



A H F M R

ALBERTA HERITAGE FOUNDATION
FOR MEDICAL RESEARCH

Ambassador Program

Pre-Videoconference Survey

Results Summary

May 29, 2006

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***Recipients:* Ambassador Steering Committee**

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Survey Details

Evaluation purpose: This report summarizes data gathered between May 12, 2006 and May 29, 2006 from the Ambassador Program's workshop participant survey. The survey was intended to gauge the participants' need for care pathways in the areas of chronic low back pain and headache, and to assess their interest in participating in a videoconference to initiate the Ambassador Program's second phase. It was not intended to be a rigorous and comprehensive needs assessment; aware of the resources and time required to conduct such an assessment on a provincial scale, the Ambassador Steering Committee opted to conduct a simple "reality check" with workshop participants before initiating the program's second phase.

A survey invitation was emailed or couriered to 141 workshop participants. Eight invitations proved undeliverable. A total of 61 survey responses were completed (59 web, 2 print) for a response rate of 45.9%.

Survey authors: Donna Angus, Christa Harstall, Saifee Rashiq, Paul Taenzer, Richard Thornley, Margaret Wanke, Amy Wong.

Proposal date: Not applicable

Snap administrator: Richard Thornley

Survey delivery period: May 12, 2006 to May 29, 2006

Survey delivery people: N/A

Survey delivery mode: Print surveys FEDEX couriered to recipients. Online survey delivered through the AFHMR website.

Survey files location: \\Eais on 'ahfmr.ab.ca' \Snap

Survey data files: \\Eais on 'ahfmr.ab.ca' \Snap\sn0605HTAAmbassador2.mdf

\\Eais on 'ahfmr.ab.ca' \Snap\ sn0605HTAAmbassador2.pdf

\\Eais on 'ahfmr.ab.ca' \Snap\ sn0605HTAAmbassador2.rdf

\\Eais on 'ahfmr.ab.ca' \Snap\sn0605HTAAmbassador3.mdf¹

¹ This version of the survey was used to produce the print version of the survey only. Otherwise, all data entry was conducted in sn0605HTAAmbassador2. Excel was used for analysis of the survey results.

Survey Snap filenames: sn0605HTAAmbassador2
sn0605HTAAmbassador3

Survey response collection: Survey responses received via web survey, n=59. Survey responses received via fax, n=2.

Report preparation: Richard Thornley and Tara Schuller

Report date: June 22, 2006

Survey statistics:

	Delivered	Returned	Response
Print surveys	19	2	10.5%
Web surveys	114 ²	59	51.8%
Total	133	61	45.9%

Duration of interview:³ Average 9.8 minutes

Response dates: May 12 (n=12); May 13 (n=1); May 14 (n=1); May 15 (n=4); May 16 (n=12); May 17 (n=9, incl. 1 fax); May 18 (n=3); May 19 (n=9, incl. 1 fax); May 20 (n=1); May 22 (n=2); May 23 (n=5); May 24 (n=1); May 26 (n=1)

Key dates: Friday, May 12 (invitation); Tuesday, May 16 (first reminder); Friday, May 19 (second and final reminder); survey scheduled to be closed on Tuesday, May 23, but remained open until Monday, May 29, 2006 at midnight.

² This number does not include the eight Ambassador workshop participants for whom we did not have correct email addresses. That is, 122 email invitations were sent initially, but eight of the email addresses were undeliverable.

³ This data, automatically collected by Snap for web survey responses, reflects the time spent by each respondent completing the survey.

Results

Question 1 – What is your discipline?

Discipline	Survey Responses	Ambassador Workshop Participants
Nursing	21 (34%)	34 (27%)
Rehabilitation (OT, PT)	15 (25%)	23 (18%)
Medicine	9 (15%)	27 (21%)
Administration	5 (8%)	20 (16%)
Pharmacy	4 (7%)	12 (9%)
Psychology	4 (7%)	9 (7%) ⁴
Social work	2 (3%)	
Other	1 (2%)	3 (3%)

Four respondents also provided “other” responses to this question, three in addition to one of the options identified in the table above. These were: kinesiology, psychiatry, palliative nurse consultant, and nursing manager.

Question 2 – Where do you work?

Region⁵	Survey Responses	Ambassador Workshop Participants
Aspen Regional Health Authority	9 (15%)	28 (22%)
Calgary Health Region	18 (30%)	23 (18%)
Capital Health	4 (7%)	11 (8%)
Chinook RHA	13 (21%)	23 (18%)
David Thompson RHA	6 (10%)	17 (13%)
East Central Health ⁶	3 (5%)	12 (9%)
Palliser Health Region	3 (5%)	8 (6%)
Peace Country Health	5 (8%)	8 (6%)

⁴ Psychologists and social workers were counted in the same category for the Ambassador workshops but separately in the pre-videoconference survey.

⁵ No surveys were completed by respondents from Northern Lights Health Region because no Ambassador workshop was delivered in that region and nobody from that region was included in this survey.

⁶ The lower response from East Central Health was probably influenced by difficulties we experienced addressing email to workshop participants from that region.

Question 3 – How often in your practice do you use care pathways for the management of...

Group	Low back pain?	%	Headache?	%	Other condition(s)?	%
All disciplines						
Frequently	8	13.1	4	6.6	5	8.2
Occasionally	9	14.8	7	11.5	20	32.8
Rarely or never	40	65.6	46	75.4	28	45.9
Not sure	4	6.6	4	6.6	8	13.1
Non-MDs						
Frequently	5	9.6	4	7.7	3	5.8
Occasionally	7	13.5	5	9.6	18	34.6
Rarely or never	36	69.2	39	75.0	24	46.2
Not sure	4	7.7	4	7.7	7	13.5
MDs only						
Frequently	3	33.3	0	0.0	2	22.2
Occasionally	2	22.2	2	22.2	2	22.2
Rarely or never	4	44.4	7	77.8	4	44.4
Not sure	0	0.0	0	0.0	1	11.1

Thirty (49.2%) of the respondents reported that they “frequently” or “occasionally” use care pathways for low back pain, headache, or some other condition (or conditions). Thirty-one (50.8%) reported that they “rarely or never” use care pathways for any of these conditions, or were “not sure” that they did so.

Question 4 – What other condition(s) were you referring to?

This question was asked of the 25 respondents (including four physicians) who reported that they “frequently” or “occasionally” use care pathways for managing an “other condition”. Other conditions are listed in the paragraphs below.

Respondents indicated they use care pathways most frequently for managing pain related to conditions other than headache and low back pain, for example, neuropathic pain, pelvic pain, complex regional pain, and cancer pain. Cardiac conditions were the second most frequently mentioned where respondents used care pathways, for example, myocardial infarction and heart failure.

Thirdly, pneumonia, perinatal care (i.e., delivery and post-natal care), vascular care (i.e., thrombolytics and vascular protection) and joint care (i.e., hip fractures and replacements) were mentioned with equal frequency as conditions where respondents have used care pathways.

A small number of respondents use care pathways for stroke and for general post-surgery care.

TURP, NRSA, ACS, asthma, endoscopy and chronic respiratory conditions were each mentioned once.

Themed data:

Freq.	THEME	DATA/RESPONSE
8	Pain – TBI	→ pain perceptions altered by TBI (traumatic brain injury).
	Pain - Pelvic	→ chronic pelvic pain
	Pain - Pelvic	→ Pelvic
	Pain - OA	→ OA
	Pain - neuropathic	→ neuropathic pain
	Pain - neuropathic	→ neuropathic pain
	Pain - CRPS	→ CRPS (complex regional pain syndrome)
	Pain - Cancer	→ cancer pain
4	Cardiac	→ heart failure → MI (myocardial infarction) → myocardial infarction → Use an MI (myocardial infarction) pathway in our region
3	Vascular care	→ Thrombolytics → Deep vein thrombosis → Use protocols for Chronic Disease Management i.e. → vascular protection
3	Pneumonia	→ Pneumonia → Pneumonia → Pneumonia
3	Perinatal care	→ C-Section → Postnatal → Vag delivery
3	Joints	→ Hip fracture → Joint replacement → Tendon Repairs
2	Stroke	→ Stroke → Stroke
2	Post-surgery	→ Post surgery → Surgical Day Care
1	TURP	→ Transurethral resection of the prostate
1	Respiratory	→ Chronic respiratory
1	Patient care	→ Care of patient & NRSA
1	Endoscopy	→ Endoscopy
1	Asthma	→ Asthma
1	ACS	→ ACS

Question 5 – Thinking about the pathways that you have used, how were they developed?

This question was asked of the 30 respondents (including six physicians) who reported that they “frequently” or “occasionally” use care pathways for the management of one or more of the conditions identified in question 3 (i.e., low back pain, headache, and/or other condition(s)).

Group	Low back pain	%	Headache	%	Other condition(s)	%
All disciplines						
Local	4	16.0	2	8.3	8	30.8
Adapted from national source	4	16.0	0	0.0	4	15.4
Adapted from international source	4	16.0	4	16.7	4	15.4
Not sure	5	20.0	9	37.5	6	23.1
Not applicable	8	32.0	9	37.5	4	15.4
Non-MDs						
Local	2	10.5	2	11.1	7	31.8
Adapted from national source	3	15.8	0	0.0	4	18.2
Adapted from international source	3	15.8	4	22.2	4	18.2
Not sure	4	21.1	5	27.8	5	22.7
Not applicable	7	36.8	7	38.9	2	9.1
MDs only						
Local	2	33.3	0	0.0	1	25.0
Adapted from national source	1	16.7	0	0.0	0	0.0
Adapted from international source	1	16.7	0	0.0	0	0.0
Not sure	1	16.7	4	66.7	1	25.0
Not applicable	1	16.7	2	33.3	2	50.0

Question 6 – In general, how useful have you found the pathways that you have used?

This question was asked of the 30 respondents (including six physicians) who reported that they “frequently” or “occasionally” use care pathways for the management of any of the conditions identified in question 3 (i.e., low back pain, headache, and/or other condition(s)).

	All disciplines	%	Non-MDs	%	MDs	%
Very useful	15	50.0	13	54.2	2	33.3
Somewhat useful	11	36.7	7	29.2	4	66.7
Not useful	1	3.3	1	4.2	0	0.0
Not sure	3	10.0	3	12.5	0	0.0

Question 7 – How did you learn about the care pathways that you have used?

This question was asked of the 30 respondents (including six physicians) who reported that they “frequently” or “occasionally” use care pathways for the management of any of the conditions identified in question 3 (i.e., low back pain, headache, and/or other condition(s)).

Multiple responses to this question were permitted.

	All disciplines	%	Non-MDs	%	MDs	%
Colleagues	19	63.3	16	53.3	3	10.0
Continuing education	10	33.3	6	20.0	4	13.3
Journal article	10	33.3	7	23.3	3	10.0
Professional meeting/conference	16	53.3	11	36.7	5	16.7
Web site	1	3.3	1	3.3	0	0.0
Other	6	20.0	0	0.0	0	0.0

“Other” responses were:

- Involved in the development
- Asking pt+fam what has worked in the past
- regional working group
- Provincial networks and projects
- worked on it
- mandated by the RHA

Question 8 – What have been the barriers to your use of care pathways...?

This question was asked of the 31 respondents (including three physicians) who reported that they “rarely or never” use or were “not sure” that they use care pathways for the management of any of the conditions identified in question 3 (i.e., low back pain, headache, and/or other condition(s)).

Multiple responses to this question were permitted.

Barrier	All disciplines	%	Non-MDs	%	MDs	%
Difficult to reconcile patient preferences with pathway recommendations	4	12.9	3	9.7%	1	3.2%
Difficult to use and/or implement	2	6.5	2	6.5%	0	0.0%
Lack of time and/or other resources	9	29.0	7	22.6%	2	6.5%
Multiple contradictory pathways	2	6.5	1	3.2%	1	3.2%
No institutional support	7	22.6	6	19.4%	1	3.2%
No obvious benefit to my patients	2	6.5	2	6.5%	0	0.0%
No obvious benefit to my practice	2	6.5	2	6.5%	0	0.0%
Not available in form/format I can use	3	9.7	3	9.7%	0	0.0%
Not aware of pathways relevant to my practice	11	35.5	11	35.5%	0	0.0%
Not compatible with my values/experience	2	6.5	2	6.5%	0	0.0%
Not practical/too rigid	1	3.2	1	3.2%	0	0.0%
Unsure of their quality	4	12.9	3	9.7%	1	3.2%
Other	10	32.3	9	29.0%	1	3.2%

“Other” responses were:

Seven out of the ten respondents indicated they are not in a clinical role, and as such do not directly use the care pathways. Of the remaining respondents who do work in a clinical capacity, one described having a lack of opportunity to use the chronic pain care pathways due to low numbers of pain patients. Another identified a barrier of palliative versus chronic pain.

Themed data:

Freq.	THEME	DATA/RESPONSE
7	Administrator/not clinical caregiver	<ul style="list-style-type: none"> → Currently in an educator not a clinical role → I am an administrator, therefore do not have a personal practice → I am not a front line caregiver. → I do not work directly with patients → In administration, so not providing direct patient care → This is a tertiary care facility, care pathways directed towards primary care → Usually my involvement with clients are to: secure benefits and funding, locate housing, assist with transition to supportive housing, personal directives or guardianship, powers of attorney or trusteeship, issues regarding competency. Awareness of pain management is beneficial when working with clients who are living with chronic pain.
1	Low demand (Few pain patients)	→ I don't have many pain patients.
1	Palliative vs. chronic	→ palliative vs. chronic
z	z	→ All my comments are in relation to chronic pain conditions, not to other chronic conditions

Question 9 – In your opinion, how useful are the Ambassador program's goals of developing locally-based care pathways in the areas of...

	All disciplines	%	Non-MDs	%	MDs	%
Low Back Pain						
1 = Not useful	5	8.5%	5	10.0%	0	0.0%
2	6	10.2%	4	8.0%	2	22.2%
3	13	22.0%	11	22.0%	2	22.2%
4	22	37.3%	19	38.0%	3	33.3%
5 = Very useful	13	22.0%	11	22.0%	2	22.2%
Headache						
1 = Not useful	4	6.7%	4	7.8%	0	0.0%
2	8	13.3%	6	11.8%	2	22.2%
3	12	20.0%	10	19.6%	2	22.2%
4	23	38.3%	20	39.2%	3	33.3%
5 = Very useful	13	21.7%	11	21.6%	2	22.2%

Question 10 – What format of care pathway fits or might fit best with your practice?

Multiple responses to this question were permitted.

Format	All disciplines	%	Non-MDs	%	MDs	%
Integrated with electronic patient record	30	49.2	24	39.3	6	9.8
One page printed diagram or flow chart	49	80.3	42	68.9	7	11.5
Personal digital assistant software	15	24.6	12	19.7	3	4.9
Printed booklet	22	36.1	21	34.4	1	1.6
Available on web site	29	47.5	23	37.7	6	9.8
Other	3	4.9	3	4.9	0	0.0

“Other” responses were:

- As we move toward electronic charting this would be helpful.
- We are currently looking at one page flow sheets for 6 different chronic conditions
- specific education on how to use it -in-service

Question 11 – Are there barriers to the use of care pathways in your health region?

Twenty-seven (44.2%) respondents responded “No” to this question. Five were physicians. Thirty-four (55.7%) others commented on the barriers to the use of care pathways in their health regions.

The barrier most frequently mentioned by respondents was a lack of time to use care pathways in the clinical setting, i.e., it is not always possible to incorporate care pathways into the work flow a busy practice, and there are challenges to allocating time to inform staff of new materials.

After “lack of time”, the next most frequently mentioned barrier was inconsistent interpretation and use of care pathways, meaning a variation in interpretation across clinicians and cases where the pathways are used by some clinicians and not others.

Another barrier mentioned was a general lack of resources, although the deficient resource was not named.

The following barriers were mentioned two or three times each:

- Resistance of clinicians to trying new approaches

- Lack of infrastructure/IT to support use of care pathways
- Lack of communication, i.e., between departments, networking
- Lack of physician buy-in
- Lack of staff
- Cumbersome approval process for pathways

Mentioned once each were education, distance, competency, patient complexity, lack of interest, lack of awareness, lack of funding and information overload. One respondent indicated the service model in their region did not support the use of care pathways. Another stated that care pathways are not necessary since, "where I work, pain management is directed by a doctor, not by a pathway".

Themed data:

Freq.	THEME	DATA/RESPONSE
8	Lack of resources: time	<ul style="list-style-type: none"> → I have no time to look up on the computer any info. Work late consistently don't get through patient load. → Large program with current model of individualized care, so getting all staff and then clients on board will take considerable time and effort. (Although I'm all for it!) → Limited time of primary care physicians to review and follow care plan. → nature of acute care setting → Time limitations to put into practice → Time seems to be a major roadblock → time to present and make sure used effectively → Time, need to be simple one pagers
6	Inconsistent interpretation/use/compliance	<ul style="list-style-type: none"> → Adherence → Compliance by multi disc team - esp. physicians → consistent interpretation and use. → not everyone uses it and therefore depending on the clinician treatment approach is different → staff participation → Turnover of physicians leads at times to re-interpreting chronic pain in negative (sometimes destructive) ways
5	Lack of resources: general	<ul style="list-style-type: none"> → availability of resources → Lack of clinical resources to establish and implement care pathways. → Lack of resources. → relative absence of some critical resources → We are yet to set up resources for management of chronic non-malignant pain
3	Resistance to trying new approaches	<ul style="list-style-type: none"> → [Lack of interest] in new ideas in some facilities. → Not all practitioners (physicians as well as other disciplines) are open to trying new things → primarily individual caregiver preference - no one wants their 'professional judgment' questioned
3	Lack of resources: infrastructure/IT	<ul style="list-style-type: none"> → electronic implementation is a barrier → Electronic record not yet available → IT resources to develop computer support and implement
3	Communication	<ul style="list-style-type: none"> → lack of communication between depts. → Limited opportunities for information sharing. → we lack networking

Freq.	THEME	DATA/RESPONSE
2	Physician buy-in	→ Communication "Buy-in" from physicians → pathway development appears to have little physician input at the practicing physician level A dissatisfaction with the initial guidelines /pathway and clinical decision making processes has led to underutilization of many useful practice decision making tools
2	Lack of resources: staff	→ Availability of staff → lack of staff on a consistent basis especially rehab
2	Cumbersome approval process	→ Any form we use has to be perused and approved by the forms committee first and this sometimes takes quite a bit of time and some red tape. → Process of review and approval through various methodologies.
1	Achieving consensus	→ There will always be barriers - I see the greatest as simply getting all the stakeholders to agree on what the best practice is and the clinical indicators to measure success.
1	Unnecessary/not needed	→ Where I work pain management is directed by a doctor, not by a pathway
1	Service model	→ Service model for our program does not allow comprehensive coverage for many of diagnoses in Ambassador Program
1	Patient complexity	→ complex patients with multiple concerns
1	Lack of resources: funding	→ funding seems to be a major roadblock
1	Lack of interest	→ Lack of interest in education
1	Lack of awareness	→ I am not aware of care pathways used in our region. I work in mental health.
1	Information overload	→ Overload of information
1	Education	→ Education
1	Distance	→ distance seems to be a major roadblock
1	competency	→ competency
Z	Z	→ Don't know
z	z	→ this should be directed at physicians

Question 12 – Are there tools other than care pathways that would be more helpful for you to incorporate research evidence into your practice with chronic pain patients?

Thirty-nine (63.9%) respondents responded “No” to this question. Seven were physicians. Twenty (32.8%) others commented on other tools. Comments are described below.

In response to this question, individuals identified three items equally frequently: having regular practice updates for clinicians, enhancing continuing education to incorporate new tools and treatments for chronic pain, and direct consultation with chronic pain experts and/or clinicians who have experienced success with patients using care pathways.

Other suggestions for tools included printed materials, i.e. resource manuals and documents that could easily be shared with colleagues. Other suggestions included summaries of and links to best practice/evidence based literature. Two respondents identified protocols (as opposed to pathways) as useful tools.

One person suggested case studies, another described a need for assistance to link pill and non-pill care.

Themed data:

Freq.	THEME	DATA/RESPONSE
3	Regular updates	<ul style="list-style-type: none"> → regular practice updates → regular updates → Regular updates for clinicians on useful clinical research findings
3	Education	<ul style="list-style-type: none"> → continuing education → Course on management of chronic pain patients → For nursing educators development of education tools pertaining to new material vs. nursing educators spending ++ time preparing information for distribution.
3	consultation	<ul style="list-style-type: none"> → Clinical experts for consultation and advice and care planning → Consultant advice. Pain clinics too difficult to contact and wait time too long. Sometime a phone consultation would be helpful. → Probably either a lecture or discussion format with practitioners who actually have found something useful.
2	Printed resource materials	<ul style="list-style-type: none"> → resource manuals → Written information on this program that could be shared with other staff
2	Literature	<ul style="list-style-type: none"> → Not MORE useful - but maybe in addition to the pathways, a website that would have connections to, or copies of the latest evidence (similar to Cochrane) → succinct summary of literature so that we can easily review best practice as needed
2	Assessment protocols (vs. pathways)	<ul style="list-style-type: none"> → Client and Resident assessment protocols associated with the RAI information system → protocols versus pathways

Freq.	THEME	DATA/RESPONSE
1	Linking assistance	→ assistance with linking pill and non pill care
1	Case studies	→ Case studies
z	Z	→ Don't know
z	Z	→ I don't know
z	z	→ Yes, but I am not sure what tools are out there

Question 13 – Are there any other chronic pain management topics or practice issues (other than low back pain or headache) where research evidence would be helpful in your practice?

Twenty-four (39.3%) respondents responded “No” to this question. Five were physicians. Thirty-four (55.7%) others commented on other chronic pain management topics or practice issues where research evidence would be helpful. Other chronic pain management topics identified are listed below. The frequency of mention is included in brackets following the topic:

- Arthritis pain (8)
- Fibromyalgia (7)
- Neuropathic pain (4)
- Neck pain (3)
- Pelvic pain (3)
- Foot (2)

Shoulder, leg, knee, hip, hand, and back and post-whiplash pain were each mentioned once as were both myofascial and musculoskeletal pain.

Other chronic pain management areas each mentioned once was pain related to Crohn’s, cancer, end-of-life, autoimmune disorders and neuralgias. Complex regional pain disorder and atypical pain (i.e., when pain cannot be treated and patient suicide is a concern.) were both noted once as well.

Some practice issues not related to a specific area of chronic pain management were also suggested for future consideration. For instance, to provide updates on new and/or alternative treatments (e.g., craniosacral and hyperbaric oxygen) and treatment supports (e.g., team approach, self-management).

Two respondents mentioned a need for information around addictions, to increase awareness of the risk of addiction even in short-term pain management and to explore the efficacy of non-drug techniques.

Stroke management, chronic fatigue syndrome and early detection of TBI (traumatic brain injury) were all mentioned once. One respondent identified sharing of positive outcomes would be useful.

Themed data:

Freq.	THEME	DATA/RESOURCE
45	Pain - shoulder	→ chronic shoulder pain
	Pain - post-whiplash	→ chronic pain post whiplash
	Pain - Pelvic	→ chronic pelvic pain
	Pain - pelvic	→ Pelvic
	Pain - pelvic	→ Pelvic Pain, to avoid unnecessary surgeries performed by gynecologists and general surgeons.
	Pain - neuropathy	→ Management of DM neuropathy pain, burning sensation
	Pain - neuropathic	→ Neuropathic pain
	Pain - neuropathic	→ neuropathic pain
	Pain - neuropathic	→ Neuropathic pain
	Pain - neuropathic	→ neuropathic pain
	Pain - neuralgias	→ neuralgias
	Pain - neck	→ chronic neck pain
	Pain - neck	→ chronic necks
	Pain - neck	→ neck pain
	Pain - myofascial	→ myofascial pain syndrome
	Pain - musculoskeletal	→ the huge topic of musculoskeletal pain- myofascial, neural mobility , joint dysfunction the combinations of the above and how to choose the best approach for treatment
	Pain - leg	→ leg pain
	Pain - knee	→ knee pain
	Pain - hip	→ hip pain
	Pain - headache	→ headache
	Pain - hand	→ Many areas of practice!! Early passive ROM with hand fractures
	Pain - foot	→ foot pain
	Pain - foot	→ foot pain as long as the research related to the source of the pain.
	Pain - fibromyalgia	→ fibromyalgia
	Pain - fibromyalgia	→ Fibromyalgia
	Pain - fibromyalgia	→ fibromyalgia
	Pain - fibromyalgia	→ Fibromyalgia
	Pain - fibromyalgia	→ Fibromyalgia is a very common concern.
	Pain - fibromyalgia	→ fibromyalgia.
	Pain - fibromyalgia	→ FM
	Pain – end of life	→ end of life pain management
	Pain - crohns	→ crohns,
	Pain – complex regional pain disorder	→ complex regional pain disorder
	Pain - Cancer	→ cancer pain
	Pain – back	→ Chronic low back pain
	Pain – autoimmune diseases	→ Many # of autoimmune diseases
	Pain - atypical	→ Atypical pain. What to do when pain can not be relieved and suicide is a concern.
	Pain - Arthritis – rheumatoid	→ rheumatoid arthritis
	Pain - Arthritis - osteo	→ OA in geriatrics and patients under 60 yr
	Pain - Arthritis - osteo	→ osteoarthritis
	Pain - Arthritis – non-rheumatoid	→ pain associated with non-rheumatoid arthritis
	Pain - Arthritis	→ Arthritic conditions
	Pain - Arthritis	→ Arthritis Pain
	Pain - Arthritis	→ chronic arthritic pain
	Pain - arthritis	→ Management of arthritis pain
4	treatments	→ all areas of management of chronic pain not specific to location - self management, team approach, strategies for support etc → Biofeedback efficacy Craniosacral other alternative treatments → Hyperbaric Oxygen in wound healing

Freq.	THEME	DATA/RESOURCE
		→ Updates on recent new treatments and medications
2	Drug abuse/ addiction	→ dispelling the myths of addiction, awareness that even short term pain management can create unexpected addictions.
		→ use/abuse of narcotics and evidence related to efficacy of simple none drug techniques
1	Stroke management	→ numerous issues in stroke management, etc. We are an acute care facility and are trying hard to incorporate evidence into our practice, but it can be an time intensive job to find and analyze the literature.
1	Sharing positive outcomes	→ Sharing positive outcomes
1	Early response (TBI traumatic brain injury)	→ Early detection of subtle TBI so that early response is possible; evidence that early response reduces chronicity in this population. Mindfulness training in v useful in chronic pain mgmt - does the accumulated evidence re this meet Ambassador standards?
1	Chronic fatigue syndrome	→ chronic fatigue syndrome
Z	Z	→ Currently we have an anesthesiologist involved in a Chronic Pain Clinic. Starting to see a variety of chronic pain conditions.
Z	z	→ I don't know
Z	Z	→ Probably but not clear on what those would be yet
z	Z	→ We are looking at developing a template for arthritis and osteoporosis management in our region

Question 14 – Are there any other professional events that you are aware of that would conflict with either of the planned videoconference dates?

Forty-four (72.1%) respondents responded “No” to this question. Four were physicians. Seventeen (27.9%) others identified events that might conflict with the planned videoconference dates.

Question 15 – On which of the following dates would you be willing to participate in a half day videoconference with the Ambassador workshop participants and organizers?

Multiple responses to this question were permitted.

Date	All disciplines	%	Non-MDs	%	MDs	%
June 12, AM	16	26.2	14	23.0	2	3.3
June 12, PM	19	31.1	15	24.6	4	6.6
June 19, AM	24	39.3	23	37.7	1	1.6
June 19, PM	21	34.4	19	31.1	2	3.3
None of these dates, but willing to participate	11	18.0	6	9.8	5	8.2
Not interested in participating	9	14.8	8	13.1	1	1.6

Question 16 – Do you have any other comments for the organizers of the Ambassador Program as we move into the next phase of the Program?

Several respondents offered the suggestion that the program target physicians and front-line health service delivery professionals to participate in the program. These are the people who will ultimately use the care pathways, and it is essential to receive their contributions and buy-in to ensure successful implementation.

The following suggestions were each made once:

- A need for organizational/administrative support
- Coordinate with the care pathways of chronic disease management
- Provide hands-on coaching to MDs to potentially increase likelihood of early response to pain

One person identified the triple prescription monitoring of the College as a barrier to effective chronic pain management. Several people made positive comments about the program and encouraged its continuation.

Themed data:

Freq.	Theme	Data/Response
6	Positive	<ul style="list-style-type: none"> → Excellent program. Need to get the info out to health care providers in a method that doesn't take time to lookup on the computer → I'm glad that you've been funded to take this next step. Your work is very valuable. Thank you. → Keep up the GREAT work! → the program has been useful in patient education in my practice → unavailable for videoconference during the identified week in June but would very much like continued involvement → work changes daily and these dates may not work if other priorities arise but otherwise I'd love to participate
4	Target clinical practitioners	<ul style="list-style-type: none"> → perhaps this is just a measure of my interest, however, did go to the first session, but have not heard much of it lately. had one physician that attended, more or less, had been asked to attend, not sure if the physicians are aware of this program, they should be targeted, as they direct the care of the patient, as well, this is more likely to be managed within their office setting. the group I remember attending, was a social worker, rehab, and myself, a [non-clinical role]. don't think you had the right people around the table, not in my region. I am fairly confident, it has not moved forward. If it has, then I am definitely not the one to have at your session, as I do not know anything about it. → We use a multidisciplinary approach but final say is between Dr and patient. I have little contribution. So unless it is a physician directed planned attack to patient's chronic pain it won't work. → Be sure to target those in clinical practice. Although the information is interesting to others, those that attend should be individuals who can apply what is learned directly to their practice, whether MD, RN, LPN or Rehabilitation discipline → The purpose of this program were not clear at the beginning and therefore, I was not likely the most appropriate person to attend from our site. When soliciting participants, a detailed explanation of the content to be evaluated would result in more appropriate participants.
1	Need - Admin/organizational	→ Organizational/admin support
1	Coordination - CDM	→ Coordinate with Chronic Disease Management with their clinical pathways
1	Barrier - Triple prescription monitoring	→ How to deal with the triple prescription monitoring by the college. This discourages adequate pain treatment. For example the many surgeons who will not handle triple prescriptions.
1	hands-on coaching?	→ Hands-on coaching of MD's might be useful increasing likelihood of early response to the pain and skipping the overuse of benzodiazepines as a mask.
Z	z	→ Where can I access the pathways for low back pain and headache?
Z	Z	→ I am unable to participate as I am moving away. I had no other choice to write not interested
Z	z	→ It has been a while and I don't remember all the details