NSW GOVERNMENT

AGENCY FOR CLINICAL INNOVATION

Spotlight on virtual care: Providing a multidisciplinary chronic pain service

Nepean Blue Mountains Local Health District
Murrumbidgee Local Health District

JUNE 2021

Virtual Care Initiative

A collaboration between local health districts, speciality health networks, the ACI and eHealth NSW.

The 'Spotlight on Virtual Care' reports showcase innovation and leadership in virtual health care delivery across NSW. The series aims to support sharing of learnings across the health system and outlines the key considerations for implementation as identified by local teams.

Each initiative within the series was selected and reviewed through a peer-based process. While many of the initiatives have not undergone a full health and economic evaluation process, they provide models that others may wish to consider and learn from.

These reports have been documented by the Virtual Care Accelerator (VCA). The VCA is a multi-agency, clinically focused unit established as a key partnership between eHealth NSW and the ACI to accelerate and optimise the use of virtual care across NSW Health as a result of COVID-19. The Virtual Care Accelerator works closely with Local Health Districts (LHDs) and Specialty Health Networks (SHNs), other Pillars and the Ministry of Health.

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Further copies of this publication can be obtained from the Agency for Clinical Innovation website at **www.aci.health.nsw.gov.au**

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Introduction

The Nepean Pain Unit uses videoconferencing technology to enable access to a multidisciplinary specialty pain service for consumers located in Murrumbidgee Local Health District (MLHD).

Chronic pain contributes significantly to the global burden of disease, with social and economic consequences. 20% of all Australians are impacted by chronic pain and one in five general practitioner (GP) consultations involve a chronic pain element.* In regional and remote areas, this burden is further influenced by factors such as employment in rural industries, an ageing population, and a higher prevalence of mental illness. Consumers in rural areas are also more likely to be on inappropriate opioid medications due to lack of access to non-pharmacological treatments.†

Regional populations face barriers to accessing specialist and allied health pain services. In part, this is due to workforce challenges and the need to cover vast distances between health services and populations in these areas.

The NSW Pain Management Plan (2012-2016) identified a number of service recommendations including that Local Health Districts (LHDs) should work with local healthcare providers to develop coordinated primary healthcare arrangements for pain management, with clinical and educational support from hospital-based pain services and/or pain linkage services.‡

In 2014, a review of the NSW Pain Management Plan (2012 -2016) identified MLHD as one of three regional areas with significant gaps in access to chronic pain services or the capacity and expertise to manage people with chronic pain. MLHD did not have a publicly accessible pain management service available to all consumers. Fly-in-fly-out (FIFO) Visiting Medical Officers (VMOs) provided limited public clinics, however all other services were only delivered by private providers.

This report outlines how the use of virtual care has enabled MLHD address service gaps for their community.

The existing tertiary pain unit at Nepean Blue Mountains Local Health District (NBMLHD) successfully tendered to provide their consultative outreach chronic pain service to the MLHD virtually. This service is led by a pain medicine specialist and supported by a full range of disciplines to deliver multidisciplinary care.

The virtual service provides:

- comprehensive biopsychosocial assessments via the Pexip videoconferencing platform
- individualised recommendations and management plans developed in partnership with local GPs
- onsite visits alternating between Wagga Wagga and Griffith (a total of three annually) to offer in-person care and clinician and consumer education.

*See MLHD Pain Presentation in Supporting documents list

†See The NSW Pain Management Plan (2012-2016) in references

‡See The NSW Pain Management Plan (2012-2016) in references

Reported benefits of the model

Consumer benefits

- Access to specialist, evidence-based multidisciplinary pain management, including to much needed non-pharmacological pain assessments and treatments
- Access to follow-up support and education, enhancing continuity of care and supporting people's engagement with their own GP
- Receiving care closer to home, removing the burden of travel for extended periods and making tangible improvements to chronic pain management
- Increased capacity to set goals and actively self-manage chronic pain.

Clinician benefits

- Healthcare professionals in rural and remote areas receive support and training, which builds local capacity and facilitates upskilling
- Personally fulfilling for Nepean Pain Unit clinicians who provide a service which is making a difference assisting consumers to adopt a self-management approach to their pain.

Service benefits

- Improved communication and collaboration between consumer, primary care and specialist services
- Rural LHD access to specialist support which complements existing allied health and nursing services
- Reduced reliance on FIFO services for specialist input, and improved continuity of care through access to a consistent specialist team
- Increased efficiency as travel time is significantly reduced for specialist care, while consumers are still supported with in-person care from their GP.

Overview of the model

Key elements of the model

Element	Detail
Patient population	Inclusion criteria: • Significant pain condition impacting on physical and psychological health • Ongoing pain for greater than 3 months • Referral received from GP or another specialist • 18 years and above (16 to 18 year old can be treated in collaboration with a paediatric pain service) • No active substance misuse (consumers with Drug and Alcohol related issues are referred to the MLHD Drug and Alcohol community service) • Consumer willingness to engage in a self-management approach
Referral pathway	GP or specialist referral letter to the Nepean Pain Unit. Referral criteria and information is available on Murrumbidgee HealthPathways. Local clinical champions and Murrumbidgee Primary Health Network (MPHN) promote referral into the Nepean Pain Unit amongst local Murrumbidgee clinicians.
Healthcare team	The Nepean Pain Unit multidisciplinary team (MDT) includes: • pain specialists • psychologists • physiotherapists • a clinical nurse specialist • an occupational therapist. The clinical team members are supported by local GPs and MLHD staff to enable the model of care, as detailed in the service outline below.
Technology	Existing technology is used to provide this service. Nepean Pain Unit end: • Computers or tablets with cameras and speakers/headsets • Pexip videoconferencing platform (planned transition to MyVirtualCare) • NBMLHD eMR. MLHD patient end: • GP rooms - videoconferencing set-ups • Patient's homes - personal computer or device with camera and stable internet connection • MLHD outpatient clinic - computers with cameras and speakers/headsets.

The Service

The Nepean Pain Unit provides virtual and in person care to consumers in the MLHD who are living with persistent pain. The service offers a multidisciplinary approach to pain management, as opposed to the currently available local options, which are medication and intervention focused.

Consumers can access the service with a referral from their GP. Following an initial virtual MDT assessment provided by the Nepean Pain Unit via Pexip, a pain management plan is formulated with the patient and their GP. This plan is based on the patient's priorities and the active changes they can make to their lives to improve their pain. Realistic goal setting forms a significant part of planning discussions.

The Nepean Pain Unit MDT join the assessment from the NBMLHD outpatient clinics. Patients may choose to join from home or in GP clinic rooms, depending on their physical needs, technology capacity and if they need support people present. They can also join from the MLHD outpatient clinic if they cannot access the appropriate technology.

GPs play a critical role providing ongoing medication review, and assisting patients to navigate services and adopt recommendations from their pain management plan.

Treatment and/or follow-up options may include (further detail is provided in figure 1):

- local allied health services, including public and private physiotherapy, psychology and occupational therapy
- follow-up virtual appointments with the Nepean Pain Unit team to provide the GP advice for changes in medication, goal assessments and further treatment options
- in-person consultations with the Nepean Pain Unit in Wagga Wagga and Griffith. The Nepean Pain Unit visit each town once or twice annually for in-person service provision (a total of three visits per year)
- use of online pain resources
- pain management education offered to consumers by the Nepean Pain Unit.

The Living with Pain Programme program session in Wagga Wagga 2021

The treatment plan is implemented by the patient and their GP until such time as the patient has reached their goals and is able to manage their pain independently. The plan is adapted as necessary throughout the journey to ensure it continues to be effective and meet the patient's personal needs, increasing the likelihood of success.

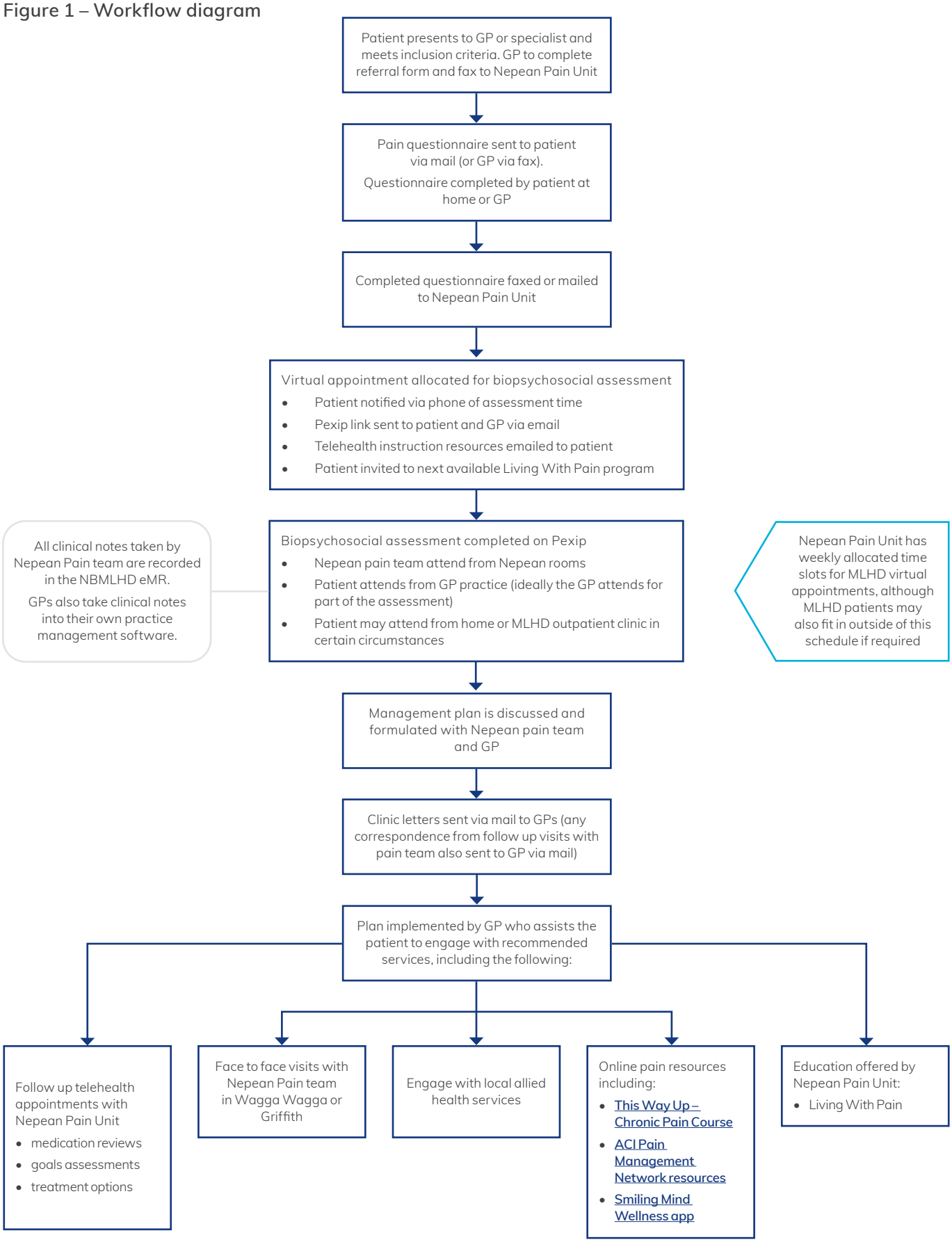
The virtual component of the service is complemented by in-person pain management education for consumers and local clinicians facilitated by the Nepean Pain Unit. This is detailed in the 'Building engagement' section.

GPs and primary healthcare services can contact the Nepean Pain Unit team for general advice or questions related to specific patients. This is managed via telephone directly to the Nepean Pain Unit or through email. The clinical nurse specialist triages enquiries and directs them to appropriate members of the MDT.

Where a referring GP determines that the wait time to access the service is too long to address the patient's immediate needs other services are explored, e.g. local allied health or private providers. The current wait time is approximately six months.

Workflow diagram

Figure 1 – Workflow diagram



Patient Story

Lisa* lives in Cootamundra and has developed osteoporosis. In the past, Lisa's husband would have to drive her two hours each way to Canberra to access a private pain specialist. Travelling in a car for this extended period was very uncomfortable for Lisa and they had to make many stops to help alleviate Lisa's back pain.

The private specialist prescribed Lisa pain medication, which she ended up being allergic to. Following this, Lisa was referred by her GP to the Nepean Pain Unit for a virtual consult. Her first appointment was at her GP's room and she joined her follow up appointments from her computer at home.

This was Lisa's first time using virtual care and it was easy.

'I suffer with back pain and I have problems with my bladder, so it is comfortable at home. Usually it is quite a long conference call. We would all disappear and come back with biscuits and coffee or tea.'

Following the virtual consultations, Lisa was able to significantly reduce her medication intake, from 16 to 18 pills a day to only two.

'The Nepean Pain Unit introduced me to other local services. I am linked up with a private physio and now do exercises I had not thought about before.

From accessing the Nepean Pain Unit via telehealth, I have got my life back to some degree. I can do more things. I got back to doing gardening and doing things around the house and walking to the shops. I don't know where I would be without them.'

* Name changed to protect client privacy and confidentiality

This is a service model that should be scaled. Pain clinics are particularly difficult to reach and people with chronic pain are often under referred. This model boosts accessibility.'

KAREN ARBLASTER, EXECUTIVE SPONSOR, DIRECTOR ALLIED HEALTH, RESEARCH AND STRATEGIC PARTNERSHIPS NBMHLHD

Making it happen

This section outlines the key enablers and challenges identified by those involved in implementing this model. Addressing these factors effectively has been critical to successful implementation and these learnings can be used by other health services in the development of local models. The resources listed in the Supporting Documents section also supplement these learnings and have been identified throughout the following sections.

Local planning, service design and governance

Service design

- A service level agreement (SLA) sets out the high-level framework within which the virtual chronic pain service operates.
  - NBMLHD, MLHD and the MPHN are parties to this agreement which is funded by the Ministry of Health (MoH).
  - The agreement includes recurrent, annual block funding to NBMLHD for provision of chronic pain services to MLHD.
  - The agreement requires that medical team members from NBMLHD complete the standard credentialing requirements for practicing within MLHD.
  - Teams implementing similar cross district models should seek guidance from their local medical workforce unit. District medical workforce unit managers should be familiar with the below policy directives (PDs).
    - PD2019_056 – Credentialing and Delineating Clinical Privileges for Senior Medical Practitioners and Senior Dentists[§]
    - PD2016_026 – Staff Specialist employment Arrangements across more than one Public Health Organisation[**]
- The roles and responsibilities for pain clinicians, primary healthcare providers and consumers within the virtual chronic pain service are guided by the ACI Telehealth Pain Tool Kit[††]. This comprehensive suite of resources provides direction on all elements of service design including:
  - model of care documentation and resources for consumers and clinicians
  - checklists for clinicians and consumers to get the best from virtual care consultations
  - templates for referral forms, which include consent, and maintaining clinical records during virtual care consultations, which include confidentiality guides
  - transfer of clinical responsibility between specialist pain team and primary healthcare clinicians.

Local clinical governance

- All parties to the SLA meet quarterly for collaborative steering committee meetings, a key structure for local clinical governance. These meetings are chaired by the ACI Pain Management Network Manager and include discussions on:
  - clinician education needs and preferences
  - local consumer education needs
  - prioritisation of in-person clinical visits
  - consumer experience and feedback mechanisms and escalation.
- Consumers and local clinicians across MLHD have regular opportunities to provide feedback into this meeting through engagement with the NBM clinical teams and MPHN.
- Executive sponsorship for the Nepean Pain Unit is provided by the NBMLHD Allied Health, Research and Strategic Partnerships directorate. Corporate and technical processes for the chronic pain service are managed within this directorate.

[§]See PD2019_056 in the references and links list **See PD2016_026 in the references and links list ††See ACI Telehealth Pain Toolkit in resources list

- The NBM team monitor patient safety during virtual consultations similarly to in-person care.
  - Should a medical issue arise during a consultation where a GP is present, the GP is responsible for examination and escalation if necessary.
  - If a medical issue arises while a patient is at home and the patient is unable to attend their GP or call an ambulance themselves, the NBM clinicians will contact the patient's GP or local emergency department.
  - Clinical issues that need to be escalated beyond local clinical governance structures are managed within the operations directorate of Nepean Hospital.
  - The protocol for concerning, non-clinical issues that may arise during a video consultation, e.g. disclosures of violence or neglect, mirror that of the in-person procedures for the Nepean chronic pain team.
- Medical responsibility and everyday care of the patient remains the responsibility of GPs. This contributes significantly to care continuity and patient outcomes.
  - GPs prescribe any medication within the pain management plan. This allows urgent reviews or requests for change of dispensary location to be completed in a timely manner.
  - GPs are crucial to the implementation of the specialists' pain management plans. GPs assist patients to navigate follow-up services and provide a regular point of contact for assessing goal progression and adapting the plan based on patient needs

Clinical processes

- All clinical processes of the virtual chronic pain service have been developed based on procedures within the ACI Telehealth Pain Tool Kit.
- The virtual service is designed to replicate in-person MDT care provided to consumers visiting the Nepean Pain Unit. The virtual service is complemented by face to face care (if needed) and consumer and clinician education.
- If patients require in-person care, this occurs during the Nepean Pain Unit teams' triannual visits to Wagga and Griffith. Patients may be identified for in-person care based on clinical judgement, including assessment of complexity, acuity and medication types. Patients may also request an in-person consultation.
- Clinic notes are recorded in the NBMLHD eMR. GPs are responsible for maintaining their own clinical records during virtual consultations and case conferencing. Following all consults, clinic letters from the NBM specialist team are sent via mail to the patient's GP.

Strategies for virtual care delivery

While the inability to provide a physical examination virtually was initially seen as a challenge, the NBM team have provided education and implemented strategies in partnership with local GPs to ensure consumers receive high quality care:

- Having the patient attend the biopsychosocial assessment in their GP's rooms allows the GP to conduct any required physical examination.
- GP's use their clinical judgement to determine if an in-person consultation is required to complement virtual consultations.
- Seeking continuous patient consent and documenting clinical observations appropriately assists in mitigating risks when a physical examination is not possible from a medicolegal standpoint.
- In-person education sessions offered to patients and their support people helps build trust with clinicians and improves patient rapport when interactions are transitioned to a virtual setting.

Building engagement

The Nepean Pain Unit outreach service is enabled through collaboration of consumers and service providers, including the Nepean Pain Unit, MPHN, MLHD, GPs and other local clinicians. The consumer is always at the centre of care. This collaboration, along with education and promotion, have been identified as key enablers of the model.

Consumer engagement

- Prior to their first visit, the service supports consumers to prepare for what to expect by electronically providing:
  - patient information sheet for telehealth consultation
  - using telehealth to attend an appointment
- Empathy is an important component of clinical care in pain management. The clinical team seeks to empathise with consumers to understand how pain is impacting their lives, this helps inform the pain management plan and increases consumer engagement.
- Goal setting is used to help consumers reimagine their lives and the MDT approach to care enhances the skills and expertise available to support goal attainment.
- The involvement of family and other support people in goal setting, and the program more broadly, strengthens motivation, improves outcomes of goal setting, and increases consumer capacity to maintain lifestyle changes.

GP engagement

- This service relies on strong integration with primary care to enable continuity of care and achievement of outcomes.
- GPs support consumers to navigate their pain management plan. The GPs' knowledge of local providers is essential to help consumers identify the services outlined in their plans.
- Advocacy from GPs (supporting, listening and adapting care) increases consumer's motivation and capacity and ultimately enhances outcomes and experience.
- A small number of local GPs and local allied health clinicians across MLHD (particularly in Wagga Wagga and Griffith), act as local champions and advocates amongst the primary healthcare workforce.
- Local champions are identified through their participation in in-person clinical education sessions run by the Nepean Pain Unit. Local clinicians that are passionate about the virtual MDT approach to pain management are more likely to engage with the clinical team, promote the service amongst primary health colleagues, and actively refer. Consumers also act as champions advocating for the service in the community.

Engagement with the local PHN

- MPHN and the MPHN GP Liaison Officer play an important role in local advocacy and education. This helps to foster collaboration across the district to:
  - improve healthcare providers' awareness of the virtual chronic pain service
  - enhance communication between the NBM clinical team and primary healthcare clinicians across the district
  - identify opportunities for clinical education.
- The MPHN facilitates promotion of the service across MLHD, through:
  - including the Nepean Pain Unit in the Murrumbidgee HealthPathways website.
  - features in newsletters to ensure local clinicians are aware of the MDT approach.

'I think with pain, a nonlinear way of communication is conducive in building safety and patient's ability to feel supported when they are trying to manage their issues.'

- DR JOHNATHAN HO, LOCAL GP CHAMPION WAGGA WAGGA

Engagement with ACI

- Collaboration with the ACI and the Pain Management Network has assisted with service governance, process design and documentation. This has helped to demonstrate value in patient outcomes and maintain recurrent funding.
- The partnership with the ACI Pain Management Network also provides the opportunity to share the benefits of the service with other clinicians.

Engagement with Aboriginal Community Controlled Health Services (ACCHS)

- The MDT approach to pain management is closely aligned with the holistic patient-centred approach to care promoted by ACCHSs. Considerations have been made to ensure Aboriginal community members are able to access the virtual chronic pain service in a culturally safe way.
  - Aboriginal consumers may choose to attend virtual consultations at their local ACCHS. This familiar environment can make virtual care less intimidating and ensures all community members have equal access to care, regardless of access to technology.
  - Access to support team members such as Aboriginal Health Workers (who may attend virtual consultations), helps build consumer engagement and maintains a patient-centred approach.
  - The Nepean Pain Unit team use triannual in-person visits to MLHD to engage with ACCHSs face to face. Site visits are conducted across the region to build relationships and trust, promote referral into the pain service and provide clinical education to staff members.

'I think it is amazing that our partners can come to this session. It is important that they are able to come and be able to be part of the journey. One of the great things about coming into a room like this is realising that you are not alone.'

PATIENT, FOLLOWING LIVING WITH PAIN EDUCATION SESSION

Engagement through education (in-person)

- The Nepean Pain Unit have developed in-person education programs to supplement their virtual care model. This allows the NBM team to regularly engage with referring GPs, other local clinicians, and consumers across MLHD.
- Consumer education is offered through The Living with Pain Programme. A five-hour session is offered once a month to all consumers and family members referred to the virtual pain service. The content introduces the MDT approach to care and the group setting boosts consumers' confidence in the possibility of change through sharing stories. Family involvement in the session is also a powerful tool for building engagement.
- The training is hosted at the MPHN premises and the PHN provides logistics and promotion. The training is provided by the Nepean Pain Unit when it coincides with their triannual in-person visits. Otherwise, local clinical champions facilitate the training.
- Clinician education is also provided by the Nepean Pain Unit during their triannual visits to Wagga Wagga and Griffith. The training programs aim to build the capacity of primary healthcare clinicians.
- Local champions for the virtual service have recently implemented the 'Pain Hub'. This is a group of clinicians from MLHD who meet monthly to consider the education needs of consumers and clinicians across the region and plan the rollout of education programs.

Workforce and resourcing

Technology

- The virtual Nepean Pain Unit service uses a simple technology set up. Consultations currently take place using the Pexip videoconferencing platform (transition to myVirtualCare is planned).
  - At the Nepean Pain Unit end, existing computers are used (video conference enabled through the addition of webcams and speakers) in either outpatient consultation rooms or private offices.
  - If a patient is attending from their GP's rooms, the individual practice's technology is used.
  - If a patient is joining from their home, they can dial in using the web-based software from their computer, tablet or mobile phone.
  - If a patient's home does not have sufficient internet connection or the required technology, they can attend the consultation from a MLHD outpatient clinic. This is arranged on an ad hoc basis by local LHD staff who are engaged with the virtual chronic pain service.
  - Patients have responded positively to the simplicity of the technology set up.
- Pain management plans may also encourage consumers to adopt technology in their day to day life. Examples include:
  - use of smartphones or smart watches for tracking steps and weight
  - including mindfulness reminders on home devices
  - using smartphone applications to support mental health (Smiling Mind, This Way Up, etc.).

'Goal setting with patients must be meaningful to patients and their families. They need to consider a future with more activity, less medication and more fun.'

DR SUYIN TAN, PAIN SPECIALIST, CLINICAL LEAD NEPEAN CHRONIC PAIN TEAM

Staffing model

- Virtual consultations account for approximately 10% of the Nepean Pain Unit's clinical workload.
- The clinical staff within the Nepean Pain Unit include:
  - two FTE staff specialist pain physicians
  - two psychologists
  - two physiotherapists
  - one occupational therapist
  - one chronic pain clinical nurse specialist (CNS).
- The dedicated CNS position is a key enabler for the operation of the virtual model. The CNS is responsible for administration and management of the service. The roles and responsibilities of the CNS include:
  - liaison between the clinical team, consumers and GPs
  - education facilitation
  - liaison with patients including scheduling appointments, providing resources and mailing clinic letters
  - providing clinical treatment for consumers
  - organising rooms in MLHD outpatient clinics, if required, for patients to attend the virtual consultation
  - liaison with local champions and other primary healthcare clinicians to assist with referring into the service
  - managing all requests from local clinicians for clinical guidance
  - managing requests from consumers for assistance with technology.

Workforce training

- The simplicity of the technology set-up means that very little training is required for the Nepean Pain Unit clinicians.
- The MDT generally attend virtual consults in the same room, meaning staff who are familiar with the videoconferencing set up can train new colleagues. Training modules on Pexip consultations (and myVirtualCare) are also available to new staff.
- The NBMLHD Telehealth team was a key enabler for the implementation of the service. They continue to provide assistance with technical issues.
  - The telehealth team assisted with the technical establishment of the virtual service supporting staff members' capacity and capability in a new virtual setting.
  - If a patient's technical difficulties need to be escalated beyond the CNS, the NBMLHD Telehealth team also provide this support.

Considerations for funding

- The virtual service is funded through the SLA. Ongoing funding is supplemented by Medicare billing by the Nepean Pain Unit. Medicare card numbers are included on referral intake forms.
- There are no out of pocket expenses for consumers to take part in the virtual chronic pain service.
- If a GP does not bulk-bill, patients may need to pay for a component of GP services. Medicare rebates are available for GP appointments related to the virtual chronic pain service.
- Medicare Benefits Schedule (MBS) item numbers billed by GPs vary based on individual circumstances. Options include billing for initial assessments, recall appointments, care planning sessions and case conferencing for MDT discussions.

The Living with Pain Programme program session in Wagga Wagga 2021

Benefits of the model

Results

The Nepean Pain Unit see approximately 30 MLHD patients each year.

Data collected, for the year 2017-18 demonstrated the following outcomes:

236 hours driving time saved

average consultation time of **53** minutes

90% of patients were satisfied with the virtual care consultations

53 local clinicians attended educations workshops

>90% of the clinicians stated the education supported them to help their patients

'Virtual care is like reaching out to those you can't get to in person. It helps me not feel isolated in a small town. It is hard to receive care, especially for old people who can't drive long distances. But with virtual care you can almost pick who you would like to see and where you would go. Without virtual care I would not have been able to reduce all of my medication – it was causing me depression.'

VIRTUAL CARE PATIENT

Benefits

1. Improved access to specialist MDT care where options for specialist chronic pain care were previously limited.
2. Sustainable treatment alternatives offering options for patients to access holistic MDT care in addition to medicinal treatments.
3. Increased continuity of care through holistic pain management plans supported by GP engagement.
4. Goal setting to ensure plans focus on what matters most to patients.
5. Empowering local clinicians and strengthening workforce capacity through education and collaboration with primary healthcare clinicians across MLHD.

Monitoring and evaluation

In 2017, the Nepean Pain Unit received funding to take part in an Electronic Persistent Pain Outcomes Collaboration (ePPOC) evaluation, facilitated by the University of Wollongong.

This program enabled the collection of a standardised set of information through several assessment tools including:

- Depression Anxiety Stress Scales - DASS
- Brief Pain Inventory - BPI
- Pain Catastrophising Scale - PCS.

The evaluation demonstrated significant improvements in clinical outcomes for Murrumbidgee consumers.

While formal evaluation of patient outcomes ceased with the funding for ePPOC after 12 months, the service has continued to collect patient appraisals following attendance at group programs and consultations. They have consistently demonstrated:

- positive experiences, especially in relation to accessing pain specialist services without the financial burden and family disruption associated with travelling long distances.
- appreciation of the option to move to in-home virtual care from patient's own homes during the COVID-19 pandemic.

Opportunities

The integrated nature of the virtual chronic pain service presents opportunities to collaborate with stakeholders, including consumers, to enhance service provision. The Nepean pain unit have identified the following opportunities to work towards:

- Leveraging off existing community healthcare and lifestyle programs to enhance consumer engagement and broaden the service options available through pain management plans.
- Building access for Aboriginal people through trusted programs such as Aunty Jean's groups that provide access to MDT allied health providers in structured groups sessions to support consumers to reach their goals.
- Fostering a closer partnership with MLHD to build available outpatient services and education of the clinical workforce. This would help build the capacity of the virtual services, especially enhancing outpatient allied health follow up options.

Opportunities also exist for further evaluation of the service. Using patient surveys and hospital admission data to understand flow on effects such as a reduction in potentially preventable hospitalisations resulting from improved capacity for consumers to self-manage chronic pain safely.

References and links

The NSW Pain Management Plan (2012-2016)

PD2019_056 - Credentialing & Delineating Clinical Privileges for Senior Medical Practitioners & Senior Dentists

PD2016_026 - Staff Specialist Employment Arrangements across more than one Public Health Organisation

ACI Telehealth Pain Toolkit in resources list

Supporting documents

Clinician resources

MLHD Pain Presentation

NBMLHD Referral Guide to Adult and Paediatric Chronic Pain Services

NBMLHD Pain Management Adult Referral Questionnaire

Consumer resources

Flyer - Living with pain programme

NBMLHD Telehealth reminders for patients and clinicians

Acknowledgements

We would like to acknowledge the current NBMLHD chronic pain service team and the supporting MLHD clinicians for their involvement in documenting this virtual care initiative, along with all past and present staff who have been involved in its development and ongoing care delivery.

The Nepean Chronic Pain Team:

Dr Suyin Tan,	Pain Specialist, Head of Nepean Pain Unit
Diana Taylor,	Nurse Clinical Specialist – Pain Management
Ricard Barclay,	Clinical Psychologist
Katie Estigarribia,	Occupational Therapist
Dr Johnathan Ho,	Local Wagga Wagga GP Champion

We would also like to thank the clinicians, consumers and virtual care experts involved in reviewing this report.

The Agency for Clinical Innovation (ACI) is the lead agency for innovation in clinical care.

We bring consumers, clinicians and healthcare managers together to support the design, assessment and implementation of clinical innovations across the NSW public health system to change the way that care is delivered.

The ACI's clinical networks, institutes and taskforces are chaired by senior clinicians and consumers who have a keen interest and track record in innovative clinical care.

We also work closely with the Ministry of Health and the four other pillars of NSW Health to pilot, scale and spread solutions to healthcare system-wide challenges. We seek to improve the care and outcomes for patients by re-designing and transforming the NSW public health system.

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