

# Network pain rehabilitation

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# IMPACT

The results reported in this thesis have led to new insights about integrated interdisciplinary care networks for patients with CMP. The purpose of this section is to describe the relevance of the main findings presented here, to explain to whom they are applicable, to discuss how research findings can be translated into innovative products and activities, and to suggest how implementation may be realized.

## Primary, secondary, tertiary care networks

The main deliverable of this thesis is a network of HCPs in primary, secondary, and tertiary care aiming to deliver integrated interdisciplinary care for patients with CMP. An important benefit of this collaboration in NPRL is that HCPs come to know each other and the treatments available for patients with CMP in the South-East Netherlands. In these local networks in primary care, HCPs already collaborate more intensively to treat these patients. Other regions or local networks in the Netherlands can then use the guidelines and protocols developed. An important element in the collaboration between primary and secondary or tertiary care appeared to be working on knowledge exchange, with HCPs

noting that there was added value in informally learning from each other: this collaboration can be further extended and intensified. Examples could be a uniform process of bi-directional communication between all healthcare practices and organizations, network evenings focusing on interdisciplinary collaboration, or discussing complex cases. Also, patients can take advantage of this integrated interdisciplinary care network and will receive treatments that fit with the complexity of their complaints. The HCPs they visit will all speak from the same biopsychosocial perspective which offers the patient an unambiguous treatment plan.

### Education programme: primary care

Working in NPRL needs a biopsychosocial perspective. Moreover, HCPs need to be well informed about the process of an integrated interdisciplinary care approach. One way to facilitate HCPs' working like this is by providing an education programme. Based on the findings of Chapters 3 (feasibility study) and 6 (IPC and satisfaction with work), an education programme containing 3 sessions of 6 hours, with 1 hour follow-up intervention sessions every 4-6 weeks for 6 months, has been developed. The programme focuses on transforming a biomedical vision to a biopsychosocial one, with early recognition of sub-acute and chronic conditions, neurophysiology, role-plays of complex situations, and collaboration strategies in primary care. The follow-up interview sessions take place separately in every local network, discussing barriers to collaboration within the team, specific patient cases, and practical implementation of learned strategies. During these meetings, GPs, therapists, and mental health practice nurses would have to be present at the same time. The educational programme should anticipate that discussing core beliefs, cognitions, emotions, and behaviour may be difficult for HCPs. The education programme applied in NPRL can be used in other settings in the future. If necessary, adaptations can be made to the programme by, for example, adding content on blended learning (Chapter 7, eHealth). The experts offering the programme should also be involved in the implementation of an integrated interdisciplinary care network and have clinical experience in providing interventions with a biopsychosocial approach.

As previously mentioned, education programmes are also relevant for incoming HCPs, such as residential GPs, physiotherapy, or occupational therapy students. Education on the biopsychosocial model and perspective should be well integrated into the curriculum to facilitate common understanding. Interdisciplinary collaboration will also be important in primary rehabilitation care and, therefore, students will need to be taught about collaboration strategies early on. Universities and Universities of Applied Sciences will need to introduce the biopsychosocial model, pain neurophysiology, and IPC into their curricula.

## Collaboration between researchers, healthcare practices, and healthcare insurers

Another area of impact concerns the increased collaboration between the researchers and healthcare insurers. NPRL was funded by three main healthcare insurers, CZ, Zilveren Kruis, and VGZ. As the organization and financing of care are the main facilitators for interdisciplinary care networks, healthcare insurers are very important stakeholders. Although these stakeholders were involved, the financing of primary care still remained to be organized. Moreover, not all patients will have all consultations reimbursed, depending on their insurance package. We recommend reimbursement of NPRL treatment, as this will make the intended treatments more accessible and recommendations presented in this thesis may be implemented in daily care. The collaboration with healthcare insurers started in NPRL will be continued in future projects on multidisciplinary consultations in primary care. The financial and organizational barriers in the organization of multidisciplinary meetings and insurance packages for patients need to be overcome with new ways of financing healthcare.

### eCoach-Pain

In Chapter 7, we discussed the eHealth deliverable of this project: eCoach-Pain. This application was only accessible for treatment facilities participating in the study. However, it is possible to distribute the application further across other primary care practices. New participating practices should get access to the existing platform to enrol their patient population. Inclusion of options for communicating with the treatment team and facilitating a form of blended care are important to improve interdisciplinary care. These options also could improve the usability of the application and facilitate the possibility of tailoring the treatments to patients' complaints in more flexible and efficient ways in terms of time and place. Another possible direction is to explore the potential of eCoach-Pain in other healthcare settings, such as secondary or tertiary care. Implementation of eCoach-Pain across different paths of the healthcare system will stimulate collaboration within the network. In this way, the patient can be the owner of his platform, and he or she can use it in all healthcare settings. HCPs can more easily communicate and disseminate treatment plans, which should stimulate interdisciplinary care in NPRL. In the studies presented in this thesis, eCoach-Pain for blended treatment was used in primary care. If financial conditions and time pressure are eased, this may enable HCPs to monitor patients in the long term. Further refinements in embedding eCoach-Pain into blended care must be made. Also, the role of each health care discipline in the application must be further explored.