Recommendations from the TRAST project

TRAnsitional STructured chronic pain program for adolescents and young adults

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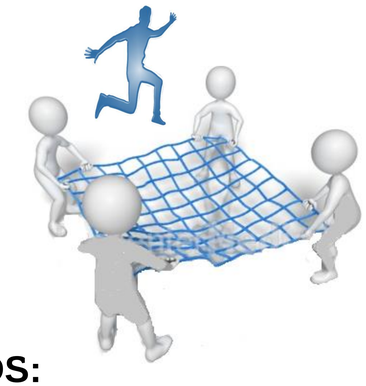
BACKGROUND:

- 12-17% of Quebec youth (18-35yo) suffer from chronic non-cancerous pain (YWP).
- Primary care providers (PCPs) and their teams should form a **safety net** for the YWP transitioning to adult care.

OBJECTIVES:

- To evaluate existing McGill RIUS practices as viewed by YWP, their caregivers, PCPs.
- Formulate multi-disciplinary recommendations on care transition process optimisation.



METHODS:

- Sequential-consensual 3-phase qualitative **design**, with a participatory component: **(1)** Interviews with patient-experts and their caregivers. **(2)** Semi-structured interviews with PCPs. **(3)** Three deliberative dialogue groups consultations (clinicians, allied health professionals, YWP and their caregivers).
- **Participants**: AEPMU (12 members), 2 primary care academic units, 12 PCPs. 10 patient-partners /-experts.
- **Analysis**: Thematic deductive-inductive analysis.

Clinicians, allied health professionals, and patients **all agree** that **improvements to transitions** should be first made at the **system-level**

RECOMMENDATIONS BY GROUP EXPERTS

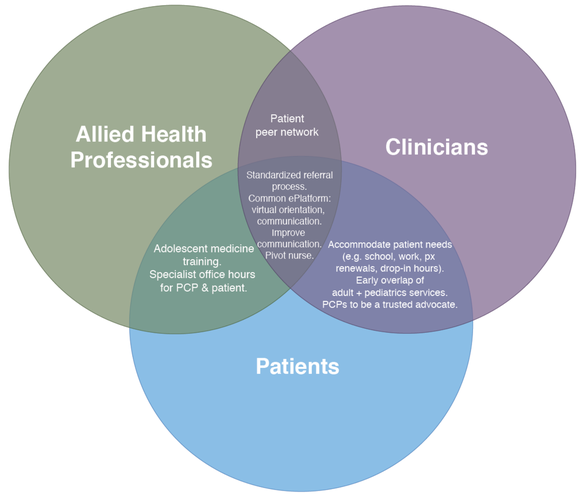
	PHASE 2	PHASE 3		
	PRIMARY CARE PROVIDERS (PCP)	ALLIED HEALTH PROFESSIONALS (AHP)	CLINICIANS (CL)	PATIENTS (PT)
PATIENT-LEVEL		PT orientation	PT orientation	
		Patient peer network	Patient peer network	
	"On-demand" appointment slots		Accommodation of individual needs	Accommodation of individual needs (drop-in hours)
		AHP to have PCP's contact for assistance. PT engagement.		
	Direct "crisis" hotline		Telephone helpline	
			PT introduced to adult pain team early on. Common ePlatform (virtual orientation, communication, "PT feedback").	
				Dedicated age-based programs. List of recommended alternative resources (e.g. physio, psych, holistic, etc.).
CLINICAL SERVICES		Communication pathway (AHP to provide detailed reports to PCP, regular updates about AHP appointments to referral source)	**Online communications & information flow (CL accessible by email to PT, eConsultations to PCPs)**	
			CL as "safety net" for patients during transition	PCP as trusted and understanding presence
			Early "overlap" between specialist and PCP before transition	
				PCP present for first adult appointment
	Pain specialist visits to PCP. PCPs receive tour of pain clinic.			
SYSTEM	**Pivot nurse**	**Pivot nurse**	**Pivot nurse**	**Pivot nurse**
	Common platform (referrals, PCP & specialist communication)	Common ePlatform (standardized referral process, youth profile)	Common ePlatform (general patient information; PCP, specialist, patient communication)	Common ePlatform (general patient information)
	Standardized referral process	**Standardized transition process across the province**	**Standardized transition process across the province**	**Standardize referral process**
	Training (**adolescent medicine,** pain management)	Training (**adolescent medicine,** practitioners referring high volume of patients)		Training (**adolescent medicine,** administrative staff to communication with patients/caregivers)
	Additional resources needed (specialist office hours for PCP, CRSD system for pain services)	**Additional resources needed (specialist office hours for PCP,** ↑ psychology services,)		
			Accommodation of individual needs (school, work)	**Accommodation of individual needs (school, work, px renewals)**
			Age-friendly clinic design	**Age-friendly clinic hours**
	Direct access telephone consult for CL and PCP	**Communication loop to/from specialist**		**Improved communication between specialist and PCP**
			Inform pain team about incoming youth patients.	
				"Overlap" between pediatric & adult services

PHASES:

- Informal meetings to identify gaps in pain services provision ("points of special significance")
  - Patient-experts
- Semi-structured interviews with primary care providers and consultation w/ Verdun GMF-U:
  - Academic and non-academic primary care providers
  - Physicians, residents, nurses
- Focus groups to formulate final recommendations:
  - Physicians, nurses
  - Allied health professionals
  - Patient-partners and caregivers

Patient-experts / patient-partners involvement

RECOMMENDATIONS



CONCLUSION:

- YWP face multiple life transitions
- Successful transitions to adult services is impossible without primary care.
- Recommendations by clinicians, allied health professionals, and patients differ significantly at the micro (patient) & meso (services) levels.
- Interdisciplinary treatment approach does not consider YWP transition needs.
- YWP recommendations were focused on individual providers.

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