1.0 Project Summary

In February 2013, the Australian College of Rural and Remote Medicine (ACRRM) were approached by the New South Wales Agency for Clinical Innovation (ACI) for the purpose of organising an educational event for rural and remote General Practitioners. This event was intended to support the ACI’s project initiative for the coordination and development of the Chronic Pain Toolkit.

ACRRM’s Fellowship Services agreed to administrate and host a virtual classroom event which would be marketed primarily to ACRRM members. The event was hosted online via ACRRM’s Blackboard Eluminate virtual classroom on the Rural and Remote Medical Education Online (RRMEO) platform. It included a one hour educational seminar on the topic of pain management, presented by pain specialist, Dr Chris Hayes, followed by a moderated focus group to discuss key areas impacting on the development of the Chronic Pain Toolkit.

The Pain Management Virtual Classroom was held on Monday 7th May, 2013 from 7:30 pm – 9:30 pm (AEST). After participating in the event, it was intended that participants would be able to:

- Describe the new evidence surrounding the neurophysiology of pain including “neuroplasty”.
- Discuss the importance of preventing the transition from acute to chronic pain.
- Describe what the ‘whole person’ approach is in the context of chronic pain.
- Identify a range of tools and resources used in the management of chronic pain.
- Evaluate safety and efficacy of long term opioid use for chronic pain in primary care.

A primary objective of the event for the ACI was the collection of insights and feedback from General Practitioners as to how chronic pain is currently being treated. This was the purpose of the moderated focus group which was structured to gather the relevant data, particularly with regard to assessment, patient education and the implementation of management plans. The focus group was moderated by Dr Louise Stone who is an experienced and skilled online facilitator.
2.0 Actual performance against the objectives of the project

The Pain Management Virtual Classroom was successfully orchestrated and seen to achieve the objective of gathering General Practitioner insights necessary to contribute the ACI’s project and the development of the Chronic Pain Toolkit.

2.1 Delivery of the event

The event was marketed to ACRRM members as the *Pain Management Virtual Classroom*. The title of the educational seminar presented by Dr Chris Hayes was “A focus on pain: applying new evidence in general practice”. Marketing initiatives commenced approximately 6 weeks prior to the event and generated a sound volume of interest with a total of 47 registrations.

The Rural and Remote Medical Education Online (RRMEO) is ACRRM’s online education platform. As ACRRM’s member base is spread across rural and remote Australia the virtual classroom is a critical tool for Practitioners, who may otherwise be isolated, to learn and collaborate online.

Actual attendance to live virtual classrooms is generally lower than initial registered numbers. The total number of attendees was twenty-seven. The education component (Dr Hayes’ seminar) was presented using a powerpoint presentation, with participants able to ask questions via the chat function. The focus group, facilitated by Dr Louise Stone, was an opportunity for participants to share opinions and insights, while also interacting with other participants. Insights were shared mostly via the chat functionality and other interactive features of the virtual classroom technology.

The facilitator used a variety of strategies to engage participants and guide the discussions including chat, polling, powerpoints, and whiteboard.

Dr Hayes’ lecture presentation incorporated the main discussion areas concerning the assessment of chronic pain, patient education, and pain management treatment plans. These areas formed the primary focus of the moderated group discussions and were reflected the data gathering exercises for pre and post activities.

The event was accredited by ACRRM for continuing professional development and awarded 2 core points toward the individual’s Professional Development Program (PDP) points.
2.2 Pre and Post Event Activities

Registered participants were given several opportunities to prepare for the technological and equipment requirements of a virtual classroom. At least three notifications were emailed to all registrations in order to avoid technology problems on the night.

One week prior to the event, all registrations were sent pre-reading materials and a link to the Pre-activity Survey. These activities served two purposes: firstly, to provide the participant with an understanding of the topics that would be presented and discussed; secondly, for the gathering of data, insights and practice methodologies. The pre-activity survey link was sent by email four times in an effort to encourage completion and heighten participation. Questions included:

1. What assessment tools do you use in your clinical practice for chronic pain?
2. What educational materials do you recommend for chronic pain patients?
3. What management strategies do you use in your clinical practice for chronic pain patients?

A total of 28 people responded to the pre-activity survey. This report is not intended to analyse results and all results have been forwarded on to the ACI.

The Post-activity Survey was sent on Wednesday 8th May, 2013, the day following the virtual classroom. The survey was a modified version of the pre-survey. It was re-sent a few days later to encourage completion. Questions included:

1. Would you consider using any of the assessment tools discussed in the presentation for your chronic pain patients? Please explain.
2. Would you consider using any of the management strategies discussed in the presentation for your chronic pain patients? Please explain.
3. Would you consider using any of the education material discussed in the presentation for your chronic pain patients? Please explain.
4. Do you have any further comments or suggestions regarding pain management tools and resources that could benefit you in your clinical practice?

A total of 14 people completed the post-activity survey. This report is not intended to analyse results and all results have been forwarded on to the ACI.

2.3 Focus Group Summary

While this report is not intended to analyse the results of the focus group, Dr Louise Stone has provided a summary of the focus group discussions. Dr Stone facilitated the focus group as guided by the ACI’s project objectives and used her own clinical
experience to manage the group process. The Focus Group Summary prepared by Dr Stone is provided in Appendix A.

3.0 Project Statistics

Of the 27 attendees, each of the rural and remote area classifications was represented. The Rural and Remote Areas classifications range from RA1-RA5, in which RA1 represents locations in major cities and RA5 represents the most remote locations. Attendees were also present from most states with NSW being the dominant representative and nil attendees from Western Australia.

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4.0 Event Advertising

The Pain Management Virtual Classroom was advertised by featuring on the front page of the ACRRM website up to 5 weeks prior to the event date. This included a direct link to the online registration form. It was also advertised 3 times in the College weekly newsletter “Country Watch”.
Appendix A: Focus Group Summary

Discussion point generated for Management Tools

- Few templates are currently in use although most participants commented that they would use the GPMP templates available to them.
- It would be helpful to have new templates articulating with medical software for ease of use.
- New templates would also need to articulate with GPMP templates, because of the high likelihood of co-morbidity of other chronic disease (e.g. depression) and the need to access other providers through the GPMP/TCA process through Medicare.
- Need to include agreements e.g. opioid agreements.

Feedback generated for Education Resources

1. Brainman:
   Rarely used
   Visually appealing and engaging with a low reading age (which makes it user friendly). Brief; this is appropriate in primary care and succinct. Not condescending or patronising and prepares the patient for multidisciplinary engagement, which is important. Would be good to have corresponding handouts that are available through the medical software so individual plans can be generated using the visual imagery (e.g. the hand) to reinforce the message.

2. Website www.hnehealth.nsw.gov.au/pain. Too visually busy and “left-brained” for the average patient and likely to be overwhelming. Reading age appears to be too high and cognitive load of the web structure is also very high. Would need a good command of written English which is often a problem. Might be an appropriate source of handouts. Would need “shepherding” through this tool, particularly if the patient was overwhelmed (e.g. with pain and/or depression). Easy to feel helpless and hopeless which would be exacerbated by such an overwhelming site. One doctor has space for patients to use websites, but mostly patients use them in their homes. Is it possible for patients to use this in the practice somewhere? Do we “prescribe” viewing? Aboriginal patients might struggle with this as English is often their third or fourth language. Internet access can be a problem in remote areas.

3. Effective pain management in general practice several participants have accessed this (prompted by pre-reading).

Suggestions for other resources:

- Brief information such as life scripts (http://www.health.gov.au/lifescripts), opiates and their limitations, nutrition (anti-inflammatory effects).
- One page mind map/ visual hand tool? Telehealth access to psychologists/allied health practitioners/chronic pain specialists. Educate specialists not to foster inactivity.
GP study into the long term use of opiates (ground up primary care study) different cohort, different results

Feedback generated for Assessment Tools

1. DN4 rarely used, but the questions are incorporated into normal practice, so may be a trigger for questions
   Could be used to validate their symptoms, make them understand that their symptoms are “real”
   Could justify that the symptoms justify use of medication other than opiates
2. Brief pain inventory rarely used
   Not readily available in medical software so “clunky” to use in practice
   Would be easier to use as an “app”
   May be too lengthy to complete: too complex for many patients as an ongoing tool
3. Orebro
   Rarely used
   Looks very formal, is that intimidating?
4. DASS
   Commonly used in general practice
   Not intuitive to use it for pain management. May be perceived as offensive, may imply “it’s all in my head”
   Patients have often been dismissed, or belittled, or stigmatised
5. K10
   Less stigmatising, less depression focussed,
   Available in community languages
   Questions around worthlessness are always difficult, and must be carefully handled.
   Brief and can be spoken as well as written, so useful for patients with low literacy or poor cognitive function

What are we missing?
- Tools that measure function: how is pain affecting your life
- Satisfaction with treatment
- Self-efficacy and powerlessness
- PTSD screen
- Tools to address fear associated with opioids (going on them) e.g. stigma/shame