PAIN

rethinking our approach to pain and the role of opioid therapy

Malcolm Hogg

Royal Melbourne Hospital

Australian Pain Society

Declaration

- Pharma research
  - Mundipharma
- Education/Advisory
  - Mundipharma
  - Sequiris
  - NPS
  - University of Melbourne
  - *move* (Arthritis OP Victoria)
- Boards
  - Australian Pain Society
  - *painaustralia*

painaustralia™
working to prevent and manage pain

move™
muscle, bone & joint health

the new voice of Arthritis VICTORIA
Inc. OSTEOPOROSIS VICTORIA

Current thinking: take home messages

- Pain is a multidimensional personal experience
  - psychosocial aspects relevant pre and post pain onset
  - neurological basis, with genetic and developmental influences
  - socio-psycho-neurological management required

- Opioids are anti-nociceptive
  - essential to (severe) acute pain management
  - role in chronic pain as part of a multidisciplinary, multimodal approach
    - function rather than pain reduction the focus

- Optimal use of opioids requires effort
  - limit opioid failure, adverse effects
    - combine with anti-hyperalgesic
  - educate, review, titrate/taper
    - boundaries

An approach to pain assessment: initial

- **Who is the person?**
  - family history, development, adversities
  - past pain experience and response
  - psychological and physical fitness: depression, anxiety, appraisals

  yellow flags: psycho-social factors associated with increased risk of disability, distress

- **What are the potential mechanisms?**
  - nociceptive, neuropathic, “sensitisation”

  red flags: clinical indicators of possible serious medical conditions

- **What is the impact?**
  - biological, psychological, social
  - bi-directional interactions/cycle development: disability

An approach to pain assessment: review

- **What is the expected/actual journey?**
  - trajectory predicts recovery, although consider neuropathy
    - tissue recovery/injury
    - social response/interactions

  Response: *how is the person and their environment responding?*

- *Flag system*
  - Based on RTW analysis/data, although applicable to other pain experiences
    - a flag suggesting increased risk of failed RTW

  - Orange: mental health disorders
  - *Blue*: workplace or social related factors/perceptions
  - **Black**: compensation system/legal factors

An approach to pain management

- **Manage from a socio-psycho-biological perspective**
  - Patient education essential
    - team liaison, including family, medical
  - Pharmacological
    - opioids è for nociceptive pain, with anti-HA'ics
    - NSAIDS, biologicals, anti-oxidants è for inflammation
    - regionals, ketamine, clonidine, TCAD/SNRI, GBP è for sensitisation
  - Non-pharmacological
    - physical rehabilitation, re-exposure
    - psychology assessment/management
      - education, cognitive re-appraisals, acceptance, mindfullness
    - social
      - judicious support, lessen solicitation, legal (?early apology)

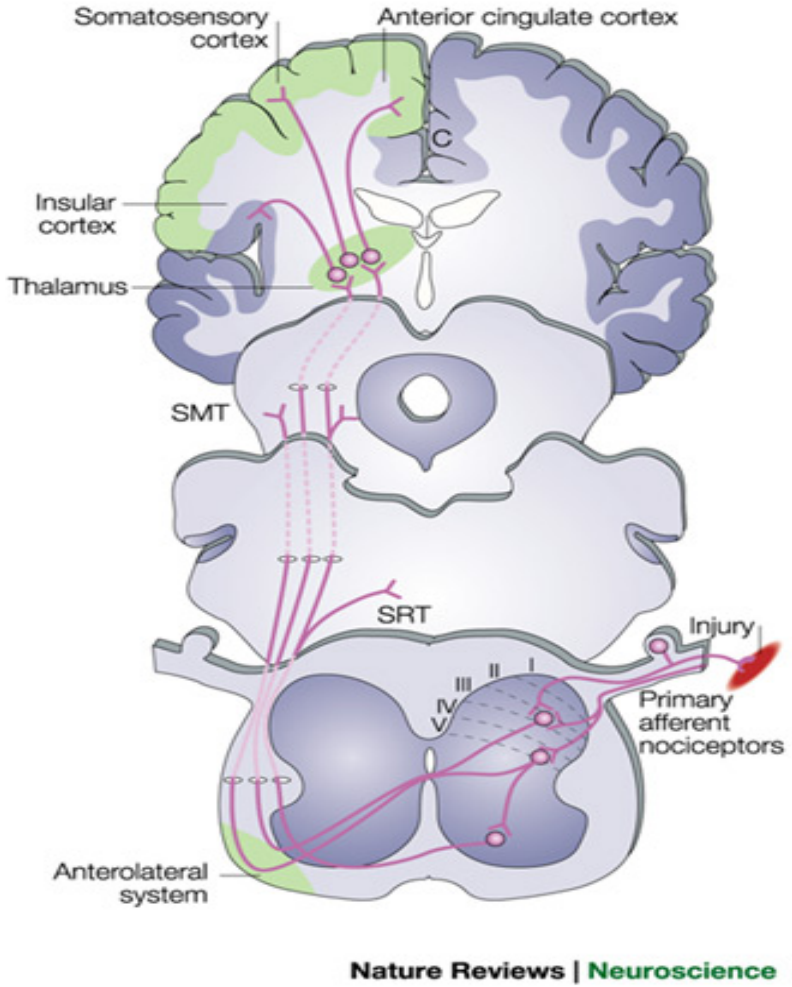
Pain pathways

- Nociception
  - respond to thermal, chemical and mechanical
  - somatic
    - deep, superficial
  - visceral
    - include vagal afferents

- Multiple brain centres activated
  - sensory-discriminative: *SS1, SS2*,
  - affective-motivational: *ACC, Insular*
  - cognitive-evaluative: *PFC*

- Pain is a multidimensional experience

Fields H. *Nature Reviews Neuroscience* 5, 565-575 (2004)



PAIN®

Do we need a third mechanistic descriptor for chronic pain states?

Eva Kosek[a,*], Milton Cohen[b], Ralf Baron[c], Gerald F. Gebhart[d], Juan-Antonio Mico[e], Andrew S.C. Rice[f], Winfried Rief[g], A. Kathleen Sluka[h]

Kosek E. *Pain* 2016; 157: 1382

- Nociceptive
  - Damage or threat to non-neural tissue, normal system
- Neuropathic
  - Clinical description, with defined pathology of somatosensory system
- Other term required for clinical description
  - Clinical and psychophysical evidence of altered nociception
    - *Nociplastic*: change in function
    - *Algopathic*: pathologic perception of pain
    - *Nocipathic*: pathological nociception

In reality: complex, combination, inferred but often unknown mechanisms

Clinical pain

- Sensitisation
  - peripheral: inflammatory mediators, nerve changes
  - spinal cord sensitisation: up-regulation (NMDA, NOS, PG's)
    - Including glial cell activation
  - brain changes: cortical re-organisation
- Behavoural change
  - sleep, mood, fear-avoidance, hyper-vigilance
- Descending modulation
  - inhibition
  - facilitation

- Catastrophising associated with é TS, ê DINC
  - » Yarnitsky D. *Pain* 2012; 153: 1193

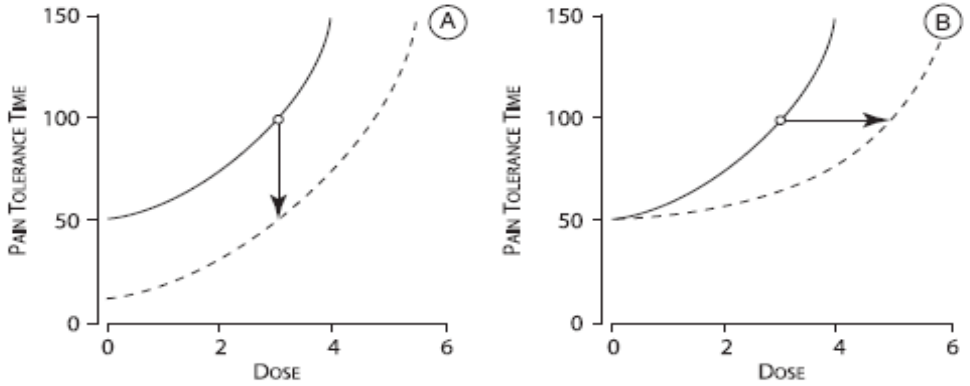
Consider a persons nociceptive spectrum in assessing current pain

Factors associated with pain severity and persistence

- Acute pain severity biggest predictor of chronic pain
  - surgical factors, post-operative care, rehabilitation
  - ? neurogenic inflammation

- Psycho-social aspects important, including the trajectory
  - genetic
    - including anxiety, catastrophising
  - adverse childhood experiences
    - » Scott K. *Arch Gen Psych* 2011; 68: 838
    - plus parental style
      - » Anno K. *BMC Psychiatry* 2015; 15: 181
  - past pain and pain cognitions
  - compensation/solicitous systems
  - perceived injustice
    - » Martel M. *Clin J Pain* 2016; aug12

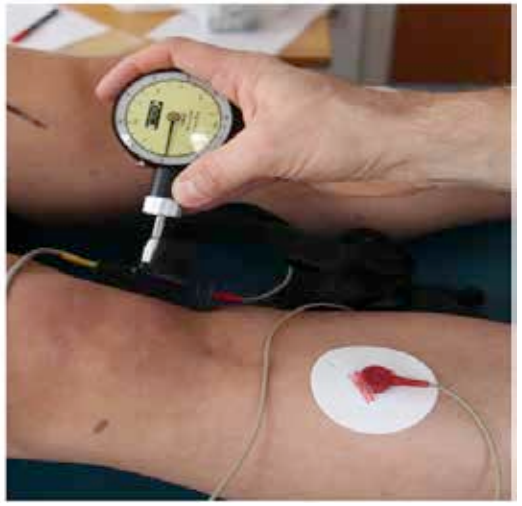
Influence of opioids



- OIHA: ê nociceptive threshold
- OT: ê anti-nociceptive processes

- Opioid exposure at moderate dose
  - pain sensitivity, including ê pressure, thermal pain threshold
  - ê DINC
  - é temporal summation
    - » Mao J. *Reg Anesth Pain Med* 2015; 40: 663

- Dose response relationship
  - >100 oral Meq associated with pressure pain sensitivity
  - hyperalgesia with fentanyl (males)
    - » Wasserman R. *Reg Anesth Pain Med* 2015; 40: 687



Mindfulness meditation-related pain relief: Evidence for unique brain mechanisms in the regulation of pain

- "non-elaborative, non-judgmental awareness" of present moment experience
  - regulated, sustained attention to sensory, emotional, cognitive events
  - recognition as momentary, fleeting and changeable
  - lack of cognitive and emotional appraisal

- EEG and fMRI suggest long term meditators change brain response to noxious stimuli (in non-meditative state)
  - less unpleasantness, greater sensory activation (insula, cingulate, OFC)
  - less med-PFC, amygdala, less connectivity between PFC-cingulate
- Increased sensory processing whilst meditating
  - » Zeidan F. *Neurosci Lett* 2012; 520: 165

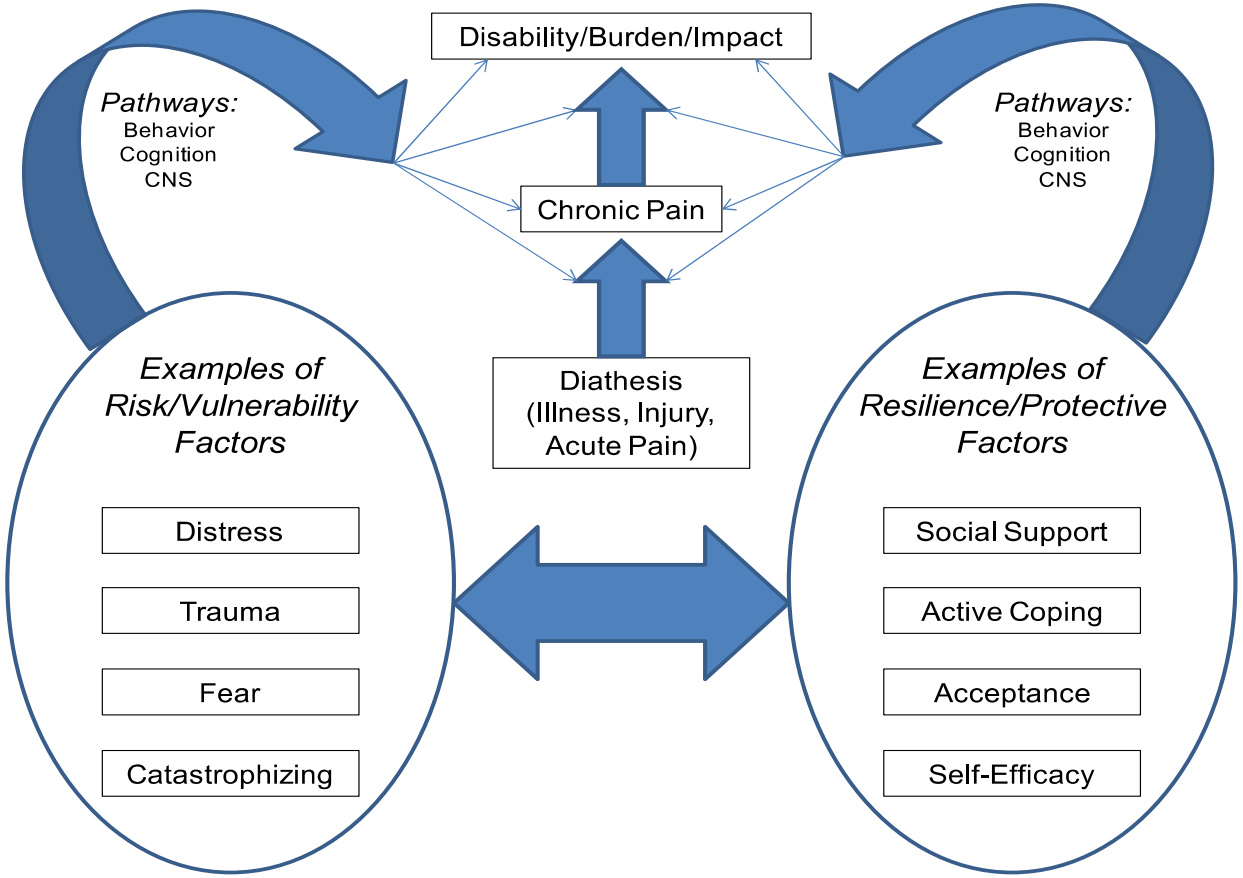
- Different fMRI activation to placebo in experimental pain
  - greater effect
    - » Zeidan F. *J Neuroscience* 2015; 35: 15307

Breast Surgery

- PVB
- SNRI x10/7
- iv LA
- top LA + GBP

- Schreiber K. *Pain Manag* 2014; 4: 445

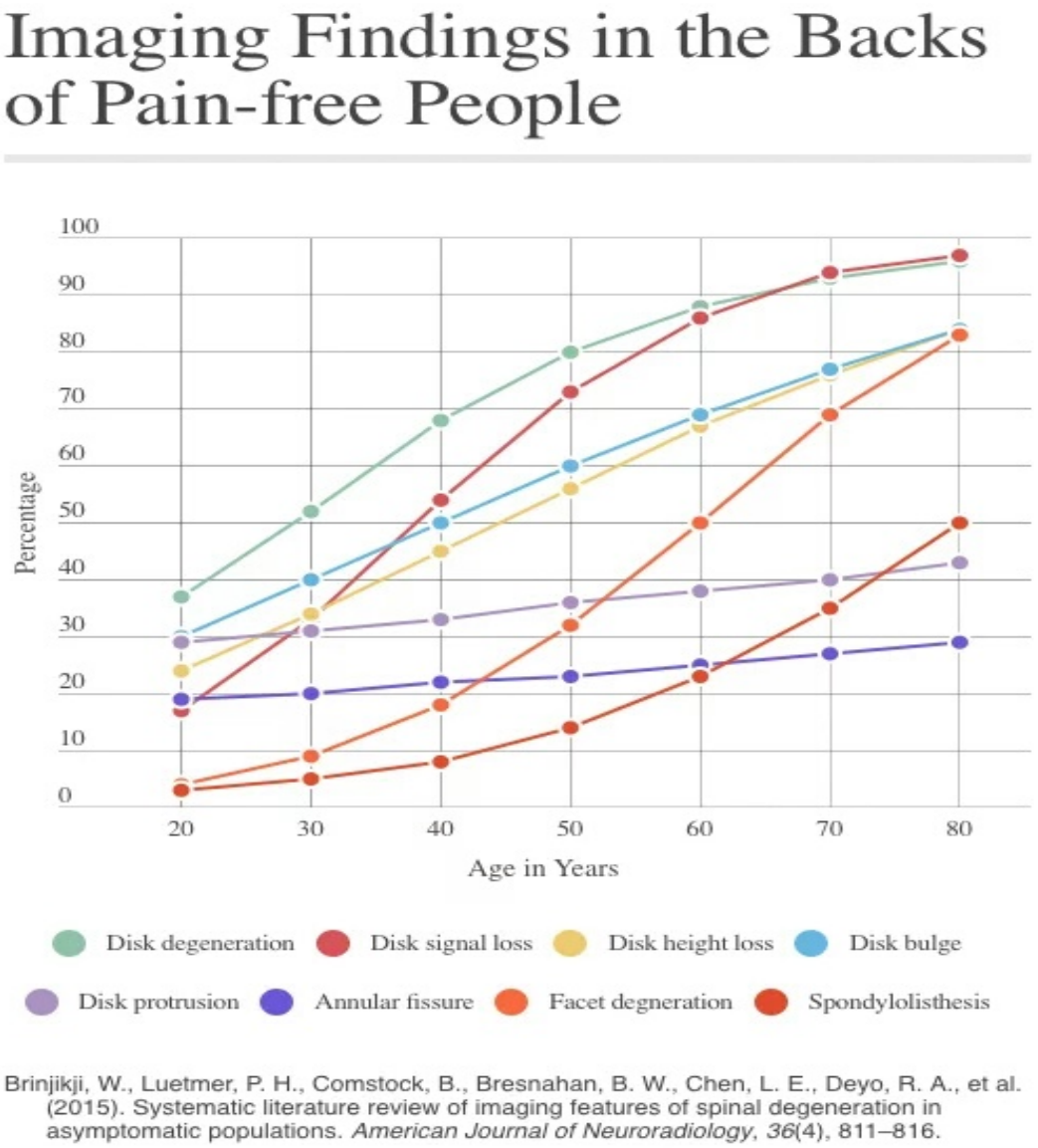
Fear-Avoidance Model and beyond



- Formulation of cumulative risk and protection to identify risk of prolonged pain and disability
  - FAM + avoidance endurance model: causality tbc
    - » Edwards R. *J Pain* 2016; 17: S2, T70

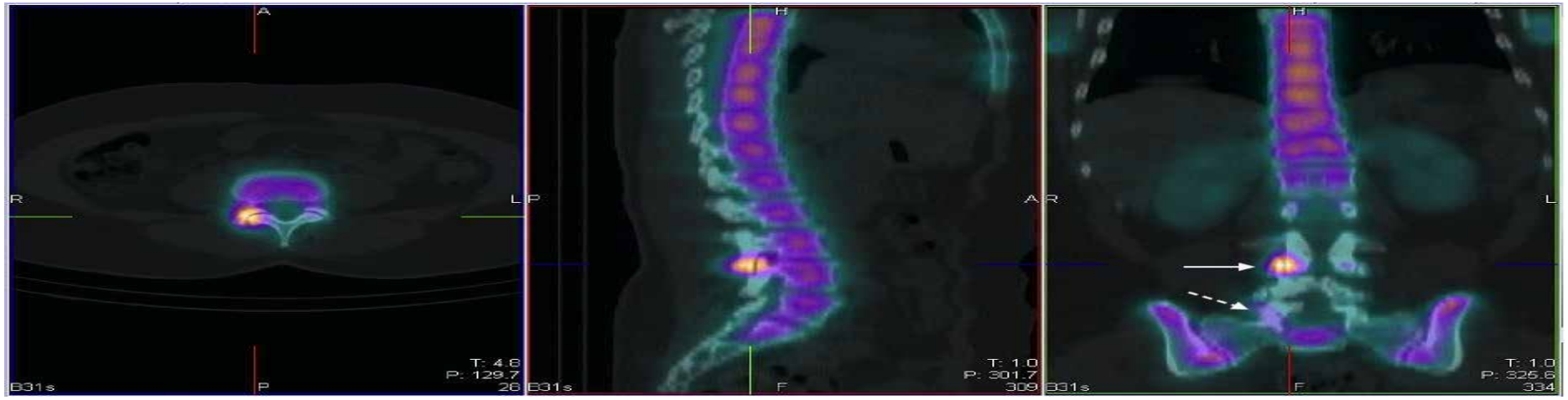
Care with investigations

- Indicated when “red flags” identified
  - potential to increase somatic focus
  - early MRI detrimental, costly
    - » Webster B. *Spine* 2013; 38; 1939
  - changes common in asymptomatic
    - » Brinjikji W. *Am J Neuroradiology* 2015; 36: 811
- Structure vs function
  - pain is dynamic CNS evaluation



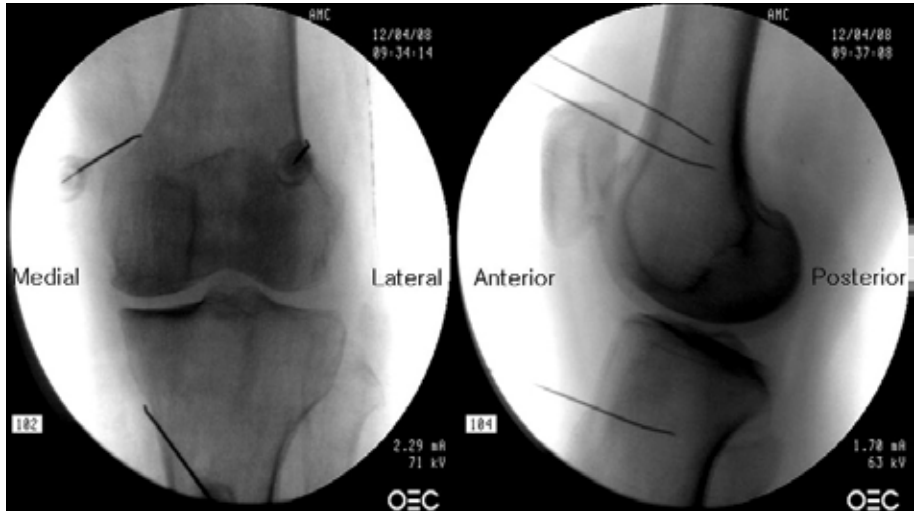
Bone Scan with SPECT

- New technology low dose CT
  - up to 6 mSv
- Limited prospective support in diagnostic approach
  - identifies alternative diagnosis, role in athletes
  - may improve outcome of interventional approaches
    - » Carstensen M. *Chiro Man Therap* 2011; 19: 2
    - » Jain A. *Clin J Pain* 2015; 31: 1054



Interventional pain management

- Influence nociceptive/pain physiology
  - steroid injections
    - ? role for PRP
  - LA/radiofrequency ablation
    - spinal facet joints
      - » van Wijk *Clin J Pain* 2005; 21: 335
    - knee, hip
  - neuromodulation
    - peripheral, spinal cord, brain stimulation
    - ? TMS
  - ? vertebroplasty
      - » Bird P. *MJA* 2017; 207: 279



Fifteen Years of Explaining Pain: The Past, Present, and Future

G. Lorimer Moseley*,† and David S. Butler*,‡

*Sansom Institute for Health Research, University of South Australia, Adelaide, Australia.
†Neuroscience Research Australia, Sydney, Australia.
‡Neuro-Orthopaedic Institute, Adelaide, Australia.

- Education psychology
  - conceptual change: pain is dynamic
  - pain as a perceived need to protect rather than as a marker of damage
  - doesn't deny peripheral nociceptor activity
  - not behavoural or educational therapy per se, rather cognitive modulation

- Effective
  - improves knowledge
  - decreases catastrophising
  - short term reduction in pain, disability
  - assists (should integrate) with MDT rehab

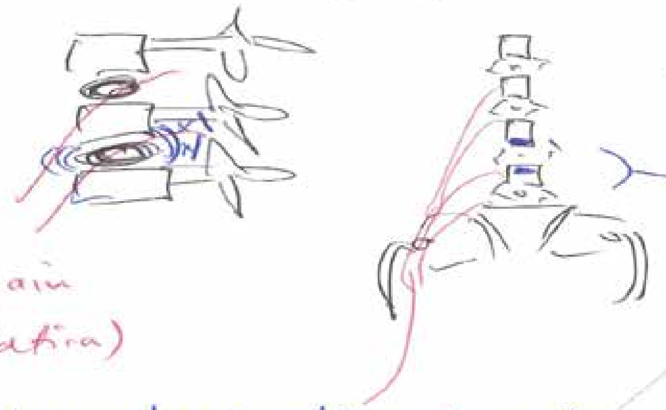
» *Journal of Pain* 2015; 16(9): 807-13

The Royal Melbourne Hospital
Royal Park Campus

Back pain — Disc's ← muscles
— Bones — ligaments
— joints
} often more than one.

STRUCTURAL

ELECTRICAL



Leg pain (sciatica)

Lowback + to hips

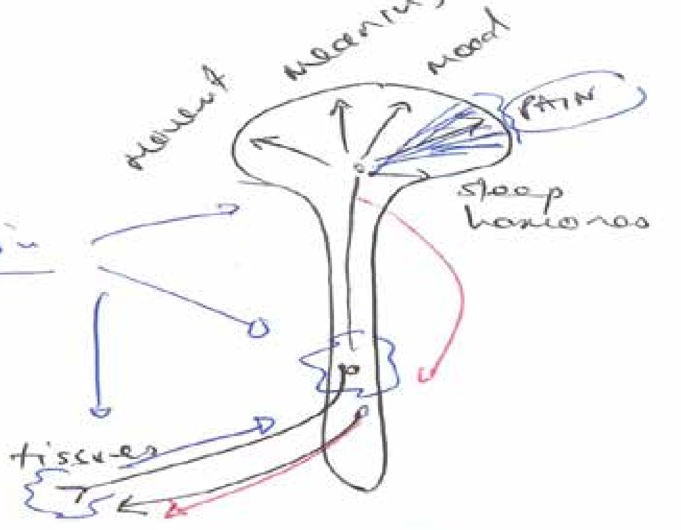
⟷ sensation & interpretation of pain

→ physio / posture / bone health
medicines
injections

psychology
relaxation
anti depressant
anti epileptic

Sensitisation

memory, impact



Influenced by
- genetics
- past pain - meaning
- hormones, sleep
- weather - stress
- opioid use

response → +/-

↑ blood flow, muscle

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MELBOURNE HEALTH

The Royal Melbourne Hospital is part of Melbourne Health.

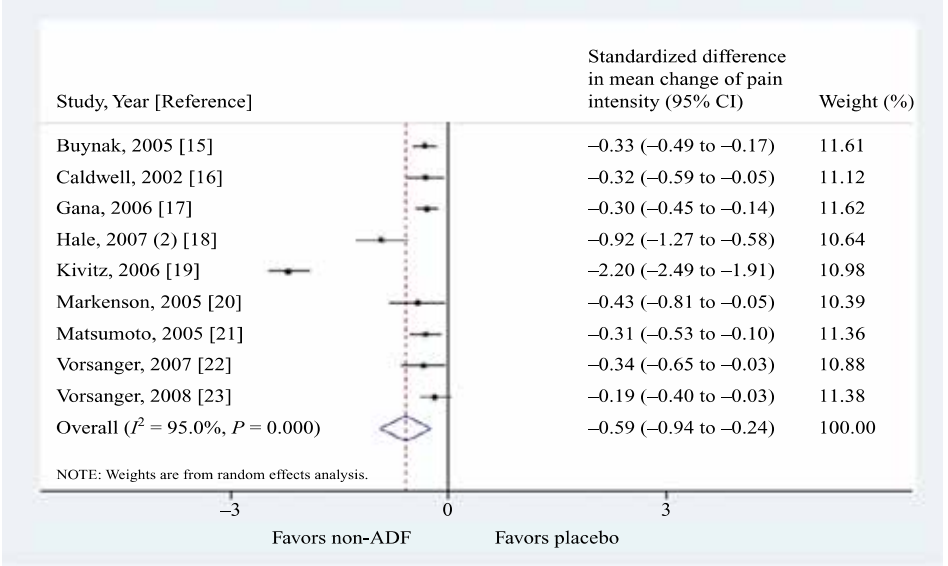
Opioids

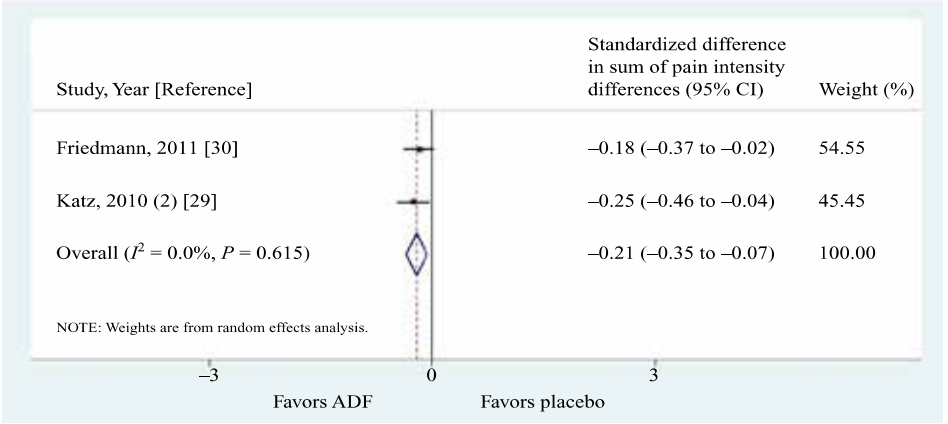
- Effective in acute (nociceptive) pain
  - up to 70% pain severity reduction
  - dose response relationship
    - potential toxicity
- Less effective in chronic pain
  - 30 % pain reduction (nociceptive)
    - varied tolerance to side effects
      - » *CMAJ* 2006; 174: 1189
  - ? role in neuropathic pain
- Higher doses associated with
  - anxiety/psychological distress
  - substance use disorder
    - » *Clinical J Pain* 2010; 26: 1
  - cancer/palliative treatment

Issues re RCT's opioids for non-cancer pain

- No RCTs >300 mg morphine (equivalent) per day for more than 16 weeks
- Mean decrease in pain intensity was 30%
  - 15-30% for placebo
- Withdrawal significant
  - no benefit 10-20%
  - adverse effects 20-30%
  - 30% remain on long term opioids

- Cochrane review > 6 mths
  - one RCT, quality of published literature an issue
  - weak evidence of efficacy in those tolerating
    - functional impact unclear
      - » Noble M. *Cochrane Database Reviews* 2010
- No difference with ADF
  - » Mincha E. *Pain Med* 2014; 15: 79



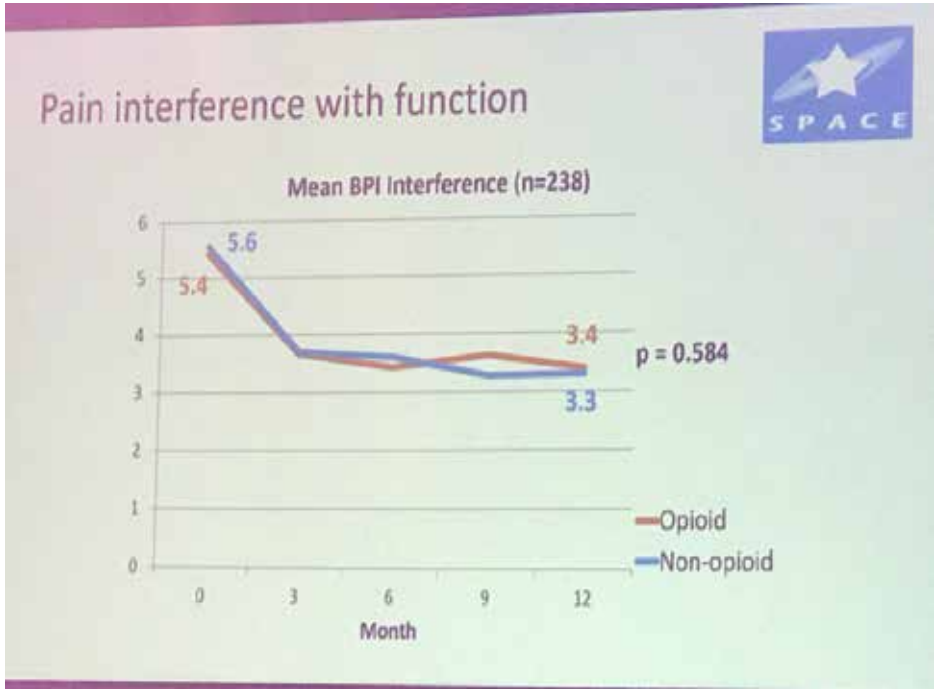


THE BACK LETTER®

Published by Lippincott Williams & Wilkins Vol. 32, No. 7, July 2017

Landmark Trial Punctures the Myth That Opioids Provide Powerful Relief of Chronic Pain

- 240 patients with moderate-severe chronic pain
  - back, hip or knee
  - mean pain BPI- severity 5.4 in both arms
    - At 12 months, opioid arm (4.0) > non-opioid arm (3.5) (P=0.034)
    - similar between groups re BPI-interference
      - » Krebs et al. Pre-publication. Society for general internal medicine 2017



Opioids

- Large range strong opioids, patient variability
  - morphine
    - longer $t^{1/2}$ in older, accumulation risk
    - more potent, equal efficacy via PCA in aged
      - » Aubrun F. *Best Prac Res Clin Anaes* 2007; 21: 109
  - fentanyl
    - potent, no metabolites, patch
  - oxycodone
    - abuse deterrent formulations
    - low dose naloxone may reduce tolerance
  - hydromorphone
  - methadone
    - long $t^{1/2}$, potent, cardiac concerns

- Tapentadol
  - nor-adrenaline re-uptake inhibition, SR only
  - ? role in neuropathic pain, ? less constipation
    - 50 mg equivalent to 10 mg oxycodone
      - » Vadivelu N. *J Pain Research* 2011; 4: 211

PALEXIA® TAPENTADOL

Buprenorphine

- Effective in cancer and neuropathic pain
  - broader pain phenotypes
- Less tolerance and dependence
  - can be combined other opioids; anti-hyperalgesic
- Less adverse effects
  - cognitive, constipation, respiratory depression no immuno-suppression, hormonal
- Safe in aged, renal disease
    - » Davis M. *J Support Oncol* 2012; 10: 209

- Low intrinsic efficacy means higher receptor occupancy required
  - no apparent ceiling for analgesia, but limited respiratory depression
    - 0.3 mg comparable to 10 mg morphine in acute studies
      - » Raffa RB. *J Clin Pharm Therapeutics* 2014; 39: 577
  - use in acute pain: 30 mcgm pca bolus, 0.2 mg S/L (*Temgesic*)

Codeine

- Metabolised to morphine
  - CPD2D6 variation
    - genetics
    - drug interactions
- Low analgesic potency
  - constipation
  - neuro-inflammation/hyperalgesia

- Easy access
  - Schedule 3: 8-16 mg
  - Schedule 4: 30 mg, with paracetamol
  - Schedule 8: 30 mg single agent

- Co-agent toxicity risk
  - NSAID enteropathy

THE CONVERSATION

Subscribe

Medicandus

A second opinion about health care and medical science

Four reasons why codeine should not be sold without prescription

April 30, 2015 2.40pm AEST

NNT (acute pain)	
codeine 60mg	7
para. 1gm /ibup. 400mg	1.5
para. 1gm/codeine 60	2.2
para. 1gm/cod. 60mg vs. para.	6.1

Other issues with opioids: persistent pain

- Improved understanding/experience of long term use
  - hormonal, immune dysfunction (T-k inhibition, glial cell activation)
    - ?? increased cancer recurrence
      - » Lennon FE *Anesthesiology* 2012; 116: 940
  - sleep disordered breathing, dental, cardiovascular risks
    - sudden/overdose deaths: increase >100 mg oral morphine equivalents/day

- Addiction: low rates if risk stratified in chronic non malignant pain
  - no history of abuse: estimated 0.19% addiction, 0.59% aberrant use
  - increases to 3.3 and 11% if risk factors
    - past addiction, genetics, alcohol, psychiatry, abuse history
      - » Fishbain D. *Pain Medicine* 2008; 9: 444
  - long term use oxycodone
    - majority dose stable after 3 months, side effects less
      - 2.6% misuse rate
        - » Portenoy R. *Clin J Pain* 2007; 23: 287
    - ? higher addiction risk

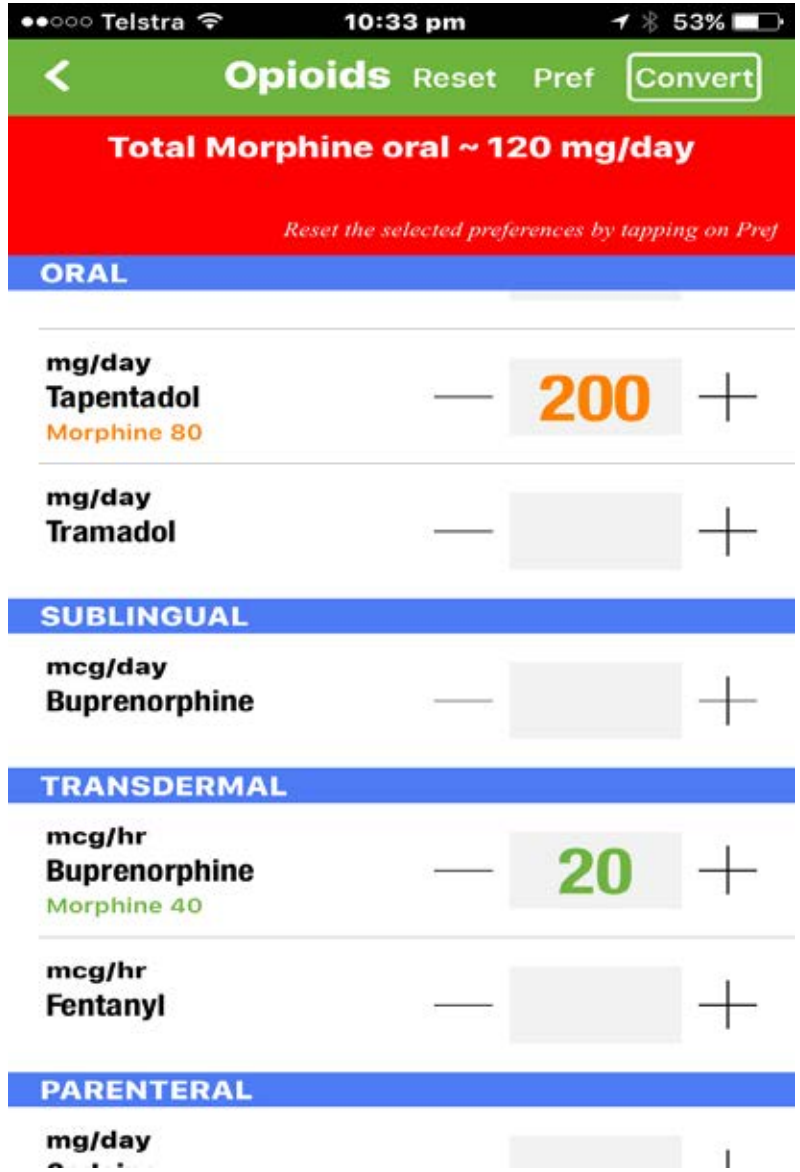
Reviewing and maintaining opioid therapy

- Regular review initially (6 A's)
  - define nociception
  - reassess/reaffirm messages, education, dose limitation
  - engage non-pharmacological management
    - Mx/care with psychological aspects

- Adjuvant medications
  - regular paracetamol +/- NSAIDs
  - anti-hyperalgesic medication
    - Gabapentin/Pregabalin
      - 100-300 mg tds GBP
    - TCAD/SNRI
      - Nortiptyline 10-25 mg nocte
      - Duloxetine 30-60 mg daily
        - » Myers J. *BMC Musculoskeletal Disorders* 2014; 15: 76
    - Clonidine 50-100 mcgm tds

Opioid Calculator App

- Linked to PM 01 2015
- Opioid dose calculator
  - Converts to OMED
    - Green
    - Amber > 40 mg
    - Red > 100mg
- http://fpm.anzca.edu.au/front-page-news/free-opioid-calculator-app



Anti-neuropathics

- Gabapentin/Pregabalin
  - evidence in neuropathic pain
  - anti-hyperalgesia
  - sedative, easy dose titration
- Valproate, Carbamazepine
- TCAD/SNRI
  - anticholinergic effects
  - effective in PHN, including preventative
  - NNT 2.2-2.6
- Clonidine/dexmedetomidine
  - anti-nociceptive, anti-hyperalgesia
  - e.g. dex 0.5-1 mcgm/kg/hr intraop in opioid tolerant
- topical therapies
  - lignocaine: 2-5%
  - amitriptyline/clonidine

Allied Health

- Principles
  - assess and engage client in self-management approach
    - stages of change, locus of control
      - role for motivational interviewing
    - aim for functional gains rather than pain reduction per se
  - target unhelpful cognitions and behaviours
    - catastrophising, low self-efficacy
    - fear-avoidance behavour
    - mood disorder
  - optimise physical-psycho-social function
    - muscle tone, posture
    - boom-bust vs pacing
    - solicitous systems

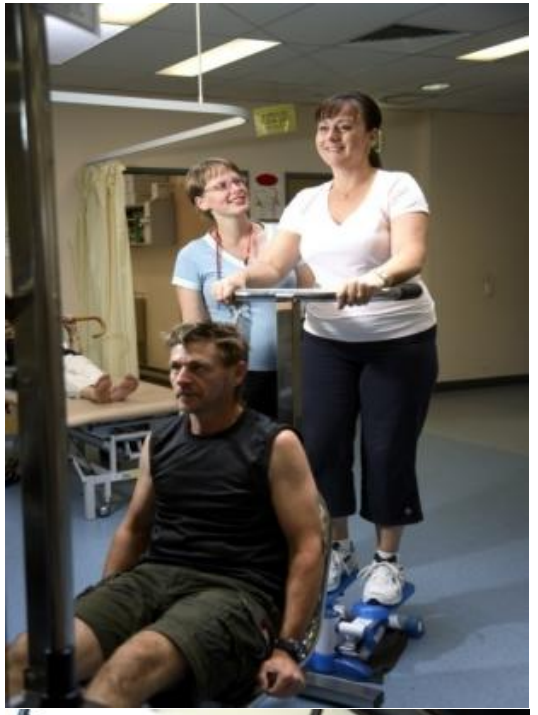
CBT
ACT
Psych Flexibility
Mindfullness

- Evidence of benefit, maintained at 12 mths
  - potential to benefit from group dynamic
    - » Kamper SJ. *Cochrane Database Syst Rev* 2014; 9: CD000963

Pain Management Programs

- Co-ordinated, multi/interdisciplinary, groups
  - selected based on prognostic indicators: ePPOC measures

- Range of processes and program structures described
  - education: 2-8 hrs, eg STEPS program
    - neurophysiology, self-management principles
    - options: directs ongoing care, shortens wait time
      - » Davies S. *Pain Medicine* 2011; 12: 59
  - PMP
    - Individual: targeted/focused program
    - Low: 6-24 hrs, low depression, disability
    - Medium: 25-50 hrs, over 4-8 weeks
    - High intensity: >100 hrs, intensive
  - specific approaches: yoga (mindfullness), Thai Chi, pilates
    - » ACI; PMP: which program for which patient? 2013



VICTORIA

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Pain and pain management

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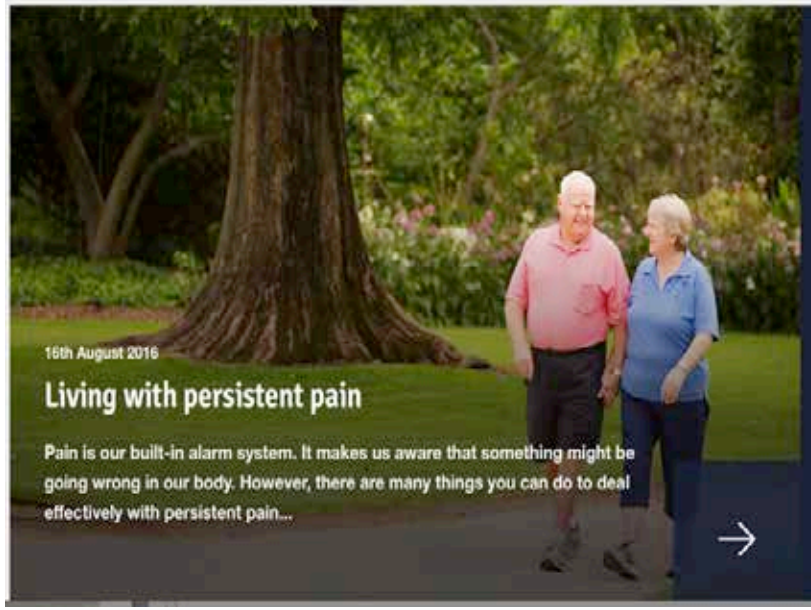


Treating persistent pain

When do I need to see my doctor about persistent pain?

Back pain

Understanding pain

Learn more about pain from these videos, developed by Hunter Integrated Pain Service (HIPS), Hunter New England Local Health District, New South Wales, Australia.

Guide to pain

About pain

Managing pain

Who to see about your pain

About pain

Living with persistent pain

Pain is our built-in alarm system. It makes us aware that something might be going wrong in our body. However, there are many things you can do to deal effectively with persistent pain

Multilingual resources on pain

Health Translations

العربية Arabic

中文 Chinese

简体字 Chinese (simplified)

繁體中文 Chinese(traditional)

Hrvatski Croatian

See more translations for Pain on Health Translations

Pain Management Network

Search...

For Everyone | For Youth: PainBytes | Spinal Cord Injury Pain | Health Professionals | Our Mob

Welcome to the ACI Pain Management Network

This website is designed to help you gain a better understanding of your pain. The site contains information to enable you to develop skills and knowledge in the self management of your pain in partnership with your healthcare providers.

You will hear from other people, just like you and learn how they too have lived with chronic pain. The website has a number of episodes which should be viewed over several days to weeks. If anyone has concerns viewing or reading the material, they should consult their doctor or health professional.

Video 1 | Video 2 | Video 3

View video transcript

If you are a young person with chronic pain, there's a youth channel with episodes for you to work through with a range of exercises and useful tips throughout.

Successful management of chronic pain can be facilitated via a range of active strategies - sleep and mood management, as well as via the

Development of an appropriate Support network is important for people in pain and health professionals alike

1 2 3 4 5 6 7 8 Pause

For Everyone

- Introduction to Pain
- Getting help from your Healthcare Team
- Pain and Physical Activity
- Pain: Lifestyle and Nutrition
- Pain and Role of Medications
- Pain and Thoughts
- Pain and Sleep

For Youth: PainBytes

- Introduction to Pain
- Pain and Physical Activity
- Pain and Feelings
- Pain and Mind-Body Connection
- Pain and School
- Pain and Family
- Staying on Track

Health Professionals

- Assessment
- Assessment
- Management of Chronic Pain
- Resources for Chronic Pain
- Quick Steps to Manage Chronic Pain in Primary Care

ACI NSW Agency for Clinical Innovation

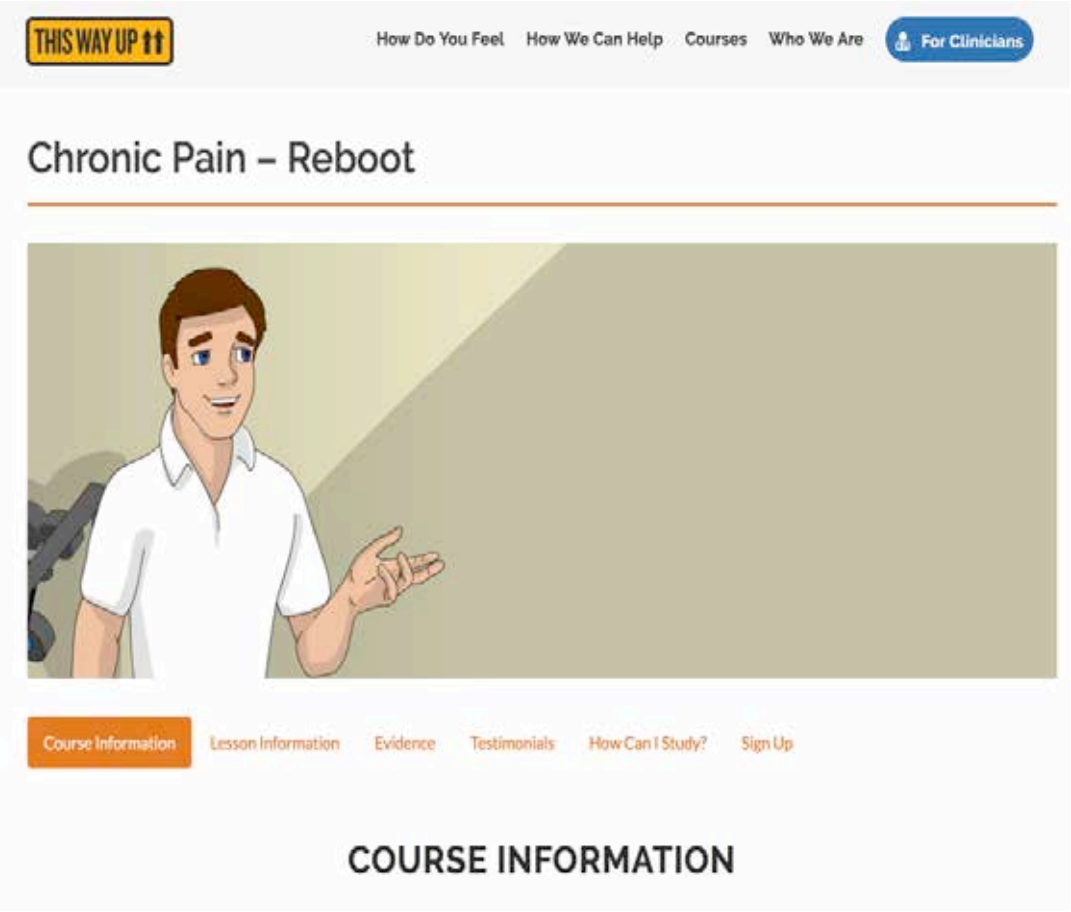
Need help for your pain?

NSW GOVERNMENT Health

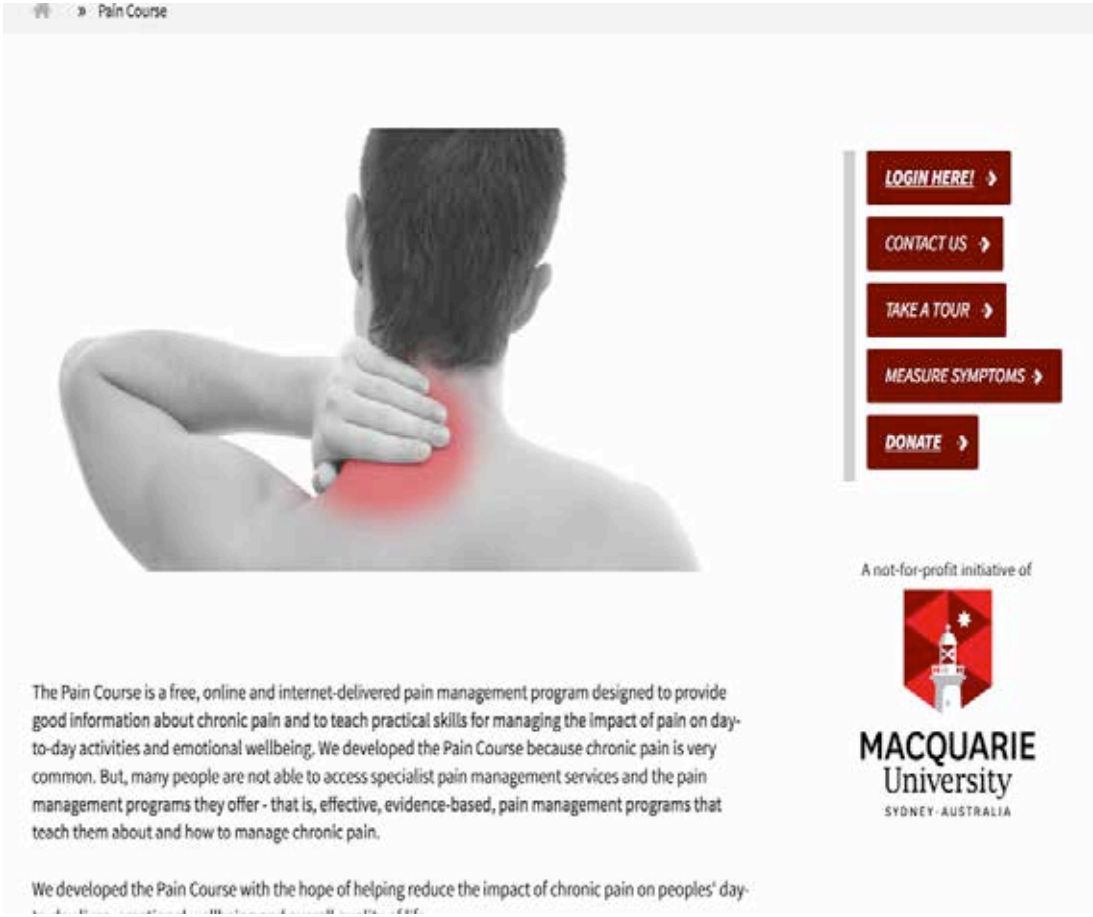
ACI NSW Agency for Clinical Innovation

Internet based pain management programs

St V's (NSW): CBT + PT, 8 modules



McQuarie Uni (NSW): CBT, interactive



Consumer groups

- CPA
  - National Pain week
  - Patient stories/forum
  - Advocacy, support

Chronic Pain AUSTRALIA

- APMA
  - Helpline
  - Local support groups

AUSTRALIAN PAIN MANAGEMENT ASSOCIATION

- Consumers Health Forum
  - National collaborative organisation

ACKNOWLEDGEMENTS

betterpainmanagement.com

FPM FACULTY OF PAIN MEDICINE ANZCA | BETTER PAIN MANAGEMENT *Pain education for professionals*

Module 9: Post-discharge acute pain management

Professor Pamela Macintyre, Dr Myles Conroy, Associate Professor Andrew Zacest, Trudy Maunsell

Module 10: Understanding pain-related procedures

Dr Marc Russo, Dr Diarmuid McCoy, Dr Geoff Speldewinde, Associate Professor Andrew Zacest, Ms Jacqueline Hunt

Module 11: High-dose problematic opioid use

Dr Matthew Frei, Jacqueline Hunt, Dr Diarmuid McCoy, Dr Bridin Murnion

Module 12: Pain in children

Dr Susan M Lord, Ms Joy Burdack, Dr Meredith Craigie, Dr Ross Drake

Painaustralia

- NFP advocacy body
  - Clinician groups
    - APS, FPM/ANZCA
  - Consumers
    - CPA, APMRA, Arthritis groups
  - Research/clinical groups
  - Industry
    - Health insurance, pharma
  - Advocates
    - philanthropy

Painaustralia

- Prosecutes case for NPS
  - Document developed 2010
  - Government submissions
    - Education grant basis for BPM program
    - Funding for prevention program, NSW
    - MBS review submissions
    - Codeine program
- Resources
- Links
  - Collaborative approach
    - consumers, clinicians, researchers

The key goals of the National Pain Strategy are:

- People in pain as a national health priority
- Knowledgeable, empowered and supported consumers
- Skills professionals and best-practice evidence-based care
- Access to interdisciplinary care at all levels
- Quality improvement and evaluation
- Research

For your patients

The following fact sheets are available for you to download and print for your patients.

- The Nature and Science of Pain (Painaustralia)
- Prevalence and the Human and Social Cost of Pain (Painaustralia)
- Clinical Assessment of Pain (Painaustralia)
- Multidisciplinary Pain Management (Painaustralia)
- Spinal Cord Stimulation (Painaustralia)
- Targeted Drug Delivery (Painaustralia)
- Chronic Pain – A Major Issue in Rural Australia (National Rural Health Alliance)
- Chronic Physical Illness, Anxiety and Depression (Beyond Blue)
- TENS; Transcutaneous Electrical Nerve Stimulation (Painaustralia)
- Neuropathic (Nerve) Pain (Painaustralia)
- Self-Managing Chronic Pain
- Shingles – Busting the myths (Seqirus)
- The Pain Toolkit Australia (www.paintoolkit.org)
- Chronic Pain Management Strategies (NSW ACI)
- Communicating and building your healthcare team (NSW ACI)

For you

- The Nature and Science of Pain (Painaustralia)
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- Chronic Pain – A Major Issue in Rural Australia (National Rural Health Alliance)
- Chronic Pain Management Strategies (NSW ACI)
- Communicating and building your healthcare team (NSW ACI)
- 8 Aboriginal Ways of Learning
- 'Yarn with me': applying clinical yarning to improve clinician–patient communication in Aboriginal health care (Australian Journal of Primary Health 2016)

GET IN TOUCH

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Email: admin@painaustralia.org.au

ACN 147 676 926

State Health websites/resources

- Better Health Channel
  - updated information (2016), limited re specialist services
- Pain Health (WA)
  - http://painhealth.csse.uwa.edu.au
- NSW Network Pain (ACI)
  - http://www.aci.health.nsw.gov.au/chronic-pain
- HNE health (HIPS)
  - Patient and clinician resources
  - Referral processes, home of “brainman”
  - https://www.youtube.com/watch?v=5KrUL8tOaQs

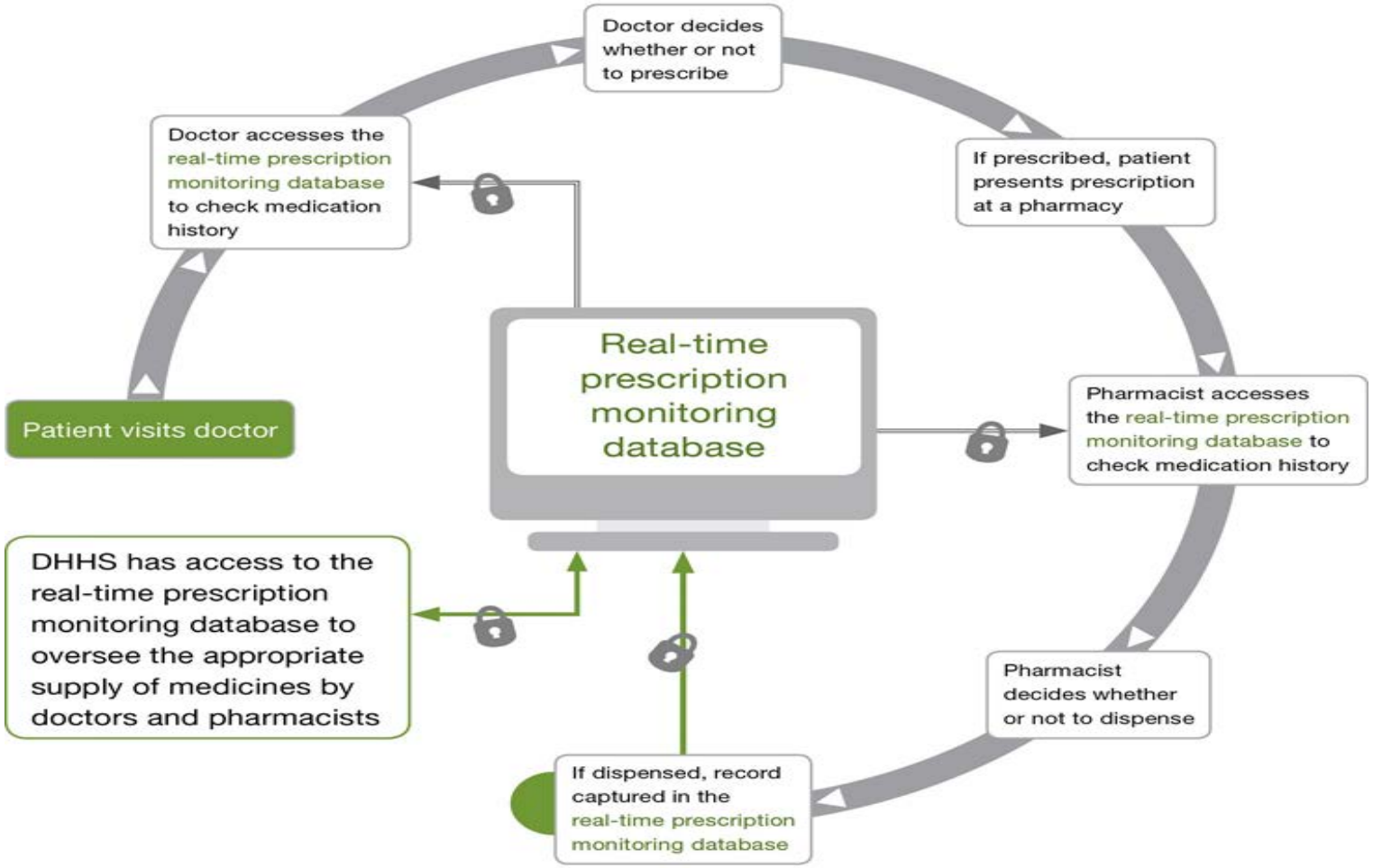
Follow-up

- Pain Clinics
  - prolonged wait times: median 150 d
    - » Hogg M *MJA* 2012; 196:386
  - role for transitional pain service
    - opioid dose reduction
      - » Huang A. *Pain Management* 2016 (july)
  - early psychology access
    - » Nicholas M. WISE study, APS 2016
    - » Vranceanu A. *Injury* 2015; 46: 552
- LMO, surgical and patient education
  - improved health literacy reduces HCU
  - community based allied health programs reduce wait times
    - » Davies S. *Pain Med* 2011; 12: 59

Recent reviews

- Reddi D. Preventing chronic postoperative pain. *Anaesthesia* 2016; 71 (S1): 64-71
- Posek JP. Et al. The acute to chronic pain transition. *Med Clin Nth Am* 2016; 100: 17-30
- Edwards RR. The role of psychosocial processes in the development and maintenance of chronic pain. *J Pain* 2016; 17: S2 T70

RTPM – Business context



RTPM Project for Victoria

Victoria: **$29.5 million investment over 4 years**

Phased implementation from 2018

Comprehensive approach:

- **Medicines to be monitored: all Schedule 8 medicines, all benzodiazepines (including diazepam), zolpidem, zopiclone and quetiapine**
- **PBS and non-PBS prescriptions for monitored medicines**
- **Workforce development**
- **Modest enhancement of AOD referral pathways**
- **Analysis of RTPM data to tailor response**

What are we trying to achieve?

- RTPM: "*decision support tool*" - more informed, safer supply of high risk medicines
- Essential, but not sufficient on its own
- Will identify:
  - **existing problems and risks**
  - **new problems - early intervention**
- Problematic prescribing - tailored individual, strategic response
- More rational supply - attitudes

RMH-Pain Management Services

The Royal Melbourne Hospital

Royal Park Campus

34-54 Poplar Road

Parkville Vic 3052

- **Clinics**
  - **Rehabilitation, Aged Care, Telehealth**
  - **Subacute, Interventional, Neurosurgical**
- **Allied Health Pain Management Programs**
- **Clinical Education and Research**
- **Acute and Interventional Services**
  - **City Campus**