

## **CHANGES FOR PAIN MANAGEMENT AT RHH.**

We are writing to inform you of some new developments in the services that the Royal Hobart Hospital offers for the management of pain. There are also some new staff appointments and revised referral procedures.

### **CHANGE OF NAME.**

The 'Pain Management Unit' has been renamed the PERSISTENT PAIN SERVICE (PPS). This is intended to better convey the core purpose of the service, and the target patient population who will best benefit from our 'new pathway' (see below).

### **NEW STAFF APPOINTMENTS**

1. Professor Michael Ashby is the new director (Pain and Palliative Medicine).
2. Ms Jo Bratt is the Nurse Unit Manager.
3. Dr Chris Orlikowski is a new Staff Specialist in Pain Medicine.

Other specialists continuing: Dr Hilton Francis (Pain and Rheumatology), Dr Phil Reid (Psychiatrist), Dr Rob Paton (Pain and Anaesthetics), Dr Gajinder Oberoi (Pain Medicine) and Dr Pauline Waites (Pain and Neurosurgery). Our registrar this year is Dr Jack Dale.

### **NEW MODEL OF CARE**

The PPS operates a multidisciplinary model of care with a strong emphasis on patient self-management, known as our 'new pathway'. This is based on the approach of the Hunter Integrated Pain Service (HIPS), which can be viewed at <http://www.hnehealth.nsw.gov.au/pain>.

This site also gives excellent clinical advice to GP's about pain management [http://www.hnehealth.nsw.gov.au/pain/health\\_professionals](http://www.hnehealth.nsw.gov.au/pain/health_professionals). Of course, NSW law does not apply here, relevant Tasmanian and Federal regulatory information can be found at <http://www.dhhs.tas.gov.au/psbtas> and [www.pbs.gov.au](http://www.pbs.gov.au) respectively.

### **REFERRAL GUIDELINES**

Clients should be over 18 years of age and have had continuous pain for more than three months in the last six.

The PPS will advise on pain relief measures where possible, but the main emphasis is on helping patients to live with and manage their own pain. Our 'new' pathway (see below) is designed to give people the information, resources and encouragement to stop pain dominating their lives. We rarely offer cure.

All patients need to be aware that medical drug-based or interventional solutions alone for their pain are unlikely to be endorsed or recommended and that to get the best out of our services they will need to engage with psychology, physiotherapy, and nursing staff from our team.

Medical consultation is still available as part of this process, as a one-off, or occasionally a short course of consultations. Long-term attendance for medical management and drug treatment is not usually appropriate and indefinite referrals will not be accepted, especially in the first instance. A one-off medication review can be undertaken if there are pressing reasons for this, but the emphasis is on multi-modal and multidisciplinary self management. One of our clinics (Friday am, Professor Ashby) is done jointly with a pharmacist and there are plans to consult jointly with Addiction Medicine in that session for selected patients.

The referral needs to provide a brief pain history: Site(s), Radiation, Onset, Character, Aggravating factors, Relieving factors, Sleep, Function, together with a postulated cause if one has been identified.

The PPS medical response will be determined in the triage process, and the referring GP may be contacted by phone to discuss this, especially if, after discussion at our weekly triage meeting, PPS attendance is not considered to be of potential benefit to the patient.

Referral to the PPS will be on the understanding that an identifiable cause of the pain has either been excluded, or identified and treated, (especially life-threatening 'red flag' conditions), together with diagnosis and treatment for underlying psychiatric, and drug and alcohol dependence problems.

Our RED FLAG list is:

1. Central nervous system space occupying lesion – intracranial, spinal cord or cauda equina
2. Peripheral neuropathy
3. Neurodegenerative condition (for example, MS)
4. Malignancy (any)
5. Infection
6. Systemic, autoimmune or rheumatological conditions
7. Injury (for example, fractures)
8. Major psychiatric illness especially depression
9. Major substance abuse.

The REFERRAL PROCESS is as follows:

1. GP initial referral on generic RHH Specialist Clinics Referral Form (web-based referral access site being developed).
2. PPS triage on receipt of completed Referral Form.

Triage outcome options:

1. 'New' pathway.
2. 'Solo' medical assessment.
3. PPS attendance not recommended (GP to be contacted by phone and/or email to discuss).

New Pathway:

1. Patient Questionnaire sent to patient direct to complete and return to PPS. The patient may approach GP for assistance in form completion. It is essential that the form is returned, and if it is not returned within 30 days the referral will not be pursued further. PLEASE ADVISE THE PATIENT ACCORDINGLY, AND ASSIST THEM IF THERE ARE SPECIAL NEEDS.
2. Questionnaire received back from patient.
3. Invitation to PPS Pain Information Session.
4. Patient invited to Multidisciplinary assessment session (MDA): medical, psychology and physiotherapy.
5. Care plan formulated and sent to the GP for implementation.

'Solo' Medical Specialist appointment:

1. Patient Questionnaire sent to patient for completion.
2. PPS sends patient an appointment
3. Patient brings completed Questionnaire to the PPS appointment.

'MOVING WITH PAIN' COURSE

This is a course run on five half days over five weeks at the PPS by our team to assist patients in a group setting to improve function and their ability to live with pain. (information leaflets available on request).

GEOGRAPHY

As our 'new pathway' model of care requires several attendances (minimum two, seven with the Moving with Pain course) reasonable access to Hobart is required. For patients outside

Southern Tasmania AHS, we will contact the referring doctor to discuss the options for management in the first instance.

## **SPECIFIC ISSUES.**

### **OPIOIDS**

It is important that all parties are aware that the PPS, in line with public policy, and both relevant state and federal laws and regulations, is dedicated to ensuring that opioid and other S8 drugs are used effectively and in accordance with international standards of practice to ensure patient safety and minimize abuse and diversion.

Referrals for approval of prolonged opioid use will be dealt with by phone in the first instance. Referring GP's and patients need to understand that 'approval' for opioid monotherapy and dose escalation is unlikely to be given. The PPS very rarely supplies opioid medication, and will normally only recommend drug regimens to referring doctors to implement.

International best practice now discourages the use of opioids for persistent pain, and PRN opioids are largely contraindicated for it. Please consult the NPS website, especially [http://www.nps.org.au/health\\_professionals/publications/nps\\_news/current/nps\\_news\\_69](http://www.nps.org.au/health_professionals/publications/nps_news/current/nps_news_69). Long term dependence on these drugs may induce pain and sensitization, lead to side effects and distract from other approaches to living with pain and improving function.

### **DRUG ACCESS/FUNDING**

Referrals solely for drug access and funding issues will not be accepted.

### **MULTIPLE REFERRALS**

Please do not make multiple simultaneous referrals to different RHH units for the same problem. Such referrals will be detected in the triage process, and no patient will be given a PPS appointment until the outcome(s) of the other referrals for the pain problem in question is/are known. Patients who are awaiting a definitive surgical procedure for their pain problem are unlikely to engage with our approach, and will not normally benefit from PPS attendance.

### **PATIENT PHONE CALLS**

Patients should also be aware that phone calls to PPS are normally only accepted on matters related to appointments, and clinical matters will not normally be discussed over the phone.

### **RE-REFERRALS**

Re-referrals will only usually be accepted for new pain problems, and will mostly be declined if there is a history of non-compliance with previous PPS care plans in the past. These will all be discussed with the GP first so please do not tell patients that they will definitely be seen.

### **UNIT TO UNIT 'INTERNAL' REFERRALS AT RHH/STAHS**

We are also now requesting that units within RHH/STAHS who recommend non-urgent referral to PPS do so via the patient's GP.

### **PHONE/EMAIL ADVICE TO GP'S**

If you wish to discuss a patient please do not hesitate to send us a completed Referral Form indicating that you wish to have a telephone discussion with us in the first instance. One of our senior medical staff will then phone you at a mutually convenient time.

### **INTERVENTIONAL PROCEDURES**

Certain small sub-groups of patients do benefit from interventional procedures. This is a highly specialized area of practice. There is considerable expertise in the unit in this area of pain medicine. Selection is usually done after assessment by other relevant specialists and direct discussions with one of our interventional specialists (Drs Chris Orlikowski, Dr Gajinder Oberoi, Dr Rob Paton, Dr Hilton Francis).

### **EMAIL CONTACT**

If you feel happy to use this medium, please provide an email address for ease of communication with the referring doctor.

Thank you for your assistance. We would be happy to receive feedback.

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