Acknowledgements

Pain BC would like to acknowledge that the 2017 Provincial Pain Summit was held on the traditional, unceded land of the Coast Salish Peoples.

The 2017 Provincial Pain Summit could not have taken place without the support and commitment of the Ministry of Health and Minister Terry Lake, and WorkSafe BC. The Pain BC Board of Directors is very grateful for their support in hosting the Summit and their commitment to working together on recommendations for change.

The participation of people living with pain was crucial to the Summit goals and format. Pain BC was honoured to have patients share their stories and contribute their expertise to the dialogue.

Pain BC appreciates the health care providers and administrators who attended, listening openly and working collaboratively to develop suggestions for action. Health care providers shared their perspectives and experiences from the front-line, while leaders and policy makers contributed the systems-perspective necessary for developing solutions.

Together, people living with pain, health care providers, and administrators will bring about change and reduce the burden of pain on individuals, families, and communities in BC. Pain BC is grateful for this commitment and collaboration.

And finally, many thanks to The Arthritis Society for sponsoring Friday night’s panel discussion and to PainPRO RMT Clinics for sponsoring our Comfort Room and for providing expert massage therapy throughout Saturday. Our gratitude also goes to Bighouse Productions for their videography, as well as to our tireless volunteers, facilitators, and staff.
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Executive Summary

BACKGROUND

Pain BC is a non-profit organization made up of people in pain, health care providers, policy makers and others with a passion for improving the lives of those living with chronic pain. Since 2009, Pain BC has been leading efforts to improve the lives of people living with pain in our province.

Pain BC launched its first Strategic Plan in November 2010. In June 2011, we held the first Provincial Summit during which diverse stakeholders identified key changes needed to improve the lives of people in pain in BC. For the five years following this, Pain BC and our partners have advanced initiatives identified at the first Summit. While there has been significant headway, considerable challenges remain.

In February 2017, we held our second Provincial Pain Summit. It proved enormously successful in fostering dialogue, as well as identifying goals aimed at transforming care and reducing stigma for the 1 in 5 British Columbians living with chronic pain. Learnings and challenges were shared, and these informed the five theme-based working sessions addressed over the course of the Summit. The Summit is both the culmination of our shared work since the first Summit in 2011 and a catalyst for the future.

SUMMIT CONTEXT & GOALS

Pain BC developed the 2017 Summit program through key informant interviews and from information collected through a survey of people in pain, clinicians and health policy experts. Five themes emerged and the Summit program was designed around these:

1. Primary Care: Increase the capacity of primary care providers to provide evidence-based pain assessment and management, including non-pharmacological approaches
2. Vulnerable Populations: Enhance outcomes for people living with addictions, mental health issues and chronic pain
3. Pharmacological Pain Management: Improve assessment, balance harms and benefits of medications, and advance appropriate pain management for patients across the continuum of care
4. Pain in Rural BC: Expand access to pain management (pharmacological and non-pharmacological) services in rural and remote parts of the province
5. Seniors in Pain: Improve pain assessment and management (pharmacological and non-pharmacological) for seniors

The survey also provided an opportunity for participants to comment on individual and systemic practices and policies that they experienced as working well for people living with pain, as well as challenges and opportunities for improvement. This information was used to further inform the Summit program.

The Summit took place in Downtown Vancouver and was timely in that the city of Vancouver and province as a whole are facing a public health emergency around overdoses related to illicit opioid use - in particular drugs tainted with fentanyl and carfentanil. While the issue of illicit opioid use is a distinct problem, the response to the crisis by the College of Physicians and Surgeons of BC and the media has had an undeniable impact on people living with pain and the health care providers who treat them.
The “opioid crisis” has brought issues related to chronic pain to the forefront and has pushed the conversation around recognition and treatment of chronic pain into the public domain. Specifically, the distinction between dependence and addiction is not being made in response to the new provincial opioid prescribing guidelines; consequently, some patients who have been functioning well on opioid therapy are suffering as a result of the new prescribing standards and guidelines. This and other related issues were discussed during the Summit.

SUMMIT OVERVIEW

The five themes that anchored Saturday’s Breakout Sessions related to primary care, vulnerable populations, pharmacological pain management, pain in rural and remote BC, and seniors in pain. The dialogues around these themes were highly informative, producing data that, in conjunction with further action planning on the Sunday, produced several strategic initiatives to be taken forward. Some of these initiatives will be led by Pain BC, others by partner organizations, and some by ad hoc groups of clinicians, policy makers, and people living with pain that formed at the Summit.

The main issues, which surfaced repeatedly during the Saturday and Sunday working groups included the need for improvements to pain education, awareness, and funding; the development of coordinated care through the pain continuum; and the creation of MSP billing codes to better enable physicians, including GPs and specialists, to engage in the care of their patients with chronic pain: in short, the need for a coordinated provincial pain strategy. This need was acknowledged by Hon. Terry Lake, Minister of Health, during his presentation on Sunday morning, at the end of which he pledged to “lay the tracks” for such a strategy.

The Summit was well attended, drawing 325 people on the Friday and 260 on the Saturday (Sunday was invitation only). Attendees included people with pain, caregivers, allied health practitioners, researchers, general practitioners, nurses, and professional associations such as Doctors of BC. Participant well-being throughout the Summit was important; supports were provided to participants and included registered massage therapy, mental health support, comfortable seating, hot and cold packs, yoga mats, analgesic gel and more.

Social media played a key role in engaging those who did not physically attend the Summit, with the hashtag #BCPainSummit trending on Twitter. The hashtag #webelieveyou emerged from the Friday panel discussion and drove engagement throughout the weekend. It was also identified as being an important message for people living with chronic pain to hear.

At the end of the Summit, attendees left with a sense of purpose, grounded in actionable commitments made earlier on Sunday morning. In those sessions, 10 initiatives were established with next steps identified so the work begun at the Summit can continue.

The commitment and energy galvanized by the Provincial Pain Summit will provide the momentum needed to advance a provincial pain strategy and through that, to improve the lives of people living in pain in BC.
Summit Program Recap

FRIDAY: AN EXPERT PANEL ON PAIN

The Provincial Summit opened Friday night with a moderated dialogue in which people living with pain told their compelling stories. This panel then engaged the audience to further develop a shared understanding of the programmatic, practice, and policy implications of these narratives.

The five panellists shared their lived experience, providing an overview of their journey, including coping mechanisms and turning points that impacted them both negatively and positively.

The conversation grounded the Summit in the lived experience of pain and inspired people in pain to tell their own stories. A central theme for all five panellists was that of the empowering nature of having their stories validated; this powerful message was incorporated into the rest of the Summit and became the hashtag “#webelieveyou”, used in social media posts over the course of the weekend.

SATURDAY: THEMATIC DIALOGUES

Energized by the panel discussions of Friday evening, more than 200 participants carried that momentum forward during the morning sessions, during which Summit co-hosts (people in pain and expert clinicians) “pitched” breakout sessions being held that afternoon. This was followed by an interactive system mapping exercise.

The mapping segment involved volunteers from the audience playing the role of 14 stakeholders in the system, specifically: patients, family care givers, primary care physicians, insurers, Doctors of BC, the Ministry of Health, opioids, psychological therapy, physical therapy, impacts of living with chronic pain, aging, social stigma, rural and remote communities, and a provincial pain strategy (fictional).

Participants were asked to deliver one sentence to represent their specific role and to position themselves in the space in whatever way they felt was appropriate. Then, the group was invited to intuitively develop three human “sculptures” that evolved from initially being a segmented and dysfunctional model of the stakeholders through to an inclusive model representative of an understanding that all areas of the system must work together. Participants ended by adding a sentence of how they felt their position had changed, and the audience was able to add responses to the exercise.

Mapping was followed by a second exercise in co-creation where participants had an opportunity to experience the healing and community-building power of music making. This set the stage for the afternoon’s break out sessions, where participants moved into their selected Summit themes, with the aim of identifying key issues and proposing solutions.
The Five Breakout Themes

Each of the five sessions below was independently moderated and findings were harvested through flip charting and diagrams:

1. **Primary Care**: Increase the capacity of primary care providers to provide evidence-based pain assessment and management, including non-pharmacological approaches.

2. **Vulnerable Populations**: Enhance outcomes for people living with addictions, mental health issues, and chronic pain.

3. **Pharmacological Pain Management**: Improve assessment, balance harms and benefits of medications, and advance appropriate pain management for patients across the continuum of care.

4. **Pain in Rural BC**: Expand access to pain management (pharmacological and non-pharmacological) services in rural and remote parts of the province.

5. **Seniors in Pain**: Improve pain assessment and management (pharmacological and non-pharmacological) for seniors.

When the breakout sessions were over, attendees reconvened to dialogue on cross-thematic topics and create further awareness for Sunday's upcoming sessions, before closing for the day.

At the end of Saturday's proceedings, Pain BC staff and the session facilitators reviewed the data harvest from the five thematic sessions. The key findings were then consolidated for use in Sunday's working groups.

Key Findings

Not surprisingly, several overlapping issues emerged across all five themes. Most prominent was the call for a coordinated, integrated system of care with appropriate supports to enable general practitioners, specialists, and allied health care providers to adequately assess and manage chronic pain.

Lack of awareness of existing programs and tools, notably the integration of self-management tools, were consistently cited by Summit participants.

Another major issue was the need for comprehensive pain management education for medical students, as well as additional training and support for primary care providers and allied health providers.

Reducing stigma around complex pain, mental health issues, and opioid medications were also of significant concern to attendees.
SUNDAY: ACTION PLANNING WORKING GROUPS

Sunday saw invited attendees, including representatives from the Ministry of Health, health authorities, Doctors of BC, health professional associations, clinical experts, people in pain, and caregivers return to review the key findings from the Saturday thematic sessions and develop actions based on those findings.

After breaking out into the five thematic groups to review the summary of work completed on Saturday, the main session reconvened and each of the five groups presented their findings. Participants were then invited to identify 10 actions, drawn from the key findings, which could be taken forward in the short term.

10 Action Initiatives

Coming together in action planning groups, participants committed to:

1. Create allied health training
2. Create a Vancouver Coastal Health (VCH) Pain Program
3. Develop opioid / medication stewardship
4. Create billing codes for chronic pain
5. Create a strategy for the public reframing of opioid use, addiction and pain
6. Create a BC Pain Agency
7. Develop and promote self-management in all BC communities
8. Establish a unified approach to chronic pain education in primary care
9. Develop trauma informed care in every pain program
10. Enable early intervention, beginning in the community

Address by The Honourable Dr. Terry Lake, Minister of Health

Following the positive action planning and commitment session, Minister of Health Terry Lake addressed attendees. He spoke of his family's experience with chronic pain, through his sister's lived experience, and the need for ending stigma around pain while simultaneously increasing access and supports.

Emphasizing the need for improved access to comprehensive assessment and management, Minister Lake noted that chronic pain should be considered a complex condition with the necessary supports to allow physicians and other members of interdisciplinary primary care teams to spend more time with patients.

Addressing the topic of a provincial pain strategy, Minister Lake said that he and his team had met with Pain BC prior to the Summit concerning the development of such a strategy. He outlined the possibility of having a tiered system of care that layers on access to specialised pain centers within every regional health authority. Minister Lake further noted that the idea of a provincial pain agency is something that could also be discussed.
Minister Lake addressed the opioid crisis, stating, “We are facing the greatest public health crisis in our province and potentially across the country. This crisis has drawn attention to the need for appropriate prescribing practices that don’t leave people stranded but look at other ways of helping people manage their chronic pain.”

In conclusion, Minister Lake thanked the audience for helping inform both himself and his team about the issues, and pledged to “lay the tracks” for a provincial pain strategy.

Following Minister Lake’s address, Executive Director for Pain BC, Maria Hudspith closed the Summit with thanks to everyone who helped make it possible and with a commitment to take the work done during the weekend forward.

“My hope is that while we develop a provincial pain strategy we will be able to give the right signals to all the health authorities to put the appropriate tools in place as well provide more tools for the primary care teams to address complex and chronic pain,” Minister Lake said.
Key Take-Aways & Action Initiatives

**BREAKOUT #1 PRIMARY CARE.**

Increase the capacity of primary care providers to provide evidence-based pain assessment and management, including non-pharmacological approaches

<table>
<thead>
<tr>
<th>Key Issues / Asks</th>
<th>Key Take-Aways (Saturday)</th>
<th>Action Initiatives based on Issues Identified in Saturday Sessions (Sunday)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The lack of a common language for specialists, GPs, allied HCP and patients.</td>
<td>Linking specialists with primary care, using models like Project ECHO to provide mentoring and ensure there is clinical decision support. Mandatory education/pain training – changing the medical school curriculum, providing information for all HCP on how/when to refer on, sparking a passion for pain management by exposing HCP to pain training and information.</td>
<td>Develop allied health training. Create a BC Pain Agency.</td>
</tr>
<tr>
<td>Lack of awareness of what is currently available (patient &amp; provider).</td>
<td>Create and distribute a standardized tool kit. Provide a centralized hub for HCP and patients to get information (currently exists in different platforms, e.g. Pain BC tools, FETCH, PATHWAYS).</td>
<td>Develop strategy for public reframing of opioid use, addiction and pain. Allied health training. Unified approach to chronic pain education in primary care.</td>
</tr>
<tr>
<td>Underfunding, patients being bounced around the system, quick turnovers equaling inadequate care and information, long wait times.</td>
<td>Provide funding for allied health services – universal access (MSP issue).</td>
<td>Create billing codes for chronic pain. Create a BC Pain Agency.</td>
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*continued on following page*
### Key Issues / Asks

<table>
<thead>
<tr>
<th>The need for community-based programs and multidisciplinary approaches to disease/condition.</th>
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<tbody>
<tr>
<td>The lack of recognition around chronic pain and the need to recognize it as a chronic disease.</td>
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<tr>
<td>The lack of set protocols for physicians/primary care to follow around how the shift from acute to chronic pain is seen, treated and when that happens.</td>
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### Key Take-Aways (Saturday)

| Provide funding for allied health services – universal access (MSP issue). |
| Designate chronic pain as a chronic condition (like diabetes, heart disease) – must be recognized, designated, and given an administrative home. |
| Linking specialists with primary care, using models like Project ECHO to provide mentoring and ensure there is clinical decision support. |

### Action Initiatives based on Issues Identified in Saturday Sessions (Sunday)

| Early intervention starts in the community. |
| Self-management in all BC communities. |
| Provincial Pain Strategy |
| Unified approach to chronic pain education in primary care. |
**BREAKOUT #2 VULNERABLE POPULATIONS:**

Enhance outcomes for people living with addictions, mental health issues and chronic pain

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<tr>
<td>Stimulate the creation of publically funded, interdisciplinary, patient-centered clinics and outpatient supports for people with pain, addiction and mental health issues.</td>
<td>Fund support groups beyond pain clinics. Educate family members.</td>
<td>Strategy for public reframing of opioid use, addiction and pain.</td>
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<td>VCH to develop and run a Pain Program.</td>
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<td>Create BC Pain Agency.</td>
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<td></td>
<td>Allied health training.</td>
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<td>Provincial Pain Strategy.</td>
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<tr>
<td>Create accessible health care for those who need it.</td>
<td>Health navigators assigned to pain patients. Fund upfront pain and addiction assessments.</td>
<td>VCH to develop and run a Pain Program.</td>
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<td>Create BC Pain Agency.</td>
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<td>Create billing codes for chronic pain.</td>
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<tr>
<td>Coordination of care and holistic pain navigation.</td>
<td>List of primary care physicians who are trained/informed in holistic &amp; trauma based pain management. Create MSP codes to permit physicians the time and incentive to treat complex chronic pain. Create a client focused central hub, a one stop shop “integrated chronic pain health unit.”</td>
<td>Opioid / Medication Stewardship.</td>
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<td>Create BC Pain Agency.</td>
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<td>Unified approach to chronic pain education in primary care.</td>
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<td>Create billing codes for chronic pain.</td>
</tr>
<tr>
<td>Embed meeting people where they are at.</td>
<td>Develop a provincial pain policy. Advocate for a workforce. Enhance advocacy. Manage current funding structures for service delivery.</td>
<td>VCH to develop and run a Pain Program.</td>
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<td>Create BC Pain Agency.</td>
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<td>Create billing codes for chronic pain.</td>
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**BREAKOUT #3 PHARMACOLOGICAL PAIN MANAGEMENT:**

Improve assessment, balance harms and benefits of medications, and advance appropriate pain management for patients across the continuum of care.

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</thead>
<tbody>
<tr>
<td>How to ensure adequate pain management while reducing the harms of pain medications?*</td>
<td>Implement robust pain management education across health systems and for the public.</td>
<td>Strategy for public reframing of opioid use, addiction and pain.</td>
</tr>
<tr>
<td>*(The issues, too numerous to list in this table, are provided in the appendices).</td>
<td>Invest in publicly funded access to physical + psychological therapies + enhancements to Pharmacare access to pharmacology + MSP fee code.</td>
<td>Opioid / Medication Stewardship.</td>
</tr>
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<td></td>
<td>Mandate free physician use of Pharmanet before opioid Rx.</td>
<td>VCH to develop and run a Pain Program.</td>
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<td>Drive evidence-based policy making</td>
<td>Unified approach to chronic pain education in primary care.</td>
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<td>Implement use of electronic health records to access previous treatments and consultations.</td>
<td>Trauma informed care in every pain program.</td>
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<td>Use existing testing infrastructure to better screen for medication metabolism and treat accordingly.</td>
<td>Create billing codes for chronic pain.</td>
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<td>Incentivize and structure collaborative, interdisciplinary, team-based pain care + support better cross-referrals.</td>
<td>Create BC Pain Agency.</td>
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<td>Strengthen access to primary care.</td>
<td>Provincial Pain Strategy.</td>
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<td>Develop a provincial BC Pain Agency to support excellence in functional/ rehabilitative components of pain + resources.</td>
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**BREAKOUT #4. PAIN IN RURAL BC:**
Expand access to pain management (pharmacological and non-pharmacological) services in rural and remote parts of the province

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</tr>
</thead>
<tbody>
<tr>
<td>Limited community support often compounds the pain experience.</td>
<td>Integrated pain management strategy. Patient-centered care and validation. Chronic pain billing codes.</td>
<td>Early intervention starts in the community.</td>
</tr>
</tbody>
</table>
| Lack of access to pain specialists is even more limited in rural and remote communities. | Draw on existing community resources.  
  - Telehealth  
  - Workshops (small)  
  - Interdisciplinary models  
  - Coordination committees of service providers  
  - Education via the Internet  
  More MSP-covered allied health services. | Allied health training.  
  BC Pain Agency.  
  Create billing codes for chronic pain. |
| Geography and distance are added barriers to support and care. | First visit to GP/therapist to create an interdisciplinary team that can assist the needs of the people in pain in their community.  
Draw on existing community resources:  
  - Telehealth  
  - Workshops (small)  
  - Interdisciplinary models  
  - Coordination committees of service providers  
  - Education via the Internet | Self-management in all BC communities.  
  Allied health training.  
  Early intervention starts in the community. |
| Stigma around both pain and pharmacotherapy can be more intense in small communities. | Sensitivity to peoples’ confidentiality/need for privacy (e.g. mental health diagnoses). | Strategy for public reframing of opioid use, addiction and pain. |
### BREAKOUT #5. SENIORS IN PAIN:

Improve pain assessment and management (pharmacological and non-pharmacological) for seniors

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<tr>
<th>Key Issues / Asks</th>
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</table>
| How can we build on existing programs (like the Practice Support Program for GPs), and create more capacity for clinicians? | Develop an integrated chronic pain program to which people can be referred and that would help coordinate all aspects of management and “system navigation”. Integrated care with standardized tools. | Allied Health Training.  
BC Pain Agency.  
Create billing codes for chronic pain.  
Provincial Pain Strategy. |
| What additional training and/or support is needed for primary care providers and family doctors with respect to pain and pain management? | Create interdisciplinary care teams who discuss patient cases in a team meeting and provide a written report. | Allied health training.  
BC Pain Agency.  
Create billing codes for chronic pain. |
| How can we improve clinician awareness of chronic pain, its triggers, and the ability to diagnose it in elderly patients? | Develop recognition of gerontology as a specialty. Comprehensive, integrated approach | Unified approach to chronic pain education in primary care.  
Trauma informed care in every pain program. |
| How can we help reduce the stigma of reporting pain amongst older adults? | Overcome barriers to communication through the use of media to educate and provide information about resources for seniors in pain and reduce the fear and stigma of pain. | Strategy for public reframing of opioid use, addiction and pain. |
Next Steps

The 2017 Summit was a dynamic, productive event that has set the direction not just for Pain BC, but for the health care system in BC, when it comes to chronic pain moving forward. The thematic breakout sessions from this Summit proved critical in informing this future work. For example, the discussion in Primary Care revealed an opportunity to build on the work of programs created out of the 2011 Summit, like the Practice Support Program for Pain. In the Seniors and Vulnerable Populations sessions, there was creation of new coalitions to improve pain management for older adults and people with addictions and mental health issues in BC.

Pain BC, the Ministry of Health and partner organizations represented at the Summit, are committed to taking forward recommendations for action items identified during the Summit. The Pain BC team will review summaries of the breakout sessions and work with champions and collaborators to advance work coming from the Summit. Working groups will continue to be established and resources allocated to take forward specific actions. Pain BC will continue to track actions against commitments made and milestones will be reported through the Pain BC website, social media channels, and monthly newsletter.
Appendix A

BREAKOUT SESSIONS: HARVEST DATA

Participant spread: physicians (with pain expertise), psychologists, allied health care practitioners (i.e. physio, OTs, nurses, RMTs, etc.), Self-Management BC representatives, people in pain.

Breakout #1. Primary Care:

Increase the capacity of primary care providers to provide evidence-based pain assessment and management, including non-pharmacological approaches

Issues
- The lack of a common language for specialists, GPs, allied HCP and patients
- Lack of awareness of what is currently available (patient & provider)
- Underfunding, patients being bounced around the system, quick turnovers equaling inadequate care and information, long wait times
- The need for community-based programs and multi-disciplinary approaches
- The lack of recognition around chronic pain and the need to recognize it as a chronic disease/condition
- The lack of set protocols for physicians/primary care to follow around how the shift from acute to chronic pain is seen, treated and when that happens

Possible Solutions
- MSP Code issues - outcome-based funding - moving away from intervention-based funding to time allotted for communication, essentially "counselling funding" (this exists, but the fee codes are so complex, not all primary care can access/use this; specialists need to be able to access this too); how to implement without losing tertiary care funding?
- Provide funding for allied health services – universal access (MSP issue).
- Clarify information about resource allocation and funding; direct people to the right resources, e.g. educate immigrants that they don't need to use the ER but can see a doctor (they may be used to doing this in their home country).
- Designate chronic pain as a chronic condition (e.g. diabetes, heart disease), must be recognized, designated, and given an administrative home.
- Create mandatory education/pain training – change the medical school curriculum; provide information for all HCP on how/when to refer on, sparking a passion for pain management by exposing HCP to pain training and information (e.g. how do you decide to become a pain specialist if you don't know about pain training?)
- Create and distribute a standardized pain tool kit.
- Offer a centralized hub for HCP and patients to get information (currently exists in different platforms, e.g. Pain BC tools, FETCH, PATHWAYS).
- Integrate medical records and improve data collection – practice-based rather than external gathering of data; ability for HCP to access the same info/records.
- Link specialists with primary care, using models like Project Echo to provide mentoring but also ensuring there is clinical decision support.
Breakout #2. Vulnerable Populations:
Enhance outcomes for people living with addictions, mental health issues and chronic pain

Issues/Questions/Possible Solutions

1. How can we stimulate the creation of publically funded interdisciplinary patient-centered clinics and outpatient support for people with pain, addiction and mental health issues?
   a. Assign health navigators to pain patients
   b. Fund upfront pain and addiction assessments
   c. Fund support groups beyond pain clinics
   d. Educate family members
   e. Continuum of care: build therapeutic relationships that last for months or years

2. How can we create accessible health care for those who need it?
   a. Provide more nurse practitioners with a holistic approach
   b. Provide needs-based types of services
   c. Provide more education to create empathy and understanding of chronic pain
   d. Build on community strength

3. How can we coordinate care and holistic pain navigation?
   a. Create a reference list of primary care physicians who are trained/informed in holistic & trauma based pain management
   b. Create MSP codes to permit physicians the time and incentive to treat complex chronic pain
   c. Create a client focused central hub, a one stop shop “integrated chronic pain health unit.”

4. How do we embed meeting people where they are at?
   a. Develop a provincial pain policy
   b. Advocate for a workforce
   c. Enhance advocacy
   d. Manage current funding structures for service delivery
Breakout #3. Pharmacological Pain Management:

Improve assessment, balance harms and benefits of medications, and advance appropriate pain management for patients across the continuum of care.

Issues

- Over the past two decades, an over-reliance on opioids has developed in the management of chronic pain. This over-reliance has resulted in harms to individuals, families, communities and to the health care system. Medical regulators, insurers and physicians are rapidly moving away from opioids as a first line of treatment and trying to advance evidence-based, multi-modal approaches. Unfortunately, many of these pain management approaches are not publicly funded or accessible in rural and remote communities.

- In 2010, the National Opioid Use Guideline (NOUG) was published, the culmination of a three year development process that involved a research group, a national advisory panel and a group of forty national faculty members working on implementation. An unintended and unforeseen outcome of this guideline has been the creation of a climate of fear within the medical community such that there is a reluctance to prescribe or maintain opioids medications for pain patients.

- For some patients, who have been well managed on opioids and who may be dependent on rather than addicted to opioids, the sudden reduction in access to these medications can cause adverse health effects, such as uncontrolled pain, depression and suicide. Evidence suggests that between 8 to 12% of people using opioids for pain will develop addiction; conversely, undertreated pain is a gateway to illicit drug use, depression and anxiety, loss of employment and suicide.

The challenge facing health care providers and policy-makers province-wide is how to ensure adequate pain management for British Columbians while reducing the harms of pain medications.

Possible Solutions

- Implement robust pain management education across health systems and for the public

- Invest in publicly funded access to physical + psychological therapies + enhancements to Pharmacare access to pharmacology + MSP fee code.

- Mandate free physician use of Pharmanet before opioid Rx.

- Drive evidence-based policy making.

- Implement use of electronic health records to access previous treatments and consultations

- Use existing testing infrastructure to better screen for medication metabolism and treat accordingly.

- Invest in early intervention with access to a range of pharmacological, physical, and psychological supports.

- Strengthen physician and patient pain literacy.

- Incentivize and structure collaborative, interdisciplinary, team-based pain care + support better cross-referrals.

- Strengthen access to primary care.

- Develop a provincial BC Pain Agency to support excellence in functional/ rehabilitative components of pain + resources.
Possible Solutions continued

- Address social determinants of health and public health interventions to strengthen conditions for recovery.
- Re-design physician compensation to account for assessment + treatment of chronic pain.
- Implement more subjective + comprehensive pain assessment tools.
- Utilize a reducing harms approach with opioid use where possible.
- Implement proper assessment + diagnostic approaches for Opioid Use Disorder.
- Collaborative discussion of full continuum of treatment options with patients.
- Ensure persistent modification + management of medication therapy to support continued improved function.
- Ensure co-occurrence of pain + mental health + addiction problems is accounted for.

Breakout #4. Pain in Rural BC:

Expand access to pain management (pharmacological and non-pharmacological) services in rural and remote parts of the province

Issues

- Limited community support often compounds the pain experience
- Lack of access to pain specialists is even more limited in rural and remote communities
- Geography and distance are added barriers to support and care
- Stigma round both pain and pharmacotherapy can be intensified in small communities

Possible Solutions

- Integrate pain management strategy
- Draw on existing community resources
- First visit to GP / therapist to create an interdisciplinary team that can assist the needs of the people in pain in their community.
- Patient-centered care and validation
- Create chronic pain billing codes
- Develop more MSP-covered allied health services
- Assist in patient navigation
- Make cost of care proportionate to income
- Utilize an holistic approach to care
- Employ active listening
- Respect sensitivity to peoples’ confidentiality//need for privacy (e.g. mental health)
- Educate patient and physician, caregivers
Promising practices to build on

- Telehealth
- Workshops (small)
- Interdisciplinary models
- Coordination committees of service providers
- Education via the Internet

Key takeaways

- People can self-manage their health when they have access to necessary tools knowledge, resources and support.
- Need a preventative health care model and funding.
- Rural communities have schools and libraries: educate around available resources is key and starts with access to ideas and resource materials.

Breakout #5. Seniors in Pain:

Improve pain assessment and management (pharmacological and non-pharmacological) for seniors

Issues

- How can we improve clinician awareness of chronic pain, its triggers, and the ability to diagnose it in elderly patients?
- How can we help reduce the stigma of reporting pain amongst older adults?
- How can we build on existing programs (like the Practice Support Program for GPs), and create more capacity for clinicians?
- What additional training or support is needed for primary care providers and family doctors with respect to pain and pain management?
- How can clinicians best provide pharmacological pain management for older adults who are not palliative or in residential care, while incorporating the new clinical guidelines on the use of opioids in non-cancer pain (Canadian Guideline for Safe and Effective use of Opioids for Chronic Non-Cancer Pain: BC College’s Prescribing Principles for Chronic Non-Cancer Pain)?
Possible Solutions

- Reduce the impact of chronic pain through public awareness, education, and transitional pain services, so that seniors remain active members of their communities.

- Develop an integrated chronic pain program to which to refer people that would help coordinate all aspects of management and “system navigation”. Integrated care with standardized tools.

- Improve collaboration, person-centered patient care, long-term care options, earlier intervention, resources, education, options, funding, mental health access, time with health care providers, access to different variety of modalities – social services, psychosocial, extended health plans for seniors.

- Overcome barriers to communication through the use of media to educate and provide information about resources for seniors in pain and reduce the fear and stigma of pain.

- Develop recognition of gerontology as a speciality. Comprehensive, integrated approach.

- Over time the cost of care would come down, patients’ pain would be reduced and quality of life would improve.

- Create interdisciplinary care teams who discuss patient cases in a team meeting and provide a written report.
Appendix B

POST-SUMMIT SURVEY FEEDBACK

The Summit model, combining interactive sessions and creative facilitation with solution-focused working groups, was very well received by participants. The expert panel of people with pain that kicked off the Summit, as well as the opportunity for dialogue between people living with pain, health care providers, and other stakeholders, in particular, were highly valued.

“Meeting people, such a wide variety, both people living with pain, and health care providers with an interest in pain, and others. Very stimulating, inspiring. I became aware of the stigma of chronic pain in a way that I never understood before.”

“As a health care provider, I was pleased to see that the public was well represented, but also the amount of other health care providers that were involved surprised me. I am happy to see that many want to be a part of change. I am hopeful.”

“Meeting people from many different components of health care - allied health, docs, policy makers, and having so many ppl with pain representing I enjoyed reflecting on big picture ideas and visualizing what they might look like. I found it amazing that so many of us are trying to do the same thing, and often struggling with the same issues.”

“I think that it was a good mix of learning modalities. I was extremely pleased that it was grounded in the lived experience of people living with pain. The most valuable part is that there is action coming from it, rather than just a one-time learning opportunity. Thanks for the comfort room!”

“As a person living with pain attending gave me a sense of empowerment. Many of my pain doctors and professionals were in attendance. As their patient hearing their views has transformed my understanding of them. I feel more hope and caring hearing the passion. I feel as though I can help make things better for myself and others. The facilitators were excellent. On the whole, it was a very well organized Summit with very thoughtful planning, strongly presented, and well documented. I look forward to see how the projects take shape and how I can get involved. Comfort room was very appreciated!!”
"The sense of inclusion for those of us in chronic pain. We are rarely asked for our opinion/thoughts on our conditions, the healthcare system, research, etc., which only exacerbates the sense of marginalization experienced by a large portion of the pain community. Being given a sense of hope, concern and compassion was like a gift."

"Gaining knowledge of how the medical system works overall. Understanding the level of “silo” that needs to be overcome. Contact with new organizations, groups, and facilitators to assist me in our local goal of improving pain management, and community wellness in our communities. Knowing that the concerns we feel here are shared province wide when it comes to rural health issues and treatment issues."

"Networking with medical professionals that were able to help with different paths to follow in determining my own care when my own physicians were not helpful."

"Thank you for stepping outside the box to create such a rich experience. I learned so much and had fun too!"

Participants also provided some valuable suggestions for improvement. Suggestions focused primarily on the need for more networking opportunities, more comfortable seating (and other accessibility issues), and the desire to attend more of the breakout sessions:

"Official presence from First Nations communities. Better accessibility for refreshments for people in chairs and other mobility aids. Lighter plates. Seating options beyond the chairs at tables."

"Provide ways to discuss issues in free form manner in smaller groups. Would require more facilitators or same facilitator appearing at multiple small groups. More free, networking time."

"It would be helpful to have a small portion of the conversation around the actual model we are trying to achieve. Something more concrete about what providers can actually begin to move towards that would be considered positive in setting the foundations for the philosophy of holistic care."
“More time to liaise with crucial service providers and organizations on what they do, how to contact, etc... was hard when working in the work groups to follow work group format for problem solving and identifying as well as meeting these awesome people and gleaning their information from them, exchanging cards, information etc.”

“Virtual networking in advance of the summit starting - I would have liked to have seen a delegate list circulated in advance so that I could research organizations/ and peoples work prior to the event.”

“As a person using a mobility aid, I found it very congested and difficult to walk around. The comfort room was nice, but they forgot the rollers. Rollers and stretchy bands with a mat would help some of us stretch out. Perhaps a few ‘2 minute’ pauses for movement would have helped. I had trouble keeping up.”

“A session directed to all stakeholders on the role, value and the importance of pain self management.”

“Felt it was very well done but would have preferred more comfortable chairs.”
Appendix C

SUMMIT MEDIA LINKS

We compiled Storify compilation of social media activity during Summit: https://storify.com/PainBC/bcpainsummit-2017/

The Provincial Summit drew several mentions in the media:

https://www.painbc.ca/news/provincialpainsummithearscallsnationalpainstrategy
https://www.painbc.ca/news/cbcsnationalcoversprovincialpainsummit
https://www.painbc.ca/news/chronicpainsufferersneedhelpprovincesayadvocates
https://www.painbc.ca/news/painbcsexecutivedirectordrmichaelnegraefftalkpainopioidsprovincialsummit
https://www.painbc.ca/news/mariahudspithdiscussespainbcprovincialsummitcpsbcopioidsguidelines
https://www.painbc.ca/news/mariahudspithtalkscoopradioaboutprovincialpainsummit

Big House Productions created a video recap of the Summit: https://youtu.be/6rfHrBHCtA