

The *Taking the Pain out of Complex Pain Management: Practical Approaches for Improved Services Across the Continuum of Care* conference was held April 11 & 12, 2008 in Edmonton. At this conference, attendees were asked to provide feedback on the Alberta HTA Chronic Pain Ambassador Program *Evidence-Informed Primary Care Management of Low Back Pain Guideline Summary*. A hardcopy guideline summary and questionnaire was distributed to attendees and they were invited to return their completed response with their conference evaluation form or to return it via fax to an Ambassador Program Team member.

In total, 41 responses from the pain conference were received.

The Ambassador Working Committee were also invited to provide a survey response with their feedback on the Guideline Summary. The committee members were asked to return their questionnaire by email or fax to the Steering Committee. A total of eight responses were received from the Working Committee.

The total number of responses from both the pain conference and Working Committee is 49. The data from the returned questionnaires was compiled using Excel and the qualitative responses analysed according to theme. Results are presented below.

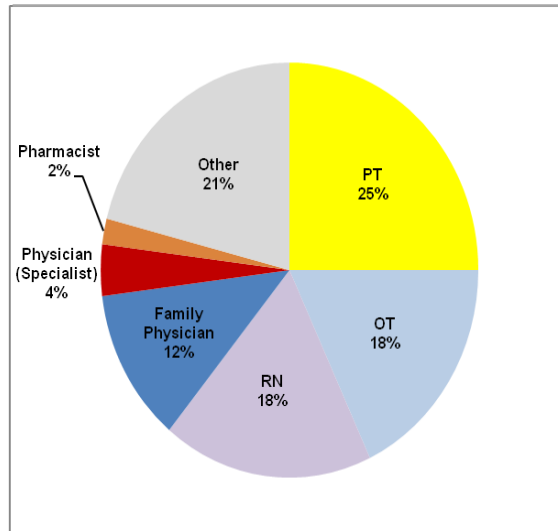
Table 1: Respondent disciplines

Discipline	# Conference Respondents	# Working Committee Respondents	Total Respondents	
			#	%
Family Physician	5	1	6	12%
Physician (Specialist)	1	1	2	4%
Physical Therapist (PT)	9	3	12	24%
Occupational Therapist (OT)	7	2	9	18%
Registered Nurse (RN)	9	-	9	18%
Pharmacist	-	1	1	2%
Other*	10	-	10	20%
TOTAL	41	8	49	100%

*Other disciplines include: psychologist (x6), exercise therapist/kinesiologist (x2), and one each of mental health coordinator (PCN) and nurse practitioner

¹ This document was prepared by Ms. Tara Schuller, Charis Management Consulting Inc., for the Ambassador Program Steering Committee

Figure 1: Respondent disciplines (n=49)



*Other disciplines include: Psychologist (x6), exercise therapist/kinesiologist (x2), and one each of mental health coordinator (PCN) and nurse practitioner

Question 1: The guideline summary has three components. Indicate your assessment of the usefulness of each component:

- i. 'do' and 'do not do' recommendations*
- ii. algorithm*
- iii. medication table*

Table 2: Usefulness of components

Discipline	'Do' and 'do not do' recommendations		Algorithm		Medication Table	
	Useful	Not Useful	Useful	Not Useful	Useful	Not Useful
Family Physician (n=6)	6		6		5	1
Physician (Specialist) (n=2)	2		2		2	
Physical Therapist (PT) (n=12)	12		12		10	
Occupational Therapist (OT) (n=9)	9		9		8	
Registered Nurse (RN) (n=9)	9		8		9	
Pharmacist (n=1)	1		1		1	
Other (n=10)	10		10		10	
TOTAL	49		48*		45**	1

* One RN indicated he/she was not sure about the usefulness of the algorithm.

** Two PTs checked both "useful" and "not useful" so their responses were omitted from the results. However, this could be interpreted as "somewhat useful". One OT did not rate the usefulness of the medication table as they felt unqualified to do so.

Question 2: How can we improve this guideline summary (e.g. layout, format, wording)?

Respondents provided suggestions to improve the guideline summary. Twenty-six respondents provided suggestions. Nine respondents indicated they were satisfied with the guideline and did not provide suggestions for improvement. There were 14 respondents who did not reply to this question.

Responses are grouped according to the following themes: suggestions regarding the recommendations, formatting, layout, algorithm, medication table, supplemental documents, and red and yellow flags. There were additional recommendations provided which are listed in the ‘other’ category. All suggestions for improvement, organized by theme and respondent discipline, are presented in the table below.

Table 3: Suggestions for improvement to the guideline summary (n=26)

Theme	Detail	Discipline
Recommendations	Explain prolotherapy.	Family Physician
	Perhaps the indication for prolotherapy should be included as family practitioners may not know who should get this.	Physician (Specialist)
	Where there are examples of type of detailed treatment, it would be great to include it (e.g., physical exercise - which types are being recommended).	OT
	I would like to see better "categorization" as a result of assessment in the acute phase, i.e., mechanical pain, discogenic, inflammatory pain with neurological involvement. Do not lump together. Rather, determine area of pathology early on before it becomes chronic and the term "non-specific LBP" is used. This is not meaningful and would like this to be more specific to add value.	PT
	Need to clearly differentiate LBP from LBP with leg pain as seems to be an assumption that they are similar.	PT
	To assist in endorsement by the College of Physical Therapists of Alberta, the Alberta Physiotherapy Association, and physiotherapists who see low back pain clients, I would recommend the following: A. Acute/Subacute: Instead of bullet re "recommend physical exercise," change that bullet to read "recommend physical activity and therapeutic exercise." Also, for the bullets re reassess and consider PT/Chiropractor/Osteopath/Physician referral, I would suggest adding the terminology "and therapeutic exercise" after the words spinal manipulation. B. Chronic: Change bullet "recommend physical exercise" to "recommend physical activity and therapeutic exercise."	PT
	A description or reference to information on what an orthopedic exam entails for the physicians.	PT
	You might consider including a family violence protocol question.	Other
	Perhaps including the "average number" of sessions of a particular modality (e.g., PT) that has been used in the studies the guideline is based on (with the caveat that this number should be used with all patients).	Other

Formatting	Hard to tell colours on B&W printer.	Family Physician
	Can the DO and DO NOT page be configured to be more appealing? Perhaps adding the DO NOTs into the algorithm might eliminate the need for a separate DO and DO NOT sheet. As it is right now, the page is not as user friendly as the algorithm.	PT
	Algorithm - blue background areas and word 'yellow flag' would not show well on B&W print, which most staff would have to use.	RN
	Algorithm - light blue shading, although attractive, could be interpreted as more significant information within shaded areas (similar to highlighting).	Other
Layout	Decrease to 1 page.	Family Physician
	Love the 1-page aspect.	OT
	One page format is key.	PT
Algorithm	In algorithm - I really think a few brief reminders re: Cauda Equina Syndrome would help (bowel/bladder difficulties).	Family Physician
	Early referral to PT during the acute and sub-acute stages for patient education, including proper posture, gentle exercises and education regarding back pain.	PT
	What about referral for psychological treatment?	Other
Medication Table	Expand the medication table to include methadone and caution the difference between duragesic and ratio – Fentanyl.	Family Physician
	Percentages for response rates and side effects.	Physician (Specialist)
Supplemental documents	Guideline-based education on sheets for patients.	OT
	This guideline is useful as a quick reference but would also be useful to provide expanded version which explains the rationale for these recommendations, e.g., on the web.	PT
Red & yellow flags	I find the 'emergency', 'urgent' and 'soon' under the red flags a little unclear. Perhaps some details as to what timeframes we are looking at. In general, the wording in the guidelines is quite unclear in terms of DO, DO NOT DO, etc. and then to use a word like 'soon' seems ambiguous.	OT
	What to do if yellow flags? Acute and sub-acute is bad, flare up good? Consider referral to psychologist.	OT
Other	Possibly put next to recommendation the level of evidence.	Family Physician
	Input on how to access resources re: actions suggested (e.g., "recommend physical exercise" how to find out best way to implement this?)	OT
	Consider ways to integrate into physicians EMR systems (including EPIC/eClinician). For example, if LBP is entered this protocol icon pops up.	OT
	No abbreviations, e.g., LBP.	PT
	Concern family physicians are not moving fast enough within "red flags" as they just think it is LBP.	PT
	Perhaps use "interprofessional" rather than multidisciplinary.	RN
	Provide reference list and or a discussion of how recommendations were devised, e.g., why are epidural steroid injections recommended.	Other
	Put a date on each page so would know how recent.	Other

Question 3: Would you use the guideline summary?

Table 4: Respondents who would use the guideline summary (n=48)

Discipline	Yes*	No
Family Physician	6	
Physician (Specialist)	2	
Physical Therapist (PT)	11	1
Occupational Therapist (OT)	9	
Registered Nurse (RN)	8	1
Pharmacist	1	
Other*	9	
TOTAL	47	2**

* Comments from those who would use the guideline include:

- **(PT)** *Probably for student education re: where do we fit in the picture, what our clients potentially already have seen/done/been exposed to.*
- **(OT)** *If applicable to my practice concerns and area.*

** Respondents who indicated they would not use the guideline summary explained:

- **(PT)** *It is not as useful at present - would use it with better "categorization" as a result of assessment in the acute phase, i.e., mechanical pain, discogenic, inflammatory pain with neurological involvement. Do not lump together. Rather, determine area of pathology early on before it becomes chronic and the term "non-specific LBP" is used. This is not meaningful and would like this to be more specific to add value.*
- **(RN)** *Not related to pediatrics.*

Question 4: Do you foresee challenges in implementing any of these recommendations? If so, please explain.

Respondents described challenges to implementing the guideline summary. Thirty-two respondents identified challenges. Six respondents indicated they did not foresee any challenges with implementation. There were 11 respondents who did not reply to this question.

These challenges identified are grouped according to the following themes: access/resources, inconsistent use, time, influencing practice, and more detail needed. There were additional challenges identified which are listed in the 'other' category. Responses, organized by theme and respondent discipline, are presented in Table 5 below.

Table 5: Challenges to implementation of the guideline summary (n=32)

Theme	Detail	Discipline
Access/resources	Availability of resources.	Family Physician
	Probably the availability of resources in the community. The ones that are available (Living Well) will need more advertising.	Physician (Specialist)
	Resource needs to be well publicized with practitioners.	OT
	Access to services.	OT
	Not particularly, in a rural context, dissemination should not be a problem in terms of allied health professionals. As explained in the points at the beginning of the guideline, access to the interdisciplinary and chronic pain programs is an issue. The guideline itself is concise and easy to read.	OT
	Access to a multidisciplinary pain program. Can we somehow reference other multidisciplinary pain-specific services as through Living Well in the CHR?	OT
	Access in each treatment area.	PT
	Resources.	PT
	Challenges will include the availability of active rehab programs and self-management programs particularly in the rural/non-urban areas.	RN
The facilities for full therapy are not always available in small rural settings.	RN	
Inconsistent use	Lack of use by others.	OT
	Antagonism between practitioners' opinions.	OT
	Compliance of practitioners (PTs, doctors, etc.) in the use of the guideline.	PT
	Individual differences (patient needs and practitioner's experience) may determine alternate treatment on some occasions).	PT
	Inconsistency treatment recommendations throughout client/patient care history.	Other
	Discrepancy among other professionals' recommendations and opinions.	Other
Time	Time limitations.	Physician (Specialist)
	Time to read them.	OT
	Time constraints of frontline workers to get the information.	PT
	Time to devote to updating clinicians. I think there is no question that you are saving them time, but I am afraid that given the shortage of MDs and the size of so many practices, there still will not be enough time to review/learn the guidelines.	Other
	I appreciate all of your efforts. Extremely useful to have the evidence in an easy to apply format. There will, however, be individuals who find they do not have the time to review; and find some of the recommendations vague.	Other

Influencing practice	The usual problem: getting physicians educated re: new protocol/treatments.	Family Physician
	Yes because physicians in practice have their established routines and may be too busy to review these.	Family Physician
	Tradition, change, awareness.	Family Physician
	For PTs, implementation may mean a change in practice for some therapists who continue to provide modalities-based treatments rather than active rehabilitation and self-management strategies.	PT
	Introducing this to MDs.	RN
More detail needed	Simplistic which is good and bad. I want qualifying statements doe the DO NOT DO items. "See guideline and background document", but no reference is given, especially when it challenges common treatments.	OT
	With regards to LBP, I do not think that I would refer to the guidelines much in my current practice. However, I would definitely refer to as needed. I think the concept is very good. Is it possible to know specific literature reviewed?	OT
	Is there any evidence regarding positioning, changing environment and providing assistive devices?	OT
Other	Awareness of and availability of guidelines.	OT
	Having physicians follow-up with clients (i.e., in acute phase).	OT
	Relevance to practice area.	OT
	As a physiotherapist, trying to communicate with primary care physicians is a problem. I rarely feel they have the time to be bothered or want to be bothered. (Of course this works both ways).	PT
	I would suggest taking into consideration in the algorithm the "high risk of chronicity" clients, as sometimes public insurance company will try to return the client to work without taking into consideration that an interdisciplinary approach would help for a successful return. Yellow flags - sometimes it is not worth it to wait for interdisciplinary approach.	PT
	Making it easy for everyone to use.	PT
	Maybe in the initial part until the knowledge gap is narrowed.	PT
	Your criteria for accepting treatments as "DO" seems to be broader or more lenient than some of the other research presented at this conference.	Other
	We will use this guide to monitor treatment events on MVA claims and to educate clients and health care professionals about the Ambassador Program.	Other
Barriers with organization resistance to recommendations.	Other	
Need to keep recommendations regularly up-to-date with new research.	Other	

Following are suggestions offered by a few respondents on how to overcome implementation barriers which have been provided by some of the respondents (Table 6).

Table 6: Suggestions to overcome implementation barriers (n=3)

Theme	Detail	Discipline
Suggestions	Should put actions with strong evidence in BOLD print or another colour.	Family Physician
	Audio CD to facilitate learning.	Physician (Specialist)
	Also, the goals for each category might be helpful. E.g., DO xyz... what are we achieving with this activity (or what to do next). Indicate the "why" of it.	PT