



Improving coordination of care between specialist and general practice for people with chronic pain

Collaboration is crucial for better patient outcomes

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Australia's National Pain Strategy describes three points in the current model of care where sufferers of chronic pain (defined as constant pain on a daily basis for 3 months or more in the past 6 months) encounter "fault lines" or disruptions in their treatment journey.¹ The first of these is the prolonged cycle of tests, medicinal therapy and referrals that occurs in the community, delaying effective treatment for those whose pain is unresolved. The second is the wait for assessment and treatment in a specialist multidisciplinary pain clinic, and the third is at the transition to ongoing community-based maintenance once treatment plans have been established. The strategy proposes an alternative model that aims to tackle these fault lines and would see seamless movement across an interdisciplinary network involving primary care and the two more specialised levels of care that employ practitioners with increasing skill in pain treatment.¹

Here, I address the second and third of these fault lines — how to facilitate interactions between general practitioners and the specialist pain team at the points of referral, for specialist care and discharge back into the community. My underlying assumption is that the patient journey is a continuum, and patients will benefit if the health system can find ways to facilitate seamless transition through these stages. At entry into the specialist system, transfer of information and assessment of the appropriateness of specialist intervention is important. After discharge from specialist intervention, the role of primary care is to ensure the approach initiated in specialist clinics is followed through. The primary care role is complex and necessitates an understanding of the importance of the behavioural and social aspects of ongoing pain, providing support to the patient, implementing and maintaining self-management strategies, managing medication strategies and interacting with the community-based multidisciplinary team.²

Compared with the normal care model, when specialists and GPs work together in patient care, there are mixed physical outcomes and, possibly, reduced costs. However, there are also improvements in patient retention rates and patient satisfaction with the service as well as in clinical practice by GPs.³ Formal collaboration between GPs and specialists has not been rigorously tested in the area of ongoing pain.

Recent trials in other areas provide more information about how this could be done. In stroke treatment, a formal

case meeting between community-based health professionals and the inpatient stroke unit team at the time of discharge resulted in a negotiated care plan being formulated.⁴ Compared with normal care, this process increased the relative likelihood of independent living at 12 months by over 50%, and the number needed to treat to gain one extra independently living patient was nine.⁴ By contrast, where a plan was generated by the inpatient team without formal involvement of community-based professionals, there was no difference in outcome compared with normal care.⁵ In palliative care, a single teleconferenced case conference between a GP and the palliative care team improved some dimensions of quality of life in the last month of life.⁶ Another study showed that face-to-face case conferences between the specialist team and the patient's GP (with or without the patient being present) reduced hospital admissions by 30%. Further, improved function was maintained from case conference to death for those who were in the service for more than 60 days.⁷

While chronic pain is complex and may need more than a single case conference to achieve a satisfactory outcome, the evidence cited above shows that even one interaction between specialists and GPs can confer a benefit in other medical conditions.

There are challenges in enabling such case conferences between GPs and other health professionals, but they are supported through Medicare.⁸ Studies have provided evidence about how to facilitate and run case conferences.^{9,10} Video consultations between GPs, specialists and patients are now being funded by Medicare, particularly in rural areas, aged care facilities and Aboriginal health clinics,¹¹ and formal trials to evaluate these interventions are currently in development. The key to success is to recognise that the work patterns and demands of general practice and the specialist team are fundamentally different, and the parties only need to make contact for a short time to conduct the case conference. Although there are not inconsiderable administrative requirements to establish and support the meeting and ensure compliance with Medicare requirements, e-health technology makes tangible the possibility of meetings between GPs and specialist teams.

It seems that chronic pain management is a perfect scenario in which to engage in this sort of practice, and the National Pain Summit seeks such an outcome.¹ However, it is crucial to gather evidence for improved patient outcomes

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that would place the practice on a firm footing, and add to the growing body of evidence on the importance of collaboration between specialists and GPs.

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