

# Pain Management Services: The North Queensland experience

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# Outline:

- A brief introduction to Chronic Pain
- 2011 Context: Nation > State > Region
- The NQPPMS Model of Care
- Successes, barriers, challenges
- Activity, outcomes
- Teaching a man to fish
- Case presentation

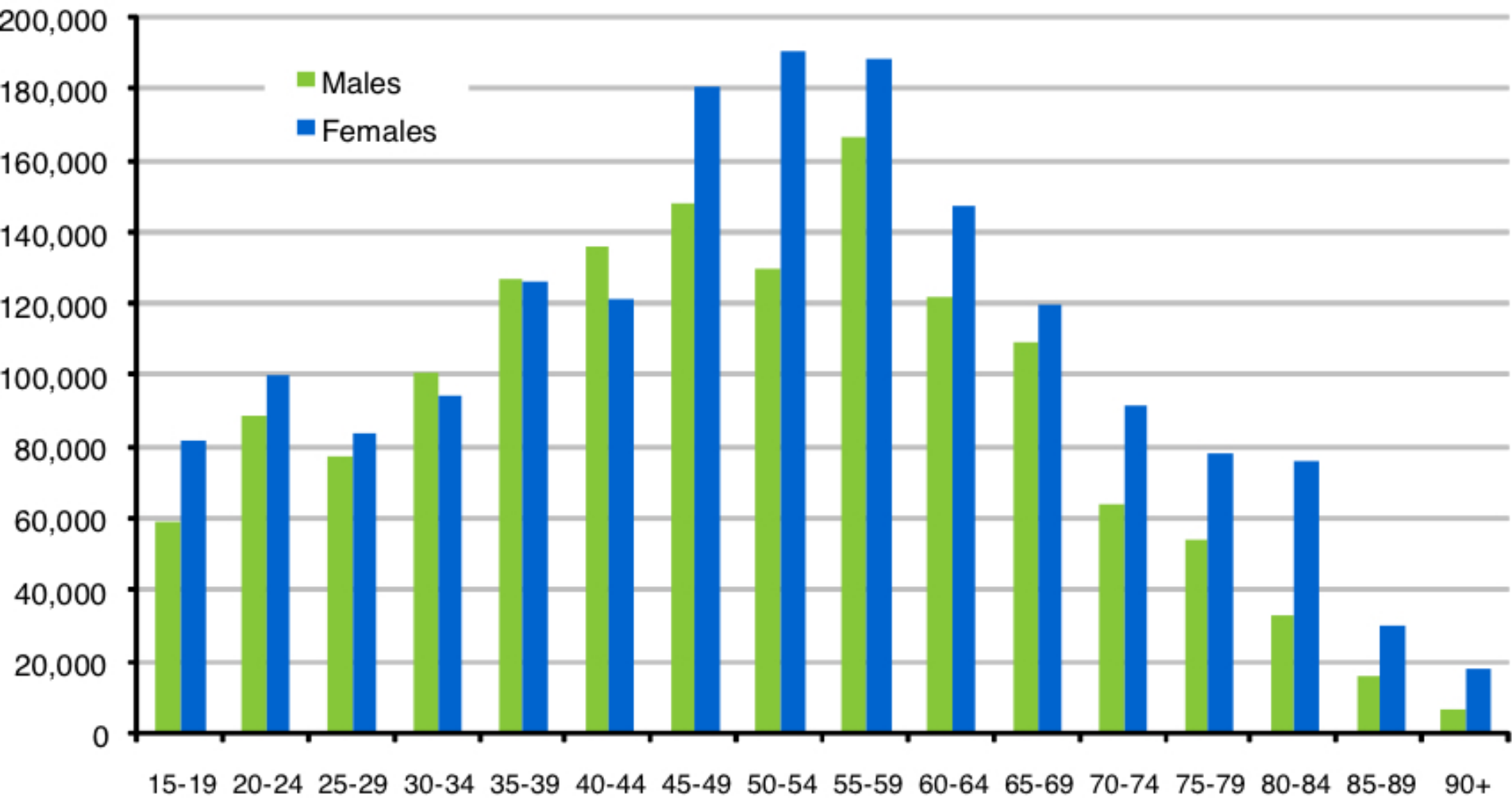
# Chronic pain: a chronic condition

- Acute pain a symptom of a condition
- Biomedical treatment / medical model
- Treatment > healing > **resolution**
- Treatment > healing > **on-going pain**
- Requires a different approach: whole of person, bio-psycho-social, rehabilitation
- Patient goals
- Patient thoughts and behaviours

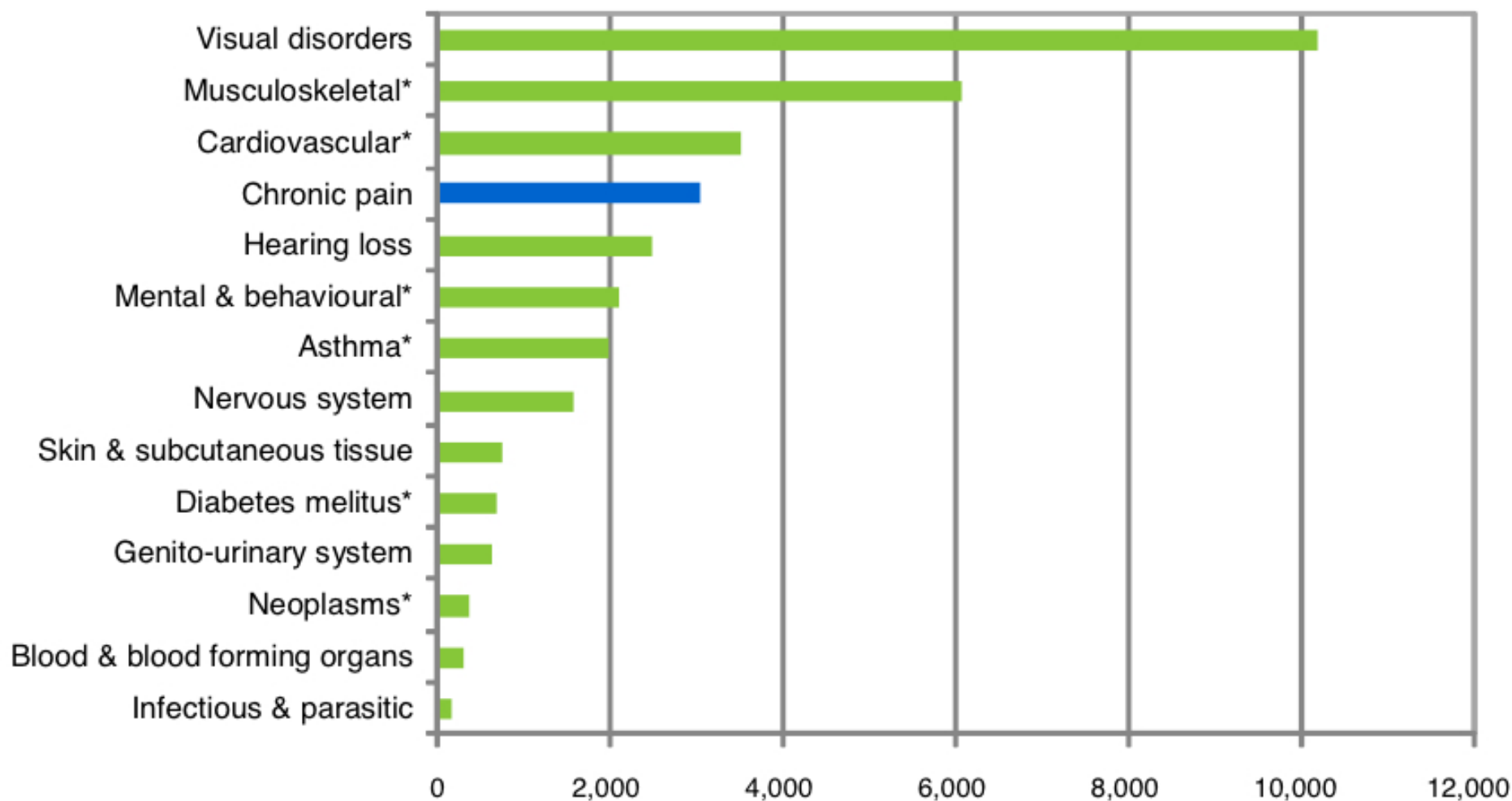
# Chronic pain: a chronic condition

- Pain duration greater than three months
- Pain that continues beyond the time expected for a painful condition or injury to heal
- Common: Point prevalence 1 in 5: 140 000 people in North Q; 4.8 M Australians
- Disabling
- Costly

# Prevalence of Chronic Pain, 2007



## Prevalence Comparisons – Chronic Pain and Other Conditions, 2005



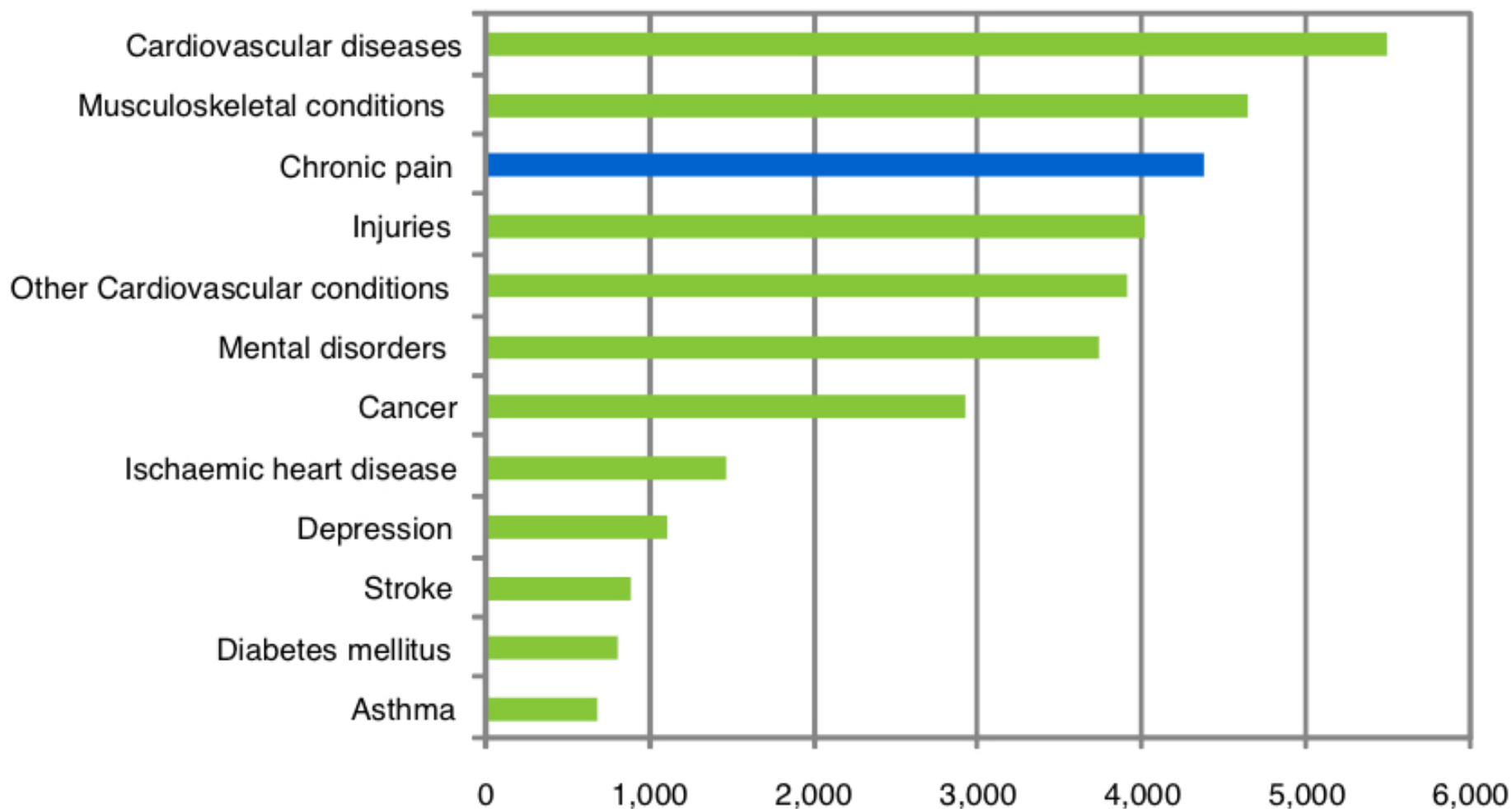
Prevalence (thousands of people).

\* National health priorities.

Source: Access Economics based on the Australian Bureau of Statistics (ABS) National Health Survey (NHS) 2004-05.

Note: Chronic pain, in addition to being a condition in its own right, is also an important component of NHPA conditions, for example cancer, musculoskeletal diseases and injuries.

## Health Expenditure Comparisons, Chronic Pain and Other Conditions, 2000-01 (\$ Million)



Source: Access Economics based on the Australian Institute of Health and Welfare - AIHW (2005).

Note: Chronic pain, in addition to being a condition in its own right, is also an important component of NHPA conditions, for example cancer, musculoskeletal diseases and injuries.

# 2011 Context

- National Pain Strategy
- New Queensland funding: Persistent Pain State wide Services Strategy
- Townsville funding: \$4M
- Local committee: GP liaison, mental health, addiction, pain medicine, rehabilitation medicine, allied health, nursing



# North Queensland Geography

- 700 000 people
- 751563 km<sup>2</sup>
- Area ~ 3.3 x Victoria
- Regional cities, rural towns, remote communities
- Indigenous population

[www.health.qld.gov.au/persistentpain/](http://www.health.qld.gov.au/persistentpain/)



# NQPPMS Model of Care

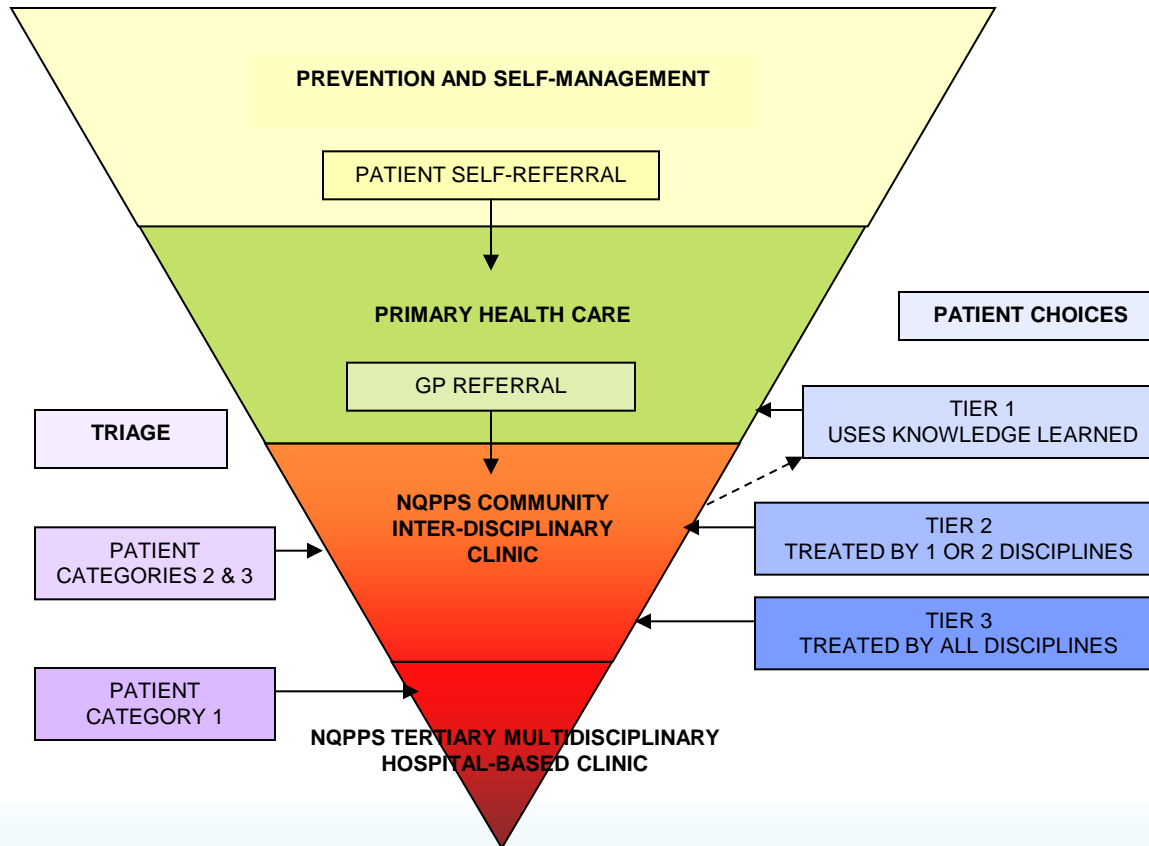
NQPPMS provides services that are

- **multi-disciplinary**
- **rehabilitation oriented**
- **self-management oriented and**
- **time-limited**

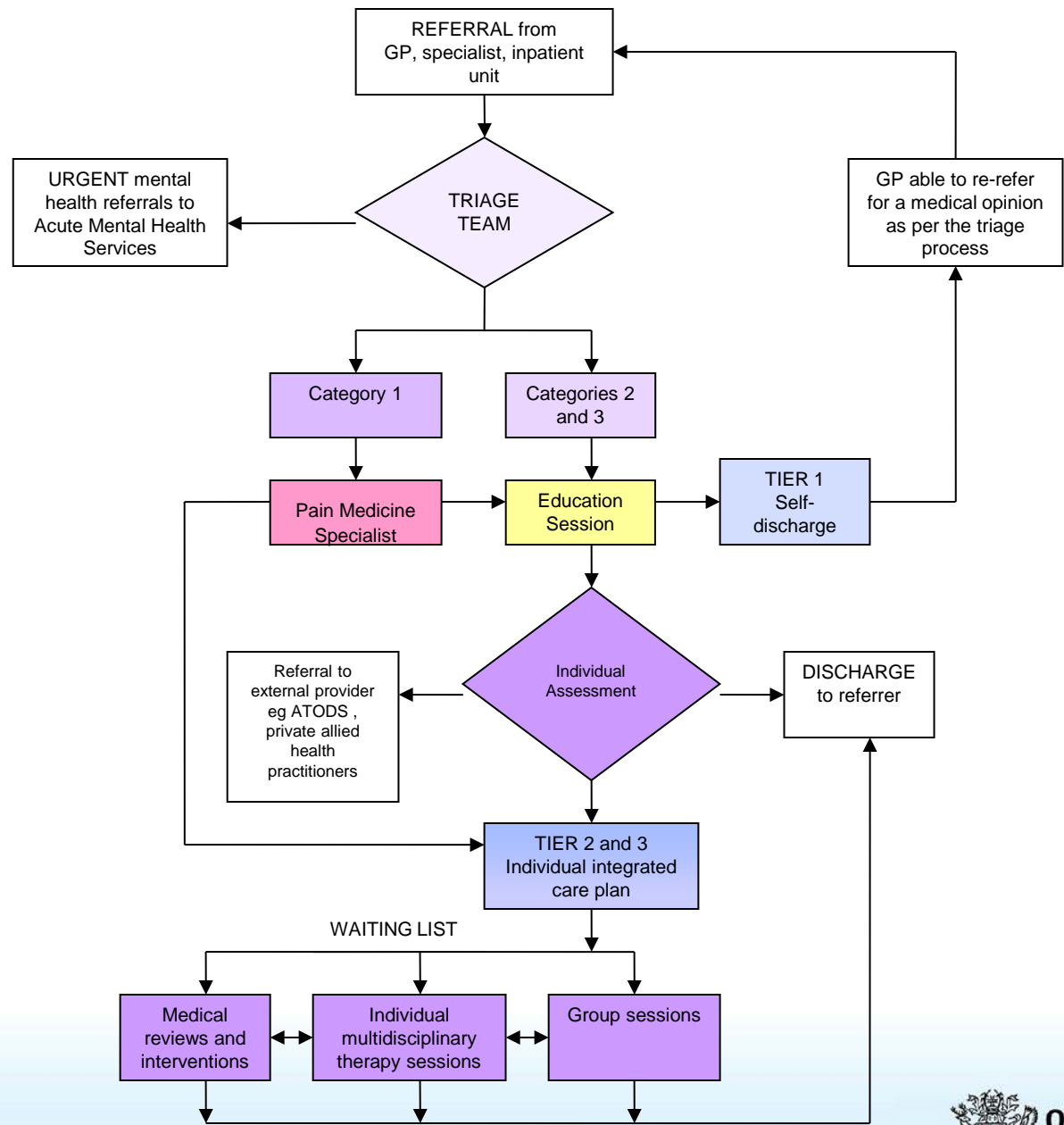
Care will return to the GP

- **Improve primary care capacity**

# Service Delivery Model

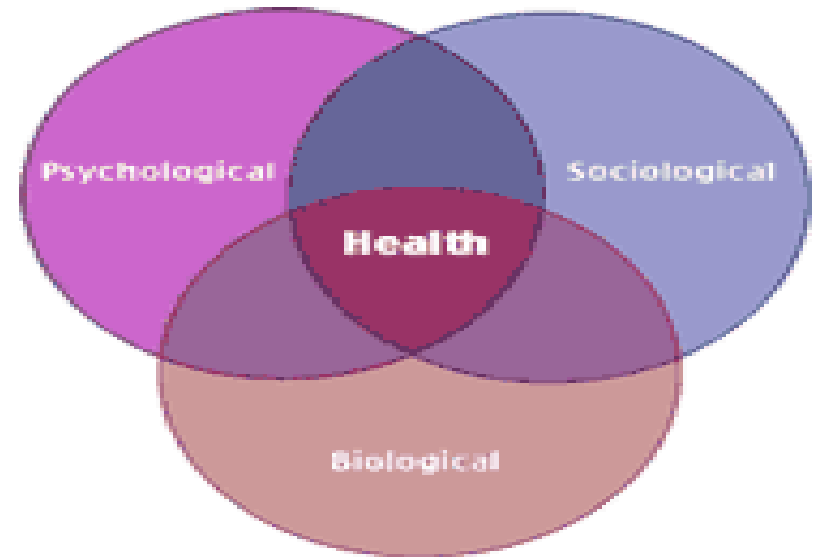


# Service Delivery Model



# A bio-psycho-social model

- Underpins the key role clinicians play in pain management
- Persistent pain is a subjective experience that involves all realms of an individuals life



# Successes

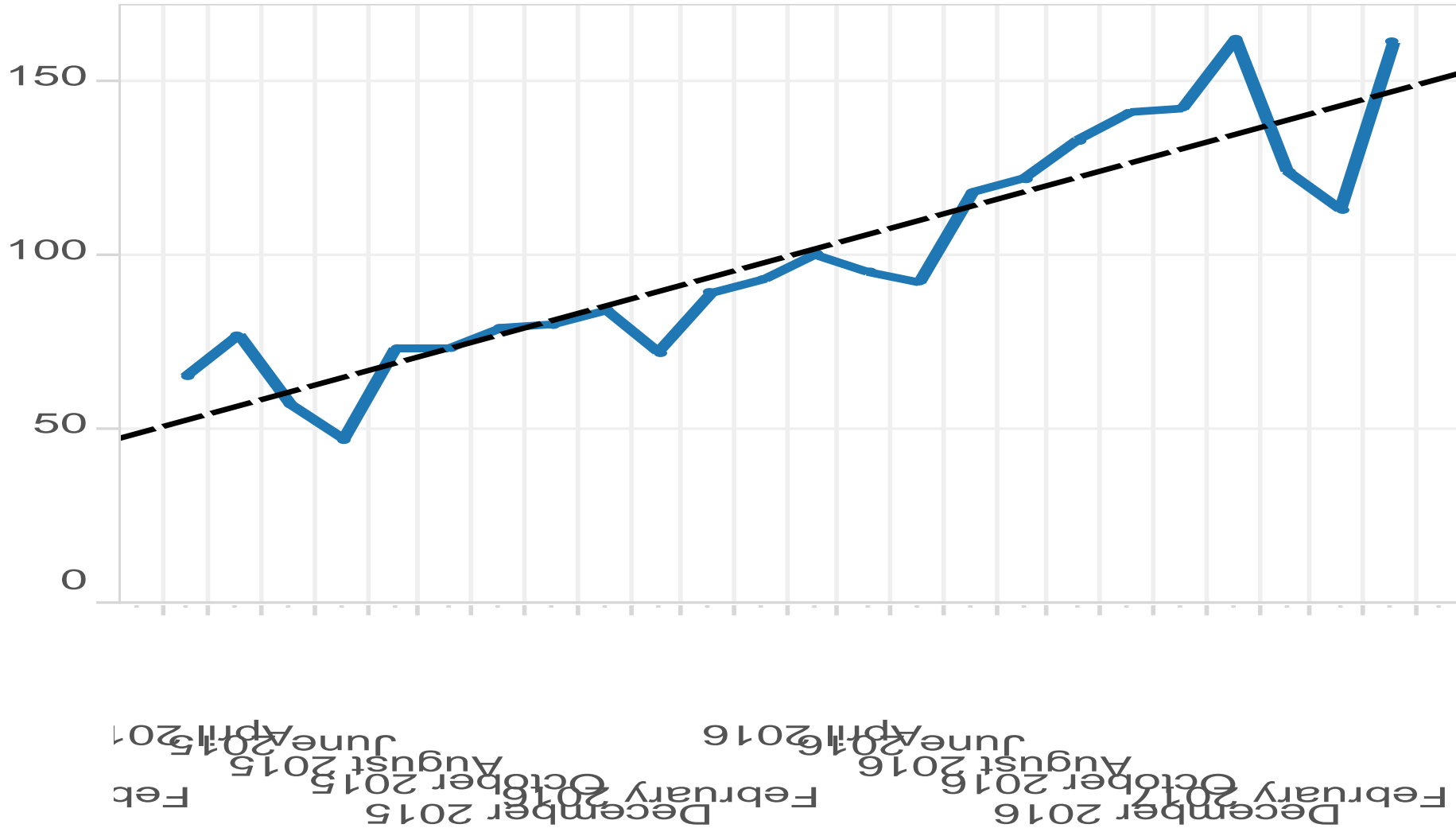
- Fresh team: Innovative model of care
- Pain management programs: EMPOWER
- Townsville hub, Cairns & Mackay spokes
- Accreditation for Pain Medicine training
- Annual Pain Management Workshops in Cairns, Mackay and Townsville
- Links with relevant specialist teams
- Telehealth
- ePPOC: benchmarking outcomes tool

# Barriers and challenges

- Fresh team: lack of experience
- Geography
- Five Hospital and Health Services
- Telehealth
- Research
- Demand > capacity
- Current model and funding inadequate to meet the demand > growing waitlists > poor team morale

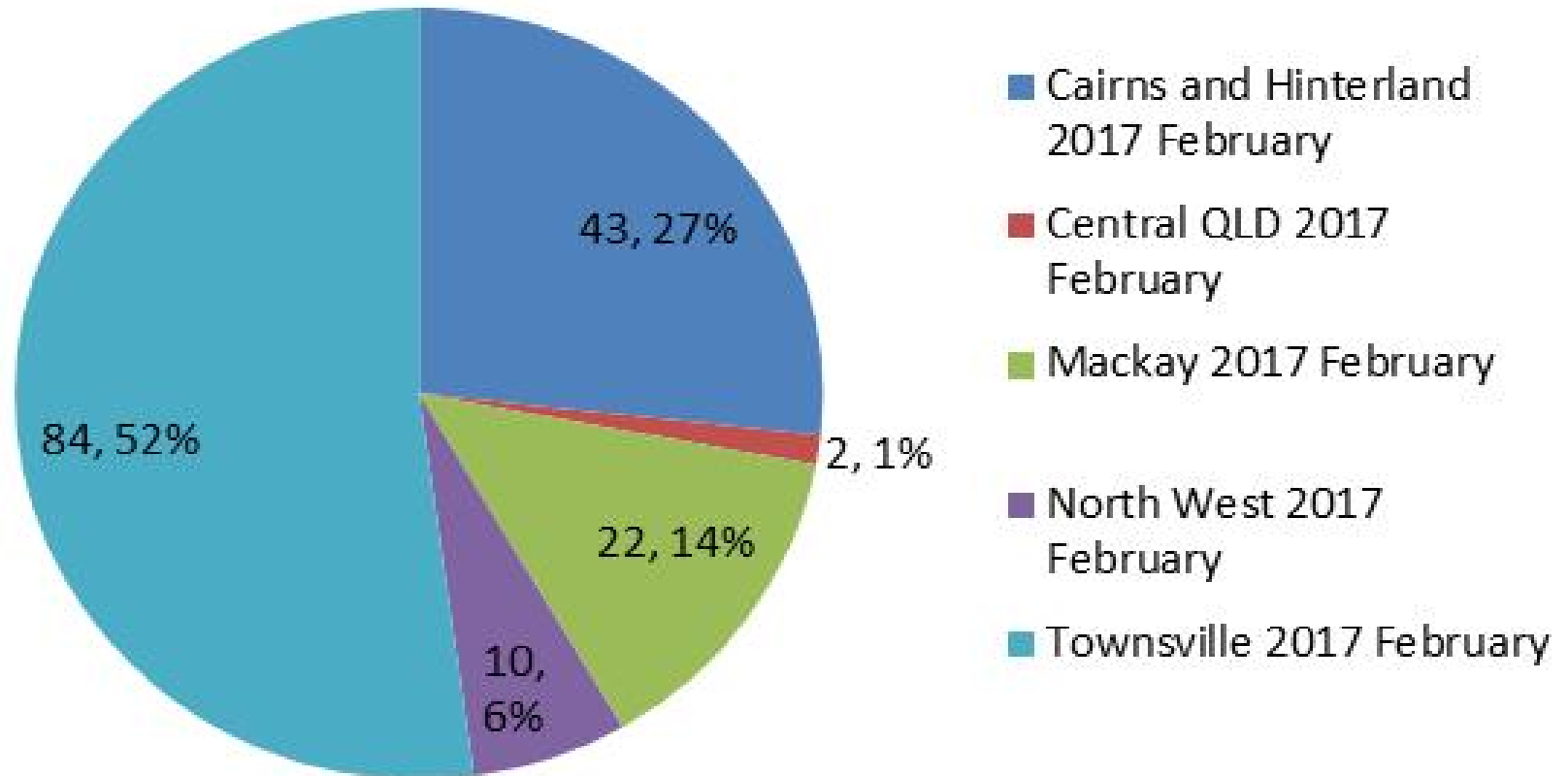
# Activity: referral numbers

Total Referrals Received



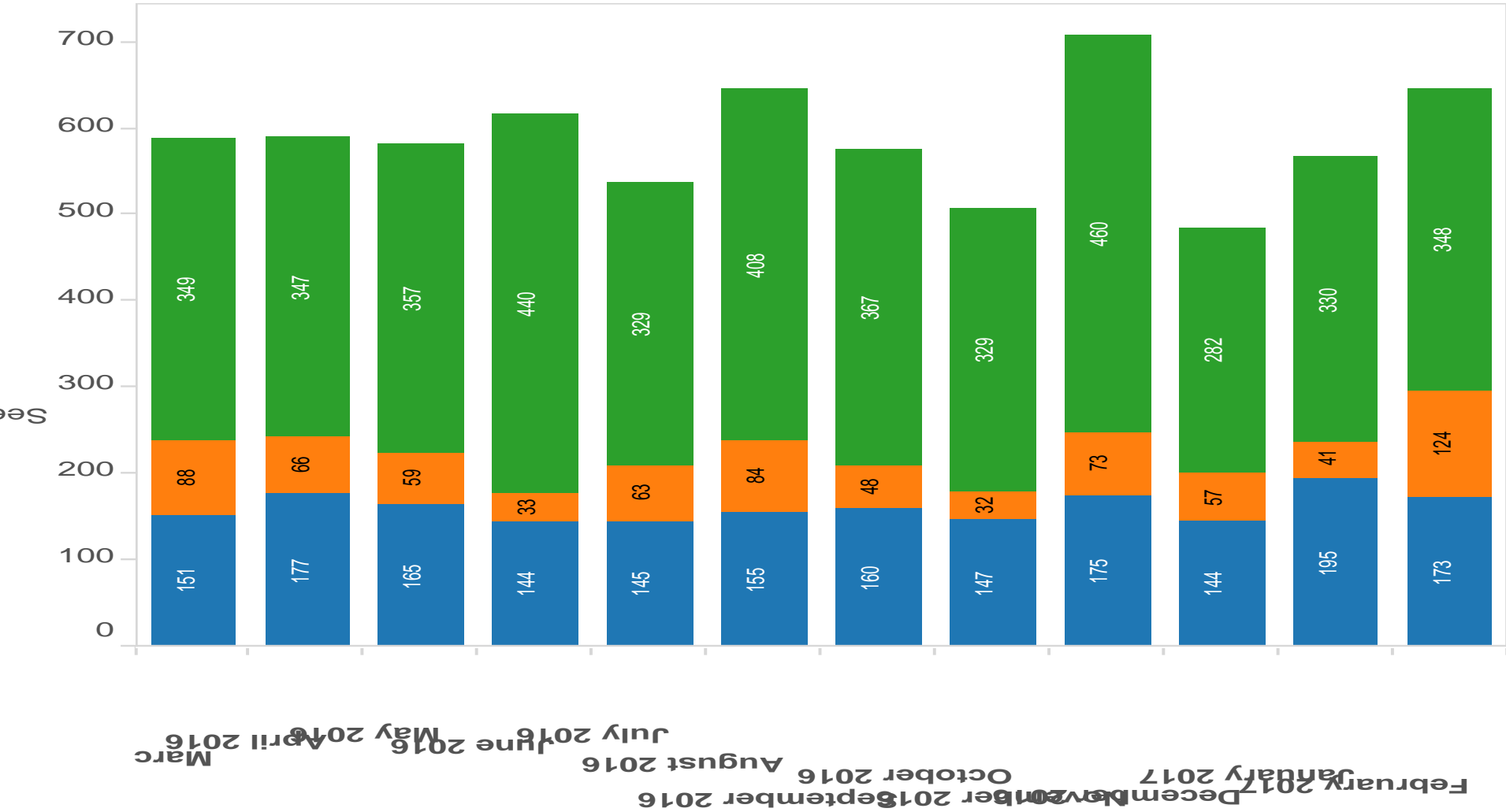


# Activity: referral geography

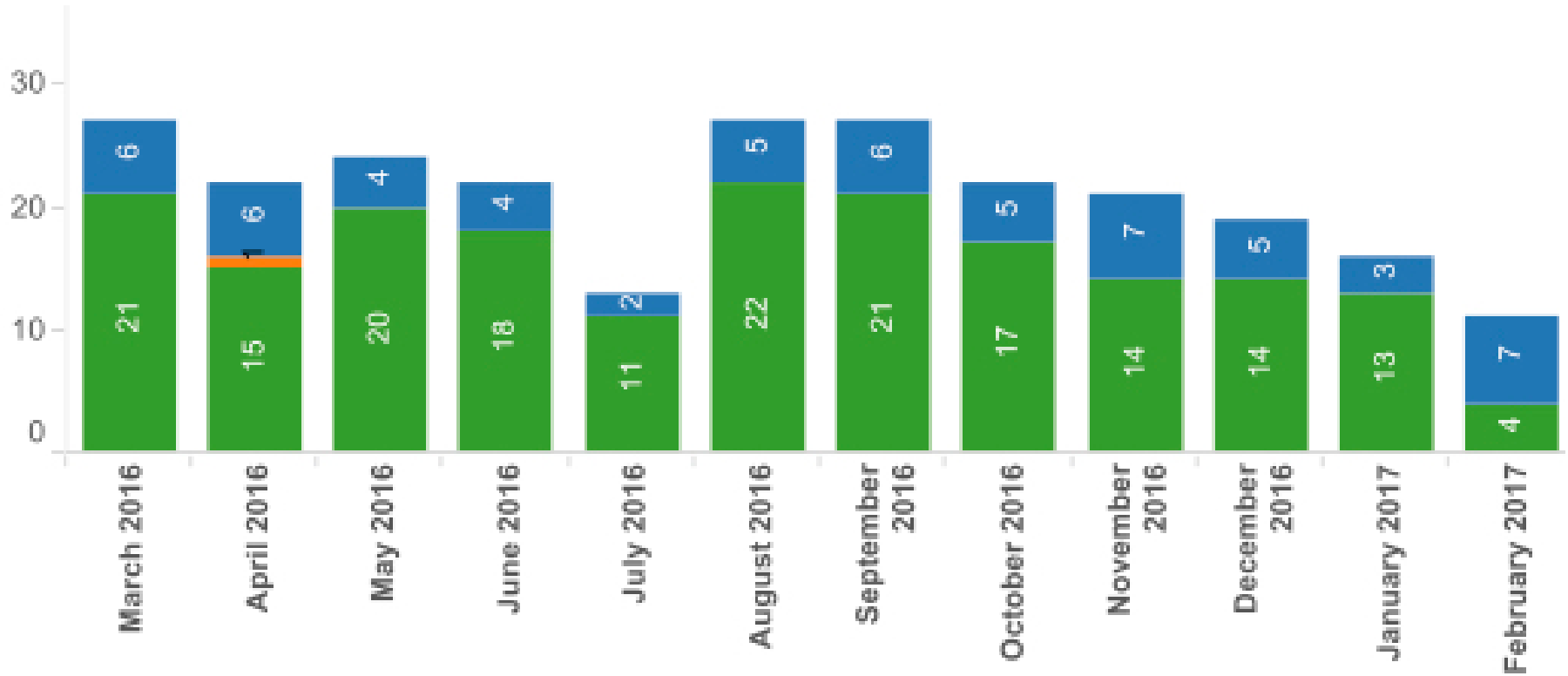


# Activity: occasions of service

DISCHARGED, SEEN, SEEN - ESWL



# Activity: tele-health OOS



# Patient demographics

	North Queensland	All services
Active patients	984	16790
Gender (female)	57.9%	58.4%
Average age (years)	50.9	51.1
Interpreter required	0.3%	5.4%
Communication assistance required	6.0%	9.7%
Indigenous status	7.2%	4.1%

# Outcomes

Percent of patients making clinically significant improvements from referral to episode end

North Queensland	Domain	All services
15.6	Average pain rating	25.1
35.9	Pain interference	57.5
21.4	Depression	50.5
21.4	Anxiety	39.3
37.5	Stress	52.1
46.9	Pain catastrophising	53.1
21.1	Pain self-efficacy	47.9

# Teaching: the need

- Pain management poorly taught
- Primary care workforce skills variable
- 1 in 5 > 700 000 people > 140 000 with chronic pain > capacity 1000 patients / yr
- Give a man a fish and you feed him for a day. Teach a man to fish and you feed him for a lifetime.
- 90% of Australians see a GP each year

# Teaching strategy

- Undergraduate medicine, nursing, physiotherapy, pharmacy and occupational therapy
- Psychology masters
- GP registrars
- GP supervisors
- GP's, primary care nursing and allied health > 400 attendees over 3 years
- RACGP accredited training provider

## Box 1 Pain management domains and core competencies

### Domain one

Multidimensional nature of pain: What is pain?

This domain focuses on the fundamental concepts of pain including the science, nomenclature, and experience of pain, and pain's impact on the individual and society.

1. Explain the complex, multidimensional, and individual-specific nature of pain.
2. Present theories and science for understanding pain.
3. Define terminology for describing pain and associated conditions.
4. Describe the impact of pain on society.
5. Explain how cultural, institutional, societal, and regulatory influences affect assessment and management of pain.

### Domain two

Pain assessment and measurement: How is pain recognized?

This domain relates to how pain is assessed, quantified, and communicated, in addition to how the individual, the health system, and society affect these activities.

1. Use valid and reliable tools for measuring pain and associated symptoms to assess and reassess related outcomes as appropriate for the clinical context and population.
2. Describe patient, provider, and system factors that can facilitate or interfere with effective pain assessment and management.
3. Assess patient preferences and values to determine pain-related goals and priorities.
4. Demonstrate empathic and compassionate communication during pain assessment.

### Domain three

Management of pain: How is pain relieved?

This domain focuses on collaborative approaches to decision-making, diversity of treatment options, the importance of patient agency, risk management, flexibility in care, and treatment based on appropriate understanding of the clinical condition.

1. Demonstrate the inclusion of patient and others, as appropriate, in the education and shared decision-making process for pain care.
2. Identify pain treatment options that can be accessed in a comprehensive pain management plan.
3. Explain how health promotion and self-management strategies are important to the management of pain.
4. Develop a pain treatment plan based on benefits and risks of available treatments.
5. Monitor effects of pain management approaches to adjust the plan of care as needed.
6. Differentiate physical dependence, substance use disorder, misuse, tolerance, addiction, and nonadherence.
7. Develop a treatment plan that takes into account the differences between acute pain, acute-on-chronic pain, chronic/persistent pain, and pain at the end of life.

### Domain four

Clinical conditions: How does context influence pain management?

This domain focuses on the role of the clinician in the application of the competencies developed in domains 1–3 and in the context of varied patient populations, settings, and care teams.

1. Describe the unique pain assessment and management needs of special populations.
2. Explain how to assess and manage pain across settings and transitions of care.
3. Describe the role, scope of practice, and contribution of the different professions within a pain management care team.
4. Implement an individualized pain management plan that integrates the perspectives of patients, their social support systems, and health care providers in the context of available resources.
5. Describe the role of the clinician as an advocate in assisting patients to meet treatment goals.



# Case illustration

- Dave, 52yo M mechanic, Charters Towers
- Married, kids left home
- 10+ years low back pain
- Oxycodone SR 80mg bd 'started by someone else', regular diclofenac
- Overweight, hypertensive
- Atenolol, amlodipine, statin
- No specialist report or investigations

# Case illustration

- **History:** deep aching low back pain, worse with forward flexion, no radiation
- **Physical exam:** tender low lumbar paraspinal muscles, normal lower limb and saddle neurological exam, FAbEr -ve
- **Investigations:** none required
- **Background:** healthy happy childhood, strong family supports / relationships, mild depression (frustration with pain)

# Case illustration

- **Formulation:** 52yo gentleman with nociceptive musculoskeletal low back pain (probably discogenic pain) with no red flags
- Opioid tolerance
- Non-prejudicial childhood
- Good supports
- Mild concomitant depressive illness

# Case illustration

- Adequate referral, Triage category 3
- Education: EQUIP 3 hour class
- Patient Assessment Day: 3 hr assessment
- 1:1 follow-up physio, psychologist
- (declined pain management program)
- Web-based videos
- Discharged after 11 months, with hand-over to rural physio and GP

# Case illustration

- **Medical management:** NSAID ceased, Opioids slowly weaned to cease over 14 months, no needle-based option
- **Physiotherapy:** graded increased activity,
- **Psychology:** CBT, relaxation techniques, sleep hygiene, mindfulness
- **Occupational therapy:** ergonomics of shed, Men's Shed

# 2011



# 2012



# 2013





# 2014



# 2016



# Management Team



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