

Provincial Pain Strategy

Saskatchewan Stakeholder Meeting Report

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Access to pain management is a fundamental human right.

Declaration of Montreal, 2010

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LETTER FROM THE AUTHORS

We are pleased to provide this report outlining the results of two facilitated discussions held in November, 2014 with stakeholders interested in the improvement of pain management in our province. These meetings advance work toward the goal of development of a Saskatchewan Pain Strategy.

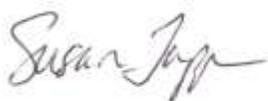
Pain management continues to be under-resourced and poorly coordinated with disparities in service provision both nationally and provincially. This not only affects the people who experience pain, their families, health care providers, and employers, but also provides additional financial burden to the health system.

Over the last four years, advocacy efforts at the national level have resulted in the development of a Canadian Pain Strategy, spearheaded by the Canadian Pain Coalition and Canadian Pain Society. Some provinces have taken this work and tailored it for the development and implementation of a provincial pain strategy. Although there are pockets of resources in the area of pain management in Saskatchewan, our province lags behind others in providing integrated services and programs for our citizens who are experiencing pain. This has led to a piecemeal approach with overt disparity between urban and rural communities.

Results of the discussions, summarized in this report, revealed priorities for structures, resources, and processes required for implementation, as well as research and data analysis needs. Structures and resources required to improve pain management include a provincial plan, leadership, education, funding, and outcome monitoring. Research and data analysis needs include cost analysis and development of a business case, ongoing provincial needs and asset assessment. Stakeholders urged that the strategy must be equal and inclusive for all people in the province who experience pain, regardless of age, gender, race, region of residence, or co-morbid health needs.

We were encouraged by the dedication and passion of the stakeholders, who continue to advocate for improved services and care. Saskatchewan has many of the essential ingredients to offer excellence in education and clinical management for pain. What is needed now is a coordinated and collaborative effort to move this work forward.

Sincerely,



Susan Tupper



Karen Juckes



Cathy Jeffery

INTRODUCTION AND BACKGROUND

This report presents the results of two stakeholder meetings held on November 7, 2014 to explore the development and implementation of a pain strategy for Saskatchewan. These meetings reflected inter-professional representation and were supported by the Saskatchewan Registered Nurses' Association (SRNA), College of Physicians and Surgeons of Saskatchewan (CPSS) and Canadian Pain Coalition (CPC). The meetings were further enriched through input from Maria Hudspith, Executive Director of Pain BC.

The report will provide a background to the problem of pain nationally and provincially, a description and results of two stakeholder meetings, and recommendations for moving forward with the development and implementation of a pain strategy for Saskatchewan.

Pain in Canada

Poorly managed pain contributes to patient suffering and dissatisfaction with care, increased health care costs, and poor patient flow outcomes including unplanned hospital readmissions, emergency department visits, and extended length of hospital stay. (Armaghani et al., 2014; Coley, Williams, da Pos, Chen, and Smith, 2002; White, Kaplan, and Eddy, 2011). Poorly managed pain after surgery or injury contributes to development of persistent (chronic) pain (Phillips, Knizner, and Williams, 2011). Despite the availability of simple, safe, and effective interventions, up to 75% of individuals receive inadequate treatment for acute pain, chronic pain, and pain related to terminal illness (Canadian Pain Coalition, 2010; Canadian Pain Society, 2007; Tunks, 2003).

One in five Canadian adults live with chronic pain with an increase in prevalence to approximately 83% of older adults living in residential care facilities (Schopflocher, Taenzer, and Jovey, 2011; Zanicchi et al., 2008). Children also live with chronic or recurrent pain conditions such as low back pain, headache, and widespread pain that interferes with school performance and mental health. (Gauntlett-Gilbert and Eccleston 2007; King et al., 2011). People living with chronic pain report the lowest health related quality of life compared to other chronic health conditions, and high co-morbidity with anxiety, depression, suicidal ideation and attempts, and addiction (Agborsangaya, Lau, Lahtinen, Cooke, and Johnson, 2013; Fischer, Lusted, Roerecke, Taylor, and Rehm, 2012; Racine, Choinière and Nielson, 2013; Sagheer, Khan, and Sharif, 2013). There are enormous direct and indirect financial costs for individuals living with chronic pain with mean publically and privately financed costs totalling \$3,112 (CDN) per person for those waiting to access scarce multidisciplinary treatment services (Guerriere, et al.,

2010).

The *Declaration of Montreal*, from the International Pain Summit meeting held in Montreal, in September 2010 makes the following three human rights affirmations:

- It is the right of all people to have access to pain management without discrimination.
- It is the right of people in pain to acknowledgment of their pain and to be informed about how it can be assessed and managed.
- It is the right of all people with pain to have access to appropriate assessment and treatment of the pain by adequately trained health care professionals (International Pain Summit of the International Association for the Study of Pain, 2011, p. 29-30).

Pain in Saskatchewan

Results from the Saskatchewan Health Quality Council *Acute Care Patient Experience Survey* indicate that pain management was rated number four of the top ten factors related to the patient's overall hospital experience. Patients reported that their pain was well controlled only 55% of the time (Saskatchewan Health Quality Council, 2012). Analysis of the Health Quality Council of Alberta *2010 Patient Experience Survey* revealed that approximately 3.4% of the general population in Alberta experiences an extreme problem with pain (Agborsangaya et al. 2013). In Saskatchewan, this would equate to over 38,000 citizens debilitated by persistent pain.

The Saskatchewan Registered Nurses' Association (SRNA) Pain Management Professional Practice Group (PPG) was established in 2009 to promote networking and collaboration among multidisciplinary health care professionals across the province in the area of pain management. The PPG hosts an annual conference entitled "Implementing Best Practices for Pain Management in Saskatchewan". In November 2012, the PPG endorsed the Saskatchewan Citizens Charter of Rights for Pain Management (Juckes & Power-Horlick, 2012). The PPG is connected with the national community of practice as a member group of the Canadian Pain Coalition and through member attendance at Canadian Pain Society meetings. The PPG has identified that Saskatchewan has an absence of dedicated pain services, an absence of dedicated pain positions, an absence of support programs for individuals experiencing pain and a lack of dedicated pain content in undergraduate health science curricula.

The Saskatchewan Ministry of Health's commitment to improving access and putting the patient first creates a landscape for raising the priority of pain. Attention to pain for the people of Saskatchewan supports provincial health care priorities identified for 2013-14 including: patient flow, access and connectivity in primary health care, surgical care, safety culture, mental health and addiction services, and emergency department wait

times. Improved pain management in our province requires a collaborative effort from all stakeholders with Saskatchewan citizens at the center of all initiatives.

STAKEHOLDER MEETINGS

Two facilitated meetings, a conference session and an invited stakeholder session, were conducted with individuals identified as having an interest in the area of pain management. Details of the methods, questions asked, data sources and session processes for both stakeholder meetings are outlined in Appendix A.

Conference Session

The first facilitated meeting was incorporated into the agenda of the 2014 *Implementing Best Practices in Pain Management in Saskatchewan* conference. Over 100 conference participants were invited to participate in a 50 minute facilitated discussion session. Participants included direct health care providers from nursing (registered nurse, nurse practitioner [RN(NP)], and licensed practical nurse), medicine, occupational and physical therapy, psychology, social work, pharmacy, academia, administration, governance, and patients/families. Areas of practice or service delivery identified by participants included health regions (with urban and rural representation), government, non-government organizations, and academic institutions that offer health sciences education. The session, “Developing a Provincial Pain Strategy: A Commitment to Action” provided the following objectives for participants:

- Describe the need for a Provincial Pain Strategy
- Identify the initiatives underway in Saskatchewan and across Canada to improve pain management
- Discuss the gaps and opportunities in pain management in Saskatchewan across the continuum of care
- Build the momentum for implementation of a provincial pain strategy

Participants were asked to discuss three questions related to the session objectives and to provide feedback using both written and verbal report mechanisms. Results of the discussions were collected and collated and broad themes were shared at the invited stakeholder session.

Invited Stakeholder Session

The second facilitated session was held in the evening following the conference speakers. The second session involved invited stakeholders, strategically chosen for their expertise and/or influence to advance the work of the development of a pain strategy for Saskatchewan. Forty three (43) invited stakeholders representing nursing,

medicine, pharmacy, dentistry, occupational and physical therapy, psychology, administration, and government participated in the second facilitated session. Areas of practice or service delivery identified by the stakeholder participants included health regions (with urban and rural representation), the provincial ministry of health, non-government organizations, health professional associations, and academic institutions that offer health sciences education.

The overall objectives for participants were to:

- Gain an understanding of pain strategies from a national and provincial perspective
- Acknowledge the roles of all health care disciplines in the development of the Saskatchewan Pain Strategy
- Identify the resources needed for the development and implementation of the Saskatchewan Pain Strategy
- Identify processes and measures that position the development and implementation of the Saskatchewan Pain Strategy

Participant discussion centered around two questions related to the session objectives. The results of discussions were captured through written and verbal report back mechanisms. In addition, the verbal reports were digitally recorded by session organizers. Results of the discussions were collected, collated, transcribed, analyzed, and sorted according to themes which are presented later in this report.

MEETING RESULTS

Results were collated from transcripts made from an audio recording of the report out period of the meeting, from written notes taken at each table during the discussion, and from additional comments notes collected from discussion tables. Three primary themes emerged from these data: structures and resources required for implementation, research and data analysis needs, and processes for implementation. Descriptions of the subthemes are presented below (Figure 1).

Structures and Resources

Plan: An overarching provincial strategy is needed to facilitate development of comprehensive and coordinated programming that addresses needs uniformly across the province. The plan must include specific objectives and goals with achievable timelines.

Leadership, Advocacy and Visibility: A provincial pain foundation or organization is required to move the pain initiative forward, bring stakeholders together, provide

advocacy for pain as an important health issue, collaborate with ministry and professional bodies, identify funding to support initiatives, and be the "official voice" of pain in Saskatchewan. Suggested examples of a visible organization or foundation are a Saskatchewan chapter of the Canadian Pain Coalition, and a Saskatchewan version of Pain BC. Credible leadership and an advisory board are needed for the foundation/organization. Broad representation on the board is needed from multidisciplinary health care providers and the public, including First Nations' & Métis (FN&M) peoples and the elderly. The foundation/organization would also house a repository for information and materials related to pain (e.g. website identifying resources and activities announcements).

Implementation of region-specific pain management initiatives, data collection and analysis, and staff education would be facilitated by creation of pain management departments and hiring an individual in each region to be responsible for pain specific improvements. Regional pain management departments would be able to collaborate on shared initiatives and work with the provincial foundation to implement and evaluate new programs and services.

Structures such as a foundation and regional pain management departments would provide leadership, increase visibility of pain as an important health issue, improve communication between health care providers across the province and with other jurisdictions, provide an access point for media and public relations, create opportunities for social marketing to improve pain, and coordinate advocacy efforts.

Education: Increased knowledge and skills of health care providers, and increased awareness of the public were identified by all groups as essential to an effective pain strategy. A curriculum review of university and college based education of entry-to-practice level professional programs is needed to ensure that evidence based education is provided on pain assessment, prevention, and management. Education must address misconceptions and attitudes, particularly towards individuals with chronic pain and mental health or addictions co-morbidities. Mandatory discipline specific and interdisciplinary entry-to-practice courses in pain education are needed.

Mandatory education on pain for practicing health region staff (multidisciplinary health care providers) is required to improve the ability of all providers to identify and appropriately manage pain. Professional bodies can be lobbied to bring pain education courses to Saskatchewan for practicing health care providers. Funding to support education of physician and RN(NP) groups was identified as being of particular importance as primary care providers will be expected to be key facilitators of pain management services for clients living with pain.

Education of the general public is needed to reduce stigmatization of pain, and to provide education on pain management resources. On-line education resources need to be identified or developed for clients and providers. Practicing health care providers will need support (time released) for pain education. Peer led education and mentorship would facilitate sharing of knowledge in an effective manner, as opposed to lecture based learning models that have limited evidence for impact on pain management practices.

Financial: Several financial related issues were identified. Funding opportunities for research and new programming need to be identified. Several groups identified the need for billing codes that allow for adequate physician compensation for pain management (e.g. time based billing codes similar to Ontario). Appropriate pain management, particularly for clients living with persistent pain, requires integrated services between multiple disciplines that address medical, pharmaceutical, psychological, physical, occupational, financial, social and spiritual needs of clients. As such, funding is needed that supports access to a range of interdisciplinary and coordinated services for pain. A review of the provincial formulary is needed to ensure that adequate coverage is provided for interventions with evidence for effectiveness. Corporate funding opportunities can be sought, such as collaborations with the Worker's Compensation Board (WCB), Saskatchewan Government Insurance (SGI), farming and mining industries. Corporations may be interested in opportunities to reduce work-place absenteeism and reduced productivity due to pain-related disability. Philanthropic funding support can also be pursued. Opportunities for seed funding for education or smaller initiatives can be identified through related provincial and national priority sources (e.g. ED Waits Initiative, Mental Health and Addictions Action Plan, National Anti-Drug Strategy) or discipline specific regulatory bodies and professional associations (e.g. SRNA, SMA, CPSS).

Outcome Monitoring: Appropriate client outcomes, and standardized tools to monitor those outcomes need to be identified for clients both in facilities (e.g. acute care, long-term care) and in the community. Structures (e.g. electronic medical records) are needed to allow monitoring of outcomes to determine efficacy of interventions, and quality of services. This will enable the identification of pain as a quality indicator, and development of targets and support systems to ensure optimum management and program development. Data management could be facilitated through regional pain management departments.

Research and Data Analysis Needs

Business Case: All groups discussed the need to develop a business case in order to advocate for ministry, regional, and research funding. Provincial and regional data can

be utilized to examine the cost of pain, and estimate cost benefit of new programming to health regions, the province (e.g. reduced disability payments), clients and families. Research collaborations, such as with health economists, can be developed to partner on cost analyses. Medical codes (ICD-9 and ICD-10 codes and procedure codes) can be used to track volume and need for services. Provider education on use of appropriate pain-related medical codes may be required. Stakeholder participants noted the complexity of this issue, in that pain is a frequent co-morbidity with mental health and addictions, and not only affects the health care system, but also justice and social services. Therefore, intersectoral collaborations must be established to evaluate the broader impact of pain management initiatives. Appropriate prevention of pain and addictions through judicious and effective acute and chronic pain management would be expected to have wide reaching cost benefits, in addition to the benefit to individual well-being.

Provincial Needs and Assets Assessment: Additional discussions with key stakeholders are required to identify diverse needs and strengths across the province. Further work is needed to identify who are the key stakeholders within all health professions, family members, and clients to identify both gaps in services, potential road-blocks, strengths, and existing services upon which a provincial pain strategy can be built. Particular attention is required to identify unique needs and strengths of Saskatchewan residents of FN&M ancestry. Collaboration with researchers with expertise in community based participatory action research may facilitate this process. Email distribution lists from professional licensing bodies can be utilized to survey health professions to identify interest in pain (e.g. identification of pain champions). The need to involve various ministry bodies (e.g. health, education, justice) was recognized in order to ensure that the pain strategy aligns with existing government priorities. Client and family involvement in this process can be identified through involvement of condition specific support organizations (e.g. the Arthritis Society).

External Review: A review of published literature and effective models in other jurisdictions can be utilized to identify a possible framework upon which to build a pain strategy for Saskatchewan. Outside consultation would expedite this process. Significant opportunities exist to learn from other established organizations, such as Pain BC.

Processes

The following specific processes were identified by groups as opportunities for improved service delivery, education, support, and organization of pain services.

- Development of a chronic disease model for persistent pain, such as is currently in place for diabetes, to ensure that clients managed in the community have a multi-disciplinary pain team involved with their care.
- Programming for persistent pain based out of primary care.
- Pooled referral forms for pain management specialists.
- Centralized triage and referral services for primary care providers to refer clients with persistent pain for assessment and management.
- Equitable services across urban and rural communities. Creation of services that can be provided in smaller urban and rural centers.
- Stratified (step-based) programming with a range of services for acute and persistent pain that are client-oriented, not provider-oriented.
- Development of acute pain services that identify and carefully manage clients at high risk of poor pain outcomes, and ensure safe and effective transition from acute care to the community. Ensure adequate supports for clients and primary care providers.
- Development of "pain pathways."
- Creation of electronic health records that support appropriate pain assessment and management in facilities, and primary care.
- Development of a pain hotline for clients and providers to access advice and information on resources.
- Development of discipline specific and interprofessional mentorship support networks similar to the ECHO project (Ontario) or the Chronic Pain Collaborative Care Network (Nova Scotia).

STRENGTHS AND LIMITATIONS

Although there was diversity among participants, some groups had larger representation in the discussions. The meetings were held in Saskatoon, and subsequently there were a high number of local participants. Approximately half of the provincial health regions were represented. There was an interdisciplinary presence with representation from nursing, medicine, physiotherapy, psychology, pharmacy, occupational therapy, and social work. It is recognized that there were higher numbers of participants from nursing and smaller numbers from other disciplines, which may limit the findings. There is a need to consult with the health regions and disciplines that were absent in order to confirm that the discussions and recommendations are representative of multiple viewpoints. An additional limitation was low representation from clients and families who have been impacted by pain and who may or may not have received services to manage pain. An identified strength was the strong representation from

direct care providers who work daily with individuals experiencing pain. Another strength was the participation by those in leadership positions e.g. health care administrators, government leaders, First Nations and Métis health leaders. These individuals have great capacity to influence decision-making in moving a provincial pain strategy forward.

MOVING FORWARD

Equitable access to pain management is a fundamental human right. Much work is needed to ensure that Saskatchewan residents have access to the best possible care within facilities, and from primary care providers through to specialty services. Health care providers require access to education and supports to facilitate provision of timely and appropriate care that addresses the complexity of pain management.

The results of stakeholder meetings presented in this report are designed to support future discussions and build momentum toward the development and implementation of a comprehensive pain strategy for Saskatchewan. The key to advancing the Saskatchewan Pain Strategy and keep the important work of improving pain resources in the spotlight is to identify a step-wise plan, guided by the results of discussions of stakeholders, and enacted through targeted initiatives.

Prioritization of action items will be accomplished through the concerted efforts of a pan-provincial interprofessional steering committee or task force. To illustrate the importance of a broad spectrum approach to pain management, representation from clinicians across the continuum of care, clients and families, academia, and governance bodies will enhance advancement of the work.

Behind momentum is force and the force now needed is the commitment of dedicated human and financial resources to support improvements in pain management. It is the ethical responsibility of health care providers, private and public organizations, governments, and individuals to come together to work towards solutions to improve resources and access to pain management for the people of Saskatchewan.

Figure 1: Stakeholder meeting results of recommendations for action

Goal: Develop a foundation of knowledge, resources, and advocacy to support pain management in Saskatchewan						
Action Categories	Actionable Initiatives					
Structures and Resources	Comprehensive provincial pain strategy	Saskatchewan Pain Foundation	Regional pain management departments	Education	Financial	Outcome monitoring
	Work with stakeholders to develop a comprehensive provincial plan for action.	Establish a Foundation to lead advocacy efforts and support public education and other initiatives for pain management.	Regional Pain Management departments to lead region specific program planning, evaluation, and staff education.	Curriculum review of health sciences training programs. Collaborate with regional pain management departments and foundation for comprehensive provider and public education.	Review billing codes to support adequate compensation for providers. Review provincial formulary to ensure support for best practice.	Structures and supports for pain specific quality indicators, metrics, and targets for pain management in facilities, home-care, and primary care.
Research and data analysis needs	Business case		Provincial needs and asset assessment		External consultation	
	Cost analysis and cost benefit analysis of new programming. Collaborate with health economist researchers.		Identify key stakeholders, existing services, and gaps. Collaborate with community participatory action researchers.		Collaborate with existing foundations (e.g. Pain BC) to gain from their learnings on development of pain services and advocacy efforts.	
Processes	Specific implementation recommendations					
	Chronic Disease Management model for pain.	Primary care based pain services.	Pooled referrals for pain management specialists.	Centralized triage.	Equitable services for rural residents.	Stratified services.
	Acute Pain Services.	"Pain Pathways."	Pain in electronic medical records.	Pain hotline.	Provider mentorship program.	

REFERENCES

- Agborsangaya, C.B., Lau, D., Lahtinen, M., Cooke, T., & Johnson, J.A. (2013). Health-related quality of life and healthcare utilization in multimorbidity: Results of a cross-sectional survey. *Quality of Life Research*, 22, 791-799. doi: 10.1007/s11136-012-0214-7.
- Armaghani, S.J., Lee, D.S., Bible, J.E., Shau, D.N., Kay, H., Zhang, C.,...Devin, C.J. (2014). Increased preoperative narcotic use and its association with postoperative complications and length of hospital stay in patients undergoing spine surgery. *Journal of Spinal Disorders & Techniques*. [e-pub ahead of print]
- Canadian Pain Society (2007). Position Statement on pain relief. Retrieved from: <http://www.canadianpainsociety.ca/policy.html>
- Canadian Pain Coalition (2010). The status of pain in Canada - Moving toward a Canadian pain strategy. Retrieved from: http://www.canadianpaincoalition.ca/media/cpc_brief_pall_comp_care.pdf
- Coley, K.C., Williams, B.A., da Pos, S.V., Chen, C., & Smith, R.B. (2002). Retrospective evaluation of unanticipated admissions and readmissions after same day surgery and associated costs. *Journal of Clinical Anesthesia*, 14, 349 –353.
- Fischer, B., Lusted, A., Roerecke, M., Taylor, B., & Rehm, J. (2012). The prevalence of mental health and pain symptoms in general population samples reporting nonmedical use of prescription opioids: A systematic review and meta-analysis. *Journal of Pain*, 13, 1029-1044. doi: 10.1016/j.jpain.2012.07.013.
- Gauntlett-Gilbert, J. & C. Eccleston (2007). Disability in adolescents with chronic pain: Patterns and predictors across different domains of functioning. *Pain* 131, 132 - 141.
- Government of Saskatchewan, Ministry of Health. Five-year and 2013-14 strategic priorities for the healthcare system. Retrieved from: <http://www.health.gov.sk.ca/plan>
- Guerriere, D.N., Choiniere, M., Dion, D., Peng, P., Stafford-Coyte, E., Zagorski, B.,...Ware, M.(2010). The Canadian STOP-PAIN project – Part 2: What is the cost of pain for patients on waitlists of multidisciplinary pain treatment facilities? *Canadian Journal of Anesthesia*, 57, 549-558. doi: 10.1007/s12630-010-9306-4.
- International Pain Summit of the International Association for the Study of Pain (2011). Declaration of Montreal: Declaration that access to pain management is a

- fundamental human right. *Journal of Pain and Palliative Care Pharmacotherapy*, 25, 29-31.
- Juckes, K. & Power-Horlick (2012). A first of its kind: A pain management charter. *SRNA Newsbulletin* 14(4): 10.
- King, S., Chambers, C.T., Huguet, A., MacNevin, R.C., McGrath, P.J., Parker, L., & MacDonald, A.J. (2011). The epidemiology of chronic pain in children and adolescents revisited: A systematic review. *Pain*, 152, 2729–2738. doi: 10.1016/j.pain.2011.07.016.
- Phillips, D.P., Knizner, T.L., & Williams, B.A. (2011). Economics and practice management issues associated with acute pain management. *Anesthesiology Clinics*, 29(2), 213-32. doi: 10.1016/j.anclin.2011.04.010.
- Racine, M., Choinière, M., & Nielson, W.R. (2014). Predictors of suicidal ideation in chronic pain patients: An exploratory study. *The Clinical Journal of Pain*, 30(5), 371-378. doi: 10.1097/AJP.0b013e31829e9d4d.
- Sagheer, M.A., Khan, M.F., & Sharif, S. (2013). Association between chronic low back pain, anxiety and depression in patients at a tertiary care centre. *The Journal of the Pakistan Medical Association*, 63(6), 688-690.
- Saskatchewan Health Quality Council (2012). Patient Acute Care Experience Survey. Retrieved from: <http://hqc.sk.ca/Portals/0/Factors%20influencing%20Patient%20Hospital%20Experiences.pdf>
- Schopflocher, D. R., Taenzer, P., & Jovey, R. (2011). The prevalence of chronic pain in Canada. *Pain Research & Management*, 16(6), 445 – 450.
- Tunks, E. (2003). The chronic need to improve the management of pain. *Pain Research & Management*, 8(4), 187 -188.
- White, D., Kaplan, L., & Eddy, L. (2011). Characteristics of patients who return to the emergency department within 72 hours in one community hospital. *Advances in Emergency Nursing Journal*, 33(4), 344-353. doi: 10.1097/TME.0b013e31823438d6.
- Zanocchi, M., Maero, B., Nicola, E., Martinelli, E., Luppino, A., Gonella, M. et al. (2008). Chronic pain in a sample of nursing home residents: Prevalence, characteristics, influence on quality of life (QoL). *Archives of Gerontology and Geriatrics*, 47, 121–8.

APPENDIX A: Stakeholder Meetings Methods

Conference Session

Participants were seated randomly at round tables of 3 – 6 per table. The session started with a short presentation of background information to frame the discussion. This included information from both provincial and national perspectives. The facilitator explained the purpose of the discussion and identified the structure for the session. The overall goal of the session was to identify challenges and opportunities in the area of pain management and care in Saskatchewan. Participants were advised that the results of the discussion would be shared with a meeting of provincial stakeholders being held later that day and would also be included in a report outlining the results of both facilitated sessions.

Three questions were presented to frame and capture the discussion and outcomes.

1. What are we doing well?
2. What are the gaps?
3. What needs to be in place to implement a pain strategy in Saskatchewan/

In addition to the questions being provided in a written format at each table for ease of the scribe to capture the discussion, each question was also provided to the group electronically on a screen at the front of the room. Each table was also provided with materials such as colored pens, paper, and sticky notes to capture the details of their discussions. Each table grouping of participants was instructed to nominate a discussion leader and scribe to move the discussion along and capture the results of the discussion on the table materials provided.

The facilitator acted as time keeper for the 50 minute session which included the presentation of background information and the instructions for discussion and report back. Participants were advised about how much time they had to discuss each question, provided with notification of the time for closing the discussion and the process for report back from participants. As there was not time for each table of participants to report back, the facilitator first asked for volunteers and then, seeing none, selected one or two tables to provide a report back while encouraging any participant to add their thoughts to the entire group if desired.

Following the end of the session, the facilitator collected the materials each table produced as a result of the discussion of the three questions provided. The facilitator then collated and aggregated, verbatim, the raw data by the headings of each of the three questions. A high level overview of general themes was identified for the purpose of reporting to the meeting of provincial stakeholders later that evening.

Invited Stakeholder Session

Invited guest speakers provided background to work in the area of pain management being done in Saskatchewan and other provinces, and also from a pan-Canadian perspective.

Stakeholders received a letter of invitation from a planning committee lead by representatives from the SRNA and the Canadian Pain Coalition. The letter of invitation included a background document outlining provincial and national efforts in the area of pain management and a description of the facilitated session, including the purpose, format, participant roles, and desired outcomes of the session. These documents served to provide stakeholders with a framework to focus their work at the session and to advise them of the intention to capture the results of the discussions for a report of the proceedings of both the stakeholder and conference facilitated sessions.

Brief presentations from representatives of the SRNA Pain Special Interest Group, the Canadian Pain Coalition, and Pain BC provided background for the facilitated discussions. Stakeholders were seated at round tables of 4 – 7 people. Assigned seating, determined by the planning committee, was targeted at offering a heterogeneity of stakeholders at each table. Following the brief presentations the facilitator shared the overall general themes from the facilitated session at the 2015 Pain Management Conference earlier that day and informed the stakeholder group about the process for their discussions.

Each table was provided with materials for capturing discussion and was asked to identify a scribe to take notes and a reporter to share key messages from the table discussion. Stakeholders were also reminded that the report back from each table would be captured by digital audio-tape and that transcriptions of this data, along with the written reports by the table scribe, would be collated, aggregated and de-identified to be used for a report of the facilitated session.

Two questions were posed to the stakeholder group for discussion:

1. What will it take to develop and implement the Saskatchewan Pain Strategy?
What structures, processes and operational measures need to be in place?
2. What resources are needed to position the development and implementation of the Saskatchewan Pain Strategy?

In addition to the questions being provided in a written format at each table for ease of the scribe to capture the discussion, each question was also provided to the group electronically on a screen at the front of the room.

SASK PAIN STAKEHOLDER MEETING

The facilitated discussion constituted a 60 minute session. The facilitator acted as time keeper for the discussion and report back of each question over roughly a 30 minute period of time for each question. Each table was allowed the opportunity and encouraged to report back the key points of their discussion. At the end of the 60 minute session, the facilitator re-visited how the information collected at the session would be organized and reported.

In addition to the results of the facilitated discussion, stakeholders were asked to complete a short demographic questionnaire and a separate information sheet outlining their interest in continued involvement with the development and implementation of a Saskatchewan Pain Strategy. Participants were reminded that the completion of both documents was voluntary.

With the proceedings of the stakeholder session completed, all completed materials from each table was gathered and sorted for the purpose of data collation and analysis.

“Pain management shouldn’t be a simple solution,
because pain is not a simple problem.”

Donna Cooke RN, Stakeholder session participant

Suggested citation: Tupper, S.M., Juckes, K., Jeffery, C. (2015). *Provincial pain strategy: Saskatchewan stakeholder meeting report*. Saskatoon, SK: SRNA Pain Management Professional Practice Group.