

Primary Health Network Webinar Summary

Supporting the commissioning of community-based pain programs

8 December 2020, 1-2.30pm (AEDT) via Zoom

Summary by Madeleine Day, Pippy Walker and Simone De Morgan

Overview

This [Australian Prevention Partnership Centre project](#) is focused on increasing knowledge and fostering knowledge sharing among Primary Health Networks to improve the secondary prevention and management of chronic pain and is funded by the Australian Government's Medical Research Future Fund (MRFF).

Jointly supported by The Australian Prevention Partnership Centre, The University of Sydney's Menzies Centre for Health Policy, Painaustralia and New South Wales Agency for Clinical Innovation (NSW ACI), this webinar was open to all Primary Health Networks that were interested in learning about best practice, the available program models and implementation considerations for commissioning community-based pain programs.

Aims and objectives

This webinar aimed to bring Primary Health Network representatives together to present research findings and share insights from experiences with commissioning community-based pain programs. The objectives were to increase knowledge on:

- the key elements and implementation enablers of community-based pain programs
- the different program models currently being supported by Primary Health Networks
- how presenting Primary Health Networks have implemented their community-based pain programs
- what successes, challenges and key considerations have been identified.

In addition to improving knowledge, it is intended that the PHN webinar and supporting information resources will enable Primary Health Networks to:

- be informed about existing program models that may be feasible for their PHN to implement considering their local context
- know who they can contact for more information.

Attendees

Research team and collaborators

Dr Simone De Morgan, University of Sydney

Pippy Walker, University of Sydney

Professor Fiona Blyth, University of Sydney

Maddie Day, University of Sydney

Carol Bennett, Painaustralia

Sue Rogers, NSW Agency for Clinical Innovation

Primary Health Network representatives and other participating organisations

Kath Carleton, ACT PHN

Philippa Gately, South Eastern NSW PHN

Annette Anido, South Eastern NSW PHN

Kate Tye, Nepean Blue Mountains PHN

Tracy Kane-White, Nepean Blue Mountains PHN

Debra Clark, North Sydney PHN

Joyce McSwan, Gold Coast PHN

Jillian van Schoubroeck, Brisbane South PHN

Brad Hales, Brisbane South PHN

Eden Malama, Brisbane South PHN

Tahni Roberts, Brisbane South PHN

Tony de Ambrosis, Darling Downs & West Moreton PHN

Belinda May, Darling Downs & West Moreton PHN

Jane Goode, Adelaide PHN

Rural Doctors Workforce Agency representatives

Christine Bellamy, Eastern Melbourne PHN

Debra Royle, Western Australia PHA

Susan Kay, Western Australia PHA

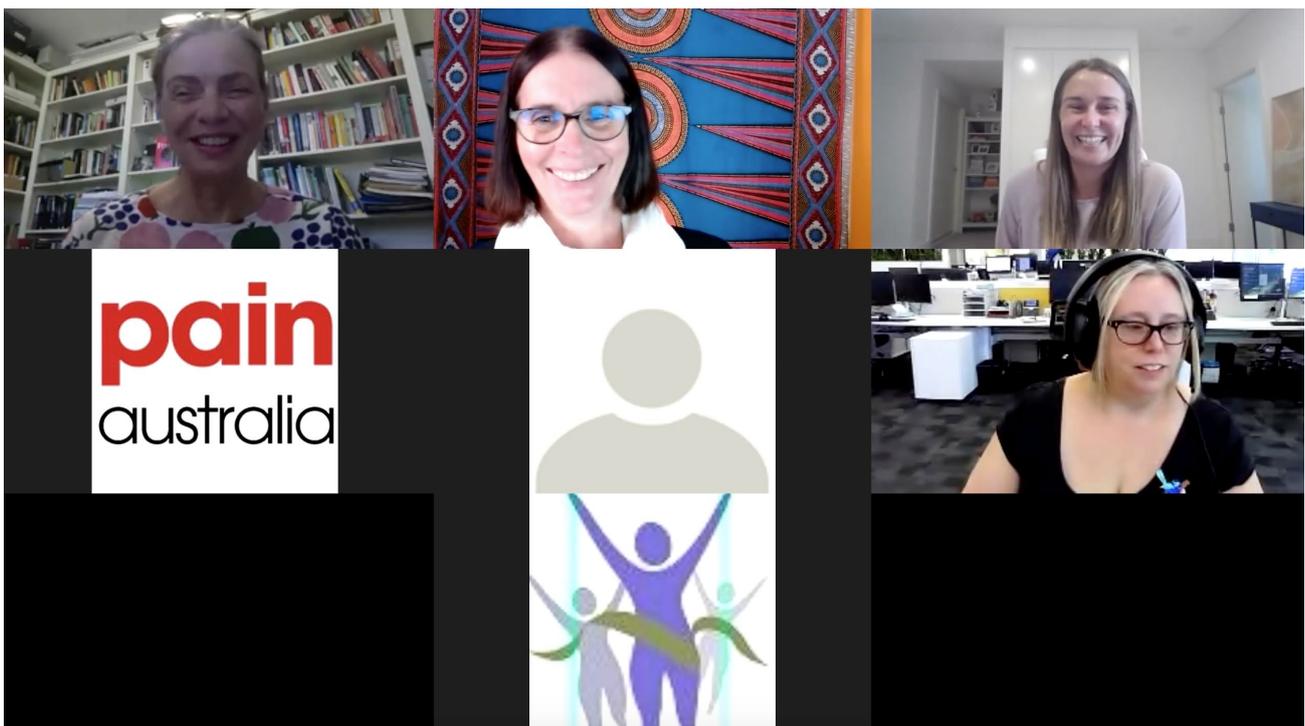


Figure 1: Screenshot of presenters and facilitators for the Primary Health Network webinar - supporting the commissioning of community-based pain programs. Top row from left to right, Professor Fiona Blyth, Dr Simone De Morgan and Pippy Walker from the University of Sydney. Middle row from left to right, Carol Bennett Painaustralia, Kate Tye Nepean Blue Mountains PHN, and Jane Goode Adelaide PHN. Bottom row, Joyce McSwan Turning Pain into Gain Gold Coast PHN.

Agenda

Time	Item	Presenter/facilitator
Part 1: Introduction and summary of research findings		
1:00-1:05pm	Welcome	Dr Simone De Morgan, University of Sydney
1:05-1:20pm	Overview of research conducted by The Australian Prevention Partnership Centre and University of Sydney including: <ul style="list-style-type: none"> - Key elements and implementation enablers of community-based pain programs - Program models being supported by Primary Health Networks 	Pippy Walker, University of Sydney
1:20-1:25pm	Question time	Professor Fiona Blyth, University of Sydney
Part 2: PHN implementation of pain programs		
1:25-1:40pm	Gold Coast PHN - Turning Pain into Gain (TPIG) Program and targeting the sub-acute pain phase	Joyce McSwan, Clinical Program Director, Turning Pain into Gain Program
1:40-1:55pm	Adelaide PHN - Supporting people from CALD communities to manage persistent pain	Jane Goode, Integration and Design Officer
1:55-2:10pm	Nepean Blue Mountains PHN – Community Chronic Pain Programme – NSW ACI	Kate Tye, Senior Manager - Primary Care Support and Development
2:10-2:20pm	Question time	Pippy Walker, University of Sydney
Part 3: Next steps and close		
2:20-2:25pm	Communicating information about pain programs to PHNs, healthcare providers and consumers	Carol Bennett, Painaustralia
2:25-2:30pm	Summary, reflections and close	Professor Fiona Blyth, University of Sydney

Summary of presentations

This section provides an overview of the presentations given by the research team, Primary Health Networks currently commissioning community-based pain programs and project collaborator Painaustralia. Further detail and slides from individual presentations are provided in the Appendix 1.

Part 1: Introduction and summary of research findings

Supporting the commissioning of community-based pain programs: a summary of research findings to support Primary Health Networks from Pippy Walker, Senior Research Officer at the University of Sydney

Background

This three-year project has been separated into three different focus areas of work, where the direction of the project has been informed by our research findings. The focus on community-based pain programs in phase 3 of this project was informed by the following findings in phases 1 and 2:

- Phase 1 focused on identifying PHNs' health and service needs and priorities related to chronic pain, current chronic pain initiatives and gaps. The mapping of chronic pain initiatives showed that only 6 PHNs were commissioning community-based pain programs
- Phase 2 focused on the secondary prevention of chronic pain. The deliberative dialogue with PHNs identified that PHNs are interested in implementing community-based pain programs for consumers with subacute pain to prevent chronic pain, as well as being interested in implementing pain programs for consumers with chronic pain.

Methods

Phase 3 of this research focused on community-based pain programs and has involved the following:

- A Zoom meeting for PHNs to discuss how face-to-face community-based pain programs have been adapted during COVID-19 to a non-face-to-face mode due to COVID restrictions; and dissemination of a PHN Summary: *How to adapt your consumer pain program during the COVID-19 period: two examples and a discussion.*
- An eDelphi study of experts to identify key elements of community-based pain programs and enablers for implementation
- A survey of PHNs that are currently commissioning pain programs to identify the different program models and how these programs are implemented
- In addition to this PHN webinar which aims to translate the findings from phase 3, a series of information resources are currently in development to support PHNs, primary health care providers and consumers, in partnership with PainAustralia and NSW ACI.

Findings

Through an eDelphi process, experts agreed on a list of key elements (n=18) and implementation enablers (n=14) for community-based pain programs. Key elements focus on ensuring programs are multidisciplinary, led by health professionals, consumer focused, accessible and appropriate, and informed by continuous improvement and evaluation. Implementation enablers support program commissioning, governance and management; health professional engagement, communication and support; consumer engagement, communication and support; and costs, funding and other resource considerations.

The survey of PHNs that are currently commissioning pain programs (n=6 PHNs commissioning 7 different programs) identified two predominant program models, which are known as:

- PainWise's Turning Pain into Gain (TPIG) program
- University of Sydney Pain Management Research Institute's Brief Pain Self-management (BPSM) program

A summary of the key elements and implementation enablers that are addressed by these program models are detailed in the webinar presentation slides (see Appendix 1).

Further information

See the [Prevention Centre website](#) for publications, resources and event summaries from this project. For further information please contact Simone De Morgan simone.demorgan@sydney.edu.au or Pippy Walker pippy.walker@sydney.edu.au.

Part 2: PHN implementation of pain programs

Early intervention subacute pain program (Gold Coast PHN) from Joyce McSwan, Clinical Program Director Turning Pain into Gain Program

Background

Subacute pain is defined as patients who experience pain 6-12 weeks post injury/surgery/trauma with 'yellow flag' risk factors that indicate possible progression to chronic/persistent pain. This pilot program started in July 2020 with the objective to prevent the progression of subacute pain to chronic pain, provide early multidisciplinary care, minimise risk of secondary changes and prevent overuse of medicines. This was done by trialling the expansion of the Turning Pain into Gain (TPIG) program criteria to include subacute pain. The need to target subacute pain was increasing over the previous 12 months and accelerated during COVID-19.

Program design

Patients can be referred direct from the GP or from specialists/ allied health with GP sign-off. Clinical personnel include a facilitator (pharmacist, physiotherapist, exercise physiologist or nurse), psychologist, physiotherapist/ exercise physiologist and a pharmacist.

The introductory program session covers what is pain, what contributes to my pain, where to from here, and the final program session covers understanding anxiety and trauma, problem solving, flare-up planning and celebrating wins. The program runs for 4-6 months (shorter than TPIG) and was funded through core flexible funding.

Enablers, challenges and lessons learnt

Enablers: Already having an existing pain program, existing stakeholders and local networks and an efficient team to operationalise the website, templates and promotion of the program.

Limitations: COVID processes and protocols, defining subacute pain – there wasn't a clear definition in literature or practice

Lessons: Involve the whole team, involve a patient ambassador (tell personal stories and experiences overcoming pain), collaborate with local research evaluators.

Further information

For further information please contact Joyce McSwan at tpigpainprogram@painwise.com.au or 0412 327 795.

Managing persistent pain with people from CALD and refugee backgrounds (Adelaide PHN) from Jane Goode, Integration and Design Officer

Background

Chronic pain in refugees can be up to three times higher than the general population due to extreme hardship resulting in missed diagnoses and inability to receive adequate/timely treatment, experiences of torture and trauma, and complex relationships between pain and trauma. Cultural beliefs, values and customs impact experiences of pain. This is obviously different to traditional biopsychosocial pain programs and therefore approaches to pain must be grounded in biopsychosocial and cultural frameworks.

Consultations were conducted with an existing provider – Survivors of Torture and Trauma Assistance Rehabilitation Service – to identify needs and gaps and create a cultural framework that would be appropriate and relevant for pain programs.

The objective of the program was to support individuals to understand and better self-manage pain, better understand and respond to specific pain needs of various cultural groups and develop resources from those groups that provide information that is accessible to others in the community.

Program design

The program runs for 10 weeks, consisting of a 1-hour gentle exercise session and a 1-hour information session. Sessions are co-designed with the participants and cover a range of topics including headache, backache, shoulder pain, gentle movement, maintaining hydration, mindfulness activities and many others. In some cultures, groups can have mixed genders and for other sessions need to be offered separately for men and women. A total of six group programs exist for three different cultural groups.

Enablers, challenges and lessons learnt

Enablers and challenges: Ensuring cultural appropriateness is a challenge, but this was overcome by partnering with an organisation that knew the communities well and were already delivering similar/ aligned programs. Additional resources were required beyond the usual personnel including venue hire, healthy refreshments, yoga mats for participants to take home for trauma informed yoga sessions, pool entry and instructor fees and a videographer (film resources were created).

Lessons learnt: The importance of collaborating with key stakeholders and community and not taking a top-down approach. Co-design and flexibility are fundamental to this program all the way down to the individual sessions with the different groups which were co-designed with the participants.

Further information

For further information please contact Kylie Hutchinson, Integration Coordinator khutchinson@adelaidephn.com.au or Jane Goode, Integration and Design Officer jgoode@adelaidephn.com.au at 08 8219 5900.

Community chronic pain management program (Nepean Blue Mountains PHN) from Kate Tye, Senior Manager – Primary Care Support and Development

Background

Locally there is a large prevalence of chronic pain in the community and a lack of services, which is resulting in patients being reliant on medication. The Local Health District delivers the COPE outpatient service at Nepean, however, there are long waitlists. The community chronic pain program was created to fill this gap with the objective to improve self-management of chronic pain, return to work, improve mental health and reduce opioid reliance.

Program design

The program consists of an information session for referred patients, a 6-week pain management course (one 3-hour session per week), and a 3-month and 6-month follow-up session (2-hours each) post course completion. Sessions include an exercise and education component. Patients have low-moderate pain complexity and are referred from GPs via HealthPathways or email. GPs receive reports back on patient progress.

During COVID-19 the program transitioned to online delivery with 2 x 1.5-hour sessions each week. Participants could print course work or collect print outs from providers. Exercise sessions included a one-on-one with a physiotherapist/exercise physiologist to ensure safety and reduce injury. Extra time was also included after sessions to encourage socialisation. An electronic Persistent Pain Outcomes Collaboration (ePPOC) evaluation is conducted by Wollongong University, who provide regular reports that indicate how the region is going, what it is achieving and benchmarking the program against similar programs in other regions.

Enablers, challenges and lessons learnt

Enablers and challenges: Funding and capacity building were both enablers and challenges. Nepean Blue Mountains is one of the smallest PHNs in terms of funding and there was limited budget for a pain program. The program needed to be short to be affordable. The capacity building opportunities for allied health providers highlighted a dual benefit for funding.

Lessons: The importance of not just orientating the manager of the service into the contract requirements and expectations of delivery but also ensuring relationships with the key facilitators are established. It is also

important to keep across the number of referrals and staff required to ensure sustainability of the program. For example, in one instance there were only three participants with a fully staffed program.

Further information

For further information please contact Kate Tye at kate.tye@nbmphn.com.au

Part 3: Next Steps

Communicating information about pain programs to PHNs, healthcare providers and consumers from Carol Bennet, CEO of Painaustralia

Painaustralia is partnering with the Prevention Centre and the NSW Agency for Clinical Innovation (NSW ACI) to produce and disseminate a series of resources that will raise awareness about community-based pain programs. This series of resources will aim to communicate the findings on key elements for program design, implementation enablers of community-based pain programs and details on all the currently available programs commissioned by PHNs.

Painaustralia will use its social media networks (6,000 followers each) and enews (5,000 subscribers) to inform practitioners and consumers about these resources, which will be housed on Painaustralia's new website which the Federal Government has funded to provide a gateway for best practice, evidence-based pain education and information in Australia.

The NSW ACI's Pain Management Network is also a valuable point of dissemination and has a dedicated chronic pain webpage that is designed to help health practitioners and consumers gain a better understanding of pain. The site contains information to enable consumers to develop skills and knowledge in the self-management of pain conditions in partnership with their healthcare providers.

Questions, reflections and points of discussion

The following points were raised and discussed throughout the webinar:

- The importance of consumer engagement and the consumer voice: key elements and enablers were drawn from an extensive literature review but there was a gap in the literature related to the need for the consumer voice in programs. This need was highlighted in the PHN survey about pain programs. The consumer voice will be considered as part of future information resource development to ensure that resources developed are consumer informed.
- Although the World Health Organisation recognises chronic pain as a distinct disease, PHNs often do not recognise this. Chronic pain is often embedded in other conditions and issues, for example, musculoskeletal conditions, chronic disease, mental health and Alcohol and Other Drugs (AOD) issues, in PHN planning documents. There is also a lack of quality local data at a PHN level about health and service needs related to chronic pain.
- Limited funding is seen as a major barrier by PHNs to implementing community-based pain programs, especially given health system level constraints such as Medicare reimbursement limitations for group-based programs. Some ideas and solutions proposed included: implementing pain programs targeting the subacute pain phase (secondary prevention of chronic pain) as these programs are of shorter duration compared to programs for chronic pain and therefore require less funds; targeting secondary prevention and early intervention of chronic pain to reduce health care system costs and community costs; and private health funds presenting a possible opportunities for public-private partnerships to reduce costs for PHN to implementing pain programs. .
- Other partnerships discussed included partnerships with local governments and other organisations that are well connected within the community. For example, Adelaide PHN partner with Survivors of Torture and Trauma

Assistance Rehabilitation Service to deliver their persistent pain program for people from CALD and refugee backgrounds.

- Co-design and flexibility are important, particularly when adapting programs to meet the needs of special interest groups such as Aboriginal and Torres Strait Islander and culturally and linguistically diverse (CALD) groups.
- A need for awareness campaigns about chronic pain. PHNs expressed interest in partnering with PainAustralia or other organisations to deliver awareness campaigns locally. For example, Adelaide PHN is currently partnering with WorkSafe SA on a campaign called Reach for the Facts – further information can be found on the website <https://reachforthefacts.com.au/>. Outcomes of the National Strategic Action Plan for Pain Management could facilitate future work in improving community awareness about chronic pain.

Webinar Feedback

A post-webinar evaluation survey was made available to attendees of the PHN webinar. Nine out of 17 (53%) Primary Health Network representatives that participated in the PHN webinar completed the survey. Feedback is summarised below:

Improved knowledge and understanding

All participants that completed the webinar evaluation survey (n=9) agreed or strongly agreed that:

- The webinar improved their knowledge of the key elements and implementation enablers of community-based pain programs.
- The webinar improved their knowledge of the different program models currently being supported by Primary Health Networks.
- The webinar improved their knowledge of how some programs have been implemented in practice.
- The webinar improved their understanding of successes, challenges and key considerations that have been identified by PHNs commissioning pain programs.
- They were interested in receiving copies of the information resources on community-based pain program models.

Most participants that completed the webinar evaluation survey (n=8; 89%) agreed or strongly agreed that they:

- Feel equipped to identify what program models may be feasible for their PHN considering their context and resources.
- Know who they can contact for further information about community-based pain programs.

Interesting and useful components

The following feedback was received from Primary Health Network representatives that completed the webinar evaluation survey about what they liked about the webinar:

- Several respondents indicated that the case studies/ presentations from PHNs on implementation of their pain programs were the most interesting and useful part of the PHN webinar
- Several respondents enjoyed the presentation from Pippy Walker on behalf of the research team, providing an overview of the project activities and results to date. In particular, participants liked the data comparing program similarities and differences, as well as the links between the eDelphi survey from experts/ steering group and the PHN survey.
- Several respondents reported that the Adelaide CALD and refugee program was interesting and inspiring. Respondents reported that it provided a good model for creating a tailored program for specific consumer needs and a great example of co-design.

- Other respondents indicated the PHN webinar was overall interesting and useful; the passion and enthusiasm from those involved was a highlight; and that the webinar was useful for demonstrating an approach to developing secondary prevention pain programs.

Primary Health Network representatives were asked to indicate the extent to which the webinar is likely to influence future decisions. Most indicated that *it was very likely* or *quite likely* that the webinar would influence the next workplan, future workplans and engagement with other PHNs who are currently implementing community-based pain programs of interest to their PHN (Figure 1).

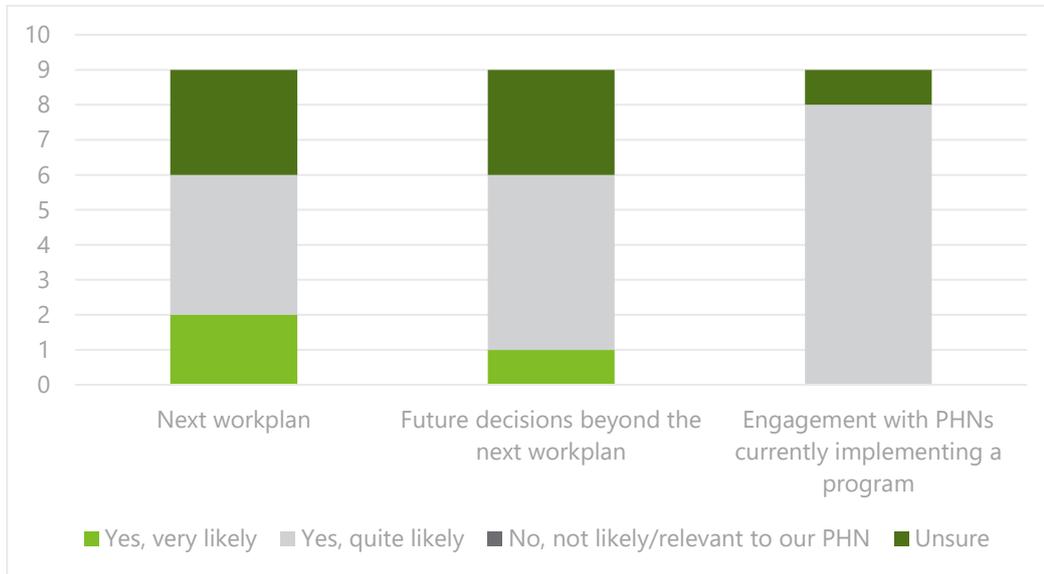


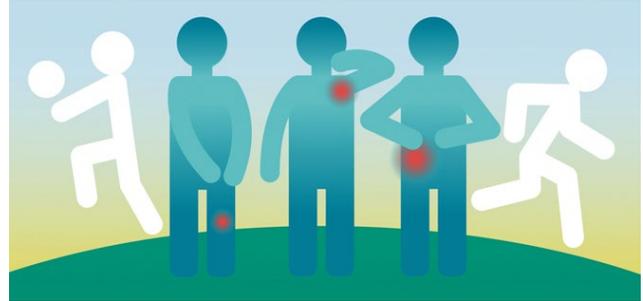
Figure 1: Likelihood of the webinar influencing future Primary Health Network decisions.

The survey also asked whether there is any specific information about programs that would be useful in the information resources that are currently in development to communicate the findings from this research about Primary Health Network pain programs. Respondents indicated that all the information about existing programs would be useful information. In particular, a focus on the commissioning approach and the tools/ methods to understand the local need, supply and demand would be most useful. A central repository of chronic pain resources that could be shared would be particularly useful as PHNs and individuals can find all the information in one place and locate information specific to their needs.

Appendix 1: Webinar Presentation Slides

Supporting the commissioning of community-based pain programs

A summary of research findings to support Primary Health Networks



Presented by

Pippy Walker MPH MHM MSc (ex rehab/diet)

Menzies Centre for Health Policy, University of Sydney and The Australian Prevention Partnership Centre

Primary Health Network Webinar, 8th December 2020

Project funding and acknowledgements



Australian Government
Department of Health

This project was made possible with funding from the Australian Government Department of Health Boosting Prevention program funded by Medial Research Future Fund. Additional funding to support this project has also been granted by the Sydney Medical School Foundation, University of Sydney.



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Research team: Professor Fiona Blyth, Dr Simone De Morgan, Professor Andrew Wilson, Leah Marks, Maddie Day



Partners:

Carol Bennett & Priyanka Rai from PainAustralia

Sue Rogers from NSW Agency for Clinical Innovation (NSW ACI)



AGENCY FOR
**CLINICAL
INNOVATION**

Participants:

Steering groups members

Primary Health Networks

Outline

- Background
 - Chronic pain as a health and health system issue
 - Chronic pain project activities and how they informed phase 3

- Phase 3: Community-based pain programs
 - Aim and methods
 - Findings
 - Key program design elements and implementation enablers
 - Current PHN community-based pain program models
 - Bringing these results together to identify whether PHN pain programs address identified key elements and implementation enablers

Background and aims of the chronic pain project



Chronic pain is defined as pain that lasts or recurs for more than three months and has recently been classified as a disease in itself (WHO-ICD-11) (Treede et al 2019)



Significant non-fatal burden globally (Deloitte Access Economics 2019)



The primary care setting has been recognised as key to achieving an efficient and sustainable health system (Painaustralia 2010; Australian Government Department of Health 2019)



The aim of the Chronic Pain Project has been to improve knowledge and foster knowledge sharing among PHNs for the secondary prevention and management of chronic pain

Chronic pain project activity overview

**Phase 3:
Community
pain programs**

PHN webinar
(Dec 2020)

PHN Survey

eDelphi Study

PHN Zoom
meeting
(April 2020)

Scoping
review

Needs
assessment
review

**Phase 1:
Needs,
activities and
gaps**

PHN
consultation

Published
resources
for PHNs

PHN workshop
(March 2019)

Rapid
evidence
review

PHN
deliberative
dialogue
(Oct 2019)

**Phase 2:
Secondary
prevention**

See Prevention
Centre website
for publications,
resources and
event summaries

Community-based pain programs

Adapted from the tertiary setting pain clinic program model for the community setting, programs generally:

- Apply the biopsychosocial model of pain using a multidisciplinary approach
- Are facilitated by PHC professionals trained in pain management
- Provide group-based sessions with individual consultations as necessary
- Focus on active self-management strategies & apply behaviour change principles
- Include resources for consumers

This model of care can reduce pain, disability and have a positive influence on work status (Williams et al 2012; Kamper et al 2014)

*It is unclear how current programs commissioned by PHNs vary
It is also unclear what processes support the implementation of these programs*

Phase 3: Community-based pain programs



Aim: To increase knowledge and foster knowledge sharing among PHNs about the implementation of community-based pain programs

Methods:

1. eDelphi survey (3 survey rounds, 16 invited experts)

- To establish consensus on a list of key elements of, and enablers important for community-based pain program implementation

2. Online PHN survey (1 survey, 8 invited PHNs)

- To identify existing program models commissioned by PHNs. The key elements and enablers of pain programs formed the basis this survey.

3. Knowledge mobilisation

- Via this webinar, and information resources currently being developed

Establishing key program elements and implementation enablers

eDelphi process:

- 10/16 (62.5%) of invited experts completed all 3 survey rounds
- All proposed elements and enablers were retained (>70% agreement), with some suggested rephrasing and additions

Themes of key elements and enablers

Key elements (n=18)	Enablers (n=14)
Multidisciplinary care	Program commissioning, governance & management
Led by health professionals	Health professional engagement, communication & support
Consumer focused	
Accessible and appropriate	Consumer engagement, communication & support
Continuous improvement & evaluation	Costs, funding & other resource considerations

PHN community-based pain programs

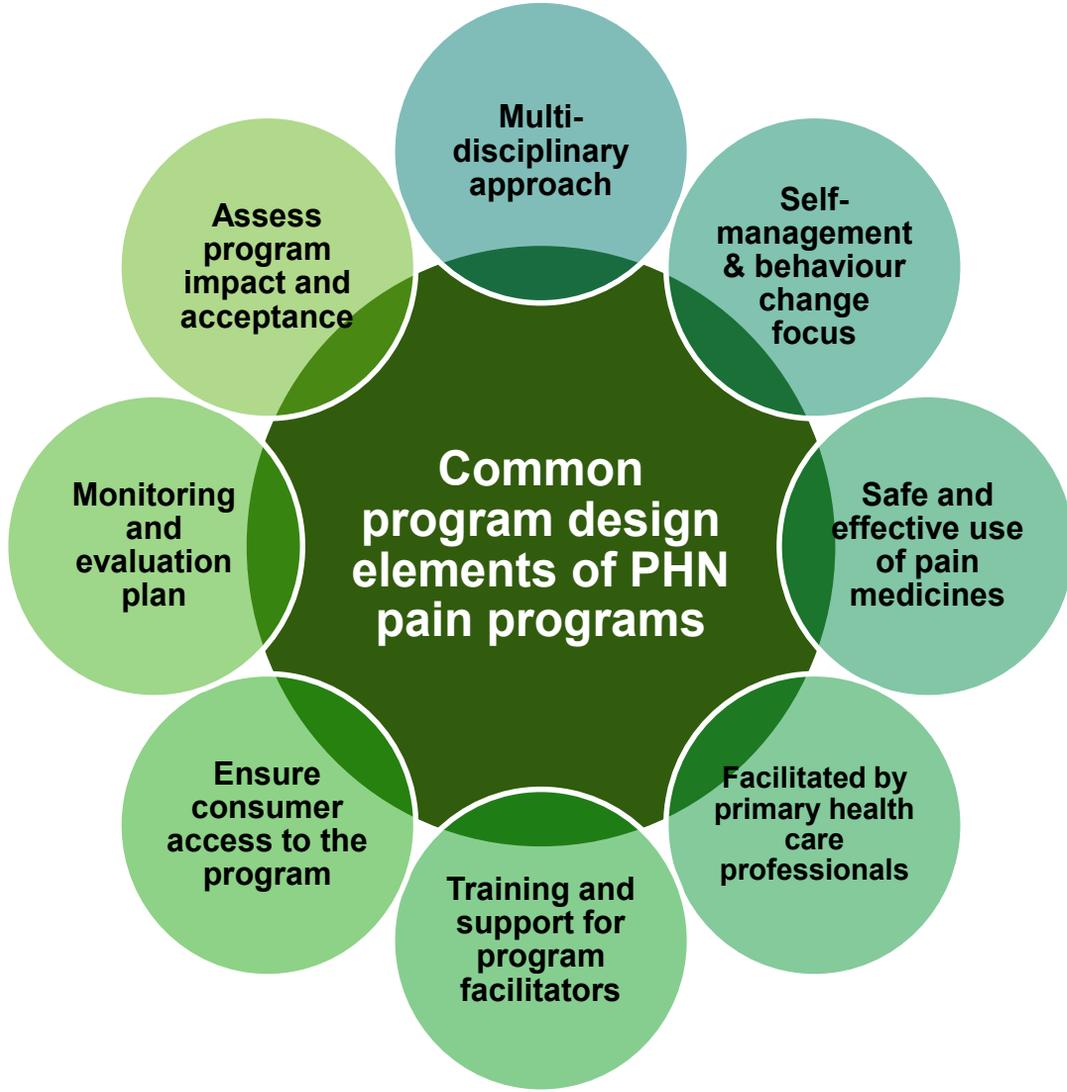


6/8 (75%) invited PHNs completed the survey to provide information on 7 pain programs, which are based on 1 of 2 program models commissioned by the following PHNs:

PainWISE's Turning Pain into Gain (TPIG) program	University of Sydney Pain Management Research Institute's Brief Pain Self-management (BPSM) program*
Gold Coast PHN (since 2013)	South Eastern NSW PHN (since 2018)
Adelaide PHN (since 2015)	Nepean Blue Mountains PHN (since 2019)
WAPHA (since 2017)	Western NSW PHN (in procurement)

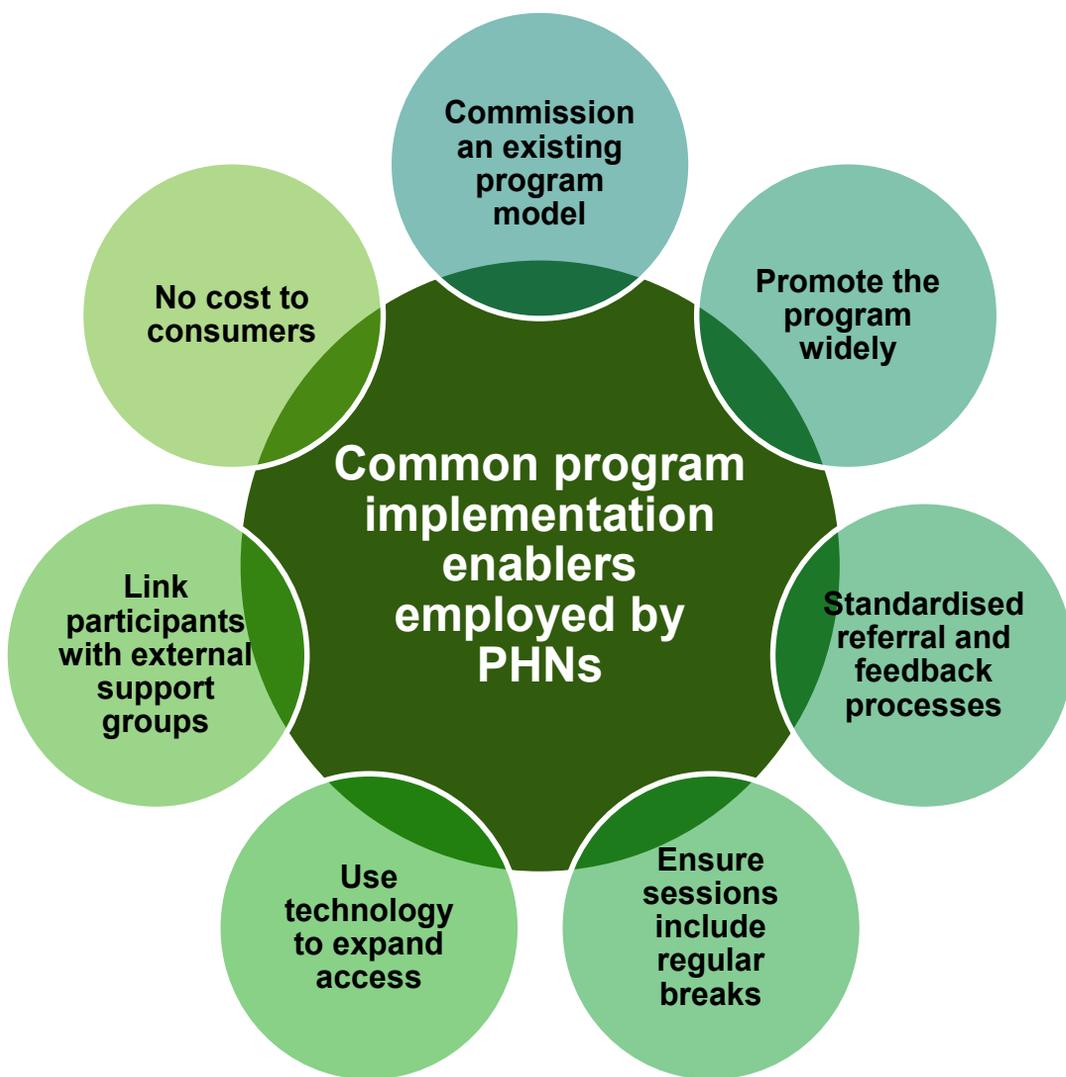
*Implementation is supported by NSW Agency for Clinical Innovation (NSW ACI)

All programs have a high level of compliance with key program elements and implementation enablers



Differences or gaps (key program design elements)

- Programs currently only **target** adults with chronic non-cancer pain, with:
 - One program for people from CALD and refugee backgrounds
 - One in development for sub-acute pain phase
- Limited **adaptation** for Aboriginal and Torres Strait Islander or culturally and linguistically diverse communities
- **Pre-program session** is not standard for some programs
- **Individual consultation referrals** are not always considered
- Involvement of **consumers in program delivery** is rare
- Participation of **family/carers** is mixed
- Not all programs have a standard process for ensuring evaluation data is used as part of **continuous quality improvement** for program delivery



Differences or gaps (program implementation enablers)

- Program **champions** and **advisory groups** are not always established
- All programs are funded using a single funding stream
 - PHNs could consider drawing on **multiple funding streams** or **co-commissioning** with other agencies





The Australian Prevention
Partnership Centre
Systems and solutions for better health



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Prevention Centre project webpage:

<https://preventioncentre.org.au/our-work/research-projects/preventing-the-development-of-chronic-pain/>

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Gold Coast Primary Health Network presents



Early Intervention Subacute Pain Program

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phn
GOLD COAST

An Australian Government Initiative

Service Objective

- Prevent the progression of **subacute to chronic pain**.
- Provide **early multidisciplinary care** to develop self-management skills for those who are at risk of transitioning from subacute to chronic pain.
- Minimise the **risk of secondary changes** due to the progression of sub-acute presentations to chronic pain e.g. physical movement compensation and adaptation, fear avoidance behaviour, depression and anxiety.
- Prevent the **overuse of medicines** that may result in long term adverse effects (e.g. addiction, dependency, tolerance, endocrine effects).
- Trial the expansion of the Turning Pain Into Gain criteria to include sub-acute presentations.

The Early Intervention Subacute Pain Program comes out of the work of the 'Turning Pain into Gain' Persistent Pain from (2013 to current)

What is Subacute Pain?

Patients who experience pain 6-12 weeks post injury/surgery/trauma with 'yellow flag' risk factors that indicate possible progression to chronic/persistent pain.

Need, Efficiency and Cost Benefit

- Since 1st June 2020 by the PBS we have observed an increase of 19% of patient referrals who have had a subacute pain presentation.
- Approximately 70% of patients who have been referred who are within 3-6 months of a pain condition diagnosis are discharged by 6-7 months of program participation.

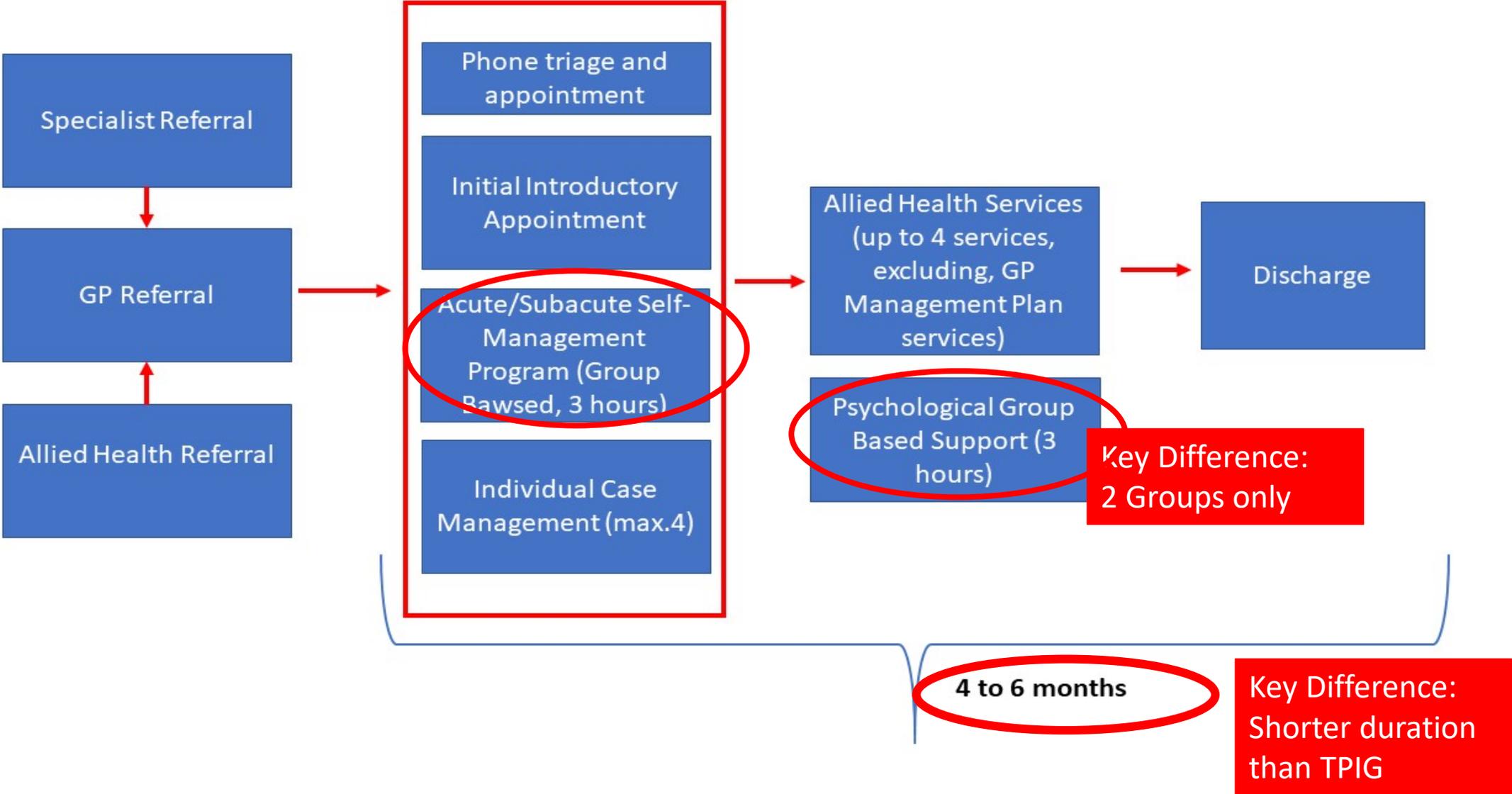
Service Eligibility Criteria

- The patient has to be **18 years old and above**
- The patient has suffered pain for **6-12 weeks and displaying Yellow Flag** indicators as indicated by the yellow flag checklist suggesting an increased risk of progression to long-term distress, disability and potential drug misuse.
- The patient is **not displaying any Red Flags** as per the red flag checklist (Red Flags are clinical indicators of possible serious underlying conditions requiring further medical intervention).
- The patient is **not suitable for surgical or urgent pain specialist interventions.**
- The patient requires **improved self-management** strategies and skills to optimise ongoing care.
- The patient is able to: **participate in group education, give voluntary, informed consent for the ongoing collection of audit data**
- If the patient has had **surgery in the past 12 weeks, a functional instruction plan** is provided with the referral from the GP.

Service Exclusion Criteria

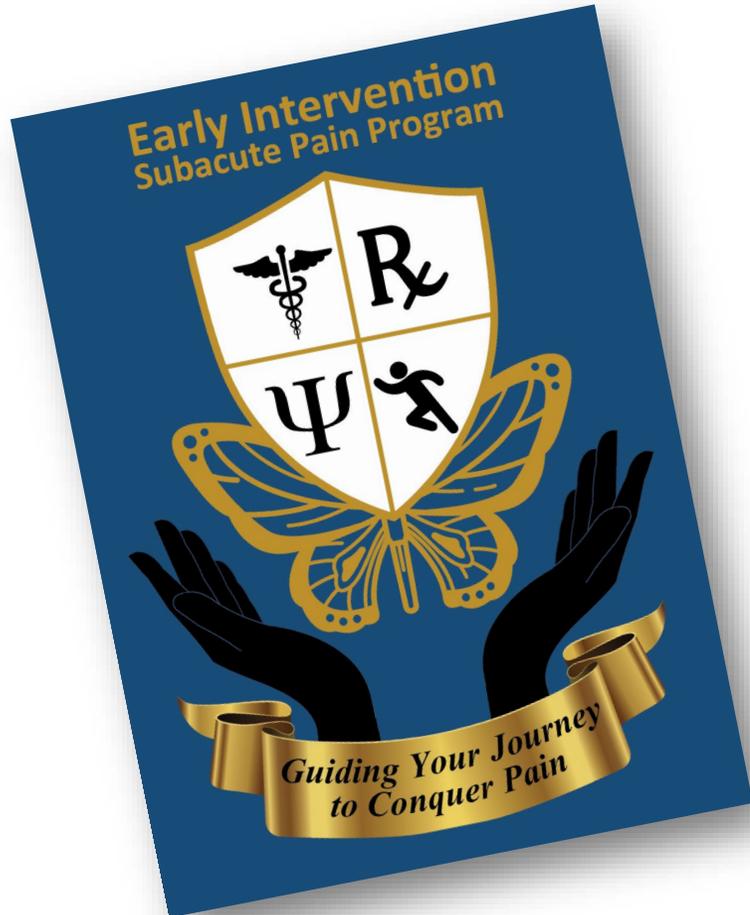
- Patients who are undergoing worker's compensation.
- Patients receiving palliative care.

Clinical Program Pathway of EISPP



Differentiating between the TPIG and EISPP program

- Using Passport of Care



Your Program Journey

Individual Sessions

Date	Time	Appointment	Completed
		Introductory Pain Assessment	Clinician Signature or stamp
		Individual Review 1.	Clinician Signature or stamp
		Individual Review 2.	Clinician Signature or stamp
		Individual Review 3.	Clinician Signature or stamp

Group Education Sessions

Date	Time	Education Session	Completed
		Group Session 1.	Clinician Signature or stamp
		Group Session 2.	Clinician Signature or stamp

Your Care Team:

Team Member	Phone:	Email:
GP:		
Pharmacy:		
Physiotherapist:		
Psychologist:		

Program Graduation

	Date	Sign
Graduation Management Plan Prepared by: "Clinician Name"		Clinician Signature
Certificate Issued		Clinician Signature

Topics covered in group sessions

Introductory Group Program

- **What is Pain ?**
 - Pain and the healing cycle
 - Why do I still have pain?
- **What contributes to my pain?**
- **Where to from here?**
 - Minimising the impact of pain on my life
 - Finding my function
 - Healing accelerators
 - Responsible medication usage

Final Group Program

- **Understanding Anxiety and Trauma**
 - Exploring tools for managing anxiety and trauma
- **Problem Solving**
- **Flare-up Planning**
- **Celebrating the Wins**

Clinical Personnel

- Clinical Facilitator – Can be a pharmacist, physio, exercise physiologist or nurse
- Psychologist
- Physiotherapist/ Exercise physiologist
- Pharmacist

Clinical Evaluation

- Researcher: Bond University
- Baseline - Orebro, K10, ACE, HRQOL, BPI
- Post program - Orebro, K10, HRQOL
- 6 months Post Program – Orebro, K10, HRQOL

Funding

- By the Gold Coast Primary Health Network
- From Flexible Funding

Program Enablers

- Existing Persistent Pain Program (Standardise practice and efficient operations)
- Existing stakeholders and local networks
- Efficient GCPHN team to mobilise website, referral templating and communications to local networks

Program Limitations/Challenges

- COVID processes and protocols
- Defining subacute pain

Learnings so far

- Involve the whole team – makes for efficient program development
- Involve a patient ambassador
- Collaborate with local research evaluators – E.g. Bond Uni
- Digitalise as much as possible

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An Australian Government Initiative

Managing persistent pain with people from CALD and refugee backgrounds

Jane Goode

Integration and Design Officer, Adelaide PHN

We acknowledge the Kurna peoples who are the Traditional Custodians of the Adelaide region. We pay tribute to their physical and spiritual connection to land, waters and community, enduring now as it has been throughout time. We pay respect to them, their culture and to Elders past and present.

Persistent pain in people from refugee backgrounds

Chronic pain in refugee clients may be up to three times higher than in the general population¹.

- Living situations of extreme hardship for prolonged periods means medical conditions may be missed, and people may not receive adequate/timely treatment.
- Experiences of torture – approximately 30% of refugees have experienced torture²
- Experiences of refugee trauma – estimates are 70% of people who arrive in Australia as refugees have experienced severe abuses of human rights.
- Many refugee women have experienced sexual abuse – complex relationship between pain and traumatic memories

Experience of pain

- Cultural beliefs, values and customs play an important part in the experience of pain.
- Beliefs about what pain means and the significance of suffering pain, in addition to the context in which pain is experienced and feelings can affect the intensity of pain.
- Pain is often differently embodied though there are commonalities yet there are important differences.
- Approaches to pain must be grounded in both bio-psychosocial and cultural frameworks.³

Survivors of Torture and Trauma Assistance and Rehabilitation Service - STTARS

STTARS had long recognised the need for their service to respond to the physical as well as psychological effects of torture and trauma. Previous work includes:

- Complementary therapies program (massage and individual coaching sessions around self-care)
- Self-care strategies at home resources
- Language specific group programs, including trauma informed yoga groups
- Refugee Health Nurse/Advocates (ARANAP program)
- Counsellors

Proposal

Aims:

- To develop group programs that support individuals to better understand their pain condition and equip them with the necessary tools to improve their quality of life,
- To better understand and respond to the specific embodied pain needs of various cultural groups
- To develop resources from those groups that facilitates key information to be accessible across time to a broader audience from those communities

Program

- An assessment for each participant to ensure safety in participation.
- A 10-week gentle exercise program of the groups' choice – approximately 1 hour per session
- Information sessions – approximately 1 hour per session

In some cultural groups it is appropriate to have groups of mixed genders and for other groups programs will need to be offered separately for men and women. An initial 3 different cultural groups were chosen:

- Bhutanese (mixed gender groups)
- Afghani (separate groups for men and women)
- Syrian (separate groups for men and women).

Proposal

Each cultural group has differences in the way that pain is understood/meaning is attributed to pain, cultural responses to pain and types of exercise/movement that are considered more appropriate.

General outline of topics below, but in actuality, topics were co-designed with participants of each group.

- Understanding the mechanisms of acute and chronic pain
- The meanings attributed to pain (your body is not the enemy)
- Thoughts and feelings – reducing stress and improving wellbeing
- Healthy lifestyle factors to reduce pain
- Gentle movement/physical activity
- The role & limitations of medication in managing pain
- Information about healthcare professionals and services

Inputs and required resources	Outputs and outcomes
A staff member to coordinate the program, assess individual participants, facilitate group programs and prepare resources	6 x 10 session group programs for 6 to 12 participants across 3 different cultural groups
Guest speakers as required	Participant reported outcomes of: <ul style="list-style-type: none"> • better understand their pain condition • increased tools to manage pain • improved quality of life • linkages with other appropriate services
Venue hire for groups	
Light healthy refreshments for group sessions	
For trauma informed yoga groups, it is advisable to provide a yoga mat for each participant to use in the group and to keep so they can continue to practice exercises at home	
For water-based activities – pool entry fees and instructor costs (possible additional costs may be incurred if a venue needs to be restricted to women only)	
Externally sub-contracted film making expertise	Development of 3 film-based resources to make key information from the group program accessible to a broader audience over time

Current groups

Afghani Female Program:

- 3 sessions complete at time of reporting
- # of clients accessing Afghani female program: 18
 - Participants referred from STTARS: 9
 - Participants new to STTARS (community referrals): 9
- Languages spoken: Hazaraghi
- Length of time in Australia: 2-14 years (av 4.27 years)

Current groups

Afghani Male Program:

- 3 sessions complete at time of reporting
- # of clients accessing Afghani male program: 12
 - Participants referred from STTARS: 4
 - Participants new to STTARS (community referrals): 8
- Languages spoken: Pashto, Dari
- Length of time in Australia: 5 months-9 years (av 3.95 years)



Contacts

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Community Chronic Pain Management Program

8 December 2020

Nepean Blue Mountains Primary Health Network

Kate Tye
Senior Manager Primary Care Support and Development

Wentworth Healthcare provider of the Nepean Blue Mountains PHN.

OUR REGION

POPULATION PROFILE



380,000 people
9,063 km²

51%
female

49%
male



3.7% identify as
Aboriginal & Torres Strait
Islander *compared to 2.9% in NSW*



18% born overseas

12% speak a language
other than English at home



17.6% projected
population increase by
2036 to over 466,000
Most rapid increase is projected
for those aged 65+ years



61% overweight and
obese significantly higher than
NSW average 2018



12% have diabetes
higher than NSW average 2018

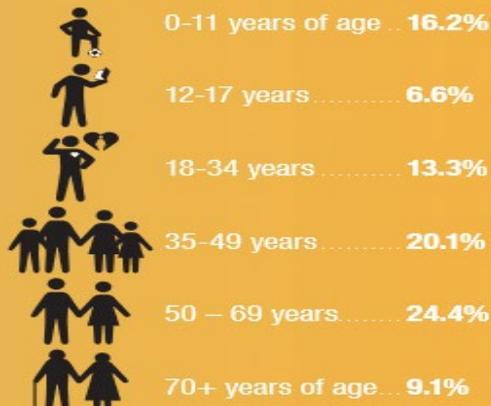


Cardiovascular disease:
leading cause of death in
females and second leading
cause of death in males



Cancer: leading cause
of death in males and
second leading cause
of death in females

AGE BREAKDOWN



Chronic Pain Management

Chronic Pain imposes a significant burden of disease on the community with 1 in 5 people reporting to experience chronic or persistent pain.

Local Health District deliver the COPE outpatient service at Nepean – long wait lists.

Patients are relying heavily on medication to manage pain in the region due to lack of access to services

Identification of the need for consumer pain programs in the region to support chronic pain management.

Community Chronic Pain Program

Program Requirements:

Course Facilitators are required to complete a 6 week webinar training program conducted by Sydney University and ACI prior to facilitation of the program.

Course Facilitator Requirements:

Exercise Physiologist, Physiotherapist, Clinical Psychologist etc with CBT training

Program Delivery:

- Information session for referred participants
- Pain Management Course – 6 weeks for 3 hours per week in one session
- Follow up at 3 months after completion of the program - 2 hour session
- Follow up at 6 months after the completion of the program - 2 hour session

Referral and Communication

Target group: consumers with low to moderate pain complexity

Referrals: GP referrals via HealthPathways or emailed directly

Communication: GP's refer in receive reports back, Consumers receive an invitation to the program and information on pain resources

Evaluation: Consumer program delivery survey and ePPOC

Referral and Communication

Suitable Referrals:

- Patients identified by their GP as having chronic pain
- Pain longer than 3 months or beyond the normal healing time of an injury resulting in declining functional and psychological well-being (e.g., musculoskeletal pain, whiplash, neuropathic pain, fibromyalgia)
- Patients with an Orebro Musculoskeletal score of ≤ 50
- Independently mobile
- Ability and willingness to attend all sessions
- Low to moderate complexity

Exclusions:

- Patients undergoing active treatment for cancer, infection or fractures
- Patients on high dose opioids (> 60 mg oral morphine equivalent per day)
- Worker's compensation or third party insurance claims

Program Evaluation

Main program aims:

- Self-management of their Chronic Pain
- Return to work
- Significant improvement in aspects of their mental health
- Opioids reliance reduced

Is an intervention effective or not?

Assessment/follow up via ePPOC questionnaire includes: DASS (Depression, Anxiety, Stress scales), PSEQ (Pain self-efficacy questionnaire), PCS (pain catastrophizing scale), BPI (brief pain inventory)

ePPOC 
electronic persistent pain
outcomes collaboration

COVID-19 Online Delivery

Online program format:

- 2 x 1.5 hour sessions on Zoom per week
- Exercise and education session in morning and relaxation in the afternoon
- Include breaks for all every half an hour for a set time
- Providers to print off workbooks and ask participants to pick up
- ePPOC was also completed but online
- The exercise component was important to ensure that all participants were doing it properly to reduce injury. Each participant had a one on one session with the physio/exercise physiologist
- Extra time was included after each session to encourage social interaction

NB. Sessions were not to be recorded (either host or participants) due to privacy concerns and no control over distribution

Commissioning and Funding Source

- Funding: Flexible funding and Rural Doctors Network - \$11,570 per program.
- Commissioning: commissioned through an EOI tender process. Had two providers one Hawkesbury and the other Blue Mountains and Penrith. Recently de-commissioned Blue Mountains and Penrith provider.



Questions?

