CONTINUITY AFTER INTERVENTION

A scoping evidence map and practical framework for patient-centered care in a pain medicine fellowship clinic

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857 unique PubMed records

164 unique registry studies

300 candidate evidence map

88 FINAL + 5 ASRA = 93 REFERENCES
10 anchors are a subset, not additional records.

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ASRA ABSTRACT

SCOPING EVIDENCE MAP **PRACTICE FRAMEWORK**

PRISMA-ScR EVIDENCE FLOW

Two-reviewer screening • English • chronic/cancer/interventional pain • continuity/follow-up • teaching or transferable model • extractable process/outcomes

full-text screening spreadsheet, and resolved the final selection through reviewer communication and consensus.

IDENTIFICATION

PubMed search stream	ClinicalTrials.gov stream
857 unique records identified	164 unique registered studies identified

↓ *relevance ranking and stream-specific retention*

PubMed candidates retained	Registry candidates retained
275 publications advanced 582 records not advanced	25 studies advanced 139 registrations not advanced

↓ *candidate streams combined*

CANDIDATE EVIDENCE MAP
300 records for structured screening
275 PubMed publications + 25 registered studies

↓ *at least two reviewers applied the prespecified eligibility criteria*

FINAL SCOPING REVIEW SET	Records excluded
88 articles retained for the final evidence list	212 records failed one or more criteria Criterion-specific subcounts were not recorded

↓ *ASRA bibliography reconciliation*

FINAL PRESENTATION REFERENCE POOL
93 references
88 final scoping-review articles + 5 original ASRA abstract references

↓ *priority evidence highlighted*

TEN ANCHOR REFERENCES
10 ePoster anchor articles within the 93-reference pool
The five submitted-ASRA references remain a separate bibliography section

Figure 1 PRISMA ScR flow diagram and final reference reconciliation

FELLOWSHIP-CLINIC MODEL

The unit of care is the patient's longitudinal pain pathway

1 ASSIGN	Named fellow + faculty dyad
2 PLAN	Diagnosis, goal, success criteria
3 FOLLOW	Visit booked before checkout
4 MEASURE	Pain, function, safety, PGIC
5 REVIEW	Escalate, adapt, hand off

MINIMUM FOLLOW-UP CLOCK

Encounter	Minimum follow-up
Routine injection	24–72 h safety contact when indicated; outcome at 2–4 wk
Diagnostic block	Pain diary; decision review within 1–2 wk
Radiofrequency ablation	4–6 wk; 3 mo if needed
Neuromodulation trial	Daily or near-daily contact; formal end-of-trial review
Implant	Wound/device follow-up; function at 1, 3, 6 and 12 mo

PATIENT-CENTERED OUTCOME SET

Pain	NRS	**Interference**	PEG-3 / PROMIS
Function	One patient activity goal	**Global change**	PGIC
Mood	PHQ-2/9, GAD-2/7	**Safety**	Complications, ED use
Continuity	Knows who owns the plan	**Disposition**	Continue, revise, refer, discharge

TEN ANCHOR ARTICLES AND EXTRACTED DATA

Set	Citation	Model	Key reported data
1	Pryzbylkowski 2015	Pain Medical Home	Care coordination + outcome tracking
2	Choinière 2017	Quebec Pain Registry	6,902 patients; baseline + 6 mo
3	Bell 2020	Ottawa stepped care	8 tiers; reported elimination of program wait
4	Connolly 2022	Resident clinics review	Continuity linked to selected outcomes; evidence heterogeneous
5	de la Calle 2023	Interventional Delphi	24 panelists; 88.4% item consensus
6	Burch 2024	Continuity review	19 studies; majority linked continuity to ≥1 outcome
7	Ahmed 2024	Integrated LBP care	n=464; ≥60% meaningful pain improvement
8	Huang 2025	Neurostimulation pathway	88% adherence; 77% reached ODI or NRS MCID
9	Breugelmans 2025	Outpatient IMPT	n=2,309; effects sustained at 12 mo
10	Saleem 2025	Long-term IPP follow-up	n=174; 56.9% reduced analgesic use

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Clinic framework: named dyad · follow-up booked before discharge · weekly exception review · structured handoff · monthly continuity dashboard

Final 88 + 5 refs **Full 300 records** **PRISMA-ScR flow**