

INTRODUCTION

1 in 4 Ontarians (2.5 million) do not have a family physician ¹

33% of ER visits (2.2 million) could be managed by primary care ²

\$360 million annually in healthcare costs from non-emergency ER visits ³
Author calculation based on Ontario Auditor General and CIHI data

Family physician burnout tripled from 2020 to 2021 ⁴

51% of family physicians work beyond desired capacity

65% of family physicians were planning to leave the profession or reduce working hours by 2028 ⁵

The Challenge: Expanding Attachment Without Further Increasing System Strain

Access to timely, continuous primary care remains a persistent challenge across Ontario, with millions of Ontarians lacking access to a family physician amid growing workforce shortages, an aging population, and increasing rates of chronic and complex disease. Efforts to improve patient attachment are further constrained by limited provider capacity, contributing to prolonged wait times, fragmented care experiences, increased emergency department utilization, and diminished patient and provider satisfaction.

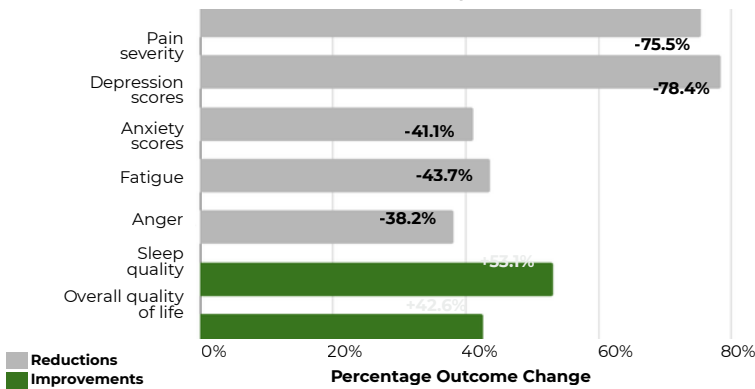
At the same time, there is growing need for scalable, team-based models of care that can improve access, continuity, and patient engagement without increasing strain on already overburdened primary care teams.

The Opportunity: A Scalable Model for Attachment & Continuity of Care

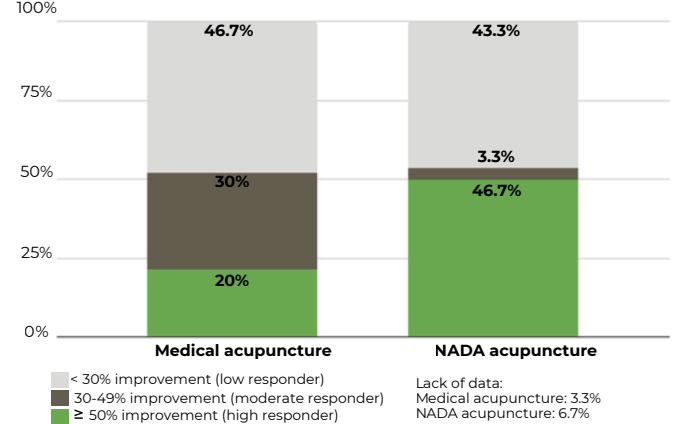
Community acupuncture offers a scalable, cost-effective model that supports high-volume, low-barrier access to care, particularly for underserved and marginalized populations. Chronic pain and mental health conditions often require frequent follow-up that is difficult to sustain within primary care without increasing provider strain. Integrating a Registered Acupuncturist or Traditional Chinese Medicine Practitioner within the Neighbourhood Health Home model expands team capacity by providing additional integrated care pathways for patients requiring frequent supportive follow-up. By providing patients with a consistent point of contact within the care team, this model supports patient attachment, continuity of care, and therapeutic engagement to expand service capacity without proportionally increasing system burden.

EVIDENCE AT A GLANCE

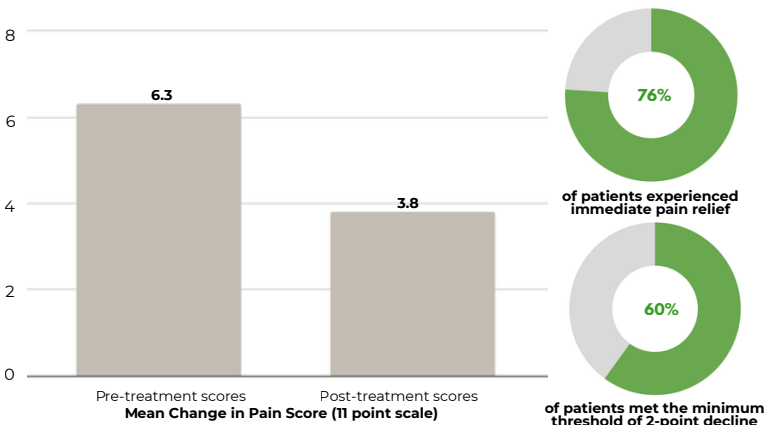
Outcomes Associated with ≥12 Acupuncture Sessions ⁶



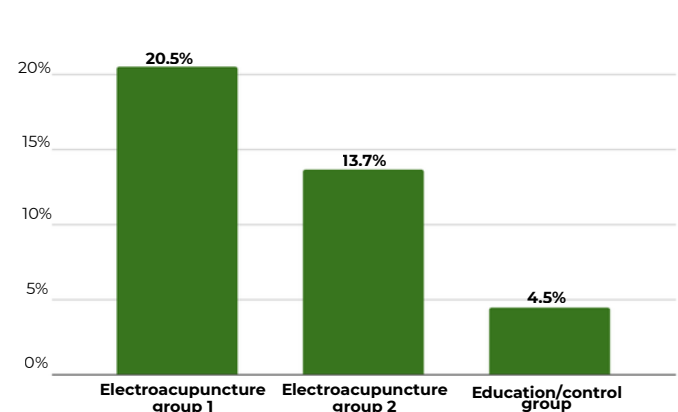
Distribution of Pain Reduction Following Acupuncture - ΔNRS ⁷



Battlefield Acupuncture: Pre & Post Treatment Pain Scores in Veterans ⁸

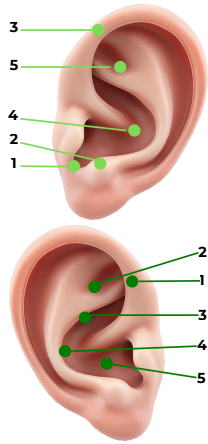


Percent Reduction in Opioid Dosage Following Electroacupuncture ⁹



SCALABLE ACUPUNCTURE PROTOCOLS FOR INTEGRATIVE PRIMARY CARE

Standardized auricular acupuncture protocols such as Battlefield Acupuncture (BFA) and the NADA protocol have emerged as scalable interventions within integrative care models. Due to their rapid application, low cost, minimal equipment requirements, and suitability for high-volume and group-based delivery, these protocols support low-barrier access to care in resource-constrained healthcare settings.



Battlefield Acupuncture (BFA) was developed in 2001 by Dr. Richard Niemtzow for the rapid management of acute and chronic pain. Originally designed for use in military settings to provide fast, low-resource pain relief in combat and field environments, the protocol has since been integrated into Veterans Affairs and civilian healthcare settings. BFA utilizes five auricular points applied sequentially: **1. Cingulate Gyrus, 2. Thalamus, 3. Omega 2, 4. Point Zero, and 5. Shen Men.**

The National Acupuncture Detoxification Association (NADA) protocol originated from the Lincoln Detox program in the South Bronx during the 1970s heroin epidemic. It was driven by grassroots health activism involving the Black Panther Party and Young Lords, and was initially utilized in addiction treatment settings to support substance use recovery, withdrawal and detoxification symptom management, stress and emotional regulation, pain management, and overall wellbeing. The protocol utilizes five auricular points: **1. Sympathetic, 2. Shen Men, 3. Kidney, 4. Liver, and 5. Lung.**

IMPLEMENTATION & EARLY OUTCOMES OF ACUPUNCTURE WITHIN PRIMARY PAIN CARE

In January 2026 an auricular acupuncture program was implemented within Afiya Spine & Pain Institute in downtown Toronto through collaboration between family medicine, psychiatry and traditional Chinese medicine health care providers. The program emerged following interdisciplinary relationship-building efforts initiated by TCMO member Meaghan Kleovoulos, R.Ac R.TCMP, and was incorporated into an existing multidisciplinary pain program led by family physician Dr. Elle Surgent and physiatrist Dr. Monty Sawalha. The program operates within the clinic's recovery room outside of regular patient hours.



Patients with chronic and complex pain conditions are referred primarily through physician intake and participate in no-cost group-based auricular Battlefield Acupuncture (BFA) sessions funded by the clinic. Sessions also incorporated breathwork, gentle movement, dimmed lighting, and 30–45 minutes of guided relaxation. Program cycles ranged from six to eight weeks, with optional attendance up to twice weekly. Group sizes averaged 7–10 participants due to space limitations, with strong retention and attendance observed throughout the program. Preliminary patient feedback described improvements in pain management, relaxation, sleep, and overall wellbeing, as well as a reduction in the use of pain medication. PROMIS questionnaires were utilized for longitudinal outcome tracking, including post-program follow-up assessments, with final outcome analysis ongoing.

Dr. Surgent reported that integrating acupuncture into the clinic enhanced therapeutic alliance, improved patient engagement and satisfaction, expanded available treatment options for physicians, and helped increase clinic capacity by directing appropriate patients toward supportive group-based care. She further noted the potential for integrated acupuncture services to benefit patients, providers, and the broader healthcare system through improved resource utilization and non-pharmacological pain management support.

Chronic pain and mental health patients often require ongoing and frequent follow-up beyond what is feasible within physician and nurse practitioner schedules alone. This pilot program demonstrates how integrating acupuncture within primary care teams can expand access necessary for these and other patients with complex needs. Delivered in a low-cost, group-based setting, this model supports scalable, low-barrier access to care while strengthening patient attachment, therapeutic engagement, and clinical capacity without proportionally increasing demand on primary care providers.

“We believe that having acupuncture as a part of the primary care team would benefit many patients, the physicians, and the medical system in Ontario. These benefits would range from patient outcomes, patient satisfaction, physician time, physician satisfaction, and health care system usage/resource management.”
— Dr. Elle Surgent, MD

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