Developing a Framework for a Low Back Pain Model of Care: Report from the National Low Back Pain Conference

March 28, 2014

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Acknowledgements

Sponsor

BJC would like to acknowledge Medtronic for the funding to support this project.

Steering Committee

BJC wishes to acknowledge the work of the Steering Committee in the development and coordination of this event.

Name	Organization
Dr. Raj Rampersaud (Co Chair)	National Director, BJC
Dr. Julia Alleyne (Co Chair)	Chair, BJC
Dr. Hamilton Hall	CEO, Canadian Spine Society
Ms. Rhona McGlasson	Executive Director, BJC
Ms. Adele Fifield	CEO, Canadian Association of Radiologists
Mr. Andre Bussieres	Assistant Professor, McGill University, Quebec
Ms. Beverly Green	Director, Chronic Disease Prevention and Management, Government of New Brunswick
Dr. Bruce Hobson	Family Physician, Bruce Hobson MD Inc. BC
Mr. Jason Busse	Assistant Professor, McMaster University, Hamilton
Mr. Clermont Dionne	Professor, University of Laval, QB
Mr. Greg Kawchuk	Professor, Faculty of Rehabilitation Medicine, University of Alberta
Ms. Jess Rogers	Director, Evidence and Guidelines, Centre for Effective Practice, Toronto
Ms. Liza Kallstrom	Lead, Change Management and Practice Support, BC Medical Association
Dr. Linda Woodhouse	Associate professor, David Magee Endowed Research Chair, University of Alberta
Ms. Munjeet Bhalla	Director, Surgical and Anaesthetic services, BC Ministry of Health
Ms. Rebecca McCollum	Director, Therapeutic Services, Horizon Health Network, St John, New Brunswick

Meeting Participants

BJC would like to acknowledge the meeting participants who provided input into the framework for low back pain.

Name	Position
Dr. Ed Abrahams	Surgeon, New Brunswick
Ms. Theresa Agnew	Executive Director, Nurse Practitioners of Ontario
Dr. Julia Alleyne	Chair, BJC
Ms. Elizabeth Badley	Director, Arthritis Community Research and Evaluation Unit
Ms. Munjeet Bhalla	Director, Surgical and Anaesthesic services, BC Ministry of Health
Mr. Andrew Bidos	Practice Leader, Interprofessional Spine Assessment and Education Centre, Toronto, Ontario
Dr. Matt Blackwood	Family Physician, Cedar Care Clinic, BC
Mr. Jason Busse	Assistant Professor, McMaster University, Hamilton
Mr. Andre Bussieres	Assistant Professor, McGill University, Quebec
Mr. Tom Carter	Senior Physiotherapist, CBI Health Group
Dr. Pierre Cote	Canada Research Chair, Disability Prevention and Rehabilitation, UOIT
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Mr. Paul Taenzer	Psychologist, Retired
Dr. Brad Waddell	Project manager, Ministry of Health
Dr. Brian Wheelock	Neurosurgeon, St John, New Brunswick
Dr. Linda Woodhouse	Associate professor, David Magee Endowed Research Chair, University of Alberta
Mr. Ed Zeismann	Director, The Arthritis Society

Introduction

Funding was obtained through Medtronic to develop a National Low Back Pain (LBP) Model of Care. The development of this model is being undertaken through a coordinated process that consolidates the evidence as well as operational information from successful LBP programs across the country. This information has been obtained through input from program leaders from each of the provinces, a series of webinars which included a wide range of stakeholders, and has culminated in a meeting hosted by BJC in Toronto on March 28, 2014. The Toronto meeting was hosted with the following objectives:

1. Share information about the programs across the country
2. Identify barriers and solutions to program implementation across the country
3. Identify tools and resources that are available for implementation
4. Identify any work that needs to be undertaken at a national level assist provinces in implementation

Meeting Background

Over the last 2 years, through work with the provinces, BJC has identified that there are consistent issues across Canada in the management of patients who are experiencing low back pain. Programs have been developed in British Columbia, Saskatchewan, Ontario and Quebec which have attempted to address these issues through a number of different approaches. In 2013 BJC partnered with the Centre for Effective Practice (CEP) to host a series of webinars to identify the opportunities for working together with the provinces to develop a national or Pan Canadian model of care. This model would leverage the learnings from the provinces that were already undertaking work at a regional or provincial level and would assist all provinces in understanding the systems approach required to implement a successful program.

Through the consultations with the provinces and health leaders across the country BJC developed a visual model which included four pillars required to support primary care in their management of low back pain: evidence based care/clinical tools, system design, education and policy. Additional elements of evaluation and implementation were identified as foundational. This framework was used to put together a proposal for Health Canada to outline the activity that would be required to develop and implement a model of care for low back pain. A proposal was also developed for funding from Medtronic to develop the national model of care and toolkit which was funded in January 2014.

Meeting organization

The March 28, 2014 meeting was arranged through a Steering Committee which included representation from across the country. The focus of the meeting was developed through consultations that were undertaken by BJC in February 2014 with the provinces who have been implementing a program at a provincial level over the last couple of years. Further input was obtained through a series of four national webinars hosted in the middle of March 2014.

The agenda for the day was developed to facilitate discussion and identify the areas where future work could build stakeholder consensus on what should be included in the framework for a national model of care within the four pillars as well as the foundation elements identified above. The day was organized with an introduction session to the challenges with low back pain and the need for a paradigm shift. This was followed by presentations from the programs across the country within the four pillars of evidence based/clinical tools, system design, education and policy. There were opportunities for questions and discussion built into the day. The final session in the afternoon was facilitated dialogue on the day and identification of the areas for further consideration in a national model of care. The agenda is attached in Appendix A and presentation summaries are in Appendix B.

Meeting attendance

The meeting was attended by representation from all provinces except for Newfoundland related to a winter storm and cancellation of flights.

Evaluation

An electronic questionnaire was sent out to participants following the event to evaluate the success of the event in meeting (Appendix C). The ratings for the hotel and event organization were good. There was good understanding of the objective of the day. The questions on the presentations were designed to identify the factors to be included in a national model of care. The following factors were identified: Ontario CORE tool, BC algorithm, Dr. Mike Evans video, appropriate use of radiology, aligning with rehabilitation professionals, E learning, train the trainer, Saskatchewan Model and ISAEC Model (Ontario). A list of challenges and strategies for implementation were provided in the responses. Overall 19 responded that the meeting did help to identify the core requirements of a model, however it was noted that this is a start and that further work needs to be undertaken.

Recommendations for the National Model of Care

The final session of the afternoon was an interactive session in which there was a facilitated review of the day and discussion on factors to be included in a national model of care. The following were identified:

General

- Patient centred approach that is focused in providers working together to manage the patients' needs i.e. shared-care strategies need to be considered
- Low back pain can result in chronic or recurrent pain and as such needs to be treated within a chronic care model that is based on an independent self management as an outcome
- Shared decision making is an important component the management of low back pain
- Informed decision making is required by patients who need to receive accurate and consistent information from health care providers and society
- Many patients have poor levels of physical conditioning therefore the treatment for low back pain must be holistic and include overall general health promotion including physical activity
- There are high-risk groups where access is influenced by their ability to seek care for examples related to age, socio-demographic status and culture e.g. aboriginal communities
- All information and decisions need to be evidence informed
- Inter professional models are ideal and should be utilized and integrated based on patient needs including virtual opportunities through IT
- Accountability to patient outcomes needs to be built in to the program
- System approaches need to be sustainable

Evidence based, clinical tools

- All processes need to be evidence based where evidence is available
- Clinical tools that support practitioners in successfully managing patients need to be used and be electronic wherever possible

System design

- There can be the development of a framework for an effective system however the implementation and day to day operations of the system will vary based on many local and provincial factors
- There needs to be a stratified approach to care which identifies the straightforward patient that respond to treatment, those who will require

more assistance due to physical and psychological presentations and those who are complex and require specialist interventions such as consultation or surgery
- The design of the model needs to facilitate the appropriate access to the relevant health care providers through coordinated (i.e. networked) referral practices
- The system designed for primary care needs to consider their working environment and be evidence based but respect time demands
- There are a number of best practice tools that should be considered in the development of a local strategy
- There needs to be a reduction in paperwork for primary care with a move towards embedding the tools into Electronic Medical records wherever possible
- Financial barriers to care need to be considered including the access to therapy treatments in the public and private sector
- System needs to provide spectrum of services to meet the needs of all patients including age, socio-demographic status and culture

Education

Provider

- Training needs to be accessible in multiple different formats for the different learning styles including face to face, web based, written materials etc.
- Train the trainer may be an effective method of ensuring there is a person available in the local community
- Follow up to the training, such as through a coordinator or other locally trained individual, may support implementation
- All education should be longitudinal and be available on a multi professional level to support the same message between the multiple stakeholders.
- Future education needs to start in the University programs however there will need to be post graduate training to provide ongoing training for health professionals
- Education needs to include training in patient self management techniques including goal setting, motivational interviewing and brief action planning
- Educational information needs to support and be supported by information being provided for other chronic conditions
- Evidence based education to develop standardization in assessment and treatments
- Education needs to take into consideration information being provided by other payer groups such as insurers and Worker Compensation Groups

Patient

- Education should be in multiple formats to address the different learning styles
- Education should be provided at all the points throughout the continuum

- Educational information needs to align between health care professionals and between payers
- Links to peer support groups should be considered whenever available

Public

- Public messages need to be available to enhance public awareness and supports an evidence based approach to care e.g. Choosing Wisely program

Policy

- Ideally the model requires an integrated system design which facilitates the appropriate use of all health care professional through a coordinated funding systems
- There needs to be support for self management through access to a coordinate approach including materials and events that promote chronic condition management strategies
- The model needs to align with other provincial and national initiatives, especially those in primary care MSK and other chronic disease programs

Evaluation

- Evidence based data is required to measure quality of care at a system, regional and local level
- The metrics and measures that are used need to reflect the patients' experience between the multiple system players including the many points of entry
- The outcomes need to measure care from the patients' perspective

Implementation

- There needs to be flexibility in the implementation strategy to allow the system to address the many factors that affect clinical practice at a local level
- Program needs to increase the capacity in primary care and strengthen the shared care model

Next Steps

The next steps for the National Model of Care for Low Back Pain are to develop a visual model and a supporting document that provides a synthesis of the information that has been provided through the consultations with representatives from the provincial programs, the webinars and through the meeting. This visual model and document will be the basis for an updated proposal to appropriate organizations for future funding opportunities to improve the management of low back pain across the country.

Appendix A: Agenda

National Model of Care for Low Back Pain

Airport Holiday Inn
970 Dixon Road, Toronto
A G E N D A

Objectives:

1. Share information about the programs across the country
2. Identify barriers and solutions to program implementation across the country
3. Identify tools and resources that are available for implementation
4. Identify any work that needs to be undertaken at a national level to assist provinces in implementation

TIME	TOPIC	PRESENTER
7:15 – 8:00	***Breakfast and Registration***	
8:00 – 8:10	**Welcome, Introduction and Project Objectives**	Dr. Raj Rampersaud
8:10 – 8:20	**Participant Introduction Ice Breaker**	Rhona McGlasson Dr. Julia Alleyne
8:20 – 8:25 8:25 – 8:45 8:45 – 9:05	**Setting the Context** 1) Setting the Paradigm Shift 2) The Value of a Pattern Approach…A Good Place to Start 3) Choosing Wisely Canada	***Moderator: Raj Rampersaud*** Dr. Raj Rampersaud Dr. Hamilton Hall Tai Huynh
9:05 – 9:25 9:25 – 9:45 9:45 – 10:05 10:05-10:25	**Evidence Based Care / Clinical Tools** 1) Ontario CORE Tool & Kit 2) BC MSK Practice Support 3) WSIB Low Back Program **Discussion**: Barriers, challenges and solutions to implementation	***Moderator: Jason Busse*** Dr. Julia Alleyne Dr. Garey Mazowita Dr. Patricia McKenna Boot
10:25 – 10:40	***Health Break***	

10:40 – 11:00 11:00 – 11:20 11:20 – 11:30 11:30 – 11:40 11:40 – 12:00	**Assessment Models** 1) ISAEC Model 2) The Spine Pathway In Saskatchewan The Experience of Changing Practice 3) Spine Care in Nova Scotia 4) Alberta PRIHS Grant (10 minutes) **Discussion**: Barriers, challenges and solutions to implementation	***Moderator: Caroline Fanti*** Dr. Raj Rampersaud Brad Waddell Alissa Decker Dr. Greg Kawchuk
TIME	**TOPIC**	**PRESENTER**
12:00 – 12:40	***Lunch***	
12:40 – 1:00 1:00 – 1:20 1:20 – 1:40 1:40 – 2:00	**Education** 1) E-Learning Primary Care Education 2) The Powers of Peers in Change Management – BC's Train-the-Trainer Approach 3) Educating Patients: Observations from The Arthritis Society **Discussion**: Barriers, challenges and solutions to implementation	***Moderator: Julia Alleyne*** Jess Rogers Liza Kallstrom & Dr. Matt Blackwood Lynn Moore & Ed Ziesmann
2:00 – 2:20 2:20 – 2:40 2:40 – 3:00 3:00 – 3:20	**Facilitating Policy Change** 1) Health Promotion for Patient Messaging 2) Medical Imaging's Role in Enhancing Appropriateness 3) Aligning with Rehabilitation Professionals **Discussion**: Barriers, challenges and solutions to implementation	***Moderator: Margie Bhalla*** Dr. Julia Alleyne Adele Fifield Linda Woodhouse
3:20 – 3:40	***Health Break***	
3:40 -4:20	**Model of Care Implementation Discussion** Patient Scenario What are the Challenges, Barriers and Solutions? What are the Strategies? What Do We Need at a National Level?	***Moderators:*** Dr. Julia Alleyne Dr. Hamilton Hall
4:20 – 4:30	**Wrap Up**	Dr. Raj Rampersaud

Appendix B: Presentations

Setting the context

Paradigm Shift in LBP Management: Dr. Raj Rampersaud

Dr. Rampersaud provided an overview of the social burden associated with the management of low back pain (lbp). He identified a number of issues including the fragmented medicalized care for patients. He reviewed the literature on why this system is ineffective in the management of low back pain and how many people experience symptoms on a chronic or recurrent basis. He identified that each episode of care is treated independently and no one takes full ownership of the complete experience for the patient. He also identified that there are many issues in the system including wait times, health care utilization and cost, third party requirements, and "big business" in the private sector. Finally he identified that the current management and system issues associated with LBP may in fact be contributing to the development or persistence of maladaptive pain behaviours including coping and cognitive processes. Dr. Rampersaud presented three principles for change including: Messaging regarding lbp has to change; stratified – integrated approaches to the assessment and management of lbp are required and shared care models with an understanding that no one provider can do it all.

Principles in low back pain: Dr. Hamilton Hall

Dr. Hall provided a presentation that was focused on "The Value of a Pattern Approach – a good place to start". Dr. Hall presented on the prevalence of low back pain and the burden to society finding that the medical profession had medicalized low back pain resulting in lack of agreement in many aspects in its management. While there is often no agreement on what the specific cause of LBP is, he reviewed what we could agree on is how a patient with lbp clinically presents. He presented a method of categorizing lbp that resulted in an overall clinical approach rather than a traditional medical /diagnostic approach which has historically been inaccurate and ineffective. The patterns approach looks at whether pain is leg or back dominant and whether it is constant or intermittent. He reviewed the need for the identification of red flags as the second step and yellow flags as the third step.

Choosing Wisely Canada: Tai Huynh

Mr Huynh reviewed the Choosing Wisely strategy that is to be released in early April. The strategy focuses on patients and their physicians choosing the need for testing wisely. The project was started 2 years ago in the USA and has now 60 associations working with it. There have been a number of physician associations in Canada that have each identified 5 tests that are over ordered. A review was provided of why these tests are ordered and Tools have been developed such as brochures to support the conversation primary care provider and there patients on

the need for the tests. Within low back pain 2 associations have identified diagnostic imaging as an unnecessary test for the majority of lbp patients.

Evidence Based care/Clinical Tools

Ontario CORE tool and kit: Dr. Julia Alleyne

Dr. Alleyne reviewed the strategy undertaken by Centre for Effective Practice (CEP) in the development of the CORE (Clinical Organized Relevant Exam) Back Tool. The tool started as an opportunity to improve integrated knowledge translation "by provider for provider" and was a key strategy to embed the toolkit within education. A formal process was undertaken to develop the tools which included input from the education planning committee as well as focus groups with primary care. From the feedback primary care wanted a concise tool with checklists that could act as documentation and fit on one page. A review was provided of the tools including the questions and flow of information. The tool provides a structured approach to assessing the LBP patients, providing key questions and information to identify common mechanical patterns of LPB as well as red and yellow flags. Stratified treatment options and recommendations for diagnostic imaging and specialist referral are provided. In addition, advice and starter exercises are provided on the tool as well as a structure approach for goal setting, education and information to facilitate patient self-management. The tool has been endorsed by a number of health care organizations and is available on the CEP website at www.effectivepractice.org/lowbackpain . Dr Alleyne reviewed the timing and implementation of the tools in Ontario as well as the results from the evaluation.

The BC Tool Kit Algorithm: Dr. Garey Mazowita

Dr. Mazowiza presented the algorithm that had been developed by Dr. Bruce Hobson. The algorithm provides an overview of the care for patients within the context of the primary care physicians' office.

WSIB: Dr Pat McKenna Booth

Dr. McKenna Booth presented on the Workers Safety and Insurance Boards approach to the management of low back pain. The strategy has included a number of activities including:

1. the use of a Back booklet which is sent to everyone who registers a low back claim,
2. a Low Back Program of Care which is a treatment program that is evidence based and is provided through the private rehabilitation clinics
3. Low Back Expert Physician Examiner program which is a program that trains primary care practitioners to assess and provide peer-peer management support for work related low back injuries in workers who have not returned to work by 6 weeks post-injury.

4. Back Specialty Clinics which are staffed by inter professional team(s) of specialists for expert consultation

Assessment Models

ISAEC Model: Dr. Raj Rampersaud

Dr. Rampersaud presented on the work that has been undertaken in the last 2 years in Ontario to develop Interdisciplinary Spine Assessment and Education Centres (ISEAC). There are 3 locations in Ontario: Toronto, Thunder Bay and Hamilton. Each centre has a number of trained primary care practitioners that have undergone the training to refer and work within a shared-care management model for LBP. The ISAEC program is focused on relatively up-stream patients with criteria for referral of persistent LBP for greater then 6 week and up to 1 year or unmanageable recurrent LBP, regardless of duration. It functions with a central referral system, a triage through 14 community based trained chiropractor or physiotherapists who primarily support PCPs as well as 3 central practice leads who facilitate streamlined access to the surgeon and selected specialist. The clinic does not provide direct treatment, but does provide stratified management plans that include chronic condition self-management recommendations and scheduled follow-ups for supportive care in patients deemed to be a moderate to high risk of chronicity. The clinics provide a series of validated questionnaires to measure patient response. The results were provided with 1478 patients seen who have an average of 6.3 days to assessment. 72% of the patient referred were complex and there were excellent results with the programs performance and patient and provider satisfaction. The lessons learned from the implementation of the program were reviewed.

Saskatchewan Model: Brad Waddell

Dr. Brad Waddell presented on the issue in SK including long waits for surgeons and poor patient experiences that resulted in the need to develop a low back pain pathway. The pathway includes the pattern recognition model, training for primary care providers (physicians, nurse practitioners, physiotherapists and chiropractors) and the use of 2 triage clinics for patients who are not responding to treatment. The clinic is staffed by physiotherapists. The primary care education is available through internet based learning but also live classroom setting (12 courses) and hand on modules for further training after the web site learning as people have many different learning styles. There were a number of learnings from the program including:

1. There is a limit to e learning
2. attaching educational credits works
3. fees for following the process are not always good incentives as many physicians do not bill for the additional lbp assessment
4. there is the need to support the change to the new model with an e based services

Data collection has been completed following implementation and has been difficult however there has been a number of providers trained: GP 66%, Chiro 80%, NP 80%, PT 30 % (as many PTs do not work with lbp patients)

Alberta: Dr. Greg Kawchuk

Dr. Kawchuk presented the work that has been undertaken in Alberta to develop a new spine program. Significant challenges with surgical assessment wait-times and fragmented patient care were identified. Their team has received a research grant to evaluate the impact of an interprofessional LPB model from variety perspectives. Specific of the model and implementation are still in development stages.

Nova Scotia: Alissa Decker

Capital Health in Nova Scotia have significant issue with wait times to surgery and the lack of ability of primary care to manage patients. They have recently received funding to develop a spine program in the Queen Elizabeth hospital working with their orthopaedic department. The work that is being undertaken include a centralized referral system, a physiotherapist doing a standardized assessment, pattern recognition (CORE tool), web based education through a platform that is connected to their health records so gives them relevant information. For patients that are deemed to present with a potential surgical issue referral will be made to the surgeon based on assessment findings and response to treatment. At this point it does not include neurosurgery.

<u>Education</u>

E Learning Primary Care Education: Jess Rogers

Ms. Rogers presented on the development of the primary care education that was developed in Ontario to train primary care in the management of low back pain. Training was provide through in person sessions which were provided in French and English, included training videos and in which a coordinated system was used for advanced metrics/data capture to evaluate knowledge acquisition and attitude. On line modules were also developed which include low back pain status report. Clinical assessment of low back pain, patient self-management and the CORE clinical tool. These modules are on the My Briefcase web site. Modules were launched in August 2013 and participation has exceeded historical rate and is 250% above target. Information is appropriate for all health care professionals. There has been participation from across the country. The early evaluation of the system is good and there have been a number of lessons learned including thinking broadly, plan for the long term and not underestimating the need or resource to coordinate and work in partnerships.

BC Practice Support System, Train the trainer: Liza Kallstrom & Dr. Matt Blackwood

The presentation was completed by Liza Kallstrom and Dr. Matt Blackwood. They presented on the primary support program in British Columbia which is a program that provides education and support for primary care physicians with 6524 FPs participating. There is an uptake of an average of 2.3 modules per FP. The content is centrally created by clinical subject matter experts. Training sessions and materials focus on the specific gaps identified through evidence informed research. The training is delivered regionally throughout BC through local peers. Within MSK there have been modules developed for OA, RA and LBP. Ongoing support is provided by regional coordinators that help with newly acquired tools and processes. Evaluation on MSK modules is good. There have been a number of lessons learned including the large number of clinical tools that are available in MSK and how to reduce this, how to embed the tools into the Electronic Medical records and the need to provide training in medical school and residency programs.

The Arthritis Society – Low Back Pain and arthritis; Lynn Moore & Ed Zeismann

The presentation from The Arthritis Society (TAS) was provided by Ed Ziesmann and Lynn Moore. They presented on the role of TAS in patient education in arthritis. The program is developed using the Stanford self-management approach through a program called the Arthritis Self Management Program (ASMP). This program facilitate that individuals know what behaviours to change and how to make those changes. In a needs assessment completed in 2011 it was evident that there are few differences by disease and that the education is about lifestyle management. Individuals are likely to make the changes to lifestyle when they are no longer able to do the things they enjoy. Caregiver can influence this and are often more proactive in seeking self-management. A review of the knowledge change strategies that need to be considered was provided including website, print, presentations and peer group forums as well as the strategies to promote behviour change. TAS has a web based on line education program for primary care called Getting a Grip in Arthritis and which includes OA and RA modules. There is also a program in Ontario called the Arthritis Rehabilitation and Education Program which includes physiotherapists in the community to provide assessment and care for patients living with arthritis.

Facilitating Policy Change

Health promotion for patient messaging: Dr. Julia Alleyne

The You Tube video on low back pain developed by Dr. Mike Evans was reviewed.

Radiology for appropriate imaging: Adele Fifield

Adele Fifield presented on the "Medical Imaging's role in enhancing appropriateness". She provided an overview of appropriateness, including appropriateness of imaging in Canada. There was information provided on the 2012 2013 referral guidelines for Diagnostic Imaging (DI) including how this can be supported in the physicians workplace and information on a Computerized Clinical Decision Support project from 2006 – 2012 which tested the effectiveness of proving referral guideline through computerized decision support in Manitoba. Finding from this project included the fact there were a range of inappropriate orders, family physicians were more likely to change their orders than specialist, software must be simple fast and integrated, physician leadership and a small interested group to lead the change are critical for success and adequate resources and time must be committed. There was also a review of the need for patient education and awareness which is to be lead through the Council of Federation work and the Choosing Wisely Program.

Align with rehabilitation professionals: Linda Woodhouse

Dr. Woodhouse presented on the triage role for physiotherapists in the health care system. This role was developed in response to the wait times issue for hip and knee replacement and was found to reduce wait lists and increase patient satisfaction by providing a more coordinated approach to care. She presented on the provincial variation to scope of practice and how in Ontario legislative changes were required. In Alberta the legislation is more permissive and as such there is more opportunity for the role. Dr. Woodhouse then went on to present on the Strategic Clinical Networks (SCN) in Alberta and how they have a mandate to link the researchers with the end users. The MSK SCN has been working on a number of programs including conservative management for hip and knee replacement, patient engagement in research, how Alberta are promoting a comprehensive assessment and plan based on evidence based decision and that this will be undertaken by using teams based care. In Alberta a resolution has been passed to encourage and support the use of Multidisciplinary Teams.

Appendix C: Evaluation results

Q1

Please rate your pre-event experience where 1 is Not satisfied and 5 is Very Satisfied.

- Answered: 31
- Skipped: 1

	1	2	3	4	5	Total
Pre-Event Registration	**0.00%** 0	**3.33%** 1	**13.33%** 4	**36.67%** 11	**46.67%** 14	30
Pre-Event Material Distribution	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	0
Welcome Reception	**4.17%** 1	**4.17%** 1	**20.83%** 5	**41.67%** 10	**29.17%** 7	24
Summit Day Organization	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	**0.00%** 0	0
Food and Beverage	**0.00%** 0	**3.45%** 1	**24.14%** 7	**44.83%** 13	**27.59%** 8	29
Flight Management	**0.00%** 0	**0.00%** 0	**25.00%** 4	**50.00%** 8	**25.00%** 4	16

Comments(5)

Q2

Please provide us with your feedback for our meeting venue partners where 1 is Not Satisfied and 5 is Very Satisfied.

- Answered: 31
- Skipped: 1

1

	1	2	3	4	5	N/A	Total
Parking	**13.33%** 4	**10.00%** 3	**13.33%** 4	**3.33%** 1	**10.00%** 3	**50.00%** 15	30
Check-in/out	**0.00%** 0	**0.00%** 0	**3.85%** 1	**15.38%** 4	**50.00%** 13	**30.77%** 8	26
Accommodations	**3.85%** 1	**0.00%** 0	**7.69%** 2	**26.92%** 7	**26.92%** 7	**34.62%** 9	26
Hotel Amenities	**0.00%** 0	**3.70%** 1	**18.52%** 5	**37.04%** 10	**18.52%** 5	**22.22%** 6	27
Level of Service	**0.00%** 0	**3.57%** 1	**17.86%** 5	**32.14%** 9	**32.14%** 9	**14.29%** 4	28

Comments(2)

Q3

How would you evaluate the objectives and rationale for the spine summit ?

- Answered: 30
- Skipped: 2

Answer Choices	Responses
Difficult to understand, needed clarification	6.67% 2
Able to understand objectives but not the rationale	0.00% 0
Understood the objectives and rationale on the surface	10.00% 3
Good understanding of objectives and rationale	50.00% 15
Would be able to clearly define the objectives and rationale to a colleague	33.33% 10
Total	30

Comments(3)

Q4

Please tell us how pertinent these topics were to the process of the overall meeting?

- Answered: 30
- Skipped: 2

	Total	Average Rating
Setting the Paradigm Shift (R.Rampersad)	30	3.80
Principles of Low Back Pain Patterns (H.Hall)	30	3.77
Choosing Wisely Canada (T. Nyugen)	30	3.27

Q5

In the section, Evidence-based Care and Tools, please give us feedback on the impact that the presentations and discussions had on you personally by choosing the most appropriate statement from the drop-down menus.

- Answered: 30
- Skipped: 2

Impact					
	I am aware of the basic concepts.	I can describe the rationale.	I would like this as a core requirement of a national model	I am unable to grasp this concept.	Total
Ontario	10.00%	30.00%	60.00%	0.00%	

Impact	I am aware of the basic concepts.	I can describe the rationale.	I would like this as a core requirement of a national model	I am unable to grasp this concept.	Total
CORE Tool - J.Alleyne	3	9	18	0	30
BC Tool Kit Algorithm - G. Mazowita	**10.00%** 3	**46.67%** 14	**40.00%** 12	**3.33%** 1	30
WSIB Tool Kit - P. McKenna-Boot	**30.00%** 9	**60.00%** 18	**6.67%** 2	**3.33%** 1	30

Comments(4)

Q6

In the section, System Assessment Models, please give us feedback on the impact that the presentations and discussions had on you personally by choosing the most appropriate statement from the drop-down menus.

- Answered: 30
- Skipped: 2

Impact	I am aware of the basic concepts.	I can describe the rationale.	I would like this as a core requirement for a national model.	I am unable to grasp this concept.	Total
ISAEC Model - R. Rampersaud	**10.00%** 3	**36.67%** 11	**53.33%** 16	**0.00%** 0	30
Saskatchewan Model- Brad Waddell	**10.00%** 3	**46.67%** 14	**43.33%** 13	**0.00%** 0	30
Alberta Model - G. Kawchuk	**40.00%** 12	**50.00%** 15	**3.33%** 1	**6.67%** 2	30
Nova Scotia Model- A. Decker	**56.67%** 17	**33.33%** 10	**0.00%** 0	**10.00%** 3	30

Comments(2)

Q7

In the section, Provider and Patient Education, please give us feedback on the impact that the presentations and discussions had on you personally by choosing the one most appropriate statement from the drop-down menus.

- Answered: 30
- Skipped: 2

Impact	I am aware of the basic concepts.	I can describe the rationale.	I would like this as a core requirement for a national model.	I am unable to grasp this concept.	Total
E-learning - J. Rogers	30.00% 9	33.33% 10	36.67% 11	0.00% 0	30
Train the Trainer- L.Kallstrom/M. Blackwood	20.00% 6	40.00% 12	40.00% 12	0.00% 0	30
The Arthritis Society - L. Moore, E. Ziesmann	20.00% 6	43.33% 13	23.33% 7	13.33% 4	30

Comments(3)

Q8

In the section, Facilitating Policy Change, please give us feedback on the impact that the presentations and discussions had on you personally by choosing the one most appropriate statement from the drop-down menus.

- Answered: 30
- Skipped: 2

Impact	I am aware of the basic concepts.	I can describe the rationale.	I would like to see this as a core component in a national model.	I am unable to grasp this concept.	Total
Dr. Mike Evans Video	3.33% 1	30.00% 9	66.67% 20	0.00% 0	30
Radiology for Appropriate Imaging - A. Fifield	13.33% 4	46.67% 14	40.00% 12	0.00% 0	30
Aligning with Rehabilitation Professionals - L. Woodhouse	26.67% 8	33.33% 10	40.00% 12	0.00% 0	30

Comments(3)

Q9

What are the challenges to defining a National Model of Spine Care?

- Answered: 22
- Skipped: 10

Challenges outlines were associated with

1. Political will and support
2. Funding
3. Competing interests of professionals
4. Education and understanding by the public
5. Working with primary care

What are the strategies for successful implementation of a National Model of Spine Care?

- Answered: 20
- Skipped: 12

Strategies provided were:

1. Pattern of pain model
2. Obtaining Federal and Provincial funding
3. Leverage the pilot models in other provinces
4. Train the trainers approach
5. High level agreement on the core tools/concepts that can be standardized for a national model.
6. The model should have some flexibility but also key requirements which include the selected tools and concepts from this survey.
7. Keep momentum going. Have a smaller core group of pan- Canadian representatives that can further define the model and communicate the strategy to their stakeholders. Aggressive timelines, key components yet some flex in the model for provincial implementation
8. Consistent education for patients and providers
9. Complete model including design,
10. Engagement of all stakeholders

Did the Low Back Pain Meeting help you identify the core requirements for a National model?

- Answered: 23
- Skipped: 9

19 responded that the meeting did help to identify the core requirements of a model.
It was noted however that this is a start and that further work needs to be undertaken.