



Model of Care for Chronic Pain Management in South Australia

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Introduction

In late 2014 SA Health began a process to develop a Model of Care for Chronic Pain Management in South Australia. A Steering Committee comprising consumers, GPs and GP representative organisations, Specialist Physicians and their representative organisations, allied health providers in primary and tertiary care settings, Primary Health Care organisations, PainAustralia and SA Health service planners was established to guide this work, which has been informed by the Australian National Pain Strategy, the NSW Pain Management Report and published models of care from interstate and overseas.

In parallel with this process SA Health was progressing with the development of the Transforming Health reform agenda which was endorsed by Government in March 2015.

It is intended that the Model of Care for Chronic Pain Management in South Australia will become one of a suite of models of care developed to drive implementation of Transforming Health.

In South Australia (SA) services for people experiencing chronic pain are limited. The current services have struggled within available resources to meet the changing needs of the SA population and to respond in a planned way to the changing evidence in relation to the best way to manage this condition.

As a result, long wait times and poor access are experienced by South Australians needing the support of secondary and tertiary services to manage their pain. Lack of access is particularly acute for children and young people, people living in regional and rural SA as well as other groups in the community including people with a disability and those in nursing homes. Currently South Australia has the longest wait list time for tertiary services in the country.

Evidence suggests that up to 80 per cent of people living with chronic pain are missing out on treatment that could improve their health and quality of life¹. Inconsistent models of care across the system and a poor understanding of treatment options in the primary health care sector mean that there could be more people than reported with chronic pain in the community.

Consumer comment

“It took 4 years of searching to find adequate multidisciplinary pain management. Being taught how to manage pain is vital. There appears to be a lack of knowledge of chronic pain and its behaviour both within the healthcare system and among the general public”

¹ Henderson JV, Harrison CM, Britt HC, Bayram CF and Miller GC “Prevalence, Causes, Severity, Impact and Management of Chronic Pain in Australian General Practice Patients” Pain Medicine 2013

Compared to other jurisdictions, SA has an older and ageing population and demonstrates increasing need for pain services. In the primary sector, GPs advise that chronic pain is in the top 3 conditions that they manage.

Other jurisdictions have introduced new models of care and pathways that have achieved marked reduction in waiting list times, better patient outcomes and increased service capacity.

The model of care described in this document seeks to address these issues.

The Current Context

Research has advanced the understanding of pain, its causes, manifestations and approaches to management. It is now understood that changes in the central nervous system may result in pain persisting beyond the time it takes for tissue damage to heal, sometimes due to inadequate management of acute pain immediately after surgery. In these circumstances, early recognition provides an opportunity for intervention to prevent the transition from acute to chronic pain conditions. Chronic pain may also be associated with a number of chronic conditions such as arthritis, multiple sclerosis and cancer, and a number of conditions where there is no identifiable origin such as low back pain and fibromyalgia.

Recognising chronic pain as a chronic condition in its own right has been identified as a key step in achieving appropriate approaches to care and management at the primary, secondary and tertiary level. Recent evidence suggests that chronic pain has its own underlying disease process – maladaptive changes to the nervous system which requires an integrated response similar in design to the models of care shown to be successful in managing other chronic diseases.

Outside of the tertiary pain services in SA the understanding of chronic pain and the evidence in relation to the best approaches to management is variable. Stigma remains strong in the community particularly in relation to those whose conditions appear to have no identifiable causes. People with chronic pain often experience scepticism from family and friends, and difficulty in finding health professionals with the knowledge and experience to support them to manage the condition. In these circumstances more people than should be are referred to the tertiary services rather than being effectively managed in the community and by primary care. At the same time, some people who could benefit from management by Tertiary services are not referred because of lack of accurate diagnosis of their condition or mistrust on the part of the primary care provider that the condition is genuine. As a consequence current tertiary services are overwhelmed and some of those most in need of these services go without.

The following factors have been shown to maximise positive outcomes for people experiencing chronic pain and have guided the planning:

- Prompt, appropriate and targeted care processes for the evidence-based management of acute and chronic pain

- Screening and appropriate referral for those at risk of needing secondary and tertiary intervention (see Glossary for definition of secondary and tertiary based care)
- Use of multimodal therapies, including cognitive-based programs that build self-management capacity among those who experience chronic pain
- High-intensity rather than low-intensity care processes for chronic pain management.

Transforming Health

Consistent with Transforming Health the Model of Care described in this document envisages a response for people experiencing chronic pain which is fully integrated across the community, primary, secondary and tertiary sectors in order to ensure that in the future the population of South Australia can access the best care, first time, every time.

The following Transforming Health Clinical Standards of Care inform this work:

Overarching system standards

1. Every South Australian has an equal right to access quality healthcare. This means specific groups may need to be targeted for affirmative action to ensure their needs are met, this includes: veterans, frail and elderly, those with mental health needs, the disabled, children, those with eating disorders, LGBTIQ people (lesbian, gay bisexual, transgender, intersex and queer) and Aboriginal and Torres Strait Islanders. All aspects of care should be patient centred and focus on quality outcomes. This includes service design, delivery and evaluation, supported by research and teaching.
2. Health literacy should be promoted in the general population.
3. A holistic approach should include individual patient preferences and involve partnerships between patients, their families, service providers including multidisciplinary professional practices and primary and community healthcare organisations.
4. Patients, their families and care-givers should be actively involved in decision making.
5. Consumers have a right to information, data and reporting that is relevant to them. All information and test results should be shared with patients and they should be advised of all options for treatment and treatment setting.
6. Patients have a right to dignity and respect at all times. Patients should be able to express their wants and needs, or complain, without fear of retribution. Their privacy must be respected. There is zero tolerance of all forms of abuse.
7. Efforts to continually improve the health system should have clinical leadership and promote multidisciplinary clinical engagement and teamwork.

8. Care should be delivered in the right place, by the right person, the first time and every time.
9. Health care is provided by the most cost effective health worker whilst ensuring quality and safety standards are met.
10. Care should be delivered in the most appropriate cost effective venue as close to home as safely possible.
11. Quality care should be determined by patient reported outcomes, patient clinical outcomes and system outcomes.
12. Agreed and uniform reporting related to patient outcomes should be made accessible to health agencies and clinical care delivery staff. There should be consistent data recording, coding. Measurement and accounting, developed by clinicians in partnership with SA Health.
13. Hospitals should all participate in morbidity and mortality reviews and use them as a learning exercise to improve quality of care.
14. Electronic systems should be used to track care pathways and collect information about key milestones to support audit, research and quality activities.
15. Information should follow the patient through the care continuum. For example, through the Personally Controlled Electronic Health Record.
16. Healthcare services should be offered seven days a week, every week. Human and infrastructure resourcing should be aligned to achieve this.
17. There should be seven day a week access to allied health and other clinical support.
18. All services should be culturally and linguistically appropriate.
19. Practice should be evidence-based where sufficient evidence, or evidence based guidelines exist. Where a new practice has been demonstrated to be successful, it should be replicated across the entire system, replacing superseded practices.
20. Effective and efficient models of care should be regularly updated and replicated across the entire system.
21. Each presentation should follow a defined end-to-end patient pathway consistent across the state. Patients may require more than one pathway for multiple diagnoses, or if they belong to a group with identified special needs. Care should be delivered against this pathway, with protocols in place to ensure continuity.
22. Clinical pathways should be developed by a multidisciplinary team and should be diagnosis or procedure specific rather than doctor specific. They should specify outcomes to be achieved, relevant timelines and should incorporate discharge planning principles.

23. Principles, protocols, pathways and procedures are state-wide, and should include telehealth and patient transfers where necessary. This can be facilitated through coordination of services across multiple sites including across Local Health Networks (LHNs) and state-wide networks.
24. There should be consistent documentation of policies and procedures to ensure safe, appropriate, accountable, effective and measureable improvement in patients and their quality of life.
25. All policies and procedures are living documents and should be updated regularly and as required by advances in evidence.
26. Technology should be used to its maximum extent to provide more effective care when appropriate. For example, shared electronic health records, tele-health, phone or SMS follow up, and SMS based appointment reminders. Tele-health should be made use of to support patient assessment if distance is a potential issue.
27. Agreed pathways and protocols should be followed by all clinicians and unnecessary duplication should be avoided. All practitioners should engage in continuous professional development, including best implementation of patient pathways.
28. Appropriately credentialed practitioners should be able to make referrals in accordance with patient pathways, including nurse and allied health referral to specialists.
29. Models of care should include escalation policies if deviation from accepted pathways is required
30. Governance and accountability structures for adhering to principles and meeting targets should be in place, with ongoing change management.
31. Clinicians should adhere to and report on the National Safety and Quality Health Service Standards.
32. Practitioners must be adequately trained and credentialed for their scope of practice. There should be appropriate response mechanisms when practice is outside accepted norms.
33. Ongoing training and development opportunities should be available to all staff to ensure development and maintenance of a skilled workforce, including advancing teamwork and leadership skills.
34. Sufficient teaching, continuing education and research should be built in to all pathways; research and development activities should facilitate continuous improvement of services. Research and training programs should evolve to fit new models of care.
35. Admission pathways need to be clearly defined and communicated to the public.
36. Admitted patients should be seen within a specified time period, pre-defined by presentation, risk-profile and age.

37. Delayed discharges should be routinely reviewed with action taken to address any identified problems.
38. Multidisciplinary criteria- led discharge should be established. Diagnostic and therapeutic support should be readily available for all disciplines to use when appropriate.
39. Referrals should be pathway based not directed to individual specialists, for example a patient with congestive cardiac failure should be referred to the congestive cardiac failure service.
40. There should be a consistent step by step process for developing a resuscitation and care plan for clinical decision making for patients near the end of their lives.
41. All patients (and relevant support persons) should be actively engaged in developing care plans and end-of-life plans. Advance Care Directives should be in place.
42. Administrative and managerial support should be available 24 hours every day.
43. Discharge planning for potentially long-stay patients should be proactively managed from admission.
44. Rehabilitation should be started immediately post-operation.
45. Hospital should be the last resort for patients: admissions and presentations to emergency departments should be minimised with alternate models of care, chronic disease pathways and palliative care.
46. Systems should be in place to ensure continuity of care along the patient pathway without gaps.
47. The skill mix and number of staff in health care should be matched with the needs and flow of patients.
48. Acute patients requiring inter-specialty input should be seen by those specialists in a timely manner.
153. The GP and the specialist clinic (outpatient service) work in partnership to share the care of patients with complex and chronic conditions.
154. Patients with chronic disease should be risk stratified with interventions targeted appropriately. Chronic disease follow-up should be by the most cost efficient, fully qualified person, such as a nurse practitioner where appropriate.
155. All patients with a chronic disease should have a self- care plan, supported by appropriately qualified staff.
156. There are effective processes in place to support the transition of care between specialist clinics and community based care.
157. There should be mechanisms for streamlined re-entry to the clinic for

Specific clinical standards which guide the chronic pain model of care development include:

the same problem once a patient has been discharged.

158. During the telehealth consultation, the main focus needs to be on direct communication with the patient

rather than communicating with the clinician. However, it is recommended that a staff member must always be present at the patient end of a telehealth consultation.

Our Aims

The key aim of the Model of Care for Chronic Pain Management in South Australia is to improve the delivery of pain management services to South Australians by:

- Implementing a best practice model of care for South Australia to improve pain outcomes and quality of life
- Increase the knowledge of the community to reduce unnecessary suffering
- Deliver programs and services so people with chronic pain can self-manage their condition and ease the frequency and burden of chronic pain.
- Deliver services that are integrated across the continuum of care and promote smooth transitions between the care settings that exist along that continuum
- Provide treatment options that are consistent with clinical evidence and promote these options across all health care sectors
- Provide easy access to specialist advice for primary health care to better manage people with chronic pain
- Provide sustainable programs that provide equity of access to specialised services
- Foster an environment of excellence in service delivery through supported workforce training, research and development.

The model of care will deliver:

- A state-wide referral pathway to improve access to services and reduce waiting list times.
- Improved integration of interdisciplinary care and services across all levels
- Improved operational capacity
- A blueprint through which to improve collaborative and effective working relationships between the primary, secondary and tertiary health systems, particularly in regard to planning future services, data collection and reporting.
- Greater awareness by consumers and health professionals about chronic pain, treatment options and how to access services.

Vision

A health system that provides:

- A patient-centred approach to treatment and care of chronic pain
- Consistent and equitable access to services across the system
- Best practice care for chronic pain management including a reduction in waiting list times and improving the quality of life for people in South Australia.

Planning Principles

A set of principles guided the development of this service plan.

1. A moral imperative. Effective pain management is a moral imperative, a professional responsibility, and an ethical issue for the community.
2. Patient-centred. The needs, values and preferences of patients and their families must be at the centre of pain services and programs. Programs and services will be developed in partnership with patients and their families and be responsive to their needs.
3. Paediatric services. Chronic pain can occur at any age and requires age appropriate services. In addition to multidisciplinary services children and young people require systems that address their particular developmental and educational needs.
4. Cultural competence. Care should reflect the diversity of the population and the individuality of the patient's needs, cultural and religious values, preferences and beliefs.
5. Wider use of existing knowledge. Substantial numbers of people suffer unnecessarily, including through being stigmatised. There is much to be learned about pain and its treatment including using existing knowledge more effectively and efficiently.
6. Chronic pain can be a disease in itself. Chronic pain has a distinct pathophysiology, causing changes throughout the nervous system that often worsen over time. It has significant psychological, cognitive and environmental correlates and can constitute a serious, separate disease entity.
7. Partnership. Reducing the burden of pain on individuals, families, carers, communities and society requires partnerships between clinicians, patients, government and health authorities, insurers, educational institutions, community partners and industry.
8. Roles for patients and clinicians. The effectiveness of pain treatments depends greatly on the strength of the clinician-patient relationship. Pain treatment is never about the clinician's intervention alone, but about the clinician and patient (and family and/or carers) working together.
9. Value of a public health and community-based approach. Many features of chronic pain lend themselves to public health approaches – the large number of people affected, disparities in occurrence and treatment and outcomes, and the goal of prevention cited below. Public health education can help counter the myths, misunderstandings, stereotypes and stigma that hinder better care.
10. Importance of prevention. Every effort should be made to prevent chronic pain through early intervention to minimise the severe impact chronic pain has on all aspects of sufferer's lives.
11. Comprehensive multidisciplinary approaches. Pain results from a combination of biological, psychological, and social factors and often requires comprehensive approaches to prevention and management.
12. Multidisciplinary assessment and treatment may produce the best results for people with chronic pain problems.
13. Research, Innovation and Evaluation. Care should be evidence-based. Continuous research, innovation and evaluation enables programs and services to improve quality and outcomes for people living with pain.

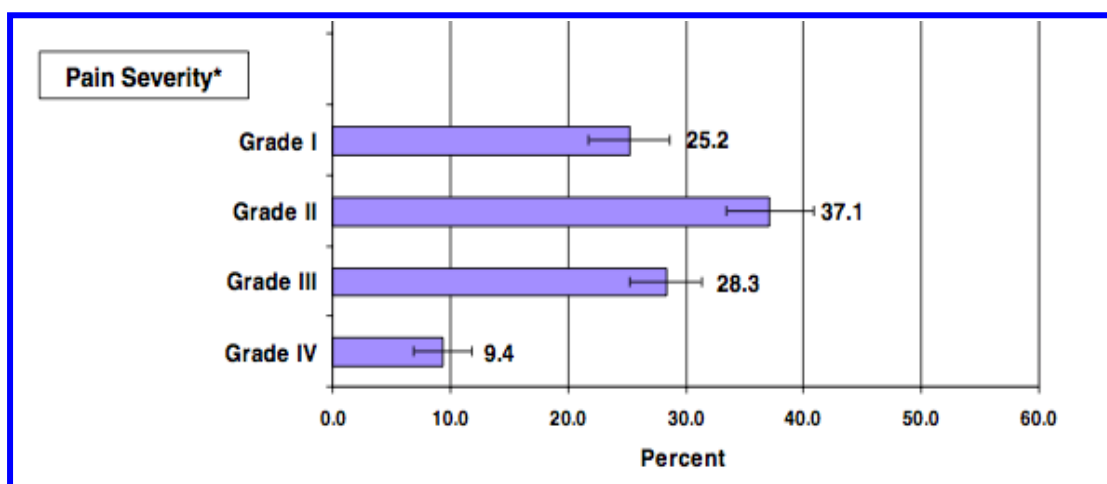
14. Abuse, dependence and diversion are recognised risks associated with the use of opioid drugs and the value of prolonged opioid use is uncertain. However, opioids may be safe and effective, particularly for acute, post-operative and cancer pain, if appropriately prescribed, used and monitored.
15. Integration across the continuum. Pain services should be coordinated and seamless throughout the service system (including home, community, general practice, hospital, residential aged care, palliative and rural and remote care).
16. Sustainability. Sustainable programs and supports for people living with pain can be achieved through the dedication of appropriate resources, the redesign of existing services, the ongoing professional development of Health Care Professionals and the use of effective, efficient and innovative models of treatment and support.

Understanding Pain

Pain Severity

The diagram below, taken from a study in 2013 involving 197 GPs and 5,793 patients from across Australia, illustrates the categorisation of pain used to assist in determining appropriate approaches² with Grade 1 signifying the lowest severity and Grade 4 the highest.

Diagram 1: Severity of chronic pain – chronic pain grades



Grade 1 and 2 – low disability, low or high intensity

Grade 3 and 4 – high disability, moderate or severe limitation

Social and economic cost of chronic pain

Chronic pain is the leading cause of long-term disability in Australia and the major cause of forced workplace retirements leading to lost productivity, reduced taxation revenue and the need for welfare payments. Arthritis and back problems, both associated with chronic pain are the most common causes for people of working age (between 45-64) to drop out of the workforce, accounting for 40% of forced retirements. The lost workforce due to arthritis and back problems alone is estimated to have cost the economy over \$4 billion in 2007.³

The MBF Foundation report *The High Price of Pain*, conducted by Access Economics using epidemiological data from the University of Sydney Pain Management Research Institute, estimated the cost of chronic pain in Australia in 2007 to be \$34.3 billion, or \$10,847 for each person affected.

The report found that:

- In 2007, around 3.1 million Australians (1.4 million males and 1.7 million females) were estimated to experience chronic pain. The prevalence in children and adolescents is the same as adults.

² Henderson J., Harrison C., Britt H., Bayram C., and Miller G., Prevalence, Causes, Severity and Management of Chronic Pain in Australian General Practice Patients. *Pain Medicine* Vol 14, Issue 9 2013

³ Painaustralia. Pre-Budget Submission 2015-16

- The number was projected to increase to 5.0 million by 2050 as Australia's population ages.
- The high cost of chronic pain was a result of both high prevalence and high impact: that is, chronic pain is common, and it has a substantial effect on quality of life and productivity.
- Productivity costs comprised \$11.7 billion, or 34 per cent, of the annual total.
- Fifty-five per cent of the total cost of chronic pain was borne by individuals with chronic pain. The next largest share was borne by the Federal Government (22 per cent), and the remainder by State/Territory Governments (5 per cent), employers (5 per cent), family and friends (3 per cent), and society (10 per cent).
- Patients with chronic pain disorders often have complex presentations which include pain overlapping and interacting with other chronic health problems (cardiovascular, musculoskeletal, inflammatory diseases, etc.) as well as additional psychological and social comorbidities.
- The report estimated that half of these costs could be saved with the provision of timely, best practice pain management services.

Pain Management

The literature related to the management of pain reflects the need for more effective management of pain, particularly for those who experience chronic pain. This necessitates a model of care which is inclusive of, yet far broader than, the traditional, biomedical approach which focuses on 'curing' pain. There are examples of comprehensive approaches to pain management in Australia and internationally and increasing consistency in the attributes of these models. The emergent models:

- recognise the interaction of biological, psychological and social factors in the experience of and response to pain and aim to provide a suite of interventions and therapies to address these;
- align to the principles of health promotion and prevention, early assessment and intervention;
- are directed toward developing greater self-management of chronic pain;
- necessitate a strong community and primary care sector;
- are multidisciplinary and operate across the interfaces of among population health; primary care and community health; and acute health sectors;
- provide specialised pain services for those who have need for these in inpatient, outpatient and outreach services;
- are increasingly oriented toward seeking to determine outcomes for both patients and the health system as a whole; and,
- are informed by the best available evidence, including expert opinion.

Prevalence in SA

The most recent prevalence study done in South Australian in 2010⁴ showed that:

- The prevalence of chronic pain is 17.9% of the overall population.
- 5% of people have severe pain that interferes with daily activity.
- Chronic pain was associated with older age, living alone, lower income, not being in full-time work and lower educational levels.

This study highlights the high levels of pain with extreme effects on day-to-day life (one in 20 people), the complex inter-relationship of the factors including educational achievement and work status associated with chronic pain, and the impact that these factors have on the people experiencing disabling pain in the longer term.

Based on SA population, approximately 250,000 people experience chronic pain, of these approximately 70,000 have severe pain requiring input from a tertiary chronic pain service. Approximately one in ten of these patients experience pain related to cancer. There are around 3,000 new cases referred to chronic pain services each year.

Future Demand

In 2010, 17.9% of the South Australian population was found to suffer from chronic pain with 5% of people having severe pain that interfered with daily activities. The majority of people rely on primary health care services with a relatively small number accessing hospital services.

However, the exact number of people that present to hospital emergency departments with chronic pain is difficult to measure due to difficulties in interpreting coding which also describes other underlying conditions.

SA Health is experiencing significant demand for pain management services with waiting lists reported to be at least 180 days, the longest in the nation.

The management of chronic pain is complex and patients require multi-disciplinary care for successful management. Whilst the majority of care should be performed in primary health care there needs to be good integration with the tertiary sector to allow for timely expert advice and recommendations that may prevent a number of specialist referrals.

Because chronic pain is an ongoing condition for the patient, education and coping mechanisms are an essential component for better self-management. Clinical evidence is changing and shows long-term use of opioid medication is not beneficial in the management of chronic pain and may, in fact, be more damaging. Evidence shows psychological support improves patient quality of life and service models need to reflect these clinical findings.

The recently released Australian Atlas of Healthcare Variation (2015) highlighted the high prescribing of opioid medications in South Australia generally and in two regions in particular – Playford in Adelaide's northern suburbs as well as on Yorke Peninsula. It suggests that prescribing primarily relates to lack of availability of options for assessment and management, and recommends that access to nonpharmacological pain management services would save significantly on PBS spending

⁴ Currow D, Agar M, Plummer JL, Blyth FM and Abernethy AP, 2010. Chronic pain in South Australia: population levels that interfere extremely with activities of daily living. *Aust NZ J Public Health* 34(3):232-239.

and have the potential to provide better health outcomes. It also recommends increased use of Telehealth to enhance rural and remote management of chronic pain.

As demand for current pain specialist services increases due to the better recognition of chronic pain and as patients presenting to General Practitioners have more complex symptoms, patient waiting times are likely to only get longer.

The key challenge is to deliver patient-centred health care for people with chronic pain that maximises their function through better access to a range of general and specialist health care services.

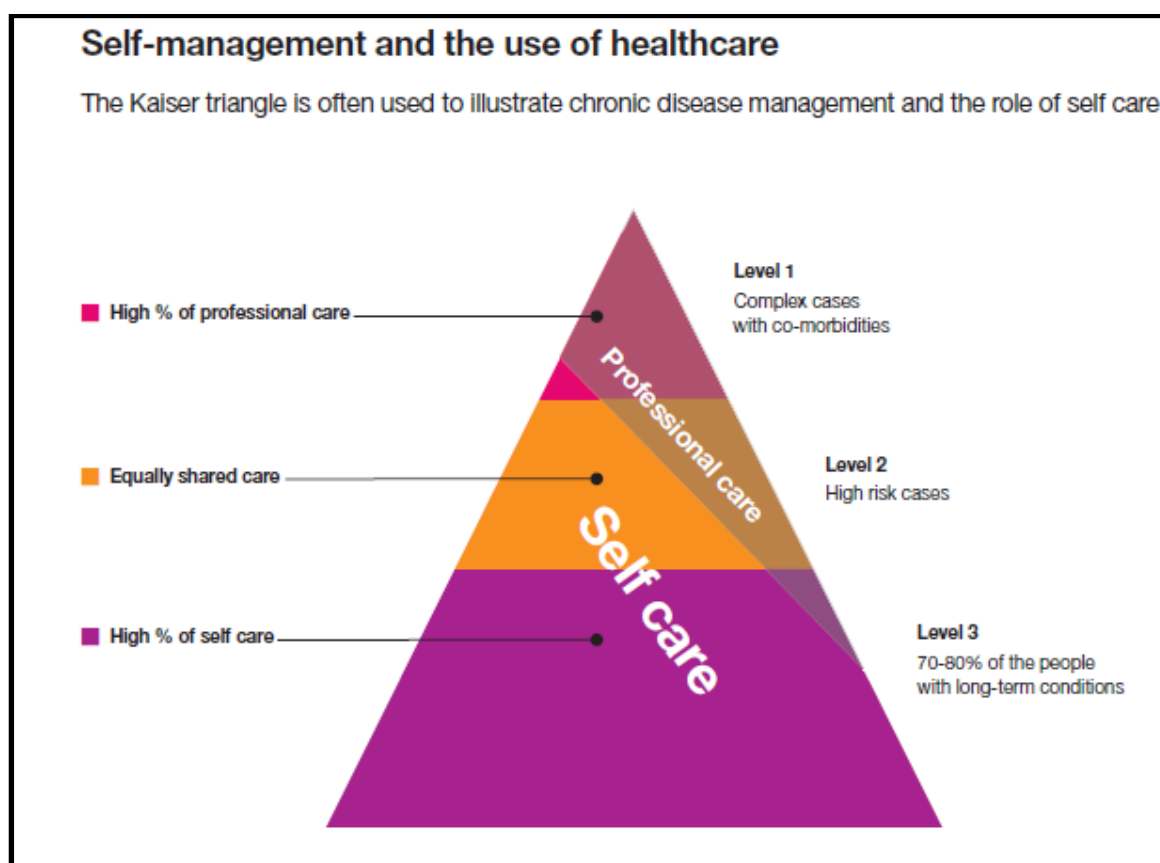
Current patient experience of services in South Australia

Services in South Australia are limited and consumers regularly report difficulties in identifying health care providers within primary care services with appropriate knowledge, experience and skill in identifying and managing their chronic pain.

Clinicians in the tertiary sector struggle to balance the demands on their time and are often torn between providing self-management development sessions to consumers, education and training to GPs, consultation and liaison to support colleagues managing patients within the acute hospital, support for palliative care services as well as direct patient care .

The 'Kaiser triangle', developed by Kaiser Permanente and based on diagram below illustrates the ideal balance of services to support the needs of people with chronic pain.

Diagram 2 – Kaiser Triangle



Primary Care

The majority of chronic pain is managed in the primary care sector with General Practitioners responsible for patient care. The number of GPs with a specialist interest in the management of chronic pain is relatively small. In SA a GP focus group involved in an SA pain project ⁵ estimated that 25% of their patients experienced chronic pain and that chronic pain represented 25% of their workload.

⁵ South Australian Collaborative Pain Project 2005-2008 SACoPP

The major findings of this project found some GP responses to treating chronic pain to be as follows:

- **“not rewarding, not satisfying” in 75% of GPs**
- **“we don’t have the time or resources”**
- **“there’s no point referring – waiting lists are too long”**

Tertiary and Secondary Services

In the metropolitan area services are provided in Central Adelaide Local Health Network (CALHN) by a unit based at Royal Adelaide Hospital (RAH), and in Southern Adelaide Local Health Network by a unit based at Flinders Medical Centre (FMC).

There are no discrete services at Northern Adelaide Local Health Network (NALHN), Women’s and Children’s Health Network (WCHN), or Country SA Local Health Network (CHSALHN).

The established services provide both secondary and tertiary level services as well as provide support, when possible, to LHN’s who do not have dedicated services. For example, outreach services of a very limited nature are provided by CALHN to NALHN and CHSALHN.

In some circumstances these services are funded via CHSALHN or the Commonwealth Government via Rural Doctors Workforce Agency and are delivered by staff from the CALHN service at RAH.

The current services provide different models of care with the RAH providing a psychosocial focussed service and SALHN a more interventional program. These different service models may result in a variation in care depending on where the patient is referred /treated.

Access

South Australia has the longest wait time of any Australian State or Territory as can be seen in Diagram 3⁶ below. Referral to chronic pain specialists in the tertiary setting have been increasing for several years forcing a rethink to the service model provided.

Diagram 3 – Waiting times for chronic pain services

		Waiting time (days)		
		Median	Range	Interquartile range
2 Waiting times for initial assessment for a non-urgent adult outpatient referral to a persistent pain service				
Total pain management services				
National	57	103	10–575	44–210
SA	4	180	42–420	69–366
Vic	16	112.3	25–370	63–173
Tas	2	120	30–210	
NSW	17	70	14–365	43–230
ACT	3	70	10–241	
Qld	8	105	30–575	38–343
NT	2	106	14–120	
WA	5	56	21–365	33–258

⁶ M Hogg et al MJA 2012

Rural Services

RAH Pain Management Unit (PMU) receives referrals from rural South Australia, western Victoria and western NSW, with 40% of referrals from these regions. Northern Territory Health has contracted Central Adelaide Local Health Network to provide specialist pain medicine outreach services to Darwin and Alice Springs to address demand in the Northern Territory.

Rural Doctors Workforce Agency funds outreach pain medicine services to Whyalla Hospital with 11 day-visits per annum since 2006. Referrals are sent to RAH PMU, triaged according to urgency and severity and allocated for consultation and review in outpatient facilities at Whyalla Hospital.

Attendance rates for appointments in Whyalla are very high compared with those for country patients at RAH with travel costs and condition-related travel-burden much reduced. Pain medicine clinician engagement with local general practitioners and allied health services as well as peer led self-management programs has enabled improved delivery of patient-centred chronic pain management plans and outcomes.

General practitioner support for this service is high with up to 10 new patient referrals per month from mid-and upper Eyre Peninsula and the upper Mid North regions with Whyalla and Port Augusta most common.

Existing services in Whyalla Hospital include substantive capacity for Tele-health consultation clinics for patient reviews and a proposal has been developed which seeks fortnightly clinics to review up to 6 patients per clinic at Whyalla Hospital outpatient department. Essentially, face-to face consultations would continue for new referrals with follow-up via tele-health which would allow more patients to be seen and impact on Country Health SA's waiting list.

It is envisaged that future clinics will be set up at Port Augusta Hospital with potential for involvement of other SA Health country tele-health sites.

Access is a particular issue for country residents, where they are currently referred to a metropolitan service or rely on a visiting pain specialist to attend country clinics. There is only limited use of Telehealth facilities. There is also a paucity of trained allied health staff with relevant scope of practice particularly in the country.

Workforce

The current size of the service and workforce in the recognised services is small and with increasing demand on the system a new approach is required. A change in the service model for chronic pain at the Fremantle Hospital has shown a reduction in outpatient waiting time from more than two years to less than two months and a four-fold increase in capacity.

Expansion of roles to include nurse practitioners and expert allied health resources will assist in delivering the most effective models of care into the future.

Private Service Providers

A significant component of services are provided by private practitioners particularly for patients covered by workers compensation or other third party payment arrangements such as for motor vehicle accidents providing expertise in injury management and rehabilitation.

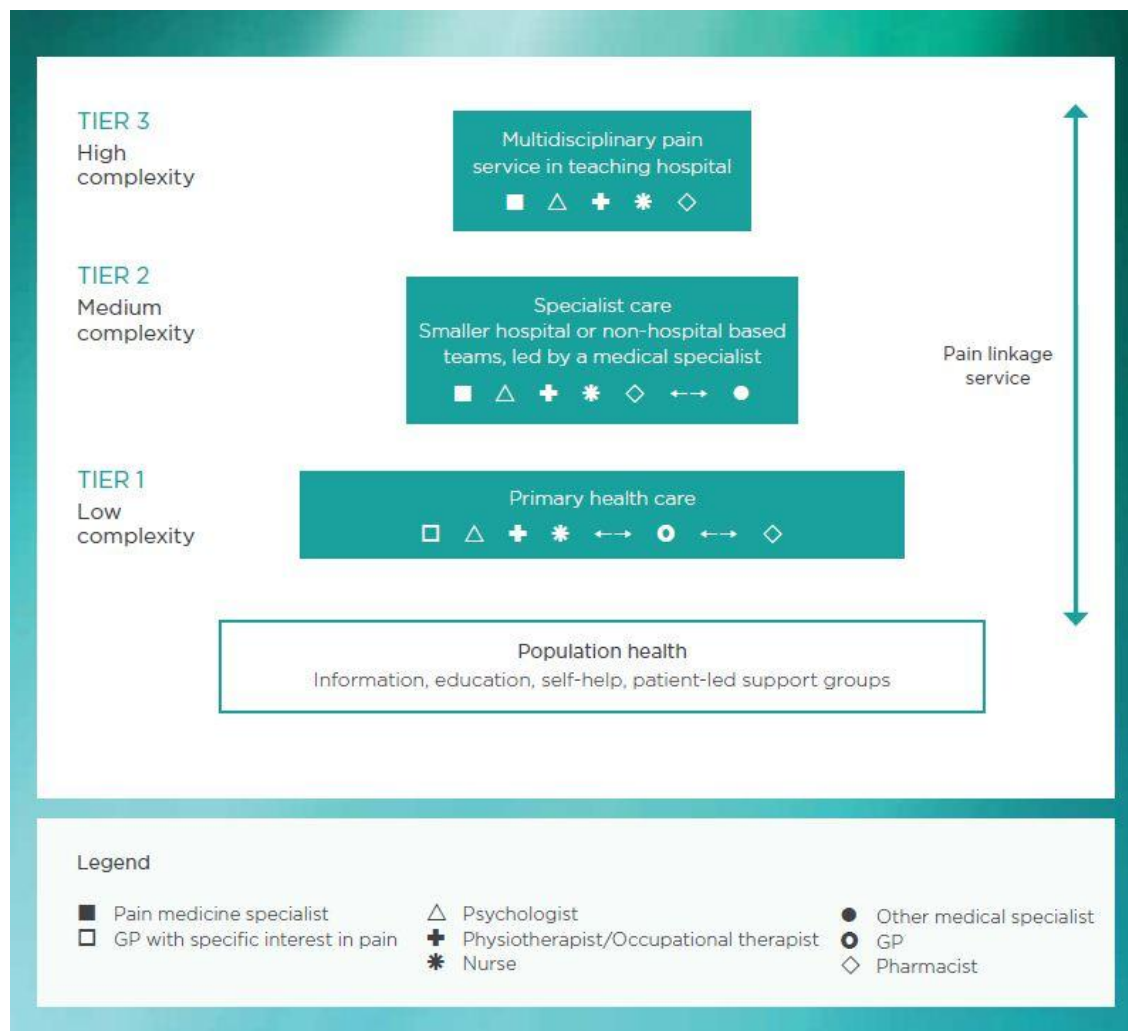
These providers include private pain specialists, psychiatrists and allied health practitioners, such as psychologists, physiotherapists, occupational therapists and occupational medicine specialists.

Model of care for chronic pain management in SA

The key strategy of the Chronic Pain Model of Care is the integration of services across the continuum with better access to pain specialist expertise and more focussed training for General Practitioners to better understand and treat chronic pain in the community setting.

The development of a Model of Care for South Australia has been informed significantly by the excellent work that has been undertaken elsewhere in Australia and overseas. The Steering committee has debated at length the applicability of these models to our local environment and it is clear that these models are very similar and that each has the same key components. The diagram below of the NSW Model of care has provided the basis for the SA model.

Diagram 4 – NSW Chronic Pain Model of Care



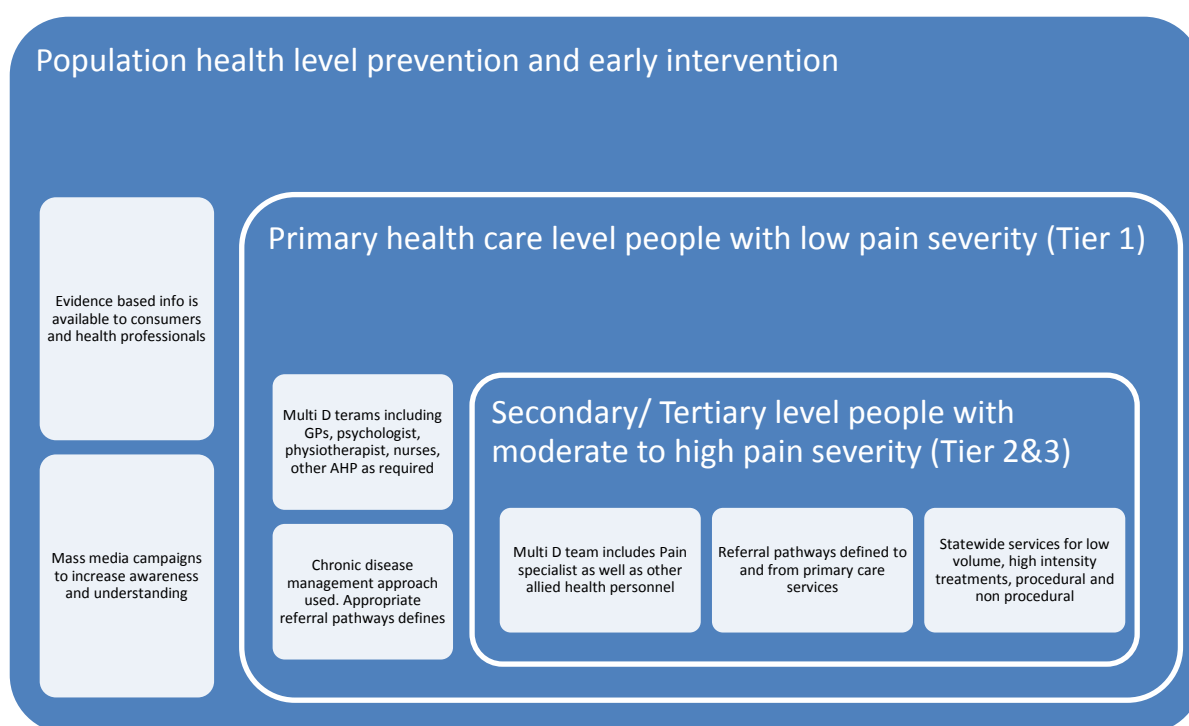
SA model of care

The development of the proposed model of care for South Australia has been overseen by the Chronic Pain Steering Committee with contribution from a broad range of stakeholders and draws on the model outlined in the National Pain Strategy and work completed particularly in NSW and WA specific to their systems.

The model below is an adaption and reflects the specific requirements and nature of the SA Health system. It is intended to guide planning and delivery of the services provided and funded by SA Health and as a guide for both the public and private sectors.

A stepped model of a care that reflects the approach utilised successfully for chronic disease management is recommended.

Diagram 5 – South Australia proposed Model of Care for Chronic Pain management



With a relatively small population compared to NSW the separation of Tier 2 and tier 3 services between General and Tertiary Hospitals is not warranted in SA. The diagram above indicates that Tier 2 and 3 services may be combined within Tertiary Services.

Specialist Services

Tertiary Chronic Pain Services cater to patients experiencing moderate to high severity pain based on the ACI NSW Agency for Clinical Innovation Guidelines. They provide assistance in the classification of patient complexity on initial presentation to a service as well as patients referred from cancer and palliative care services for specialised management of pain.

The services include:

1. Consultation and Liaison with

- **GP and GP with a Special Interest**
- **Specialist- Cancer, Palliative care, Rehabilitation, Rheumatology, Orthopaedics, Mental Health, Drug and Alcohol**

2. Assessment

Depending on the presenting condition the assessment may be undertaken by one or a number of members of the multidisciplinary team through sequential consultations followed by a combined case conference to achieve consensus regarding the approach. A case conference is held with the patient and their support person/s in order to agree the management plan.

3. Treatment and management

Treatment and management most commonly includes both a pain management program and a pain education program tailored to meet the needs of the individual as determined during the assessment.

- Pain management program – may include physical, psychosocial, pharmacological components.
 - Cognitive behavioural therapy
 - Mindfulness
 - Acceptance and commitment therapy
 - Physical therapy
 - Medication
 - Procedures
 - nerve blocks, epidural, guided sympathectomy under CT,
 - Implants – stimulators, pumps.
- Pain education program/s
 - A general overview of pain (science of pain)
 - Understanding and education in the evidence-based methods of chronic pain management
 - A series of interactive sessions with pain specialist and/or other members of the multi-disciplinary team with different sites offering a range of programs.
 - Goal/s of pain education program/s⁷ include:
 - To improve a patient/s understanding of chronic pain and its effects
 - To improve the level of physical functioning and promote return to daily living tasks
 - To modify perceived level of pain, disability and suffering
 - To provide coping strategies for dealing with pain, disability and distress

⁷ ACI NSW Agency for Clinical Innovation. Pain Management Programs April 2015

- To promote self-management
- To reduce or achieve appropriate future utilisation of healthcare services related to pain
- Prepare for discharge/maintenance of gains

Diagram 6 – Proposed service – SA Health



Adult services

The location of services provided at CALHN, NALHN and SALHN needs to be determined based on ease of access for patients and may be at a main location with in-reach to other sites. The services need capacity to service inpatient workload, including cancer and palliative care patients.

It is proposed that combined tier 2 and 3 services be provided by CALHN and SALHN and WCHN (sites to be determined), where Tier 3 is defined as provision of highly specialised procedural interventions or the most intensive interdisciplinary programs, while tier 2 services should be available in NALHN and CHSALHN. Appropriate pathways for referral and or / consultation and liaison should be clearly defined for Tier 2 services where patients require access to Tier 3 services.

These services will use a common model of care, clinical protocols and approach to service delivery utilising an integrated interdisciplinary approach.

The use of telemedicine is an effective strategy for improving health service access to rural communities, provided it is appropriately supported and resourced in both country and metropolitan areas. Telemedicine can also assist in developing professional links and in the provision of continuing professional development.

Paediatric services

Children and adolescents can experience chronic pain through a wide range of medical conditions such as juvenile rheumatoid arthritis, scoliosis, cancer, migraine and chronic abdominal pain, or as a result of spinal cord injuries. Untreated chronic pain in children is likely to manifest in low school attendance, poorer grades, and cessation of sporting or other activities. For some, the eventual result is social isolation and depression, and these children tend to become adults who are not able to achieve their potential.

It is proposed that combined tier 2 and 3 paediatric services are provided at the WCHN (site to be determined).

Governance Arrangements

It is proposed state-wide governance arrangements are put in place to oversee the implementation of the Chronic Pain Model of Care. These arrangements would also work to make best use of a small workforce, especially to achieve most effective coverage of NALHN and Country, as well as meeting training and research requirements.

Workforce requirements

A workforce team consistent with the range of services offered will be available at all sites and will operate using a multi-disciplinary team approach. These teams will apply their collective specialist expertise to deliver a range of chronic pain services that will be integrated with, as well as support and enhance, those services provided by generalist and primary health care providers.

Team approach (multi-disciplinary)

Multi-disciplinary teams with specialised knowledge and clinical expertise in the management of chronic pain form the basis of the tertiary service. The multi-disciplinary team includes the following health professionals:

- Pain specialist
- Nurse/Nurse practitioner
- Allied health professionals with chronic pain expertise
- Psychologists
- Psychiatrists
- Occupational therapists
- Physiotherapists
- Pharmacists
- Exercise physiologists
- Social workers

These teams may also include:

- General Practitioner
- General Practitioner with special interest in pain management
- Community support

A generic pain education program offered in the community is a necessary precursor to multi-disciplinary involvement in the Tertiary sector.

Equipment requirements

It is recommended that all consultation/education/group activity be performed at a site linked with rehabilitation medicine services that have hydrotherapy pool and gym facilities available.

Clinical Pathway

1. GP referral

Members of the Chronic Pain Steering Committee have developed a comprehensive GP referral form to support referral to public specialist services which is included at Appendix 3.

Appropriate and accurate triaging of patients requires that appropriate information, including findings of diagnostic tests, are completed prior to referral.

Primary care management of chronic pain needs to be employed prior to a referral to a tertiary service and the aim of specialist services is to achieve improvements for the patient to the point where they can manage their condition with the support of their GP. Pathways will be established for easy re-referral should the condition require this.

It is recommended that a clinician-based central referral triaging system be put in place in the near future to ensure consistency of service as well as the ability to compare demand, activity and waiting lists.

2. Emergency presentation

When a patient known to the specialist pain service presents to ED the Pain Management Unit will be notified. Management care plan should include mechanisms for accessing advice and support after hours.

3. Specialist referral

Clinical Pathways for the four Triage categories identified in the GP Guidelines for Referral are included at Appendix 4.

GP Guidelines for Referral

Guidelines for referral by General Practitioners or other specialists are provided in the table below. The following table details the triage categories and associated target wait times and treatment team required.

Triage Categories

Triage categories	Wait time/ Management Team	Examples
Cancer Refractory cancer pain	See within 2 days Pain Specialist	Pain related to malignancy and palliative care.
Category 1 Acute painful conditions (< 3 months since onset) not responding to treatment with risk of deterioration or significant impairment of quality of life; patients in whom it is believed a procedure may be beneficial as either a diagnostic or therapeutic modality.	See within 1 month Pain Specialist	Complex regional pain syndrome, post herpetic neuralgia, acute radicular pain. Children whose pain interferes with school attendance; pain interfering with sleep or self-care.
Category 2 Pain < 1 year not responding to GP management; frequent pain exacerbations occasioning ED presentations or hospital admissions.	See within 3 months Pain Specialist Psychologist	Neuropathic pain, persistent pain following trauma or surgery, pain associated with marked physical interference or emotional distress, children, adolescents and elderly.
Category 3 Pain > 1 year not responding to GP management, diagnostic advice, medication optimisation, psychological distress, physical interference.	See within 3 months Pain specialist Psychologist Physiotherapist/occupational therapist Nurse Pharmacist	Headaches, fibromyalgia, non-specific low back pain, medication issues Chronic pain without obvious organic pathology with significant psychosocial issues.

Strengthening Partnerships with Primary Care

Improving the health and wellbeing of people with chronic pain will require a combined approach with individuals, community groups, government and non-government sectors including the Department for Veteran's Affairs, Workcover, Arthritis SA and the Pelvic Pain Foundation and involve working closely with general practice, allied health professionals, the community and other private health care providers, including the Pharmacy Guild.

General practice, as the focal point of care for people with chronic pain, provides a major access point to the rest of the health, community and allied health care system. In fact the primary care sector is the most appropriate place for the majority of people with chronic pain to be managed.

Strong partnerships provide the basis for effective, high quality and integrated health care for people with chronic pain.

Improved Primary Care

The Adelaide Primary Health Network have developed a set of Primary Care Pain Management Pathways and accompanying notes for GP's seeing people with pain management issues which is provided as Appendix 5

This document covers a range of issues including GP management, assessment for chronic pain, primary care management, referral to primary care pain management program and referral to tertiary care.

It is important to continue to engage and educate GP's in working with people living with chronic pain. Suggested strategies include:

- Raising general awareness of GP's knowledge about extent of pain management activity and available information and resources via Primary Health Networks or other appropriate bodies
- Increasing access to multidisciplinary assessment and treatment at the primary health care level to enable better integration of expertise, especially via GP's with a special interest in pain management
- Increasing access to standardised pain assessment and management toolkits for GP's i.e. The Chronic Pain Toolkit for Clinicians produced by the NSW Agency for Clinical Innovation (ACI) as well as training in self-management techniques and approaches
- Providing specialist telephone support for GP's to seek pre-referral and completing on-line referral advice as well as get information on wait times via an 1800-PAIN number. This service allows direct access to a pain specialist for advice and information. Detail on set-up and running of this service is still to be determined.
- Providing support for the development and production of a set of pain management fact sheets for GP's and consumers
- Providing access for GP's to education and training resources for multidisciplinary pain management in primary health care via:
 - outreach support from pain specialists
 - online resources i.e. the new RACGP online training program
 - linking GP's with a GP with a special interest in pain management

- the formal involvement of Australian Medical Association (AMA), the Royal Australian College of General Practitioners (RACGP) and the Australian College of Rural and Remote Medicine (ACRRM) in providing information and education to GP's; and
- general upskilling activities in either a face-to-face or online capacity
- Access to education and training for nurses and allied health practitioners in primary care settings, including in country areas.
- Providing the ability for GP's to refer to local Pain Management Programs/active group education activities i.e. the Living Well with Persistent Pain program offered by the Northern Health Network at Elizabeth

In order to achieve consistent, well co-ordinated and integrated primary care in the community the following is required.

- Access to and availability of psychology and physiotherapy services in primary care settings.
- A need for extended care plans for people with chronic pain issues
- Improved support via Medicare benefits schedule for chronic pain services including payments for development of extended care plans and increased access to funded allied health services

Shared-Care Approaches

The GP and Specialist services work in close partnership to deliver the best outcome for the patient.

The start and end of care should be with the GP and begins with the patient taking an active role in the management of their pain.

Following tertiary care, patients must have a good discharge plan that is sent to the GP with a copy for the consumer.

Development of a care plan/self-management plan could be done at any level of care with the patient owning as well as contributing to it.

There needs to be a consistent process in place for patients to re-access the tertiary sector if necessary.

The on-going management of the pain condition should ensure access back into the range of self-management resources available on-line and through various pain support groups if necessary.

Self-management

Self-management is a key component of successful treatment of chronic pain. An individual learning about the concept of pain and developing an understanding about why it occurs can help in managing it more effectively.

Blyth FM et al (2005)⁸ undertook an Australian-based random telephone survey, which included 474 adults, to find out how they deal with their chronic pain and found that the most common strategies used were passive, including medication and rest. However those using active strategies had reduced

⁸ Blyth F.M., March, L., Nicholas, M.K. and Cousins, M.J. (2005). Self-management of chronic pain: a population based study. *Pain*,113,285-92

pain-related disability and use of health services compared with passive strategy users. The study strongly advocates for more attention to community-based strategies for awareness and uptake of active self-management.

Options for self-management support and education include:

- Online – videos, resources and chat forums
- Face-to-face – group programs or individual patient education
- Telephone coaching
- Handouts and resources to be used as supporting documents

Online pain management courses are an excellent resource for people in rural areas who are isolated or unable to travel. The 6-week Stanford online chronic condition management course was run successfully in South Australia from 2009-2011 and evaluated in 2012 with promising results. It demonstrated that an Internet self-management program, which includes social media, could reach rural and underserved people as well as be effective and reduce health care costs⁹.

This resource is endorsed by the Pain Management Units and is recommended that it be revisited for future use.

Community based supports

The document developed by the Adelaide Primary Health Network lists a number of community based services providing primary care support options for people living with chronic pain.

A relatively new program in South Australia and auspiced by the Adelaide Primary Health Network is the *Living Well with Persistent Pain* program which is based on a similar model developed on the Gold Coast. It is a community based pain management program for people living in northern Adelaide which runs for 8–12 months and includes group education sessions and an individual treatment plan. Group education sessions are held monthly for 2 hours and cover a variety of self-management topics led by health professionals. The individual treatment plan provides access to a care coordinator, a GP with a special interest in pain and extended allied health services as determined by the needs of the participant.

This model could be replicated in other parts of metropolitan Adelaide.

Other examples of community based supports include community-based programs for people with chronic pain provided by Arthritis SA which aims to help people implement health behaviour change and use self-management principles to reduce their pain.

LEAP (Let's Empower All People) SA offers training courses for both consumers and health professionals in pain management and living with chronic pain. The Stanford Chronic Disease Self-Management Program known as "Moving Towards Wellness" is also offered through Leap SA.

Health in our hands is a community based and operated organisation run by volunteers that runs workshops and support groups out of Whyalla hospital. Their activities are also run around the Stanford Chronic Disease Self-Management model.

⁹ Lorig K, Ritter P.L., Plant K, Laurent D.D., Kelly P., Rowe S. (2012). The South Australia Health Chronic Disease Self-Management Internet Trial. *Health Education and Behaviour* 40 (1) 67-77

Health literacy

Health literacy is the ability of the patient to navigate the health system in a positive way as well as work in an equal partnership with a care team. Improving knowledge and understanding of chronic pain in the community will assist to address the stigma associated with the condition and provide a more supportive environment for those living with the condition. Availability of information will assist in this regard.

Consideration could be given to a nationally or state funded advertising program concerning chronic pain similar to initiatives like breast cancer and diabetes. It could raise awareness of the issues associated with chronic pain and work to remove the stigma.

The SA Health website has a page devoted to chronic pain and provides links to useful information for both patients and service providers.

<http://www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/health+topics/health+conditions+prevention+and+treatment/pain/chronic+pain/chronic+pain>

Reporting, Monitoring and Evaluation

Reporting

Promotion of safe and high quality chronic pain services across all metropolitan and rural service sites is essential, combined with measuring and reporting performance.

The ePPOC (electronic Persistent Pain Outcomes Collaboration) is a national benchmarking system which aims to improve services and outcomes for patients living with chronic pain and produce information on the efficacy of interventions through the systematic collection of outcomes information in both inpatient and ambulatory settings. It also provides annual reports that summarise the Australasian data and provides information that allows comparisons across hospitals within a state.

There is also a paediatric version of ePPOC (PaedePPOC).

The Chronic Pain Steering Committee recommends South Australia join ePPOC given the national benchmarking opportunities it provides.

Data collection may improve if waiting times for outpatient services are part of mandatory reporting data within activity-based funding agreements.

Ensuring in-patient consultation liaison activity is collated and coded to casemix data is necessary as well as ensuring Emergency Department attendances for Chronic Non Cancer Pain are captured.

Monitoring and evaluation

Agreed minimum data sets, outcomes and national benchmarking processes will be collected on all chronic pain activity regardless of setting.

These benchmarking tools must be used independent of funding tools.

Contributions to the Plan

A number of professionals across the health system, including Medicare Locals, General Practice, pain interest groups and clinical experts were invited to participate in a Steering Committee (see list below) to oversee the development of a statewide plan for the delivery of chronic pain services.

A larger stakeholder group were invited to participate in a series of workshops to assist in the development of a patient pathway and to provide input into any papers that are created by the Steering Committee.

The stakeholder group (see list below) included a larger group of clinicians including pain specialists, psychologists and pharmacists as well as GPs, consumers and representatives from medical Locals, SAHMRI and other pain interest groups.

List Steering Committee Members

Shelley Horne (Chair) – Director Planning and Commissioning, Department of Health and Ageing (DHA) replaced by Lynne Cowan, Director, System Design and Strategy September 2015

Dr Tim Semple, Deputy Director, Pain Management Unit, RAH

Professor Paddy Phillips, Chief Medical Officer, SA Health

Dr Penny Briscoe, Head of Unit, Pain Management Unit, RAH

Brett Webster, Advanced Clinical Lead Occupational Therapist, CHSALHN

Dr Simon Jenkins, Director Department of Anaesthesia, Lyell McEwin Hospital

Dr Peter Slattery, Director, Pain Management Unit, RGH

Joe McDonald, Deputy Chief Operating Officer, SALHN

Dr Laura Burgoyne, Clinical Lead, Children's Acute Pain Service, WCH

Deb Lee, Adelaide Primary Health Network

Dr Daniel Byrne, General Practitioner replaced by Dr Chris Wagner, General Practitioner April 2015

Dr Patricia Montanaro, General Practitioner

Lesley Brydon, CEO Painaustralia

Mary Wing, Consumer representative

Lyn Whiteway, Consumer Representative

Ken Lang, Manager, Planning and Commissioning, DHA

Leanne Goodes, Principal Project Officer, DHA

Melissa Stokes, Senior Project Officer DHA

List Stakeholder/Workshop attendees

Dr Meredith Craigie, CALHN

Dr Graham Wright, Complex Injury Group

Anne Burke, Director of Psychology RAH

Kerin Montgomerie, Senior Pharmacist, Drugs of Dependency Unit

Dr Stephen Leow, General Practitioner

Professor Alex Brown, Leader Aboriginal Research Unit SAHMRI

Dr Philip Gribble, General Practitioner

Cathie Powell, Bridges and Pathways/Fibromyalgia Australia

Dr Jonathon Chan, Pain Management Unit, FMC

Dr Porhan Kang, Pain Management Unit, FMC

Karen Eldredge, SALHN

Dr Alastair Bonnin, Palliative Care, TQEH

Dr Chris Holmwood, DASSA

Dr Johanna Saltis, Psychologist, RGH

Dr Rene Pols, Psychiatrist, FMC

Jeannie Burnett, Private Physiotherapist

Cindy Wall, Private Psychologist

Pam Castle, COTA

Daniel Cox, Central Adelaide Medicare Local

APPENDIX 1

Current Services in South Australia

Royal Adelaide Hospital Pain Management Unit offers a mix of Tier 2 and Tier 3 services with a multi-disciplinary team made up of Pain Specialists, Pain Fellows, Nurse Practitioner, Psychiatrists and Psychologists (15.1FTE). They also offer Pain Management groups and information sessions as well as outreach services to rural South Australia and the Northern Territory

Site	Services provided	Staff	Current staff FTE
RAH Pain Management Unit	After hours on-call 24/7	Pain Specialist	
	Outpatient clinics (pain medicine)	Pain Specialist Pain Fellow	3.3 FTE equivalent 1.4 FTE equivalent
	Procedures/interventions (epidurals, facet joints RF, nerve blocks, drug infusions, implantable devices etc.) 10 clinics a week	Staff as above	
	RAH inpatient ward consults (neurosurgery, orthopaedic, oncology/palliative, rheumatology, neurology, gen Med etc.)	Pain Fellow Pain Specialist	0.6 0.2
	Psychiatry clinic (1-on-1 or part of multidisciplinary assessment and treatment programmes)	Psychiatrist	0.3 FTE equivalent
	Psychology (1-on-1 or part of multidisciplinary assessment and treatment programmes and pain education sessions)	Psychologist	2.2 FTE equivalent
	Physiotherapy (1-on-1 or part of multidisciplinary	Physiotherapist	0.8 FTE

	assessment and treatment programmes)		
	Administrative support	ASO 3 ASO 2	1 FTE 2 FTE
	Nursing Support (pump refills, stimulator programming, TENS, pain education, procedural clinic, bookings, phone calls)	CSC CN	1 FTE 2.3 FTE equivalent
	Pain Management Groups and information sessions	Information session Groups/modules	1 morning per month 2 mornings per week
	Outreach services	Whyalla NT Alice Springs / Darwin	1 day per month 3 days each/12 per year
	Teaching and research	Teaching to multiple health disciplines	

The Flinders Medical Centre Pain Management Unit offers a mix of Tier 2 and Tier 3 services with a multi-disciplinary team made up of Pain Specialists, Registrar, Registered Medical Officer, Nurse Practitioner, Psychiatrist, Psychologist and Physiotherapist (10.2 FTE)

Site	Services provided	Staff	Current staff FTE
FMC Pain Management Unit	Outpatient clinics (pain medicine)	Pain Specialist	3.2 FTE equivalent
		Registrar (pain medicine)	1.0FTE (vacant)
		RMO (Pain Medicine)	1.0 FTE
	Procedures/interventions (epidurals, facet joints RF, nerve blocks, drug infusions, implantable devices etc.)	As above	As above

	Up to 2000 per year		
	FMC inpatient ward consults (neurosurgery, orthopaedic, oncology/palliative, rheumatology, neurology, gen Med etc.) averaging 10 referrals per week	RMO +/- consultant on call	Included in above FTEs
	Psychiatry clinic (1-on-1 or part of multidisciplinary assessment and treatment programmes)	Psychiatrist	0.5 FTE
	Psychology (1-on-1 or part of multidisciplinary assessment and treatment programmes)	Psychologist	0.8 FTE equivalent
	Physiotherapy (1-on-1 or part of multidisciplinary assessment and treatment programmes)	Physiotherapist	0.5FTE
	Administrative support	Admin support officer	1.9 FTE equivalent
	Nursing Support (pump refills, stimulator programming, TENS, pain education, theatre, procedural bookings, phone calls)	CSC Nurse Nurse	1.0 FTE 1.0 FTE 0.6 FTE
	Teaching and research	All senior and junior medical staff Senior nursing staff	Included in FTEs

At December 2015, the Repatriation General Hospital Pain Management Unit offers a limited Tier 3 service with a small team made up of Pain Specialist and Nurse Practitioner providing “in-reach” services. These services will cease with the closure of the RGH in mid-2017

Site	Services provided	Staff	Current staff FTE
RGH Pain Management Unit	Interventional services RGH ward/Hospice consults Administration (referral	Pain Specialist	0.35 FTE 3 sessions

	triage/GP letters and correspondence and EPAS matters)		
	Procedural support, outpatient administration ward nursing liaison, direct patient contact for education, pump refills, stimulator reprogramming.	Clinical Nurse Consultant	1.0 FTE

The Flinders Medical Centre Paediatric Pain Management Unit offers a reduced Tier 3 service

Site	Services provided	Staff	Current staff FTE
FMC Paediatric Pain Management Clinic	Now reduced to assessment clinic once every second month from January 2015	Paediatrician	1 session per 2 months for paediatrician Prior to this year, 1 session per month
	continuing to see old patients	Specialist pain medicine physician	Access appointment only, unfunded service since January 2014 Prior to January 2014, 1 session per month supported through Department of Anaesthesia
		Access to physiotherapy through usual hospital referral system	

The Northern Health Network offers a Primary Health Care Tier 2 service with a multi-disciplinary team made up of a General Practitioner, Pharmacist, Physiotherapist, Exercise Psychologist, Psychologist and Dietitian

Site	Services provided	Staff	Current staff FTE
Northern Health Network <i>Living Well with Persistent Pain</i>	A community based persistent pain management program for people living in northern Adelaide. The	Currently available: - Program coordinator - Management	Variable depending on the needs of participants.

<p>Program</p>	<p>program runs for 8–12 months and includes group education sessions and an individual treatment plan.</p> <p>Group education sessions are held monthly for 2 hours. They cover a variety of self-management topics led by health professionals.</p> <p>The individual treatment plan provides access to a care coordinator, a GP with a special interest in pain and extended allied health services as determined by the needs of the participant. These services could include:</p> <ul style="list-style-type: none"> - Physiotherapy - Psychology - Exercise physiology - Dietetics - Home medicines review - Occupational therapy - Podiatry 	<p>support</p> <ul style="list-style-type: none"> - Care coordinator - GP - Pharmacist - Physiotherapist - Exercise Physiologist <p>In negotiations:</p> <ul style="list-style-type: none"> - Psychologist - Dietitian <p>To be investigated if required:</p> <ul style="list-style-type: none"> - Occupational therapist - Podiatrist 	<p>Care coordinator role is 0.2FTE (0.1FTE participant appointments and 0.1FTE for follow-up/admin).</p> <p>Program coordinator role is 0.2FTE.</p> <p>GP has currently allocated 0.1FTE for participant appointments.</p>
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APPENDIX 2


Glossary

Accredited pain service	An accredited pain service is one that meets the requirements for pain medicine specialty training set by the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists
Acute pain	Pain immediately following surgery or injury, which is expected to be of relatively short duration.
Cancer pain	Pain that can occur in patients at any stage of disease, and in cancer survivors. Pain may be caused by the disease itself or by cancer treatment, such as surgery or radiotherapy.
Chronic pain	Chronic pain, also known as persistent pain or chronic non-malignant pain, is constant daily pain for a period of three months or more in the last six months. Chronic pain may occur after an injury but beyond the time it usually takes for tissues to heal, or it may be associated with a comorbid condition (such as arthritis, cancer, diabetes, endometriosis, multiple sclerosis, or dental condition). Sometimes chronic pain has no identifiable origin. Low back pain is a common presentation.
Complex regional pain syndrome (CRPS)	A severe chronic pain condition that most often affects one of the arms, legs, hands or feet. It is thought to result from dysfunction in the central nervous system. Typical features include intense burning pain, dramatic changes in the colour and temperature of the skin over the affected limb or body part, skin sensitivity, sweating, swelling, and dysfunction in the movement control system. Older terms used to describe CRPS are reflex sympathetic dystrophy syndrome and causalgia. CRPS may occur (though not always) after surgery or injury, though pain is out of proportion to the severity of the injury and may get worse rather than better over time.
Diagnosis related groups (DRGs)	A patient classification system that provides clinically meaningful way of relating the types of patients treated in hospital to the resources required by the hospital to treat the patient.
Interdisciplinary	Clinicians working together in an interactive manner to assess and manage patients.
Multidisciplinary	A number of different health care disciplines available at one clinic.
Neuropathic pain	Pain initiated or caused by a primary lesion or dysfunction in the nervous system. Nerve injury can occur at the level of the brain, spinal cord or peripheral nerves. Damage can be caused by trauma, surgery or disease processes including infection and cancer.
Non –accredited pain service	A non-accredited pain service is one that is not accredited for pain medicine specialty training by the Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists
Opioids	Medicines with actions similar to those of morphine, including substances derived from the opium poppy (morphine, heroin, codeine and thebaine) and

	synthetic and semi-synthetic medicines (such as pethidine, hydromorphone, fentanyl, methadone, buprenorphine, oxycodone, dextropropoxyphene, dextromoramide, pentazocine, tramadol and others).
Pain	An unpleasant sensory and emotional experience, associated with actual or potential tissue damage, or described in terms of such damage. That is, pain is a subjective human experience, and can only be truly appreciated by the individual experiencing the pain.
Primary health care	The first level of care or point of entry to the health care system for consumers. It includes (but is not limited to) services delivered by GPs, practice nurses, nurse practitioners, community nurses, allied health providers, Aboriginal health workers, pharmacists and dentists.
Recurrent pain	Pain that occurs on a recurrent or cyclical basis, such as migraine, recurrent abdominal pain or pelvic pain.
Secondary health care	Medical care provided by a specialist or facility upon referral by a primary care physician. It includes services provided by hospitals and specialist medical practices.
Subacute pain	A transitional stage between acute and chronic pain: the time between tissue healing (usually one or two months) and the six-month time point that defines chronic pain. During the subacute phase, appropriate intervention (pharmacological, psychological and social) may prevent progression to chronic pain.
Tertiary health care	Care provided in a service that has the personnel and facilities required for specialist investigation and treatment, such as within a teaching hospital.

APPENDIX 3

Referral Guide to Adult and Paediatric Pain Management Units

 Government of South Australia SA Health
REFERRAL GUIDE TO ADULT AND PAEDIATRIC PAIN MANAGEMENT UNITS
<p>There are a range of publicly funded multi-disciplinary chronic pain services in SA providing expert assessment, advice, treatment and access to a range of interventions and self-management based 'Pain Programmes' from a bio psychosocial perspective. The services are time-limited and require a named referral from a medical practitioner with a provider number.</p> <p>This is a guide to assist practitioners to navigate the referral system and establish suitability of the referral. Once received, referrals will be assessed and prioritized by the Pain Service.</p> <p>Indications for referral to a Pain Service</p> <ul style="list-style-type: none">• Consider referral when the patient has persistent pain* and;• all reasonable investigations have been completed;• reasonable and accessible management in the primary care sector has been tried with insufficient success;• pain has significant impact on some aspects of life – sleep, self-care, mobility, work or school attendance, recreation, relationships and/or emotions <p>Referrals are particularly encouraged when the patient has:</p> <ul style="list-style-type: none">• exacerbations of persistent pain that resulted in an Emergency Department presentation or hospital admission• complex psychosocial influences on pain behaviour requiring specialised assessment and care• significant pain in the setting of current or past history of addiction or prescribed medication use that seem to be complicating current management (e.g. an escalating opioid requirement)• difficult to control neuropathic pain• difficult to control cancer pain. <p>* Pain constant, and daily for a period of 3 months or more over the previous 6 months, or where the natural history of the painful condition suggests this is likely to be the case. Also episodic severe pain ; e.g. headache which interferes with daily life.</p> <p>The Pain Management Unit will require</p> <ul style="list-style-type: none">• Completion of the attached referral form IN FULL. <p>The Pain Management Unit will:</p> <ul style="list-style-type: none">• Work actively in partnership with the General Practitioner for ongoing management• Work in close communication with other specialist services that are providing treatment for the patient. <p>The following details the triage categories and associated target wait times</p> <p>Cancer - Seen within 2 days Refractory cancer pain</p> <p>Category 1 - Seen within 1 month Acute painful conditions (< 3 months since onset) not responding to treatment with risk of deterioration or significant impairment of quality of life; patients in whom it is believed a procedure may be beneficial as either a diagnostic or therapeutic modality.</p> <p>Category 2 - Seen within 3 months Pain < 1 year not responding to GP management; frequent pain exacerbations occasioning Emergency Dept. presentations or hospital admissions.</p> <p>Category 3 - Seen within 3 months Pain > 1 year not responding to GP management, diagnostic advice, medication optimization, psychological distress, physical interference</p>

	FAMILY NAME	MRN
	GIVEN NAME	MALE FEMALE
Facility:	D.O.B. / /	M.O.
REFERRAL GUIDE TO ADULT AND PAEDIATRIC PAIN MANAGEMENT UNITS	ADDRESS	
	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
Pain Management Unit Referral Please complete this form fully and email to enable appropriate triage. Incomplete forms will be returned to the Referrer. ***For Categories 2 and 3, complete Patient Screening Questionnaire at same time and return with Referral form. Date:		
Patient details		
Family name	Given Names	
Sex M F	Date of Birth	Age >70< 18
Address		
Phone (H)	Phone (W)	Phone (M)
Indigenous/ CALD status Islander Y N	Aboriginal and or Torres Strait	CALD background YN
Country of Birth	Preferred language	Interpreter required YN
Medicare card no	Medicare expiry date	
Referring Medical Officer's details		
Family Name	Given Name	
Organisation/practice name	Provider number	
Address	Post code	
Phone	Fax	Email
Nominated General Practitioner's details Should be identified if not referring medical officer		
Family Name	Given Name	
Organisation/practice name	Provider number	
Address	Post code	
Phone	Fax	Email
Will the patient require prior approval from an insurer to attend a clinic Y N	Insurer:	
	Claim no:	
Reason for referral. Please tick the relevant box(es)		
All reasonable investigations have been completed		<input type="checkbox"/>
Reasonable management in the primary care sector has been tried with insufficient success		<input type="checkbox"/>
Pain has significant impact on life <ul style="list-style-type: none"> • Sleep, self care or pain necessitating the assistance of others • Pain impacting on mobility, work or school attendance, recreation, relationships and/or emotions 		<input type="checkbox"/>
Pain exacerbations have resulted in extreme distress or repeated hospital presentations / admissions. There seem to be complex psychosocial influences relating to pain behaviour requiring specialised assessment and care		<input type="checkbox"/>
Current drug management is not resolving pain or leading to improved quality of life; e.g. escalating Opioids requirements but inadequate relief or concerns about "drug regimen".		<input type="checkbox"/>

	FAMILY NAME	MRN
	GIVEN NAME	MALE FEMALE
Facility:	D.O.B. / /	M.O.
REFERRAL GUIDE TO ADULT AND PAEDIATRIC PAIN MANAGEMENT UNITS	ADDRESS	
	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
Difficult to control neuropathic pain is suspected	<input type="checkbox"/>	
Difficult to control cancer pain	<input type="checkbox"/>	
Ongoing pain following trauma or surgery where there is concern regarding transition to persistent pain	<input type="checkbox"/>	
Location of pain.....	<input type="checkbox"/>	
What is the impact of the pain?	<input type="checkbox"/>	
Comment:		
Priority category: 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> (See Referral Guide)		
Patient History		
Relevant Clinical history		
Background surgical and imaging history (PLEASE ATTACH RELEVANT REPORTS)		
Is the patient and others involved in their care are aware and supportive of referral? Please provide details	Y <input type="checkbox"/> N <input type="checkbox"/>	
Outline current or previous treatments from other specialist or allied health service providers for the same pain problem? Please provide details	Y <input type="checkbox"/> N <input type="checkbox"/>	
Previous medications and why ceased		
History of previous assessment by another pain service or rehabilitation service for pain management. We would usually recommend review by the previous service. Name of Service: Please attach relevant correspondence	Y <input type="checkbox"/> N <input type="checkbox"/>	
Current medications (include dosage, route, frequency and include analgesics)		

	FAMILY NAME	MRN
	GIVEN NAME	MALE FEMALE
Facility:	D.O.B. / /	M.O.
REFERRAL GUIDE TO ADULT AND PAEDIATRIC PAIN MANAGEMENT UNITS	ADDRESS	
	LOCATION / WARD	
	COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	
Allergies/adverse reactions?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Psychiatric history? Name of Psychiatrist	Y <input type="checkbox"/>	N <input type="checkbox"/>
Past and present treatments		
Psychological stressors? Please describe	Y <input type="checkbox"/>	N <input type="checkbox"/>
Have any addiction services been involved? Please provide details	Y <input type="checkbox"/>	N <input type="checkbox"/>
Could the patient have difficulty accessing information/services? Impaired cognitive function? Visual or hearing impairment? Difficulty reading and or accessing forms? Can they read and write English? If not what is their primary language? Difficulty travelling? Comment:	Y <input type="checkbox"/>	N <input type="checkbox"/>
Has the patient consented to the referral?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Does the patient require an advocate/parent/guardian to be involved in consultations and management? If yes: • Relationship to patient: • Name: • Contact details: Why? Has carer strain been identified?	Y <input type="checkbox"/>	N <input type="checkbox"/>
Would you like the relevant Pain Management Unit to contact you for telephone advice as soon as practical?	Y <input type="checkbox"/>	N <input type="checkbox"/>
*REFERRAL to parallel services such as Addiction Medicine, Psychiatry and Mental health may be essential		

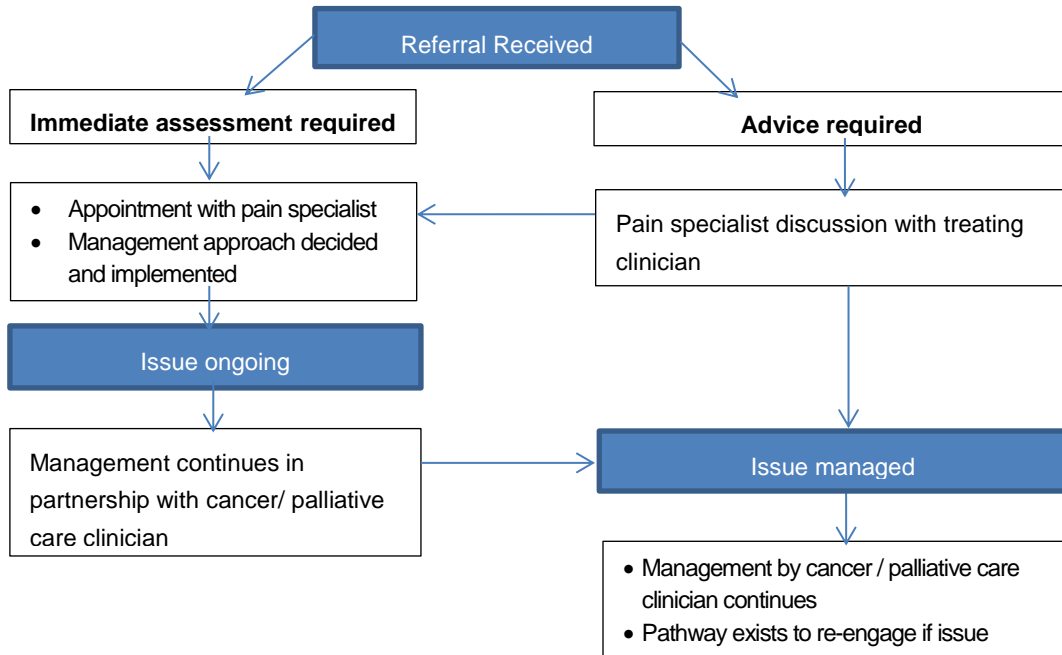
APPENDIX 4

Secondary and Tertiary Pain Management Clinical Pathways

1. Cancer related pain

Refractory cancer pain- pain related to malignancy

Seen within 2 days

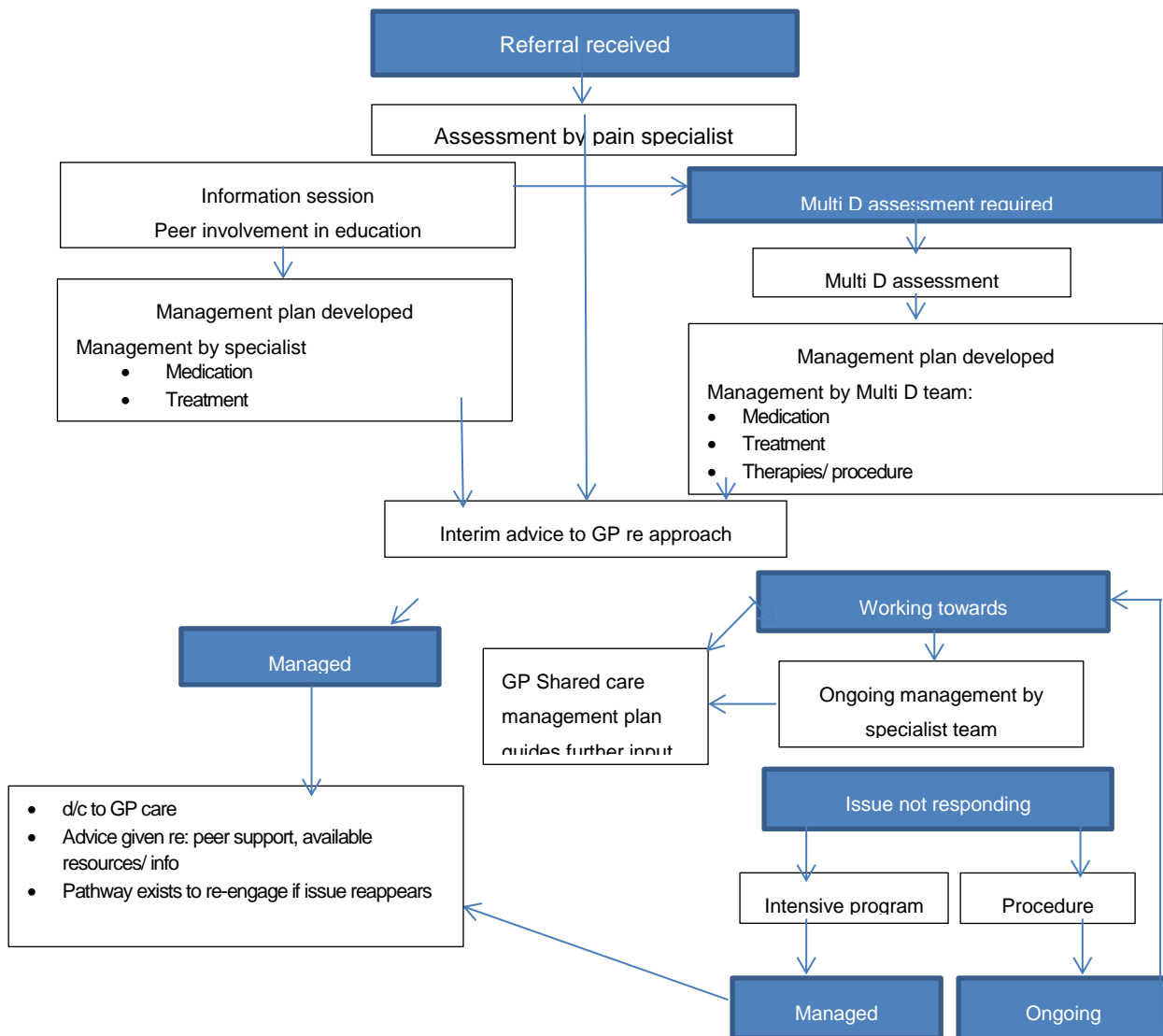


2. Category 1

Acute painful conditions (< 3 months since onset) not responding to treatment with risk of deterioration or significant impairment of quality of life; patients in whom it is believed a procedure may be beneficial as either a diagnostic or therapeutic modality.

Complex regional pain syndrome, acute radicular pain, children whose pain interferes with school attendance, pain interfering with sleep or self-care.

See within 1 month



3. Categories 2 and 3

Category 2

Pain < 1 year not responding to GP management, frequent pain exacerbations occasioning Emergency Department presentations or hospital admissions.

Neuropathic pain, persistent pain following trauma or surgery, pain associated with marked physical interference or emotional distress, children, adolescents and elderly.

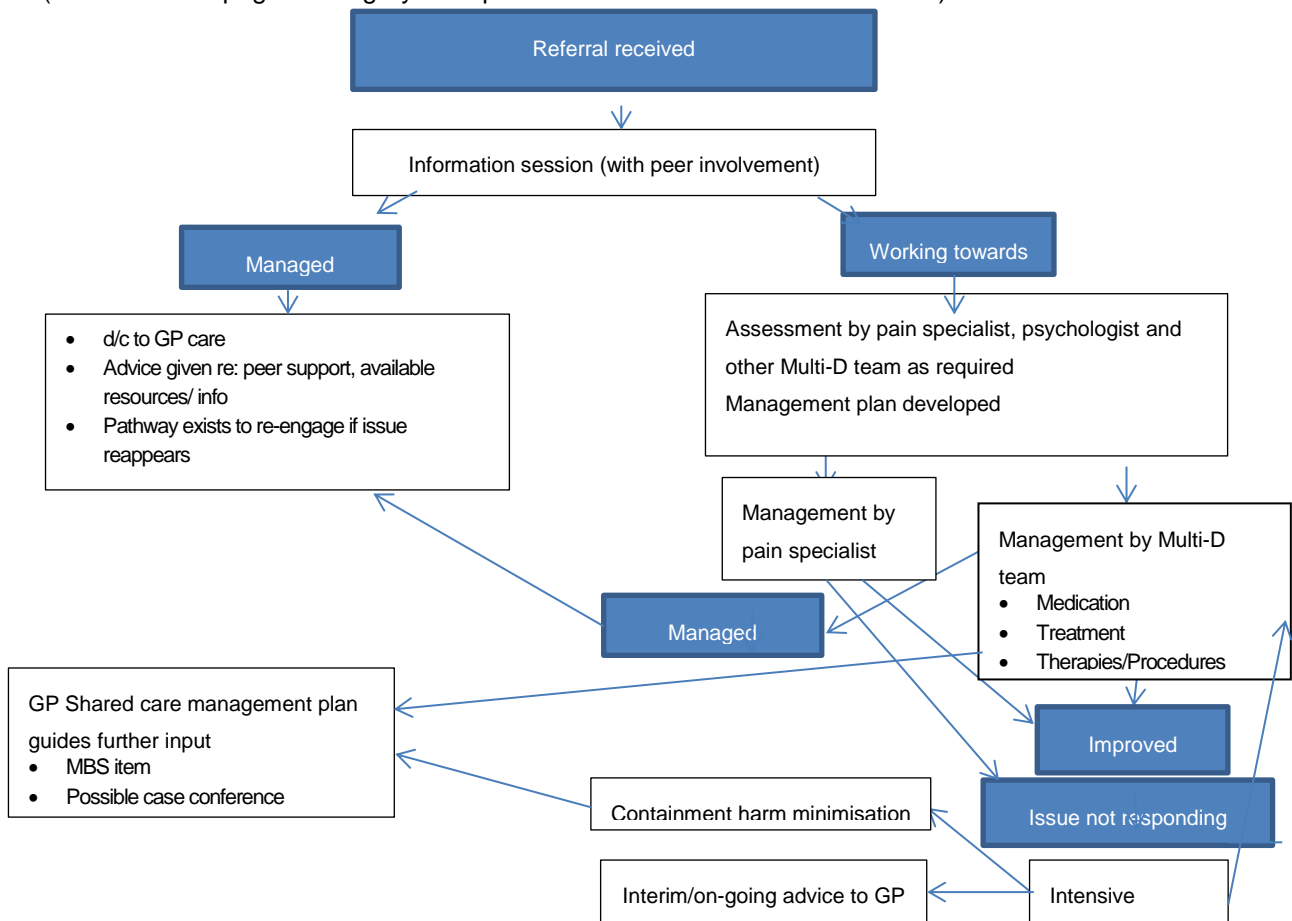
Category 3

Pain > 1 year not responding to GP management, diagnostic advice, medication optimization, psychological distress, physical interference.

Headaches, fibromyalgia, non-specific low back pain, medication issues. Chronic pain without obvious organic pathology with significant psychosocial issues.

See within 3 months

(See 4 on next page - Category 3 for patients with medication related issues)

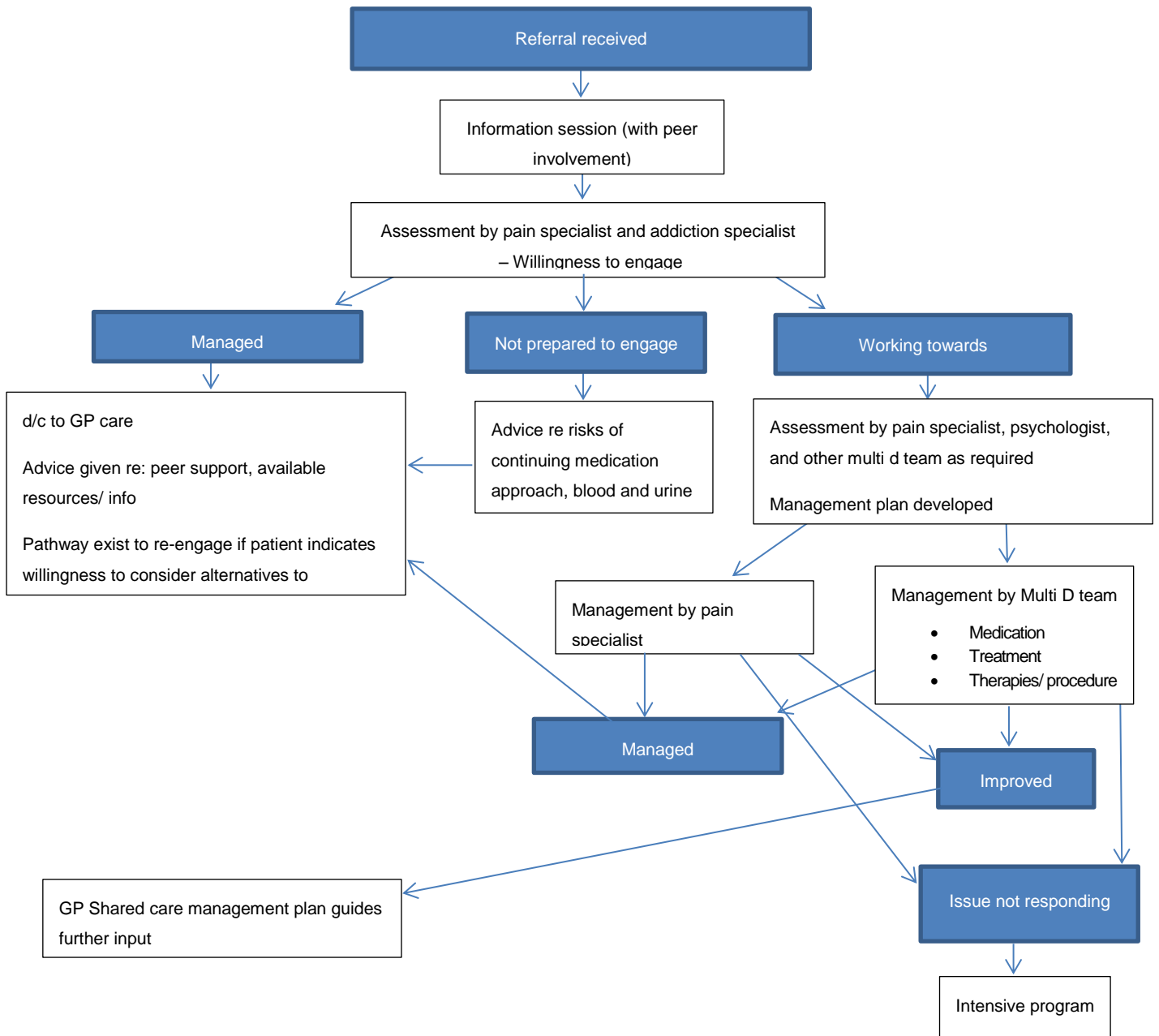


4. Category 3

Pain > 1 year not responding to GP management, diagnostic advice, medication optimization, psychological distress, physical interference.

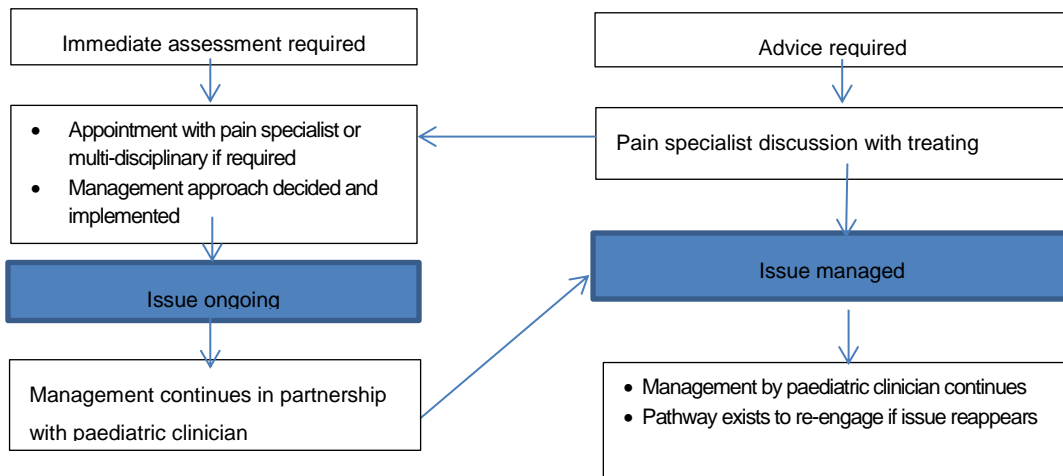
Medication optimisation.

Seen within 3 months



5. Paediatric Pathway

Seen as soon as possible



APPENDIX 5

FIGURE 1. Pain Management Pathway – Primary Care

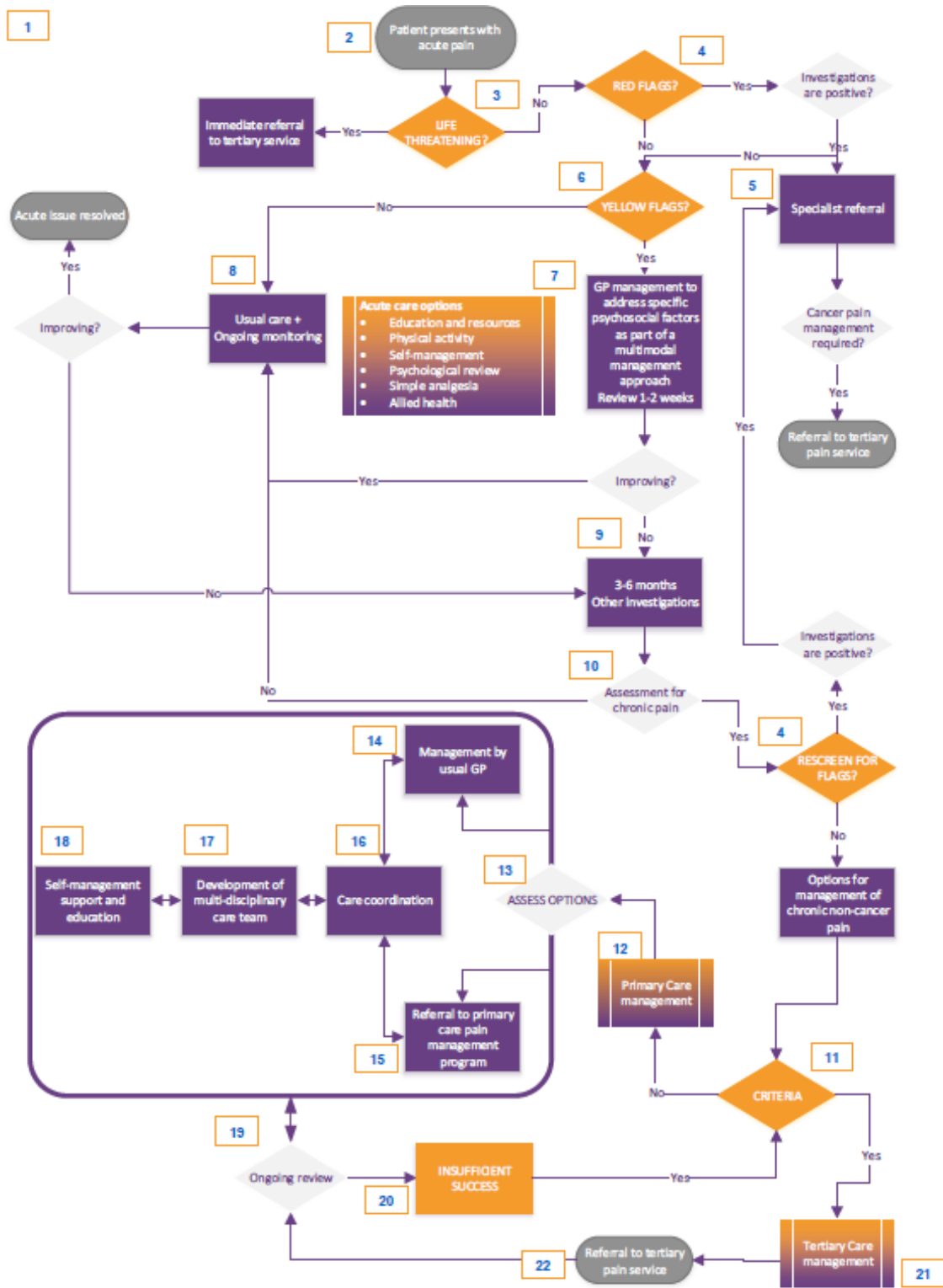
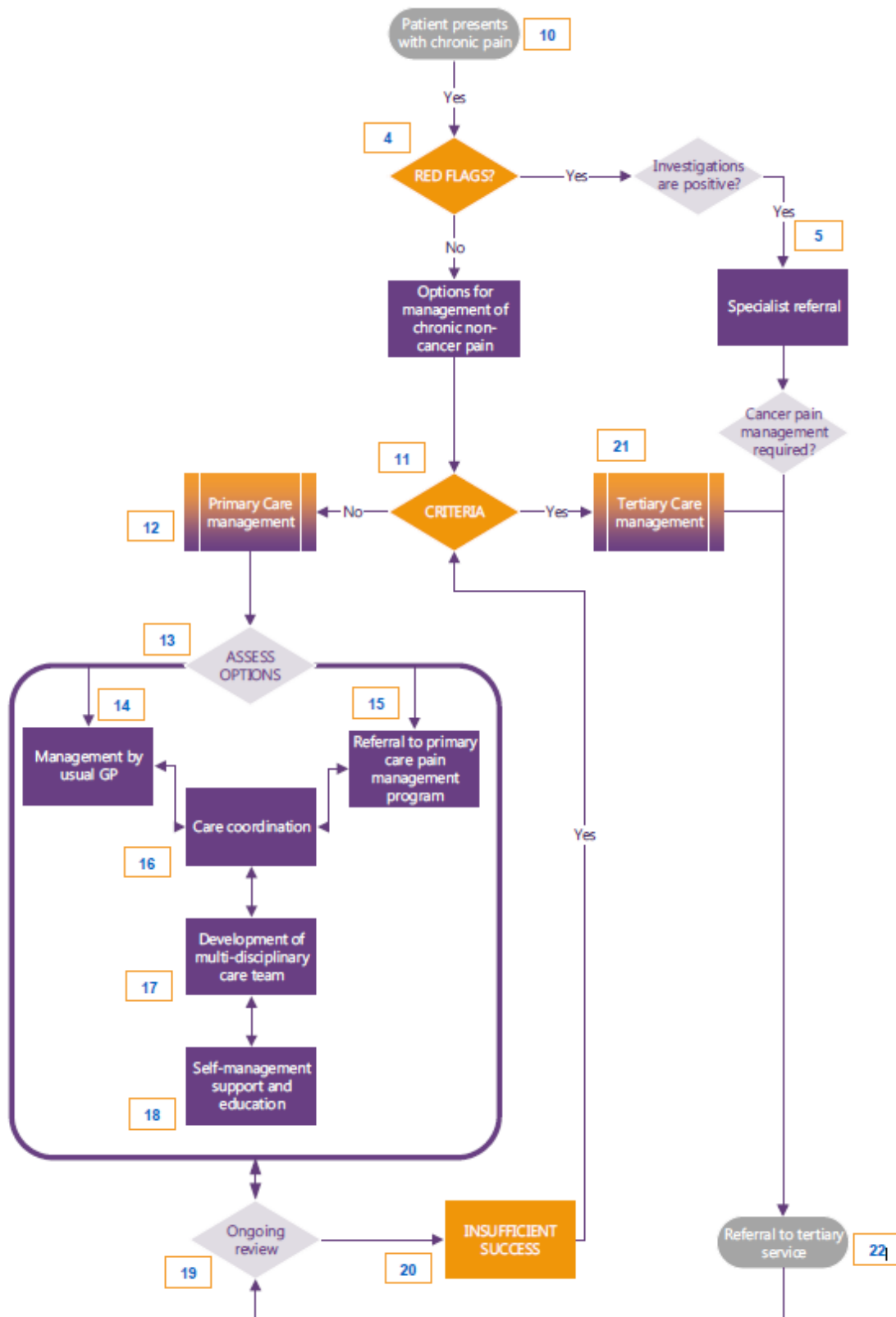


FIGURE 1. Chronic Pain Pathway – Primary Care



Additional Information

1. OVERVIEW

Information in this document has been adapted from a variety of resources on the assessment and diagnosis of chronic pain including:

- [ACI Pain Management Network](#)
- Macintyre PE, Schug SA, Scott DA, Visser EJ, Walker SM; APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine (2010), Acute Pain Management: Scientific Evidence (3rd edition), ANZCA & FPM, Melbourne.
- [Southern Adelaide LHN specialist and outpatient clinics documents](#)
- Gloucestershire Hospitals & NHS Foundation Trust. [Advice for Referrers to the Pain Service](#)
- [Map of Medicine](#)
- [NPS](#)
- [National Institute for Health and Care Excellence](#)
- SIGN 136: [Chronic pain assessment, early management and care planning in non-specialist settings](#)

2. PATIENT PRESENTATION

Pain is a very common reason for self-medication and entry into the health care system. It is an individual, multi-factorial experience influenced by culture, previous pain experience, belief, mood and ability to cope. Pain may be an indicator of tissue damage but may also be experienced in the absence of an identifiable cause. The degree of disability experienced in relation to the experience of pain varies; similarly there is individual variation in response to methods to alleviate pain. This combination of biological, psychological and social factors leads to a biopsychosocial approach to pain management being widely understood and used in practice.

Consider if pain is as a consequence of work-related injury or insurance claim (including life insurance). Management of these patients is often challenging when based solely in the primary care setting and specialised care providers can be accessed by these patients.

3. LIFE THREATENING CONDITIONS

Exclude life-threatening or major health conditions:

- Cauda equina
- Rapidly progressing motor neurological or gait disturbances
- Myocardial infarction
- Pulmonary embolism
- Acute peripheral ischaemia
- Infection

- Acute abdomen
- Metastasis

4. RED FLAGS

[Clinical indicators](#) of possible serious underlying conditions requiring further medical intervention

- When to use:
 - Initial assessment
- What to do:
 - ≥ 1 red flags indicates urgent referral to appropriate provider

The detection of red flags may be one of the few areas where simple investigations may be required in primary care:

- X-rays in patients with a history of trauma
- ESR/CRP in patients with suspected inflammatory disorders

5. SPECIALIST REFERRAL

Other than for red flags, consider referrals for:

- Mental health problems
- Rheumatology
- Serious pathology

6. YELLOW FLAGS

[Psychosocial indicators](#) suggesting increased risk of progression to long-term distress, disability and pain

- When to use:
 - Initial assessment
 - If considering prescribing opioids
- What to do:
 - ≥ 1 yellow flag indicates need for psychological or mental health plan or referral with ongoing review or Pain Management Plan;
 - Opioids are not a treatment for distress and unhelpful beliefs. Poor functional improvement with escalating use, side effects and aberrant behaviour would indicate reconsideration of opiates

7. GP MANAGEMENT

Management of acute pain in general practice should include a reliable and accurate assessment of location, circumstances, characteristics, intensity, associated symptoms and effects on functioning.

See: [ACI Pain Assessment](#)

It is important that health professionals involved in the management of acute pain are appropriately educated and have access to recent guidelines and options for referral to acute pain services if required. Other requirements include close liaison between care providers and active patient participation, including accurate and up-to-date information and being partners in discussions relating to choice of care. Even 'simple' techniques of pain relief can be more effective if attention is given to education, documentation, patient assessment and provision of appropriate guidelines and policies.

Use of analgesic medicines should follow appropriate guidelines including monitoring, recognition and management of adverse effects.

Consider the use of physical therapies for musculoskeletal pain and therapies such as TENS and acupuncture may be of benefit in some situations.

Local psychology referral under Mental Health Treatment Plan if there are significant psychosocial component or impact for CBT/relaxation/distraction Include referral to psychologist with the presence of yellow flags or when the patient

- has moderate to high levels of distress
- has difficulty adjusting to a life with pain
- is struggling to change their behaviour to maintain normal activities

8. USUAL CARE

Advise, reassure and prescribe medicine as appropriate. It is likely that the patient will not require any further intervention. Usual care is underpinned by:

- Good assessment
- Thorough explanations
- Signposting to sources of information and support
- Evidence-based management
- Listening and validating

Promote:

- Self-management
- Use of appropriately prescribed and/over-the-counter analgesics
- Keeping active
- Staying in work as far as possible

9. 3–6 MONTHS AND OTHER INVESTIGATIONS

When review is required, use the four A's:

- Analgesia
- Adverse effects
- Activity
- Adherence

Avoid further investigations unless serious pathology is suspected. Identify the stage at which no more investigations are planned and explain this clearly to the patient.

10. ASSESSMENT FOR CHRONIC PAIN

Comprehensive Pain Assessment Tools include: [ACI Pain Assessment](#), [BPI](#), [DN4](#), [K10](#), [STarT Back](#).

- When to use: Initial assessment and when appropriate
- What to do: Consider management strategies and use of further questionnaires if indicated

Things to consider as part of an assessment for chronic pain:

- Divide assessment and initial management over multiple consultations. Investing time at the initial presentation may improve outcomes for patients and minimise unhelpful use of resources in future.
- Use a patient-centred, culturally sensitive approach, explaining the treatment options and encouraging patients' involvement in decision making.
- Identify the type, duration and severity of pain at different sites.
- Assess functional impact as part of a biopsychosocial assessment. Consider work, relationships, sleep, mood, disability etc. The depth of the assessment will depend on the severity of the problem and it may be completed over multiple consultations.
- Identify patients at risk of poor outcomes including the presence of yellow flags if not already identified.

11. CRITERIA REVIEW

As per SA Health Referral Guide to Adult and Paediatric Pain Management Units, the following indications exist for a referral to a tertiary service:

- Persistent Pain AND
 - All reasonable investigations have been completed
 - Reasonable and accessible management in the primary care sector has been tried with insufficient success
 - Pain has significant impact on some aspects of life – sleep, self-care, mobility, work or school attendance, recreation, relationships and/or emotions

It is important to note that primary care management of chronic pain needs to be employed prior to a referral to a tertiary service.

Referrals to the SA Health units are particularly encouraged when the patient has:

- Exacerbations that have resulted in ED presentation or hospitalisation
- Complex psychosocial influences requiring specialised assessment and care
- Significant pain in the setting of current or past history of addiction or prescribed medicine use that seems to be complicating management (e.g. escalating opioid requirements)
- Difficult to control neuropathic pain
- Difficult to control cancer pain

12. PRIMARY CARE MANAGEMENT

Persistent pain is a long-term condition and treatment should focus on functional goals and ongoing management rather than unrealistic expectations of elimination of pain. An over-emphasis on pain reduction will often result in frustration for the treating doctor and the patient

- Avoid opioid analgesics
- Appropriate use of anti-neuropathic pain agents such as – amitriptyline, pregabalin, carbamazepine
- Referral to local physiotherapy under GPMP for active, low grade regular self-stretches and strengthening program (avoid passive massage/manipulation) to minimise muscular component of pain, allowing less painful procedures and post procedural muscular pain.
- Local psychology referral under Mental Health Treatment Plan if there are significant psychosocial component or impact for CBT/relaxation/distraction
- Avoid referral for interventions/injections based on imaging findings unless clinically correlated (refer Pain Interventions guidelines)
- Psychiatry input if required
- Regular review and reassurance if no new pathology or if there are no pathology (Containment approach)
- Explanation on realistic expectation from pain unit assessment as detailed above

13. OPTIONS FOR PRIMARY CARE

Service name	Location	Patient Group	Funding	Services
NHN Living Well with Persistent Pain Program	Elizabeth	Tier 2	APHN/MB S	GP + Multi-D + group education
Green Dispensary PainWISE® Program	Blackwood; Stirling	Tier 1 & 2	FFS	Pharmacist + group education
Complex Injury Group	North Adelaide	Tier 2	MBS/FFS/EPC	Occupational Physician + Multi-D
OccmedSA	Adelaide	Tier 2	MBS/FFS/Insurance	Occupational Physician
Pain Medicine of South Australia	Marion; Welland	Tier 2	MBS/FFS/Insurance	Pain specialist + Multi-D
Flinders Private Hospital	Bedford Park	Tier 2	MBS/Insurance	Pain specialist + Multi-D
Corporate Health Group	Mile End; Gillman; Elizabeth Vale	Tier 2	Insurance/WorkCover	Occupational Physician + GP + Multi-D
Arthritis SA - Take Charge of Pain Course	Marleston	Tier 1 & 2	FFS/NGO	Group education
LEAP SA – K.E.A.P. & T.I.P.S	[metro]	Tier 1 & 2	FFS/Workplace	Group education
Royal District Nursing Service	[metro]	Tier 2 & 3	In development	Home support + Multi-D + group education
Pelvic Pain SA	Norwood	Tier 2 & 3	MBS/FFS/Insurance	Pain specialist + Multi- D + group education
Bridges and Pathways	Southern areas	Tier 1,2 & 3	Grants/donations	Limited variety of consumer support
NB&A Group	Richmond	Tier 1 & 2	WorkCover / Insurance	Allied health services + education (not group)
Roberts Physiotherapy	Modbury; Beverley	Tier 1 & 2	EPC/FFS/Insurance	Physio + group education with psych
Marion Physiotherapy	Marion	Tier 1 & 2	EPC/FFS/Insurance	Allied health services + education (including mindfulness)

14. USUAL GP

- Listen, validate, educate and reassure. Acknowledge that pain may never entirely resolve.
- Ensure adequate verbal and written information is given about diagnosis and management of pain. Consider the use of a pain management plan such as those provided by [NPS](#) or [ACI Pain Management Network Quick Steps](#)
- Ensure that common misconceptions about pain have been discussed with the patient.
- Support a self-management approach which includes self-help and responsibility for control of pain. General information on pain and its management may be helpful, and it may be useful to direct patients towards online or other easily accessible resources such as [ACI Pain Management Network](#)
- Advise the patient to stay active
- Support the patient to stay at work
- Treat the underlying cause of the pain where possible
- Encourage the appropriate use of analgesics. See an analgesic management chart for further information e.g. [Drug treatments for low back pain](#)
- Be aware of past history of anxiety and depression. Treat depression early as it assists to reduce pain.
- Utilise available resources from [ACI Pain Management Network](#) and [NPS](#)

15. REFERRAL TO PRIMARY CARE PAIN MANAGEMENT PROGRAM

People with chronic benign pain who do not need specialist medical input, but who want help to cope with their pain can be referred directly to local, community pain self-management services if available.

Refer to primary care pain management program when the patient has:

- poor functional capacity
- moderate to high levels of distress
- social and occupational problems related to pain
- failed to benefit from other, less comprehensive therapies
- a preference for a self-management rather than a medical approach

Delaying referral until other treatment avenues are exhausted can be dispiriting and unhelpful. Ensure that patients are aware that PMP will be a group based treatment focused on improving quality of life and participation in normal activities. It is also important that the patient understands the likely composition of the PMP team.

16. CARE COORDINATION

Care coordination is “the deliberate organisation of patient care activities between two or more participants involved in a patient’s care to facilitate the appropriate delivery of health care services.”

This means that all providers working with a particular patient share important clinical information and have clear, shared expectations about their roles. Equally importantly, they work together to keep patients, families and carers informed and to ensure that effective referrals and transitions take place.

17. MULTI-DISCIPLINARY TEAM

The coordinated multidisciplinary approach is the most effective way of helping patients to manage their chronic pain, and possibly the most cost effective. Multi-D management requires a broad whole person treatment approach addressing multiple aspects of pain and lifestyle. Self-management is key along with targeted medical and social support. The focus is on making gradual changes and assessing responses.

Treatments can include:

Biomedical – Surgery, nerve blocks, medication. Evidence is weak and time-limited approaches are preferred. Pharmacological treatment for depression and anxiety can also be considered.

Psychological – Addresses patterns of thinking. Consider referral to psychologist when the patient

- has moderate to high levels of distress
- has difficulty adjusting to a life with pain
- is struggling to change their behaviour to maintain normal activities

Physical therapy – May be passive or active. Include physiotherapy, exercise physiology and occupational therapy. Active strategies are often preferred and therapy should promote self-management strategies.

CAM – Complementary and alternative medical therapies which are active strategies are preferred. Such strategies may include Tai Chi and Mind-body therapies which overlap with psychological strategies. Care is required to ensure evidence based approaches.

18. SELF-MANAGEMENT SUPPORT AND EDUCATION

Self-management by the patient is recognised as a key component of pain management. Patients and consumers should be encouraged to access and engage with self-management strategies. [Active management strategies](#) such as exercising and meditation decrease the likelihood of pain-related disability whereas passive strategies such as hot/cold packs, resting and medicines show the opposite. Patient education commencing early in the process, including at the first assessment, will support patients toward self-management. Education should not be restricted to providing leaflets. Identify how the patient learns to direct them to appropriate resources. The aim of management for persistent pain is to “retrain the brain”. A slow reduction of pain over a 6–12 month period may occur.

Options for self-management support and education include:

- Online – Videos, resources and chat forums
- Face-to-face – group programs or individual patient education

- Telephone coaching such as [APMA](#) (1300 340 357)
- Handouts and resources to be used as supporting documents
- Patient support groups can be considered to aid in the reduction of social isolation.

19. ONGOING REVIEW

Pain management plans should be reviewed within 6 months, but this can take place earlier if required. Assess whether the pain problem is resolving. If not, a detailed re-assessment is required. Revisit advice and information previously provided to identify progress. If no progress has been made, reinforce the plan and consider change in treatment.

Issues to consider include:

- Unhelpful beliefs
- Messages from others
- Family dynamics
- Mental health problems
- Diet and sleep
- Passive coping strategies
- Workplace issues
- Unrealistic expectation of self and others

Assessment tools as listed earlier can be revisited

20. INSUFFICIENT SUCCESS

- As per SA Health Referral Guide to Adult and Paediatric Pain Management Units

If effective pain management cannot be achieved in the primary care setting, referral to a tertiary service can be considered. It is important to clearly define the term 'effective', so as to minimise unnecessary and inappropriate referrals. Efficacy in pain management refers to minimising the impact of persistent pain on a person's lifestyle and functioning (quality of life), and reducing use of health services, rather than complete cure of the problem.

Points to consider include:

- Appropriate diagnostic investigations in other specialities as appropriate have been exhausted.
- The pain has been assessed, particularly as to whether there is an element of neuropathic pain, and treated accordingly – suggested website: [Neuropathic Pain Treatment Pathway](#)
- First line interventions have been tried:
 - Optimise analgesia
 - Consider TENS

- Consider physiotherapy
- Advice on self-management
- Address common misconceptions
- The patient has been encouraged in self-management approaches and that appropriate expectations have been given to the patient.
- Mood and sleep have been assessed and treated appropriately
- If the patient has back pain, ensure Red Flags have been screened for. If present, they should be referred appropriately.

21. TERTIARY CARE MANAGEMENT

Services provided by CALHN and SALHN occur according to the SA Health Secondary and Tertiary Pain Management Clinical Pathways.

22. REFERRAL TO TERTIARY CARE

Appropriate conditions for initial referral

Please see the Referral Guide to Adult and Paediatric Pain Management Units. Further consideration should cover:

- Problematic pain conditions (e.g. chronic benign pain or difficult cancer pain) especially if the person is distressed and disabled by the pain. E.g. chronic back pain; osteoarthritis; fibromyalgia; pain with unclear pathology; phantom limb pain; complex regional pain syndrome (early referral recommended); poorly controlled trigeminal neuralgia (early referral recommended)
- Analgesic advice or guidance including difficulty weaning opioid therapy. Opioid doses equivalent to more than *40mg of morphine equates to a moderate risk of harm* and doses equivalent to more than *100mg equates to a high risk of harm*. Opioids taken for more than 90 days will have a reduced likelihood of benefit.
- Consideration of other specialist pain interventions (e.g. injections, TENS)
- Recent onset sciatica and chronic spinal pain - for specialist medication advice e.g. anti-neuropathic agents, advice about opiate prescribing and long term control, or specialist intervention (such as nerve blocks, epidural steroid injection etc.)

Inappropriate conditions for initial referral

Some conditions are not considered appropriate for initial referral, as further specialist investigation may be needed. It is for the responsible clinician to decide whether an initial referral to tertiary pain management services would be correct or whether to refer to other services.

- New neurological symptoms or signs, except unilateral sciatica.
- Recent trauma.
- Inflammatory conditions, such as suspected connective tissue disorders, poly-arthropathies or ankylosing spondylitis (consider initial referral to Rheumatology).

- Headache disorders may be more appropriate for initial assessment in Neurology.
- Pain problems where treatable pathology has not been adequately assessed and excluded (e.g. abdominal or pelvic pain) - consider referral to appropriate specialist
- When there has been a clear statement by a pain consultant that there are no further reasonable therapeutic options other than for a rehabilitative approach, the patient should not normally be re-referred with the same pain problem.

Information to be included in referral

Please give a thorough medical history and, to avoid these being repeated unknowingly, documentation of:

- Previous pain treatments tried and their outcome (efficacy/side effects).
- Investigations already performed. A significant number may not have a firm diagnosis.
- Reason for making the referral e.g. specialist medical advice/treatment or self-management advice/support.
- Relevant psychosocial information
- Current medications

For more information

SA Health

System Performance and Service Delivery

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Adelaide SA 5001

www.sahealth.sa.gov.au

Confidentiality I1-A1



www.ausgoal.gov.au/creative-commons