Queensland
Clinical Senate

Connecting clinicians to improve care

Managing the pain of opioids

19-20 July 2018
Meeting report
Royal on the Park, Brisbane

Queensland Government

Queensland Clinical Senate, Meeting Report

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Chair's report

There is no doubt that opioid medication has a place in pain management. The evidence is clear that well-managed opioid use is effective in a very defined group of patients. Outside of this group however, prescription opioid medication is putting patients at unnecessary risk of harm and even death.

With opioid prescribing and use at an all-time high across Australia, we are seeing increased dependency and significant impact on morbidity, particularly in elderly patients. Deaths from pharmaceutical opioids exceed those from heroin. Now is the time for us to make a change before more lives are harmed and lost.

At the Senate's July 2018 meeting, 'Managing the pain of opioids' clinicians and consumers considered whether a stewardship program could help ease the state's opioid pain and what the program could look like.

Stewardship programs are working successfully in other jurisdictions to better manage opioid use and prescribing, and there was strong belief among delegates that stewardship would complement the opioid management initiatives already underway or planned for Queensland.

There was however agreement that a stewardship program must have the broader focus on pain management and high-risk pain medications, not just opioids.

Delegates were also of the same mind that:

- strong clinical governance of the stewardship program was imperative
- a stewardship program must include real time monitoring to provide prescribers with access to their patients' prescription history for high-risk medications. This will allow for safer clinical decisions on whether to prescribe or dispense high-risk medicine.

We were extremely fortunate to have had a number of consumers and carers contribute actively and enthusiastically to our discussions. Their incredibly honest and engaging stories of opioid use and dependency strengthened the breadth of our discussions. A topic like this cannot be truly understood without hearing the real impact. One of the strong messages from consumers was to include them as part of the treating team: 'I think we need to do this together. I get sick of having things done to me.' I sincerely thank each of the consumers who shared their time and experience with us.

There was an overwhelming desire among consumers, clinicians and system leaders to minimise unanticipated harm from opioids while ensuring people have access to alternative and appropriate treatments to relieve their pain. Consumer wellbeing and safety must be at the center of all that we do.

Recommendations from the meeting focus on the implementation of a pain management stewardship program for high-risk medicines, education for consumers and clinicians and real-time monitoring. The full suite of recommendations from the meeting can be found on page 7 of this report.

I am certain that this conversation will remain high on the agenda in Queensland and if we all continue to champion the cause we will see progress in this space.

Dr David Rosengren

Chair, Queensland Clinical Senate

Introduction

Opioid[1] prescribing is at an all-time high in Australia. Close to three million Australians were prescribed at least one opioid under the Pharmaceutical Benefits Scheme (PBS) or Repatriation PBS (RPBS) in 2014.[2]

The consequences are serious:

- Significant morbidity among the general population including car accidents, increased pain intensity, immunosuppression and recurrent infections, hormonal dysfunction, and osteoporosis.
- Elderly patients are experiencing complications such as confusion and delirium. This often leads to falls and other adverse outcomes resulting in a hospital readmission.
- Overdose and accidental overdose numbers are at record levels across the country.[2]
- Drug related and accidental deaths from pharmaceutical opioids are increasing — Queensland recorded a 2.7 fold increase from 2001-05 to 2011-15.[3]

Prescribing opioids is very challenging—prescribers must balance the need to effectively treat pain with the risk of side effects, misuse and abuse.

While evidence supports the use of opioids for cancer and palliative care patients, and short-term use for patients experiencing acute pain in a controlled setting, it is often inappropriately prescribed for longer periods and for persistent non-cancer pain patients.

'Indication creep' and inconsistent evidence to support non-opioid alternatives are among the factors contributing to the problem.

The Senate meeting

The Queensland Clinical Senate hosted more than 150 clinicians, consumers, carers and senior health administrators at its 'Managing the pain of opioids' meeting on 19-20 July 2018.

Delegates explored the potential benefits of a stewardship program to support the State's response to prescription opioid use in Queensland.

Recommendations from the Queensland Clinical Senate meeting, 'Managing the pain of opioids' are presented to the Queensland Health Director-General and Queensland Minister for Health for consideration.

1. Opioids are prescription only drugs controlled (schedule 8) and restricted (S4)
2. Consultation: Prescription strong (Schedule 8) opioid use and misuse in Australia – options for a regulatory response (2018) Retrieved from https://www.tga.gov.au/consultation/consultation-prescription-strong-schedule-8-opioid-use-and-misuse-australia-options-regulatory-response
2.3. Australia's Annual Overdose Report 2017 (2018, May 2).
3.Retrieved from http://www.penington.org.au/australias-annual-overdose-report-2017/

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Managing the Pain of Pain Management

The management of pain, both acute and chronic, can be complex. Effective pain management comprises multiple strategies including emotional and physical interventions. Optimal outcomes are delivered by an integrated model that is based on stepped-care depending on acuity of pain, supported by a multidisciplinary team that works in partnership with the consumer across the various healthcare settings.

The Queensland Clinical Senate recognises the importance of multimodal support for clinicians and consumers and strongly endorses the development and implementation of a statewide stewardship program to manage pain and minimise the risk of unintended harm from opioids and other high risk pain medications.

An effective pain management stewardship program requires a balance of persuasive and restrictive interventions and should be built around the following key principles:

- Strong multidisciplinary clinical governance with culturally appropriate consumer engagement;
- A commitment to ongoing clinician education which includes consideration of all available pharmacological and non-pharmacological options to best manage pain;
- A commitment to improving consumer health literacy which empowers consumers to partner with health care providers for optimum pain management;
- Timely and informative communication of pain management plans between hospital, primary and community care;
- Analysis of all relevant data to inform high-risk medication prescribing interventions; and
- Support a nationally consistent approach that ensures the program has broad coverage and supports regional and rural communities.

Actions

- Establish a clinical governance framework for safe medication prescribing in Queensland;

- Establish a multidisciplinary pain management clinical and consumer governance committee within the Queensland Department of Health to:
  - Analyse data to understand current state and identify priority areas for improvement;
  - Support the identification and implementation of stewardship strategies with an initial focus on statewide agreement on the key components of a pain management stewardship program that can then be implemented locally by HHSs; and
  - Guide the Queensland implementation of the soon to be released National Strategic Action Plan for Opioid Management following the 2018 review of the National Pain Strategy.

- Commitment to the implementation of Real Time Monitoring (RTM) of opioid prescribing and dispensing including:
  - Ensuring a scalable solution to accommodate inclusion of non-opioid analgesics and other high-risk medications;
  - Leveraging off digital hospital implementation to identify a solution for inclusion of public hospitals (both inpatient and outpatient prescribing); and
  - Engaging prescribers in understanding the role of RTM data in supporting strategies to improve prescribing practices and patient outcomes.

- Support improved prescriber competency through identification and implementation of education strategies that promote:
  - The importance of non-pharmacological alternatives to pain management.
  - The lack of evidence for opioids in the management of chronic non-cancer pain;
  - The role of validated risk assessment tools to identify consumers with a higher likelihood of adverse outcomes;
  - Realistic objectives and expectations of pain management interventions;
  - Improved understanding of Opioid Treatment Programs, particularly among general practitioners and psychiatrists, to recognise where registration on these programs may be the appropriate response; and
  - Supporting transition of ongoing care to primary care and community health care providers.

- Specifically support a project team to continue development and implementation of the Opioid Prescribing Toolkit (appendix B) and relevant NPS MedicineWise strategies (Appendix C) with the initial focus on the prescribing of opioids within emergency departments and perioperative settings of Queensland public hospitals.

- Partner with Choosing Wisely Australia (facilitated by NPS MedicineWise) to champion a consumer focused ‘Opioid Wisely’ campaign.

- Advocate for a national prescribing strategy that:
  - Informs appropriate restrictions to prescribing in accordance with the evidence;
  - Avoids stigmatisation and enables safe prescribing and access for consumers who benefit from such medication; and
  - Supports consumers experiencing unintended adverse consequences of analgesic medications.

Presenters and Panelists

- Dr Matt Bryant, Pain Specialist and General Practitioner, North Queensland Persistent Pain Management Service
- Dr Hance Clarke, Director of Pain Services, Toronto General Hospital
- Adj/Prof Tim Greenaway, Chief Medical Advisor, Therapeutic Goods Administration
- Dr Krispin Hajkowicz, A/Director, Department of Infectious Disease, Royal Brisbane and Women's Hospital and Infectious Diseases Physician, Queensland Statewide Antimicrobial Stewardship Program
- Assoc Prof Malcolm Hogg, Head of Pain Services, Melbourne Health
- Ms Rustie Lassam, healthcare consumer representative
- Dr Tania Morris, Chair, Statewide Persistent Pain Management Clinical Network
- Dr Ewan McPhee, Rural Generalist, Emerald Medical Group
- Ms Champika Pattullo, Quality Use of Medicine Pharmacist, Royal Brisbane and Women's Hospital
- Ms Lara Pullin, healthcare consumer representative
- Ms Debbie Rigby, community pharmacy representative and Director, NPS MedicineWise
- Prof Philip Siddall, Chair, Pain Management Network, NSW ACI and Director of Pain Management Service, Greenwich Hospital
- Ms Benita Suckling, Clinical Pharmacist, Redcliffe Hospital Pharmacy
- Dr Norman Swan, meeting facilitator
- Dr Marc Walden, Pain Medicine Physician, Royal Brisbane and Women's Hospital
- Dr Jeannette Young, Chief Health Officer, Queensland Health

Prescription opioid use and abuse in Australia – possible regulatory options

Adj/Prof Tim Greenaway, Chief Medical Advisor, Therapeutic Goods Administration (TGA)

- TGA is reviewing opioid regulation following codeine up-scheduling and with regard to developments internationally
- Among the options considered in the discussion paper 'Prescription strong (schedule 8) opioid use and misuse in Australia – options for a regulatory response', include:
    - review the pack sizes of S8 opioids
    - review the indications for S8 opioid prescription
    - restricted prescribing for high dose opioids
    - strengthening risk management plans for S8 opioids
    - review label warnings and consumer medicines information
    - increase health professional awareness of opioid alternatives in the management of chronic pain.
- 93 submissions received
- Regulatory approaches by themselves are not going to solve the issues; education is going to be critical.

The International Perspective

Dr Hance Clarke, Director of Pain Services, Toronto General Hospital (via live video-link)

- Canada experienced 4000 deaths relating to opioid use in 2017 - 80 per cent of these were related to illicitly manufactured fentanyl (different to the pharmaceutical fentanyl available in Australia)
- New national opioid prescribing guidelines recommend safe maximum dose of 50 or 90mg per day - above those amounts a second opinion is required.
- After specific doses, prescribing no longer helps with the pain but helps with other issues such as anxiety and underlying traumas.
- As access to prescription opioids tightens, some patients are lost to the illicit market.
- A program at Toronto General Hospital aims to optimise the system for the 15 per cent of surgical patients identified as being at potential risk of developing chronic post-surgical pain.
- Among these patients are those already taking opioids on admission to hospital, patients with a history of anxiety and depression, patients already struggling with pain management, and those with chronic pain.

'If you're going to take off, you had better know how to land.' Dr Hance Clarke

- The program provides a multidisciplinary approach that engages the patient pre-admission, during admission and after discharge.
- The service has been able to change the path for almost 35 per cent of the people already on an opioid medication when they came into hospital.
- For patients not using an opioid pre-surgery: the higher the dose of opioids for post-surgical pain, the greater the risk of being unable to wean them back to their base of zero.
- There is now less prescribing past 90-100mg.
- Mandatory opioid prescribing course – education is key here. Nurse practitioners are trained to expand the knowledge base of prescribers.

Panel Discussion

Panel members: Dr Matt Bryant, Dr Ewan McPhee, Ms Lara Pullin, Ms Debbie Rigby

- When opioids were first marketed for non-cancer pain, the evidence was quite tenuous.
- There is a great deal of evidence for alternatives that work in pain medicine, but we are not taught them. For example, graded exercise, occupational therapy, team-based approach.
- Lack of education is a problem for trainee doctors, non-pain specialists, physiotherapists etc.
- Rural and regional clinicians are less likely to get access to education.
- Evidence is available to guide practice in acute pain but not in chronic pain.
- When you initiate an opioid it needs to be very carefully managed. Starting an opioid for chronic pain is fraught with challenges.
- Education and working as a team is key - having information to make the informed decision and being part of shared decision-making.
- Expectations vary and need to be discussed right from the start.
- The conversation should be around drugs of addiction not just opioids.

Delegates at the ‘managing the pain of opioids’ meeting

Consumer perspectives

Denise ‘Rustie’ Lassam was addicted to prescription opioids for more than 30 years.

‘I did not get into this alone. I can’t get out of it alone’

‘I’ve lived all around Australia, mostly in regional areas, where there are no services (opioid treatment), or not very good services, with no access to services, you have to have money to access services. I currently live in a rural area, travel 450 km per week, it costs a fortune, but I’m one of the lucky ones as I work part-time’

The low point for Lara Pullin was realising she had lost a lot of control of her life.

‘Patients need to know the alternatives and the pros and cons of the approaches to make an informed

The clinical perspective

Dr Tania Morris, Chair, Statewide Persistent Pain Management Clinical Network

‘Good pain management aims to relieve pain, improve function and quality of life - people want to live their life. It’s not just opioids.’ Dr Tania Morris

- Competing priorities for prescribers - we want to treat pain effectively and well but we need to balance that with avoiding worsening of prescription opioid abuse.
- Opioid prescription is evidence-based and supported in acute pain within a controlled setting – trauma, illness, peri-operative, cancer and palliative care patients.
- It is not supported for the long-term treatment of chronic non-cancer pain.
- Long-term use of opioids increases the risk of opioid use disorder and overdose.

- When patients have persistent/chronic pain they change in complex ways. There is no single, therapeutic agent to switch this off.
- Management often requires an equally complex and time-intensive approach - team is the power in persistent pain management.
- A number of pharmacological strategies that are not opioids can be effective but can also have indication creep.
- Patient expectations can be difficult to manage. We need to speak about manageable pain.
- Non-opioid alternatives – you have to have conversations with patients and these conversations can take time. You have to have compassion and identify with them as another human being suffering.
- Education is important for doctors and patients. I think it's everybody's issue – there are not too many patients who come into hospital without pain.
- The inherited patient (been to another GP) and the legacy patient. A lot of our prescribers don't challenge the status quo and don't reassess the patient's pain and function – it can be difficult to go there.
- Importantly, it's a subjective experience, you need to ask the patient the questions and not assume. Ask about their function.
- Self-management needs to be the cornerstone of non-pharmacological treatment. Acceptance is the biggest stumbling block.
- Patients need to be engaged in a conversation early. Medication has a finite role.
- Reassurance – we need to reassure patients.

The role of stewardship in driving change – case studies

New South Wales

Professor Philip Siddall, Chair, Pain Management Network, NSW Agency for Clinical Innovation

- To reduce the risk associated with opioid prescribing, the Pain Management Network in consultation with a broad range of clinicians, academics, health managers, consumers and policy advisors recommended:
    - Moving toward 60mg OME (oral morphine equivalents) as an appropriate maximum daily dose in the treatment of people with chronic pain
    - improving education about pain management for health professionals and people living with pain
    - comprehensive assessment and plans, taking a multidisciplinary approach
    - the use of opioids occurring alongside non-pharmacological treatment options
    - the importance of a trial – one to three months of below 60mg a day
    - increased monitoring of prescribing patterns
    - regulatory or legislative changes to limit prescribing
    - Increased resourcing for pain management services

- making pain a national health priority for policy change and health promotion

- Implementation involved:
  - Developing a simple five-step pathway for opioid use – with guidelines for each step
  - Promoting a consistent message
  - Policy development and implementation in different settings
  - Working with a wide range of regulatory bodies

Victoria

A/Prof Malcolm Hogg, Head of Pain Services, Melbourne Health

- Engagement of Government and Department of Health is needed to endorse and support consistency in pain management and subsequent opioid prescribing.
- Linkages between the well-developed and specialist services with rural and regional areas to be explored including telehealth connections, health pathways, supporting specialist services going into areas to upskill the workforce.
- Having a standard opioids toolkit information package available across the state for GPs, hospitals and consumers.
- Monitoring systems need to be implemented with plans and pathways to identify and manage the issues in the community and to support the prescribers. A monitoring system needs to be a decision-support tool.
- Grant funding to establish a model of care that would provide early access to multidisciplinary support for people transitioning from acute to chronic prescribing.

Queensland – Redcliffe Hospital Pharmacy

Benita Suckling, Clinical Pharmacist

- Opioid stewardship should be aimed at optimising analgesic selection, dosing, route and duration of therapy to maximise a patient's pain management and function while limiting unintended consequences.
- The stewardship service at Redcliffe Hospital has three pillars of care – inpatient review with the acute pain service, outpatient follow-up of patients referred from acute pain service and providing quality improvement and education within the hospital to achieve a broader impact than just those patients within the acute pain service.

- Among the key elements of the service are the development of an exit strategy for opioids, patients going home with the exact number of tablets required rather than a full pack, post-discharge follow-up to ensure exit strategy is actioned.
- More than 200 outpatients followed-up in just over a year, compared with 10 patients in previous year before stewardship program implementation.
- Learnings: form a multidisciplinary steering committee at the outset, achieving consensus and guidelines around pain management with opioids is essential but not necessarily easy, communicating with GPs about patients returning on high dose opioids is essential but optimal communication path is not known.
- Recommendations: stewardship should prioritise pain management while limiting unintended consequences, a local multidisciplinary steering committee should be formed at the outset, a suite of statewide resources available for adaption and implementation at the local level.

Queensland – Royal Brisbane and Women's Hospital

Champika Pattullo, QUM (Quality Use of Medicines) Pharmacist,

- Key elements of stewardship for opioids:
  - coordinated approach with multi-pronged interventions that are context sensitive.
  - Underpinned by rational prescribing and in partnership between patient and clinicians.
  - Provide adequate pain management while minimising risk associated with opioids and other analgesics.
- Patients requiring pain management are managed by a multidisciplinary team, which is supported by the specialist team such as the acute or chronic pain services.

'A one size fits all approach doesn't work.' Champika Pattullo

- Guidelines, regular education and conducting practice audits and reviews are part of the strategy.
- Initial opioid focus was optimizing oxycodone (Endone) in orthopaedic and general surgery, and emergency department in patients who are often opioid naïve and are discharged from hospital with 20 tables of Endone.
- Improvement strategy goals were to individualise care, improve clinical handover including de-escalation plans for GPs and improve patient education.
- Outcomes: marked improvement in quality and quantity of communication on discharge, and patients going with an average of 11 Endone tablets rather than a full box of 20.
- Established a multidisciplinary analgesia steering committee in 2018 with the aim of helping to guide best practice implementation.

- Developed the opioid prescribing toolkit – a framework for introducing opioid stewardship in acute care setting through a systematic approach to improving opioid prescribing practices.
- Key to success was continuous evaluation of practice and education that included local data and consistent messaging. The use of implementation science theory to understand different contexts and utilise this information in the development of the intervention was also an integral component to success.

Panel discussion

Panel members: Ms Champika Pattullo, Ms Benita Suckling, A/Prof Malcolm Hogg, Prof Philip Siddall, Dr Tania Morris, Ms Rustie Lassam

- Opioid stewardship should be part of an overall pain management stewardship program.
- A program should include rational prescribing and individual care.
- Community providers need to be engaged in the process of pain management through clear discharge and pain management plans.
- Must provide patients with alternatives to opioids for pain management such as mindfulness.
- Patients are more on board with reducing their opioid dose when they understand the harm of opioids and the benefits of alternatives that can help with pain relief and function.

'I have a positive story – my story on opioids mean I can interact and get back into society.' **Consumer, Kevin**

- Stewardship isn't about a rulebook but encouraging prescribers to reconsider what and how much they are prescribing based on guidelines.
- Why don't we have an opioid risk assessment that takes into account dementia, side effects, etc.?
- How do we bring GPs and patients along on the journey? Do we need a mass marketing campaign to get the messages out and close the health literacy gap?
- It is a complicated issue that requires multi-level solutions. One of the solutions has to be within primary care and in the community, such as community-based primary care pain programs led by allied health that are easy to access and get very good outcomes.
- Leadership at the State Government health level is required as there is a large population that needs support and containment in the community until they are ready to engage in a pain program.
- The healing needs to come out into our communities.
- Public education does work over time and we have to sustain this education over decades, like we have done with smoking, to make changes to empower patients to look for other options and treat them as valuable and useful as a pill.

'The pain that analgesics let alone opioids gives you is far worse than the pain you had in the first place.' **Consumer, Carin**

- GPs are going to be the frontline in this and pain medicine as a specialty needs to be more innovative in supporting that and not just expecting patients to wait 18 months – two years.
- We also need to encourage GPs to give us feedback so that we don't undo the gains they have made with their patients.
- Communication is fragmented and therefore plans are fragmented.
- From an acute prescribing perspective, dependency risk factors need to be identified in the first 6 to 12 weeks to allow early intervention.

'We have to empower patients to look for other options and treat them as being as valuable as a pill.' **Consumer & carer, Phil**

- Significant risk in not having access to opioid treatment programs: US experience has shown that if not readily available then attempts to limit access lead to adverse behavior and failure of the initiative

The ethics of opioids

Dr Marc Walden, Pain Medicine Physician, Royal Brisbane and Women's Hospital

- Bioethics of opioid stewardship — the rights, the wrongs, harms and benefits of how we prescribe and use narcotic medications.
- When asked to tackle a new problem such as opioid stewardship or asked to provide an ethical opinion about something we may not be an expert in, it is usually necessary to put away our own set of morals and make judgements based on a more widely held set of morals that represent the community affected by the issue.
- We should strive to avoid our own cognitive biases by way of a committee structure or using an ethical framework such as duty ethics.
- The four qualities of duty ethics are: beneficence, justice, non-maleficence, and respect for autonomy.
- An ethical dilemma is when a choice has to be made between two equally undesirable alternatives
- Analysis of ethical conflict and ethical action can help to work through the conflict.

- Ethical discussion is powerful as it allows us to expand the argument and the subjects, it helps us to slow down the decision making, forces us to consider alternative perspectives and look for analogies.

Lessons learned from antimicrobial stewardship

Dr Krispin Hajkowicz, Infectious Diseases Physician, Queensland Statewide Antimicrobial Stewardship program

- Relationships are the foundation of successful stewardship programs.
- The positive cultural aspects of rural and remote settings make them a great place to start a stewardship program. Stewardship programs should definitely be rolled out to rural and remote locations.
- Stewardship programs require a long-term commitment of five to 10 years as a minimum for change to happen and to adjust to challenges along the way.
- Persuasive interventions of stewardship are important but will not work on their own. Must be coupled with a restriction program to achieve outcomes.
- Research is very important to establish an evidence-base for the program – implementation is much easier from a research/evidence base foundation.

Real-time monitoring and other strategies

Dr Jeannette Young, Chief Health Officer and Deputy Director-General, Prevention Division, Queensland Health

'Fundamentally, patient wellbeing and safety is at the core.' Dr Jeannette Young

- Regulatory framework is multifaceted including international conventions, Commonwealth scheduling process, and regulation by the State for monitoring compliance, data collection and reporting.
- Queensland operates an opioid prescription-monitoring database that captures all community pharmacy dispensed prescription opioid drug information.
- From, October 2017 pharmacists are required to notify the department weekly (instead of monthly) on dispensing of opioids. More than 95% of pharmacies are compliant and data on more than 60,000 scripts is received per week.
- Queensland is seeking to develop a model of real time reporting of Schedule 8 drugs

that allows direct access for community doctors and pharmacists to check a patient's history at their desktops.

- Three significant impacts of real-time electronic prescription monitoring in Queensland:
    - Changes to practitioner's administrative and technology systems – needs to be an integrated system not stand-alone.
    - Medical practitioners and pharmacists will need to check a patient's prescription and dispensing history.
    - Patients will need to understand that this change is happening.
- Queensland working closely with Victoria during the State's implementation of real-time reporting with SafeScript giving doctors and pharmacists access to prescription history for certain high-risk medicines.
- My Health Record has the ability to dramatically impact prescribing.
- The effective management of opioids will require a coordinated and collaborative effort across the health system.
- Balance – maintaining access for legitimate needs and limiting harms from inappropriate access.

Potential *Pain Wisely* consumer questions:

The Queensland Clinical Senate will engage with Choosing Wisely Australia to promote the development and promotion of a Consumer awareness campaign developed around the '5 Questions' to ask your doctor

1. What is the underlying cause for my pain and how long should I expect it to last?
2. Do I really need this pain medication?
    a. What are the risks or side effects?
    b. Will I get addicted to this medication?
    c. Will it reduce my pain or make it go away completely?
3. Are there simpler, safer options?
    a. Are there things I can do to reduce my pain that do not involve medications?
4. What happens if I don't take these medications?
5. Can I have a pain management plan to share with my family and other health care providers?
    a. How long I should be on the medication?
    b. How do I reduce my doses?
    c. What level of pain should I expect?
    d. What do I do if the pain medication is not working as expected?
    e. Do I have to take the medications regularly until I finish the box?
    f. What do I do with any unused medication?

Appendix

Appendix A – Table Work Summary

Approximately 150 attendees participated in the table work sessions, across 18 tables. The responses to the questions from each of the 18 tables has been thematically summarised below.

Question 1 - What are the essential elements of success for an opioid stewardship program? Some examples include:

a. Agreement on the problem and the need for change
b. Baseline current-state data
c. Understanding 'what good future-state looks like'
d. Agreed best practice clinical guidelines
e. Combination of persuasive and restrictive interventions
f. Supporting clinicians to understand the value of the program
g. Analysis and feedback of outcomes

Thematically collated table responses
1. Clear objective for the program – e.g. Reduced prescribing, better care etc. 2. Nationally consistent approach. 3. Clarity of scope - Pain management and not just opioids. 4. Systems approach with clinical and consumer governance (lead by Department of Health). 5. Evidence-based with implementation science methodology applied. 6. Accurate effective recording and coding to allow analysis and feedback of outcome data. 7. Utilise technology: • Telehealth; • Real time monitoring (RTM); and • Integrated Electronic Medical Record (ieMR). 8. Collect, monitor and act upon data for individual consumers and prescribers, as well as facilities and services, for the public good, benchmarking across HHSs and for GPs 9. Identifying trigger points re: prevention / mitigation / management 10. Focus the program around and empower patients • Identify the root cause of a consumer's need/situation, • Understand the consumer's history - avoid repeated retelling of the story, • Honest conversations with effective communication, • Appropriate risk screening tool, • Establish and agree on expectations 11. Support use of opioids when appropriate - avoid stigmatization 12. Community-based and Integrated care across disciplines, sectors (keep GPs in the conversation), engage insurers, PBS and community with sound clinical handover and follow-up, GPs with special interest (GPWSIs), identify who 'owns' the patient 13. Control dispensing for >60 morphine equivalents, traffic light system for dosage, short acting v slow release, enable patient to take responsibility for own pain management, prescription pack size tailored to patient need (not standard '20 tablets'), with appropriate advice on disposal of unused medications 14. Communication and marketing – ensure appropriate terminology for 'stewardship', clarify meaning, leverage high-profile overdose deaths 15. Ongoing education including clinical guidelines, online training, agreed provision to clinicians and community, mentoring of and support for clinicians, starting at university for doctors 16. Equity of access to services including Opioid Treatment Programs, pain clinicians in primary care, incl. rural locations, access to senior clinicians

Question 2 - What is the best way to monitor and avoid untoward consequences such as a shift to other adverse prescribing, e.g. antipsychotics, Lyrica (Pregabalin) and mind-altering sedatives?

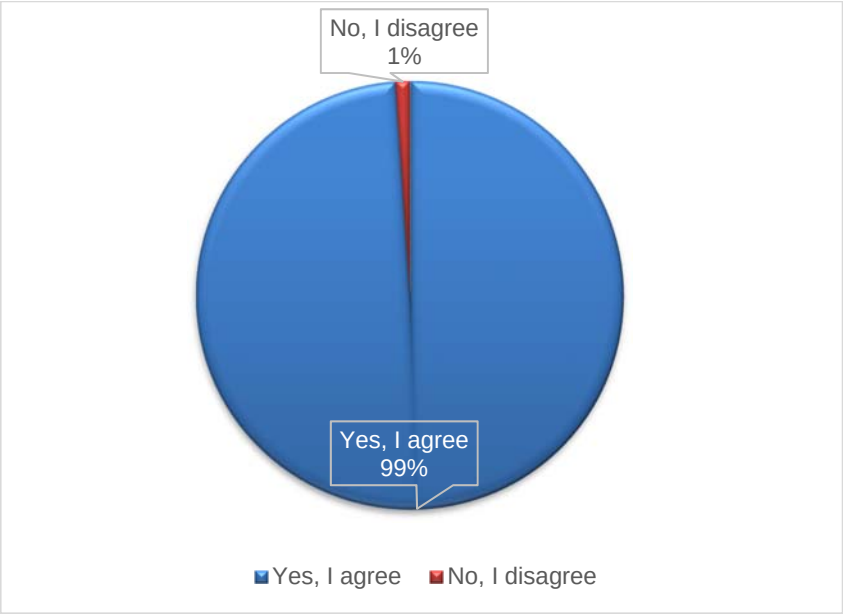
Thematically collated table responses

1. Acknowledge the potential for unintended consequences of a stewardship program.
2. Program to be integrated across all sectors and include opioid alternatives.
3. Maintain availability of high-risk medications where appropriate, and the risk that restriction will result in higher-risk pain management, prescribe naloxone for overdose risk, decriminalize illicit drugs.
4. A consumer 'Quitline' for high-risk pain medications and a prescription-shopping hotline for clinicians.
5. Adequately address the cause of acute pain, with better recognition of pain - Need to provide alternative if not offering opioids.
6. Optimize management of cancer pain.
7. Discharge plan for high-risk medications and routine procedures and pain management plan
   - GP Management Plan with triggers (dose or polypharmacy)
   - Book GP follow up visit prior to hospital discharge
   - Pain 'passport'
8. Use focus groups to monitor, with feedback loop of GPs, consumers and allied health reporting to morbidity and mortality, or quality and safety
9. Team-based / multidisciplinary approach, with nurse navigators, practitioners, physio, psychology, partner with mental health services
10. Messaging and awareness around opioids
11. PBS: support for providers re: access to integrated data, collect, utilise and publish data
12. Accessible health record providing inputs, outputs and outcomes, focus on consumer outcomes, measure and benchmarks, encourage doctors to utilise the record, enable 'flags' to link various services (beware alert-fatigue)
13. Education and clinical guidelines for clinicians (commencing at undergraduate level) and consumers, including through NPS, pharmacists to assist junior doctors in appropriate prescribing
14. Improve health literacy to increase awareness of consequences of polypharmacy on mental health
15. Monitor ATODS for impact
16. If decreasing prescription medications, need to monitor ambulance and hospital presentations for illicit drug use

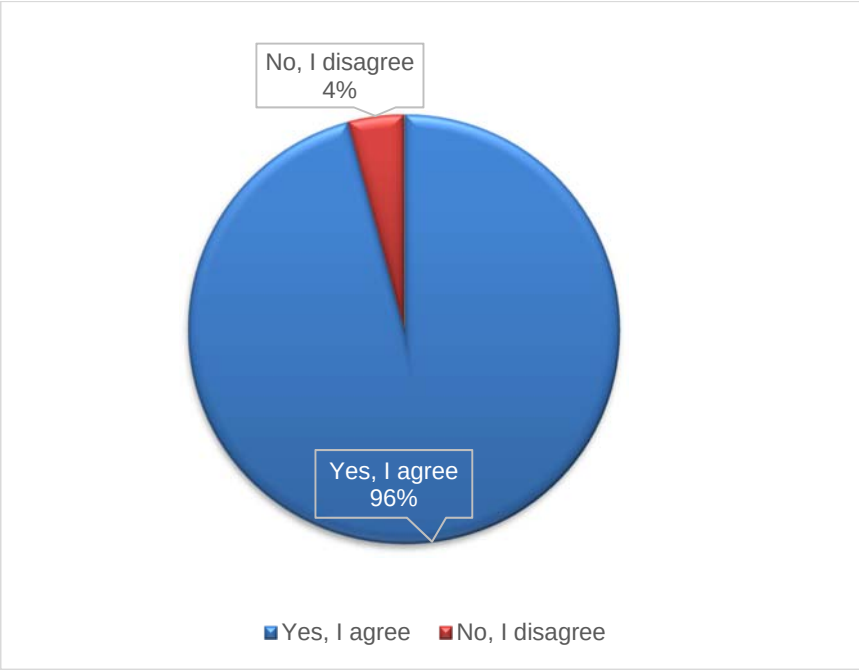
Question 3 - Real-time-monitoring (RTM) will provide data on individual prescribing practises. How would you monitor and provide feedback to individual prescribers (hospital and primary care)?

Thematically collated table responses
1. Right dispensing systems with decision support, access to prescribing history, benchmarking against like facilities, auditing, and My Health Record for patient feedback 2. Medicines Regulation and Quality (MRQ) involvement, already have data, need better resourcing 3. One system to capture all prescribing (good care, poor care, addiction issues) across private, PBS, etc. 4. Medications dashboard (IR v SR, dose, sedation score, RR, SIO2, MET, team intervention, e.g. deaths in hospital) 5. How often is a prescriber going over 60, 90 dose equivalent units – trigger point for flagging 6. Develop no-blame culture of safe use of medications, senior clinicians to influence juniors, ensure notification isn't out of the blue, and avoid perverse outcomes such as abandoning pain management 7. Show prescribers where they sit on a distribution curve (ensure comparing like with like) 8. Academic detailing as per NPS 9. Structured intervention for highest volume prescribers, taking into consideration case-load and specialty variance (target high-yield areas), utilise traffic light system, useful competencies and mandatory training, utilise NPS online tools, guidelines a. DMS and Director of Pharmacy review their hospital's clinicians and educate individuals accordingly b. PHN targets GPs c. Collaborative organisations, e.g. private midwives, NPs, educate their prescribers 10. Deliver feedback from credible source, is contextual, positive, timely, takes prescriber on a journey, and is respectful 11. More effort required for clinicians with fixed mindset - customized education, utilise data 12. Task a relevant authority with providing feedback (Dr shopping hotline doesn't act on data), be firm with poor practice 13. Health Roundtable approach a. Understand variances, mentoring to support change, forum approach to explore alternative practices 14. Patient Reported Outcome Measures (PROM) 15. Focus on patients, not prescribers

Question 4 - Current reporting of opioid prescribing and dispensing only includes community pharmacies. Proposed real time reporting needs to include access to prescribing information for all prescribers & dispensers (public hospitals as well as private and community sectors) – 93 votes in total



Question 5 - A stewardship program should be broader than just opioids and encompass other related, potentially harmful prescribing? – 95 votes in total



Question 6 - Education is acknowledged as a key component of an opioid stewardship program. How should we educate to strengthen clinician confidence and competence around pain management?

Thematically collated table responses

1. Consistent messaging
2. Educate about all pain management options, including pharmacological and non-pharmacological strategies
    a. Inter-professional evidence based education incorporating consumer voice and including risk-factor identification and treatment, with demonstrated competence (annually assessed) and ongoing review of the education model/s
    b. Educate across the entire healthcare spectrum, acute to chronic, public to private, children to adult, etc.
    c. Start at university and embed in professional college and post graduate curriculums
    d. Hospital orientation and in-service education
    e. Link to accreditation, CPD, Credentialing, bedside audit
3. Access to champions and mentors - Authentic, respected, authoritative information
4. Challenge the existing knowledge of senior clinicians utilizing proven change management techniques
5. Specific training for ‘pain disciplines” EM, RACS, Palliative Care, OT across
6. Inclusion in core GP training (with 1:1 paid time, GPwSI) – specific training for AST in anaesthetics, specialist pain GP
7. M&M meetings – in a non-confrontational way
8. Clinical Pharmacists integrated into ward rounds and clinical review meetings
9. Leverage off ieMR and Clinical Decision Support in prescribing software.
10. Informed consent for oral opioids (benefits / risks / alternatives / expectant management)
11. Keep consumers informed about why and why not to prescribe, commence health literacy early, multi-modal promotion, shared understanding of expected outcomes, e.g. learning how to live
12. Nationally agreed, evidence based guidelines (incl. procedure specific discharge analgesia guidelines), social/multi-media
13. Project ECHO model (weekly videoconference, multidisciplinary, patient included on panel, etc.)
14. Special consideration of rural and remote, and international medicine graduates – most vulnerable

Question 7 - Drawing on the Choosing Wisely concept of 'Questions for consumers to ask their doctor', Design up to 3 Questions for consumers to ask their healthcare provider about pain management that can support improved health literacy and reduce potentially harmful prescribing. See printouts of the following on your tables:

- Opioid Wisely Canada - https://choosingwiselycanada.org/campaign/opioid-wisely/
- Choosing Wisely Australia - http://www.choosingwisely.org.au/getmedia/e8c9a5d6-35e3-487a-bb40-60606bbae94e/LATEST-5-QUESTIONS-Nov-2017.pdf.aspx

Thematically collated table responses

1. Fundamentals:
    a. Patients need to be empowered to question their doctor
    b. Doctor's question: not: "what is wrong with you?", rather: "what is important to you?"
    c. Provide generic responses to common questions – consumer information
    d. Questions as per Choosing Wisely sheet
    e. BRAN (Benefits / Risks / Alternatives / Nil Option)
    f. Canada model – join conversation with prescriber

2. About the prescriber:
    a. What is your specific experience / training / skills in managing pain
    b. Can I have a second opinion?
    c. What is your network for dealing with complex pain patients?

3. About the pain:
    a. Why do I have pain, what is causing it?
    b. How long will this pain last?

4. Options for managing the pain
    a. Is this the best way to manage my pain; what is the evidence?
        i. What are the benefits and how likely are they?
        ii. What is the cost?
        iii. What are the risks?
    b. Can we discuss levels of functioning; what is going to help me get back on my feet
    c. Is there anything else I can do to help my pain?
    d. Are there simpler, safer options, including doing nothing?
    e. How long will this treatment take?
    f. Can I have a written pain management plan?
    g. What do I do if this doesn't work?
    h. Where can I get more information?
    i. If it was your family member, what would you do?

5. About medication:
    a. Is this the right medication in the right dose?
    b. Do I need this medication?
    c. What is expected from this medication, will it get rid of all my pain?
    d. What is this medication going to do to me?
    e. Can I drive and travel on this medication?
    f. How does the medication work, e.g. slow release, build to required levels?
    g. What are the side-effects and/or interactions with other medications?
    h. What is the likelihood that I will become dependent on this medication?
    i. How long can I expect to be taking the medication? When do I stop taking the medication?
    j. What if the medication does not control my pain?
    k. What else should I do in addition to taking this medication?
    l. Should I take the tablets regularly, or just when I need them?
    m. Should I take the entire box of tablets? What should I do with unfinished tablets?

Question 8 - How can an opioid stewardship program support better transition of care into general practice and primary care?

Thematically collated table responses
1. Keep consumer central: a. Shared-care, integration and communication b. Culturally and linguistically appropriate 2. Regardless of starting point (hospital or community), accept that the doctor has commenced a journey with the patient 3. Structured discharge summary with analgesic section or prompt, a. Link electronic discharge summary to automatic pain management plan (mindful of available services, e.g. city v rural/remote) b. GP appointment made by AO at discharge (planned and managed) c. Upload to Viewer for GP access (and/or My Health Record or secure messaging), GP must agree to participate in management plan for S8 prescriptions, d. Direct phone number for GP to call with queries / concerns / discuss major medication changes- Utilise advice hotline and telehealth e. Follow-up plan including phone call to all consumers dispensed over a certain threshold or identified as high risk f. Plan for if patient not settling (what to do and who to contact) 4. Nurse practitioners / nurse navigators bridge gap and embed in general practice 5. GPLO and hospital liaison with available contact point 6. Engage and support GP with Special Interest (GPwSI) in pain 7. Standardised processes and frameworks, e.g. a. Clinical pathways – can start prior to hospitalisation, b. Chronic disease plans within general practice 8. Consistent messaging, educate primary health care clinicians to promote benefits of ‘not having opioid treatment and the available alternatives’, keep communications short and sharp 9. Coordinate with community pharmacist 10. Identify complicated acute pain early to prevent complications (including progression to chronic pain), a. Risk stratification - Catastrophising, anxiety and depression, already on high dose opioids, rural & remote, Aboriginal and Torres Strait Islander, migrant, English as a second language 11. Real-time information sharing, whole team knows what pain specialist knows 12. KPIs for hospital funding linked to timely discharge summary and number of patients discharge on >60mg / day opioids

Question 9 – In addition to real-time-monitoring (RTM):

- what are some immediate (within 12 months) and intermediate (within 3 years) opportunities to promote stewardship that are realistic and within our acute public hospital remit?
- where should responsibility for driving local implementation sit?

Thematically collated table responses

1. Within 12 months
    a. Establish a statewide working group to provide overarching governance for pilots - including PHN, HHS, pain networks and consumers
    b. Collect data and determine current situation with high-risk pain medications
    c. Pilot an opioid stewardship program in a metro and rural/remote site
        i. Jointly commissioned by PHN and HHS
        ii. Road test tools and resources
            1. Opioid Prescribing Toolkit)
            2. NPS MedicineWise interventions
            3. ACI 5 steps, etc.
        iii. Utilise Clinical Excellence Division resources
        iv. QCS to endorse program
    d. Standardised single-system Real Time Monitoring across Australia
    e. Ensure all HHSs have Persistent Pain Management Units or partnership with existing units to ensure access,
    f. Improve access to Opioid Treatment Programs for patients with dependency,
    g. Clinicians
        i. Better utilisation of allied health and nursing resources
        ii. Bring GPs into planning and expand GPwSI models
        iii. Map current skills sets in respective HHSs
    h. Education:
        i. Mandatory education module for prescribers and dispensers
        ii. Education at vulnerable points in system, e.g. interns
    i. Promote consumer questions – Choosing Wisely
    j. Improve hospital / GP interface, (leverage off ieMR if possible) including:
        i. Structured discharge summary and 'warm' handover,
        ii. Formal printed Pain Management plan including who and how to contact with any concerns,
        iii. Enhanced communications with nominated GP for after-hours ED presentations,
    k. Limit discharge prescribing to 3-day supply
    l. Identify 'frequent flyers' and design program for intervention
    m. Support groups (by teleconference as necessary), patients supporting other patients
    n. Increase consumer input into pain networks, consumer forums and education
    o. Make Naloxone more readily available

2. Within 3 years
    a. Patient medication management app
    b. Refine trigger point concept and resultant actions / outcomes
        i. E.g. patient MDT assessment, MDT includes GP education
    c. Mechanism for returning unused medications
    d. Support group / consumer advocacy – Choosing Wisely campaign
    e. Pain management education and training for health professionals including at undergraduate level (all disciplines)
    f. Multidisciplinary diploma (or equivalent) in pain management
    g. Expand Persistent Pain Management Units, utilise MDTs, community and hospital based Persistent Pain / Alcohol and Other Drugs Services
    h. Responsibility needs to be shared by HHSs and the Department of Health
    i. Spread program demonstrated in pilot
    j. Service Agreements to include pain management component

Appendix B – Opioid Prescribing Toolkit

Please access via the following link:

https://metronorth.health.qld.gov.au/wp-content/uploads/2018/09/mn-opioid-prescribe-toolkit.pdf

Or contact the Queensland Clinical Senate Secretariat: qldclinicalsenate@health.qld.gov.au

Appendix C – NPS MedicineWise work in opioids and pain management

National programs delivered locally

As a national implementation body with a locally deployed field force working across Australia to deliver programs in primary care, our multifaceted educational and quality improvement activities and resources for health professionals include audit and feedback, online learning modules, targeted visiting programs, facilitated small group meetings, and compelling evidence-based information, tools and materials. These activities are supported by consumer information and tools. Data driven interventions are playing an increasing role and enabling our activities to be highly targeted.

We know that repeat messages are needed to achieve sustained behaviour change. NPS MedicineWise has delivered multiple therapeutic programs on pain management to optimise outcomes and reduce harm from high-risk analgesics.

- ***Chronic pain: opioids and beyond*** launched in 2015 and aimed to improve well-being in patients with chronic non-cancer pain who are managed in primary care. Over 7,000 GPs participated in the 12-month program. Pharmacists, specialists and nurses also received the materials, pharmacists took part in self-audits and pharmacists and nurses joined GPs in small group learning. https://www.nps.org.au/medical-info/clinical-topics/chronic-pain Evaluation found that the program produced a significant increase in the proportion of GPs who discussed individual goals of therapy with their patients and developed pain management plans (+56%), used pain diaries (+43%) and/or opioid contracts (+35%).
- Our current program ***Neuropathic pain: touchpoints for effective diagnosis and management*** looks at the role of **gabapentinoids** and aims to improve quality of life for people with neuropathic pain who are managed in primary care. https://www.nps.org.au/medical-info/clinicaltopics/neuropathic-pain#resources

These build on and reinforce our previous pain management programs: *Analgesics in musculoskeletal pain* (2003)*, Analgesic choices in persistent pain* (2006)*, Neuropathic Pain (2008)* and *Opioid use in chronic pain: use a planned approach* (2010) and we would be happy to provide further details.

Collaborations in the design and delivery of our programs with relevant consumer and health professional groups (including Pain Australia, Chronic Pain Australia, the Australian Pain Management Association, NSW ACI Pain Management Network, the Royal Australian College of General Practitioners, Pharmaceutical Society of Australia, Pharmacy Guild of Australia) have enabled us to work synergistically to amplify efforts in this area.

Working with pharmacists

Pharmacists have a key role to play when it comes to pain management and NPS MedicineWise activities for pharmacists and pharmacy interns including online learning, CPD accredited clinical audit activities and regular electronic direct mail communications provide a suite of tools for connecting with pharmacists and improving practice.

Encouraging better conversations between health professionals and consumers about pain management

Encouraging and supporting health professionals and consumers to have better conversations about managing pain, opioids and other high-risk analgesics will be critical to the success of a pain management stewardship program.

- **Codeine up scheduling**: As part of our collaboration with AMA, RACGP and RACP, the Commonwealth Department of Health commissioned NPS MedicineWise to develop tools and resources for general practitioners and other health professionals about the 1 February 2018 upscheduling of codeine. Products included MedicineWise News, an evidence-based summary providing up-to-date information; a desktop reference guide for GPs to support conversations with patients who may present with codeine dependence; podcasts providing succinct evidence based education on pain management and dependency; 'Talking heads' videos with addiction medicines specialists and pain management experts; a GP resource kit (digital collation of all the resources); online and editable patient action plan supported by direct mail marketing and social media promotion.

  https://www.nps.org.au/medical-info/clinical-topics/over-the-counter-codeine-changes-tosupply

  Social media evaluation found that consumer sentiment improved and health professional confidence increased significantly over the duration of the campaign.
- **Choosing Wisely Australia®** facilitated by NPS MedicineWise, and led by Australia's medical colleges and societies, is encouraging a national conversation about the appropriate use of tests, treatments and procedures – including reducing use of those that may be unnecessary and cause harm. With membership comprising 80% of Australia's specialist medical colleges and 25 champion Health Services driving engagement and implementation activities, Choosing Wisely Australia® can play a key role in influencing a culture change around use of opioids and other high-risk analgesics. Indeed, there are already recommendations relevant and specific to appropriate use of analgesics for pain. http://www.choosingwisely.org.au and http://www.choosingwisely.org.au/resources/consumers/5-questions-to-ask-your-doctor
- NPS MedicineWise's phone line services – **Medicines Line** and the Adverse Medicines Events line, **AME Line** assist individual consumers with questions and concerns about their medicines. https://www.nps.org.au/medicines-line and

  https://www.nps.org.au/adverse-medicine-events-line .
- **MedicineWise app** supports consumers and carers in their desire to be responsible for managing their own health and the health of those they care for. It enables consumers to build and share their current medicines list, set dose and appointment alerts, track tests and results, record important health information, and view trusted, relevant medicines information. It also has the capability to send targeted information to particular consumers such as those who have a high-risk analgesic in their medicine list.

  https://www.nps.org.au/medical-info/consumer-info/medicinewise-app
- **Written and audio-visual content on our website** includes several pain related resources**.** https://www.nps.org.au/medical-info/consumer-info
- **Consumer campaigns such as *Be Medicinewise Week*** help Australians get the most out of their prescription, over-the-counter and complementary medicines. In 2017, the seventh annual Be Medicinewise Week promoted the safe and wise use of medicines and reminded Australians that medicine misuse can happen to anyone. https://nps.org.au/bemedicinewise

A multi-sectoral approach: improving pain management stewardship in hospitals and RACFs

A pain management stewardship program requires multi-sectoral effort to be consumer centred and support continuity of care. NPS MedicineWise has undertaken a number of activities in hospitals and residential aged care facilities (RACFs), related to the use of opioids, non-opioid analgesics and psychotropic medicines. These could be adapted and leveraged as part of a coordinated pain management stewardship program.

Hospitals

- Drug Use Evaluation (DUE) projects in hospital to improve quality use of medicines. For example, 62 Australian hospitals participated in our Acute Post Operative Pain (APOP) program which utilised DUE, an established, evidence based quality improvement methodology, to improve management of acute post-operative pain in hospital and at the point of discharge. Significant improvements were seen in documentation of pain management education and pain scores, appropriate prescribing and communication of discharge management plans. More recently, Choosing Wisely Australia®, facilitated by NPS MedicineWise, is providing a means to engage with hospitals and health services about improving the quality of healthcare by eliminating unnecessary and sometimes harmful tests, treatments, and procedures. See above and http://www.choosingwisely.org.au

Residential aged care

- Collaboration with **Webstercare** to design a **Quality Use of Medicine report** within its medication management software that helps residential aged care facilities (RACFs) understand and analyse their antipsychotic medicine usage over time and flag patients who need review. This enables pharmacists to provide information to staff and prescribers working in RACFs to help them understand, analyse and effectively manage the use of antipsychotic medicines for residents.
- **Drug Use Evaluation** learning activities that help promote best practice medicines use.
- **Balancing benefits and harms of antipsychotic therapy** (2011) program focused on the safe and effective use of antipsychotics. An economic evaluation of the program was conducted in terms of reduced stroke incidence due to reduction in antipsychotic prescribing.
- Supported the **Reducing Use of Sedatives (RedUSe) program** by working with University of Tasmania to design and deliver academic detailing activities aimed at reducing the use of sedative medicines in RACFs.

Real time prescription monitoring: building capability

We agree on the importance of any stewardship program providing prescribers with real time access to their patients' prescription history for high-risk medications. Not only do prescribers and pharmacists need to know how to use any real-time prescription monitoring system but they also need to be supported to more safely respond to patients who may be misusing prescription medicines or receiving supplies of high risk medicines beyond therapeutic needs. NPS MedicineWise has supported actions to address drug misuse in a number of ways including:

- **National Pharmaceutical Drug Misuse Framework for Action implementation**: NPS MedicineWise was involved in the development of the framework and its implementation. This included the delivery of an online module *Drug misuse: implications for pharmacists* focusing on preventing harmful use of pharmaceutical opioids, and provided pharmacists with the opportunity to understand their role in identifying and preventing drug misuse including conversation starters when discussing sensitive issues with patients, and ways to manage difficult conversations.
- **Supporting roll out of RTPM in Victoria:** As part of the consortium led by Western Victoria PHN that is designing and delivering training to prescribers and pharmacists on how to use the Victorian RTPM and more safely respond to patients, NPS MedicineWise developed and implemented three online training modules and a Facilitators resource kit to enable face-to-face training to support the introduction of the SafeScript program across Victoria.

  Our highly skilled field force of Clinical Service Specialists deliver around 27,000 visits to GPs across Australia each year meaning we are well placed to deliver face-to-face training on a national scale to further support implementation of these types of programs.

Data to drive and track quality improvement

A successful stewardship program will require data to inform quality improvement, evaluate the success of interventions and measure outcomes. Our **MedicineInsight program**, developed with funding from the Australian Government Department of Health, extracts data from over 650 general practices across Australia. Thousands of general practitioners are now contributing deidentified data for millions of regular patients, providing insights to inform quality improvements and population health outcomes at the local, regional and national level. Participating practices are offered customised quality improvement activities that support alignment with best practice and identify key areas for improvement. At NPS MedicineWise we are also increasingly using this data to evaluate the effectiveness of our programs.

These insights can be used by policy makers, health systems and health professionals to identify evidence gaps in primary health care and improve clinical practice and health outcomes in Australia. MedicineInsight's ability to link patient conditions and treatments over time to show how and why medicines are being prescribed means it could be a powerful tool in driving and monitoring better stewardship of prescription analgesics.
For more information see: https://www.nps.org.au/medicine-insight.

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