Provider Survey: Chronic Pain Spread Network

Preamble/Introduction

We want to know about your experiences providing care to patients with chronic pain in your community.

Please take a few minutes to complete this survey. Your answers will help to inform improvements to the way patients with chronic pain are cared for locally in your community.

Why are we asking?

Shared Care has initiated a Chronic Pain Spread Network to improve access and coordination of care for patients with chronic pain. Spread networks will enable providers to support one another in sharing resources, tools and successful approaches among communities. The goal is to create opportunities for good work to spread efficiently and make it easier for successful models to be shared and adapted to local needs.

As part of the Chronic Pain Spread Network, we are surveying healthcare providers in order to help us to develop actions locally to improve your experience as a provider and for patients with chronic pain.

How do we protect your information?

We are asking for your consent to participate in this survey. Your participation will provide us with valuable information that will be used to improve the primary health care system in our community. Your responses are totally anonymous and no one will be able to link your answers back to you. It is important that you know that you may withdraw from the survey at any time. By completing this form, you are giving us consent to collect demographic information.

If you have any questions, concerns or comments about this survey, please contact [insert local division information here].

ABOUT YOUR CURRENT PATIENTS WITH CHRONIC PAIN

**1. Please indicate the patient groups where improvements are MOST needed in your community. Please select all that apply.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patients with Chronic pain**   * Mild. A small number of symptoms that have a limited effect on daily life. * Moderate. Symptoms that can make daily life much more difficult than usual. * Severe. Many symptoms that often make daily life extremely difficult. * This is not a significant issue in my community. | | **Please briefly describe 3-5 key characteristics of the group of patients with chronic pain you serve.** | |
| |  |  |  | | --- | --- | --- | | **Approximately, how many of your patients are you treating for chronic pain?** | Number *per month* | Percent *per month* | | | | |
| **What are the challenges with this patient group in your community? Please check all that apply.** | | | |
| * Volume of patients * Time required to manage patients * Lack of resources to effectively manage patients * Difficulty managing complexity of chronic pain | * Difficulty coordinating services * Wait time or ability to access services * Lack of evidence-based guidelines * Lack of professional education * Lack of time/tracking systems required for regular follow-up | | * Difficulty with detection and/or assessment * Time required for a careful differential diagnosis * Barriers related to the patient * Other. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

1. **Do you routinely screen your patients with chronic pain for mental health issues?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Yes, frequently | * Yes, sometimes | * Yes, occasionally | * No, not really | * Doesn’t apply to me |

***If yes,* do you experience challenges caring for patients with chronic pain for mental health issues?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Yes, frequently | * Yes, sometimes | * Yes, occasionally | * No, not really | * Doesn’t apply to me |

If yes, please elaborate on the challenges:

1. **Do you routinely screen your patients with chronic pain for substance use issues?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Yes, frequently | * Yes, sometimes | * Yes, occasionally | * No, not really | * Doesn’t apply to me |

***If yes,* do you experience challenges caring for patients with chronic pain for substance use issues?**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Yes, frequently | * Yes, sometimes | * Yes, occasionally | * No, not really | * Doesn’t apply to me |

If yes, please elaborate on the challenges:

***Please use this space to elaborate on anything above***

**HEALTH SERVICES: Thinking about your** **patients with chronic pain:**

1. **Please indicate the frequency you provide or recommend the following resources:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Frequently | Occasionally | Never | Not available in my area | Doesn’t apply to me |
| Medication |  |  |  |  |  |
| In-office counselling |  |  |  |  |  |
| Outpatient services from local hospital |  |  |  |  |  |
| Education/ Patient self-management |  |  |  |  |  |
| Group medical visits |  |  |  |  |  |
| Private counselling |  |  |  |  |  |
| Community support group |  |  |  |  |  |
| Crisis line |  |  |  |  |  |
| Mental health team |  |  |  |  |  |
| Emergency department |  |  |  |  |  |
| Physician who will provide narcotic substitution prescriptions |  |  |  |  |  |
| Exercise |  |  |  |  |  |
| Complementary /Alternative Medicine (e.g. acupuncture, herbal medicine, meditation, nutritional regime) |  |  |  |  |  |
| Other. Please specify: |  |  |  |  |  |

1. **Are there additional services available in your community that you provide or recommend?**

* Yes
* No
* Prefer not to answer

***Please use this space to elaborate:***

1. **Thinking about your patients with chronic pain, during the past six months, how often did you:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Always | Frequently | Half the time | Rarely | Never | Doesn’t apply to me |
| Delay care or need to turn away to apatientdue to WORKLOAD capacity concerns? |  |  |  |  |  |  |
| Provide care to apatient who experienced problems due to SUBOPTIMAL CARE COORDINATION? |  |  |  |  |  |  |
| Provide care to a patient who was UNABLE TO ACCESS CARE from another provider in a timely manner? |  |  |  |  |  |  |
| Provide care to a patient when there are NO TIMELY, LOCAL RESOURCES AVAILABLE? |  |  |  |  |  |  |

1. **What is the average wait time for a patient with chronic pain to access services for the following areas:**

|  |  |  |
| --- | --- | --- |
| Community-based services? | \_\_\_\_ months | \_\_\_\_No additional services available |
| Specialist services? | \_\_\_\_ months | \_\_\_\_No additional services available |
| Other. Please specify | \_\_\_\_ months | \_\_\_\_No additional services available |

**EXPERIENCE & COLLABORATION:**

1. **Thinking about your experience providing care to patients with chronic pain, how satisfied are you with:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Very satisfied | Satisfied | Acceptable | Dissatisfied | Very dissatisfied | Doesn’t apply to me |
| your community as a PLACE to provide care? |  |  |  |  |  |  |
| the QUALITY of care provided in your community? |  |  |  |  |  |  |
| how colleagues[[1]](#footnote-1) understand each other’s roles and scopes of practice? |  |  |  |  |  |  |
| how colleagues communicate with one another? |  |  |  |  |  |  |
| how colleagues respect and support each other? |  |  |  |  |  |  |
| your relationship with other care providers[[2]](#footnote-2) in your community? |  |  |  |  |  |  |
| your experience of providing care for *patients with chronic pain* overall? |  |  |  |  |  |  |

1. **Thinking about providing care to patients with chronic pain, how strongly do you agree with:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Strongly agree | Agree | Neutral | Disagree | Strongly disagree | Doesn’t apply to me |
| I am confident managing care for *patients with chronic pain*. |  |  |  |  |  |  |
| I can communicate with specialists about my *patients with chronic pain* easily. |  |  |  |  |  |  |
| I know how to access appropriate community resources. |  |  |  |  |  |  |
| My patients can access appropriate community resources. |  |  |  |  |  |  |
| I am aware of available resources to support my *patients with chronic pain*. |  |  |  |  |  |  |
| I am confident providing resources/referrals to my *patients with chronic pain*. |  |  |  |  |  |  |
| I am confident prescribing opioids for *patients with chronic pain*. |  |  |  |  |  |  |

**TRAINING OPPORTUNITIES**

1. **Are you interested in training opportunities related to providing care for patients with chronic pain?**

* Yes
* No

**If yes, please specify what training opportunities you are interested in?**

**OPEN-ENDED QUESTIONS:**

1. **What is needed to improve coordination/collaboration for patients with chronic pain in your community?**
2. **What is needed to improve care for patients with chronic pain in your community?**

**ABOUT OPIOIDS**

1. **Have you received training in any of the following opioid agonist treatments? Please check all that apply**

* Suboxone
* Methadone
* Slow release oral morphine
* Injectable hydromorphone

1. **Have you prescribed any of the following opioid agonist treatments? Please check all that apply**

* Suboxone
* Methadone
* Slow release oral morphine
* Injectable hydromorphone

1. **Is there a pharmacy in your community dispense opioid agonist treatments?**

* Yes
* No
* Prefer not to answer

1. **In your opinion, what could help you better care for your patients at risk for an overdose?**

**ABOUT YOU**

**Demographics**

1. Gender:

* Female
* Male
* X
* Prefer not to say

1. Age (years):

* < 25
* 25-35
* 36-45
* 46-55
* 56-65
* > 65

1. Current role:

* Family physician
* Psychiatrist
* Emergency department doctor
* Nurse Practitioner
* Psychologist
* Nurse
* Counsellor
* Social Worker
* Complementary or alternative person (e.g., acupuncturist, chiropractor, registered massage therapist, etc.)
* Other. Please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Years in practice (post-residency or training): \_\_\_\_\_
2. What community do you practice in: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Current practice status:

* Practicing full-time
* Practicing part-time
* No longer practicing
* Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your level of experience?

* Early career (less than 7 years)
* Mid-career (8-15 years)
* Later Career (more than 15 years)

1. Number of FTEs in your community providing chronic pain services\_\_\_\_\_
2. Do you consider your practice to be mostly:

* Urban
* Rural
* Remote
* Mixed

1. How satisfied are you with the balance between your personal and professional commitments?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| * Very satisfied | * Satisfied | * Acceptable | * Dissatisfied | * Very dissatisfied |

1. In this section, we use the term “colleagues” to refer to family physicians, nurse practitioners, psychiatrists, mental health workers, nurses and others you work with to provide care for patients that you work with regularly with this patient group. [↑](#footnote-ref-1)
2. In this section, we use the term “other care providers” as providers that you DO NOT work with regularly with this patient group. [↑](#footnote-ref-2)