Australian Nursing and Midwifery Federation submission to

NATIONAL OPIOID ANALGESIC STEWARDSHIP PROGRAM – DISCUSSION PAPER

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INTRODUCTION

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of more than 300,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions.

Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

The ANMF appreciates this opportunity to provide comment on the Australian Commission on Safety and Quality in Healthcare's (ACSQHC) *National Opioid Analgesic Stewardship Program Discussion Paper*, which contributes to other measures to reduce inappropriate prescribing of opioid analgesics, including regulatory reforms and the introduction of real-time prescription monitoring. We acknowledge the serious impact opioid over-prescription and misuse has on people's lives, and support both the measures that have already been introduced, and those proposed in the discussion paper.

In addition to the harms identified in the discussion paper's introduction, we note a growing body of research over the past five years indicating that abnormal pain sensitivity caused by opioid use (opioid-induced hyperalgesia) can last for months after receiving opioids,[1] and people with chronic pain have improved function and reduced pain with opioid cessation.[2] While the discussion paper's focus is on measures to reduce the introduction of opioid analgesics, to be fully effective in addressing opioid overuse, a prescribing framework must also include measures for people experiencing and at risk of chronic pain.

We acknowledge that the discussion paper explores opioid prescribing in the context of health sector areas of highest use (emergency departments, perioperative and surgical services) and prescriber education and training. To avoid repetition, our response relates to the document as a whole rather than addressing the discussion questions by section.

1. What are the system-wide challenges that need to be addressed?

Funding models

The healthcare landscape has changed over the past century, from a predominant focus on treating and managing acute and emergent issues to managing and minimising the effects of chronic conditions, including chronic pain. This has not been well reflected in healthcare funding, which continues to be directed to hospital care and acute illness or exacerbation over continuity of care models. Although the Medical Benefits Schedule Review Taskforce (MBSRT) recommended the introduction of a greater range of long consultations, general practitioners are still financially advantaged by multiple short consultations (which facilitate assessment and prescription) than fewer, longer consultations[3] (allowing holistic evaluation, discussion, and an opportunity to discuss multiple options). As a consequence, some people present to emergency departments once their symptoms become unbearable.[4]

Pressured and under-resourced acute health care services

With rising demands on acute health care services, as evidenced by recent reports of ambulance ramping outside hospital emergency departments, long wait lists for elective surgery and increasing hospital admissions, the health care system is under extreme pressure to expedite patient discharge in order to accept new admissions. This directly impacts on patient care and pain management across the clinical areas identified in the discussion paper.

In emergency departments, people are experiencing long wait times which may increase patient stress and agitation, which in turn worsens perceptions of pain.[5 6] Due to demands on health services there is also a structural emphasis on sorting patients who need admission from those who can be discharged from the department. This results in assessments aimed at rapid resolution, increases the pressure on prescribers to write a prescription for analgesia and discharge the patient for primary care follow up, with little time for appropriate discharge planning and education.

In post-surgical wards, an emphasis on shorter hospital stays condenses the period of time patients receive skilled assessment and management of pain, as well as discharge planning and education for pain medication cessation. It also increases the pressure on prescribers to write a prescription for analgesia and discharge the patient for primary care follow up. This is compounded by routine prescription by case presentation rather than individualised care. Subsequently, the system contributes to excess opioids in the community, a reliance on opioid prescribing at the time of discharge and poor pain management planning and oversight for individuals.

Public expectation

In addition to the time pressures that make a quick prescription appealing, particularly in emergency departments but also in general practice, many people expect and prefer medication to less immediate, more time consuming interventions, even if these are more effective and have fewer adverse reactions. Health practitioners are educated about the fundamentals of appropriate opiate prescribing however the public are less aware of the risks of prescribed opioid use.

2. What are the gaps that inhibit achieving positive patient outcomes?

Funding structures

Non-pharmacological modalities that take more time but more effectively address pain, including supported exercise programs and therapeutic massage, are often not recognised or poorly funded through Medicare. While some of these are partially covered by private health insurance policies, this depends on the level of coverage and frequency of need. As of 2019, 53% of adults in Australia had some form of general treatment health insurance cover,[7] but this figure is steadily falling, with a recent report predicting the industry is in decline.[8] Without mass funding for holistic, evidence-based alternatives, this funding paradigm will continue to channel people with pain to emergency departments and pharmacological resolution.

Insufficient services

Even for people who have the means to seek comprehensive management of chronic or intractable pain, there are very few health practitioners specialising in chronic pain, even in major metropolitan areas. This means long wait times for both an initial consultation and follow up appointments to review progress.

Apart from emergencies (ambulances and emergency departments), there are few health care services available outside business hours. Telephone triage programs like Victoria's Nurse On-call are useful for advising people about whether they can delay seeking healthcare until an appropriate health practitioner is available, but are not equipped to provide the kind of support needed to avoid presentation to a hospital.

As noted under the heading 'pressured and under-resourced acute health care services,' multiple factors can affect the perception of pain. These include comorbidities that range from physical symptoms (for example, nausea) to concomitant mental ill-health. Inadequate mental health services, particularly for non-acute and complex needs, contribute to both increased perception of pain and to longer wait times in emergency departments.

3. What is considered best practice in 2021?

<u>What works and should be done more?</u>

Education

While most health practitioners are aware of the both the short-term physical risks of opioids and the potential for dependency and misuse, the relationship between opioid use and increased pain is not as well known. Information regarding these risks should be made available to prescribers, along with posters designed for patients.

Education for health practitioners who are non-prescribers is also important as they are often involved in, or lead, pain assessment, medication administration, discharge and patient education components of care. This includes improving early career management of high risk medications through changes to final year of undergraduate education, training and induction processes, continuing professional development and mentoring of newly graduated health practitioners through specific graduate supported positions in the acute health sector.

An education campaign to change public perception to prescribed opioid use should include the message that the aim of analgesia is not to eliminate pain, which in many cases may not be possible, but to reduce it to a level that the person can tolerate.

Nurse practitioners

The ANMF strongly support further expansion of the nurse practitioner (NP) role in emergency departments and walk-in community clinics in relation to pain management and prescribing. NPs manage episodes of care, including wellness-focussed care, as a primary provider of care in collaborative teams. They are therefore well-placed to care for individuals experiencing pain and would ably bridge existing gaps in patient education regarding acute pain and opiate analgesia, and the management of chronic pain. However, despite robust local and international evidence that NPs provide care that is safe, timely, and cost-effective, they are grossly underutilised in Australia. This is due to the overrepresentation of medicine in Australian healthcare decision making – as noted last December,[9] rather than endorsing any of the expert Nurse Practitioner Reference Group's 14 recommendations, the MBSRT's final report ignored them all. Instead, the report recommended three new, unsupported suggestions that will further restrict MBS-subsidised NP practice and services.

More nurses and midwives

Greater numbers of nurses and midwives in all contexts of practice, including emergency departments, hospital units/wards, follow up care, primary health and general practice would facilitate holistic care, including education about pain management, and alternatives to opioids. Mandated nurse and midwife staffing levels/ratios in in-patient settings allow nurses and midwives enough time to plan, provide and evaluate care that takes longer than prescribing, dispensing and administering a medication. Workforce strategies need to be implemented now to ensure future workforce capacity.

Augmenting pain assessments

Evaluation of pain processes identify the location, duration, and characteristics of pain, but rarely include concomitant psychological assessment frameworks. As previously noted in this submission, perception of pain is influenced by multiple subjective aspects that are as important for pain management as these more measurable components.

Follow up services

In addition to education at the time of prescribing, people who are discharged from hospital (whether from emergency or as an in-patient) should receive post discharge follow up services that include discussion about their pain and its management, as a matter of course. Providing escalation services to patients following discharge will also reduce "just in case" opioid prescribing and re-presentation, by giving patients a supported avenue to discuss their situation and concerns relating to their pain. It would be useful if this included access to a 24-hour pain management telehealth support service, staffed by experienced health practitioners providing evidence-based best practice advice and referral. Offering a service of this kind would also contribute to a reduction in presentations to emergency departments, and to changing public expectations about pain and its management.

Clear prescribing guidelines

National guidelines that relate to the type of presentation, along the lines of the study by Scully et al. cited on p. 23 of the discussion paper would further assist prescribers to determine the most appropriate dose and duration of opioids for each patient. This would still allow individual clinical assessment that incorporates features specific to the patient, but would standardise practice in line with evidence. These guidelines should be informed by the risk factors for opioid overuse listed in Table 3 of the discussion paper (p. 24), thereby bringing prescriber's attention to populations at higher risk.

Health care system review

As described above the overall design and function of the health care system is a factor in the way pain is managed. Improving patient flow through the provision of increased in and out-patient services, increased availability of community-based care services out of business hours, and greater leadership to address these overarching issues impacting on best practice, is essential.

What doesn't work and should be done less?

Please see our response to question one.

4. What indicators should be used to measure progress?

- Data demonstrating greater utilisation of nurse practitioners, particularly in emergency departments, surgical units, outpatient pain clinics, and general practice;
- Increased number of community clinics operating outside business hours;
- Higher levels of access to non-pharmacological modalities;
- Increased uptake and utilisation of My Health Record (with recognition that this data is influenced by multiple factors, and that a majority of Australians already have a My Health Record, albeit often only partially complete);[10]
- The implementation of real-time prescribing programs in all states and territories to better enable prescribers to evaluate the opiate knowledge of their patients, individual risk, and patterns of opiate use;
- Fewer prescriptions for opiates, measured as number of scripts, number of doses prescribed, and number of repeats; and
- Increase in unused opioids being returned to pharmacies for disposal.

CONCLUSION

Thank you for the opportunity to participate in this consultation and provide feedback on the ACSQHC *National Opioid Analgesic Stewardship Program Discussion Paper* on behalf of our membership. The Commission's Discussion Paper highlights the need for a multi-faceted and integrated approach to quality use of medicines. As nurses and midwives have a crucial role in managing and administering medicines, prescribing, providing patient education and planning care, their involvement in successful opioid stewardship is essential. The ANMF supports the work of the Commission to address opioid over use and misuse.

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