



# PRIMARY CARE LOW BACK PAIN

Mount Forest Family Health Team

# THE 7 FAMILY HEALTH TEAMS INVOLVED IN THE PRIMARY CARE LBP PILOT PROGRAM

- The PCLBP pilots are currently operating at the following seven areas:
  1. Belleville: Belleville Nurse Practitioner-Led Clinic (South East LHIN)
  2. Estrie: Centre du santé communautaire de (Champlain LHIN)
  3. Mount Forest/Wellington/Maple: Mount Forest, East Wellington and Minto-Mapleton Family Health Teams (Waterloo Wellington LHIN)
  4. Orillia/North Simcoe: Couchiching Family Health Team (Muskoka LHIN)
  5. Scarborough: Taibu Community Health Centre (Central East LHIN)
  6. Sudbury: Shkagamik-Kwe Aboriginal Health Access Centre (North East LHIN)
  7. Windsor/Essex: City Centre Health Care & Essex Court Nurse Practitioner Led Clinic (Erie St. Clair LHIN)



# RURAL WELLINGTON LOW BACK PAIN PROGRAM



3 Family Health Teams

6 chiropractors

1 Occupational therapist

3 kinesiologists

3 physiotherapists

1 pharmacist

# MOUNT FOREST FHT

7 Doctors

2 nurse  
practitioners

2 primary care  
nurses

1 kinesiologist

1 dietician

2 mental health  
workers

1 occupational  
therapist

1 pharmacist



# ISAEC MODEL

Research model launched in Toronto, Hamilton and Thunder Bay in November 2012.

Is to be rolled out to LHINs over next two years

Acts as a specialist referral process for people with low back pain over 6-12 months

Care provided in centralized location pts receive some 1:1 education and support

The expectation is that the patient will self-manage without a lot of support

Those not eligible for surgery were referred back to primary care without support

Appears less valuable for pts with low social determinant of health challenges,

Little provision for knowledge translation in managing low back pain over time

It is a 'late stream' model of care rather than a 'front end' model of care.

# HOW DID WE START ?

- MOHLTC pilot program Jan 2015-March 2016
- Application process
- Initial pilot tested three main ideas
  1. Improving PCP knowledge about evidence informed treatment of LBP will reduce the rate of x-rays, specialist referrals and use of opioids
  2. Providing access to manual therapy will improve patient outcomes and reduce disability over time
  3. Access to inter-professional, collaborative team will improve patient outcomes and enhance the knowledge and skills of all disciplines involved in the care of people with low back pain



Pilot: Primary Care Low Back Pain (PCLBP)

#### APPLICATION TEMPLATE

Aboriginal Health Access Centres  
Community Health Centres  
Family Health Teams  
Nurse Practitioner-Led Clinics

Please note completed applications must be received by the ministry by 5:00 p.m on November 21, 2013 by email to [pclbppilot@ontario.ca](mailto:pclbppilot@ontario.ca)

Applications should be submitted with the subject line:

"Pilot: Primary Care Low Back Pain (PCLBP) Application" – "(Name of Organization)"

If additional information is required regarding the application process please contact: Suzann Trivers

Email/phone contact information: [stivers@mountforestfht.com](mailto:stivers@mountforestfht.com) 519-323-0255 x5004

#### Disclaimer

It is the applicant's responsibility to ensure that all information provided by the applicant is up date and correct to the best knowledge of the applicant.

It is the applicant's responsibility to ensure that the application reaches the ministry on, or prior to the application closing deadline. The ministry is not responsible for applications that are lost, delayed, misplaced or misdirected.

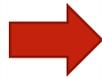
By submitting applications, applicants acknowledge that this is not a competitive procurement/tender and that determination of the successful candidates for funding shall be made at the ministry's sole and absolute discretion.

#### Consent

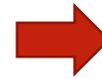
The ministry frequently receives requests for the release of contact information. By submitting this application template, your group consents to the release of the information contained in question 1 to requesting individuals or organizations, if the group's application is successful.

The Rural Wellington LBPP required a different model of care  
WHY?

Concerns for rural FHTs of hiring chiropractors or physiotherapists internally



High risk of putting independent practitioners out of work



Reducing access to the general population overall.



Using a private/public partnership



Reduces this risk



Provides access to these services for the largely uninsured rural population.

# FINDINGS

Reduced use of opioids for pain

Reduced use of pain medication overall

Improved function for patients who engaged in education and self-management activities

Improvements less for those who received manual therapy without engaging in education and self-management.

No significant change in the use of x-rays, largely due to a low rate of x-ray use as a starting point.

Very high rates of patient satisfaction.

Very high rates of primary care provider satisfaction

Very high rates of low back pain provider satisfaction

# WHAT NEXT ?

- Second Phase Pilot – December 2016 to March 2017
- Funding was not confirmed for the pilot extension until late summer 2016.
- In order to ensure program sustainability & “spreadability” across the province, we needed to approach the program from a more “defined plan of care” perspective
- We needed a standard starting level of care that could be modified based upon patient need over time
- Required some care coordination for two of three sub-populations identified largely on their readiness to change and presence of “yellow flags”
  1. “Independent Self-manager”
  2. “Supported self-manager”
  3. “Fully assisted management group”

# THIS APPROACH CAN BE MORE FINANCIALLY RESPONSIBLE

Not all patients are accessing all services eg. Chiropractic/physiotherapy

Participants get an individualized treatment approach which may improve adherence

This approach may make the program more sustainable over time.

Inter-discipline approach allows members to focus on their area of specialty

Other team members are linked and easily accessible to allow providers to consult and plan care for the patient that ensures consistency and coordination of care.

# VALUE OF EMR TOOLS

We developed a self-assessment tool for the patient to complete to ensure patients were “streamed” to the appropriate group at initial appointment

The score from this tool & physical assessment completed by PCP work together to guide next steps for the PCP

One of the three FHTs are using the tool with great success.

The transition to this new system took a bit longer with the other teams

Information is in the EMR and accessible to PCP to enhance coordinated care

**Low Back Pain Impact Questionnaire**

- 1) How long have you had low back pain
- less than 12 weeks
  - More than 12 weeks
  - Constant
- 2) Have you experienced any of the following in the last 1 to 4 weeks?
- Fever
  - Fatigue
  - Weight loss
  - Bowel or bladder problems
  - Night sweats
  - Tingling/numbness
  - Night pain that wakes you up
  - Other (please describe below)

3) In order to understand the impact that your low back pain has had on your life, please place a checkmark in the column that best describes your thoughts or beliefs about low back pain.

	Not much	Some	A lot
How much do you know about the causes of your back pain?			
How much do you know about taking care of your back pain?			
How confident are you with taking care of your low back pain?			
In the context of your life, how important is learning to take care of your back pain at this time?			

4) For the next questions, indicate whether you Disagree or Agree with the statement.

	DISAGREE	AGREE
It's not really safe for a person with a condition like mine to be physically active		
Worrying thoughts have been going through my mind a lot of the time		
I feel that my back pain is terrible and it's never going to get any better		
In general I have not enjoyed all the things I used to enjoy		

Score: 9

# PRACTICE SOLUTION'S CUSTOM FORMS



### Low Back Pain Assessment and Planning Tool

NOTE: This program is not eligible to patients who are receiving service through WSIB or NVA Insurance.

#### RED FLAGS

- No Red Flags
- Neurological symptoms: diffuse motor/sensory loss, progressive neurological deficits, cauda equina syndrome
- Infection: fever, IV drug use, immune suppressed
- Fracture: trauma, osteoporosis risk
- Tumour: hx of cancer, unexplained weight loss, significant unexpected night pain, significant fatigue
- Inflammation: chronic low back pain > 3 months, age of onset <45, morning stiffness >30 minutes, improvement with exercise, disproportionate night pain

Acute cauda equina syndrome is NOT suspected. Symptoms: [i](#)

#### LOW BACK PAIN IMPACT QUESTIONNAIRE

Score 16

How long has the patient had low back pain?  less than 12 weeks  more than 12 weeks  constant

#### Results:

##### Fully Assisted Managers:

The patient is likely needing full assistance to coordinate their care plan as well as full coaching with self-managing their low back pain. This patient may have difficulty implementing changes and will likely require full support.

#### ONSET

Acute LBP  Chronic

(first onset: less than 12 weeks since onset) (more than 12 weeks since first onset)

Based on results of Low Back Pain Impact Questionnaire (if completed)

When did the most recent change begin? # of days # of wks # of mths # of yrs

Do you think your back pain might be due to a recent work related injury or car accident?  Yes  No

How did these symptoms start (triggering event)?

Sudden  Gradual  After activity  Not sure

How many times have you had these symptoms in the past year? # of times

How long do these symptoms usually last?

Minutes  Hours  Days  Weeks

How much are these symptoms interfering with your ability to do your day to day activities?

Not at all  A little bit  Some  Fair bit  Completely

Have you missed work or school due to your pain?

Yes  No  N/A

#### HISTORY

1. Where is your pain the worst?

Back/Buttock Dominant  Leg Dominant

2. Is your pain:

Constant (rule out red flags)  Intermittent

3. Does bending forward increase your typical back or leg pain?

Yes  No

4. Have you ever had unexpected accidents with your bowel or bladder function since the episode of your low back/leg pain started?

Yes  No

5. If age of onset is <45 years, are you experiencing morning stiffness in your back >30 minutes?

Yes  No

Is a Surgical Referral being made now?  Yes  No  Pending [i](#)

There is still value in a patient being referred to the LBP Team for education and treatment while waiting for surgical referral.

# PRACTICE SOLUTION'S CUSTOM FORMS

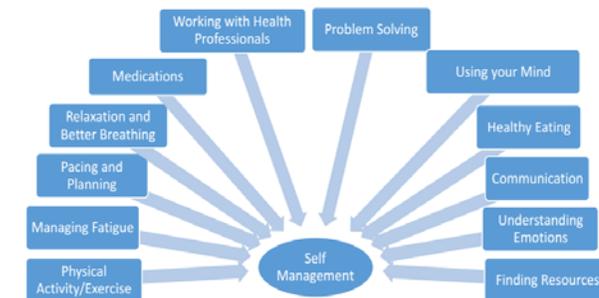
# PATIENT TOOLS

## Patient Feedback Questionnaire

When invited to offer optional feedback, this is what our patients shared...  
(67 out of 175 patients volunteered their comments)

- "The LBP program took me up to my surgery date and allowed me to work up to that point."
- "still having pain"
- "THANK YOU!"
- "Program was well worth my time. I continue to do daily exercises. Many thanks for all the help. TD"
- "I've had back pain for 8 years and always thought my pain only could be fixed with surgery. Thank GOODNESS for this program - I now realize with exercise and physio I can take control and make this better! Thank you SO much - I have GREATLY improved and continue to do so. Bas explained what my problem is and now I understand. Thank you! MK"
- "My issues arise when my back goes out on me. When that happens I need to see someone right away. I find the program has helped and I hope my back continues to be good. This program is a good thing for back pain patients."
- "Great program. Very helpful. Feel great after it was over. Thank you. "
- "I feel treatment might have been more successful had it been a less busy time of year." (December)
- "Many thanks for wonderful, comprehensive services that have given me a better understanding of what I need to do to manage my low back issues."
- "Back is a lot less stiff. Pain still present. Exercise program helping."
- "The RM Disability Questionnaire is tricky to answer as the "How do I feel TODAY" question can change throughout any given day. So we answer as best as possible. The care provided to date has been extremely helpful. Look forward to additional direction. It takes a lot of focus and assistance and encouragement to change old habits. Thank you."
- "Coping strategies have been most helpful. Understanding my condition has helped me to change the way I sit and do household tasks."
- "Dr Townsend has helped a lot and is teaching me a lot of new exercises to help my back. I feel a bit better and I think if I continue with the exercise program it will improve."
- "This program has been very helpful to me. The combination of different people (and services) has made a great difference. All have supplied me with information to help cope or to adapt. I wish this program would continue as without it I am afraid I will regress and my pain will get worse; also my mobility will get worse."
- "I would like to say I feel a lot better, but some days my back is really sore, other days not too bad. I can't honestly say it is a lot better. I do not understand why my medical doctor hasn't discussed my problem with me or at least an x-ray or CAT scan."
- "I appreciate the program would be helpful if it could continue for a while longer; at least another year."

## Patient Self Management Toolbox



Tool	How it can help
Physical Activity/Exercise	Hurt vs. harm: starting an exercise program may cause some muscle soreness, which is normal and will not cause harm. Physical activity is proven to be most beneficial for easing low back pain.
Managing Fatigue	Practice good sleep habits and routines for a good night's sleep.
Pacing and Planning	Avoid too much rest, over-doing it, or repetitive activities. Plan and pace your day by alternating activities and rest or low-impact activities throughout your day - not all at once!
Relaxation & Better Breathing	Ineffective breathing can lead to stress and anxiety; try deep breathing to relax your body and muscles.
Medications	Non-prescription and prescription medications can enable more activity; ask your healthcare provider.
Working with Health Professionals	Prepare for the visit, ask lots of questions, repeat key points, make notes or ask the specialist to write notes for you. Take action by including their recommendations into your daily routine; give feedback!
Problem Solving	Approach daily activities in a different manner i.e. to get dressed, sit on the edge of the bed to put socks and pants on; while sitting or driving, roll up a towel to support your back.
Using your Mind	Use distraction, or focus on positive and healthy thinking. Your thoughts have a powerful influence!
Healthy Eating	A balanced diet will help maintain a healthy weight and increase energy. (Let your care provider know if you wish to speak to a family health team dietician).
Communication	Use active listening and clear, direct statements to improve communication between family, friends, and healthcare providers.
Understanding Emotions	Suffering chronic pain can lead to feeling isolated, depressed, anxious, or stressed. Reach out to family or friends, or ask your healthcare provider about how to connect with a family health team therapist.
Finding Resources	Books, internet, relaxation tapes – ask your healthcare provider for ideas on where to find useful information.

Adapted from Chronic Pain Self-Management Program Workbook, S.M. LeFort, & L. Webster

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# KEY IS TO FOCUS ALL PARTNERS IN CARE ON FUNCTIONALITY RATHER THAN PAIN

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TO DATE, THE TYPICAL APPROACH TO LBP IS AN ACUTE CARE APPROACH WHERE THE FOCUS IS ON PAIN MGMT.

A FUNCTIONAL RESTORATIVE APPROACH IS WELL SUPPORTED BY RESEARCH. PATIENTS DO NOT COME TO SEE US IF THEIR PAIN IS NOT INTERFERING WITH THEIR ABILITY TO FUNCTION. THEREFORE, WE SHOULD BE FOCUSING ON THE PARTICIPANT AND THEIR ABILITY TO FUNCTION





# HOW DID WE MEASURE SUCCESS

- Patient disability questionnaires
- Oswestry scoring
- Primary care provider feedback questionnaires
- Low back pain care provider feedback questionnaires
- Patient feedback questionnaires

# OBSERVATIONS & LESSONS LEARNED

- Patients need to be mentally motivated & medically appropriate
- Multiple access points into program was a benefit to patients PCP not the gatekeeper
- Trend toward less diagnostic imaging at same time as referral to LBPP as program went along
- Many initial referrals were for very complex patients
- Weekly team meeting very successful in helping guide patient care
- Lack of access to EMR for outside providers was a challenge
- Non LBP patients of LBP providers would be referred if able into the LBP program as providers saw value of interprofessional team care model
- Group education sessions was a very effective way of reaching out larger group, often before being able to see a care provider

# OBSERVATIONS & LESSONS LEARNED

- Uncertainty around long term funding was a barrier to some PCP participation
- Active participants in the program had improved results
- Participants who entered the program initially as supported or fully assisted and later after discharge reentered the program during a flare utilized less resources than initially
- Care coordination facilitated the process to act as a coach and primary contact for participants which helped to improve outcomes
- Chronic low back pain participants showed a significant improvement in perceived disability scores

# MORE FINDINGS

- Patients benefit from greater understanding of their medications
- Education around Self Management and an awareness of what is happening in the body is of paramount importance
- Physicians gained awareness of what other healthcare providers can bring to management of low back pain
- No perceived greater benefit of chiropractic care vs physiotherapist care
- Universal appreciation of R.Kin and OT as a central benefit to LBP treatment
- Appreciation by MD that what works for LBP can work for other chronic pain
- Pharmacist services have been very valuable education component

# PCLBPP VS ISAEC

- Less patients appropriate for ISAEC model about 7% pts with LBP
- Pts referred to surgeon had a good foundation of education and self management which improved outcomes
- Patients receive their education soon after they first present to their primary care provider with low back pain.
- Identification and addressing of yellow flags early might reduce chronicity
- Education provided by a team member who the PCP knows and trusts, thereby ensuring that the teachings will be supported by the PCP on subsequent visits.
- Documentation of the care provided is made in the EMR on a visit by visit basis
- PCP can see improvements as time goes on & the impact of non-medical interventions

# BLENDED ISAEC AND PCLBPP

- What might be the best way to serve the total population of Ontario
- One that targets the vast majority of patients across the province
- Those able to self-educate and self-manage with a small amount of education and coaching
- Another approach for those requiring more supported coaching over time
- This multi-option approach would support primary care providers working independently
- Independently self-managing patients then have options for where they receive their care.
- Ideally one could refer into the other if appropriate

# LEARNINGS

- Chiropractic and physiotherapy Lunch and Learns contribute to knowledge translation and ongoing collaboration
- Introduction of an allied health professional referral tool into the EMR would facilitate collaboration
- Consistent easy to understand messaging to patients would be beneficial
- Patients get hung up on language used and sometimes come away from PCP interaction thinking “there is no hope” or “nothing can help”
- Improved communication between PCP and PCLBPP helped to establish improved trust and responsiveness & may help that patient communication
- VOMIT ..... ugggh

# CHALLENGES FOR THE FUTURE

- Ongoing funding is not yet guaranteed
- Is a chronic condition... what is the process for referral back into the program
- OT and KIN not easily available in rural communities or part of FHT structure
- Use of a referral stream or tiered plan to STRATIFY PARTICIPANTS INTO sub populations eg, chronic vs acute, complicated vs uncomplicated
- Communication back to PCP provider for “outside” care providers
- Providing EMR access to “outside” care providers
- Process for allied health providers to refer into FHT programs.. eg. Mental health, outreach, dietician
- PCP attending weekly team meetings on an ongoing basis

# PHARMACIST AS PART OF PCLBPP

Only LBPP pilot with a pharmacist imbedded

EWFHT had first time access to a pharmacist

EWFHT pharmacist contacted each LBP pt referral into the program

Most patients declined or preferred to try without medication at first

Were offered OTC options and general discussion around medications

Pharmacist consulted for pts on opioids often as a resource for reduction

# PHARMACIST AS PART OF PCLBPP

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MFFHT over course of pilot 35/108 pts seen by pharmacist

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Pts seen by Rph overall much more complicated from med perspective 11 medications daily vs 8 for non Rph referred

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Use of opioids seen as an extra layer of complexity by other care providers

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71% of pts seen by pharmacist using opioids vs 13% not seen by Rph

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Only 3 of the 35 pts seen actually reduced their opioids during pilot

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10/35 of the patients on opioids had an intervention to improve their pain management more in accordance with guidelines on Opioids in Non Cancer Pain

# KINESIOLOGY AS PART OF PCLBPP

Motion is Lotion – many patients with LBP fear movement

Many patients accessed Kinesiology services to develop personalized home exercise programs

Pts met with Kinesiologist on average 2-8 times to learn and implement home exercise routines

Exercise intensity varied across the LBP population depending on the goals and need of each pt

The number of exercises prescribed to each pt varied, average of 5-15 exercises/pt

# CHIROPRACTORS AS PART OF THE PCLBPP TEAM

- If it is thought that manual therapy will benefit the patient they are referred to a Physiotherapist (PT) or Chiropractor (DC) on the team for an assessment.
- The patient is assessed and a treatment plan is developed with use of the other team members when appropriate.
- Patient visits for manual therapy are capped at 12.
- There is frequent communication with the family physician in the form of reports that are uploaded to the EMR, and faxes or calls if necessary.
- Family physicians are becoming more comfortable with DCs as an important part of the team.
- PCLBPP cases, especially in the beginning of the program, are generally more complex than typically seen in general chiropractic practice.

# COLLABORATIVE CARE TEAM ENVIRONMENT

- Ease of referral to other practitioners within the program.
- Tremendously beneficial to patient outcomes and practitioner comfort level.
- Weekly team meetings improve patient care, educate practitioners, and strengthen practitioner bonds/comfort level with other practitioners.
- The team approach allows each practitioner to work in the area they are most comfortable and allow others to do the same with each patient, instead of trying to “wear multiple hats” and be everything to each patient.
- Just like any relationship, communication and mutual respect is key.
- Benefit to have a coordinator who manages referral between practitioners.

# INTERPROFESSIONAL RELATIONSHIPS

- In most cases chiropractors work “on an island” and have to build their own referral network with other health professionals
- This can be challenging and is often hindered by barriers.
- The collaborative approach to care in this program allows for all involved practitioners to learn about how each one of us would approach the same case.
- This leads to improved confidence in the other practitioners, less worry about referring to someone else, less time taken doing things with a patient that another practitioner may be better equipped to do, and better patient care.
- The benefit of these relationships transcends the program in that this new referral network also makes interprofessional collaboration easier for non-LBP patients.

# EXAMPLES OF INTERPROFESSIONAL COLLABORATION WITH CHIROPRACTORS

- The Ontario Chiropractic Association (OCA) has long been a driving force of encouragement for interprofessional collaboration in patient care.
- Other examples of collaborative care models involving chiropractors:
  - ❑CONSULTING CHIROPRACTOR DEMONSTRATION PROJECT (MID 2011-MARCH 2012): 4 consulting DCs were partnered with 4 group primary care practices for a six-month pilot phase. Assessment clinics took place in the primary care practice. A total of 213 patients were seen in the Assessment Clinics across the 4 sites. This was not a treatment model.
  - ❑PRIMARY CARE LOW BACK PILOTS - The OCA proposed to the Ministry a second project to evaluate the impact of having a chiropractor in a primary care setting provide treatment. This eventually evolved into the Primary Care Low Back Pain Pilots. In November 2014, Eric Hoskins, the Minister of Health and Long-Term Care announced that seven sites were awarded the pilots. Chiropractors are included in six of the seven pilot sites.
  - ❑INTER-PROFESSIONAL SPINE ASSESSMENT AND EDUCATION CLINICS (ISAEC)