

Referrals to a Regional Rehabilitation Clinic in South Western New South Wales, Australia

Yuriko Watanabe*

Sacred Heart Rehabilitation Service, St Vincent's Hospital, Sydney, Australia

Abstract

An outreach fly-in fly-out rehabilitation medicine service has been established at a regional centre in south western, New South Wales, Australia to support local practitioners. This service includes an outpatient clinic, and an inpatients case conference and consultations. This study examined new referrals to the regional rehabilitation clinic over a 12 month period. There were 94 new patients with the median age of 57.5 years. The main reason for referral was non-cancer pain assessment and management (60 patients, 63.8%); followed by post hospital discharge follow up (26 patients, 27.7%). The majority of patients with pain were already on opioid therapy at the time of initial consultation. 18 patients were found to be on a high dose of opioids (>100 mg/day of oral morphine or equivalent) with no recent pain specialist input. Risks of opioid related problems were assessed and identified in those patients with a high dose of opioid therapy. Reasons and barriers influencing opioid therapy for non-cancer chronic pain in the regional area are discussed. Further study is required to establish specialist rehabilitation medicine needs from local general practitioners perspective in regional areas.

Keywords: Regional rehabilitation clinic; Chronic non-cancer pain; Opioids therapy; Opioid risk assessment

Introduction

Health services in rural and remote areas in Australia are different from the ones in urban areas. In rural and remote areas, facilities are generally smaller and health services are more dependent on primary health care services [1]. People living in outer regional and remote areas seem to require travelling further and waiting longer to access primary care or local hospital services [1]. In addition, access to specialist services is more difficult when compared to people who live in urban areas [1].

The Sacred Heart Rehabilitation Service at St Vincent's Hospital in Sydney provides outreach fly-in fly-out rehabilitation medicine services to regional hospitals in New South Wales (NSW), Australia. The outreach rehabilitation service includes an outpatient clinic, inpatient consultations and an inpatients/outpatients case conference.

A rehabilitation physician flies to Griffith, south western NSW (570 km from Sydney) every Monday to run a clinic in the morning followed by an inpatient case conference and consultations at the Griffith Base Hospital (GBH). The rehabilitation physician runs an all day clinic on alternative Tuesday. The GBH which is the 114 bed facility provides medical services including emergency and intensive care, surgical and renal dialysis. According to the Australian Standard Geographical Classification - Remoteness Area, Griffith is classified as Outer Regional Australia [2]. The GBH has a role in providing a hub for health care services for surrounds (ie, Remote Australia).

The majority of outpatient referrals to the rehabilitation clinic are from local general practitioners (GPs) who practice in Griffith and surrounds. The remainder is post hospital discharge follow up. However, relatively little is known about the types of conditions seen in regional rehabilitation clinics.

Aim

This study reviewed new referrals to the rehabilitation clinic at Griffith Base Hospital over a 12 month period.

Methods

Data were extracted from consultant's letters to GPs from January 2012 to December 2012. Simple descriptive analysis was used. Ethics approval was not required as this was purely an audit project.

Results

A total of 94 new patients were reviewed during the study period. The mean age was 57.9 years old (median 57.5, range 12 - 91). The main reason for referral was pain assessment and management (60 patients, 63.8%); followed by post hospital discharge follow up (26 patients, 27.7%) (Table 1).

In the pain assessment and management group (n=60), 58 patients had chronic non-cancer pain and 2 patients had subacute non-cancer pain. Out of 60 patients, 47 patients (78.3%) were already on opioids. Of these, 18 patients (1 in 2.6 patients) were taking a high dose of opioids, >100 mg/day of oral morphine or equivalent [3]. Only 3 patients out of 18 patients were reviewed by pain specialists in the past, however none of these patients were regularly monitored by the pain specialists at the time of the initial assessment in the rehabilitation clinic. Table 2 shows

Reasons for referrals (or conditions)	No. of patients	%
Non-cancer pain assessment and management	60	63.8
Hospital discharge follow up	26	27.7
Stroke (did not require hospital admission)	2	2
Fitness to drive (dysphasia following stroke)	1	1
Unspecified myopathy	1	1
Assessment of neck posture of the nursing home resident	1	1
Spinal Cord Injury (traumatic)	1	1
Spinal Cord Injury (non-traumatic)	1	1
Mobility assessment following vestibular disease	1	1

Table 1: Reasons for referrals to the regional rehabilitation clinic in Griffith, NSW (n=94).

*Corresponding author: Yuriko Watanabe, Sacred Heart Rehabilitation Service, St Vincent's Hospital, 170 Darlinghurst Road, Darlinghurst, NSW 2010, Australia, Tel: +61 2 8382 9516; Fax: +61 2 8382 9431; E-mail: ywatanabe@stvincents.com.au

Received October 18, 2013; Accepted October 28, 2013; Published November 30, 2013

Citation: Watanabe Y (2013) Referrals to a Regional Rehabilitation Clinic in South Western New South Wales, Australia. Int J Phys Med Rehabil 1: 167. doi:10.4172/2329-9096.1000167

Copyright: © 2013 Watanabe Y. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

characteristics and opioid related risks [4,5] of those who were on a high dose of opioids at the initial assessment.

In the post discharge follow up group (n=26), the main underlying conditions were orthopaedic related (eg, fractured neck of femur) (n=15) and stroke (n=6) (Table 3). Among these 26 patients, 7 patients experienced chronic pain.

Discussion

This study showed that chronic non-cancer pain was the most common reason for referrals to the regional rehabilitation clinic in Griffith. It is difficult to compare this outreach rehabilitation service with other research studies because of different rehabilitation care settings. The Australasian Rehabilitation Outcomes Centre (AROC) provides annual reports of outcomes information in ambulatory settings [6]. However, the AROC analyses data of multidisciplinary ambulatory rehabilitation programs [6]. Further studies from other outreach rehabilitation services will be useful to find out if there are geographical differences.

In this study, opioid therapy was already commenced among the majority of patients with pain. This may be because of a number of factors, including increased awareness of chronic pain conditions and developments in pharmaceutical opioid preparations [7]. Blyth and her colleagues reported that one in five Australians suffers chronic pain during their lifetime [8]. However, rural patients have less access to

pain clinics when compared to urban patients [9]. There are also limited non-pharmacological chronic pain treatments (eg, physiotherapy and psychology) in regional and rural areas [10]. Therefore rural GPs might tend to treat their chronic pain patients with opioids. Rural GPs may benefit from greater education about opioid therapy for non-cancer pain management, for example, 'Opioid Risk Management in Chronic Pain Module' organised by the Australasian Chapter of Addiction Medicine [11].

There has been an escalation of the therapeutic use of opioids in chronic non-cancer pain despite inconclusive efficacy [5,7,12]. Adverse consequences such as tolerance, dependence, abuse and opioid-related death seem to be increasing [5,12,13]. Therefore opioid risk assessment is very important before initiating and during opioid therapy [3,5,7]. Chronic non-cancer pain patients who have a history of substance abuse and/or alcohol abuse are at risk of developing opioid misuse [4]. The presence of a mood disorder, a history of legal problems and younger age seem to be predictors of opioid misuse [4,13]. In this study, these problems were found in some patients who were on a high dose of opioids. Such patients should be regarded as 'high risk' and need to be monitored cautiously [5].

There are a number of limitations to the study. People tend to underreport substance problems, therefore predicting opioid misuse among chronic non-cancer pain patients remains a challenge [4]. Patients' information presented here was obtained at the initial assessment only. Further information such as urine drug screen, prescription shopping program service and correspondence from other specialities (eg, psychiatry) is required at follow up [3,5,7]. Lastly, local GPs might just misunderstand about the role of specialist rehabilitation medicine service (eg, drug rehabilitation and functional rehabilitation). Assessing GPs views and perceptions towards the current outreach rehabilitation service and their expectations is necessary in order to meet local GPs needs.

Nevertheless the present study has important implications for provisions of rehabilitation services in regional areas. Rehabilitation physicians who provide services at regional or remote areas need to understand the characteristics of local patients as well as the areas. Locally available other specialist services including fly-in fly-out outreach and telehealth video consultations [14] should be explored to enable local patients to access appropriate health care. A telehealth pain consultation will have a significant role for such chronic non-cancer pain patients seen at GBH. There is also a need to improve communication between a visiting rehabilitation physician and local GPs regarding patient care and specialist rehabilitation medicine needs from GPs perspective.

		comment
Age (mean, (range))	48.6 (27-83)	
Gender	11 Males (61%)	
Previous illicit drug abuse (eg, marijuana, speed, heroin)	3 patients	
Previous alcohol abuse	1 patient	Being seen by the alcohol and drug team
Current illicit drug abuse (self report)	1 patient	marijuana
Current cigarette smoking	7 patients	
Psychiatric comorbidities (from self report and GP referrals) (eg, depression, anxiety, PTSD*, ADHD*)	10 patients	
History of legal problems	2 patients	
Obvious aberrant drug-related behaviours	3 patients	<ul style="list-style-type: none"> • 2 patients insisted specific opioids scripts. • 1 patient reported taking friend's valium and seroquel

*PTSD: Post traumatic stress disorder. ADHD: Attention deficit hyperactivity disorder

Table 2: Characteristics and risk assessment of the patients who were on a high dose of opioids (>100 mg/day of oral morphine or equivalent) (n=18).

Conditions	No. of patients	No. of patients who experienced chronic pain at follow up	No. of patients who were on opioids at follow up
Orthopaedic related	15	5	3
Stroke	6	1	-
Guillain-Barre syndrome	1	-	-
Post spinal surgery	1	-	-
Low back pain	1	1	1
Respiratory condition	1	-	-
Facial palsy (affecting mobility)	1	-	-
Total	26	7	4

Table 3: Underlying conditions in the hospital discharge follow up (n=26) and pain experience.

References

1. Commonwealth of Australia (2012) National Strategic Framework for Rural and Remote Health.
2. <http://www.health.gov.au/internet/otd/Publishing.nsf/Content/RA-intro>
3. Drug and Alcohol Services Australia (2008) Opioid prescription in chronic pain conditions. Guidelines for South Australian general practitioners.
4. Turk DC, Swanson KS, Gatchel RJ (2008) Predicting opioid misuse by chronic pain patients: a systematic review and literature synthesis. Clin J Pain 24: 497-508.
5. Manchikanti L, Abdi S, Atluri S, Balog CC, Benyamin RM, et al. (2012) American Society of Interventional Pain Physicians (ASIPP) guidelines for responsible opioid prescribing in chronic non-cancer pain: Part 2--guidance. Pain Physician 15: S67-116.
6. Australasian Rehabilitation Outcomes Centre (AROC) Ambulatory National Report. January 2012- December 2012.

7. RACP (2009) Prescription Opioid Policy: Improving management of chronic non-malignant pain and prevention of problems associated with prescription opioid use.
8. Blyth FM, March LM, Brnabic AJ, Jorm LR, Williamson M, et al. (2001) Chronic pain in Australia: a prevalence study. *Pain* 89: 127-134.
9. Hogg MN, Gibson S, Helou A, DeGabriele J, Farrell MJ (2012) Waiting in pain: a systematic investigation into the provision of persistent pain services in Australia. *Med J Aust* 196: 386-390.
10. National Rural Health Alliance Inc (2011) Australia's health system needs re-balancing: a report on the shortage of primary care services in rural and remote areas. *Australian Journal of Rural Health*.
11. Australasian Chapter of Addiction Medicine. Opioid Risk Management in Chronic Pain Module. AChAM Online Education Modules.
12. Manchikanti L, Helm S 2nd, Fellows B, Janata JW, Pampati V, et al. (2012) Opioid epidemic in the United States. *Pain Physician* 15: ES9-38.
13. Manchikanti L, Giordano J, Boswell MV, Fellows B, Manchukonda R, et al. (2007) Psychological factors as predictors of opioid abuse and illicit drug use in chronic pain patients. *J Opioid Manag* 3: 89-100.
14. Royal Australasian College of Physicians. Telehealth Guidelines and Practical Tips.

Citation:Watanabe Y (2013) Referrals to a Regional Rehabilitation Clinic in South Western New South Wales, Australia. *Int J Phys Med Rehabil* 1: 167. doi:[10.4172/2329-9096.1000167](https://doi.org/10.4172/2329-9096.1000167)