAL ASPECTS OF THE PROGRAM ACROSS THE ERIE ST. CLAIR LHIN GEOGRAPHY

- Windsor-Essex would become the designated site of the regional chronic pain program with Telemedicine consultative support of satellite centres. Weekly or biweekly videoconference patient rounds. Biweekly outreach clinics would supplement ambulatory care provided in Chatham-Kent and Sarnia-Lambton.

- Chatham-Kent would have a NP and part-time family physician team to provide an ambulatory pain program. Biweekly outreach clinic with Windsor based team (may include occupational therapy [OT], physio-therapy [PT], psychology). Telemedicine clinics from Windsor (specialists) as needed. Liaise with local palliative care physician team to integrate care.

- Sarnia-Lambton would have a NP and part-time family physician team to provide ambulatory pain program. Biweekly outreach support with Windsor based team. Biweekly outreach clinic with Windsor based team (may include OT, PT, psychology). Telemedicine clinics from Windsor (specialists) as needed. Liaise with local palliative care physician team to integrate care.

Rationale:

Patients have viewed Telemedicine consultations for chronic pain very favorably in a study by researchers from St. Michael's Hospital and the Wasser Pain Centre. Cost effectiveness was suggested when round trip distances exceeded 200 km. Studies indicate that patients reported telemedicine preferable to traveling for a physician visit.

PROPOSED STAFFING LEVEL BY TYPE ACROSS THE ERIE ST. CLAIR LHIN GEOGRAPHY

- Windsor-Essex: staffing requirements will depend on the location of integration of the main site. Integration within an existing health care organization (Community health centre, hospital, CCAC, or the Hospice of Windsor and Essex County Inc.) may permit a phased-in introduction of staff.

  In year 1, a full-time nurse practitioner, 1 administrative assistant, 2 family physicians to provide 5 half day clinics weekly, 1 part-time psychologist (0.5 FTE), 1 part-time social worker (0.5 FTE), 0.5 FTE occupational therapist and a 0.5 FTE physiotherapist initially, additional specialists with an interest in pain management (anaesthesia, neurology, oncology, physiatrist, neurosurgery) to provide weekly to monthly half day clinics. In Year 2, an additional nurse and increasing the roles of the OT and PT may be required.

  The Hospice of Windsor and Essex County Inc. has indicated an interest in this proposal. Conceivably, the entire chronic pain program could be delivered on site, on the Hospice campus. The Hospice presently provides pain and symptom management to individuals with chronic pain due to advanced or chronic illness (20% of their referrals are non-cancer related). Therefore, they may be best equipped to assist program development, train staff, and implement a regional chronic pain program given their ongoing activities and experienced professionals. There is ample room on the Hospice campus to expand or build an ambulatory pain centre.

- Chatham-Kent: in year 1, a dedicated nurse practitioner (1 FTE), part-time family physician (2-3 half day clinics), part-time administrative assistant.

- Sarnia-Lambton: a dedicated nurse practitioner (1 FTE), part-time family physician (2-3 half day clinics), part-time administrative assistant.

Rationale:

The STOPPAIN investigators group recently reviewed the role of health care professionals in multidisciplinary pain treatment facilities in Canada* A survey of 102 pain treatment facilities in 2008 indicated that general practitioners, anesthesiologists, and physiatrists were the most common types of physicians integrated in these facilities. Physiotherapists, psychologists, and nurses were the most common non-physician professionals working in them.

* Peng, P. et al. Role of health care professionals in multidisciplinary pain treatment facilities in Canada. Pain Res Manag 2008;13:484-488.

PROGRAM ELIGIBILITY AND REFERRAL PROCESSES

- Access to the program would mirror the previous successful centralized referral process of the Hospice of Windsor and Essex County Inc.:

  - Single point of access – centralized physician or NP referral.
  - Eligibility criteria will depend on patient populations initially targeted. A process below assumes the initial population is patients with neuropathic pain.
  - Triage to appropriate health care provider via NP and family-practice pain specialist, based on initial assessment and previous tests/diagnostic imaging.
  - Urgency of referral to be noted by family practice physician and again at time of triage.

- Chronic Pain Referral Process (Neuropathic Pain):

  i) Standardized patient assessment and referral tool:

  - Include patient history, p/e and any recent test results
  - All patients will have had a (family) physician complete a neurologic examination (standardized form) and indicate the level of pain related disability/pain intensity
  - All referrals will include a completed Neuropathic pain diagnostic questionnaire (DN4) diagnostic instrument for neuropathic pain
  - On initial assessment with the NP, the Brief Pain Inventory (BPI) or Edmonton Symptom Assessment System (ESAS) instrument will be completed
  - The referring physician will be notified by fax if the patient is not appropriate (based on provided information) with a suggestion for an appropriate referral if possible.
  - Patients will sign an agreement to use one pharmacy
  - Patients with a history of substance abuse or addiction will complete a standardized opioid risk tool, meet with the program psychologist, provide an initial urine sample for drug testing, and at the discretion of a team member, agree to random urine drug testing.

  ii) Electronic patient records:

  - All patients will provide consent for the sharing of their medical record with another treating health care provider. The goal will be to provide emergency physicians especially, with electronic access to such records at the time of ED visit.
  - The patient record will include all prescriptions details (those prescribed by the clinic and other physicians)

IMPACTS AND SUCCESS MEASURES

- Anticipated Results:

  - Improved pain control, with a significant proportion of patients discharged to the care of their family physicians within a few visits.
  - Improve the proportion of physicians appropriately prescribing opioids for chronic non-cancer pain while monitoring for misuse
  - Reduction of addiction related behavior (via improved pain control)

- Success Measures:

  - Improved pain control (BPI) and quality of life (ESAS) among index prevalent patient groups: diabetics, failed back surgery syndrome, chronic rheumatic disease for example.
  - Reduced number of ED visits for pain related to chronic illness
  - Reduced number of readmissions within 30 days for pain related reasons among CMGs
  - Reduced number of repeated unplanned ED visits within 30 days for substance abuse conditions

REFERENCES

1. Moulin, D et al. Chronic pain in Canada – Prevalence, treatment, impact, and the role of opioid analgesia. Pain Res Manag 2002;7:179-184.

2. Boulanger, A et al. Chronic pain in Canada: Have we improved our management of chronic noncancer pain? Pain Res Manag 2007;12:39-47.

3. C. Beck et al. Regional variation of Multiple Sclerosis in Canada. Multiple Sclerosis 2005;11:516-519.

4. Piwko, C et al. Pain due to multiple sclerosis: Analysis of prevalence and economic burden in Canada. Pain Res Manage 2007;12:259-265.

5. White, KP et al. The London Fibromyalgia Epidemiology Study: the prevalence of fibromyaglia syndrome in London, Ontario. J Rheumatol 1999; 26;1570-6.

6. Lipscombe, L et al. Trend in diabetes prevalence, incidence, and mortality in Ontario, Canada 1995-2005: a population based study. Lancet 2007; 396(9563): 750-756.

7. Bair, MJ et al. Prevalence of pain and association with quality of life, depression, and glycaemic control in patients with diabetes. Diabetes Med 2010;27:578-584.

ERIE ST. CLAIR PAIN MANAGEMENT WORK GROUP MEMBERSHIP (JUNE 2010)

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Virginia Walsh	Director, Peri-operative Services and Intensive Care Unit	Hôtel Dieu Grace Hospital
Nicole Williams	Administrative Assistant, Medical Director of ICU, LHIN Leads Critical Care/ED	Hôtel Dieu Grace Hospital
Rosemary Lemmon	Clinical Manager, Obstetrics	Leamington District Memorial Hospital
Dr. Christopher Leighton	Adjunct Professor, Department of Oncology	Schulich School of Medicine & Dentistry University of Windsor Campus
Dr. Nathania Liem	Physiatrist, Medical Director	Windsor Regional Hospital
Dr. Americo (Rico) Liolli	Department Chief, Anesthesia	Windsor Regional Hospital
Mohamed-Rida Alsaden	Anesthesiologist	Windsor Regional Hospital
Dr. Sid DaSilva	Anesthesiologist Pain Management Physician	Windsor Regional Hospital Private Practice, Windsor, ON
<u>ESC LHIN Staff</u>:		
Alec Anderson	Regional Planner	Erie St. Clair LHIN
MaryAnn Stirling	Program Assistant, Regional Planning	Erie St. Clair LHIN

*Changed Organizations