ANZCA
FPM

4 June 2021

Adjunct Professor Debora Picone
Chief Executive Officer
Australian Commission on Safety and Quality in Health Care
Level 5, 255 Elizabeth Street
Sydney NSW 2000

By email: Steve.Waller@safetyandquality.gov.au

Dear Professor Picone,

## National Opioid Analgesic Stewardship Program - Discussion paper

Thank you for inviting the Australian and New Zealand College of Anaesthetists (ANZCA), including the Faculty of Pain Medicine (FPM), to provide feedback in relation to the Australian Commission on Safety and Quality in Health Care's *National Opioid Analgesic Stewardship Program - Discussion paper*.

ANZCA is committed to setting the highest standards of clinical practice in the fields of anaesthesia, perioperative medicine and pain medicine. In addition to promoting best practice and ongoing continuous improvement that contributes to a high quality health system, the college is responsible for the postgraduate training programs of anaesthetists and specialist pain medicine physicians.

Opioid analgesic stewardship is of great relevance to specialist pain medicine physicians, who treat acute pain (including post-operative and post-trauma), cancer pain and chronic non-cancer pain, as well as anaesthetists, who have an important role in the perioperative care of surgical patients including treatment of postoperative pain.

We are pleased to note the inclusion of the college's *Statement on principles for identifying and preventing opioid induced ventilator impairment (OIVI)*, and FPM professional document *PM01 (Appendix 2) Opioid Dose Equivalence - Calculation of oral Morphine Equivalent Daily Dose (oMEDD)*. We would like to advise that these documents are both currently under review, as are ANZCA professional documents *PS41 Guideline on acute pain management* and *PS45 Statement on patients' rights to pain management and associated responsibilities*.

We also note the intention to develop a clinical care standard for opioid analgesic prescribing. However, noting that the scope of the current consultation is limited largely to situations of acute pain, we would hope that any such standard clearly identifies that scope for two reasons. Firstly, the intention of such a standard clearly has a large preventative component with respect to opioid harms, and secondly, it is unlikely that such a standard would be equally applicable to opioid analgesic prescribing in the situations of cancer pain and of chronic non-cancer pain. The college would be pleased

ANZCA
FPM

to provide suitable nominations for specialist pain medicine and anaesthesia representatives for the development of this clinical care standard.

Further feedback on the discussion paper is attached.

Thank you again for the opportunity to comment. Should you require any further information, please do not hesitate to contact ANZCA policy staff in the first instance at policy@anzca.edu.au.

Yours sincerely

Associate Professor Michael Vagg
**Dean, Faculty of Pain Medicine**

Feedback on the National Opioid Analgesic Stewardship Program Discussion Paper

| | |
|---|---|
| Name | Associate Professor Michael Vagg |
| Organisation | The Australian and New Zealand College of Anaesthetists, including the Faculty of Pain Medicine |
| Email Address | Policy@anzca.edu.au |
| | |
| With the aim to reduce potentially inappropriate prescribing of opioid analgesics in the EMERGENCY DEPARTMENT: | |
| **1. What is considered best practice in 2021? What works and should be done more? What doesn't work and should be done less?** | Acute pain management that is individualised, evidence-based, consistent with policy and guidelines, appropriate for patient risks (most notably addiction), and takes into account patient values/goals. This must be taught well to doctors at all levels of training. Use of lower-risk opioids such as buprenorphine and tapentadol where there is no contraindication to their use should be preferred.<br><br>What does not work:<br>Some patients get nonsteroidal anti-inflammatory drugs (NSAIDS) when they should not, and some do not get them when they should. Opioids are started without a clear plan of when/how to stop them, in a variety of contexts. There appears to be a growing number of children and adolescents prescribed newer opioids (such as buprenorphine and tapentadol) in the absence of the safety and efficacy data for this age group.<br><br>Communication between individuals/teams/hospitals and the community is poor. This applies to medication reconciliation on admission to hospital and variable timeliness of discharge communication from EDs and hospitals. Communication often does not include step-down plans for medications started to treat acute, time-limited conditions.<br><br>It is important to recognise that pain management is much more than opioids - we should be talking about pain management stewardship. The prescribing of non-opioid analgesics also needs to be safe, individualised, and best practice including plans for medication discontinuation. Furthermore, analgesic prescribing should never be 'stand-alone' – that is, treatments other than drugs should be used, such as education, reassurance, physical therapies, treating health-related anxiety, catastrophizing, co-existing anxiety or depression. |
| **2. What are the system-wide challenges that need to be addressed?** | The teaching of pain management in primary medical programs has much room for improvement. Curricula are available, but not applied well across Australia. |
| **3. What are the gaps that inhibit achieving positive patient outcomes?** | There are gaps between evidence and practice in the management of acute pain, cancer pain and chronic non-cancer pain. Each and all of these types of pain are being seen in emergency departments. There are also knowledge gaps; as mentioned above, pain is not taught well and consistently to doctors and nurses. Achieving safety and quality improvements that benefit patient outcomes requires the investment of leadership, time (money) and effort. There is currently a gap in leadership and culture in relation to |

| | |
|---|---|
| | supporting the required change and improvements. Pain management stewardship needs to be prioritised by health boards, executives, and government. |
| **4. What indicators should be used to measure progress?** | Patient education is provided about what to expect – minimum would be documentation of the medication tapering instructions on discharge summaries; ideal would be a patient pain education 'checklist' including things like: what is acute pain; assurance of bodily safety (as appropriate); things to consider alongside medication (healthy eating, meaningful and fun activity while recovering); how to use medication; when to reduce and cease it; when to see local doctor.<br><br>Safe opioid prescribing is tailored to documented need.<br><br>Consumer satisfaction.<br><br>Reduced opioid-related harms, in and out of hospital. |
| | |
| With the aim to reduce potentially inappropriate prescribing of opioid analgesics FOLLOWING SURGICAL PROCEDURES: | |
| **5. What is considered best practice in 2021? What works and should be done more? What doesn't work and should be done less?** | See response to Q1.<br><br>Multimodal opioid-sparing analgesia including use of local anaesthesia, keeping in mind that many patients are intolerant/allergic to NSAIDS and need something in addition to paracetamol alone.<br><br>Care is taken to avoid unconscious bias in analgesic prescribing and pain management in general. In particular, stigmatised groups include but are not limited to: Aboriginal and/or Torres Strait Islander peoples, those with mental health conditions, and those who have past or current alcohol and other drug disorders. Unfamiliarity with or fear of prescribing to children can also create unconscious bias that is detrimental to analgesic decision-making. Prescriber education on managing analgesia for individuals in these groups is needed. The Declaration of Montreal requires that pain management is delivered without discrimination.<br><br>Medical staff should be able to provide adequate inpatient care, including provision of analgesia without fear of recrimination/reporting. Inpatient and outpatient analgesia should be differentiated, with pathways for each, as they are likely to be different. |
| 6. What are the system-wide challenges that need to be addressed? | Challenges include:<br>• Bridging practice in public and private; in the hospital and the community; and between regions.<br>• Disconnect between hospital pharmacy and community pharmacy/General Practice.<br>• There is a need for real-time prescription monitoring that connects with hospitals. |

| | |
|---|---|
| | • Patients and their medications 'live' in households. Medicine's focus on the individual patient out of context may place entire households at risk. Lethal overdose in children who access household medicines is one example. Currently real time prescription monitoring tends to perpetuate this focus. A social view of 'every patient, every time' is needed.<br>• Lack of organized acute pain teams, which with appropriate support can be led by nurse specialists.<br>• Lack of immediate-release tapentadol and buprenorphine availability on the Pharmaceutical Benefits Scheme (PBS) encourages use of higher-risk opioids. |
| 7. What are the gaps that inhibit achieving positive patient outcomes? | Patient education in relation to expectations for pain, pain management, and rehabilitation.<br><br>Those writing discharge scripts may not have an understanding of the operation or the post-operative course. There is often considerable time-pressure at these discharge 'moments' – this would benefit from safety measures that have been applied elsewhere in medicine such as developing a culture that values a discharge preparation 'time-out' in which education, prescription and tapering instructions are checked, and handover of care is assured.<br><br>Lack of dedicated pain teams means that pain management decisions are not given enough thought or are made with incomplete information to be optimal. |
| 8. What indicators should be used to measure progress? | Dispensing/prescribing practice by procedure/specialty, by region.<br><br>Analysing variance in above between stigmatised groups and others to determine whether variations are warranted or unwarranted.<br><br>Incidence of harm.<br><br>Patient/General Practitioner satisfaction with discharge planning. |
| | |
| With the aim of improving quality and safe use of opioid analgesics through improved prescriber competency, education, training and continuing professional development, interventions have a role to play in changing prescriber behaviour. | |
| 9. What is considered best practice in 2021? What works and should be done more? What doesn't work and should be done less? | See response to Q1. |
| 10. What are the system-wide challenges that need to be addressed? | It may be difficult to avoid multiple prescribers for one patient in some settings, for example perioperatively when the patient is discharged back to the care of the General Practitioner, or in the |

| | |
|---|---|
| | private setting for similar reasons. An emphasis on closed-loop communication in relation to pain management plans and principles, and a shared understanding of the models/principles to inform practice between specialties may help to address this. The discussion paper refers to the role education has at an early postgraduate level, involving key personnel like Pharmacists, and works to establish a standard for common practice, which is helpful.<br><br>There is an enormous gap in entry-to-practice (undergraduate) education and training for health care professionals including medical students, pharmacists, nurses and physiotherapists regarding acute pain management and how to respond when acute pain should have subsided but ongoing pain persists (the transition to chronic pain state). |
| 11. What are the gaps that inhibit achieving positive patient outcomes? | Gaps include:<br>• Individual access to this education, as well as understanding and adherence in prescribing practice.<br>• Patient understanding and expectations.<br>• Lack of uptake of existing resources/practice tools such as those provided by NPS Medicinewise. |
| 12. What indicators should be used to measure progress? | Patient and staff surveys that target knowledge/understanding, and satisfaction i.e. patients with pain control and education received and how this affected expectations; prescribers with knowledge, impact on prescribing, individual impression of efficacy of guidelines when instituted. |
| 13. Do you have any further comments or feedback? | |

Pain management stewardship involves policies, guidelines, and procedures that support best practice pain management: not limited to opioids but including non-opioid drugs and non-drug treatments (exercise, cognitive behavioural therapy, rehabilitation, consumer knowledge/confidence). Patient goals and values, risks and benefits, and informed choices should be the focus, rather than opioids. This requires cultural change, leadership, funding, and clinician training with quality improvement processes.

With regard to the scope vs outcome – there appears to be a mismatch. The scope of the consultation refers to 'patients presenting with acute pain' and includes clinical settings in which acute pain is the majority problem. It does not include nor specifically address complex, chronic or cancer-related pain. That the outcome is proposed to lead to a (singular) Clinical Care Standard is concerning unless the scope of that standard is explicitly limited to 'patients presenting with acute pain'.

With regard to the World Health Organisation (WHO) section – the latest WHO *Guidelines for the management of chronic pain in children* acknowledged that whenever opioid is prescribed for acute pain or pain in the context of life-limiting conditions, the principle of opioid stewardship should be applied, and defined opioid stewardship as follows (p.vii):

> ***"Opioid stewardship:*** *Opioid stewardship refers to a series of strategies and interventions involving the appropriate procurement, storage, prescribing and use of opioids, as well as the disposal of unused opioids when opioids are appropriately prescribed for the treatment and management of specific medical conditions. The goal of opioid stewardship is to protect and optimize individual and population health. Specifically, the goals are to ensure the rational use of opioids: meeting the*

*needs of individuals who require pain control, while minimizing harms to the individual and to other persons and populations. These harms include those that may arise from opioid overuse, misuse and diversion. The essential practices of opioid stewardship in children are fourfold:*

i. *Opioids must only be used for appropriate indications and prescribed by trained providers, with careful assessments of the benefits and risks.*
ii. *The use of opioids by individuals, their impact on pain and their adverse effects must be continuously monitored and evaluated by trained providers.*
iii. *The prescribing provider must have a clear plan for the continuation, tapering or discontinuation of opioids according to the child's condition. The child and family must be apprised of the plan and its rationale.*
iv. *There must be due attention to procurement, storage and the disposal of unused opioids."*

Aligning with this new definition would be wise.

In addition in point 5 of the WHO section – *'Establish a nationally consistent measure of morphine equivalents (for example oral Morphine Equivalent Daily Dose – oMEDD)'* requires inclusion of child conversion factors (e.g. per kg body-weight oMEDD) lest children and adolescents be left out of risk mitigation strategies.

There is an error on p.15: 'the Sydney Children's Hospital' should be 'The Children's Hospital at Westmead' or 'Sydney Children's Hospital Network – Westmead Campus' – correct attribution is important.

Missing sources that seem relevant include:

- Therapeutic Guidelines – Pain & Analgesia
- Australian Medicines Handbook Children's Dosing Companion
- Prescription opioid dispensing in Australian children and adolescents: a national population-based study - The Lancet Child & Adolescent Health
- Prescription Opioids in Adolescence and Future Opioid Misuse (nih.gov)