Appendix

Improving Opioid Prescribing

Caring for Patients with Chronic Pain

Fourth Edition

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This Toolkit reflects knowledge based on the regulatory environment of the State of Vermont, 2012–2025.
Please check indicated websites for updates and new information as you proceed with this project.

University of Vermont
Larner College of Medicine
Office of Primary Care & AHEC

Appendix

Table of Contents: Screening Tools, PDMP Data & Reports

Appendix 1: Initial Assessments

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
		TOTAL	_____	_____

Total Score Risk Category
Low Risk 0 – 3
Moderate Risk 4 – 7
High Risk $\geq$ 8

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005;6(6):432-442. Used with permission.

Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 - 14Q

The Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0 is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP® version 1.0 is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. Version 1.0 -14Q is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Preliminary reliability data (coefficient α) from 175 patients chronic pain patients
- Preliminary validity data from 100 patients (predictive validity)
- Simple scoring procedures
- 14 items
- 5 point scale
- <8 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP® is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP® is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP® scores to decide on a particular patient's treatment.
- The SOAPP® is **NOT** intended for all patients. The SOAPP® should be completed by chronic pain patients being considered for opioid therapy.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

SOAPP® Version 1.0-14Q

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?	0 1 2 3 4
4. How often have any of your close friends had a problem with alcohol or drugs?	0 1 2 3 4
5. How often have others suggested that you have a drug or alcohol problem?	0 1 2 3 4
6. How often have you attended an AA or NA meeting?	0 1 2 3 4
7. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
8. How often have you been treated for an alcohol or drug problem?	0 1 2 3 4
9. How often have your medications been lost or stolen?	0 1 2 3 4
10. How often have others expressed concern over your use of medication?	0 1 2 3 4

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

11. How often have you felt a craving for medication?	0 1 2 3 4
12. How often have you been asked to give a urine screen for substance abuse?	0 1 2 3 4
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
14. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

Scoring Instructions for the SOAPP® Version 1.0-14Q

To score the SOAPP® V.1- 14Q, simply add the ratings of all the questions:

A score of 7 or higher is considered positive.

Sum of Questions	SOAPP® Indication
> or = 7	+
< 7	-

What does the Cutoff Score Mean?

For any screening test, the results depend on what cutoff score is chosen. A score that is good at detecting patients at-risk will necessarily include a number of patients that are not really at risk. A score that is good at identifying those at low risk will, in turn, miss a number of patients at risk. A screening measure like the SOAPP® generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The table below presents several statistics that describe how effective the SOAPP® is at different cutoff values. These values suggest that the SOAPP® is a sensitive test. This confirms that the SOAPP® is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 7 or higher will identify 91% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 7 is .90, which means that most people who have a negative SOAPP® are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP® score (at a cutoff of 7) is nearly 3 times (2.94 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 7 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP® score suggests the patient is really at low-risk, while a high SOAPP® score will contain a larger percentage of false positives (about 30%), while at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

SOAPP® Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 7 or above	.91	.69	.71	.90	2.94	.13
Score 8 or above	.86	.73	.75	.86	3.19	.19
Score 9 or above	.77	.80	.77	.80	3.90	.28

Screener and Opioid Assessment for Patients with Pain (SOAPP)® Version 1.0-SF

The Screener and Opioid Assessment for Patients with Pain (SOAPP)® is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP® version 1.0-SF is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. Version 1.0-SF is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Preliminary reliability data (coefficient α) from 175 patients chronic pain patients
- Preliminary validity data from 100 patients (predictive validity)
- Simple scoring procedures
- 5 items
- 5 point scale
- <5 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP® is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP® is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP® scores to decide on a particular patient's treatment.
- The SOAPP® is **NOT** intended for all patients. The SOAPP® should be completed by chronic pain patients being considered for opioid therapy.

It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

Appendix 1: Initial Assessments

SOAPP® Version 1.0 - SF

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

1. How often do you have mood swings?	0 1 2 3 4
2. How often do you smoke a cigarette within an hour after you wake up?	0 1 2 3 4
3. How often have you taken medication other than the way that it was prescribed?	0 1 2 3 4
4. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0 1 2 3 4
5. How often, in your lifetime, have you had legal problems or been arrested?	0 1 2 3 4

Please include any additional information you wish about the above answers. Thank you.

Scoring Instructions for the SOAPP® Version 1.0-SF

The five questions that make up the SOAPP V.1-SF have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP V.1-SF, add the ratings of the all the questions:
A score of 4 or higher is considered positive.

Sum of Questions	SOAPP® Indication
> or = 4	**+**
< 4	**-**

What does the Short Form Cutoff Score Mean?

In general, there is a trade off between the length of a questionnaire and its accuracy as a screener. Thus, to achieve a shorter form, one must live with poorer sensitivity and specificity. Naturally, the question becomes, "how much accuracy is traded for a shorter form?" The table below compares the Standard 14-item statistics with those of the SOAPP V.1-SF. In our view, while these parameters are clearly not as good as for the full 14-item scoring, the reduction in sensitivity, specificity, positive and negative predictive values and likelihood ratios suggests that the five-item version retains most of the predictive validity of the Standard SOAPP version. As with any screener, the scores above a cutoff will necessarily include a number of patients that are not really at risk. Scores below the cutoff will, in turn, miss a number of patients at risk. A screening measure like the SOAPP generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The values in the table show that the SOAPP short form, like the Standard SOAPP, is a sensitive test. This confirms that the SOAPP is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 4 or higher will identify 86% of those who actually turn out to be at high risk (compared to 91% for the 14-item version). The Negative Predictive Values for a cutoff score of 4 is .85, which means that most people who have a negative SOAPP are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP score (at a cutoff of 4) is more than two and half times (2.59 times) as likely to come from someone who is actually at high risk (compare with 2.94 for the Standard SOAPP). Note that, of these statistics, the likelihood ratio is least affected by prevalence rates. All this implies that by using a cutoff score of 4 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP score suggests the patient is really at low-risk, while a high SOAPP score will contain a larger percentage of false positives (about 33%), while at the same time retaining a large percentage of true positives. The SOAPP is less good at identifying who is not at-risk. Thus, the SOAPP V1-SF appears to strike a reasonable balance between length and ability to detect future aberrant behavior.

SOAPP Version	SOAPP Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ratio
Short Form	Score 4 or above	.86	.67	.69	.85	2.59	.20
Standard	Score 7 or above	.91	.69	.71	.90	2.94	.13

Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R)

The Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R) is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. This is an updated and revised version of SOAPP V.1 released in 2003.

Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP-R is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. SOAPP-R is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Validated with 500 chronic pain patients
- Simple to score
- 24 items
- <10 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP-R is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP-R is **NOT** a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP-R scores to decide on a particular patient's treatment.
- The SOAPP-R is **NOT** intended for all patients. The SOAPP-R should be completed by chronic pain patients being considered for opioid therapy.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

Appendix 1: Initial Assessments

SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

Appendix 1: Initial Assessments

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

Scoring Instructions for the SOAPP®-R®

All 24 questions contained in the SOAPP®-R have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP, add the ratings of all the questions. A score of 18 or higher is considered positive.

Sum of Questions	SOAPP-R Indication
> or = 18	**+**
< 18	**-**

What does the Cutoff Score Mean?

For any screening test, the results depend on what cutoff score is chosen. A score that is good at detecting patients at-risk will necessarily include a number of patients that are not really at risk. A score that is good at identifying those at low risk will, in turn, miss a number of patients at risk. A screening measure like the SOAPP-R generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The table below presents several statistics that describe how effective the SOAPP-R is at different cutoff values. These values suggest that the SOAPP-R is a sensitive test. This confirms that the SOAPP-R is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 18 or higher will identify 81% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 18 is .87, which means that most people who have a negative SOAPP-R are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP-R score (at a cutoff of 18) is 2.5 times (2.53 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 18 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP-R score suggests the patient is very likely at low-risk, while a high SOAPP-R score will contain a larger percentage of false positives (about 30%); at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

SOAPP-R Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ration
Score 17 or above	.83	.65	.56	.88	2.38	.26
Score 18 or above	.81	.68	.57	.87	2.53	.29
Score 19 or above	.77	.75	.62	.86	3.03	.31

How does the SOAPP-R help determine appropriate treatment?

The SOAPP-R should only be one step in the assessment process to determine which patients are high-risk for opioid misuse. The following discussion examines the assessment and treatment options for chronic pain patients who are at risk (high risk or medium risk) and those who are likely not at risk.

Who is at a high risk for opioid misuse? (SOAPP-R score = 22 or greater*)

Patients in this category are judged to be at a high risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at a higher risk for opioid misuse. Some examples of these behaviors or beliefs include a current or recent history of alcohol or drug abuse, being discharged from another physician' care because of his/her behavior, and regular noncompliance with physicians' orders. These patients may have misused other prescription medications in the past. It is a good idea to review the SOAPP-R questions with the patient, especially those items the patient endorsed. This will help flesh out the clinical picture, so the provider can be in the best position to design an effective, workable treatment plan.

Careful and thoughtful planning will be necessary for patients in this category. Some patients in this category are probably best suited for other therapies or need to exhaust other interventions prior to entering a treatment plan that includes chronic opioid therapy. Others may need to have psychological or psychiatric treatment prior to or concomitant with any treatment involving opioids. Patients in this category who receive opioid therapy should be required to follow a strict protocol, such as regular urine drug screens, opioid compliance checklists, and counseling.

Specific treatment considerations for patients in this high-risk category:

- Past medical records should be obtained and contact with previous and current providers should be maintained.
- Patients should also be told that they would be expected to initially give a urine sample for a toxicology screen during every clinic visit. They should also initially be given medication for limited periods of time (e.g., every 2-weeks).
- Ideally, family members should be interviewed and involvement with an addiction medicine specialist and/or mental health professional should be sought.
- Less abusable formulations should be considered (e.g., long-acting versus short-acting opioids, transdermal versus oral preparation, tamper-resistant medications).
- Early signs of aberrant behavior and a violation of the opioid agreement should result in a change in treatment plan. Depending on the degree of violation, one might consider more restricted monitoring, or, if resources are limited, referring the patient to a program where opioids can be prescribed under stricter conditions. If violations or aberrant behaviors persist, it may be necessary to discontinue opioid therapy.

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

Who is at a moderate risk for opioid misuse? (SOAPP-R score = 10 to 21*)

Patients in this category are judged to be at a medium or moderate risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at some risk for misuse. Some examples of these behaviors or beliefs are family history of drug abuse, history of psychological issues such as depression or anxiety, a strong belief that medications are the only treatments that will reduce pain and a history of noncompliance with other prescription medications. It is a good idea to review the SOAPP-R items the patient endorsed with the patient present.

Some of these patients are probably best treated by concomitant psychological interventions in which they can learn to increase their pain-coping skills, decrease depression and anxiety, and have more frequent monitoring of their compliance. They may need to be closely monitored until proven reliable by not running out of their medications early and having appropriate urine drug screens.

Additional treatment considerations for patients in this category:

- Periodic urine screens are recommended.
- After a period in which no signs of aberrant behavior are observed, less frequent clinic visits may be indicated. If there are any violations of the opioid agreement, then regular urine screens and frequent clinic visits would be recommended.
- After two or more violations of the opioid agreement, an assessment by an addiction medicine specialist and/or mental health professional should be mandated.
- After repeat violations referral to a substance abuse program would be recommended. A recurrent history of violations would also be grounds for tapering and discontinuing opioid therapy

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

Who is at a low risk for opioid misuse? (SOAPP-R score < 9*)

Patients in this category are judged to be at a low risk for opioid misuse. These patients have likely tried and been compliant with many other types of therapies. They should be able to handle their medication safely with minimal monitoring. They are apt to be responsible in their use of alcohol, not smoke cigarettes, and have no history of previous difficulties with alcohol, prescription drugs, or illegal substances. This patient probably reports few symptoms of affective distress, such as depression or anxiety.

As noted previously, the SOAPP-R is not a lie detector. The provider should be alert to inconsistencies in the patient report or a collateral report. Any sense that the patient's story "doesn't add up" should lead the provider to take a more cautious approach until experience suggests that the person is reliable.

Patients in this category would be likely to have no violations of the opioid treatment agreement. These patients are least likely to develop a substance abuse disorder. Additionally, they may not require special monitoring or concomitant psychological treatment.

Additional treatment considerations for patients in this category:

- Review of SOAPP-R questions is not necessary, unless the provider is aware of inconsistencies or other anomaly in patient history/report.
- Frequent urine screens are not indicated.
- Less worry is needed about the type of opioid to be prescribed and the frequency of clinic visits.
- Efficacy of opioid therapy should be re-assessed every six months, and urine toxicology screens and update of the opioid therapy agreement would be recommended annually.

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

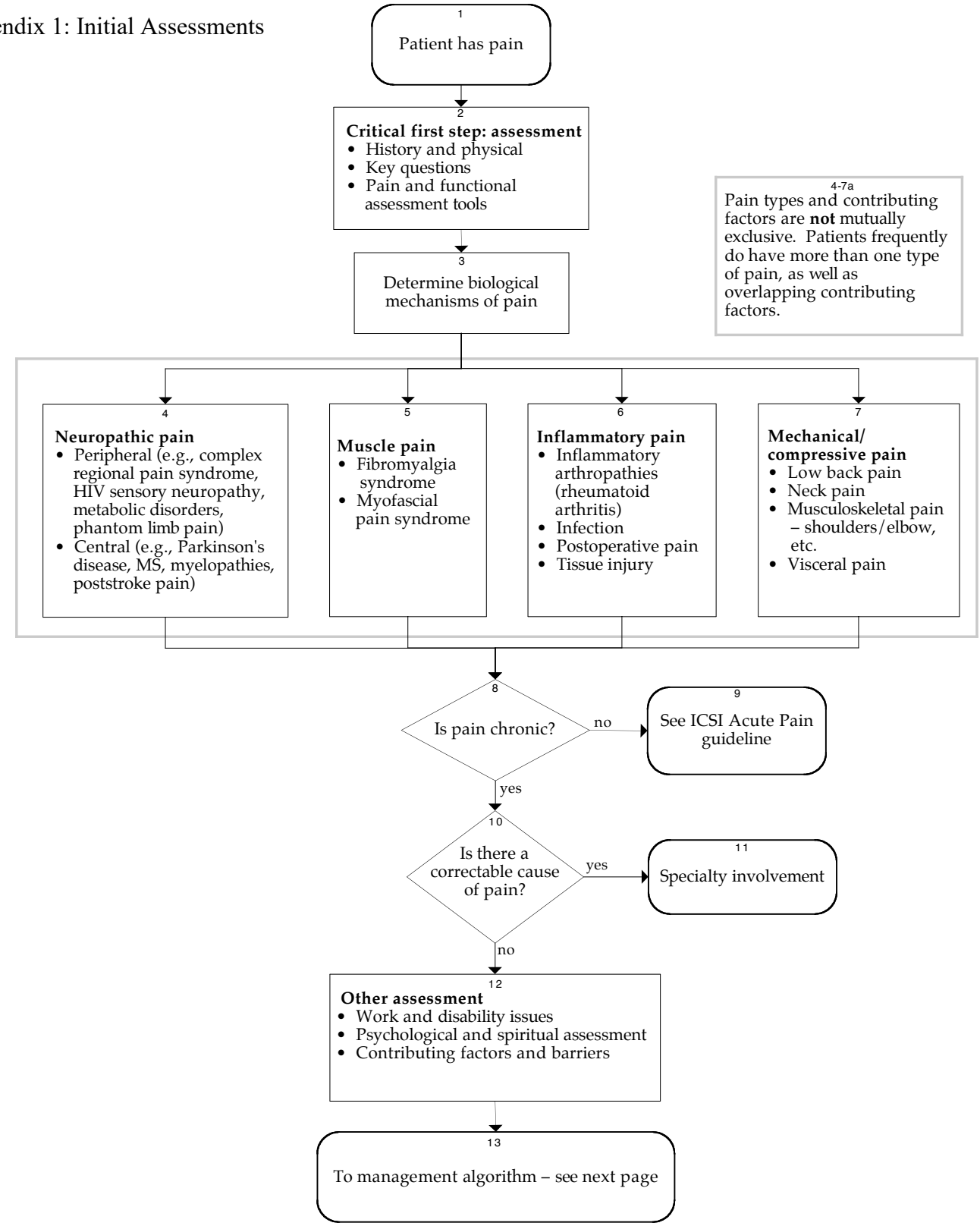
Implementation Tool:

Assessment and Management of Chronic Pain Guideline Summary

Assessment Algorithm

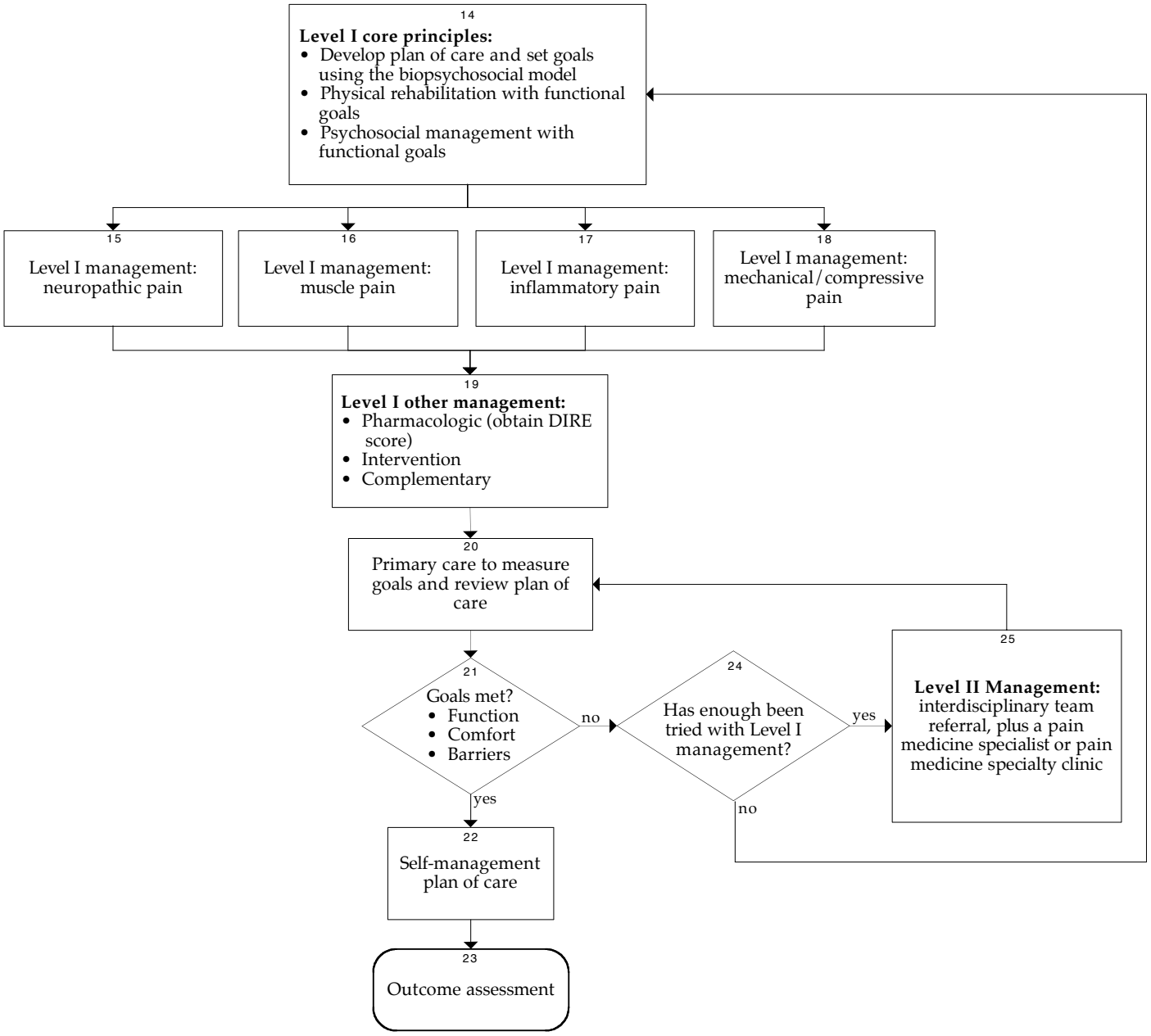
A = Annotation

Appendix 1: Initial Assessments



Management Algorithm

A = Annotation



Key Principles

Chronic pain is defined as persistent pain, which can be either continuous or recurrent and of sufficient duration and intensity to adversely affect a patient's well-being, level of function, and quality of life *(Wisconsin Medical Society, 2004 [R])*. If the patient has not been previously evaluated, attempt to differentiate between untreated acute pain and ongoing chronic pain. If a patient's pain has persisted for six weeks (or longer than the anticipated healing time), a thorough evaluation for the cause of the chronic pain is warranted.

The goals of treatment are an emphasis on improving function through the development of long-term, self-management skills including fitness and a healthy lifestyle.

Assessment

- Chronic pain assessment should include determining the mechanisms of pain through documentation of pain location, intensity, quality and onset/duration; functional ability and goals; and psychological/social factors such as depression or substance abuse.
  - See ICSI Chronic Pain Guideline, Appendix A, "Brief Pain Inventory."
  - See ICSI Chronic Pain Guideline, Annotation #12, "Other Assessment," for example of questions regarding behavioral health, chemical health, spirituality and occupational health.
- The goal of treatment is an emphasis on improving function through the development of long-term, self-management skills including fitness and a healthy lifestyle.
  - A variety of assessment tools have been used in the medical literature for measuring, estimating or describing aspects of a patient's functional ability. See ICSI Chronic Pain Guideline, Appendix C, for an example.

Management

- A patient-centered, multifactorial, comprehensive care plan is necessary, one that includes addressing biopsychosocial factors. Addressing spiritual and cultural issues is also important. It is important to have a multidisciplinary team approach coordinated by the primary care physician to lead a team including specialty areas of psychology and physical rehabilitation.
  - Empathetic listening is critical.
  - Recognize that the term "chronic pain" may elicit a highly emotional resonance with some patients.
  - Use diagnostic and anatomical terms.
  - Focus on improving function.
  - See ICSI Chronic Pain Guideline, Appendix D (or page 7 of this summary) "Personal Care Plan for Chronic Pain."
- Level I treatment approaches should be implemented as first steps toward rehabilitation before Level II treatments are considered.
- Medications are not the sole focus of treatment in managing pain and should be used when needed to meet overall goals of therapy in conjunction with other treatment modalities.

- Careful patient selection and close monitoring of all non-malignant pain patients on chronic opioids is necessary to assess the effectiveness and watch for signs of misuse or aberrant behavior.
    - Physicians should not feel compelled to prescribe opioids or any drug if it is against their honest judgement or if they feel uncomfortable prescribing the drug.
- Review care plan and goals at every visit.

Follow-up Considerations: Involvement of a pain specialist in the care of a patient with chronic pain occurs optimally when the specialist assumes a role of consultation, with the primary care provider continuing to facilitate the overall management of the patient's pain program. It is recommended that the primary care provider receive regular communications from the pain specialist and continue visits with the patient on a regular schedule, even if the patient is involved in a comprehensive management program at a center for chronic pain. The primary care provider should not expect that a consulting pain specialist will assume primary care of a patient unless there has been an explicit conversation in that regard between the consultant and the primary care provider. This is particularly true in regard to the prescribing of opioids: the primary care provider should expect to continue as the prescribing provider, and ensure the responsible use of the opioids through contracts, urine toxicology screens, etc. (the exception to this may occur with the admission of the patient into a opioid tracking program). Conversely, the consulting pain specialist should not initiate opioids without the knowledge and consent of the primary care provider.

Patient Focus Group: Key Learnings for Providers

- Be aware that the term chronic pain may elicit a highly emotional response. Patients may feel discouraged that the pain will never go away despite their hope a cure will be found.
- Although patients would like a quick fix to their pain, frustration occurs when interventions that only provide temporary relief are found or utilized.
- Patients want to be included in the treatment plan. They are often proactive in seeking ways to alleviate or eliminate their pain. They may see several types of physicians and may have also tried to find relief from their pain in additional varieties of ways. **Teamwork and empathetic listening in the development of a treatment plan are critical.**
- When the physician acknowledges that chronic pain affects the whole person and really listens, patients are more likely to be open to learning how to live by managing their pain versus curing their pain.
- Most patients want to return to a normal routine of completing activities of daily living, (e.g., playing with children/grandchildren, going for a walk, and working within their limitations). The focus should be on improving function.
- Many patients have utilized a variety of interventions including medications and complementary therapies.

Cognitive-Behavioral Strategies for Primary Care Physicians

There are a number of cognitive-behavioral strategies that primary care providers can utilize to help their patients manage chronic pain.

- Tell the patient that chronic pain is a complicated problem and for successful rehabilitation, a team of health care providers is needed. Chronic pain can affect sleep, mood, levels of strength and fitness, ability to work, family members, and many other aspects of a person's life. Treatment often includes components of stress management, physical exercise, relaxation therapy and more to help them regain function and improve the quality of their lives.
- Let the patient know you believe that the pain is real and is not in his/her head. Let the patient know that the focus of your work together will be the management of his/her pain. ICSI Patient Focus Group feedback included patient concerns that their providers did not believe them/their child when they reported pain.
- Ask the patient to take an active role in the management of his/her pain. Research shows that patients who take an active role in their treatment experience less pain-related disability.

Opioids: Important Considerations

Before prescribing an opioid, the work group recommends using the DIRE tool to determine a patient's appropriateness for long-term opioid management. See ICSI Chronic Pain Guideline Appendix E (or page 8 of this summary), "DIRE Score: Patient Selection for Chronic Opioid Analagesia."

When there is non-compliance, escalation of opioid use, or increasing pain not responding to increasing opioids, consider whether this represents a response to inadequate pain control (pseudoaddiction, tolerance, or opioid-induced hyperalgesia) or a behavioral problem indicating the patient is not a candidate for opioid therapy.

Physicians must bear in mind that opioids are not required for everyone with chronic pain. The decision to use or continue opioids depends on many factors including type of pain, patient response and social factors. Physicians must have the fortitude to say no to opioids when they are not indicated, and to discontinue them when they are not working.

Discontinuing of opioids is recommended when it is felt that they are not contributing significantly to improving pain control or functionality, despite adequate dose titration. It is recommended that the primary care physician discontinue when there is evidence of substance abuse or diversion. In these cases, consider referral to substance abuse counseling. It is recommended to not abruptly discontinue but to titrate off by decreasing dose approximately 10%-25% per week. When a patient is unable to taper as an outpatient, a clonidine patch or tablets, or referral to a detox facility are potential options.

Personal Care Plan for Chronic Pain

This tool has not been validated for research; however, work group consensus was to include it as an example of a patient tool for establishing a plan of care.

1. Set Personal Goals

- ☐ Improve Functional Ability Score by _____ points by: Date _____
- ☐ Return to specific activities, tasks, hobbies, sports, etc., by: Date _____
  1. _____
  2. _____
  3. _____
- ☐ Return to limited work /or ☐ normal work by: Date _____

2. Improve Sleep (Goal: _____ hours per night, Current: ____hours per night)

- ☐ Follow basic sleep plan
  1. Eliminate caffeine and naps, relaxation before bed, go to bed at target bedtime _____
- ☐ Take night time medications
  1. _____
  2. _____
  3. _____

3. Increase Physical Activity

- ☐ Attend physical therapy (days per week _____)
- ☐ Complete daily stretching (____ times per day, for ____minutes)
- ☐ Complete aerobic exercise/endurance exercise
  1. Walking (____ times per day, for ____minutes) or pedometer (_____ steps per day)
  2. Treadmill, bike, rower, elliptical trainer (____ times per week, for ____ minutes)
  3. Target heart rate goal with exercise _____ bpm

  Strengthening
  1. Elastic, hand weights, weight machines (____ minutes per day, ____ days per week)

4. Manage Stress – list main stressors _____

- ☐ Formal interventions (counseling or classes, support group or therapy group)
  1. _____

  Daily practice of relaxation techniques, meditation, yoga, creative / service activity, etc.
  1. _____
  2. _____

  Medications
  1. _____
  2. _____

5. Decrease Pain (best pain level in past week: ____ / 10, worst pain level in past week: ____ / 10)

- ☐ Non-medication treatments
  1. Ice/heat _____
  2. _____
- ☐ Medication
  1. _____
  2. _____
  3. _____
  4. _____
- ☐ Other treatments _____

Physician name: _____ Date: _____

DIRE Score: Patient Selection for Chronic Opioid Analgesia

The DIRE Score is a clinician rating used to predict patient suitability for long-term opioid analgesic treatment for chronic non-cancer pain. It consists of four factors that are rated separately and then added up to form the DIRE score: Diagnosis, Intractability, Risk and Efficacy. The Risk factor is further broken down into four subcategories that are individually rated and added together to arrive at the Risk score. The Risk subcategories are: Psychological Health, Chemical Health, Reliability, and Social Support. Each factor is rated on a numerical scale from 1 to 3, with 1 corresponding to the least compelling or least favorable case for opioid prescribing, and 3 denoting the most compelling or favorable case for opioid prescribing. The total score is used to determine whether or not a patient is a suitable candidate for opioid maintenance analgesia. Scores may range from 7 at the lowest (patient receives all 1s) to 21 at the highest (patient receives all 3s).

For each factor, rate the patient's score from 1 to 3 based on the explanations in the right-hand column.

Score	Factor	Explanation
	Diagnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, non-specific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	Intractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	Risk	(R= Total of P+C+R+S below)
	Psychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	Chemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug focused or chemically reliant.
	Reliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	Social Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	Efficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

_____Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia
Score 14-21: May be a good candidate for long-term opioid analgesia

Used with permission by Miles J. Belgade, M.D.

Appendix 2: Ongoing Assessments

PEG: A Three-Item Scale Assessing Pain Intensity and Interference

1. **What number best describes your <u>pain on average</u> in the past week?**

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

2. **What number best describes how, during the past week, pain has interfered with your <u>enjoyment of life?</u>**

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

3. **What number best describes how, during the past week, pain has interfered with your <u>general activity</u>?**

0	1	2	3	4	5	6	7	8	9	10
No pain										Pain as bad as you can imagine

From Krebs et al., 2009.

Appendix 2: Ongoing Assessments

COMM 9-- Current Opioid Misuse Measure with 9 items

1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?

2. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from your medications? (i.e., another doctor, the emergency room)

3. In the past 30 days, how often have you seriously thought about hurting yourself?

4. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?

5. In the past 30 days, how often have you needed to take pain medications belonging to someone else?

6. In the past 30 days, how often have you gotten angry with people?

7. In the past 30 days, how often have you had to take more of your medication than prescribed?

8. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?

9. In the past 30 days, how often have you had to visit the emergency room?

Appendix 2: Ongoing Assessments

NAME:_____ TODAY'S DATE: _____

5As Plus

Values By

PEG Pain Screening

What number best describes your pain on average in the past week:	0 (No Pain) 1 2 3 4 5 6 7 8 9 10 (Pain as bad as you can imagine)
What number best describes how, during the past week, pain has interfered with your enjoyment of life?	0 (Does not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interferes)
What number best describes how, during the past week, pain has interfered with your general activity?	0 (Does not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interferes)
PEG Score	

Additional Assessment Questions

What number best describes how, during the past week, pain has effected your mood?	0 (Does not interfere) 1 2 3 4 5 6 7 8 9 10 (Completely interferes)
How often in the last year have you used your prescription medication for non-medical reasons?	0 (Never) 1 2 3 4 5 6 7 8 9 10 (Frequently)
How often do you use your prescription more often than prescribed?	0 (Never) 1 2 3 4 5 6 7 8 9 10 (Frequently)
Are you having any constipation or difficulty with bowel movements?	0 (No constipation) 1 2 3 4 5 6 7 8 9 10 (Severe constipation)
Are you having any other side effects from your medication?	Yes No

Pain Interference – Short Form 6b

Please respond to each item by marking one box per row.

In the past 7 days…

		Not at all	A little bit	Somewhat	Quite a bit	Very much
PAININ3	How much did pain interfere with your enjoyment of life?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ8	How much did pain interfere with your ability to concentrate?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ9	How much did pain interfere with your day to day activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ10	How much did pain interfere with your enjoyment of recreational activities?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAININ14	How much did pain interfere with doing your tasks away from home (e.g., getting groceries, running errands)?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

In the past 7 days…

		Never	Rarely	Sometimes	Often	Always
PAININ26	How often did pain keep you from socializing with others?.....	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

Pain Intensity

Please respond to each item by marking one box per row.

	In the past 7 days…	Had no pain	Mild	Moderate	Severe	Very severe
PAINQU6	How intense was your pain at its worst?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
PAINQU8	How intense was your average pain?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
		No pain	**Mild**	**Moderate**	**Severe**	**Very severe**
PAINQU21	What is your level of pain right now?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

The SF12 survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. **Answer each question by choosing just one answer**. If you are unsure how to answer a question, please give the best answer you can.

1. **In general, would you say your health is**:

☐1 Excellent ☐2 Very good ☐3 Good ☐4 Fair ☐5 Poor

The following questions are about activities you might do during a typical day. Does <u>your health now limit you</u> in these activities? If so, how much?

	YES, limited a lot	**YES, limited a little**	**NO, not limited at all**
2. **Moderate activities** such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	☐1	☐2	☐3
3. Climbing **several** flights of stairs.	☐1	☐2	☐3

During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of your physical health</u>?

	YES	**NO**
4. **Accomplished less** than you would like.	☐1	☐2
5. Were limited in the **kind** of work or other activities.	☐1	☐2

During the <u>past 4 weeks</u>, have you had any of the following problems with your work or other regular daily activities <u>as a result of any emotional problems</u> (such as feeling depressed or anxious)?

	YES	**NO**
6. **Accomplished less** than you would like.	☐1	☐2
7. Did work or activities **less carefully than usual**.	☐1	☐2

8. **During the <u>past 4 weeks</u>, how much <u>did pain interfere</u> with your normal work (including work outside the home and housework)?**

☐1 Not at all ☐2 A little bit ☐3 Moderately ☐4 Quite a bit ☐5 Extremely

These questions are about how you have been feeling during the <u>past 4 weeks</u>.
For each question, please give the one answer that comes closest to the way you have been feeling.

How much of the time during the <u>past 4 weeks</u>…

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm & peaceful?	☐1	☐2	☐3	☐4	☐5	☐6
10. Did you have a lot of energy?	☐1	☐2	☐3	☐4	☐5	☐6
11. Have you felt down-hearted and blue?	☐1	☐2	☐3	☐4	☐5	☐6

12. **During the <u>past 4 weeks</u>, how much of the time has your <u>physical health or emotional problems</u> interfered with your social activities (like visiting friends, relatives, etc.)?**

☐1 All of the time ☐2 Most of the time ☐3 Some of the time ☐4 A little of the time ☐5 None of the time

Patient name: Date: PCS: MCS:

Visit type (circle one)
Preop 6 week 3 month 6 month 12 month 24 month Other:_____

NAME:_____ DATE: _____

PDR Oswestry Neck Pain Questionnaire

This questionnaire is designed to enable us to understand how much your neck pain has affected your ability to manage everyday activities. Please answer each Section by circling the ONE CHOICE that most applies to you. We realize that you may feel that more than one statement may relate to you, but **Please circle the one choice which closely describes your problem *right now***.

Section 1 – Pain Intensity

A. I have no pain at the moment.
B. The pain is mild at the moment.
C. The pain comes and goes and is moderate
D. The pain moderate and does not vary much.
E. The pain is severe, but comes and goes.
F. The pain is severe and does not vary much.

Section 2 – Personal Care

A. I can look after myself without causing extra pain.
B. I can look after myself normally, but it causes extra pain.
C. It is painful to look after myself and I am slow and careful.
D. I need some help, but manage most of my personal care.
E. I need help every day in most aspects of self-care.
F. I do not get undressed, I wash with difficulty and stay in bed.

Section 3 – Lifting

A. I can lift heavy weights without extra pain.
B. I can lift heavy weights but it causes extra pain.
C. Pain prevents me from lifting heavy weights off the floor, But I can manage if they are conveniently positioned (e.g on a table)
D. Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
E. I can lift only very light weights.
F. I cannot lift or carry anything at all.

Section 4 – Reading

A. I can read as much as I want to with no pain in my neck.
B. I can read as much as I want to with slight pain in my neck.
C. I can read as much as I want to with moderate pain in my neck.
D. I cannot read as much as I want to because of moderate pain in my neck.
E. I cannot read as much as I want to because of severe pain in my neck
F. I cannot read at all.

Section 5 – Headache

A. I have no headaches at all.
B. I have slight headaches that come infrequently.
C. I have moderate headaches that come infrequently.
D. I have moderate headaches that come frequently.
E. I have severe headaches that come frequently.
F. I have headaches almost all the time.

Section 6 – Concentration

A. I can concentrate fully when I want to with no difficulty.
B. I can concentrate fully when I want to with slight difficulty.
C. I have a fair degree of difficulty in concentrating when I want to.
D. I have a lot of difficulty in concentrating when I want to.
E. I have a great deal of difficulty in concentrating when I want to.
F. I cannot concentrate at all.

Section 7 – Work

A. I can do as much work as I want to.
B. I can do my usual work but no more.
C. I can do most of my usual work, but no more.
D. I cannot do my usual work.
E. I can hardly do any work at all.
F. I cannot do any work at all.

Section 8 -- Driving

A. I can drive my car without any neck pain.
B. I can drive my car as long as I want with slight pain in my neck.
C. I can drive my car as long as I want with moderate pain in my neck.
D. I cannot drive my car as long as I want because of moderate pain in my neck.
E. I can hardly drive at all because of severe pain in my neck.
F. I cannot drive my car at all.

Section 9 – Sleeping

A. I have no trouble sleeping.
B. My sleep is slightly disturbed (less than 1 hour sleepless).
C. My sleep is mildly disturbed (1-2 hours sleepless).
D. My sleep is moderately disturbed (2-3 hours sleepless).
E. My sleep is greatly disturbed (3-5 hours sleepless).
F. My sleep is completely disturbed (5-7 hours sleepless).

Section 10 – Recreation

A. I am able to engage in all my recreational activities, with no neck pain at all.
B. I am able to engage in all of my recreational activities, with some pain in my neck.
C. I am able to engage in most, but not all of my usual recreational activities because of pain in my neck.
D. I am able to engage in only a few of my usual recreational activities because of pain in my neck.
E. I can hardly do any recreational activities because of pain in my neck.
F. I cannot do any recreational activities at all.

Section 11 – Numeric Rating Scale (NRS)

Try and assign a number from 0 to 10 to your current pain level. If you have no pain, use a 0. As the numbers get higher, they stand for pain that is getting worse. A 10 means the pain is as bad as it can be.

0 1 2 3 4 5 6 7 8 9 10
No pain Mild Moderate Severe Worst Possible Pain

OSW-SCORE:_____%

P-SCORE:_____

RAPID3
ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID3 includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID3 scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	___ 0	___ 1	___ 2	___ 3
b. Get in and out of bed?	___ 0	___ 1	___ 2	___ 3
c. Lift a full cup or glass to your mouth?	___ 0	___ 1	___ 2	___ 3
d. Walk outdoors on flat ground?	___ 0	___ 1	___ 2	___ 3
e. Wash and dry your entire body?	___ 0	___ 1	___ 2	___ 3
f. Bend down to pick up clothing from the floor?	___ 0	___ 1	___ 2	___ 3
g. Turn regular faucets on and off?	___ 0	___ 1	___ 2	___ 3
h. Get in and out of a car, bus, train, or airplane?	___ 0	___ 1	___ 2	___ 3
i. Walk two miles or three kilometers, if you wish?	___ 0	___ 1	___ 2	___ 3
j. Participate in recreational activities and sports as you would like, if you wish?	___ 0	___ 1	___ 2	___ 3
k. Get a good night's sleep?	___ 0	___ 1.1	___ 2.2	___ 3.3
l. Deal with feelings of anxiety or being nervous?	___ 0	___ 1.1	___ 2.2	___ 3.3
m. Deal with feelings of depression or feeling blue?	___ 0	___ 1.1	___ 2.2	___ 3.3

1. a-j FN (0-10):

1=0.3	16=5.3
2=0.7	17=5.7
3=1.0	18=6.0
4=1.3	19=6.3
5=1.7	20=6.7
6=2.0	21=7.0
7=2.3	22=7.3
8=2.7	23=7.7
9=3.0	24=8.0
10=3.3	25=8.3
11=3.7	26=8.7
12=4.0	27=9.0
13=4.3	28=9.3
14=4.7	29=9.7
15=5.0	30=10

2. PN (0-10):

3. PTGE (0-10):

RAPID3 (0-30)

2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK? PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

HOW TO CALCULATE RAPID 3 SCORES

1. Ask the patient to complete questions 1, 2, and 3 while in the waiting room prior to his/her visit.

2. For question 1, add up the scores in questions A-J only (questions K-M have been found to be informative, but are not scored formally). Use the formula in the box on the right to calculate the formal score (0-10). For example, a patient whose answers total 19 would score a 6.3. Enter this score as an evaluation of the patient's functional status (FN).

3. For question 2, enter the raw score (0-10) in the box on the right as an evaluation of the patient's pain tolerance (PN).

4. For question 3, enter the raw score (0-10) in the box on the right as an evaluation of the patient's global estimate (PTGE).

5. Add the total score (0-30) from questions 1, 2, and 3 and enter them as the patient's RAPID 3 cumulative score. Use the final conversion table to simplify the patient's weighed RAPID 3 score. For example, a patient who scores 11 on the cumulative RAPID 3 scale would score a weighed 3.7. A patient who scores between 0–1.0 is defined as near remission (NR); 1.3–2.0 as low severity (LS); 2.3–4.0 as moderate severity (MS); and 4.3–10.0 as high severity (HS).

ROUTINE ASSESSMENT OF PATIENT INDEX DATA

The RAPID includes a subset of core variables found in the Multi-dimensional HAQ (MD-HAQ). Page 1 of the MD-HAQ, shown here, includes an assessment of physical function (section 1), a patient global assessment (PGA) for pain (section 2), and a PGA for global health (section 3). RAPID scores are quickly tallied by adding subsets of the MD-HAQ as follows:

1. PLEASE CHECK THE ONE BEST ANSWER FOR YOUR ABILITIES AT THIS TIME:

OVER THE LAST WEEK, WERE YOU ABLE TO:	WITHOUT ANY DIFFICULTY	WITH SOME DIFFICULTY	WITH MUCH DIFFICULTY	UNABLE TO DO
a. Dress yourself, including tying shoelaces and doing buttons?	X 0	1	2	3
b. Get in and out of bed?	0	X 1	2	3
c. Lift a full cup or glass to your mouth?	0	1	2	X 3
d. Walk outdoors on flat ground?	X 0	1	2	3
e. Wash and dry your entire body?	X 0	1	2	3
f. Bend down to pick up clothing from the floor?	0	X 1	2	3
g. Turn regular faucets on and off?	0	1	X 2	3
h. Get in and out of a car, bus, train, or airplane?	0	1	X 2	3
i. Walk two miles or three kilometers, if you wish?	0	X 1	2	3
j. Participate in recreational activities and sports as you would like, if you wish?	0	X 1	2	3
k. Get a good night's sleep?	X 0	1.1	2.2	3.3
l. Deal with feelings of anxiety or being nervous?	0	1.1	2.2	X 3.3
m. Deal with feelings of depression or feeling blue?	0	1.1	X 2.2	3.3

1. a-j FN (0-10): 3.7

1=0.3 16=5.3
2=0.7 17=5.7
3=1.0 18=6.0
4=1.3 19=6.3
5=1.7 20=6.7
6=2.0 21=7.0
7=2.3 22=7.3
8=2.7 23=7.7
9=3.0 24=8.0
10=3.3 25=8.3
11=3.7 26=8.7
12=4.0 27=9.0
13=4.3 28=9.3
14=4.7 29=9.7
15=5.0 30=10

2. PN (0-10): 2.5

3. PTGE (0-10): 1.0

RAPID3 (0-30) 7.2

2. HOW MUCH PAIN HAVE YOU HAD BECAUSE OF YOUR CONDITION OVER THE PAST WEEK? PLEASE INDICATE BELOW HOW SEVERE YOUR PAIN HAS BEEN:

NO PAIN — PAIN AS BAD AS IT COULD BE

0 0.5 1.0 1.5 2.0 **X 2.5** 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

3. CONSIDERING ALL THE WAYS IN WHICH ILLNESS AND HEALTH CONDITIONS MAY AFFECT YOU AT THIS TIME, PLEASE INDICATE BELOW HOW YOU ARE DOING:

VERY WELL — VERY POORLY

0 0.5 **X 1.0** 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10

CONVERSION TABLE

Near Remission (NR): 1=0.3; 2=0.7; 3=1.0
Low Severity (LS): 4=1.3; 5=1.7; 6=2.0
Moderate Severity (MS): 7=2.3; 8=2.7; 9=3.0; 10=3.3; 11=3.7; 12=4.0
High Severity (HS): 13=4.3; 14=4.7; 15=5.0; 16=5.3; 17=5.7; 18=6.0; 19=6.3; 20=6.7; 21=7.0; 22=7.3; 23=7.7; 24=8.0; 25=8.3; 26=8.7; 27=9.0; 28=9.3; 29=9.7; 30=10.0

HOW TO CALCULATE RAPID 3 SCORES

1. Ask the patient to complete questions 1, 2, and 3 while in the waiting room prior to his/her visit.
2. For question 1, add up the scores in questions A-J only (questions K-M have been found to be informative, but are not scored formally). Use the formula in the box on the right to calculate the formal score (0-10). For example, a patient whose answers total 19 would score a 6.3. Enter this score as an evaluation of the patient's functional status (FN).
3. For question 2, enter the raw score (0-10) in the box on the right as an evaluation of the patient's pain tolerance (PN).
4. For question 3, enter the raw score (0-10) in the box on the right as an evaluation of the patient's global estimate (PTGE).
5. Add the total score (0-30) from questions 1, 2, and 3 and enter them as the patient's RAPID 3 cumulative score. Use the final conversion table to simplify the patient's weighed RAPID 3 score. For example, a patient who scores 11 on the cumulative RAPID 3 scale would score a weighed 3.7. A patient who scores between 0–1.0 is defined as near remission (NR); 1.3–2.0 as low severity (LS); 2.3–4.0 as moderate severity (MS); and 4.3–10.0 as high severity (HS).

Progress Note
Pain Assessment and Documentation Tool (PADT™)

Patient Name: _____ Record #:_____

Assessment Date: _____

Patient Stamp Here

Current Analgesic Regimen

Drug Name	Strength (eg, mg)	Frequency	Maximum Total Daily Dose

The PADT is a clinician-directed interview; that is, the clinician asks the questions, and the clinician records the responses. The Analgesia, Activities of Daily Living, and Adverse Events sections may be completed by the physician, nurse practitioner, physician assistant, or nurse. The Potential Aberrant Drug-Related Behavior and Assessment sections must be completed by the physician. Ask the patient the questions below, except as noted.

Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

2. What was your pain level at its worst during the past week?

No Pain 0 1 2 3 4 5 6 7 8 9 10 Pain as bad as it can be

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%.)

_____

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?

☐ Yes ☐ No

5. Query to clinician: Is the patient's pain relief clinically significant?

☐ Yes ☐ No ☐ Unsure

Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

	Better	Same	Worse
1. Physical functioning	☐	☐	☐
2. Family relationships	☐	☐	☐
3. Social relationships	☐	☐	☐
4. Mood	☐	☐	☐
5. Sleep patterns	☐	☐	☐
6. Overall functioning	☐	☐	☐

***If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.**

(Continued on reverse side)

Progress Note

Pain Assessment and Documentation Tool (PADT™)

Adverse Events

1. Is patient experiencing any side effects from current pain reliever? ☐ Yes ☐ No

Ask patient about potential side effects:

	None	Mild	Moderate	Severe
a. Nausea	☐	☐	☐	☐
b. Vomiting	☐	☐	☐	☐
c. Constipation	☐	☐	☐	☐
d. Itching	☐	☐	☐	☐
e. Mental cloudiness	☐	☐	☐	☐
f. Sweating	☐	☐	☐	☐
g. Fatigue	☐	☐	☐	☐
h. Drowsiness	☐	☐	☐	☐
i. Other_____		☐	☐	☐
j. Other_____		☐	☐	☐

Potential Aberrant Drug-Related Behavior

This section must be completed by the physician

Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (eg, appears intoxicated), while others may require more active listening and/or probing. Use the "Assessment" section below to note additional details.

- ☐ Purposeful over-sedation
- ☐ Negative mood change
- ☐ Appears intoxicated
- ☐ Increasingly unkempt or impaired
- ☐ Involvement in car or other accident
- ☐ Requests frequent early renewals
- ☐ Increased dose without authorization
- ☐ Reports lost or stolen prescriptions
- ☐ Attempts to obtain prescriptions from other doctors
- ☐ Changes route of administration
- ☐ Uses pain medication in response to situational stressor
- ☐ Insists on certain medications by name
- ☐ Contact with street drug culture
- ☐ Abusing alcohol or illicit drugs
- ☐ Hoarding (ie, stockpiling) of medication
- ☐ Arrested by police
- ☐ Victim of abuse
- ☐ Other: _____

_____

_____

2. Patients overall severity of side effects?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Assessment: (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (eg, benefits, such as pain relief, outweigh side effects) from opioid therapy? ☐ Yes ☐ No ☐ Unsure

Comments: _____

_____

Specific Analgesic Plan:

Comments:_____

- ☐ Continue present regimen
- ☐ Adjust dose of present analgesic
- ☐ Switch analgesics
- ☐ Add/Adjust concomitant therapy
- ☐ Discontinue/taper off opioid therapy

Date:_____ **Physicians Signature:** _____

Appendix 3: Roster Instructions using PDMP Data

Opioid Prescribing Patterns and Analysis of Secular Events: a Quality Improvement Project of the Larner College of Medicine at the University of Vermont and Maine Health.

Procedure 1: Providers download records of their opioid prescribing

The purpose of this procedure is to create and download a report of your opioid prescribing for your patients from the PDMP system as part of developing a roster of the patients and opioid prescribing patterns at your practice.

A video version of these instructions is available here.

Please follow this procedure to download records of your prescribing from the Prescription Drug Monitoring Program (PDMP). Each participating prescriber at your practice will also follow this procedure.

Steps:

1. Log into the PDMP with your username and password. Go to Menu in the upper left. Click on the MyRx link to open the MyRx page.

2. At the MyRx page:
   - Enter the date range for the past six years or the number of years you have been at the practice if less than six. *For example,* 01/01/2017 – 3/31/2023. Use a date range that goes up to a recent day.

   - Click the search button to get a report. This request may take a few minutes to process.

3. Click on green "View Report" link after processing.

The link will open the report of your patients in the main viewer window.

4. Download the data by clicking on the “Download CSV” button in the upper right corner.

   - Green circle will appear when your report is ready to download.
   - After the report has been downloaded, open the file in Excel and save it giving it a descriptive file name and date such as [lastname_mmddyyyy].

- Save this file behind your organization's firewall as it contains protected health information

You now have a spreadsheet that has columns for date, DEA number, patient name, year of birth, drug name, the days' supply, MME per day, and pharmacy information. These column names are in the third row.

Lastly, send a copy of this Excel spreadsheet to the designated person in your practice who will combine your data with others in the practice.

Appendix 3: Roster Instructions using PDMP Data

Opioid Prescribing Patterns: A quality improvement project of the Larner College of Medicine at the University of Vermont and Maine Health.

Procedure 2: Combine Prescribers PDMP Data

This procedure is performed by the designated staff person at the practice site. Basic knowledge and experience using Excel software is needed for this procedure.
Purpose: To make a practice-level roster of opioid prescribing.
The procedure describes how to:

1. Summarize each prescriber's patient list downloaded from the PDMP
2. Combine the prescribers' patient lists into one master spreadsheet for the practice,
3. Create a unique patient ID number

A video version of these instructions is available here.

1 Summarize each prescriber's spreadsheet by deleting unnecessary rows. For this step, the spreadsheets can be in one Excel file as worksheets (tabs), or in separate Excel files for this step.

a. Delete the first two rows of each PDMP spreadsheet. Highlight the first two rows and right click. Select Delete.
   Row 1 now has column headers Date, DEA number, Patient name, Year of birth, Drug name, Days' supply, MME per day, and Pharmacy name and address.
b. Make the columns easier to read. Click the arrow in the upper left corner to select the entire spreadsheet and double-click on any one of the bars separating the columns to make them re-size.

2. Combination of Prescriber worksheets into one Master spreadsheet

a) Begin this step with the separate spreadsheets created by each prescriber/provider in one Excel workbook with a separate tab for each prescriber. Or, you may start with the separate spreadsheets and copy them into the Master tab.
b) In the video example, data from the fictitious prescribers, Osler and Smith, are located in a separate tab for each. The tab name is the name of the prescriber.
c) Create a new tab (click on + sign) in the Excel workbook. Name it Master. This will contain the combined prescribers' data.
d) Select all data including header row from the first prescriber and COPY (ctrl c). Then PASTE (ctrl v) in row 1 column 1 in the new MASTER spreadsheet. This will bring all the 1st prescriber's data into the new Master spreadsheet.
e) Next COPY everything EXCEPT the first header row for the next prescriber and PASTE the data at the end of the MASTER data for the first prescriber. The header row should appear only in row 1.
f) Repeat this step appending data (excluding the header row) for each prescriber to the end of each prescriber's data.

3. Create a unique patient ID number and a static version: These next steps create a unique patient ID number for each patient by means of an IF statement that modifies the ID number for each unique patient by comparing name and birth year. Then we create a static ID that eliminates the formula needed to create the number.

a) Sort the data by patient name. From the "DATA" menu, click the SORT option. Agree to expand the selection to the whole spreadsheet.

b) SELECT the "My data has headers" box and SORT by PATIENT and Year of Birth. Click OK.

c) Insert a new column for the ID number to the left of the patient name by right-clicking and selecting INSERT. (New column C) Label this column ID. Enter a value "1001" as the first patient id number. The IF statement compares the name and birth year with the row above it, and if they match it keeps the same number, and if it doesn't match it adds a number.

d) Select the cell in Column C row three C3 (the cell below the first PTID number) and type in this statement: =IF(D3&E3=D2&E2,C2,C2+1)

e) At the lower right corner of C3, pull down using the right lower corner. You will see that the sequence number changes for patients in the video example. Double click on the right lower corner of the last cell highlighted to fill down across the entire spreadsheet.

   a. Excel tip to copy a cell down a column: Click the lower right corner of the first cell and pull down to copy the formula across all rows OR double-click on the lower right of the first cell, and it will fill-down the length of the column.

f) Create a static version of the Patient ID number (without the formula)

Note: We need a static version of the patient id number that does not depend on the formula to create it. In Excel, values created by formulas such as the PATID number will continuously update, so when the patient name is deleted during the de-identification process, the formula will break down.

- Insert a new column (D) to the left of Patient name column by selecting the Patient name column and right-clicking . Select Insert a column to the left of Patient name. Name this column PTID.

- Right-click in column C (ID) and Copy the ID values. Then right-click in the new column D and use PASTE Special/ paste - values in Column D.

INSTEAD OF DOING A SIMPLE PASTE Choose PASTE-SPECIAL, then choose VALUES. This pastes the ID numbers only, but not the formula.

- Delete the calculated (formula) PATID in column C. Right click on column C and select DELETE. The PATID column is no longer needed.

SAVE THIS COPY WITH PATIENT NAMES in your practice file system, behind your firewall. This will serve as a reference if there are later questions about which patients are included in your roster of patients treated with controlled substances.

The remaining step is NOT needed, unless you need a de-identified list to share outside your organization. If not, STOP here.

4. De-identify the list, if needed

a. Delete the patient names in the Master tab by right-clicking in the PATIENT name column (now column D) and selecting Delete.

b. Delete the individual prescriber named tabs in the spreadsheet, if present. Keep only the Master tab. Right-click on each individual tab and select DELETE.

c. As a last step, delete the pharmacy name and address columns. Delete those by clicking to select them, right click and choose Delete.

After this, you should have only one remaining MASTER tab with no specific identifiers. Save this as the master de-identified roster for your practice with the name "[Practice_name] deidentified".

Appendix 4: Panel Management Report Examples using PDMP Data

Report 1: Example of population report by prescriber, 2018-2022

Prescriber	Year					% change MME (18-22)
	2018	2019	2020	2021	2022	
Clinician A	305,416	310,398	252,561	261,959	245,404	-20%
Clinician B			4,883	115,775		-
Clinician C	99,240	125,679	177,528	157,548	111,174	+12%
…						
Clinician Y		1,158	4,655	63,156	136,104	-
Clinician Z	1,271,132	1,007,300	683,920	799,567	792,123	-38%
Practice Total *	1,961,865	1,695,875	1,348,993	1,631,280	1,526,990	-22%

* Totals may not sum because of partial practice data shown

Appendix 4: Panel Management Report Examples using PDMP Data

Report 2: Example of detailed population report by prescriber, 2018-2022

Prescriber	2018	2019	2020	2021	2022
Clinician A					
Count of opioid patients	151	103	112	91	80
Count of chronic opioid patients	49	36	33	33	32
Proportion 7 pill increments	36%	46%	47%	47%	49%
Count of benzo patients	76	65	51	60	51
Count of overlap patients	16	14	16	16	13
Count of MOUD* patients	0	0	0	21	17
Clinician B					
Count of opioid patients			8	62	
Count of chronic opioid patients			1	22	
Proportion 7 pill increments			36%	36%	
Count of benzo patients			6	43	
Count of overlap patients			1	12	
Count of MOUD patients			0	0	
Clinician C					
Count of opioid patients	46	56	55	43	38
Count of chronic opioid patients	15	22	21	22	21
Proportion 7 pill increments	66%	76%	77%	74%	79%
Count of benzo patients	74	74	70	69	56
Count of overlap patients	17	18	9	12	10
Count of MOUD patients	0	0	0	0	0

* MOUD Medication for Opioid Use Disorder