CHRONIC PAIN

The Australian Prevention Partnership Centre
Systems and solutions for better health

Secondary prevention of chronic pain – PHN dialogue

A dialogue with Primary Health Networks

November 2019

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Prepared by: Menzies Centre for Health Policy, Faculty of Medicine and Health, University of Sydney for The Australian Prevention Partnership Centre

Contributing authors: Dr Simone De Morgan, Ms Leah Marks, Dr Duncan Sanders, Professor Fiona Blyth

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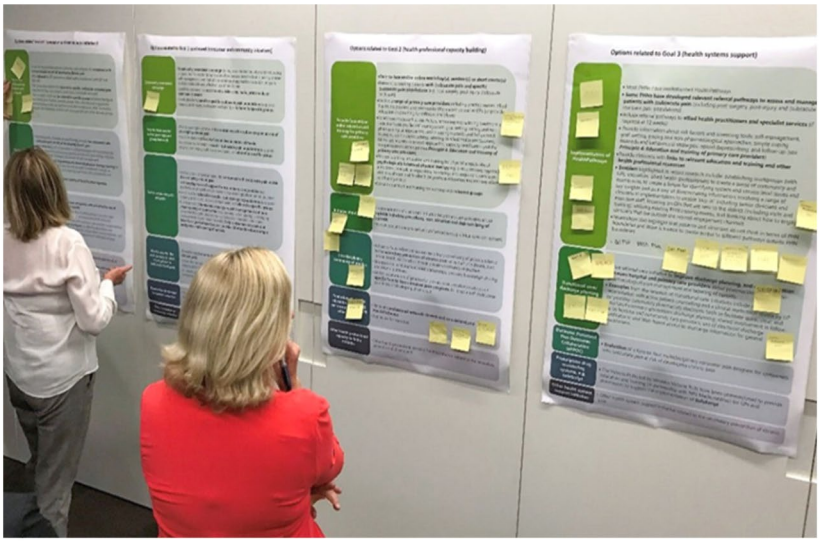

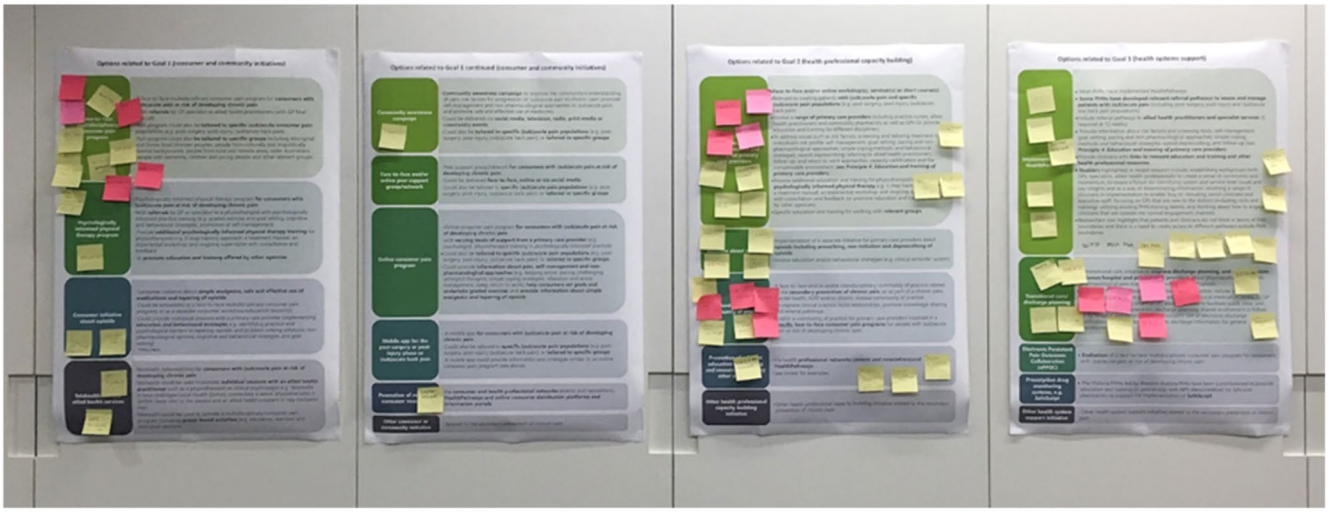

Dialogue summary

Chronic Pain Project

Chronic pain is a substantial public health issue that has a major impact on individuals, their families, workplaces and the community. The 2011-12 Australian Health Survey reports that 15.4% of Australians aged 15 years or older report are living with chronic pain. The prevalence of chronic pain is higher for women (16.9%) than it is for men (15.0%) and 68% of people with chronic pain are of working age. A recent report commissioned by Painaustralia estimated the cost of pain in Australia to be $73.2 billion each year including health system costs, productivity losses and other costs (e.g. informal care, aids/modifications).[1]

Overall objectives of the Chronic Pain Project[2]

The overall objectives of the project are to:

1. Synthesise knowledge about the secondary prevention and management of chronic pain; and
2. Improve knowledge, knowledge-sharing and knowledge use among Primary Health Networks (PHNs) about options to address the secondary prevention and management of chronic pain in primary care.

Steering group

A small, time-limited project steering group involving lead clinicians, consumers, PHN and Local Health Network representatives and key researchers in the field was identified with Painaustralia (the peak national body for pain advocacy and policy) to provide rapid guidance and input across the course of the project. *Steering group members are listed in* ***Appendix 1***.

Funding

The Chronic Pain Project at The Australian Prevention Partnership Centre is funded by the Medical Research Future Fund Boosting Preventive Health Research Program. Additional funding to support this project has been provided by the Sydney Medical School Foundation, University of Sydney.

Definitions

- **Pain** is defined as an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.
- **Chronic pain** is defined as pain that lasts or recurs for more than three months. Chronic pain has recently been classified as a disease in itself by the World Health Organization, International Classification of Diseases (WHO-ICD-11).
- **Acute pain** is defined as pain that occurs immediately post-trauma or post-surgery. It is often self-limiting and usually resolves with healing within 3 months.
- **Subacute pain** is defined as the phase that lasts between six to twelve weeks post onset of acute pain.
- **Secondary prevention** of chronic pain is the early intervention of acute and subacute pain [herein referred to as (sub)acute] to prevent the progression to chronic pain and associated disability.

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[1] Deloitte Access Economics. The cost of pain in Australia. Painaustralia March 2018.

[2] The Australian Prevention Partnership Centre: Strategies and models for preventing or reducing the risk of the development of chronic pain in primary care (2018–2020)

A framework of the types of chronic pain initiatives implemented in PHNs

In Phase 1 of the Chronic Pain Project, a framework of the different types of initiatives that PHNs were implementing related to the secondary prevention and management of chronic pain was developed. The framework is based on three goals adapted from the goals of the National Pain Strategy (Painaustralia)[3] and aligned with PHNs' remit**:**

Goal 1: Access to multidisciplinary care and improving consumer health literacy and care navigation

Goal 2: Ensuring health professionals are skilled and provide best-practice evidence-based care

Goal 3: Quality improvement and health system support

Results of the consultation with PHNs in Phase 1 of the project

The mapping of PHN chronic pain initiatives in Phase 1 of the project found a gap related to the secondary prevention of chronic pain with most initiatives currently being implemented by PHNs relating to the management of chronic pain.

As a result of the gap highlighted in Phase 1, the opportunities for PHNs to improve the secondary prevention of chronic pain is the primary focus of Phase 2 of the Chronic Pain Project.

Rapid review and mapping of the options

A report (including a rapid review and mapping of the options for PHNs)[4] was developed to inform a deliberative dialogue with PHNs about the secondary prevention of chronic pain. A deliberative dialogue is an evidence-based method used to support policy making by discussing and contextualising research evidence in the light of the real-world experiences of policymakers.(1-5) Participants received the report one week before the deliberative dialogue.

A range of options for the secondary prevention of chronic pain were developed for PHNs based on the evidence and the consultations with PHNs conducted in Phase 1 of the project. The options were stratified by the three goals of chronic pain initiatives implemented by PHNs, developed in Phase 1 of the project. Each option requires different implementation considerations, organisational and behaviour change, funding and adaptation to the local PHN context.

Participation in the PHN dialogue

- Twenty one participants, representing 16 PHNs and a state PHN alliance - WAPHA[5] participated in the PHN dialogue (61% of PHNs/WAPHA with a total of 31 PHNs - 28 PHNs, WAPHA - PHN=3). *Participants are listed in* ***Appendix 2***.
- All states and territories in Australia were represented in the PHN dialogue apart from Tasmania.
- Half of PHNs that participated in the PHN dialogue were metropolitan (N=8),[6] half were regional (N=8) and WAPHA (two metropolitan and one regional PHN).

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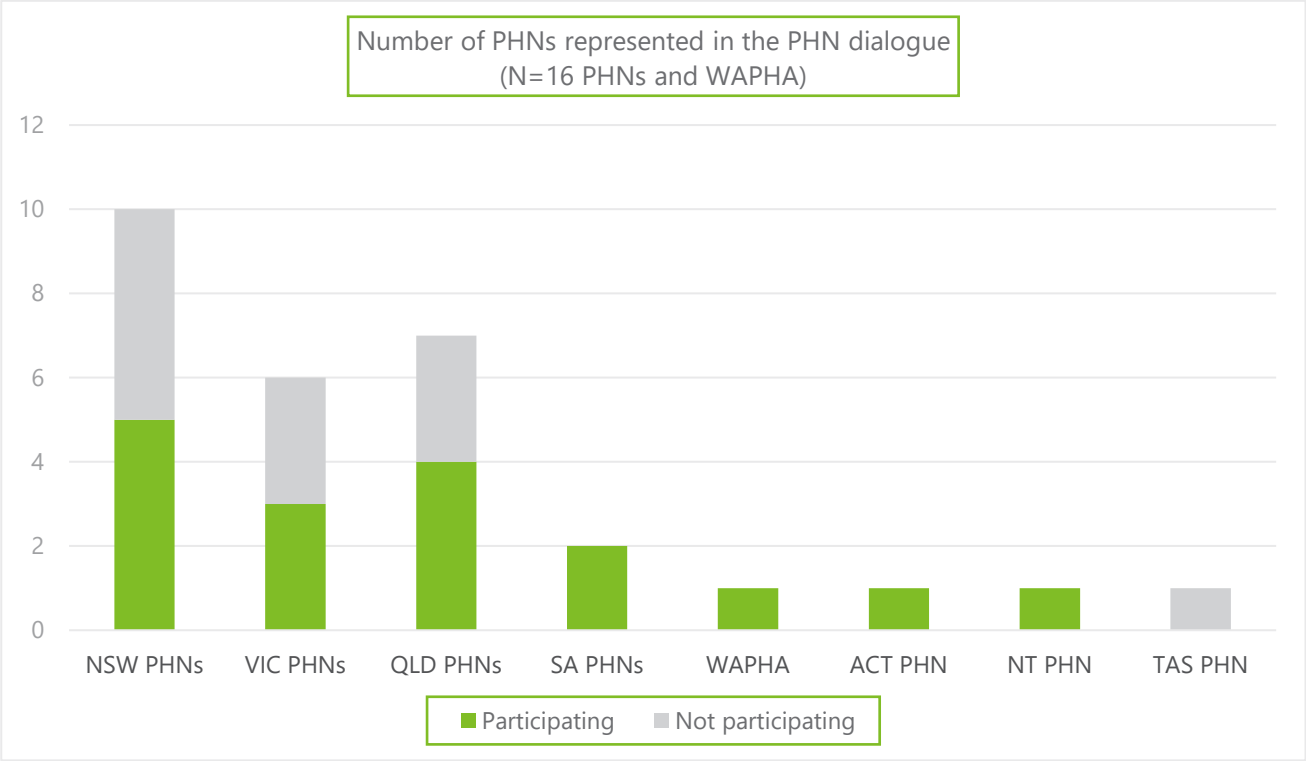
[3] Pain Australia. National Pain Strategy 2010. Available at: www.painaustralia.org.au/the-national-pain-strategy/national-painstrategy.html

[4] De Morgan S, Blyth F, Marks L, Sanders D, Mittinty M, Nicholas M. Secondary prevention of chronic pain: rapid review and mapping of options for Primary Health Networks. The Australian Prevention Partnership Centre and the University of Sydney, October 2019.

[5] WA Primary Health Alliance oversees the strategic commissioning functions of the three Western Australian Primary Health Networks: Perth North, Perth South and Country WA

[6] See Appendix 4 for the list of metropolitan and regional PHN areas



Description of PHN dialogue activities

i. Presentation of the evidence and options included:

a. Rationale for the secondary prevention of chronic pain informed by the evidence

b. Principles for the secondary prevention of chronic pain informed by the evidence

c. Map of options for PHNs related to the secondary prevention of chronic pain informed by the evidence and the consultations with PHNs conducted in Phase 1 of the project. The options were stratified by the three goals of chronic pain initiatives implemented by PHNs, developed in Phase 1 of the project.

ii. Activity 1 – Whole group discussion

- Participants were asked to think about the options for the secondary prevention of chronic pain presented, and highlight any other options, or examples of options, that they know of, have implemented, are implementing, plan to implement or think would be a good idea and were not yet included in the map of options or presented as examples. Four large posters displaying the options under Goal 1, Goal 2 and Goal 3 were used as visual aids to stimulate discussion.

iii. Activity 2- Sticky notes

- Participants were asked to review the complete map of options (including any additions from Activity 1) shown on the posters (and outlined in the presentation) and asked to:
  - Place up to three yellow sticky notes on the options that participants are implementing or interested in implementing in their PHN

- Place a pink sticky note on <u>one option</u> that participants are most interested in discussing in the dialogue

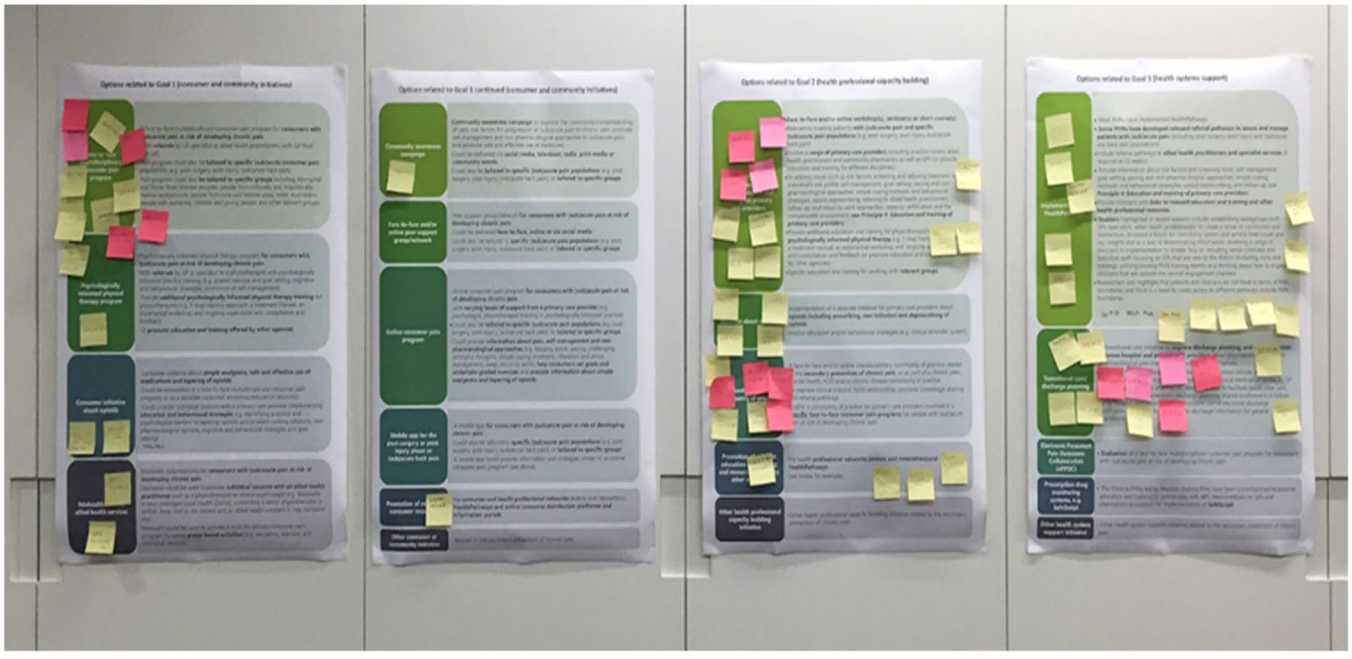
iv. Activity 3 - Small group discussion

- Participants formed small groups to discuss the option that they were most interested in discussing in the dialogue.
- Participants were asked to think about how the option could be implemented by their PHN, considering, for example, the role of the PHN, partners/commissioned agencies, resources required, funding models, organisational or behavioural change strategies and other enablers to implementation.
- Participants were asked to record on butcher's paper their ideas.
- Each group nominated a scribe and a person to report back to the larger group what they had discussed for whole group discussion.

v. Activity 4 – Whole group discussion

- Participants from each of the four groups reported back to the whole group their ideas, implementation considerations and related issues.

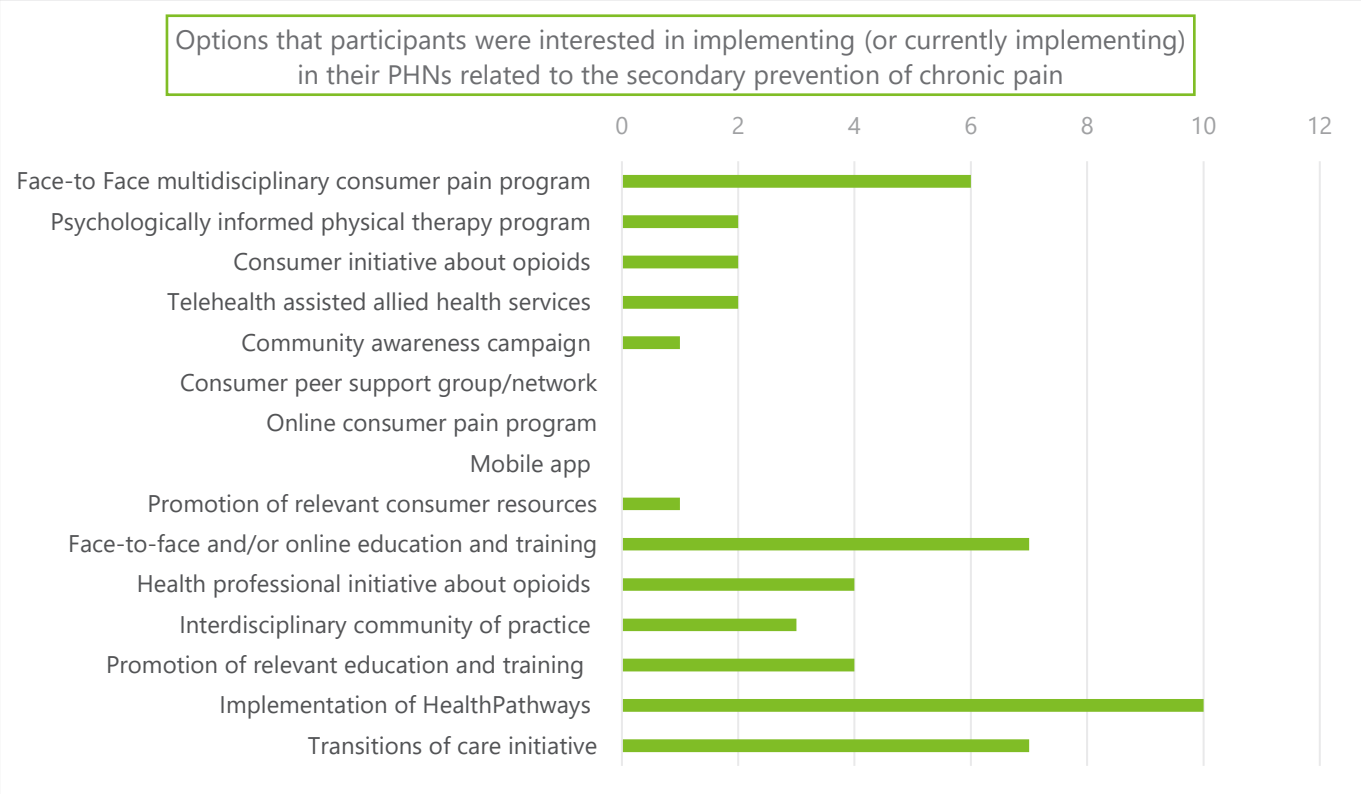
*See the PHN Dialogue Agenda in **Appendix 3** for information about the key features of the dialogue, purpose, outcomes and format of the dialogue.*



Results of the PHN dialogue

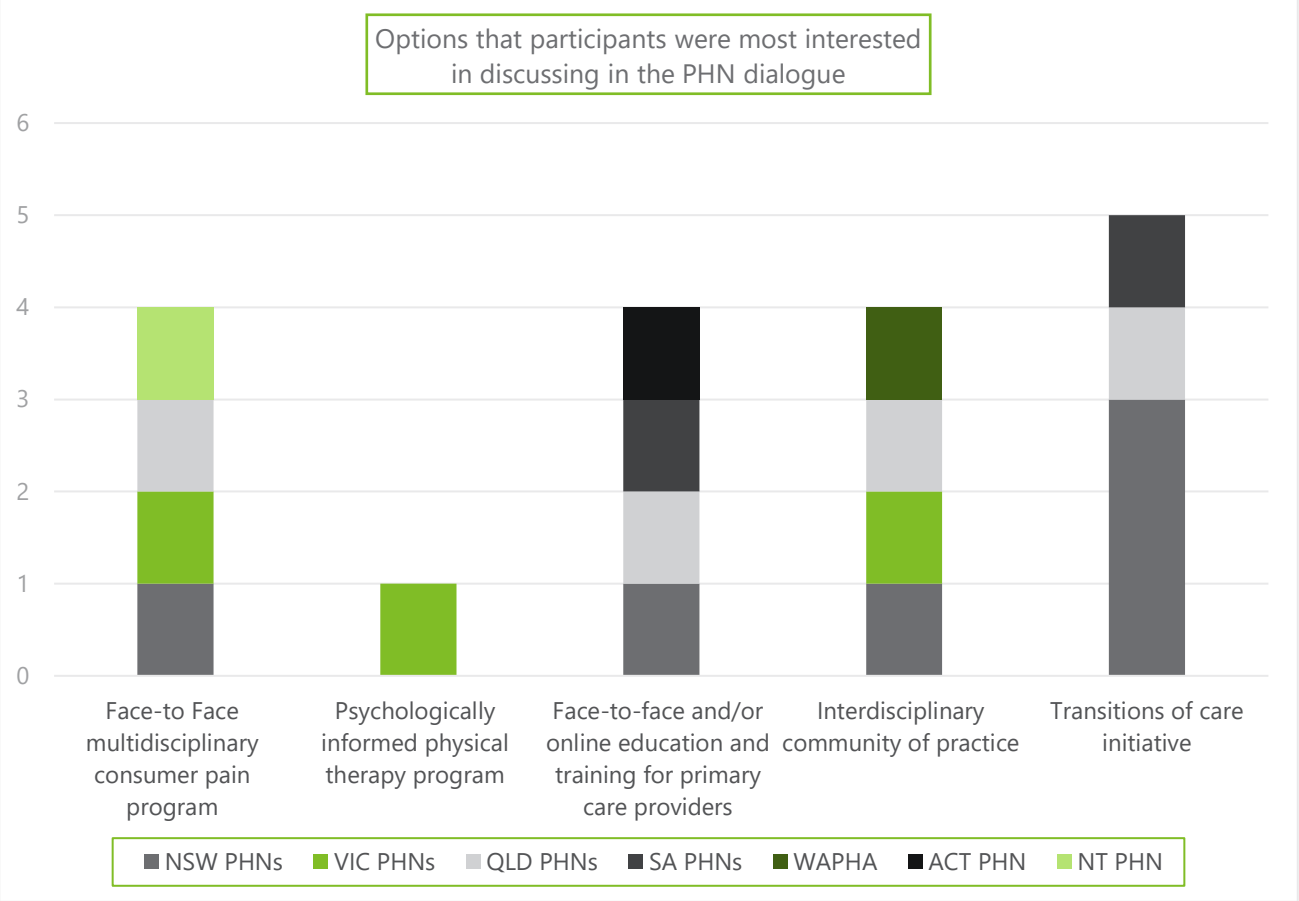
Options that participants are interested in implementing (or currently implementing) in their PHN related to the secondary prevention of chronic pain

- A range of options were selected by participants related to options they were interested in implementing in their PHNs (or currently implementing), as shown in the figure below.
- Responses for each of the selected options represented participants from a range of state and territory PHNs and both metropolitan and regional PHNs (apart from options that were chosen by one PHN - community awareness campaign; and promotion of relevant consumer resources).



Options that participants were most interested in discussing in the dialogue

- Five options were selected by participants as of interest to them to discuss in the dialogue (collapsed into four options as the fifth option had been selected by only one participant), as shown in the figure and table below.
- Responses for each of the selected options represented participants from a range of state and territory PHNs and both metropolitan and regional PHNs (apart from the option that was chosen by one PHN - psychologically informed physical therapy program).



Group 1: Face-to face multidisciplinary consumer pain programs	• N=7 participants representing 5 PHNs • Representing a range of state and territories PHNs including VIC (N=2), QLD (N=1), NSW, (N=1) and NT (N=1) • Including metropolitan PHNs (N=4) and regional PHNs (N=1) • Note, one participant (VIC) who was interested in discussing a psychologically informed physical therapy program joined this group
Group 2: Face-to-face and/or online education and training for primary care providers	• N=4 participants representing 4 PHNs • Representing a range of state and territories PHNs including NSW (N=1), QLD (N=1), ACT (N=1), SA (N=1) • Including metropolitan PHNs (N=2) and regional PHNs (N=2)
Group 3: Interdisciplinary community of practice	• N=4 participants representing 3 PHNs and WAPHA • Representing a range of state and territories PHNs including NSW (N=1), QLD (N=1), VIC (N=1) and WAPHA (N=1) • Including regional PHNs (N=3) and WAPHA
Group 4: Transitions of care initiatives	• N=6 participants representing 5 PHNs • Representing a range of state and territories including NSW (N=3), QLD (N=1), SA (N=1) • Including metropolitan PHNs (N=3) and regional PHNs (N=2)

Group 1 discussion: Face-to face multidisciplinary consumer pain programs

The following ideas, implementation considerations and related issues were discussed:

i. **Planning the initiative**

- **Different approaches to implementing consumer pain programs will be needed by different PHNs** in order to account for variation in geographic region and population need. Consumer pain programs will need to be adapted to the local context while maintaining fidelity to core features such as the target group and principles of best practice pain management.
- **Co-design of consumer pain programs is needed** with input from a range of local stakeholders such as consumers, GPs, hospital-based pain specialists, allied health practitioners, practice nurses, community pharmacists and commissioned providers. Establish a working group to plan the initiative. The co-design process also helps to create the 'buy-in' necessary to implement and sustain the consumer pain program.
- **Identify local champions** to help drive the implementation of the initiative, create the local 'buy-in' and engage the community, such as clinical local champions (for example, GPs with a special interest) and non-clinical local champions (for example, consumers, administrators).
- **Pilot the consumer pain program** and assess the feasibility and acceptability of the program. Modify the program based on feedback about what is working well and not working well (see below evaluation).

ii. **Target group for the consumer pain program**

- **Consumers with acute or subacute pain at risk of developing chronic pain (<12 weeks)**.
- **Screening tools and/or other risk-based assessments** (e.g. 'Yellow flags") implemented by GPs and allied health practitioners to identify people at risk of developing chronic pain.

iii. **Content and format of the consumer pain program**

- **Multidisciplinary and multi-modal** programs targeting physical as well as psychological and social aspects of pain and involving a team of different primary care providers.
- Programs should involve **education** (and practice-based learning), **physical activity** and **psychological strategies** (i.e. cognitive and behavioural strategies) and focus on self-management.
- Programs should include **group sessions and individual case management** (and referral to individual allied health practitioners as required)
    - See example of the Turning Pain into Gain consumer pain program adapted to the (sub)acute phase, discussed in the dialogue and included as a prototype in Appendix 9 of the report (A rapid review and mapping of options for PHNs).[7]
- **Delivery**
    - **Face-to-face**

[7] De Morgan S, Blyth F, Marks L, Sanders D, Mittinty M, Nicholas M. Secondary prevention of chronic pain: rapid review and mapping of options for Primary Health Networks. The Australian Prevention Partnership Centre and the University of Sydney, October 2019.

- Consider implementing an additional **online pain program** to enable greater access to care

iv. **Health professional education and training**

- **Upskilling of primary care providers**
  - **How to identify patients that would benefit the most from participating** in the consumer pain program including education and training about how to conduct screening and other risk-based assessments ('Yellow flags")
  - **The referral processes and procedures**
  - **To deliver the program** (for health professionals involved in delivering the program)
- **Promotion and engagement**
  - Promote the initiative and referral processes and procedures to relevant stakeholders e.g. primary care providers, hospital-based health professionals, consumers, hospital administrators, other stakeholders and partners (e.g. newsletters, events, HealthPathways)
- **Create incentives for GPs** (and other primary care providers) to refer to patients to the program (e.g. as part of Practice Incentives Program (PIP) introduced in August 2019 by the Department of Health (Australian Government)

v. **Integration of care**

- **Establish standardised referral pathways and processes** (*for example, Turning Pain into Gain consumer pain program adapted to the (sub)acute phase, proposes referrals by GP, specialist or allied health practitioner with final GP sign-off*).
- **Integrate screening tools and/or risk-based assessments and referral templates into HealthPathways**.
- **Develop and implement a plan for post-program community activities**, for example, community walking groups.

vi. **Evaluation**

- **Evaluation of the program is crucial for implementation success and sustainability**
- **Include regular feedback from consumers and health professionals** (surveys/interviews); and commissioned providers (*see example of the Turning Pain into Gain consumer pain program adapted to the (sub)acute phase, discussed in the dialogue).*
- **After the pilot**, if the consumer pain program has been shown to be feasible and acceptable, consider impact evaluation.

vii. **System level barriers**

- System level barriers highlighted by participants included **lack of reimbursement under Medicare for group-based consumer pain programs**; lack of recognition of acute and subacute pain as opposed to chronic pain for reimbursement under Medicare; and inadequate number of visits reimbursed under Medicare for allied health practitioners.
- Participants suggested that **PHNs should lobby the Commonwealth Government in partnership with peak consumer bodies** such as Painaustralia to prioritise the management and secondary prevention of chronic pain; and to change reimbursements under Medicare.

viii. **Cost, funding and sustainability**

- Participants acknowledged that **cost was a barrier** for PHNs to implementing consumer pain programs.
- Participants suggested that **PHNs need to be creative when considering funding streams** within the PHN to support the implementation of consumer pain programs.
    - Consider funding outside of their flexible funding budget.
    - Review all funding areas which might provide funding opportunities by integrating across different program areas, for example, Mental Health, Integrated Team Care and AOD budgets (with possible link to existing services)
- **PHNs may consider other funding models**, perhaps in combination with PHN funding, such as user pays and a consumer co-payment.
- Apart from financial sustainability, **local champions and engagement and 'buy-in' from GPs and other health professionals** were acknowledged as key factors to the sustainability of consumer pain programs

Group 2 discussion: Face-to-face and/or online education and training for primary care providers

The following ideas, implementation considerations and related issues were discussed:

i. **Greater education and training of primary care providers is needed:**
    - To improve their **knowledge about the secondary prevention of chronic pain**.
    - About how to conduct **screening and other risk-based assessments** ('Yellow flags") to identify patients at risk of developing chronic pain.

ii. **Integration of care:**
    - **HealthPathways** could be used to provide relevant information and tools to be accessed by GPs at the point of patient care.

iii. **Multi-modal delivery of education and training for primary care providers:**
    - Include **face-to-face and online training (e.g. webinars)**. Although GPs often prefer face-to-face training, online webinars will allow greater access to education and training particularly in regional and rural areas.

iv. **Incentives:**
    - Continuing Professional Development points (**CPDs**) accredited by the relevant professional bodies
    - **Practice Incentives Program (PIP)** introduced in August 2019 by the Department of Health (Australian Government)

v. **Funding:**
    - The **main barrier for PHNs** in implementing education and training for primary care providers about the secondary prevention of chronic pain is funding.
    - Consider **adapting chronic pain education and training** currently provided by most PHNs to include information about early intervention in the acute and subacute phase of pain.

vi. **Greater education and training at the undergraduate and post-graduate level about the secondary prevention of chronic pain**

- Although not in the PHNs scope to implement this training, **PHNs could promote undergraduate and postgraduate education** focusing on early intervention.

vii. Project Extension for Community Health Outcomes (ECHO)

- Project ECHO is a capacity-building intervention for sharing knowledge, disseminating best practices, and building a community of practice. **Project ECHO** offers ongoing support for primary care providers in pain management and enables greater access to specialists and other primary care providers practicing in similar settings. The model is based on two components: a) education modules delivered by specialists, tertiary allied health practitioners and primary care providers; and b) case management (telementoring) of clinical cases presented by primary care providers. The model has expanded rapidly with over 140 ECHO projects currently established globally. *For more information about Project ECHO see* **Appendix 5**.
- **Western Victoria PHN** has implemented Project ECHO Opioid Management Clinic. The Project ECHO Opioid Management Clinic is currently available on a weekly basis as an online one-hour meeting connecting addiction medicine specialists and psychiatrists and allied health at St Vincent's hospital (hub) with primary care providers (spoke) to upskill primary care providers in opioid management. The program is funded through the Pharmacotherapy Area Based Networks, PHN and health service provider.
    - Western Victoria PHN is currently in **the planning phase for implementing Project ECHO (chronic pain)** to be launched in February 2020.
- *For information about the costs of implementing Project ECHO see* ***Appendix 5***.

Group 3 discussion: Interdisciplinary community of practice

The following ideas, implementation considerations and related issues were discussed:

i. To establish a PHN Chronic Pain Community of Practice (CoP) related to the secondary prevention and better management of chronic pain

- **Led by WAPHA and three PHNs** (Western Victoria PHN, Murrumbidgee PHN, Darling Downs and Western Moreton PHN, representing four states – WA, VIC, NSW and QLD).
- **Utilising an existing framework** for establishing a community of practice, for example,
    - Community of Practice to promote best practice and build capability in consumer/carer engagement and participation across the health sector in WA. https://www.healthengagement.org.au/landing?from=https%3A%2F%2Fwww.healthengagement.org.au%2Fposts%2F4042738
    - Community of practices to support Health Care Homes trial sites
- **Aims** may include (see CoP – WA example above)
    - Sharing information, resources and experiences with other PHN members of the community, to develop understanding and improve initiatives
    - Supporting the reduction of duplicated process and systems and improved coordination of initiatives where appropriate
    - Providing each other with online and live forums or other activities that add value to the purpose and inspires and sustains our work
    - Exploring opportunities for collaborative projects among PHNs members

- Fostering the commitment to the secondary prevention and better management of chronic pain

- Initial action: **Set up a space on PHNSharepoint as a PHN-only Community.**

ii. **PHNs could participate in existing Community of Practices.** Examples include:

- The **Pharmacotherapy Area-Based Networks (PABN)** are a Victorian Government initiative to provide opioid pharmacotherapy support for primary care medical practitioners and pharmacists across the state of Victoria including metropolitan, regional and rural areas. There are two metropolitan and three regional PABNs (Barwon South West, Grampians, Loddon Mallee, Gippsland, Hume, Southern and Eastern Melbourne, North West Melbourne). Each PABN is structured to meet local need and includes management and specialist teams such as GPs, Addiction Medicine Specialists (AMS), Clinical and AOD nurses, and pharmacists. The PABNs offer a range of support, including: direct access to Addiction Medicine Specialists; clinical networks and peer based mentoring; professional development events and accredited training; whole-of-practice staff training; e-Newsletters and communications delivering important updates; expert advice regarding best practice and up-to-date medical findings; and support for health professionals to navigate the pharmacotherapy system (e.g. permits, MBS items, referral pathways).
- **Project Extension for Community Health Outcomes (ECHO)**. *For more information about Project ECHO see Health professional education and training below.*
- **Murrumbidgee Mental Health and Drug and Alcohol Alliance** through which stakeholders from the health, community and social services sectors can develop a strategic approach to meeting the mental health and drug and alcohol needs and expectations of consumers.
    - Murrumbidgee Local Health District project funded by the Mental Health Commission of NSW in 2015.
    - The Alliance includes the Murrumbidgee Primary Health Network, Family and Community Services, Riverina Medical and Dental Aboriginal Corporation and community-managed organisations.
    - *Map My Recovery Services Mapping* and *Integrated Referral form.*
- **Pain Revolution Hubs** e.g. Murrumbidgee- monthly meetings, case conferencing
    - The Pain Revolution (https://www.painrevolution.org) runs community awareness and health professional education events in rural and regional areas of Australia. Community-based interdisciplinary Local Pain Collectives (LPCs) of rural and regional health professionals deliver peer learning exchange meetings in order to promote best-practice pain education and care.
- The **Mental Health Professionals' Network (MHPN)** provides practitioners the opportunity to participate in two interdisciplinary programs: MHPN practitioner networks and the National online professional development program. https://www.mhpn.org.au/
    - The MPHN aims to improve interdisciplinary and collaborative care practices between mental health professionals. MHPN works with member, partner and other organisations, as well as professional associations, within the mental health arena. These relationships allow MHPN to work collaboratively to help practitioners work together better, to improve referral pathways and consumer outcomes.
    - Governance for the MPHN is provided by a board of directors from four member organisations: The Royal Australian College of General Practitioners, Australian

Psychological Society, The Royal Australian and New Zealand College of Psychiatrists, Australian College of Mental Health Nurses.

- **Mental Health and Alcohol and Other Drugs (AOD) Collaborative Working Groups**
    - E.g. Perth, WA- facilitated by North Metro Health Service
    - E.g. Southwest Mental Health and AOD collaborative, WA (includes WAPHA and WA Country Health Service)
- The **NSW Agency of Clinical Innovation (ACI), Pain Management Network**
    - Brings together consumers and clinicians to promote equity of access to pain management services for patients with chronic pain and determine priorities for action. It also develops and supports implementation of new evidence-based models of care to improve integration and co-ordination of care between hospital-based specialist multidisciplinary pain clinics and community and primary health services. The Pain Network offers specialist care within a pain clinic environment but also aims to develop knowledge management strategies aimed at the community, addressing the stigma associated with chronic pain, and provides resources for primary care practitioners to better manage patients with chronic pain.
    - Monthly teleconferences of the executive
    - Contact: Sue Rogers, Pain Management Network Manager +61 2 0436 611 400 Susan.Rogers1@health.nsw.gov.au

Group 4 discussion: Transitions of care initiatives

The following ideas, implementation considerations and related issues were discussed:

i. **Examples of enablers of transitions of care initiatives related to surgery were identified:**

- A PHN **Integrated Care Strategy** in partnership with Local Health Districts/Local Hospital Networks to ensure care is patient centred and coordinated across different providers in the health system.
- **General Practitioner Liaison Officers** (GPLOs) co-funded by PHNs and Local Health District/Local Hospital Networks that aim to improve communication between local GPs and hospitals. Drug and Alcohol GPLOs can also help to improve communication between local GPs and hospitals related to opioids (and other drugs).
- **Drug and Alcohol Clinical Nurse Consultants (CNCs)** integrated within general practices.
- **Programs to support local general practices by integrating a non-dispensing pharmacist** within the general practice with the aim of providing medication-related advice to patients.
- **Partnerships with government and non-government agencies that focus on pharmacist services**, for example, SA Pharmacy provides pharmacy services to South Australia's metropolitan public hospitals and at country hospitals with on-site pharmacy departments and associated outreach sites.
- **Links to opioid stewardship programs in hospitals** to improve opioid prescribing in the peri-operative phase and at discharge from hospital.

ii. **Ideas about transitions of care initiatives related to the pre-surgical and/or post-surgical phase**

- A **local model of care for the pre-surgery phase could be developed by PHNs**. Ideas include:

- GPs to conduct **screening or other risk-based assessment** ('yellow-flags") of patients at the point of surgical referral (or other appropriate timepoint prior to surgery such as shortly before their surgery date) to determine the risk of developing chronic pain and opioid dependency.
    - Screening tools or other risk-based assessment should be provided to GPs via IT software that they regularly use (e.g. Medical Director or Best Practice), and linked to HealthPathways, to embed screening into routine care
    - Ensure results from screening or other risk-based assessment are integrated into the patient's Electronic Medical Record (EMR)
- In addition, implement a **patient education initiative**, for example:
    - Patient consultation with a practice nurse or pharmacist (if within the general practice) prior to surgery and dissemination of patient information sheets.
    - Patient information sheets may include questions to ask, a list of practitioners who have additional training in pain in their area (including GPs, allied health practitioners e.g. physiotherapists, and specialist pain services), and information about pharmacological and non-pharmacological pain management.
    - Patient information sheets could also be available in the waiting rooms in general practices (and surgery practices) and available on HealthPathways for GPs to promote to their patients

- A **local model of care for the post-surgery phase** could be developed by PHNs. Ideas include:
    - Involve **a range of health professionals** in the planning phase, for example:
        - Specialist pain services (if available in the PHN); hospital-based specialists such as surgeons, anaesthetists and allied health practitioners; co-ordinators of hospital opioid stewardship programs; managers of hospital drug dependency units; General Practitioner Liaison Officers; community pharmacists (especially pharmacists integrated into general practices); practice nurses in general practices; GPs; and community allied health practitioners.
    - Develop a **discharge referral pathway** on HealthPathways
        - Ensure GP engagement via a clinical working group
        - May be able to be fund this initiative using the PHN HealthPathways budget
    - Develop a **standardised discharge template**
        - Ensure information is integrated into the patient's Electronic Medical Record (EMR)
    - Could include a patient **education initiative** about recovery after surgery, for example, patient consultation with a practice nurse or pharmacist (if within the general practice) after surgery and dissemination of patient information sheets.
    - Initiatives must be supported by **education and training** of GPs, community pharmacists and allied health practitioners (with CPD points) about best-practice pain management (pharmacological and non-pharmacological) for the acute and subacute pain phase.

Other options identified by PHNs not included in the map of options

- The **Practice Incentives Program (PIP)**[8] introduced in August 2019 by the Department of Health (Australian Government) was identified by participants as having the potential to drive quality improvement activities related to the secondary prevention and better management of chronic pain, including consumer and health professional initiatives. Suggestions from participants during (and after) the PHN dialogue included:
    - **NPS MedicineWise** - Education visit (e.g. Opioids and the bigger picture when treating chronic pain), Clinical e-Audit (e.g. Neuropathic pain - a roadmap for diagnosis and management), Online course (e.g. VIC- use of SafeScript), Clinical case study (e.g. Taking action for acute low back pain - a clinical update on quality use of imaging and managing patients with low back pain; Chronic pain: Opioids and beyond case study), Webinar, Pharmacy Practice Review (Opioids: reducing harms from long-term use), RACF Medicinewise Report, Medicines Use Review, National Prescribing Curriculum https://www.nps.org.au/cpd/professions/activities?
    - **Health professional education and training for primary care providers offered by other agencies** such as Pain Management Research Institute, University of Sydney; Faculty of Pain Medicine, Australian and New Zealand College of Anaesthetists (ANZCA); NSW Agency for Clinical Innovation (ACI); Royal Australian and New Zealand College of Radiologists (RANZCR); and the Royal Australian College of General Practitioners (RACGP). *See Section 5 in the rapid review and mapping of options report for more information.*
    - **Health professional education and training for primary care providers developed and implemented by PHNs or commissioned by PHNs**
    - **Examples of topics** for health professional education and training for primary care providers:
        - *Principles for the secondary prevention of chronic pain* (e.g. explaining pain; imaging; risk factors for the progression of acute pain to chronic pain; psychologically informed practice; safe and effective use of medicines/opioid education; follow-up of acute pain patients to monitor patient progress; integration of care between hospital setting and primary care and between primary care providers; and return to work)
        - Standardised coding of acute and chronic pain

Examples of options identified by PHNs not included in the options

- An example of an option, related to *Consumer initiative related to safe and effective use of medications and tapering of opioids* in the map of options, proposed during the PHN dialogue is an adaptation of the Chronic Pain MedsCheck initiative.[9]

[8] The PIP is a payment to general practices that participate in quality improvement activities to improve patient outcomes and deliver best-practice care. Most payments are for quality care activities, including for eHealth, quality improvement, teaching, Indigenous health, after hours care, procedural activities and rural locations. https://www.humanservices.gov.au/organisations/health-professionals/services/medicare/practice-incentives-program The PIP Eligible Data Set is collected against 10 specified improvement measures from the Clinical Information Systems (CIS) of participating practices and is submitted to the local PHN quarterly. The Australian Institute of Health and Welfare (AIHW) is the National Data Custodian for the PIP Eligible Data Set.

[9] The Chronic Pain MedsCheck Trial is funded by the Australian Department of Health as part of the Sixth Community Pharmacy Agreement (6CPA) Pharmacy Trial Program (PTP). The trial intervention includes: a) Supported self -management of patients taking medication who are dealing with chronic pain for more than three months through pharmacist advice; b) Pharmacy-based evaluation of patient's medicine; c) Provision of an action plan incorporating education, self-management and referral to other health professionals where additional support is required; and d) Three month follow up after the initial service. The final patient recruitment and initial service deadline has now been extended until 30 November 2019 and final patient follow up services will be completed 3 months later by the end of February 2020. http://6cpa.com.au/pharmacy-trial-program/chronic-pain-medscheck-trial/

Overall themes of the PHN dialogue

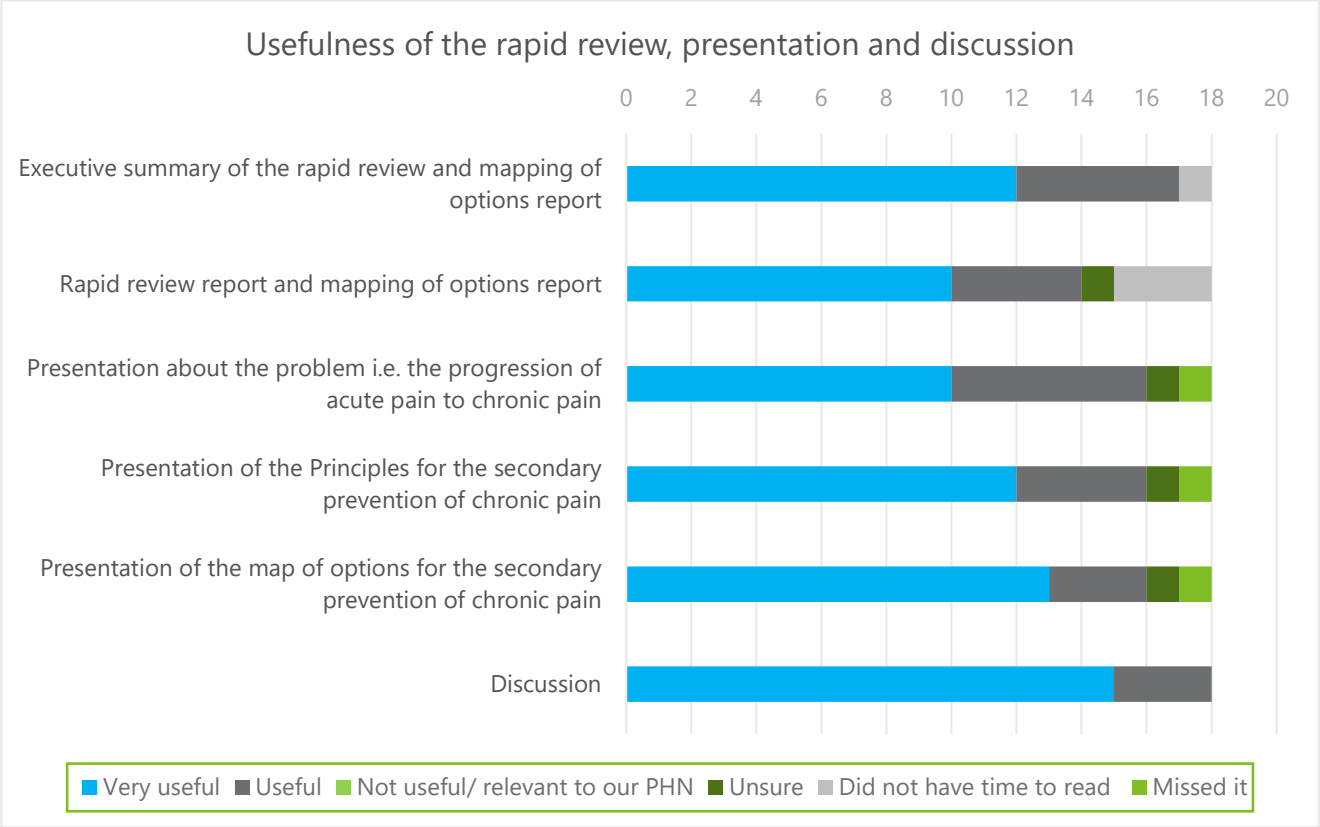
Collaboration between PHNs	○To share information, resources and experiences ○To decrease the duplication of processes and systems ○To explore opportunities for collaborative projects ○To foster committment to the secondary prevention and better management of chronic pain
Upskilling of GPs and other primary care providers	• To improve their knowledge about the secondary prevention of chronic pain • To conduct screening and other risk-based assessments ('Yellow flags") to identify patients at risk of developing chronic pain • Multi-modal delivery (face-to-face and online webinars) • Continuing Professional Development points (CPDs) accredited by the relevant professional bodies
Co-design initiatives	• Co-design initiatives with input from a range of local stakeholders such as consumers, GPs, hospital-based pain specialists, allied health practitioners, practice nurses, community pharmacists and commissioned providers • Co-design process also helps to create the 'buy-in' necessary to implement and sustain initiatives • Establish working groups to help plan, implement and monitor initiatives
Integration of care approach	• Initiatives should improve communication between different primary care providers and between primary and secondary care • System support is needed to ensure that initiatives are embedded into routine practice • e.g. Establish standardised referral pathways and processes • e.g. Screening tools or other risk-based assessments should be provided to GPs via IT software that they regularly use • e.g. HealthPathways could be used to provide relevant information and tools to be accessed by GPs at the point of patient care. • e.g. Ensure information is integrated into the patient's Electronic Medical Record (EMR)
Strategic partnerships	• Link with partners who have established relevant initiatives • e.g. opioid stewardship programs in hospitals
Funding	• PHNs need to be creative when considering funding streams within the PHN • Consider funding streams outside of PHNs' flexible funding budget. • Review all funding streams which might provide funding opportunities by integrating across different program areas, for example, Mental Health, Integrated Team Care and AOD budgets (with possible link to existing services); and HealthPathways budget • Consider other funding models, perhaps in combination with PHN funding, e.g. for consumer pain programs, a user pays or a consumer co-payment might be considered
Quality improvement programs	• Practice Incentives Program (PIP) introduced in August 2019 by the Department of Health (Australian Government) was identified by participants as having the potential to drive quality improvement activities related to the secondary prevention and better managment of chronic pain, including consumer and health professional initiatives.
Promotion and dissemination strategy	• Promote the initiative and referral processes and procedures to relevant stakeholders e.g. primary care providers, hospital-based health professionals, consumers, hospital administrators, other stakeholders and partners (e.g. newsletters, events, HealthPathways)

Perceptions of the PHN dialogue

Eighteen participants (86%), representing 14 PHNs and WAPHA, participated in the evaluation survey.

Usefulness of the rapid review, presentation and discussion

- The vast majority of participants reported that the rapid review, the presentation and the discussion were very useful or useful, as illustrated in the figure below.



Aspects of the discussion that participants found most interesting included the following:

- **Understanding the principles for the secondary prevention of chronic pain and the options to address it**

  "Identifying key principles and options."

  "Linking and learning about options."

- **Hearing different perspectives of the problem of the secondary prevention of chronic pain and how to address it**

  "Hearing about differences and opportunities as described by others. Different eyes on the problem."

- **Learning about what initiatives other PHNs are implementing, or considering implementing, to improve the secondary prevention of chronic pain**

  "How other PHNs would do it and ideas for implementation."

> *"Group discussion. Really great to hear what others are doing, share ideas and expertise."*

"It was interesting to hear from other PHNs about what they're doing or the direction they want to head in."

"Group discussion. Really great to hear what others are doing, share ideas and expertise."

- **Brainstorming ideas with other PHNs**

  "Group discussion on initiatives and brainstorming ideas."

- **Sharing ideas about potential funding streams**

  "Hearing about what other PHNs have tried, what funding buckets they are using. Sharing ideas."

- **Strengthening relationships with other PHNs for collaboration**

  "Having the opportunity to collaborate with other PHNs about initiatives in their region. Looking at working together on some pain initiatives e.g. Community of practice, so that we can learn from each other and not re-invent the wheel."

  "Finding out what other 'like' PHNs are doing and what we could replicate or collaborate on."

- **Sharing about the challenging aspects of implementing initiatives in PHNs**

  "Common PHN difficulties in progressing 'good ideas'- funding, expertise, scope, evaluation."

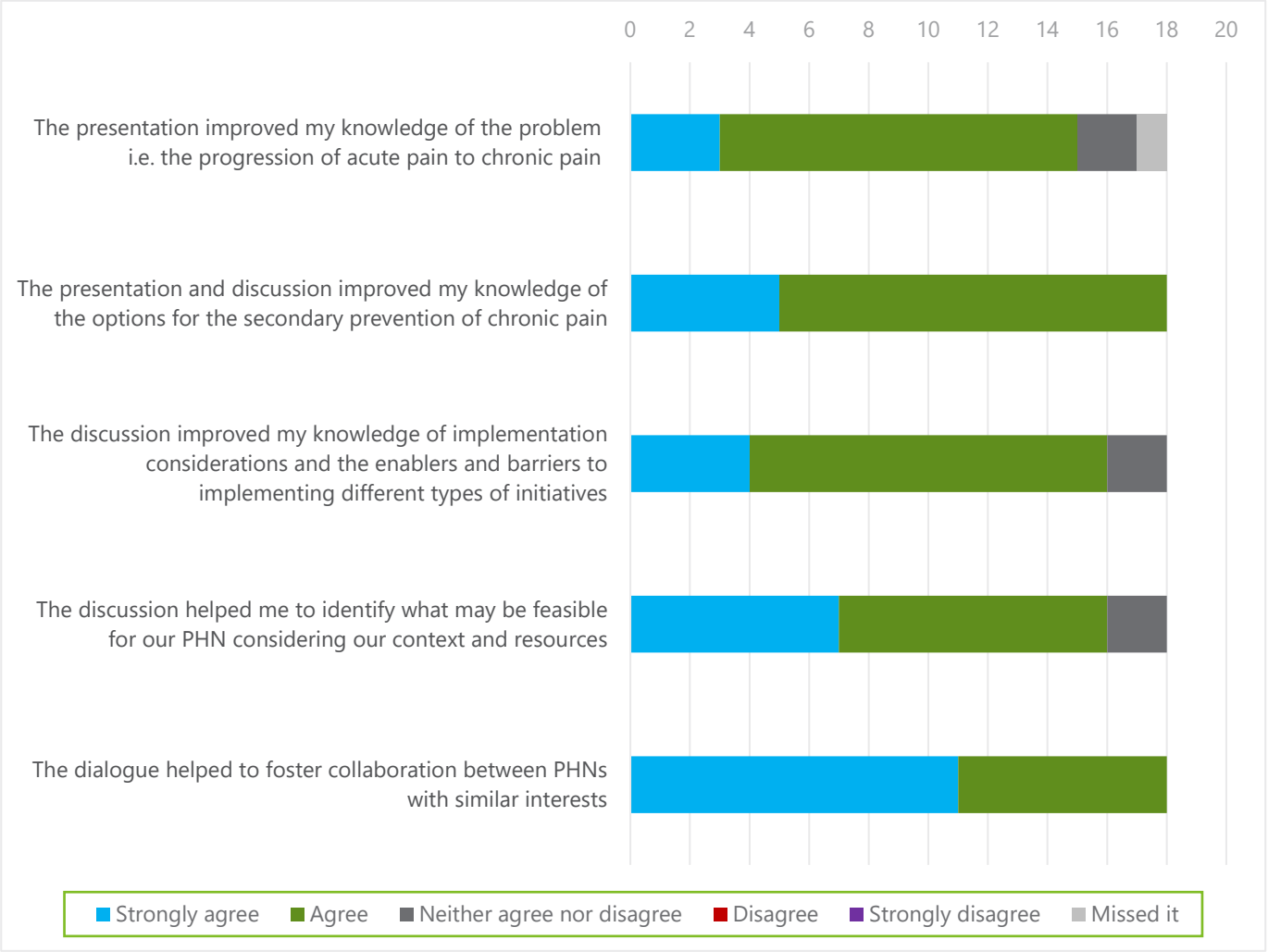
  "Useful to share what works or challenges/solutions. Useful to discuss national advocacy and links between PHNs."

  "Useful to know that other PHNs are facing the same challenges. Interesting to hear what is working in other PHNs. Good opportunity for ideas swap."

"Useful to know that other PHNs are facing the same challenges."

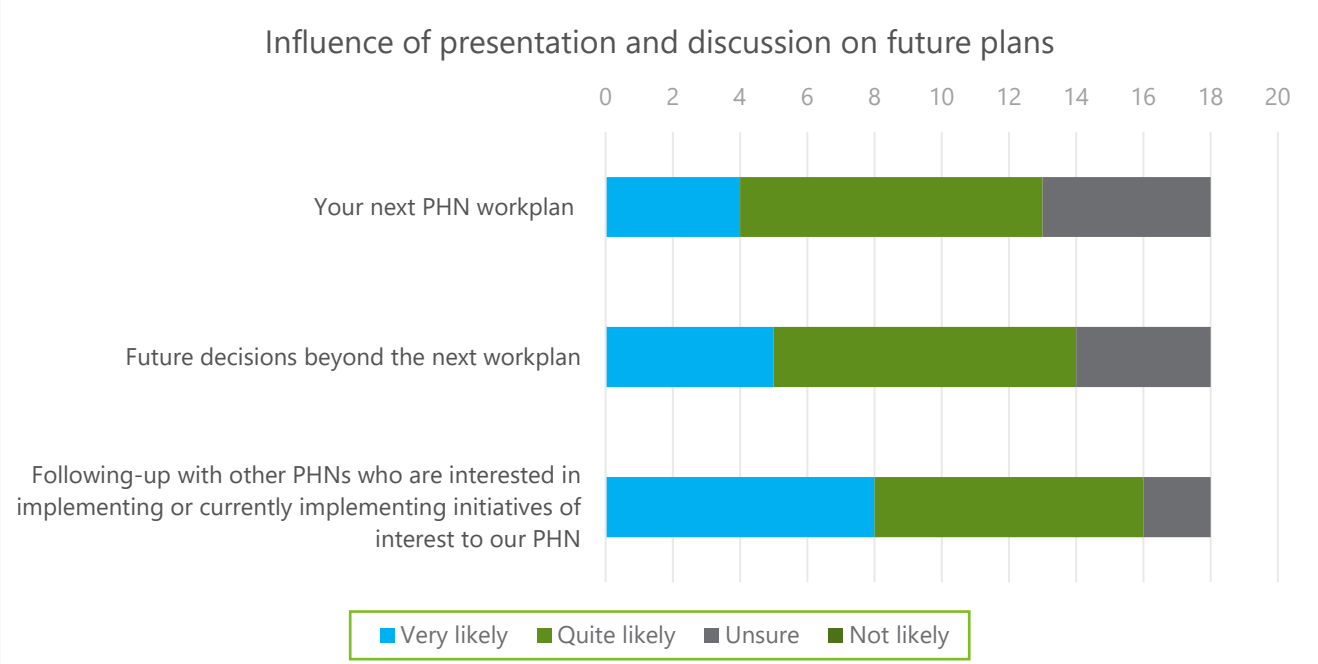
Perceived impact of the presentation and discussion

- The vast majority of participants reported that the presentation and discussion had improved their knowledge of the problem; options to address the problem and implementation considerations; helped them to identify what may be feasible for their PHN; and fostered collaboration between PHNs, as illustrated in the figure below.



Influence of the presentation and discussion on future plans

- Most participants reported that the presentation and the discussion were very likely or quite likely to influence their future decision-making. Some participants were unsure of the potential influence, as illustrated in the figure below.



Other comments from participants

- *"Unsure about impact as not a decision maker."*
- *"There are competing priorities for PHN funding, so will require discussion at management level."*
- *"We are only just embarking on a chronic pain focussed services so unclear if branching to acute/subacute makes sense for us at this time."*
- *"Discussion about what everyone is doing currently in the chronic pain (not specifically secondary prevention/subacute) space would have been useful as that feels more aligned to where we're all up to with regard chronic pain."*
- *"A greater focus on projects/ideas for population groups (i.e. Aboriginal population) would be useful."*
- *"Co-design of any initiative should include the consumer voice and provider voice."*
- *"I was interested in a few options [in small group work] so it would have been great to have the time to change groups so we could learn more about other options."*
- *"It would be terrific if you could be a champion for assisting PHNs to secure funding for pain initiatives like Project Echo."*

"A greater focus on projects/ideas for population groups (i.e. Aboriginal population) would be useful."

"Co-design of any initiative should include the consumer voice and provider voice."

Overall feedback about the dialogue

- *"Well done- thank you! This project has been well organised. The phase 1 mapping is a valuable resource for future planning and making better use of existing resources."*
- *"Thank you! This is one of the few opportunities I have to talk to other PHNs about a problem that affects us all, and I really value it."*
- *"Thanks for the opportunity to come down and discuss strategies/ideas/enablers and barriers. It's inspiring!"*
- *"Enjoyed the day and congratulations on all the work."*
- *"Good opportunity to learn from each other and space to think."*
- *"Appreciate the pre-reading material and excellent communication and planning involved. Hope not to lose the momentum."*
- *"The rapid review and mapping document is very comprehensive and I'm sure will be a great tool for planning in this space."*

"Appreciate the pre-reading material and excellent communication and planning involved. Hope not to lose the momentum."

Updated map of the options for PHNs for the secondary prevention of chronic pain

The map of the options was updated after the PHN dialogue to incorporate other options that PHNs were implementing, or considering implementing, in their PHN. *See table below*.

Mapping of the options for Primary Health Networks related to the secondary prevention of chronic pain

- Options relate to acute and subacute pain populations (e.g. post-surgery, post-injury, (sub)acute back pain) with a focus on people at risk of developing chronic pain.
- Options could be tailored to specific groups including Aboriginal and Torres Strait Islander peoples, people from culturally and linguistically diverse backgrounds, people from rural and remote areas, older Australians, people with dementia, children and young people and other relevant groups.

1. Options related to Goal 1 (consumer and community initiatives)

1.1 Face-to-face multidisciplinary consumer pain program (one or several group-based education sessions with/without individual consultation sessions with primary care providers)

The program may include:

- Group-based sessions (education and active, practice-based learning; physical activity; cognitive and behavioural strategies)
- Case management with individual consultation sessions with a primary care provider (e.g. physiotherapist, psychologist) as required
- Information resources (paper-based, links to online resources)

1.2 Psychologically-informed physical therapy program (individual consultation session(s) with a physiotherapist)

The program may include:

- Individual consultation sessions with a physiotherapist with psychologically-informed practice training (e.g. graded exercise and goal setting, cognitive and behavioural strategies, promotion of self-management)
- Information resources (paper-based, links to online resources)

1.3 Consumer initiative related to safe and effective use of medications and tapering of opioids (a group-based education session or webinar; and/or individual consultation session(s) with a primary care provider)

The initiative may include:

- Group-based sessions (education and active, practice-based learning) may be embedded in a face-to-face multidisciplinary consumer pain program or a separate consumer workshop/education session(s)
- Or an online consumer initiative (e.g. webinar) including education and behavioural strategies
- Or individual consultation session(s) with a primary care provider e.g. GP, practice nurse, community pharmacist (education and behavioural strategies)
- Information resources (paper-based, links to online resources)

1.4 Transitions of care / pre-surgery consumer initiative (a group-based education session or webinar; and/or individual consultation session(s) with a primary care provider)

The initiative may include:

- Individual consultation sessions with a primary care provider e.g. GP, practice nurse. The sessions may include:
  - Pre-surgery risk assessment for developing chronic pain after surgery
  - Education about pain and pharmacological and non-pharmacological pain management
  - Behavioural strategies such as coping methods, though-reframing, relaxation, goal setting and self-management
- Or an online consumer initiative (e.g. webinar) including education and behavioural strategies
- Information resources (paper-based, links to online resources)

1.5 Transitions of care / post-surgery consumer initiative (a group-based education session or webinar; and/or individual consultation session(s) with a primary care provider)

The initiative may include:

- Individual consultation sessions with a primary care provider e.g. GP, practice nurse, community pharmacist. The sessions may include:
  - Post-surgery risk assessment for developing chronic pain
  - A clinical medication review including medication reconciliation with active patient counselling
  - Education about pain and pharmacological and non-pharmacological pain management
  - Behavioural strategies such as coping methods, though-reframing, relaxation, goal setting and self-management
  - Follow-up at, for example, 2 weeks, 6 weeks and 12 weeks
- Or an online consumer initiative (e.g. webinar) including education and behavioural strategies
- Information resources (paper-based, links to online resources)

1.6 Telehealth-assisted health care

- Delivery of healthcare at a distance using information communications technology (ICT).
- Telehealth connects clinicians or any other person(s) responsible for providing care to a patient and carer/s.
- Telehealth can be used for the purposes of assessment, intervention, consultation, education and/or supervision.
- Various models of care, for example,
  - Individual sessions connecting the patient (with/without their GP) to hospital-based clinician(s) (e.g. pain specialist, anaesthetist, surgeon, psychiatrist, nurse, physiotherapist)
  - Individual sessions connecting the patient with an allied health provider in the community such as a physiotherapist or clinical psychologist
  - Group sessions e.g. telerehabilitation (education, exercise)

1.7 Online consumer pain program (a webinar or several online education sessions)

- The program is based on the same principles as face-to-face programs and uses online modules to teach pain management information and support patients to develop their self-management skills and encourage non-pharmacological approaches
- The program may have varying levels of telephone and/or email support from a primary care provider (e.g. psychologist, physiotherapist training in psychologically informed practice)

1.8 Mobile app

- Providing information and strategies similar to an online consumer pain program

1.9 Peer support group/network

- Delivered face-to-face, online or via social media

1.10 Community awareness campaign

- Delivered via social media, television, radio, print media or community events

- Campaign may aim to improve the community's understanding of pain; how to prevent chronic pain; promote self-management and non-pharmacological pain management; and promote safe and effective use of medicines.

1.11 Promotion of relevant consumer resources and programs implemented by other agencies

- E.g. paper-based and online information resources, online and face-to face consumer pain programs and support groups
- Promotion via consumer and health professional networks (events and newsletters), HealthPathways and online consumer distribution platforms (e.g. GoShare) and information portals (e.g. Patientinfo, Health Resource Directory)

2. Options related to Goal 2 (health professional capacity building)

2.1 Face-to-face and/or online education and training for GPs and other primary care providers

- Delivered face-to-face or online e.g. webinars, online modules or online platforms (Project ECHO)
- Education and training may include didactic sessions and case-based learning related to the following:
  - Explaining pain
  - Imaging
  - Risk factors for the progression of acute pain to chronic pain
  - Psychologically-informed practice (e.g. graded exercise and goal setting, cognitive and behavioural strategies, promotion of self-management)
  - Safe and effective use of medicines/opioid education
  - Follow-up of acute pain patients to monitor patient progress
  - Integration of care between hospital setting and primary care; and between primary care providers
  - Return to work

2.2 Opioid initiative about prescribing, non-initiation and deprescribing of opioids (face-to-face and/or online)

- Delivered face-to-face or online e.g. webinars, online modules or online platforms (Project ECHO)
- The initiative may include:
  - Didactic sessions and case-based learning
  - And/or behavioural strategies e.g. clinical reminder system

2.3 Interdisciplinary community of practice (CoP) (face-to-face and/or online)

- Delivered face-to-face or via online platform
- Chronic pain CoP or as part of a mental health CoP or Alcohol and Other Drugs (AOD) CoP
- And/or a network for primary care providers involved in a specific face-to-face consumer pain program

2.4 Promotion of relevant education and training and resources implemented by other agencies

- E.g. information resources, webinars, online modules, online platforms (Project ECHO), undergraduate and postgraduate training
- Promotion via health professional networks (events and newsletters) and HealthPathways

3. Options related to Goal 3 (health systems support initiatives)

3.1 Implementation of HealthPathways

- To assist general practitioners (GPs) with the management of patients with acute, subacute and chronic pain, and the referral of patients to specialists and allied health professionals

3.2 Transitions of care / health systems support initiative

The initiative may include:

- Electronic tools to facilitate quick, clear, and structured summary generation
- Use of electronic discharge notifications

• Online access to discharge information for general practitioners • Discharge planning with shared involvement for follow-up of patients by hospital and community care providers
3.3 Prescription drug monitoring systems • E.g. SafeScript is a real-time prescription monitoring and clinical decision support system that aims to provide doctors and pharmacists access to an up-to-the-minute medication supply history for certain high-risk medicines for their patient at the point of consultation
3.4 Electronic Persistent Pain Outcomes Collaboration (ePPOC) • The Electronic Persistent Pain Outcomes Collaboration (ePPOC) is a national benchmarking system for the pain sector. • It aims to improve clinical outcomes for people experiencing persistent pain through reporting and benchmarking. • It is implemented and managed by the Australian Health Services Research Institute (AHSRI), University of Wollongong. It includes ePPOC for adults and PaedePPOC for children. • ePPOC data is used to evaluate hospital-based pain services and community-based consumer pain programs
3.5 Other quality improvement systems • E.g. The Practice Incentives Program (PIP), introduced in August 2019 by the Department of Health, Australian Government is a payment to general practices that participate in quality improvement activities to improve patient outcomes, and deliver best-practice care.

For more information about each option and the supporting evidence see the report, *Secondary prevention of chronic pain: rapid review and mapping of options for Primary Health Networks (October 2019).*

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Appendix 1: Chronic Pain Project Steering Committee

Ms Carol Bennett, CEO, painaustralia

Mr David Beveridge, Nurse Practitioner, Lismore Base Hospital, Multidisciplinary Pain Management Clinic

Dr Matthew Bryant, Director Townsville Pain Persistent Pain Service and NQPPMS

Sr Mary-Lynne Cochrane, Consumer Representative

Dr Anne Daly, Physiotherapy and Pain Management Consultant

Ms Terina Grace, CEO and Managing Director Black Swan Health

Ms Fiona Hodson, Clinical Nurse Consultant Pain Management, Hunter Integrated Pain Service, Surgical Services

Associate Professor Malcolm Hogg, painaustralia

Dr Simon Holliday, GP and Addiction Medicine Specialist

Ms Jenni Johnson, Manager, Pain Management Network, NSW ACI (February 2018-June 2019)

Ms Susan Rogers, Manager, Pain Management Network, NSW ACI (July 2019-)

Ms Margaret Knight, Consumer Representative

Ms Joyce McSwan, Pharmacist, Pain Educator Gold Coast PHN

Professor Michael Nicholas, Director, Pain Education & Pain Management Programs, PMRI, University of Sydney

Dr Milana Votrubec, GP specialising in pain

Ms Leanne Wells, Consumers Health Forum and consumer representative on Pain Australia

Professor Andrew Wilson, Director, TAPPC and Co-Director Menzies Centre for Health Policy

Appendix 2: Dialogue participants

PHN Representatives

- Ms Caz Brancatisano, Program Officer – Primary Care Initiatives, Nepean Blue Mountains PHN
- Ms Kate Tye, Senior Manager – Primary Care Support & Development, Nepean Blue Mountains PHN
- Ms Michelle Roberts, Integrated Health Manager, South Western Sydney PHN
- Ms Natalie Thompson, Integrated Health Coordinator, South Western Sydney PHN
- Ms Philippa Gately, Manager, System Service and Integration, South Eastern NSW PHN
- Ms Bronwyn Penny, Manager Integrated Care, Hunter New England and Central Coast PHN
- Ms Anita McRae, Senior manager, Mental Health, Drug & Alcohol, Murrumbidgee PHN
- Dr Jonathan Ho, GP Liaison Officer, Murrumbidgee PHN
- Ms Christine Bellamy, Lead – Quality Use of Medicines, Eastern Melbourne PHN
- Ms Katrina Martin, Practice Facilitator, Western Victoria PHN
- Mr Jesse Osowicki, Manager, Integration, North Western Melbourne PHN
- Ms Natalie Seed, Program Officer, Integration, North Western Melbourne PHN
- Ms Libby Carr, Director of Commissioning (Programs), Gold Coast PHN
- Ms Suzanne Harvey, Person Centred Care Lead, Brisbane South PHN
- Dr Theresa Johnson, Senior Manager - Primary Care & GP Liaison Officer, Darling Downs and West Moreton PHN
- Ms Jodie Sargent, Education Coordinator, Central QLD, Wide Bay and Sunshine Coast PHN
- Ms Noelene Cooper, Project Manager, Country SA PHN
- Ms Jane Goode, Innovation & Design Officer, Adelaide PHN
- Ms Kate Lehmensich, Population Health Planning Officer, Capital Health Network
- Ms Debra Royle, Regional Coordinator - Metro North West, WA Primary Health Alliance (WAPHA)
- Ms Karen Thomas, Research Policy Integration Lead, Northern Territory PHN

Project Team participating in the dialogue

- Professor Fiona Blyth, Clinical Epidemiology Program Director, School of Public Health, University of Sydney
- Dr Simone De Morgan, Research Fellow, Menzies Centre for Health Policy, University of Sydney
- Ms Leah Marks, Research Assistant, Menzies Centre for Health Policy, University of Sydney
- Dr Duncan Sanders, Senior Lecturer and Academic Coordinator, Pain Management Research Institute, University of Sydney
- Ms Pippy Walker, Senior Research Officer, Menzies Centre for Health Policy, University of Sydney

Australian Prevention Partnership Centre representation

- Professor Lucie Rychetnik, Deputy Director, The Australian Prevention Partnership Centre

Apologies

- Central and Eastern Sydney PHN, Western Sydney PHN, Northern Sydney PHN, Western NSW PHN, North Coast PHN, Gippsland PHN, South Eastern Melbourne PHN, Murray PHN, Western Queensland PHN, Northern Queensland, Brisbane North PHN, Tasmania PHN

Appendix 3: PHN Dialogue Agenda - Secondary prevention of chronic pain

Date: Tuesday 8 October 2019

TIME: 9:30am – 2pm (9:30am registration and tea/coffee)

LOCATION: Level 6 Seminar Room, Charles Perkins Centre, The University of Sydney, Johns Hopkins Dr, Camperdown NSW 2006

Key features of the dialogue

The dialogue:

- Addresses a key problem currently being faced in Australia (and internationally)
- Is informed by the peer-review and grey literature (rapid review pre-circulated to participants)
- Engages a wide range of PHNs (including different states and territories, metropolitan and regional PHNs)
- Focuses on options for PHNs to help address the problem and implementation considerations
- Recognises the similarities and differences between PHNs and does not aim for consensus or 'one solution fits all model'. It recognises that there is a range of options and also recognises the importance of the local context and differences in resources and capacity.
- Recognises that participants' views, experience and knowledge are key inputs to the dialogue
- Allows for frank off the record discussion
- Engages two facilitators to assist with the discussion
- Is designed to increase participants' knowledge of the problem and options to address the problem
- Aims to spark insights which occur when those involved in addressing a problem are brought together
- Aims to generate action while recognising the resource limitations faced by PHNs

Purpose

The purpose of the deliberative dialogue is to:

1. Provide context to PHNs about the problem
2. Provide a map of the options to improve the secondary prevention of chronic pain identified in the peer-review and the grey literature including initiatives currently implemented by PHNs (identified by the consultation with PHNs in Phase 1 of the Chronic Pain Project)
3. Provide PHNs with the opportunity to share their knowledge about relevant initiatives that they know of, or have implemented, are implementing or plan to implement in the near future
4. Provide PHNs with the opportunity to discuss the options considering their context
5. Provide PHNs with the opportunity to discuss implementation and resource and capacity requirements

Outcomes

By the end of this dialogue, we hope to:

1. Improve PHNs' knowledge of the options for the secondary prevention of chronic pain
2. Help PHNs to identify initiatives that may be feasible for their PHN to implement and improve their knowledge about implementation considerations
3. Foster collaboration between PHNs with similar interests

AGENDA

Date: Tuesday 8 October 2019		
Time	**Item**	**Facilitators/ Presenters**
9:30am	**Registration and tea/coffee**	
10.00am	• Welcome • Purpose of the day • Introductions to the research team • Participants to briefly introduce themselves	Professor Lucie Rychetnik
10.15-10.45am	Why is the secondary prevention of chronic pain so important and what are the options for PHNs informed by the evidence?	Professor Fiona Blyth, Dr Simone De Morgan
10.45-11am	**Morning tea (15 minutes)**	
11am	Dialogue with PHNs about the options for the secondary prevention of chronic pain Introduction and rules for the dialogue: "Participants are free to use the information received during the dialogue but should excise caution and consideration in identifying particular participants after the dialogue."	Professor Lucie Rychetnik and Professor Fiona Blyth
	Activity 1 – Group activity Thinking about the options for the secondary prevention of chronic pain presented, participants will highlight: • **Other options** • **Or examples of options** *that participants know of, have implemented, are implementing, plan to implement or think would be a good idea and are not currently included in the map of options or presented as examples*	
	Activity 2- Sticky notes • Participants will think about the options for the secondary prevention of chronic pain presented (and shown in the posters) • **Each participant will place a sticky note on 1 option (on the posters) that they are most interested in discussing today** • Facilitators will summarise the results	

	Activity 3 – Small group activity *(to be continued after lunch)* • Participants will form small groups (chairs moved to accommodate groups) to discuss **the option** that they are most interested in discussing • Each group will nominate a scribe and a person to report back to the larger group • Participants in each group will discuss their option and record on butcher's paper their ideas **Think about how this option could be implemented by your PHN Consider e.g. role of the PHN, partners/commissioned agencies, resources required, funding models, organisational or behavioural change strategies, other enablers to implementation** **Record on butcher's paper ideas about how this option could be implemented by the different PHNs in your group**	
12-12:30pm	**Lunch (30 minutes)**	
12:35pm	Activity 3 – Small group activity *(continued)* • One participant from each group will report back to the larger group • Further discussion	Professor Lucie Rychetnik and Professor Fiona Blyth
1.25pm	Activity 4- group activity • Participants will discuss how they could collaborate after the dialogue to help plan and implement some of the options discussed at the dialogue	
1:45pm	Next steps and completion of evaluation survey • Participants are encouraged to form ongoing networks after the dialogue with other PHNs who are interested in implementing or currently implementing similar options • **A participant list** will be circulated before the end of the dialogue and participants are given the opportunity to record the options that they are most interested in discussing with other PHNs and whether they would like to take on a co-ordination role • **Dialogue summary and update of rapid review and mapping of the options** to be sent to participants after the dialogue • **Participants to complete evaluation survey before leaving**	
2pm	Dialogue concludes- tea/coffee **Thank you for participating in the dialogue**	

Appendix 4: Metropolitan and regional PHN areas

Metropolitan PHN areas' have ≥85% of the population in 'major cities', as defined by the Australian Bureau of Statistics. All other PHN areas are classified as 'regional PHN areas'.

State	PHN	PHN type
NSW	Central and Eastern Sydney	Metropolitan
NSW	Northern Sydney	Metropolitan
NSW	Western Sydney	Metropolitan
NSW	Nepean Blue Mountains	Metropolitan
NSW	South Western Sydney	Metropolitan
NSW	South Eastern NSW	Regional
NSW	Western NSW	Regional
NSW	Hunter New England and Central Coast	Regional
NSW	North Coast	Regional
NSW	Murrumbidgee	Regional
VIC	North Western Melbourne	Metropolitan
VIC	Eastern Melbourne	Metropolitan
VIC	South Eastern Melbourne	Metropolitan
VIC	Gippsland	Regional
VIC	Murray	Regional
VIC	Western Victoria	Regional

State	PHN	PHN type
QLD	Brisbane North	Metropolitan
QLD	Brisbane South	Metropolitan
QLD	Gold Coast	Metropolitan
QLD	Darling Downs and West Moreton	Regional
QLD	Western Queensland	Regional
QLD	Central Queensland, Wide Bay and Sunshine Coast	Regional
QLD	Northern Queensland	Regional
SA	Adelaide	Metropolitan
SA	Country SA	Regional
WA	Perth North	Metropolitan
WA	Perth South	Metropolitan
WA	Country WA	Regional
TAS	Tasmania	Regional
NT	Northern Territory	Regional
ACT	Australian Capital Territory	Metropolitan

Appendix 5: Project Extension for Community Health Outcomes (Project ECHO)

From the literature

- Originally developed by the University of New Mexico's Health Science Centre to build the capacities of primary care providers and to increase access to specialist care in rural and underserved populations.(6)
- Project ECHO expands primary care provider capacity to manage complex diseases by sharing knowledge, disseminating best practices, and building a community of practice. The model has expanded rapidly with over 140 ECHO projects currently (in 2018) established globally.(7)
- Project ECHO uses **a "Hub" and "Spoke" model** to promote knowledge exchange between health care specialists typically located at academic centres ("the hub") and primary care providers (PCPs) at the front line of community health care (the "spokes"). Through regularly scheduled virtual educational clinics, Project ECHO creates a supportive community network where PCPs can connect with specialists and with other PCPs practicing in similar settings via multipoint video technology to discuss best practices in care and complex cases managed within their practice. This multifaceted knowledge and capacity-building intervention includes two fundamental components: a didactic lecture delivered by a member of the hub team (based on curriculum developed from guidelines, best practices, and/or a needs assessment); and recommendations for case management (telementoring) offered by the community in response to anonymised clinical cases presented by spoke sites.(7)
- Project ECHO has been implemented **to address chronic pain**.(8-13)
- A systematic review of the impact of Project ECHO on participants and patient outcomes has shown it to be an effective and potentially cost-saving model.(14)
- Key factors in the literature found to increase registrant engagement include relevant and practical curriculum content; strong and supportive relationships among learners, ECHO faculty, and workplace colleagues; and innovative learning approaches that included opportunities for active, virtual participation through technology, participant management activities, and ECHO's unique curriculum design.(15)

PHNs

- **Western Victoria PHN has implemented Project ECHO Opioid Management Clinic**. The Project ECHO Opioid Management Clinic is currently available on a weekly basis as an online one-hour meeting connecting addiction medicine specialists and psychiatrists and allied health at St Vincent's hospital (hub) with primary care providers (spoke) to upskill primary care providers in opioid management. The program is funded through the Pharmacotherapy Area Based Networks, PHN and health service provider.
    - Topics guided by cases to be presented ~ 1 hour session + 25min didactic + 2 cases.
    - Modules developed by St Vincent's and Project officer at Murray PHN - cases sent to project officer for approval by steering group
- Western Victoria PHN is currently in **the planning phase for implementing Project ECHO (chronic pain)** to be launched in February 2020.
- Potential costs include:
    - Training costs: Brisbane $2000 per person for 2 days training through the Children's Health Queensland Hospital and Health Service https://www.childrens.health.qld.gov.au/chq/health-professionals/integrated-care/project-echo/
    - IT infrastructure costs: set-up costs for two big screens, a good camera and microphone system

    - Co-ordination of speakers, participants and case studies: approximately 0.5/0.7 to 1/7 days per week including presence at the ECHO session
    - Monitoring/evaluation costs (surveys and interviews to see how Project ECHO is working and impact): may be able to get stakeholders to fund this in-kind
    - Costs of speakers: may need to pay the expert members of the Hub who are members of the clinical panels; and clinicians who run the sessions may do this free of charge as part of their salaried position
    - Curriculum development costs: Project ECHO Resource Library contains all the resources that have been created for ECHOs worldwide including curricula, documents on evaluation, costings, publications. People who have done the training can gain free access to it. A librarian at the Uni of New Mexico curates it. https://echo.unm.edu/about-echo
- Continuing Professional Development points for health professionals attending a session e.g. two CPD points per hour for CPD (Cat. 2) Activities (for GPs)