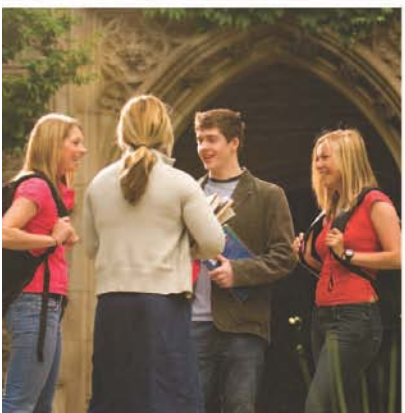




DIALOGUE
SUMMARY

SUPPORTING CHRONIC PAIN
MANAGEMENT ACROSS
PROVINCIAL AND TERRITORIAL
HEALTH SYSTEMS IN CANADA



9 DECEMBER 2009

EVIDENCE >> INSIGHT >> ACTION

**Dialogue Summary:
Supporting Chronic Pain Management Across
Provincial and Territorial Health Systems in Canada**

9 December 2009

McMaster Health Forum

For concerned citizens and influential thinkers and doers, the McMaster Health Forum strives to be a leading hub for improving health outcomes through collective problem solving. Operating at the regional/provincial level and at national levels, the Forum harnesses information, convenes stakeholders, and prepares action-oriented leaders to meet pressing health issues creatively. The Forum acts as an agent of change by empowering stakeholders to set agendas, take well-considered actions, and communicate the rationale for actions effectively.

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Conflict of interest

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SUMMARY OF THE DIALOGUE

Several dialogue participants argued that significant stigma was associated with chronic pain and that this stigma translated into a lack of legitimacy of the need for care, which in turn added to the burden of chronic pain. Some of these dialogue participants argued that having “no recognition of chronic pain as a disease” was a significant dimension of the problem, however, other dialogue participants were not fully convinced by this argument. Dialogue participants generally agreed that effective chronic pain management programs, services and drugs are not always available or accessible to all Canadians, but they also agreed that there are significant gaps in our knowledge about these shortcomings and their causes. Dialogue participants also generally agreed that current provincial and territorial health system arrangements do not support chronic pain management for all Canadians. As one dialogue participant said, “access is terrible and getting worse.”

Several dialogue participants argued strongly that a patient registry/treatment-monitoring system (option 1) was definitely needed in order to support efforts to monitor the implementation of new approaches to organizing chronic pain management and the evaluation of their impacts. Several dialogue participants saw the registry/system as a pre-condition for other options. A number of dialogue participants voiced strong support for the research, patient support and provider support functions that a national network of centres with a coordinating “hub” (option 2) could undertake. Many dialogue participants also supported the idea of a cross-discipline model of patient-centred primary healthcare-based chronic pain management, which could include primary healthcare practices/clinics assuming the primary responsibility for chronic pain management, these practices/clinics having facilitated access to mentoring and support to enable them to fulfil this role, and these practices/clinics being able to periodically engage multi-disciplinary and multi-modal secondary- and tertiary-level supports for patients with more significant complexity.

Several dialogue participants noted that the prospects for success with the registry/system (option 1) were much greater if this option was implemented in the form of a program of research rather than as a government or regional health authority initiative. Some dialogue participants argued that the successful implementation of a national network of centres (option 2) hinged on getting the right champions (clinicians, leaders in teaching institutions, and patients) around the table from the beginning. Several dialogue participants suggested that brokering and supporting the implementation of a cross-discipline model (option 3) could best be facilitated in the short term through demonstration projects, coupled with rigorous monitoring and evaluation, and in the long term through a systematic effort to “move beyond the early adopters.”

One dialogue participant argued that governments won’t take action in the short term, so “stakeholders have to be the ones who make it happen.” The critical step, several dialogue participants argued, was to engage key opinion leaders, both those leading the push for strengthened chronic pain management and those in primary healthcare practices, regional health authorities and government, who can take action. A number of dialogue participants argued that success stories need to be identified, their cost-effectiveness relative to the status quo studied, and the findings from this effort popularized in a systematic way.

SUMMARIES OF THE FOUR DELIBERATIONS

DELIBERATION ABOUT THE PROBLEM

Dialogue participants generally agreed with how the burden of chronic pain, and the stigma associated with it, were described in the evidence brief. Several dialogue participants argued that having “no recognition of chronic pain as a disease” was a significant dimension of the problem that had been overlooked in the evidence brief. They pointed out that acute pain is typically viewed as a symptom of an underlying condition, and that this way of thinking often gets carried over unhelpfully into discussions about chronic pain. One dialogue participant noted that there are no diagnostic codes for chronic pain in the World Health Organization’s classification of disease. Another dialogue participant noted that the lack of recognition of chronic pain as a disease means continued uncertainty about “where to put it” and “where to teach it.” However, several other dialogue participants held a different view, arguing that chronic pain remains a symptom of an underlying condition for many people. These dialogue participants worried that labeling chronic pain a disease would hurt such individuals, even though they recognized that such labelling may be a good political strategy to draw greater attention to chronic pain.

Several dialogue participants argued that significant stigma was associated with chronic pain and that this stigma translated into a lack of legitimacy of the need for care, which in turn added to the burden of chronic pain. These dialogue participants noted that stigma in the workplace and in society more generally (including among third-party payers for healthcare programs, services and drugs) remains a significant problem – a “huge barrier” in the words of one participant. One dialogue participant lamented that “we’re working in tainted ground.” Another dialogue participant suggested optimistically that the stigma associated with chronic pain may be addressed, at least in part, if research about the neuroscience of chronic pain shows it to be a neurological disease.

One dialogue participant noted that drawing parallels to other chronic diseases, including when describing the burden of chronic pain, may not be helpful clinically because of the co-morbidities that often accompany chronic pain. Another dialogue participant reminded everyone that while the dialogue’s focus was on chronic pain, “many transitions into chronic pain can be stopped,” such as after surgery, and that preventing such transitions was another significant challenge (albeit not one to be addressed in this dialogue).

Box 1: Background to the stakeholder dialogue

The stakeholder dialogue was convened in order to support a full discussion of relevant considerations (including research evidence) about a high-priority issue in order to inform action. Key features of the dialogue were:

- 1) it addressed an issue currently being faced in provincial and territorial health systems;
- 2) it focused on different features of the problem, including (where possible) how it affects particular groups;
- 3) it focused on three options (among many) for addressing the policy issue;
- 4) it was informed by a pre-circulated evidence brief that mobilized both global and local research evidence about the problem, three options for addressing the problem, and key implementation considerations;
- 5) it was informed by a discussion about the full range of factors that can inform how to approach the problem and possible options for addressing it;
- 6) it brought together many parties who would be involved in or affected by future decisions related to the issue;
- 7) it ensured fair representation among policymakers, stakeholders and researchers;
- 8) it engaged a facilitator to assist with the deliberations;
- 9) it allowed for frank, off-the-record deliberations by following the Chatham House rule: “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed”; and
- 10) it did not aim for consensus.

Participants’ views and experiences and the tacit knowledge they brought to the issues at hand were key inputs to the dialogue. The dialogue was designed to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. The dialogue was also designed to generate action by those who participate in the dialogue, and by those who review the dialogue summary and the video interviews with dialogue participants.

Dialogue participants generally agreed that effective chronic pain management programs, services and drugs are not always available or accessible to all Canadians, but they also agreed that there are significant gaps in our knowledge about these shortcomings and their causes. One dialogue participant noted that little is known about the degree to which Canadians are receiving effective components of comprehensive chronic pain management (particularly outside multidisciplinary pain clinics), or about healthcare providers' beliefs about and use of different approaches to chronic pain management. A second dialogue participant observed that we "don't know enough about what does work... what's effective" or "what to do for and with those with chronic pain." This individual noted that third-party payers don't like the confusion that arises when there are lots of options and lots of contestation about these options, and that there was a need to find common ground where possible and to point out "here are the people you shouldn't listen to." A third dialogue participant noted that assessments need to include social benefits and costs as well as clinical benefits and costs. This individual suggested, as one example, that "there are social costs to managing things pharmacologically," such as with pain medications like oxycodone. A fourth dialogue participant attributed part of the cause of our knowledge gaps to a lack of organization on the research side: "The research agenda is not well organized. For example, research is based on one's own professional perspective." This individual argued that we need to know which multidisciplinary programs work and which do not... "because they don't all work." A fifth dialogue participant attributed part of the cause to a competitiveness among those involved in the management of chronic pain: "People's need to defend their discipline... this discipline parochialism or turf war... is a big barrier that stands in the way of what does help... which we need before knowing what to teach and pay for.... We're not far from snake oil salesmen."

Dialogue participants also generally agreed that current provincial and territorial health system arrangements do not support chronic pain management for all Canadians. As one dialogue participant said, "access is terrible and getting worse." Dialogue participants pointed to five features of existing delivery arrangements that they considered to be contributors to the problem. First, dialogue participants noted the limited support for self-management in provincial and territorial health systems. One dialogue participant made a plea to "give patients the tools... pain is part of their lives, but it doesn't have to run it." A second dialogue participant said, "some patients need help getting through the day with their chronic pain," which they interpreted as "dealing with the hurt, but not having to deal with any harm or damage." A third noted that patients with chronic pain need "help with expectations about what healthy is. Recovery from a heart attack doesn't mean having a 20-year-old's heart. Similarly, recovery from chronic pain may be recovering the ability to perform some activities of daily living, but perhaps not be back to full functioning." A fourth dialogue participant argued that "you have to think about how to assist people with pain to better advocate for themselves," while another agreed, but also argued that people living with chronic pain "also need to take responsibility."

Second, dialogue participants noted the inadequate access to primary healthcare providers for some Canadians and inadequate management of chronic pain by some primary healthcare providers and some specialists, which may be related to inadequate training and continuing professional development. Dialogue participants generally agreed that a significant part of the problem was at the primary healthcare level, which was perceived as not being well organized (or sufficiently responsive) to meet the needs of those living with chronic pain. One dialogue participant argued that chronic pain management should not be conceptualized outside multidisciplinary primary healthcare, given the need for many different types of services (and the existence of many "unimodal" pain clinics). The same individual argued that what is needed is a cost-effectiveness study of treating pain at the primary healthcare level, such as is being done in what is sometimes called the Sherbrooke model, with an appropriate remuneration mechanism.

Third, dialogue participants noted that many non-physician healthcare providers (including community-based rehabilitation practitioners) are not actively engaged in chronic pain management at the primary healthcare level. As one dialogue participant said, "primary healthcare teams don't have the right disciplines." Another dialogue participant observed that many outpatient rehabilitation clinics have now closed down. This

individual gave the example of Hamilton, where no outpatient rehabilitation clinics exist for those without coverage through a third-party payer or enough money to pay for their own rehabilitation.

Fourth, dialogue participants noted the inequitable geographical access to regional multidisciplinary chronic pain management centres, although several dialogue participants cautioned that a “centre is just the start.”

Fifth, dialogue participants noted the lack of a monitoring system to identify patterns of under- and over-utilization of programs, services and drugs.

Dialogue participants added a number of features of existing financial arrangements and one feature of existing governance arrangements to the list of contributors to the problem. In terms of financial arrangements within provincial and territorial health systems, several dialogue participants noted that: 1) public payment mechanisms for many primary healthcare practices and clinics lead them to try to keep focused on a single clinical problem per visit, and to keep these visits as short as possible (often only five minutes in length), which in turn leads them over time to “cherry pick” the easy patients; 2) public payment mechanisms for those providing medical care to those with chronic pain encourage some forms of chronic pain management (e.g., injections), but not others (e.g. counselling and monitoring), and do so in an inconsistent way across provinces and territories; 3) the absence of public payment mechanisms for those providing rehabilitation to many of those with chronic pain create financial barriers to access for some patients (e.g., a minimum out-of-pocket payment of \$50 per physiotherapy session as part of a multidisciplinary program); and 4) the involvement of third-party payers in chronic pain management both complicates matters significantly and focuses attention on “the elephant in the room... they want to know what they should be paying for” and what their \$1.4 billion in annual expenditures on chronic pain management is “getting them.” One dialogue participant argued strongly for provincial and territorial health systems to transition from paying for services (which the individual argued “perpetuated chronic pain”) to paying for performance, as many workers’ compensation boards have begun to do. This dialogue participant argued that chronic pain management cannot be done well under a fee-for-service remuneration model because such a model does not create the incentives for primary healthcare practices and clinics to acquire and periodically refresh their training in chronic pain management, or to spend the time doing what will help their patients, and it does not give them access to the expertise needed when they reach the limit of what they can do. In terms of governance arrangements within provincial and territorial health systems, several dialogue participants lamented the lack of both credentialing of chronic pain providers and accreditation of chronic pain clinics.

Several dialogue participants complemented the points about current health system arrangements by expanding on the contribution of the educational system to problems with these arrangements. Some dialogue participants noted that we “don’t teach [chronic pain] well” in most health professional programs, “few hours are spent [on chronic pain] in most curricula,” and “even musculoskeletal [injury] is typically not there.” One dialogue participant noted that many of those faculty members currently teaching future health professionals about chronic pain are ready for retirement. Another dialogue participant noted that the problem isn’t just in the education about the “content” of care, but it’s also in the education about the “process” of care. As this individual noted, healthcare providers “learn many things during their training, but not how to work well with each other,” and “they don’t appreciate one another’s knowledge and skills.” This individual lamented the lack of inter-professional education in most provinces and territories. Some dialogue participants extended this argument about flaws in the educational system to include how we support those already in practice. One dialogue participant observed: “Numerous clinical practice guidelines exist for the management of chronic pain, yet there is no ‘home’ for the development, updating, implementation and monitoring of these guidelines.”

One dialogue participant noted that “there are limited data about the problem in relation to specific groups, including people living with mental illness and/or addiction problems, and in rural and remote communities,” which complicates a full assessment of the problem.

DELIBERATION ABOUT POLICY AND PROGRAM OPTIONS

Many dialogue participants liked aspects of each of the options that had been “worked up” as concrete examples of what could be done differently, whereas others had concerns with one or more options, or thought that elements of the options needed to be combined, and in some cases complemented, by elements not covered within any of the options.

Option 1 - Create a model patient registry/treatment-monitoring system in a single jurisdiction

One dialogue participant began the deliberation about this option by arguing that such a registry/system wasn’t feasible given the lack of a defining event that would determine eligibility (as opposed to the case with, say, a total joint arthroplasty). This individual argued that “there are lots of observational data out there, but the system is so flawed that the observational data provide little usable information.” Another dialogue participant worried about the opportunity cost of such an investment, given it would be expensive to maintain, it would need both a long-term commitment and additional resources for supporting action based on the data, compliance (and hence data comprehensiveness) could be low, and privacy issues difficult to overcome (if dialogue participants’ experience with Ontario’s biologics registry is any indication).

Other dialogue participants argued strongly that a patient registry/treatment-monitoring system was definitely needed in order to support efforts to monitor the implementation of new approaches to organizing chronic pain management and the evaluation of their impacts. These individuals argued that “getting local data is critical” and “it’s a must.” They also argued that such a registry/system was feasible given there’s always the possibility of triggering enrolment with a diagnosis of chronic pain, although they recognized that coming to a consensus about diagnostic criteria would take some work. One individual noted that enrolment would likely need to be made mandatory and compliance enforced in order to ensure the comprehensiveness of the minimum dataset.

Several dialogue participants saw the registry/system as a pre-condition for other options and as “an indispensable part of a bigger effort to induce change” in behaviours, such as through performance measurement and quality improvement initiatives. These individuals noted, however, that what would still be needed is the allocation of responsibilities to act on what emerges from the use of the registry/system.

Other dialogue participants identified possible “testing grounds” for a registry/system. One dialogue participant noted that the province of Quebec was well on its way to developing a registry/system within the context of a Fonds de la Recherche en Santé du Québec (FRSQ)-funded research project. A second dialogue participant noted that the Department of National Defense might be another excellent place to introduce and evaluate a registry/system. A third dialogue participant noted that this option could also be implemented and evaluated at a sub-provincial level, much like what was done with the multidisciplinary Sherbrooke clinic focused on workplace injuries.

Option 2 - Create a national network of centres with a coordinating “hub” to provide chronic pain-related decision support

A number of dialogue participants voiced strong support for the research functions that such a network could undertake, including the analysis of data about treatment patterns (which can include the analysis of data from a patient registry/treatment-monitoring system, which was the focus of the preceding option), the synthesis of research evidence about chronic pain and chronic pain management, and the monitoring of efforts to improve care (across the full range of payers and the full continuum of care, including primary healthcare,

post-surgical care, etc.) and the evaluation of their impacts. One dialogue participant endorsed a focus on more primary research and the need for a targeted research strategy. A second dialogue participant emphasized the need for a well considered program of research given the individual's recent systematic review had found no high-quality studies. A third dialogue participant argued that the remit for such a network needed to be extended to include the development, implementation and evaluation of public policies and public-education campaigns. This individual noted that researchers in Australia had successfully developed, implemented and evaluated a public-education campaign focused on back pain. A fourth dialogue participant agreed that raising public awareness was critical, and cited cancer and HIV/AIDS as examples of conditions that have been the focus of such campaigns.

A number of dialogue participants also voiced strong support for the idea that the network could be created in partnership with consumers and be made accessible to them, and the idea that the network could (among other functions) develop and disseminate resources and tools to support self-management. One dialogue participant liked the option's focus on "consumers driving policy," whereas they had found option 1 too research- and researcher-oriented. Speaking to the issue of supporting self-management, a second dialogue participant noted the importance of not ignoring the many citizens for whom English or French are their second languages, and who have low levels of health literacy.

Many dialogue participants also endorsed the array of provider supports included within this option, which included: 1) developing and disseminating clinical practice guidelines and other resources and tools to support providers and organizations in prevention, early identification and ongoing treatment; 2) offering support to undergraduate professional training programs; and 3) offering continuing professional development and other strategies to support evidence-based care (both for single disciplines and multidisciplinary teams). One dialogue participant embraced the option's dual focus on excellence in decision support and excellence in care, the coverage of many target audiences (patients, providers and health system managers and policymakers), and the strong "knowledge translation" mandate. Another dialogue participant emphasized the importance of building on existing programs (such as those in Quebec and in the Calgary Health Region) and existing resources (such as MacPLUS).

Several dialogue participants liked the notion of centres of excellence because they could provide the credibility that seems to influence why programs like the Stanford program are being taken up, and they could lead the push for consistency. One dialogue participant noted that third-party payers would like the notion of a coordinating "hub" because it would reduce the confusion and uncertainty they face. However, this individual noted that the challenge for the publicly financed part of the system is that these third-party payers would want to "jump the queue" (i.e., buy access for their patients to whatever is identified by these centres of excellence as optimal care). This individual noted that the multi-payer perspective embedded in option 3 would also be critical for this option as well. A second dialogue participant took this a step further, arguing that, like the registry/system described as option 1, the network of centres described in option 2 would ideally be part of the more comprehensive option 3.

One dialogue participant argued that "if [the option is] implemented right, it would be transformative for Canada" and that "Canada is small enough to do it... from sea to sea," but, given the way research environments reward being first or being the lead (as opposed to being collaborative), the prospects for progress on this option are low. Another dialogue participant suggested that current dynamics made this option unworkable because: 1) university-based centres of excellence will focus on what individual disciplines are comfortable with (e.g., behaviour modification, narcotics and nerve blocks) rather than what multidisciplinary practices and clinics need; and 2) primary healthcare providers remain in short supply and are remunerated under a fee-for-service model that doesn't support the appropriate multidisciplinary management of chronic pain.

One dialogue participant questioned whether a national organization was needed for coordination, particularly for the many issues that are province or territory specific (e.g., traffic injuries in Quebec), although the individual acknowledged that initiatives like public-education campaigns would benefit from

national coordination. A second dialogue participant noted that this option is already being pursued successfully in Quebec, with four expert centres anchored in university networks, each with a specific mandate in terms of tertiary-level clinical services, training, research and support to a defined region of the province. This individual noted that the registry/system described in option 1 is embedded within the approach being used in Quebec. Ministry and regional agencies were said to have played a convening role during the planning phase because they became convinced that the new approach would better serve the needs of patients, and that it would cost them less than the “poorly organized status quo.” The Ministry provided a small budget for a coordinator, but they found that “people lined up at the door to be [designated] an expert centre, in part because it would allow them to leverage research dollars.” This individual noted that in Quebec they still have to work out how to line up these four expert centres with regional centres like those focused on palliative care. Two dialogue participants noted that the nascent chronic pain guideline-development group at McMaster University could become the nidus for a national hub, and another noted that the Institute for Healthcare Improvement’s webinars and the “Breakfast with the Chiefs” series are examples of low-cost approaches to spreading the impact of a coordinating hub. One dialogue participant noted that there were lessons to be learned from the Canadian Stroke Network in terms of creating a national hub, designing a good structure for the hub, and obtaining funding for the hub from the Canadian Institutes of Health Research.

Option 3 - Broker and support the implementation of a cross-payer, cross-discipline model of patient-centred primary healthcare-based chronic pain management

Many dialogue participants supported the idea of a cross-discipline model of patient-centred primary healthcare-based chronic pain management that addresses the full spectrum of comprehensive care (e.g., early prevention, early intervention, treatment, management and rehabilitation). One dialogue participant said, “an interdisciplinary on-the-ground system is needed,” and a second affirmed the importance of the “first line” being the essential service point. A third dialogue participant argued that the reality is that primary healthcare physicians are in the driver’s seat, so they need to be engaged, ideally at the practice level. However, this individual acknowledged that most primary healthcare practices are administrative groupings, not true teams, which makes engagement very difficult. A fourth dialogue participant argued that the focus had to be on early adopters of a cross-discipline model of care (such as Family Health Teams in Ontario) and groups comprised of recent graduates. A fifth dialogue participant noted that organizations like the Canadian Pain Society are not focused on primary healthcare, which means that the engagement of this sector is not getting the attention it deserves. Spurred by the mention of the Canadian Pain Society, a sixth dialogue participant noted that the Society’s charter argues that people living with chronic pain need to take responsibility for managing their condition, and that they should be seen as the team leader in any cross-discipline model of patient-centred primary healthcare-based chronic pain management.

A few dialogue participants cited Calgary’s primary healthcare network (involving about 250 physicians) as a good example of a cross-discipline (but not cross-payer) model of primary healthcare-based chronic pain management for patients with mild to moderate complexity. One dialogue participant described how the network physicians are provided with both training and mentoring by secondary- and tertiary-level specialists (e.g., rounds, tools and telephone consultations), and how a variety of non-physician primary healthcare providers (e.g., nurse coordinator, physiotherapist, mental health worker and pharmacist) are paid by the network. This individual noted that a challenge with this model is how pain-focused efforts intersect with efforts to strengthen the management of chronic conditions like diabetes or chronic obstructive lung disease, and how pain-focused efforts taken as a whole can be evaluated in terms of their cost-effectiveness.

Several dialogue participants noted that critical elements of patient-centred primary healthcare-based chronic pain management include primary healthcare practices/clinics assuming the primary responsibility for chronic pain management, these practices/clinics having facilitated access to mentoring and support to enable them to fulfil this role, and these practices/clinics being able to periodically engage multi-disciplinary and multi-modal secondary- and tertiary-level supports for patients with more significant complexity. One dialogue

participant noted that the current system of disciplines fighting with each other is like firefighters and paramedics fighting over who does what (and this dialogue participant noted that this observation also applied to option 2, which is why the individual pushed for interprofessional education as part of that discussion). A second dialogue participant echoed this sentiment, arguing that it's "not just having a team, but how a team works. How often is the patient at the centre of care?" Another dialogue participant noted the opportunity cost associated with having multiple secondary- and tertiary-level chronic pain management centres and cautioned against allowing these centres to set up "eight-week programs" that maximize their revenues and then sending the patients back to their primary healthcare clinics/practices without any ongoing mentoring and support.

One dialogue participant admitted that the discussion of a cross-discipline model of patient-centred primary healthcare-based chronic pain management "made the hairs on the back of my neck stand up" because the current "medicalized" model misses many opportunities for early curative diagnoses, mismanages many chronic conditions by focusing on pain and not on function, and does not provide linkages to community resources that can help people stay active regardless of whether they have extended healthcare insurance coverage. This individual argued that better engagement of rehabilitation professionals (which the individual noted were wanted by a large percentage of surveyed patients) and more exposure to "musculoskeletal training" in medical schools were needed to make this option more palatable. Without these additional elements, this dialogue participant argued that this option would just result in "more people doing ineffective things."

Many dialogue participants also supported the idea of rewarding quality and efficiency, however, they often differed in how they thought these rewards could best be structured. In terms of rewarding quality, some dialogue participants endorsed the re-balancing of fee schedules away from what is done (e.g., procedures) and towards either payment for the time demands associated with assessment, management, support and dealing with payers and employers, or (better yet, in the view of some dialogue participants) for "what is accomplished." One dialogue participant cautioned against abandoning fee-for-service remuneration in skill-intensive specialties, but acknowledged that fee-for-service remuneration doesn't accommodate complexity well. A second dialogue participant argued against the use of "negative fees, which are obstacles to referral." A third dialogue participant acknowledged that the co-morbidities that patients living with chronic pain often have may create difficulties in establishing a fair rewards system. Dialogue participants also discussed accrediting chronic pain "specialist" providers or centres as another mechanism to reward quality. One dialogue participant asked who would do the accrediting of chronic pain "specialist" providers or centres, while another argued that the accreditation must be clinic-based (and primary healthcare clinic-based primarily), not practitioner-based, given how clinic set-up is key, and that accreditation must be a quality-based assessment. In terms of rewarding efficiency, some dialogue participants endorsed engaging the most cost-effective providers at each level of care required, although one dialogue participant didn't like this option element (but was uncertain as to whether this was a reaction to the phrase or the concept or both).

Relatively few dialogue participants commented on the cross-payer element of the option. Only one dialogue participant touched on the Ministry's role as the steward for the system regardless of who pays for care (although one pointed to another system where this role was better articulated, to the benefit of patients in this individual's view), or on the need to bring the Ministry together with third-party payers like workers' compensation boards and private insurers. One dialogue participant noted that established clinical centres have negotiated deals with automobile insurance companies, but care needs to be taken to ensure that these deals don't impinge on the clients being treated in the publicly financed system. Another dialogue participant emphasized the importance of aligning funders, and that at some point the ministers of health, labour (which handles workers' compensation systems), and finance (which handles automobile insurance in some provinces) should be pushed to meet.

Several dialogue participants identified merits in combining other options or elements of other options as part of this option. For example, one dialogue participant wanted to see consumer input and enhanced decision

support added to this option, while another wanted to see training and continuing education added to this option.

Considering the full array of options

Several dialogue participants argued that having “pain recognized as a disease” (to reduce stigma and legitimize the need for care) and “improving access to appropriate care” were the two single most important elements of any option(s) to be pursued. Several dialogue participants argued that another option worthy of discussion was addressing “disciplinary turf wars,” which these individuals saw as a key step before considering “what to teach and pay for.” Having pain recognized as a disease was not formally part of any of the three options, whereas addressing disciplinary turf was a part of option 2 and improving access to appropriate care was a significant part of option 3.

Dialogue participants also debated “different ways in,” which could include primary healthcare practices/clinics “given that’s where the actions are most needed,” university networks given they have a mandate for care, training and research (which has worked in Quebec), and regional health authorities given they have the lead role in planning, organizing, integrating and funding many programs and services, and given they have the potential to set objectives that could inform decisions by physicians (which has worked in Calgary and Edmonton, although arguably not in other regions of Alberta which have had different priorities). One dialogue participant reminded others that many regional health authorities do not have an academic centre within their region. This dialogue participant also noted that a key way to access any region is through their statement of goals (e.g., one regional health authority has as a goal to reduce the time spent in emergency rooms, and chronic pain is a contributor to emergency-room use). Those seeking to strengthen chronic pain management could form a coalition with others interested in addressing this goal.

DELIBERATION ABOUT IMPLEMENTATION CONSIDERATIONS

Several dialogue participants noted that the prospects for success with option 1 (i.e., creating a model patient registry/treatment-monitoring system in a single jurisdiction) were much greater if this option was implemented in the form of a program of research rather than as a government or regional health authority initiative. One dialogue participant argued that agreement about a number of issues – definition of chronic pain, a triggering event for inclusion in the registry/system, a minimal data set, and how to address privacy issues (which may influence recruitment and the sharing of information) – would be easier to address in the confines of a research program. Moreover, another dialogue participant argued that this option lends itself to an iterative process of progressive improvements (as opposed to running the risk of “biting off more than one can chew”), including making use of datasets (such as health claims data from automobile insurers) that already exist and that can be a building block for a bigger system. One dialogue participant noted that intellectual property concerns represent a significant barrier to implementing this option because the patient registry/treatment-monitoring system needs to be accessible to and used by a broad range of groups, not just the ones who developed or maintain it. Another dialogue participant argued that the Canadian Institute for Health Research (CIHR) requirement for putting data (created using CIHR funding) in the public domain will help to address this barrier, however, this individual argued that work will need to be done to balance the database developers’ rights to benefit from their significant investments in the database (through time-limited privileged access), and the system’s need to access the data in a timely way. The same dialogue participant suggested that there might be significant lessons to be learned from both successes and failures with similar databases, as well as related ones such as guideline databases.

A number of dialogue participant argued that the successful implementation of option 2 (i.e., creating a national network of centres with a coordinating “hub” to provide chronic pain-related decision support) hinged on getting the right champions (clinicians, leaders in teaching institutions and patients) around the table from the beginning. Several dialogue participants emphasized the importance of having patients at the

table. One dialogue participant worried that getting the right champions around the table would be a very large hurdle to overcome “given the egos involved and the silos that exist” within and between disciplines. This participant argued that having research funders emphasize the importance of decision support would motivate people to “get beyond the egos and silos.” A second dialogue participant affirmed that having credible champions was key to success at critical junctures in the province of Quebec. A third dialogue participant argued that a parallel investment was needed to support the production of research evidence, otherwise any decision support being provided would not be on “a sound footing.” A number of dialogue participants pointed to examples that could be learned from, including Quebec’s efforts in this exact domain, the Ontario Diabetes Strategy supporting the development of a patient portal, and the Canadian Stroke Network. In Quebec, the key steps had been to: 1) convene an advisory committee; 2) establish “clear basic elements that are required,” namely accessibility, quality and continuity; 3) document problems from the points of view of patients and providers; 4) identify workable solutions to those problems; and 5) write letters to the Minister of Health to share ideas for a way forward. Many dialogue participants emphasized the need to “start somewhere” with the network idea, and to build on early successes.

Several dialogue participants suggested that the implementation of option 3 (i.e., brokering and supporting the implementation of a cross-payer, cross-discipline model of patient-centred primary healthcare-based chronic pain management) could best be facilitated in the short term through demonstration projects (such as the one in Calgary), coupled with rigorous monitoring and evaluation, and in the long term through a systematic effort to “move beyond the early adopters.” And in making the case for more demonstration projects, one dialogue participant emphasized the importance of saying: “If we re-organize primary healthcare, it’s not just chronic pain that we’ll be able to handle better.” One dialogue participant argued that monitoring and evaluation is likely the reason the Calgary program continues to exist, and another argued that being able to show that a model is more cost-effective than the status quo is key. Another dialogue participant noted that the vicious cycle of “we don’t have the studies because we don’t have the structures” and “we don’t have the structures because we don’t have the studies” needed to be broken.

DELIBERATION ABOUT NEXT STEPS FOR DIFFERENT CONSTITUENCIES

One dialogue participant argued that governments won’t take action in the short term, so “stakeholders have to be the ones who make it happen.” This individual pointed to the difficulty in getting policymakers to this dialogue as a symptom of the bigger problem of governments not wanting to engage with the issue of chronic pain management. A second dialogue participant noted that the Canadian Pain Society National Task Force on Service Delivery might be well positioned to lead a push (although they are not currently focused on primary healthcare), while another noted that the coordinating “hub” envisioned in option 2 could play this role if it can begin to foster a vibrant, credible network. A third dialogue participant noted that there are also provincial-level groups that would need to be engaged in such stakeholder-led efforts, such as the multi-stakeholder group convened by the College of Physicians and Surgeons of Ontario to focus on improving access to healthcare. The critical step, several dialogue participants argued, was to engage key opinion leaders, both those leading the push for strengthened chronic pain management and those in primary healthcare practices, regional health authorities and government who can take action. Those leading the push need to develop a strategy and a business plan, and facilitate and coordinate awareness-raising and education and the scaling up of “ground-up” efforts.

One dialogue participant argued that “hard data” are needed from researchers about what’s working and not working before progress can be made either at the regional or provincial level. This dialogue participant noted that “it’s embarrassing for a payer to know that there are better ways to do things,” and embarrassment can be a strong motivator. A number of dialogue participants built on this point, arguing that success stories need to be identified, their cost-effectiveness relative to the status quo studied, and the findings from this effort popularized in a systematic way (including through the use of powerful anecdotes). One dialogue participant argued that the research findings need to be brought to the attention of civil servants responsible for primary

healthcare, which the individual argued is where real change in front-line chronic pain management is going to come from, or at least where it's going to be supported and consolidated from.

One dialogue participant noted that payers need to begin to explore a cross-payer forum, and that pilot projects could be a means “to rally them.” However, this dialogue participant also noted that there is a large collective-action problem given the more than 200 insurance companies involved (and the slow-moving nature of the insurance industry association) and the many jurisdictions involved. The dialogue participant suggested that this payer-engagement step might best be sequenced later when there is some progress to show.

Several dialogue participants noted that any follow-up stakeholder dialogues should continue to focus on cross-jurisdictional issues and be planned in a way that increases the prospects for the engagement of policymakers in government (particularly those engaged in primary healthcare policy development), and decision-makers in workers' compensation systems and the automobile insurance sector. One dialogue participant noted that single-jurisdiction meetings can also help to advance the agenda in a given jurisdiction. Another dialogue participant noted the importance of identifying how those seeking to strengthen chronic pain management can intersect with and strengthen initiatives that those in the primary healthcare sector are leading (e.g., performance measurement and quality improvement in primary healthcare). This dialogue participant also suggested that there were lessons to be learned about how conditions like diabetes captured the attention of those in the primary healthcare sector.