



Summary Report

BEST BRAINS EXCHANGE INTERPROFESSIONAL CHRONIC PAIN COMPETENCIES

Canadian Institute of Health Research
in collaboration with
Pain Care BC,
Provincial Health Services Authority
March 10, 2026

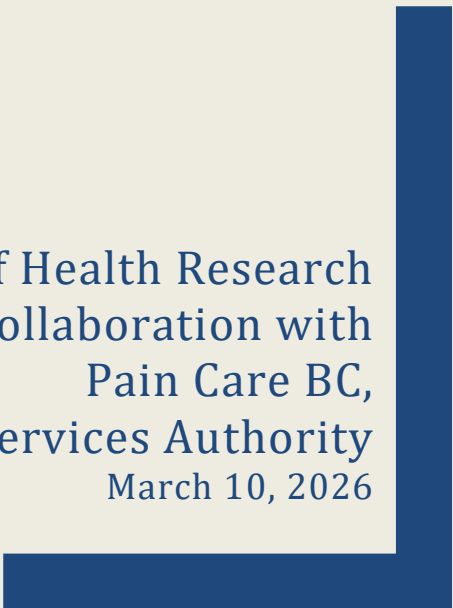


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Introduction

Background and Objectives

On March 10, 2026, the Canadian Institutes of Health Research (CIHR) and Pain Care BC (PCBC) co-hosted a Best Brains Exchange (BBE) focused on Interprofessional Chronic Pain Competencies. The meeting created a forum for national dialogue among researchers, clinicians, educators, policymakers, health system partners, and people with lived experience. Discussions focused on how chronic pain competencies could be more clearly articulated, embedded in education and training, and supported through clinical and system-level implementation.

The meeting was held in response to a significant and ongoing mismatch between the prevalence of chronic pain in Canada and the current state of workforce preparation. Chronic pain affects approximately one in five Canadians¹ and remains a major contributor to disability, health care utilization, and significant system pressure. However, British Columbia and Canada do not yet have a consistent interprofessional competency framework for health care providers involved in non-opioid chronic pain care. This gap has contributed to uneven care experiences, inconsistent role expectations, limited clarity across disciplines, and challenges in advancing coordinated, person-centred, team-based approaches to pain care.

The meeting was designed to support a shared understanding of the current landscape, identify knowledge and implementation gaps, and surface successful models from Canada and other jurisdictions. The discussion also aimed to inform the most effective path forward for British Columbia while contributing to broader national alignment on chronic pain competencies and workforce readiness.

The objectives of the BBE were to:

- Identify national and international competency models for health care professionals in chronic pain care or other chronic conditions of similar complexity and consider how they can inform a standardized Canadian framework.
- Discuss key educational, clinical, and systemic barriers and enablers to implementing interprofessional, non-interventional and non-pharmacological chronic pain care.
- Explore how policymakers, educators, and frontline clinicians can collaboratively promote and support the implementation of evidence-informed interprofessional pain care competencies across disciplines, care settings, and regions across Canada.

Summary

The meeting opened with Pain Care BC (PCBC) presenting, grounding the discussion with emphasis on the need to strengthen chronic pain education, improve workforce readiness, and move to coordinated implementation. PCBC described its provincial competency work as part of a broader strategy to improve how pain is understood and addressed, increase health-care professional capacity, and support better treatment, prevention, and self-management for people living with chronic pain.

The scene-setting presentation emphasized that pain education has not evolved at the same pace as pain science or models of care. Speakers noted that chronic pain is not a niche issue, but a major population health, disability, primary care, and system-planning issue. The field has moved from a predominantly biomedical model toward biopsychosocial, trauma-informed, equity-oriented, and interprofessional approaches, but health professional education remains highly variable and fragmented.

The presentations highlighted both the existence of strong competency and education models and the challenge of embedding them into practice. Examples included the IASP curriculum outlines, Australia's coordinated national pain education strategy, Canadian physiotherapy pain competency work, Western

¹ Canadian Pain Task Force. (2021). *An Action Plan for Pain in Canada*. Health Canada.
https://www.canada.ca/en/health-canada/corporate/about-health-canada/public-engagement/external-advisory-bodies/canadian-pain-task-force/report-2021.html?utm_source=chatgpt.com

University's interprofessional pain management degree program, continuing professional development frameworks, and Project ECHO as a practical model for interprofessional learning and mentorship.

Across the facilitated discussion, participants strongly emphasized that competencies cannot remain as aspirational frameworks. Adoption requires a sustainable implementation infrastructure to include shared standards, accreditation and curriculum alignment, clinical onboarding, mentorship, protected learning time, funding models, data systems, implementation toolkits, performance indicators, and ongoing engagement with people with lived experience. Participants also flagged that competency work must be grounded in cultural safety, trauma-informed language, person-centred care, and have an equity-oriented lens.

Summary of Presentations

Welcome and Opening Remarks

Canadian Institute of Health Research (CIHR) and Pain Care BC (PCBC) opened the session by emphasizing the need for coordinated national and provincial action on interprofessional chronic pain competencies. The BBE was framed as an opportunity to bring together policy, education, clinical practice, research, and lived experience perspectives to identify a practical path from competency development to implementation.

Pain Care BC Provincial Competency Work

Tori Etheridge, Lead, Provincial Clinical Initiatives and Innovation, Pain Care BC (PCBC); Clinical Assistant Professor, UBC MPT program; Mayday Pain & Society Fellow, Provincial Health Services Authority (PHSA)

Pain Care BC described its role as a provincial health improvement network dedicated to optimizing outcomes for people living with pain, improving quality and coordination of pain care services across British Columbia, and promoting innovation in pain care. PCBC situated the competency work within one of its strategic priorities: increasing the capacity of health care professionals to assess, treat, and manage pain effectively.

- PCBC's competency work is organized across three connected areas: specialization in pain care, pre-licensure academic education, and post-licensure continuing education.
- The current focus is on specialization in pain care for allied health professionals and nurses, with attention to foundational and advanced competencies.
- PCBC's process has included a literature review, national partner engagement, focus groups with clinicians in British Columbia, thematic data analysis, establishment of a competency working group, and development of a competency manual.

PCBC's presentation highlighted that existing chronic pain competency work is inconsistent across disciplines and jurisdictions, with limited cross-disciplinary standards for chronic pain care. A literature review identified significant variation across countries and professional groups, limited chronic pain education in most pre-licensure programs, and existing competency work that is often discipline-specific rather than interprofessional.

PCBC presented findings from focus groups with health care professionals across physiotherapy, occupational therapy, mental health, private practice, and nursing. Participants reported that chronic pain education was often absent or limited before graduation, and many clinicians described entering pain roles feeling overwhelmed, isolated, anxious, unprepared, or uncertain. Mentorship was identified as highly valuable, but often absent, and onboarding was described as fragmented or minimal.

Scene-Setting Presentation: Why are we here?

Rachael Bosma, Director, University of Toronto Centre for the Study of Pain, Assistant Professor, Faculty of Dentistry, University of Toronto; Associate Scientist, Women's College Hospital; Chair of the Board, Pain Ontario

The scene-setting presentation emphasized that chronic pain affects every level of the health system and requires care models that move beyond siloed, profession-specific approaches. The presentation traced a

shift from biomedical understandings of pain toward biopsychosocial and interprofessional models, while noting that education systems have not consistently kept pace.

Several milestones were highlighted: Watt-Watson et al.'s 2009 Canadian survey of pre-licensure health science curricula, which found that most health science programs could not specify designated hours for pain education, while veterinary programs reported more clearly defined and substantially greater mandatory pain education content; the 2013 North American Core Pain Competencies; the 2018 IASP Global Year for Excellence in Pain Education and curriculum outlines; Australia's 2023 national strategy for health practitioner pain management education; and Canada's Action Plan for Pain, which calls for improved awareness, education, specialized training, and equity-informed approaches.

Key themes included:

- Pain education in Canada remains variable across institutions and disciplines.
- Education must be understood as a continuum, from university classroom to first job, to mid-career practice, to senior clinical leadership.
- The issue is no longer only defining what pain education should include; it is ensuring that competencies are embedded, implemented, evaluated, and sustained.

Barriers and Enablers to Interprofessional Pain Management

Interprofessional Pain Management Degree Program

David Walton, Professor, School of Physical Therapy, Western University

David Walton described Western University's Master of Clinical Science in Advanced Health Care Practice, Interprofessional Pain Management field as a one-year online post-professional degree program launched in 2019. The program was designed around competency development and mentorship and brought together 30 learners across 12 disciplines between 2019 and 2023.

The program demonstrated the value of interprofessional learning, practical competency development, mentorship, and patient-informed design. Graduates moved into roles in regulatory bodies, teaching, mentorship, and new pain program development. At the same time, the program faced barriers related to the lack of recognized professional credentialing, difficulty marketing to many disciplines, scalability, funding, and fitting a highly personalized competency-based model into traditional academic structures. The program is currently paused and being restructured with the goal of relaunching in 2027.

From Competency Development to Implementation

Nathan Augeard, PhD in Rehabilitation Sciences, McGill University, Founder, Physio Connection

Nathan Augeard used the development of national entry-level pain management competencies in physiotherapy as a case study for moving from competency development to implementation. A key feature of this work was the development of a practice-oriented competency profile that focused on how pain management competencies are demonstrated and applied in real-world physiotherapy education and clinical practice, rather than remaining limited to theoretical knowledge. The profile also included a standalone domain for interpersonal competencies, emphasizing the importance of communication, therapeutic relationships, and person-centred care in pain management.

A key message was that endorsement does not equal integration. Successful implementation required more than broad consensus or motivated champions; it required structural supports, operational tools, alignment with accreditation and regulation, and clear ownership of implementation. High-level competencies need to be accompanied by usable tools such as cases, scripts, assessment templates, milestones, and implementation toolkits.

Team-Based Primary Care and Interprofessional Pain Management

Jordan Miller, Associate Professor, School of Rehabilitation Therapy, Queen's University; Member, Health Services Research Institute, Queen's University, Scientist in Integrated Primary Care, Providence Care

Jordan Miller positioned team-based primary care as a shared solution to two major challenges: gaps in access to evidence-based pain care and broader gaps in access to primary care. The presentation emphasized that many people with pain seek care in primary care, but most do not have access to an interprofessional primary care team. Specialized pain clinics are often concentrated in urban centres, have high wait times, and provide episodic rather than continuous care.

The presentation described physiotherapist-led primary care models as one example of team-based care for musculoskeletal pain. Published evidence suggests these models can support good outcomes, high patient satisfaction, reduced prescribing, lower costs, and fewer visits with primary care providers. However, adding a team member does not automatically create interprofessional care. Interprofessional collaboration requires role clarity, shared workflows, direct access, funding models that support team-based work, shared documentation, leadership, and competencies in collaboration.

Overview of Evidence and Implementation Models

Continuing Professional Development as a Health Policy Intervention

Abhimanyu Sud, Research Chair, Primary Care and Population Health Systems, Humber River Health; Assistant Professor and Clinician Investigator, Temerty Medicine, University of Toronto

Abhimanyu Sud framed continuing professional development (CPD) as an intervention that sits at the intersection of education, behaviour change theory, implementation science, health services and policy planning, and population health. The presentation asked whether education can be deliberately designed to achieve health system, patient, and population health aims.

Drawing on realist synthesis work across 90 programs over 40 years, five mechanisms for CPD were described: motivation transformation, expert influence, confidence development, self-efficacy facilitation, and community of practice expansion. Each mechanism works differently, achieves different outcomes, and is suited to different contexts. A major implication is that CPD should not be treated as a generic solution; program design should match the problem being addressed, the learners being reached, and the outcomes being sought.

The presentation highlighted the need for a more coordinated national pain CPD ecosystem, including stronger collaboration among program leaders, better integration with health system improvement initiatives, improved surveillance and performance metrics, learner self-assessment tools, common evaluation frameworks, formal engagement of people with lived and living experience, and a national CPD hub or centre of excellence.

Project ECHO as an Interprofessional Learning Model

Andrea Furlan, Lead, Rehabilitation Pain Service, University Health Network; Chair, ECHO Chronic Pain and Opioid Stewardship

Andrea Furlan presented Project ECHO Chronic Pain and Opioid Stewardship as a practical model for promoting interprofessional care and building capacity in primary care, rural, remote, and underserved settings. The ECHO model connects a hub of interprofessional experts with community-based providers through person-centered case discussions and an 'all teach, all learn' approach.

The University Health Network ECHO Chronic Pain and Opioid Stewardship Hub began in 2014 and includes expertise from multiple professions, including psychiatry, pain medicine, addiction medicine, family medicine, psychiatry, psychology, nursing, occupational therapy, physical therapy, pharmacy, social work, chiropractic, and an embedded clinical librarian. Over ten years, the program delivered 20 learning cycles, trained more than 1,500 health care professionals, provided more than 25,000 CME credits, and discussed more than 500 cases. Key outcomes of this program are:

- ECHO provides mentorship and case-based learning for complex pain cases.
- Participants reported improved understanding of their own roles and other professionals' roles.

- The interprofessional nature of ECHO was seen as contributing to changes in practice collaboration.
- Related tools, including the Pain Competence Assessment Tool and observational tools for virtual communities of practice, offer possible approaches to evaluating interprofessional education.

Facilitated Discussion

Following the presentations, participants took part in a facilitated discussion on how interprofessional chronic pain competencies could be adopted and implemented across policy, education, and clinical practice. Input was gathered through both Mentimeter and verbal discussion. The discussion was organized around four questions focused on sector roles, alignment mechanisms, coordinated actions, and system reinforcements needed to make competency adoption part of routine practice.

1. What is the specific implementation role of each sector — policy, education, and clinical practice — and where must coordination occur?

Participants emphasized that policy, education, and clinical practice each have a distinct role in implementing interprofessional chronic pain competencies. However, they also stressed that these roles need to be aligned so that competencies move beyond endorsement and become embedded in education, workforce development, and day-to-day care.

Key roles identified included:

- **Policy creates the conditions for implementation**
Participants identified policy as a key lever for setting expectations, establishing standards, aligning funding, supporting workforce development, and creating incentives for interprofessional chronic pain care. Accreditation standards, provincial and national pain strategies, funding models, and system-level accountability were seen as important tools to support adoption.
- **Education prepares the workforce**
Participants emphasized that chronic pain competencies need to be integrated across the full education continuum, including pre-licensure education, post-licensure training, continuing professional development, faculty development, and interprofessional learning. Education was also seen as essential for building shared language, foundational knowledge, role clarity, and confidence across disciplines.
- **Clinical practice operationalizes the competencies**
Participants described clinical practice as the setting where competencies must be translated into daily care. Suggested strategies included embedding competencies into onboarding, job descriptions, role expectations, mentorship, documentation, team workflows, care pathways, audits, and feedback. Clinical leaders were seen as essential in setting expectations and creating supportive practice environments.
- **Coordination is needed where sectors intersect**
Participants highlighted the need for coordination across accreditation, curriculum development, onboarding, continuing professional development, referral systems, care pathways, data collection, and evaluation. These were identified as the points where policy, education, and clinical practice must connect.
- **Shared accountability is required**
Participants cautioned against siloed action. Competency implementation requires shared responsibility across policymakers, educators, clinical leaders, professional organizations, health authorities, and people with lived experience. The overall message was that policy enables, education prepares, and clinical practice embeds competencies into care.

2. What are the top coordinated actions that policymakers, educators, and clinicians could initiate within the next 12 months?

Participants identified several practical actions that could be initiated within the next year to build momentum and support early implementation. The discussion focused on steps that could create shared direction, reduce duplication, and begin testing how competencies can be embedded in real-world education and clinical settings.

Priority actions identified included:

- **Agree on a shared foundational competency framework**
Participants emphasized the need for a common set of foundational interprofessional chronic pain competencies. This would help establish shared language, baseline expectations, and clearer alignment across professions, sectors, and jurisdictions.
- **Map competencies to existing frameworks and curricula**
Participants suggested reviewing existing health professional competency frameworks to identify where pain already fits. This would help avoid duplication and support integration into current curricula, accreditation standards, and continuing professional development structures.
- **Create a cross-sector implementation mechanism**
Participants recommended establishing an implementation working group, national coordination table, or learning network to move the work forward. This mechanism could bring together policymakers, educators, clinicians, researchers, professional organizations, accreditation bodies, health authorities, and people with lived experience.
- **Launch academic–clinical implementation pilots**
Participants suggested testing implementation through partnerships between academic programs and health authorities or clinical settings. Pilots could explore how competencies can be integrated into curricula, onboarding, mentorship, clinical workflows, team-based care, and continuing professional development.
- **Identify and promote existing educational resources**
Participants noted that Canada already has useful pain education resources and models. Early work could include identifying existing assets, mapping gaps, promoting freely available evidence-based resources, and developing short interprofessional learning modules.
- **Build communities of practice and implementation supports**
Participants identified ECHO hubs, mentorship networks, interprofessional learning hubs, and communities of practice as practical mechanisms to support early adoption. These approaches could help clinicians apply competencies in practice and learn from peers across regions.
- **Develop common measures for uptake and impact**
Participants emphasized the need to define what success looks like. Early measurement could include competency uptake, learner confidence, clinical workflow changes, patient experience, interprofessional care processes, and system-level outcomes.

Overall, participants identified three major near-term priorities: agree on the foundational framework, establish a coordination mechanism, and test implementation through academic–clinical pilots.

3. What incentives or system reinforcements are necessary to make competency adoption normative rather than optional?

Participants emphasized that competency adoption will become routine only if it is reinforced by the systems that shape education, clinical practice, funding, leadership, and accountability. Competencies cannot rely only on individual interest or champions; they need to be built into expectations, workflows, and supports.

Key reinforcements identified included:

- **Funding and payment models that support interprofessional care**
Participants highlighted the need for funding models that make team-based chronic pain care

feasible. Suggested reinforcements included billing codes, payment for case discussions, funding for allied health services, protected learning time, support for ECHO-style participation, and resources for mentorship and clinical tools.

- **Formal education and professional requirements**

Participants suggested embedding competencies into accreditation standards, licensure exams, continuing professional development requirements, maintenance of licensure activities, onboarding expectations, job descriptions, interview processes, and annual professional development plans.

- **Leadership expectations and organizational priorities**

Participants noted that adoption becomes more likely when leaders consistently signal that chronic pain care is a core component of quality care. This includes making pain care visible in program priorities, team-based care models, staff training, performance expectations, and recognition of good practice.

- **Integration into clinical workflows**

Participants emphasized that competencies should be embedded into everyday practice rather than treated as a separate educational activity. Suggested approaches included EMR prompts, standardized documentation, care pathways, referral systems, assessment tools, team huddles, case conferences, audit, and feedback.

- **Data, evaluation, and accountability**

Participants identified data as an important driver of behaviour change. Suggested measures included competency uptake, patient experience, clinical outcomes, continuity of care, interprofessional collaboration, access to non-pharmacological care, and system value, including potential cost savings.

- **Meaningful involvement of people with lived experience**

Participants emphasized that people living with pain should help shape competencies, education, service design, and evaluation. Their involvement was seen as essential to ensuring that competencies support person-centred, non-stigmatizing, culturally safe, and meaningful care.

- **Culture change across the system**

Participants noted that competency adoption will become normative when chronic pain care is understood as a core health system responsibility rather than a niche specialty issue. This includes normalizing ongoing learning, mentorship, interprofessional collaboration, equity-informed care, and shared accountability.

Overall, participants emphasized that competency adoption needs to be expected, funded, supported, measured, and embedded into routine practice.

Conclusion and Next Steps

The BBE confirmed strong cross-sector interest in advancing interprofessional chronic pain competencies. Participants emphasized that chronic pain care is a core health system issue requiring a prepared workforce, coordinated implementation, and sustained system support.

A central message was that competency development alone is not enough. To make a meaningful difference, competencies need to be embedded into education, clinical practice, onboarding, continuing professional development, accreditation, funding models, and evaluation. Participants also emphasized that people with lived experience must remain central to this work to ensure competencies support person-centred, culturally safe, and non-stigmatizing care.

Key conclusions included:

- **A shared competency framework is needed** to create common language, baseline expectations, and clearer roles across professions and care settings.

- **Implementation requires coordination** across policy, education, clinical practice, accreditation, CPD, onboarding, care pathways, and evaluation.
- **Endorsement is not sufficient**; competencies need practical tools, funding, mentorship, protected time, leadership support, and communities of practice.
- **Clinical settings need support** to translate competencies into workflows, documentation, team processes, referral pathways, and quality improvement.
- **System reinforcement is essential** through funding models, accreditation standards, CPD expectations, leadership priorities, data, and accountability.

Suggested next steps include:

- Refine and validate Interdisciplinary Core Competencies for Chronic Pain as a PCBC-led framework for strengthening chronic pain education, practice, and interprofessional collaboration in BC.
- Map competencies to existing curricula, professional frameworks, accreditation standards, CPD structures, and health authority expectations.
- Establish a cross-sector implementation roadmap to coordinate action across policy, education, clinical practice, and lived-experience partners.
- Develop practical implementation supports, such as onboarding modules, case-based learning tools, self-assessments, mentorship models, and evaluation indicators.
- Identify early academic–clinical or health authority pilots to test implementation.
- Build on existing CPD and community-of-practice models, including ECHO.
- Define common measures of success, including competency uptake, provider confidence, interprofessional collaboration, patient experience, and system impact.

Overall, the BBE highlighted a clear opportunity to move from competency development to coordinated implementation, with the next phase focused on the structures, tools, partnerships, and accountability needed to embed competencies into routine education and care.