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CANADIAN PAIN CARE FORUM

Meeting Minutes

June 17, 2016

Organizing Committee:

Dr. Norm Buckley, Director, Michael G. DeGroote National Pain Centre, McMaster University
Dr. Angela Carol, Medical Advisor, College of Physicians and Surgeons of Ontario
Dr. Reuven Jhirad, Deputy Chief Coroner, Office of Chief Coroner for Ontario
Dr. Ramesh Zacharias, Medical Director, Michael G. DeGroote Pain Clinic, Hamilton Health Sciences
Ms. Sonya Altena, Coordinator, Michael G. DeGroote Pain Clinic, Hamilton Health Sciences
Mrs. Dale Tomlinson, Manager, Michael G. DeGroote National Pain Centre, McMaster University

Participants:

Chris Auger
Linda Blake-Evans
Jason Busse
Lynn Cooper
Robert Eves
Michael Hamilton
Wade Hillier
Oliver Johnston
Pat Kelly
Craig Landau
Fleur-Ange Lefebvre
Sandra MacDuff
Glenn McAuley
Carrie-Lynn Meyer
Anna Roberts
Sandy Smeenk
Andrew Smith
Suneel Upadhye
Owen Williamson

- Dr. Buckley welcomed participants to the forum. The forum was organized as the need to develop a national strategy for pain care has been widely recognized. The objective is to begin developing concrete strategies toward this goal. A clear message from the government is to show them what we are able to do.

- The path to getting where we are today has been by way of the *Canadian Opioid Guideline* and the Canadian Centre for Substance Abuse (CCSA) *First Do No Harm: Responding to Canada's Prescription Drug Crisis*. The First Do No Harm Strategy has very specific actions, for knowledge and treatment of pain with short, medium and long term goals.

- Previous meetings developing the *Template for Action* brought together a wide range of individuals, e.g. physicians, pharmacists, law enforcement. The meetings worked to identify the problems, solutions, and to create a template with concrete actions.

- The objective today is to begin to identify strategic goals for a national pain strategy and communicate accomplishments along the way. In 2012 the Canadian Pain Coalition developed a strategy which was eventually handed off to lobbying groups. It is recognized that a unified message is necessary. We cannot have a number of one-offs when seeking funding. A national strategy for pain that can be recognized by the community at-large and that recognizes the value in what we are proposing is vital.

- As forum participants introduced themselves, the following comments/feedback were received:

Name/Organization	Comments
Chris Auger, Ontario Provincial Police	The OPP utilizes as many legal ways as they can to address the problem, e.g. surveillance on seizures, looking at new trends (*facethefentanyl* , Humber College - http://www.facethefentanyl.ca/), advocacy (Patch 4 Patch Program). Treatment and guideline solutions are important. Resources are also focussed on those profiting from addiction (e.g. trafficking).
Linda Blake-Evans, Program Manager, Hamilton Public Health	The current focus is on the naloxone program; they are awaiting its non-prescription availability. There is a need for advocacy that includes families. They support access to data, impact of pain on patients and family, and workplace health.
Jason Busse, Michael G. DeGroote National Pain Centre	Currently working on updating the Canadian Opioid Guideline with funding from Health Canada (to be released in early 2017). Pain is an enormous issue with disability insurers. Insurers are not using best-evidence to make decisions or inform their practices. It would be beneficial to have a participant from the insurance industry.
Lynn Cooper, President, Canadian Pain Coalition; and voice for those living with pain	We need inclusivity/stakeholders. A strong message developed by all involved is necessary. The CPC want to

	work to make a new national pain strategy happen.
Robert Eves, Director, Strategic Partnerships and Knowledge Mobilization, Canadian Centre on Substance Abuse (CCSA)	We need a balanced approach with key players that look at the distribution system and enforcement around it. All CCSA work is evidence-based. A prescription monitoring and surveillance system with champions at high levels is needed.
Michael Hamilton, Physician Lead and Medication Safety Specialist, Institute for Safe Medication Practices Canada (ISMP Canada)	ISMP is interested in a system and process-based approach for medication. ISMP has been collecting data for 15-20 years. They do multi-disciplinary research and surveillance. Working to see how far up-stream you can put a lever (e.g. tamper proof).
Wade Hillier, College of Physicians and Surgeons of Ontario (CPSO)	People are vocalizing the need for obtaining adequate treatment. The College is trying to do what it can; that is, looking at the physician piece. The major piece is what the Ontario prescription monitoring program can give them. They are also looking at those physicians who are on the cusp of getting into trouble. The College can educate physicians who are in difficult situations. They can provide physicians with feedback and direct them to resources to improve their practice.
Oliver Johnston, Market Access Director, Purdue Pharma	Echoed comments from Craig Landau (see below).
Pat Kelly, Pain Advocate	Came to this area as a result of personal experiences. The gap between what we know and what we do is the advocacy gap. Various organizations (e.g. Arthritis Society, Canadian Pain Society) will be important when we go to government with the support of all groups. We need to make the case and build the coalition.
Craig Landau, President, Purdue Pharma (Anesthetist by training)	There is no silver bullet for pain care. Excited to be part of an opportunity for a national pain strategy and to mitigate risk for treating/not treating. Recognizes that we all have roles to play. From an industry perspective, they have an opportunity to raise awareness, provide education (for opioids), and develop and distribute drugs that are less vulnerable to manipulation and misuse.
Fleur-Ange Lefebvre, Executive Director & CEO, Federation of Medical Regulatory Authorities of Canada (FMRAC)	FMRAC's recent annual conference was devoted to opioids. A need was identified for a cohesive regulatory approach which includes access to data; a drug monitoring program in real-time, enhanced education and programs (through colleges) and regulatory partners.

	There is a need to talk to pharmacy regulators and the government.
Sandra MacDuff, Clinical Leader, Michael G. DeGroote Pain Clinic	Diversion is an important piece of this work. There is a great need for better communication amongst the stakeholders and information needs to be more reportable.
Carrie-Lynn Meyer, Clinical Manager, Michael G. DeGroote Pain Clinic	Member of Ontario's Advisory Group for chronic pain.
Anna Roberts, Policy Analyst, Controlled Substances Directorate, Health Canada	Health Canada is concerned about the opioid crisis. The Minister has asked for all ideas to address the problem.
Sandy Smeenk, Executive Director, Improving the Lives of Children Foundation (ILC)	The ILC's focus is to support efforts to providing pain care with a commitment to advocacy, treatment and research. They have gained support from Eric Hoskins to support a multi-disciplinary centre for Ehlers-Danlos Syndrome (EDS).
Andrew Smith, Medical Lead, Inter-professional Pain and Addiction Recovery Clinic; Staff Physician, Pain and Addiction Medicine, Centre for Addiction and Mental Health (CAMH); Executive Member, ECHO Ontario – Chronic Pain	Has tried to support and approve care among primary care-givers. Access to care is a passion. We need to: 1) identify stakeholders and engage them in an open and collaborative process, 2) identify the scope and opportunity of the problem, 3) secure champions.
Suneel Upadhye, Emergency Physician; CAEP Standards Committee	Emergency physicians have difficulty communicating with physicians/pharmacy when people show up in the ER. Pain guidelines are lacking for physicians in emergency. Internally, they have a mandate to work on it. They will be looking at what is being done in other provinces around managing ER pain issues. They are not able to undertake the pain diagnosis in the ER that should be taking place.
Owen Williamson, Chair, Academic Pain Directors of Canada	It was recognized that were was not an obvious voice for pain medicine doctors in the province. Poor decisions were being made without discussion; as a result they developed a society – pain medicine doctors within British Columbia.

- Dr. Zacharias noted that the pain care forum in the United States meet six times a year. Meetings are followed by a discussion of the issues. Speakers are invited to three of the meetings. Dr. Zacharias would like us to consider holding 4 meetings per year. Some meetings can take place via teleconference in order to move our agenda forward.

- Prior to this June 17th meeting, participants were asked to provide responses to the following questions:

  1) What three actions need to occur in order to place a pain strategy clearly on the national agenda?
  2) What role can your organization plan in implementing or supporting these actions?

- Some of the main themes that emerged were: Advocacy, the need for champions, surveillance, developing an inclusive collaboration with a broad representation, need for a formal strategic plan, communicating accomplishments.

- From feedback received, participants were then asked to rank the four themes they feel to be most important by placing stickers on the flip chart pages posted in the room.

- A comment raised was that when voting, it depends on the outcome you have in mind as to how one might vote. If the outcome recommendations are for a national pain strategy, it might make a difference in how items are prioritized. If we start with the end in mind, it might look like what we want to deliver; that is, a set of living recommendations.

- We are getting constant messages from people across the country wanting to talk about a pain strategy. There needs to be a consistent case presented at both the provincial and federal levels. The nature of pain is a multi-factorial problem requiring multi-factorial solutions. We need an optimal pain treatment strategy. The clear message that we must come back with is a package to inform all levels (e.g. healthcare policy-makers, employers). We need a clear endpoint to reach people, with a national solution.

- Provinces have their own wish lists. The most important piece is stakeholder engagement and respect.

- FMRAC want to be part of this; the board will have to consider what approach to take and what they can work on. A national approach is vital; it must be focussed and worthwhile.

- Pat Kelly stated that this is the type of work that Pain Action Canada (PAC) has been undertaking. We need to demonstrate what the framework looks like. PAC has already been working on creating a framework that they can make available. A year ago PAC developed a social marketing strategy to create awareness.

- Attendees were thanked for their contribution and participating in the forum. They were asked to forward to the names of others who should be included in this ongoing work. Attendees

were also asked to look at the top strategies and consider what one solution their organization can contribute to this national pain strategy.

- Pat Kelly suggested that the *Canadian Pain Care Forum* name be changed. We need a burning platform for this. We have content expertise, however content does not sell. We need to gain the hearts and minds of people on this initiative.

- We will work to ensure that there is pharmacy representation at the next meeting targeted for fall 2016.

NATONAL STRATEGY FOR PAIN CARE THEMES **June 17, 2016**
1) Surveillance (20 votes)
▪ Real-time drug monitoring (Rx monitoring) ▪ Trend analysis ▪ Police data ▪ System/process analysis and breakdown of adverse events ▪ Define norms and early detection of outliers
2) Treatment Guidelines (Solutions) (19 votes)
▪ National pain strategy ▪ Effective management approach (inter-disciplinary) (access/management evidence-based) ▪ Improved – care practice/management ▪ Useable format of guidelines ▪ Prevention of diversion ▪ Dealing with those profiting from pain medications ▪ Medication options (increase) ▪ Balance between access/treatment ▪ Reimbursement of drugs ▪ Site-specific considerations (e.g. ER)
3) Education/Research (17 votes)
▪ Public education (e.g. use, medication safety) for the general public and those living with pain ▪ Partnerships between institutions (inclusive) ▪ Systematic reviews of existing protocols ▪ Impact of pain (e.g. workplace, economic) ▪ System/process analysis ▪ Drug development – less susceptible to abuse (mandatory build-in of safety measures)
4) Advocacy (15 votes)
▪ Avoid labels ▪ Removal of stigma attached to pain care ▪ Clear navigation through systems

▪ Clear partnerships with “accented” organizations/families ▪ Harm reduction programs, e.g. Naloxone, drug drop-offs ▪ Target certain pharmacies/people ▪ Risk mitigation (treatment versus non-treatment)
5) Stakeholders (Vision/Mission) (10 votes)
▪ Protect the public ▪ Unified voice (professional/public) ▪ Cohesive national approach ▪ Champions at various levels ▪ Identify players ▪ Clear communication channels ▪ Legislation (e.g. government, practice-based) ▪ “Who owns the problem?” ▪ Strategic plan for ‘role-out’

Action Items	
All Participants	▪ Who else needs to be included (provide names from pharmacy, insurers, etc.). ▪ What can your organization do to support a national strategy for pain care? Email responses to: npc@mcmaster.ca