

POWELL RIVER LOCAL PAIN TEAM PILOT PROJECT EVALUATION

Final evaluation report for the Powell River Division of Family
Practice and Vancouver Coastal Health Local Pain Team

January 2019



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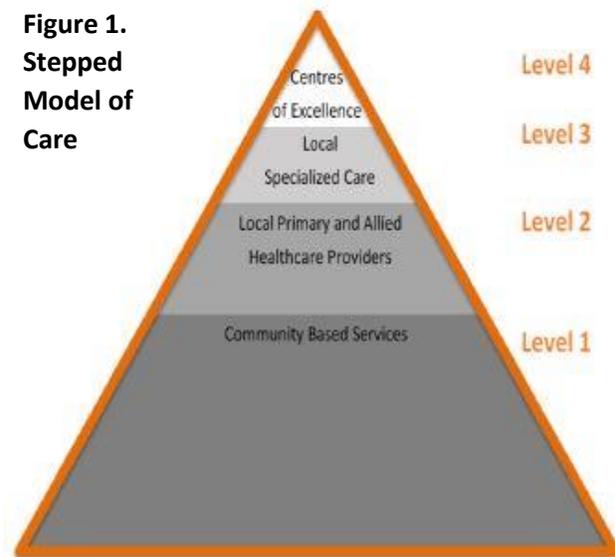
Introduction

This is the final evaluation report for the Powell River Division of Family Practice’s Local Pain Team (LPT) pilot program. The first patient intake for the pilot program was June 6, 2018. The purpose of this report is to present evaluation findings related to the operations, outcomes, successes, and challenges of the pilot, and to support future decision-making with regards to supporting people living with chronic pain in the region.

About the LPT Pilot

The Local Pain Team (LPT) pilot program was initiated as part of the Powell River Division of Family Practice’s (PRDoFP) Chronic Pain initiative, in partnership with Vancouver Coastal Health (VCH). Project funding was provided through Shared Care¹, and the nursing position was funded by VCH. The overarching goal of the Chronic Pain initiative is **to increase chronic pain patients’ self-management capacity and functionality with the support of a coordinated network** of local allied and primary healthcare workers, community organizations, and specialists in the community. The Chronic Pain initiative uses a stepped approach to address the diverse needs of chronic pain patients; the LPT pilot program falls under the ‘local specialised care’ stepped level of care (Level 3; Figure 1).

Figure 1.
Stepped
Model of
Care



To access the pilot, patients were referred by their family physician (FP) or other primary care provider. Once accepted, they began a 12-week self-management program with support from the LPT nurse. The program included individual sessions with the nurse, group sessions with other participants, and a review of their case by the local pain team (LPT)². The LPT discussed patients as a team and developed individualized care plans. Based on their healthcare needs and desires, patients in the program were referred to additional providers, such as a physiotherapist, or for individual sessions with the LPT members. The LPT program was designed to be 12-weeks long, with flexibility for individuals to remain in the program longer if needed. Additionally, at the end of 12 weeks, individuals may be referred to a specialized clinic for additional pain support. See Appendix A for a diagram of the LPT process.

Participation in the LPT intended to complement patients’ regular care, and not to replace care from their primary care provider. The specific aim of the LPT program was **to improve functionality of people suffering from chronic pain through self-management and education.**

¹ Shared Care is a joint funding collaborative between Doctors of BC and the Government of British Columbia.

² The Pain Team included two family physicians (one with a focus on opioid use disorder, and the other with a chronic pain focus), a psychiatrist and a pharmacist in addition to the LPT nurse and administrative assistant.

Participation in the LPT Pilot

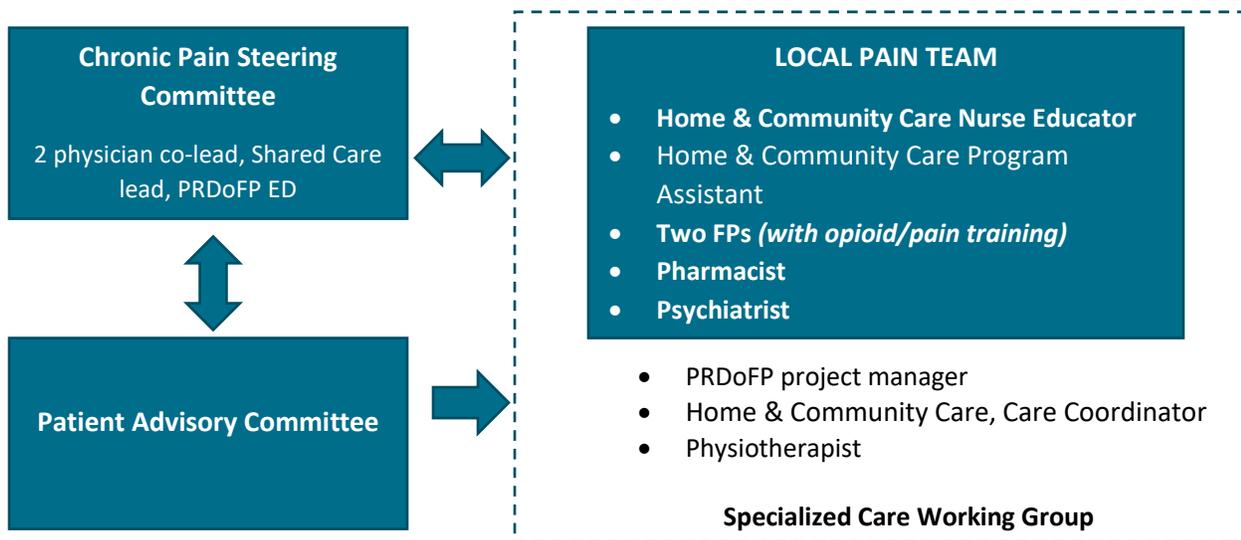
The LPT pilot program began in June 2018. 18 individuals were enrolled in the LPT pilot between June and September 2018. Fourteen participants completed the program, while 4 (22%) discontinued the program before it ended.

A control group containing 24 participants received ongoing care as usual from their primary care provider and had access to other Chronic Pain events, activities, and resources in the community, such as Gentle Movement and Relaxation classes and public information seminars.

Organizational Structure

The LPT pilot was developed by the Local Specialized Care working group, which was overseen by the PRDoFP Chronic Pain Steering Committee. The Local Specialized Care working group also received input from a patient advisory committee, which met on a quarterly basis to provide input to the program. During the operation of the program, the project manager was available to solve practical issues and provide oversight.

Figure 2. Project Committees and Team Members



About the Evaluation

The evaluation was designed to be a **non-randomized experimental design** with a treatment ('LPT group') and a control group ('non-LPT group')³. This design was complemented by descriptive and qualitative data collection to improve understanding of the context within which the evaluation is operating.

Document and Administrative Data Review. As part of the evaluation, materials produced by the pilot for planning and development were reviewed. This was an ongoing process, enabling the evaluation to remain up-to-date and to have a contextual understanding of the initiative. The evaluation was provided administrative data

³ The first 18 people referred to the program were included in the LPT pilot. Those who were referred later became the control group.

tracked by the pilot, including number of referrals to the program and discontinuation rates. As well, Emergency Department (ED) visit data was collected (i.e., number of visits before and after the pilot, and reason for visit).

Key Informant Interviews. Interviews were conducted in September 2018 with 9 of 10 members of the Local Pain Team and Specialized Care Working Group. The interviews were semi-structured and open-ended, allowing the evaluation team to ask similar questions to all respondents, while enabling additional themes to surface from the interview process. Interviews were analyzed qualitatively, using the evaluation questions and stated program goals to guide the analysis.

Surveys and Intake Assessments. The LPT pilot involves a pre/post comparison of participants in treatment group, as well as a comparison to the control groups using surveys and intake assessments at the point of entry into the pilot, as well as follow-up surveys 6 weeks into the LPT, and at the closure of the 12 weeks (Table 2). For the 4 individuals who did not complete the LPT program, a non-completion survey was administered.

The surveys included two psychometric scales (Personal Health Questionnaire (PHQ-8), which measures depression, and the Pain Disability Index (PDI), which measures impact of pain on daily activities). These scales were scored and analysed using paired t-tests to test for statistically significant changes. The surveys also included Likert-type questions that allowed comparison of responses pre-post program. Lastly, open-ended questions were included for participants to provide additional feedback, which were analysed qualitatively.

Table 2. Assessment tools for pilot program participants

	Pre	6-week	Post
Control	Pre-LPT Control Survey (n=11)	6-week follow-up survey (n=8)	Post-LPT Control Survey (n=4)
Treatment	Intake Assessment Form (n=14)	6-week follow-up survey	Post-LPT Treatment Survey (n=11)
Treatment - Discontinued	Intake Assessment Form (n=4)		Discontinued Survey (n=4)

Referring Provider Survey At the end of the program, the primary care providers who referred a patient to the program (n=10) were provided a survey to share feedback on the program and their perceptions of how it impacted their patients. 10 providers responded, for a response rate of 100%.

Limitations

From a statistical perspective, the program had a low number of participants, which leads to limitations in the ability to detect statistically significant changes over time. In addition, not all participants completed both the pre and post questionnaires, thereby further decreasing the statistical power. It was also intended that there would be a control group, however the response rate for the control group was too small to include in the analysis. While the pre-post analysis of participants provides valuable information on the impact of the program, without a control group it is possible that the impact of the larger chronic pain project in Powell River influenced any effects demonstrated (i.e., “a rising tide raises all boats”).

A general limitation associated with survey and interview methods is the potential for response bias, such as social desirability bias and recall bias. To mitigate this, a variety of stakeholders were asked similar questions to ensure the inclusion of an array of perspectives in the response data. Moreover, the evaluation combined qualitative and quantitative data to provide multiple lines of evidence and increase the validity of findings with richer data triangulation.

Evaluation Findings

Experience of Participants

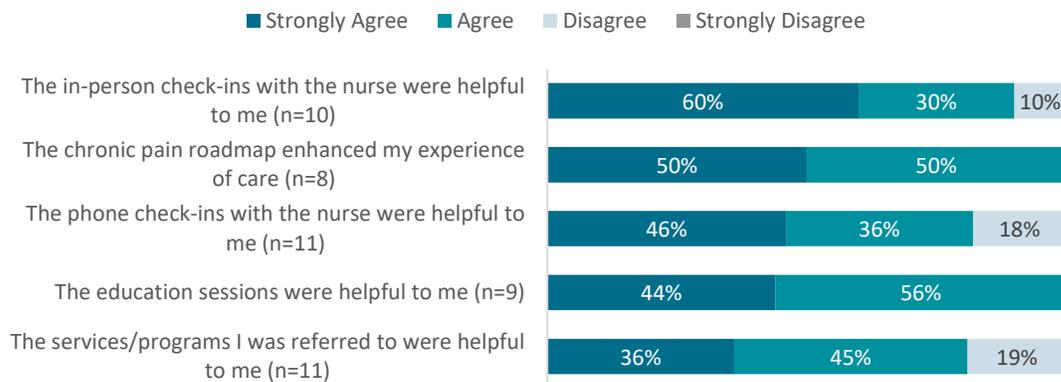
Participants in the LPT Pilot provided feedback on their experience through surveys, which were administered at the beginning of the program and at the end of the program.

1. Satisfaction with the program

Overall, final survey respondents reported high satisfaction with the LPT program. 91% (10 of 11) participants reported that they would recommend the LPT Program to friends/family. In addition, 9 of 11 participants (82%) reported that they were satisfied with their past three months of chronic pain care (ranking their care 4 or 5 out of 5). This care included the LPT as well as any regular support/ care they receive, for example from their family doctor.

Survey respondents reported that they valued all aspects of the program. The most highly rated aspects of the program included the in-person check-ins with the nurse and the chronic pain road map that was developed by the PRDoFP Chronic Pain project to help guide their journey (Fig. 3).

Fig. 3 - Value of different aspects of the program



Respondents also specified specific aspects of the program that they found most useful:

- Learning new skills and accessing education (n=4)
- Having support and “being heard” (i.e., one-on-one support from nurse) (n=4)
- Referrals for additional programs and services (i.e., getting onto CPAP machine) (n=2)
- Providing motivation (n=2)

What was the most valuable aspect of the program?

“Being heard, one on one - very valuable. Having someone caring was just wonderful. [The nurse] was very encouraging - she helped me focus.” – Participant

“I use the mindfulness and breathing exercises. If the pain (spasms) becomes excruciating I will stop whatever I am doing (even driving - pulling over) and do my breathing. I can keep from stiffening up which exacerbates the pain.” – Participant

Impact on Participants

1. Coping Skills

The data show that the LPT Program helped improve and diversify participant’s coping skills. As one participant commented, through the program they “realized that I have to do it myself. No magic bullet or pill. Daily preventative exercises and life modification.”

Prior to participating in LPT, clients reported using an average 2 different methods to cope with their pain. At the end of the program, they reported an average of 4 different methods. These methods included medications, breathing exercises, massage, physical exercise, physiotherapy, acupuncture, counselling, ice, topical gels, etc.

The most common method to cope with pain was medication use, which included over-the-counter pain relievers (such as ibuprofen or acetaminophen) as well as prescription drugs (i.e., opioids). An LPT team interviewee noted a sense that there was less reliance on opiates to manage pain, and increased patient-driven conversations with primary care providers about opioid doses. A further exploration of medication class use may reveal further information about how the pilot impacted the type of medications patients are using, and how they are using them.

In addition, 60% of primary care providers (GP/NP) who referred a patient to the program (6 of 10) reported that their patients’ coping skills had improved as a result of the program.

2. Sleep

Another improvement associated with the program was an increase in participants who reported they were able to sleep (Fig. 5) Prior to the program 1 person (11%) reported being able to sleep, while 5 (56%) reported coping with sleep following the program.

Fig. 4 - Number and diversity of coping skills reported by participants doubled following the program (n=9)

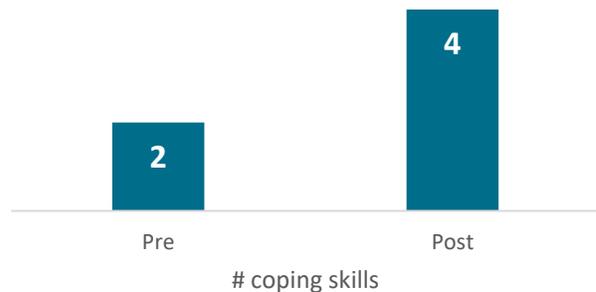
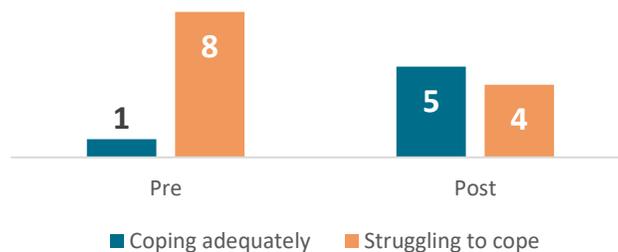


Fig. 5 - "How are you sleeping?" (n=9)



3. Support, Motivation and Self-management

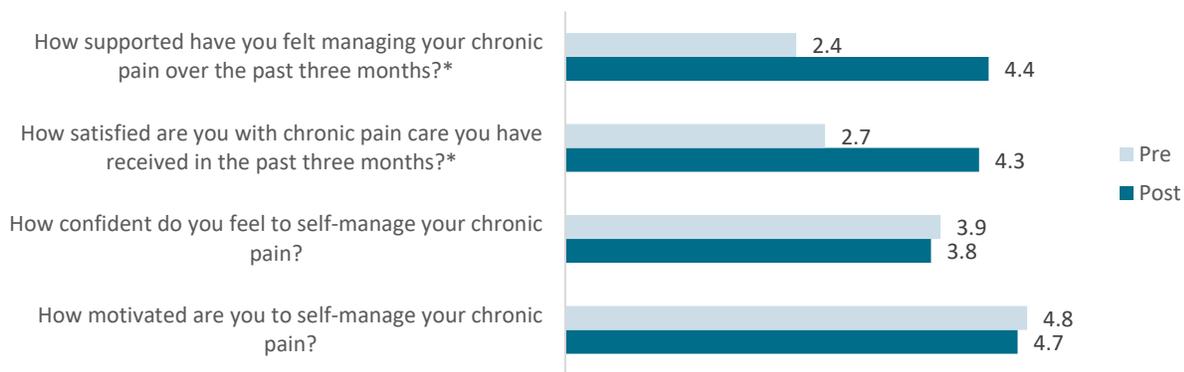
Results further indicate that the program had a positive impact on participant’s satisfaction with the care they received for their chronic pain, as well as their level of perceived support to manage their pain (Fig. 6).

Results indicate that the program did not impact participant’s confidence self-managing their pain, nor did it increase their motivation to do so. However, it is noted that their confidence and motivation were already fairly high at the outset of the program (average 3.9/5 and 4.8/5 respectively).

I am more positive with more avenues of support.” – Participant

Fig. 6 - Changes in Support, Confidence and Motivation

(On a scale of 1-5, where 1=low, 5=high) (n=9)



* denotes a statistically significant difference $p < 0.05$

4. Depression and Functionality

Data from the psychometric scales (PHQ-8 and PDI) indicated no statistically significant differences following the program. However, 60% of primary care providers who referred a patient to the program (6 of 10) noticed improvements in their patient’s mental health following the program.

Data from the locally developed Functionality Scale (Fig. 7) showed that there were not statistically significant changes in function over time. However, the trend is moving in the right direction, with an average score of 31% in week one to 38% at follow-up (Fig. 8). See Appendix for individual scores. Two participants did comments that filling out the scale daily increased their focus on their chronic pain in a negative way, suggesting a weekly rating would be more useful to them.

Fig. 7 – Functionality Scale

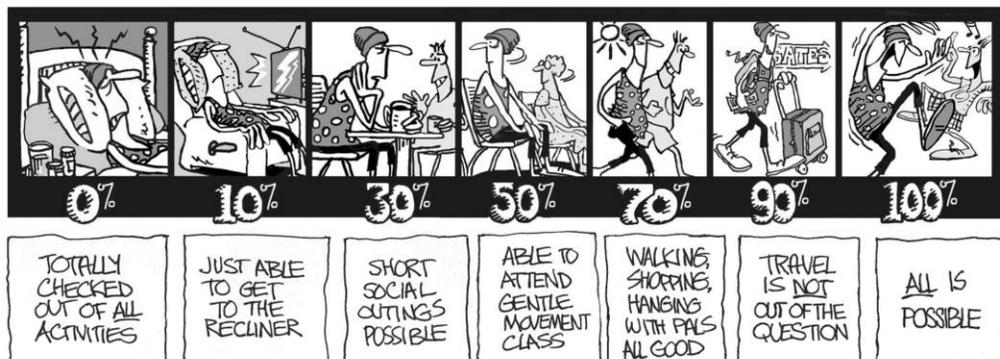
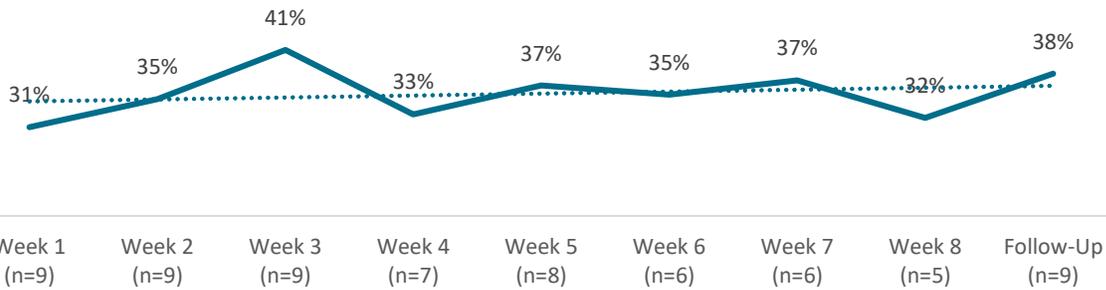


Fig. 8 - Average Functionality Scores



At the end of the program, the majority of respondents (7 of 11; 64%) recorded their function at 50% or higher on the functionality scale. This indicates that they were at least able to get out of the house, attend gentle movement classes and meet with friends.

5. Progress Towards Personal Goals

Eight of the eleven final survey respondents provided insight into their pain-related goals, and how they were making progress relative to those goals. Of the 19 goals listed⁴, the average progress recorded was 4.8/10. Results indicate 26% of the 19 goals listed had significant progress made towards achievement (Fig. 9).

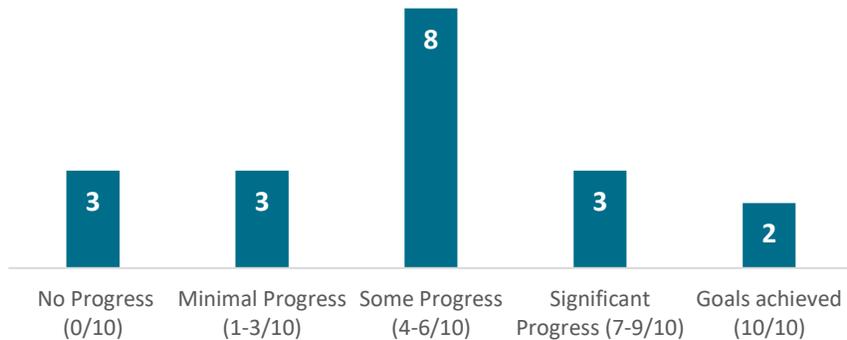
Goal Setting

The most common goals included:

1. Increased physical activity (n=9)
2. Improved sleep (n=4)
3. Learning/applying coping skills (n=2)

Fig. 9 - Progress towards goals (n=19 goals reported)

Progress towards goals was rated out of 10.



6. Health Care Utilization

Analysis of emergency department visits for participants before, during and after the pilot project indicated that there was no statistically significant difference in the rate of ED presentations at Powell River General Hospital as a result of the pilot. It is intended that the data will be analyzed again in March 2019 to assess any changes in the six months following the program.

Reports from primary care providers who referred a patient to the program indicate that 30% of providers noticed a decrease in their patient’s office visits during and following participation. The remaining 70% did not notice any changes.

⁴ Participants were able to list up to three goals.

Experience of Providers: Impact of the LPT

The operation of the Local Pain Team also impacted the providers involved in the team. According to LPT member interviewees, the most salient impact was the **opportunity to provide team-based care**.

Team-based care in this instance included the opportunity to meet together as a team to discuss complex patients. This enabled **increased referrals between providers as well as improved continuity of care for patients** when patients saw other providers, because the providers were more aware of the patient's situation. In addition, the team-based care setting allowed providers to learn from one another, which they took back to their practices and used to support other patients.

"I learned, as a physician, so much from my colleagues when we're sitting and discussing these patients. I can take back what I learned to my other patients. So, it's really helpful to me." – LPT Member

"It's a real luxury to be able to sit down with your professional colleagues and talk about patients and find meaningful local solutions." – LPT Member

Family physicians and NPs who referred patients to the program further endorsed the LPT, with all 10 survey respondents reporting that they would recommend the LPT to a colleague or another patient. In addition, they reported that the LPT was helpful to their practice and to their patients (Fig. 10).

Fig. 10 - Primary Care Providers' ranking of value of LPT (n=10)
(Rank out of 5)



Discussion

Strengths of the LPT Pilot

1. Engaged, multidisciplinary team

A key strength of the program identified by interviewees was the engagement of a **dedicated multidisciplinary team**, who worked together to create shared care plans for patients in the pilot program. As one LPT member noted, *“multidisciplinary care is the gold standard for treating chronic pain patients. However, to my knowledge, there are very few examples in BC... I’m not aware of any other multidisciplinary teams of this calibre in a small community. So, we’re kind of breaking the mold”*.

Moreover, it was noted that meetings were scheduled well in advance and were only held if all members could attend. This created a team environment where everyone’s skills and perspectives were valued and ensured patient care plans included all team members’ input. Decisions by the team were reported to be made in a **consensus-based** and cooperative manner. One team member highlighted that they *“felt [their] recommendations were respected and implemented as needed.”*

2. Support of the Chronic Pain Nurse

A central component of the pilot was the chronic pain nurse, who met with the patients at regularly scheduled times throughout the 12-week program. In particular, her role was to provide support and education on self-management of their condition, and ensure they were linked to other programs and resources. When participants were asked to identify the most valuable aspect of the program, four of ten (40%) specifically commented that the one-on-one support from the nurse was the most valuable aspect (see *“Experience of Participants”*, above).

Relatedly, the administrative support the nurse received from the Home & Community Care program assistant was also indicated to be a strength of the program and was noted as a key resource.

3. Operating within the Chronic Pain Shared Care project

The operation of the LPT within the larger Chronic Pain project in Powell River was identified as a strength for the pilot. First, it has increased community awareness and support for chronic pain: interviewees commented that *“the community has really come through in the past year,”* providing exercise classes, support groups and developing a pain network to connect people to resources. In addition, the pilot began operating just after local physicians, other care providers, and community members were provided with an education session on Chronic Pain, which was offered through the larger project.

Challenges Faced and Lessons Learned

1. Planning Phase Challenges and Delays

In the planning phase of the project, interviewees noted that there were challenges due to external factors, which caused delays in the implementation of the pilot. First, during the planning phase, there was staffing turnover occurring at the health authority (VCH), which precluded them from being able to participate in early planning meetings. Secondly, once there was health authority representation at the working group and the project was ready to hire the Chronic Pain nurse, there were further delays in the hiring process due to union-related issues and medical leave for the nurse during her first months working. Therefore, the first intake of patients was delayed from early April to late May. While not ideal, this meant that the pilot was run during the summer months, coinciding with pre-planned holidays for both patients and staff. However, further delay of the

pilot was not feasible due to the funding cycle of the project. Despite these scheduling challenges all of the members of the Local Pain Team met once per month as they had committed to during the pilot project months (June -September 2018).

2. Referral Process

In the early stages of implementation, family physicians reported that the referral process (specifically, the amount of paper work) was too onerous. As a result, the process was modified to a simplified one-page referral form that required less physician time to fill out, taking less time out of their day.

3. Early Operation of the Nurse Role

Due to the delays in project start-time, there was little time left once the nurse was hired to go through a rigorous training and onboarding process for the nurse. Interviewees noted that additional training or mentorship opportunities for the nurse would have been valuable to the role. Specifically, these included site visits to other chronic pain teams prior to implementation, and additional education about chronic pain and mental health specifically, such as Cognitive Behavioural Therapy (CBT) skills training. The nurse did have the opportunity to visit St. Paul's hospital chronic pain team later in the pilot project, but it was noted that this would have been more beneficial earlier on. However, due to time constraints this was not possible.

In addition, the LPT RN reported that patient intake ended up taking double the expected time per patient to complete (2 hours as opposed to the expected 1 hour). This compounded the issue of having time to complete additional training in the early stages of the pilot, since so much time was needed to intake the patients and get the program running.

4. Early Operation of the Local Pain Team

Since this was a new team, LPT members who were interviewed identified that the first few meetings were a *"work in progress"*, with the different members getting to know how each worked and what they could contribute.

Lessons learned from creating a new multidisciplinary team included taking time to: learn each others' strengths, set expectations of what a patient care plan looks like, and decide on the amount of time to spend discussing each patient. It was noted that this was facilitated by having an "mediator" who was not involved from a clinical perspective at the table, in this case the project coordinator from the Division. It was identified that by the third meeting, *"we found our rhythm, and roles became defined"*.

5. Accessibility of Chronic Pain Services and Supports

Interviewees noted that patients with chronic pain are more likely to have accessibility issues (such as limitations in mobility). First, the total volume of visits associated with the pilot was identified as a potential barrier for participants, and second, that the location of services offered by the pilot were spread out across town, with some services more difficult to reach. Third, not all services are available for free or low cost, introducing financial barriers for patients. To address the geographic/ transportation related issues, the program included telephone check-ins with the nurse, which reduced the amount of travel needed to participate.

6. Gaps in services for patients with chronic pain

An additional challenge faced by the LPT Pilot project were gaps in services for patients with chronic pain available in Powell River. This results in some patients being referred to services outside of the community, further compounding accessibility and cost issues. It was identified that the lack of these supports represents a

challenge for the sustainability of patient outcomes following the program. While some of these were known/ identified at the outset of the program, persistent gaps that evaluation participants drew attention to included:

- Lack of long term, free mental health counselling, especially for patients dealing with trauma and/ or addictions
- Access to low cost physiotherapy

Opportunities for Consideration

In interviews with working group and local pain team members, as well as surveys from participants, the following recommendations and considerations for future iterations of a local pain team/ chronic pain support were identified. They are included here for the consideration of the project team and working group and may also be beneficial for other organizations/ Divisions interested in implementing a similar program.

1. Clarifying feedback loops and communication between all providers

A common comment from LPT members was that there was a lack of clarity on whether the information/ care plans developed at the LPT meetings were being communicated back to the family physicians. Relatedly, the nurse would sometimes give patients information to take back to their family physician and was not sure if the information had been relayed. In the follow-up survey with primary care providers who referred a patient to the program, one specified that they would like more follow-up from the LPT about their patient.

Opportunities:

- a) Exploring how family physicians would like to be included, and what information is most useful to them. Potentially having brief check-ins between the nurse and family physician and the half-way and end-point of the program.
- b) Developing communication procedures for how information from the LPT is shared with family physicians, and whether additional input from family physicians is needed back to the team.

2. Assessing patient readiness for change and clarifying expectations of patients

Interviewees identified that patient readiness for change is a significant factor in the success of a self-management focused program. While completion rate of the program was fairly high (78% completed the program), there is room for improvement, which may be facilitated by assessing patient readiness prior to starting the program. Developing inclusion criteria for patients based on their readiness for change may also improve the outcomes associated with the program (such as PDI and functionality scores).

The four participants who did not complete the program noted that it was not meeting their expectations. Therefore, it may be beneficial to have an initial conversation with participants to ensure their expectations are aligned with what the program can and cannot offer. In addition, primary care providers who referred patients to the program indicated that they found the program best suited for motivated patients.

Opportunity: a) Since the nurse has more time than the family physician, it was recommended by interviewees that the nurse assess the patient during intake and clearly outline the expectations of the program⁵.

3. Considerations for Sustainability

Additional considerations for sustainability of the program were identified through key informant interviews and with the Steering Committee. A decision has been reached with the Chronic Pain Steering Committee to

⁵ Note that since this data was collected, the nurse has started assessing patient readiness at the beginning of the program.

continue to run the program for an additional 30 weeks, pending funding extension discussions, to ensure sustainable operations are in place. Areas to be addressed in this additional phase include:

- Ensuring sustainable compensation for LPT members
- Monitoring management/organization of LPT without the support of a coordinator attending LPT meetings and facilitating meeting schedules.
- Collection of additional data on patient and system outcomes (see “Additional Evaluation Opportunities” below).

4. Additional Evaluation Opportunities

- a) **Follow-up check-in with Cohort 1 patients.** One year following the patient’s initial intake into the LPT program, the evaluation team will follow up with the 14 participants who completed the first round of the LPT (i.e., those participants who were included in this report) to assess any lasting impacts from the program. This will also include a reassessment of ER utilization by these patients 6-months post-program.
- b) **Evaluation of Cohort 2 patients.** With the planned extension of the program, the evaluation will collect administrative data and surveys for new patients entering the program. This will enable the analyses to be based on a greater number of patients completing the program, further increasing the reliability and validity of findings. It will also allow the evaluation to assess the LPT as a mature program, without the contextual challenges associated with the implementation of a new program.

Summary

Overall, the Local Pain Team pilot project showed promising results, especially related to increasing the number and variety of coping skills patients rely on, as well as improving sleep, which is a cornerstone to all aspects of health. The pilot project was also successful in developing and implementing a new, local model of care for patients with chronic pain, that uses a multidisciplinary team to create tailored care plans and increase the capacity for care providers to serve local patients.

The evaluation recommends further operation of the LPT to continue to gather data and monitor impacts with a larger sample of patients, as well as following up on system-level outcomes such as health care utilization over time. Extension of the program will also enable further discussion and exploration of factors impacting sustainability, such as care provider compensation to participate on the Local Pain Team.

Appendix A

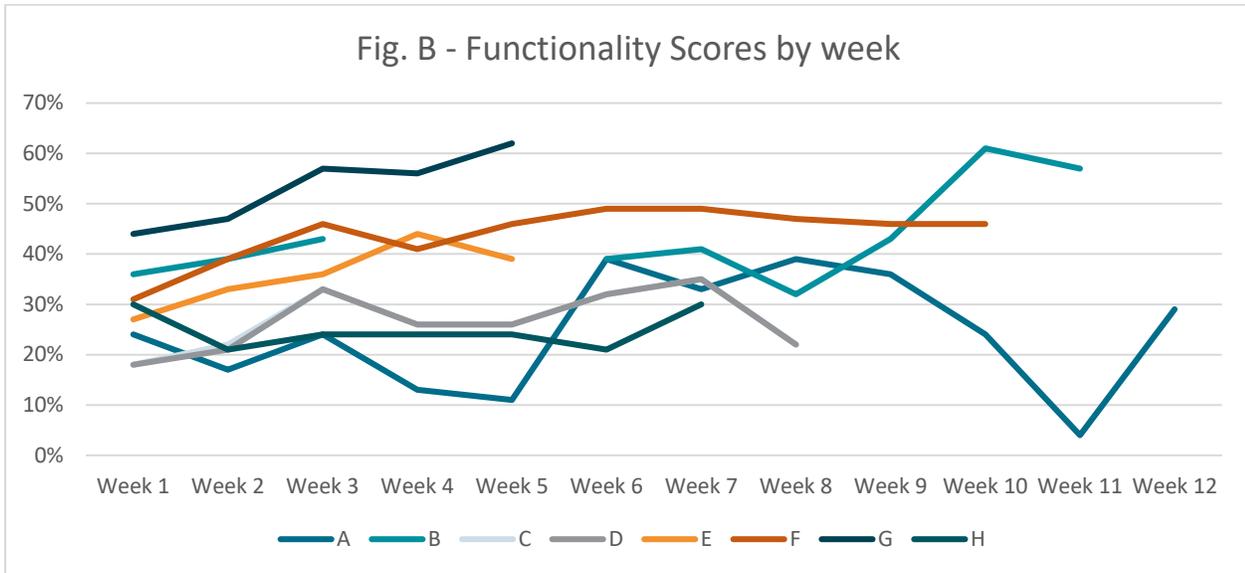
LPT FLOW DIAGRAM

Draft Program Outline

Week 1		<p>The nurse will conduct an intake assessment and develop an integrated care plan. The plan will be reviewed at the next monthly team meeting and adjusted if needed. During the first or second week, the nurse will refer the program participant to the Self Management BC program and the gentle movement class if appropriate.</p>	
Week 2		<p>In a group, or individually, the nurse will provide education about chronic pain and self-management using the Chronic Pain Management Roadmap. The nurse will also support the program participant with execution of the care plan.</p>	
Week 3		<p>The nurse will call to support self-management and answer questions. The program participant will continue executing the care plan. Around this time, the nurse will discuss the care plan with the Local Pain Team (LPT).</p>	
Week 4		<p>The nurse will call to support self-management and will discuss adjustments to the plan if applicable. Another group education session might be provided. The program participant will continue executing the care plan.</p>	
Week 5		<p>The program participant will independently continue executing the care plan.</p>	
Week 6		<p>The program participant will meet with the nurse in-person to evaluate progress. The participant will be encouraged join People in Pain local self-management support group and consider increasing activities.</p>	
Week 7		<p>The LPT will review progress and possibility to increase the activity level of the participant. If needed the nurse will adjust the care plan. The program participant will independently continue executing the care plan.</p>	
Week 8		<p>The nurse will call to update the participant about potential changes to the care plan and to support self-management. The program participant will continue executing the care plan.</p>	
Week 9		<p>The program participant will independently continue executing the care plan.</p>	
Week 10		<p>The nurse will call to support self-management. The program participant will continue executing the care plan.</p>	
Week 11		<p>The program participant will independently continue executing the care plan. The local pain team will review progress and discuss readiness to graduate from the program.</p>	
Week 12		<p>The nurse will have an in-person meeting to discuss readiness to exit the program. If the participant continues to show increase in function without plateau of progress, they may remain in the program to repeat week 8 – 12. When participants are ready to exit the program, the family doctor or nurse practitioner will be informed.</p>	
Week 14 & Week 20		<p>A group of recently graduated program participants are invited to attend a meeting and share experiences.</p>	

Appendix B

The following graph represents the variability and range of functionality scores by individual participants each week during the pilot program.



This roadmap provides a brief overview of steps you can take to improve your function. Not all steps will be applicable to you. Research indicates that **self-management is key to living easier with pain**, so it plays a central role in this roadmap. You can use this roadmap on your own or together with your family doctor or nurse practitioner.

SET YOUR GOALS

It helps to focus on a goal when you want to make a change. When setting goals, try to focus on improving activities. Make your goals for the near future and realistic. For example: This fall I want to be able to watching my grandson's soccer game. When you reach your goal, you can always set a new one.

MY GOALS. By following this roadmap, I hope to:

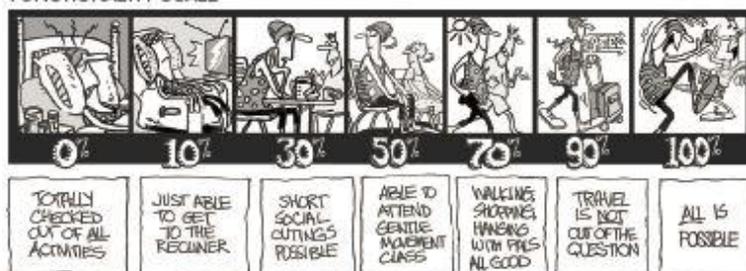
- 1 _____
- 2 _____
- 3 _____

MONITOR YOUR PROGRESS

You can monitor your progress in a journal to see what works for you (see Step 2 for an online journal). You can also use this Functionality scale, e.g. by writing down every Monday morning your average value for the previous week. The Pain Disability Index is another tool to monitor your progress.

<http://www.gpscbc.ca/sites/default/files/uploads/Pain-Disability-Index.pdf>

FUNCTIONALITY SCALE



_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %	_____ %
DATE									

SELF MANAGEMENT

If possible, do the activities in the order they are presented: First Step 1, then Step 2 and complete with Step 3. You do not have to do everything. Pick the things that you like and try to focus on **one thing at a time**.

STEP 1

GETTING STARTED Check out these resources one at a time to increase your knowledge about chronic pain.

- Visit Pain BC website www.painbc.ca
- Visit People in Pain website www.pipain.com
- Hear from others with chronic pain www.liveplanbe.ca/real-stories
- Watch Bob's pain story <https://www.youtube.com/watch?v=wXFLsr6bFgY>
- Visit self-management portal Live Plan Be www.liveplanbe.ca
- Learn about the science behind pain www.youtube.com/watch?v=nifGFUkUk

EDUCATION

- Watch the video to learn about pain www.youtube.com/watch?v=C_3phB93rvi&feature=youtu.be
- Take the free course to learn about pain www.retrainpain.org
- Research at least two things about pain www.liveplanbe.ca/pain-education
- Watch one of the chronic pain webinars www.wdpi.org/Webinars/Pages/ChronicPain.aspx
- Learn about box breathing www.healthline.com/health/box-breathing
- Learn about self management www.wdpi.org/Webinars/Pages/ChronicPain-SelfManagementTechniques.aspx
- Learn about mindfulness www.mrsmindfulness.com/what-is-mindfulness
- Learn about meditation <https://www.uclahealth.org/marc/body.cfm?id=22&i1rf>
- Learn about movement and exercise www.lifelsnow.ca/courses/first-five-steps-free
- Learn about healthy eating www.youtube.com/watch?v=fqHyBTg73fw
- Learn about opioids and chronic pain www.youtube.com/watch?v=7Na2m7lx-hU or read www.wdpi.org/ChronicDisease/WhatIsChronicPain/Pages/OpioidsandChronicPain.aspx

STEP 1 (Continued)

READ A BOOK:

- Bruce N. Eimer. **Hypnotize yourself Out of Pain Now!**
- David Corey & Stan Solomon. **Pain: Learning to Live Without It**
- Dennis C. Turk & Frits Winter. **The Pain Survival Guide-How to Reclaim Your Life**
- Dennis Starlanyl & Mary E. Copeland. **Fibromyalgia and Chronic Myofascial Pain. A Survival Manual**
- Jacky Garner-Nbx. **Mindfulness Solution to Pain**
- Joel Levey. **The Fine Art of Relaxation, Concentration and Meditation.**
- Joanne Dahl & Tobias Ludgren. **Living Beyond Your Pain: Using Acceptance and commitment Therapy to Ease Chronic Pain**
- Spencer Smith & Steven C. Hayes. **Get Out of Your Mind and Into Your Life**
- Kelly McGonigal. **Yoga for Pain Relief**
- Martha Peterson. **Move without Pain**
- Martin Roland. **The Back Book**
- Neil Pearson. **Understand Pain, Live Well** (Available in all BC public libraries)
- Vidyamala Burch & Danny Penman. **You are Not Your Pain** (work book)
- Wendy Brown. **OWwww! Traveling with Chronic Pain.**

STEP 2

TOOLS Some of these tools may be useful, while others are not. Select the tools that you feel fit your pain journey.

- Review the Pain Toolbox www.painbc.ca/find-help/pain-bc-toolbox
- Review the Canadian Pain Toolkit www.pipain.com/pain-toolkits.html
- Make a pain plan www.liveplanbc.ca/manage-my-pain
- Review video on Bounce Back to know more about anxiety and depression www.cmha.bc.ca/programs-services/bounce-back
- Take the free online 8-week mindfulness course www.palousemindfulness.com
- Keep a pain diary for _____ weeks www.caremark.com/Imagebank/Health_Diaries/DailyPainDiary.pdf
- Review My Opioid Manager www.opioidmanager.com/Images/omcontent/documents/myom_book_final.pdf
- Take the assessment when using opioids <https://www.divisionsbc.ca/sites/default/files/Divisions/Powell%20River/Current%20Opiod%20Missuses%20Measurement.pdf>
- Review the Opioid Pain Medicines Information www.ismp-canada.org/download/OpioidStewardship/opioid-handout-bw.pdf
Try apps Breath2Relax, Headspace or GPS for the Soul

STEP 3

ACTIVITY PLAN Remember, Take it Slow!

Now you have learned about chronic pain and reviewed some of the tools it is time to develop an activity plan.

- _____ min. daily box breathing
- _____ min. daily gentle movement
- _____ min. daily relaxation
- _____
- _____ min. daily walking
- _____ min. swimming, _____x/week
- _____ min. yoga, _____x/week
- _____

COMMUNITY HEALTHCARE PROVIDERS AND SERVICES

While this roadmap focusses on self-management, there are other services that could be helpful for you.

-  Fetch is an online listing of health and social services in many communities. Visit <https://www.divisionsbc.ca/provincial/what-we-do/patient-support/fetch> to find resources in your community.
- Physiotherapy
 - Occupational Therapy
 - Massage Therapy
 - Acupuncture
 - Chiropractor
 - Psychology
 - Counselling
 - Mental Health & Addictions
 - Nutritional Counselling

Other community groups, services, or online support groups that could be helpful:

- Self-Management BC supports self-management www.selfmanagementbc.ca or 604-940-1273/Toll Free: 1-866-902-3767
- People in Pain connects you with peers powellriver@pipain.com or 1-844-747-7246
- Pain Support Line supports with social challenges www.painbc.ca/pain-support-line or 1-844-430-0818
- Bounce Back Online provides online support when feeling depressed, stressed or anxious <http://www.bouncebackonline.ca/>

This Roadmap is available online at www.painbc.ca/roadmap