ARTICLE

Physiotherapists' Experiences with and Perspectives on Implementing an Evidence-Based, Chronic Pain Self-Management Programme in Primary Health Care: A Qualitative Study

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ABSTRACT

Purpose: Evidence suggests that a physiotherapist-led chronic pain self-management programme in primary health care (PHC) improves function for people living with chronic pain; however, implementing a new approach to care can be difficult. In this study, we sought to understand the experiences of physiotherapists who had implemented the ChrOnic pain self-ManageMent support with pain science EducatioN and exerCisE (COMMENCE) programme; its perceived barriers, facilitators, benefits, and drawbacks; and how the physiotherapists tailored the programme to their own clinical contexts. ***Method:*** This interpretive description qualitative study used semi-structured interviews with physiotherapists who had implemented the COMMENCE programme in PHC. ***Results:*** Themes from 11 interviews included experiences of personal and professional growth, increasing confidence with experience, and changing the culture of pain management. Barriers and drawbacks to implementation included resource intensiveness, balancing programme demands with other clinical work, and challenges with patient attendance and participation. Facilitators included training, programme design and materials, supportive teams, and previous knowledge. Benefits included offering group and individualized support, evidence-based content, and sparking interest in learning more about pain management. The participants made small changes to tailor the programme content and delivery to their context. ***Conclusions:*** This study provides a rich understanding of the experiences, barriers, facilitators, benefits, drawbacks, and tailoring related to the COMMENCE programme in PHC. The results will facilitate future implementation of this intervention in PHC settings.

Key Words: chronic pain; pain management; primary health care; self-management.

RÉSUMÉ

Objectif : selon les données probantes, un programme d'autogestion de la douleur chronique dirigé par un physiothérapeute en soins primaires améliore la fonction des personnes qui vivent avec la douleur chronique, mais il peut être difficile de mettre en œuvre une nouvelle approche des soins. La présente étude visait à comprendre les expériences des physiothérapeutes qui avaient créé le programme COMMENCE (acronyme anglais pour soutien pour l'autoprise en charge de la douleur chronique par l'éducation et l'exercice de la science de la douleur), les obstacles perçus, les incitations, les avantages et les inconvénients, de même que l'adaptation du programme aux contextes cliniques. ***Méthodologie :*** étude qualitative par description interprétative faisant appel à des entrevues semi-structurées auprès de physiothérapeutes qui avaient mis en œuvre le programme COMMENCE en soins primaires. ***Résultats :*** les thèmes des 11 entrevues portaient sur les expériences de croissance personnelle et professionnelle, l'augmentation de la confiance grâce à l'expérience et le changement de la culture de gestion de la douleur. Les obstacles ou les écueils de mise en œuvre incluaient l'intensité de ressources nécessaires, l'équilibre entre les exigences du programme et le reste du travail clinique et les difficultés relatives à l'assiduité et à la participation des patients. Les incitations incluaient la formation, la conception et le matériel du programme, les équipes solidaires et les connaissances antérieures. Les avantages incluaient l'offre d'un soutien collectif et individuel, le contenu fondé sur des données probantes et l'intérêt à en apprendre davantage sur la gestion de la douleur. Les participants ont apporté de petits changements pour adapter le contenu et la prestation du programme à leur contexte personnel. ***Conclusions :*** la présente étude fournit de riches données sur les expériences, les obstacles, les incitations, les avantages, les écueils et l'adaptation du programme COMMENCE en soins primaires. Les résultats faciliteront la future mise en œuvre de cette intervention en soins primaires.

Mots-clés : autogestion; douleur chronique; gestion de la douleur; soins primaires

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Chronic pain is a leading contributor to years lived with disability, and it places an immense burden on individuals and their families.[1–3] Its economic impact is significant because of its effects on health care costs,[4] missed work,[5,6] and reduced productivity at work.[5,6]

It has become increasingly clear that primary health care (PHC) systems are struggling to address the needs of people living with chronic pain.[7,8] Despite a rise in PHC of the rate of opioid prescriptions to manage chronic pain over the past three decades,[9] function and return-to-work outcomes have not improved for this population.[10] Physicians in PHC have also reported a lack of confidence in managing musculoskeletal pain,[11,12] and patients report low levels of satisfaction with how chronic pain is managed in PHC.[13] As the population ages, more people are living with chronic health conditions associated with pain, and the challenges faced by PHC are expected to grow.[14–16] As a result, new approaches to care that integrate additional primary care team members, such as physiotherapists, are beginning to emerge to manage chronic pain.[17–19]

PHC reform has increased the focus on team-based approaches to care; the most common models of team-based PHC are found in Ontario, in the form of Family Health Teams (FHTs) and Community Health Centres (CHCs).[20–23] Both FHTs and CHCs are examples of interprofessional PHC teams: CHCs deliver care to priority populations that experience barriers to accessing traditional health services, and FHTs serve a broader population that may, or may not, experience barriers in accessing health services.[21]

Physiotherapists can play an important role in the PHC team.[24–26] They can assess and treat individuals with chronic pain, provide education about preventing and managing chronic health conditions, and facilitate group-based programmes.[19,27] They are also well suited to take on a key role in supporting self-management,[28] an important strategy in PHC reform.[22] Physiotherapists are currently underrepresented in PHC, despite their ability to contribute to positive health outcomes for conditions that PHC can commonly manage.[27,29]

Self-management is an effective strategy and one that may help address the growing burden on PHC of treating chronic pain.[30–32] Although multiple definitions of *self-management* exist, Barlow and colleagues have defined it as an "individual's ability to manage the symptoms, treatment, physical and psychosocial consequences, and life style changes inherent in living with a chronic condition."[31(p. 178)] With the aim of enabling patients to improve their physical function and increase their engagement in life role activities, a physiotherapist-led self-management programme, ChrOnic pain self-ManageMent support with pain science EducatioN and exerCisE (COMMENCE), was developed.[33–35] In addition to using the traditional elements of self-management support, COMMENCE incorporates pain science education; additional cognitive–behavioural principles; and tailored, goal-oriented exercise.[33–35] A single-site randomized controlled trial found that COMMENCE was effective at improving function for people living with chronic pain.[35] However, implementation research is needed as part of a knowledge translation process to incorporate this programme into additional PHC settings.

The knowledge-to-action cycle suggests that after new knowledge has been created, the barriers, facilitators, and tailoring related to implementing that knowledge in a local context should be evaluated to successfully transfer the evidence to clinical practice.[36] Informed by this knowledge translation framework, our objectives in this study were to understand (1) the experiences of physiotherapists delivering COMMENCE in PHC; (2) its perceived barriers, facilitators, benefits, and drawbacks; and (3) how physiotherapists tailored COMMENCE to meet the needs of the local context.

METHODS

Study design

We used an interpretive description qualitative study design[37–39] to meet our study objectives. Interpretive description seeks to "provide a thematic or integrative description of a phenomenon of applied or practical interest."[39(p. 83)] It differs from other methods, such as qualitative description, in that data are interpreted in clinical and applied contexts.[37–39] We selected interpretive description as the methodological orientation for this research because it emphasises the generation of knowledge that can result in clinically meaningful findings, which can then be applied in clinical contexts.[37–39]

We obtained ethical approval for this study from the Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at Queen's University. Our reporting is consistent with the Consolidated Criteria for Reporting Qualitative Research guidelines.[40]

Research team

This research team included five Master of Science in Physical Therapy (MScPT) students from Queen's University (EB, NC, MD, NE, and MK), a physiotherapist and PhD student who focuses on chronic pain management (KV), and a physiotherapist and faculty member of the School of Rehabilitation Therapy at Queen's University who developed COMMENCE (JM). JM was known to all the study participants because he had delivered the training for the programme. He did not conduct any interviews or complete the initial coding.

Participants and setting

We used a purposive sampling strategy to recruit physiotherapists (11) who had experience implementing COMMENCE in PHC in Ontario.[41] All physiotherapists who had

been trained to deliver COMMENCE in PHC ($N = 16$) were invited to participate in this research. Individuals were able to participate if they were a physiotherapist who had been trained in and had delivered COMMENCE at least once in a PHC setting.

Intervention design and training

COMMENCE is a 6-week self-management programme for people living with chronic pain; it consists of individualized self-management support, pain science education, and goal-oriented exercises.[33–35] It is delivered twice weekly, with one individual visit and one group session each week.[33–35] Before they can deliver the programme, physiotherapists must complete 2 days of training. During the training, JM models how the programme should be delivered and then discusses and clarifies the programme content; physiotherapists practise the components of delivery and receive feedback from their peers and the instructor.

Data collection

We collected demographic information from all participants. A pre-piloted, semi-structured interview guide rooted in the study objectives was used (see Box 1). Telephone interviews,[42] ranging in length from approximately 30 to 90 minutes, were conducted by three team members (EB, NC, and NE). Two interviewers were present for each interview. The interviews were audio recorded, transcribed verbatim, and reviewed for accuracy, and both interviewers took field notes. The interview transcripts and demographic data were kept anonymous throughout this research through the use of unique alphanumeric codes (e.g., PT01). Before their participation in this research, all study participants provided verbal informed consent.

Data analysis

We uploaded interview transcripts to NVivo, Version 12 (QSR International, Doncaster, VIC, Australia) to assist with data management. The qualitative data were then analyzed inductively.[37–39] Thematic analysis was performed, as described by Braun and Clarke,[43] and consisted of (1) familiarizing ourselves with the data, (2) generating initial codes, (3) searching for themes, (4) reviewing the themes, (5) defining and naming the themes, and (6) producing a report. In addition, we considered questions such as "What is happening here?" and "What am I learning about this?" as the data were analyzed.[37–39] Five study investigators (EB, NC, MD, NE, and MK) performed the initial coding of two interviews to establish a preliminary coding scheme. After this, a meeting was held with all team members, who had familiarized themselves with the transcripts, to discuss the codes and preliminary themes. The remaining nine transcripts were independently coded by at least two investigators.

Throughout the analysis, the codes were grouped into larger themes. The data collection and analysis occurred concurrently. Thematic saturation was discussed throughout the interview process, and recruitment continued until we determined that thematic saturation had been reached – that is, no new themes were being identified from the qualitative data.[44] (Thematic saturation differs from theoretical saturation, a concept commonly used in grounded theory, in that thematic saturation describes a state in which no more patterns are emerging from the data.[45]) Throughout the data analysis, we engaged in regular discussion and reflexive conversation to ensure the trustworthiness of the results.[46]

RESULTS

We interviewed a total of 11 physiotherapists (4 men, 7 women) across 10 PHC sites (3 FHTs, 7 CHCs). Participants had between 3 and 35 years of clinical experience as a physiotherapist and had delivered COMMENCE between one and seven times to groups of patients in PHC. See Table 1 for information about the participants and PHC sites. In this section, we give an overview of the themes that were inductively identified. They are organized by study objective in Table 2.

BOX 1 KEY QUESTIONS FROM THE INTERVIEW GUIDE

1. What has been your experience implementing and evaluating COMMENCE?
2. What have been the benefits of implementing COMMENCE at your clinical site?
3. What have been the drawbacks of implementing COMMENCE at your clinical site?
4. What have been facilitators in implementing and evaluating COMMENCE at your clinical site?
5. What have been barriers in implementing and evaluating COMMENCE at your clinical site?
6. How have you tailored COMMENCE at your clinical site?
7. Describe the impact of implementing COMMENCE on the health care system as a whole.
8. What advice would you give to others when implementing and evaluating COMMENCE at your site?
9. Do you have any other comments that you would like to share regarding the implementation and evaluation of COMMENCE at your site?

COMMENCE = ChrOnic pain self-ManageMent support with pain science EducatioN and exerCisE.

Table 1 Participant Information (*N*= 11)

Variable	Information
Gender	4 men; 7 women
Current work status in PHC site	10 full time; 1 part time
Type of PHC site	4 physiotherapists from FHTs; 7 physiotherapists from CHCs
Median experience in clinical practice (range, min-max), y	10 (3–35)
Median experience in clinical practice at PHC site (range, min-max), y	3.5 (0.5–10.0)
Median number of times that COMMENCE had been delivered (range, min-max)	1 (1 –7)

PHC = primary health care; FHT = Family Health Team; CHC = Community Health Center; COMMENCE = ChrOnic pain self-ManageMent support with pain science EducatioN and exerCisE.

Table 2 Themes from the Findings, Organized by Study Objective

Objective				
Participants' experiences	Programme facilitators	Programme barriers and drawbacks	Programme benefits	Tailoring of programme
Personal and professional growth	Training as a foundation	Resource intensiveness	Format	Content
"The more you do it, the easier it becomes"	Packaged well for patients and health care practitioners	Balancing programme demands with other clinical tasks	Evidence-based content	Delivery (e.g., integrating other team members)
Changing the culture of pain management	Support from the clinical and leadership team	Attendance and participation	"It got me going in the right direction"	
	Previous knowledge or skill set		Potential benefits for health care system	

Experiences with programme implementation

Many participants thought that receiving training and subsequently delivering COMMENCE had given them opportunities for personal and professional growth.

> The material is there, and it is digestible and tangible, and you really don't need to be a clinical expert to be able to successfully deliver the programme. And it will enrich your own clinical practice. (PT7)

The participants noted that although delivering the programme initially required a substantial investment of time to learn the material and prepare, it became easier over the initial 6-week delivery period as well as with subsequent delivery.

> It [was] definitely more fluid with each time. … Like most things [you] do, the more you go through it, the more you know [how to] engage and envelope yourself in the material. (PT6)

The participants thought that delivering COMMENCE reflected a shift in the culture of pain management from a biomedical to bio-psychosocial model.

> I think there's still a heavy viewpoint that pain is related to tissue-level issues, so I think highlighting the fact that it's more than just that. That there is a large psychosocial component to one's pain experience. (PT7)

Facilitators of programme implementation

The participants thought that the training for COMMENCE provided a strong foundation for delivering the programme, giving them the confidence to deliver it effectively.

> The structure of the training aligned with what it'd actually be like teaching the programme. And even when [the instructor] was presenting the slides, he presented the information in a way, like he sort of role played a little bit, like being a [physiotherapist] presenting the material. So I think that was also really helpful because it kind of gave us a sense of, you know, what is the language you would use. (PT1)

The participants noted that the programme's design facilitated its delivery because it gave patients information in an organized way.

> It's kind of a nice systematic, organized way to go about the process of helping someone understand why they're feeling the way they are when they're having chronic pain. (PT11)

In addition, they thought that COMMENCE was well designed to meet their own needs, making it easier for them to deliver it.

> I think having the programme also set for us, in a scripted and prescribed manner … because you don't have to worry about changing things, or relearning material, or doing the research. … That's sometimes the most challenging part of doing a presentation or a programme. (PT5)

They noted that the support of other health care providers and the leadership team in a PHC organization was

a crucial facilitator of programme delivery. In particular, support was needed to allow the appropriate amount of time to prepare for and deliver the programme; this time could take away from delivery of other programmes and one-to-one patient care.

> I think a supportive clinical team is important and making sure that they're all on board and aware of this, as well [as] a supportive clinical director who provides you with flexibility in your … schedule. (PT3)

The participants thought that previous experience with the topics covered by the programme affected how they delivered it. All participants noted that feeling comfortable with the material was important to implement the programme effectively. Those with experience or knowledge of the topics explored in the programme saw this previous experience as an asset.

> You have to definitely know the material well to be able to deliver it well. … I would say I felt pretty confident. I've also had quite a few years of experience as a therapist, so that was helpful for me coming into it. Knowing some of those concepts. (PT1)

Barriers and drawbacks to programme implementation

The barriers to implementing and delivering COMMENCE were considered obstacles that the participants had to overcome, whereas the drawbacks were seen as the disadvantages of delivering COMMENCE in PHC. Those that the participants described most often were the resources required to implement the programme. In particular, the participants suggested that the time required to prepare to deliver and implement the programme was both a barrier and a drawback.

> I know a couple of my colleagues felt they had to really devote a lot of time because it was new, in terms of [the] amount of, umm, time they have to commit to create a better understanding for themselves so that they could then present this in a competent way. (PT3)

Some participants spoke about the difficulties of balancing the demands of the programme with other clinical tasks. This balancing act was viewed largely as a barrier that had to be overcome when delivering COMMENCE in PHC. These participants noted high caseload volumes and other areas of practice as the primary contributors to their time management challenges.

> So if you're committing a whole bunch of resources to a group programme, and you're still getting in that influx of referrals for one-to-one care, there can be a significant waitlist develop[ed] during that time period when the group is being delivered. (PT1)

The participants described the barriers to patient participation and attendance as other barriers to implementing COMMENCE. These barriers varied depending on the site, but transportation, geographical accessibility, and parking were examples at multiple sites. The participants also described patient-specific barriers including difficulty committing to the time required to participate and difficulty comprehending the material if English was not their patients' first language.

> You're fortunate if you have 50 percent of your originals stay with you. And why people stop coming? Not everyone tells you why. Some people have said that it's too much, two times a week. Some people have said that it's too difficult to understand … [whereas others are] saying it's too much of a commitment in terms of all the activities they have to do in the programme. (PT09)

Benefits of programme implementation and delivery

The participants believed that a major benefit of COMMENCE's group format was the sense of peer support that the individuals felt because everyone in the group was sharing a common experience.

> I think the thing that stood out to me the most was just the richness of interactions between the participants. … But they did build really strong relationships [that] extended beyond the boundaries of the class, which were probably really positive, and they were able to build off of each other's coping strategies and experiences in a really positive way. (PT11)

Many participants also stated the benefit of the one-to-one sessions was that they enabled them to take a patient-centred approach and develop patient-specific goals.

> The one-on-one sessions were very helpful in that I was able to work through what they found the most challenging, or pick through what they took away from that session, and then kind of fill in the gaps. (PT10)

The fact that COMMENCE includes evidence-based education, self-management strategies, and a bio-psychosocial approach was seen as an important benefit.

> I think [it] is very important through this programme the way that it incorporates that framework of a bio-psychosocial theory and then incorporate[s] self-management tools whether it be cognitive, emotional, or physical activity. (PT3)

The participants thought that COMMENCE provided a complete, prepared, and organized programme that they were able to use as a starting point for building further competence in pain management.

> So the biggest thing with [the] programme is [it] got me going in the right direction. Gave me the references, the information to get started. Sparked my interest. And now, as a result, I've done a lot more research in my own learning to supplement those slides and make them better. (PT2)

Although the participants suggested that they were unable to measure the benefits of COMMENCE to the health care system, some believed it could have a positive impact.

> Well I think that, at the end of the day, you're hoping by implementing these programmes, you're potentially maybe,

> from a cost-effectiveness point of view, decreasing visits to their doctor. Because now they're in a pain programme. … Hopefully during that time you're reducing unnecessary visits to the doctor in regard to pain. And you're hoping that there will be less use of medication, in particular opioids. (PT2)

Tailoring of programme implementation and delivery

Some participants reported changing the material slightly to better reflect their own knowledge base and enable them to feel more comfortable with the programme material.

> Making the slides my own and adjusting things with the new information that I've gathered makes it even that much easier for me to deliver and answer questions because it's material that I've put together. (PT10)

The participants tailored the delivery of the programme in three main ways. Most included other PHC team members (e.g., social workers or occupational therapists) when delivering content that they had less experience with, such as describing the link between thoughts and pain.

> I think that, based on the material we've been provided, we feel comfortable dealing, or going over that material but we also know too that some other people have more experience and skill there that maybe that would be a chance to sort of have some more interdisciplinary team work. (PT3)

A second way they tailored the programme was to have two physiotherapists co-present the material instead of just one. This had benefits because it decreased their own fatigue, and the variety of presentation styles helped to keep the patients engaged.

> Two opinions, two approaches. So even just the words, the labels, kind of just tweaking that resonated with some people more than others. (PT8)

Finally, a few participants reported incorporating additional material to further engage the patients (e.g., through videos and additional group discussions).

> One thing is I did go out and find some really good YouTube videos, two to three minutes long to capture their interest. I think that was really helpful in topic areas like mindfulness and neuroplasticity. (PT2)

DISCUSSION

To our knowledge, this is the first qualitative study to explore the experiences, perceived barriers, facilitators, benefits, drawbacks, and tailoring related to a physio therapist-led chronic pain self-management programme in PHC. The participants in this research study experienced personal and professional growth from delivering the programme and found that it became easier to deliver as the 6-week programme progressed and when they delivered the programme multiple times with different patient cohorts. The participants suggested that the resource intensiveness of the programme and the challenges of balancing its demands with their other clinical responsibilities were potential barriers or drawbacks to implementing the programme but that a supportive team, strong training, and previous knowledge facilitated its implementation. They noted that the evidence-based content and the combination of group and individual visits were two benefits of the programme. They often tailored programme content and delivery to better suit the needs of their patients or their own abilities.

By investigating the experiences of physiotherapists delivering chronic pain self-management support in PHC, our study adds to previous research, which has investigated the barriers to and facilitators of receiving chronic pain self-management support from the perspective of people living with chronic pain.[47,48] Our study also provides an example of a knowledge translation approach in PHC, informed by the knowledge-to-action cycle.[36] Thus, this research provides foundational knowledge for understanding how an evidence-based, physiotherapist-led chronic pain self-management support intervention can be implemented in PHC.

The participants in our study suggested that the barriers to and facilitators of delivering chronic pain self-management support in PHC existed at the level of the health professional (e.g., previous knowledge and skill set), health care team (e.g., support from the clinical and leadership team), and organization (e.g., balancing programme demands with other clinical tasks). These results align with the findings from a systematic review that described the importance of considering the individual professional, the health care team, and the organization when incorporating research into clinical practice.[49]

In addition, at the level of the individual professional, previous work has described how knowledge and attitudes can act as a barrier to implementing evidence.[50] Our finding that previous knowledge and skill set acted as facilitators in implementing COMMENCE agrees with these previous findings. Moreover, the result that the programme's intensive use of resources acted as a barrier to delivery reflects previous research that described how organizational constraints, such as time, equipment, and support services, can act as barriers to implementing a new approach to care.[50]

Some participants indicated that they had tailored COMMENCE by including other PHC team members, such as social workers or occupational therapists, when delivering content related to thoughts and pain. This finding is consistent with previous research that has found that physiotherapists report a lack of confidence in applying psychosocial strategies in their daily practice.[51]

The results of this study present important evidence that could contribute to implementing this evidence-based intervention in PHC practise more broadly by providing a better understanding of barriers, facilitators, and tailoring strategies from sites that have implemented COMMENCE. It has been suggested that increased knowledge

of the facilitators of and barriers to self-management programmes can aid in ensuring that these programmes are appropriately tailored to patients.[52] This information could also help other sites adapt the programme to their local context and tailor the intervention to their own sites, as suggested by the knowledge-to-action cycle.[36]

Despite the barriers and drawbacks to delivering COMMENCE in PHC, all 11 participants we interviewed saw its value and recommended that other physiotherapists implement it. Although running the programme was initially seen as resource intensive, this attitude changed as the participants delivered the programme and gained experience. An important clinical implication of these findings is that individuals and organizations that are considering implementing chronic pain self-management interventions such as COMMENCE should prepare for the upfront investment in time and resources.

This research explored the barriers and facilitators related to implementing an evidence-based self-management programme that is informed by the knowledge-to-action cycle.[36] This study focused on the perspectives and experiences of physiotherapists delivering a chronic pain self-management programme in PHC. Future research could explore the perspectives of patients who have participated in COMMENCE as well as those of other PHC team members at sites that offer the programme. An improved understanding of these stakeholder perspectives could inform how chronic pain self-management support, such as COMMENCE, is implemented in PHC. A strength of this study is the representative sample: of the 16 physiotherapists who had implemented COMMENCE in PHC, 11 were interviewed, and thematic saturation was achieved.

This study had several limitations. First, a limitation inherent in qualitative methods is that findings may not be transferable to other settings. This study was limited to physiotherapists practising in team-based PHC organizations in Ontario, where COMMENCE was offered at no cost to patients. Its results may not be transferable to other health care or geographic contexts, but they do provide in-depth qualitative findings that can inform how such a programme is implemented in PHC organizations in which physiotherapists are integrated into the team. Second, our participants had delivered COMMENCE between one and seven times in PHC, so they might have had more information to add as they continued to deliver it. Third, data analysis was conducted by a team of physiotherapy students, a practising physiotherapist and PhD student, and a physiotherapist and researcher who had developed COMMENCE and had trained all the participants in this research how to deliver the programme in PHC; it is possible that researchers with different experiences and backgrounds (e.g., non-physiotherapists) would have conceptualized the data differently.

CONCLUSION

This study qualitatively explored the experiences and tailoring strategies of physiotherapists who had delivered COMMENCE, a chronic pain self-management intervention, in PHC settings, as well as the facilitators, barriers, benefits, and drawbacks they accorded to the programme. The results of this research provide foundational knowledge about how a chronic pain self-management programme can be implemented; the study's ultimate aim is to bridge the knowledge-to-practice gap and support improved chronic pain management in PHC.

KEY MESSAGES

What is already known on this topic

Evidence from a single-site randomized controlled trial suggests that a physiotherapist-led chronic pain self-management programme in primary health care (PHC) improves function for people living with chronic pain; however, it can be difficult to incorporate new approaches to care into everyday clinical practice in PHC.

What this study adds

This study provides foundational knowledge about the experiences and tailoring strategies of the physiotherapists who have delivered the ChrOnic pain self-Manage Ment support with pain science EducatioN and exerCisE (COMMENCE) programme, as well as the perceived barriers, facilitators, benefits, and drawbacks related to delivery of this evidence-based chronic pain self-management programme in PHC.

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