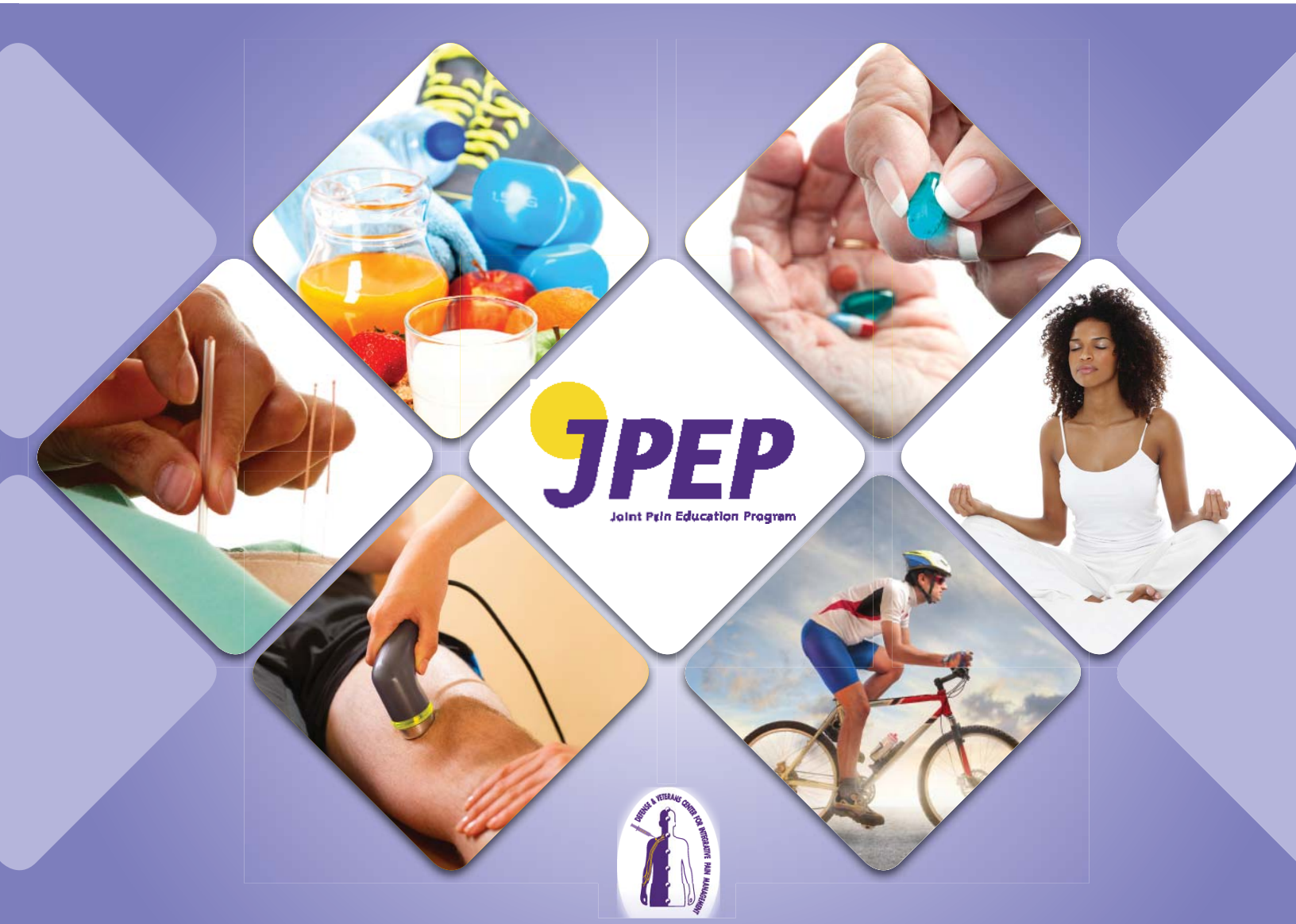
# Pain Management for Primary Care

DoD/VHA
JOINT INCENTIVE FUND (JIF)
PROJECT




## Series: Three
Clinical Assessment of Pain

## Module 3-2
Assessment Tools

# Module 3-2

## Assessment Tools

### By the end of the module, you will be able to:

- Describe the utility of validated chronic pain assessment tools within the primary care setting
- Use in practice brief assessment tools appropriate for the multi-dimensional assessment of pain, psychiatric conditions, medical conditions, addiction, and treatment response

### We will review:

Topic One: Common Assessment Tools

Topic Two: Monitoring and Adjusting Treatments


Lead Authoring Subject Matter Experts

Veterans Health Administration
Dr. Aram Mardian

Department of Defense
MAJ Kevin Guthmiller, USA

# Topic One

## Common Assessment Tools

Assessment tools can provide a quantification of the biopsychosocial contributors to chronic pain and can both help identify important factors to address in the interview and also serve as quantifiable longitudinal metrics.

## Brief validated assessment tools can help with a treatment plan.

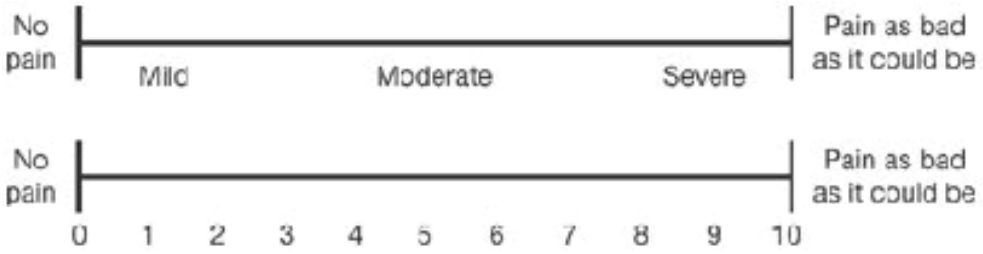
Assess function, screen for comorbidities and risk for addiction.

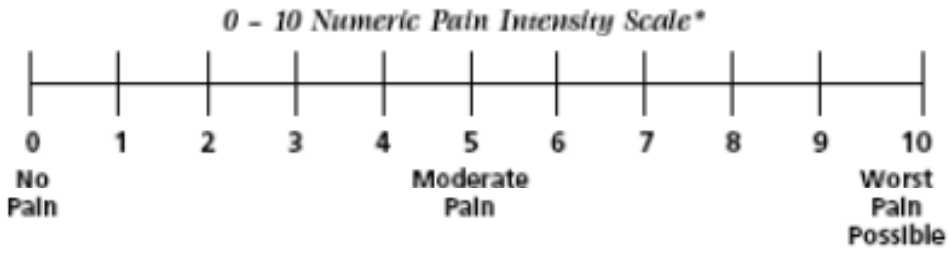
Notes

The pain interview is aimed at building a therapeutic relationship and understanding the patient's unique biopsychosocial story. However, the interview process may not identify all biopsychosocial domains that are disrupting the patient's life.

Use of brief screening tools can aide in identification of important dysfunctional domains and therefore assist with biopsychosocial synthesis. For example, much of the interview may focus on the description of the physical aspects of the pain experience as well as problems with sleep and not identify problems with mood or anxiety.

## Pain intensity measured by a unidimensional scale like NRS or VRS, is not enough for patients with chronic pain.




Notes

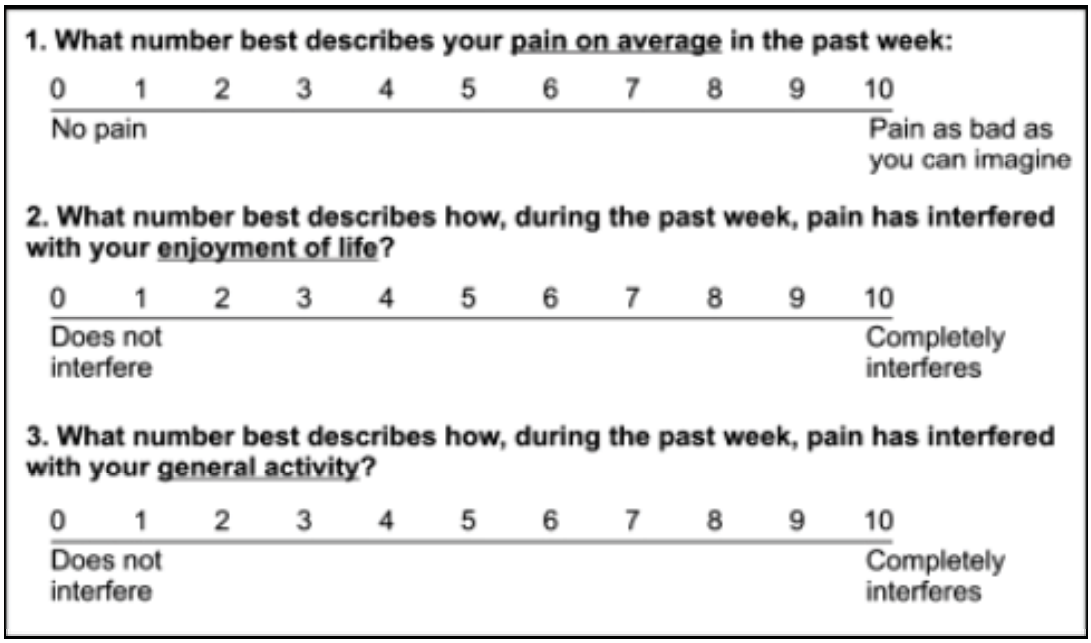
The first line is a VRS, second line is a NRS, and the third is a combined VRS and NRS.

Numeric rating scale (NRS)

Verbal rating scale (VRS)

Each of these scales has good reliability and validity. Individuals with cognitive impairment may not be able to complete the NRS and may do better with the VRS or a visual scale (Jensen and Karoly, 2001).

## A short multidimensional assessment scale like PEG is better and can be used in the primary care setting.



**1. What number best describes your pain on average 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 enjoyment of life?**

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

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

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Notes

Pain, Enjoyment, and General Activity (PEG) is a brief multidimensional assessment tools. As stated, the tools are brief and can be self-administered. Tools can assist in shifting focus from only using pain intensity to assess treatment response and patient well-being, to whole person assessment of function and quality of life.

Melzack (1968) suggested that, based on the underlying neurophysiological mechanisms of pain, pain assessment should include three dimensions: sensory-discriminative, motivational-affective, and cognitive- evaluative.

Measures multiple domains of pain experience

- Often include pain intensity, mental functioning, physical functioning

Brief Pain Inventory (BPI) – Short Form

- Multiple pain ratings (worst, least, average, current) & Interference Scale
- BPI in longer version also contains questions about treatment and treatment response

Time to administer and scoring complexity limit usefulness in primary care

The PEG is an Ultra-brief, 3 question pain measure derived from the Brief Pain Inventory (BPI)

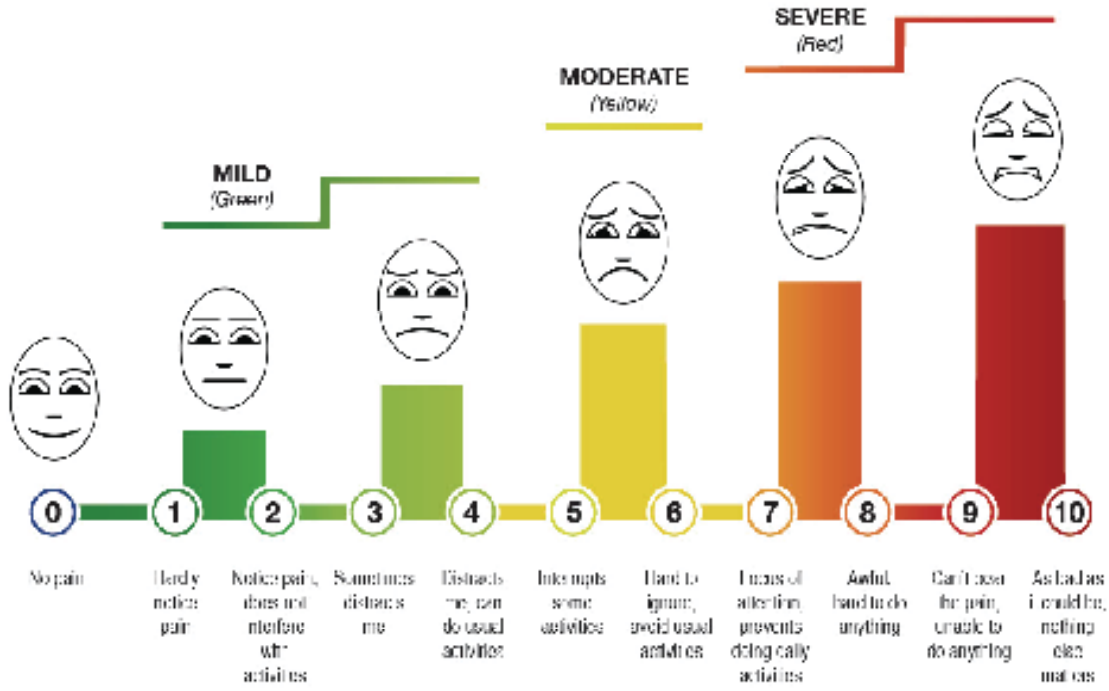
Benefits of the PEG for assessing chronic pain include:

- assessment of average pain over the past week rather than only pain at the time of the question
- assessment of pain interference with quality of life (enjoyment of life)
- assessment of pain interference with function (general activity)

Critiques of the PEG include – no assessment of sleep or stress

DoD/VHA, prefers the DVPRS tool to measure pain intensity and assess how much pain interferes with activity, sleep mood and stress.

Defense and Veterans Pain Rating Scale

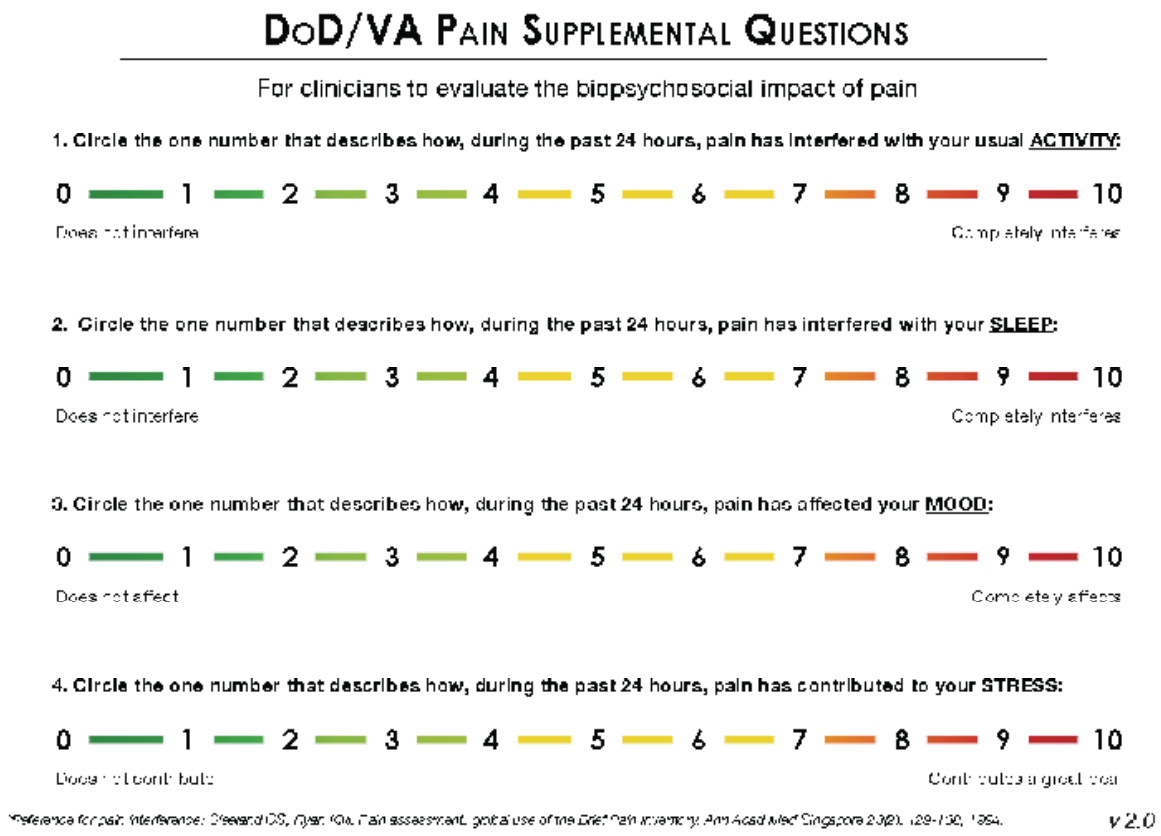



Notes

Defense Veteran Pain Rating Scale (DVPRS) is a tested and validated brief multidimensional assessment tool for chronic pain. It integrates pain rating features to improve interpretability of incremental pain intensity levels, and improves communication and documentation during transition of care, necessary in the DoD/VHA.

One critique is that the integration of the faces scale (useful in individuals with limited language skills –pediatric and geriatric populations) with other pain intensity scales may not be ideal for adults with chronic pain as it implies that the emotional and cognitive aspects of pain must coincide with the sensory aspect of pain. The supplemental questions of the DVPRS (discussed next) allows assessment of other dimensions of pain (activity, mood, sleep).

Using a patient-centered interview, start to gather information using your clinician-centered interview skills.



## DoD/VA Pain Supplemental Questions

For clinicians to evaluate the biopsychosocial impact of pain

**1. Circle the one number that describes how, during the past 24 hours, pain has interfered with your usual ACTIVITY:**

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere ... Completely interferes

**2. Circle the one number that describes how, during the past 24 hours, pain has interfered with your SLEEP:**

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not interfere ... Completely interferes

**3. Circle the one number that describes how, during the past 24 hours, pain has affected your MOOD:**

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not affect ... Completely affects

**4. Circle the one number that describes how, during the past 24 hours, pain has contributed to your STRESS:**

0 — 1 — 2 — 3 — 4 — 5 — 6 — 7 — 8 — 9 — 10

Does not contribute ... Contributes a great deal

*Reference for pain interference: Cleeland CS, Ryan KM. Pain assessment: global use of the Brief Pain Inventory. Ann Acad Med Singapore 23(2): 129-138, 1994.*

v 2.0

Notes

The Supplemental Questions of the DVPRS are useful to explore other important dimension in chronic pain. These questions also assist in shifting the therapeutic conversation to a whole person, biopsychosocial approach.

A short multidimensional scale like PHQ 4 can be useful in primary care to assess anxiety and depression.

| PHQ-4 | | | | | |
|---|---|---|---|---|---|
| **Over the last 2 weeks, how often have you been bothered by the following problems?** *(Use "✔" to indicate your answer)* | Not at all | Several days | More than half the days | Nearly every day | |
| 1. Feeling nervous, anxious or on edge | 0 | 1 | 2 | 3 | Anxiety |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 | |
| 3. Little interest or pleasure in doing things | 0 | 1 | 2 | 3 | Depression |
| 4. Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 | |

Scoring: normal (0-2), mild (3-5), moderate (6-8), and severe (9-12)

Notes

Screening Instruments - A score of 8 on the PHQ-4 would necessitate further assessment of depression and anxiety using Patient Health Questionnaire (PHQ-9) or Beck Depression Inventory-II (BDI-II).

One study showed that asking, "Do you want help with this today?" increased the specificity of the PHQ-2 to 89%–98%, but did not increase the sensitivity. Asking this question can also increase the specificity of a two-question anxiety screen.

The PHQ-4 combines the two questions from the PHQ-2 depression screen and the GAD-2 anxiety screen. Elevated scores have been shown to relate to decreased patient functional status in several areas, including mental and physical domains. The sensitivity and specificity of the PHQ-4 as a diagnostic tool for depression or anxiety disorders has not been specifically determined.

Therefore, its use at this time is limited to identifying patients with decreased quality of life who should undergo further assessment for major depression or anxiety disorders.

- normal (0-2), mild (3-5), moderate (6-8), and severe (9-12)

A positive answer to the PC-PTSD screen indicates that a patient may have PTSD or a trauma-related problem and needs further support.

## Primary Care PTSD Screen

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in **the past month**, you*

1. Have had nightmares about it or thought about it when you did not want to?

YES NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

YES NO

3. Were constantly on guard, watchful, or easily startled?

YES NO

4. Felt numb or detached from others, activities, or your surroundings?

YES NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

Notes

Many patients with PTSD may suffer from anxiety that can be identified by using the Generalized Anxiety Disorder , GAD-2 questionnaire.

The GAD-2 has high sensitivity (86%) and high specificity (86%) for Generalized Anxiety Disorder in primary care, with similar results for the GAD-7. Sensitivity and specificity are much lower for other types of anxiety disorders, but a score of 10 or over on the GAD-7 can be used to identify patients with panic disorder, social anxiety disorder and PTSD.

## More than three 'yes' on the STOP-BANG screening tool indicates the presence and need to treat obstructive sleep apnea.

- S Snoring?
- T Tired?
- O Observed apnea?
- P High Blood Pressure?
- B BMI > 35?
- A Age > 50?
- N Neck circumference > 40 cm (16 inches)?
- G Gender is male?

Notes

MoA score of ≥3 has shown a high sensitivity for detecting OSA: 93% and 100% for moderate and severe OSA, respectively.

A STOP-Bang score of 5–8 identified patients with high probability of moderate/severe OSA.

## Diagnose and assess the severity of fibromyalgia using the widespread pain index (WPI) and the symptom severity (SS) score.

### Widespread Pain Index (WPI) rated 0-19

- Ask patient; not based on tender point exam
- Number of areas in which the patient has had pain over the last week

| | |
|---|---|
| • Shoulder L/R | • Jaw L/R |
| • Hip L/R | • Chest |
| • Upper arm L/R | • Abdomen |
| • Lower arm L/R | • Lower back |
| • Upper leg L/R | • Upper back |
| • Lower leg L/R | • Neck |

### Symptom Severity (SS) Score rated as 0-12

- Fatigue
- Waking unrefreshed
- Cognitive symptoms

- Rate each symptom separately (0-3)
  - 0 = no problem
  - 1 = slight or mild (mild, intermittent)
  - 2 = moderate, considerable
  - 3 = severe

- Somatic symptoms

- Rate overall somatic symptoms (0-3)
  - as no, few, moderate, to great deal of symptoms

Notes

- In 2010, the American College of Rheumatology published preliminary diagnostic criteria for Fibromyalgia diagnosis
- No tender point exam required
- Sum of Widespread Pain Index and Symptom Severity Scale scores

2010 American College of Rheumatology Preliminary Diagnostic criteria for fibromyalgia (all 3 conditions are met):

1. Widespread pain index (WPI) ≥7 and symptom severity (SS) scale score ≥5 or WPI 3 - 6 and SS scale score ≥9.
2. Symptoms have been present at a similar level for at least 3 months.
3. The patient does not have a disorder that would otherwise explain the pain.

The 2010 ACR criteria can be used to assess sub-threshold "fibromyalgianess" of patients as well as assess the severity of fibromyalgia symptoms over time.

## ORT is a simple opioid screening tool that can be used in primary care: 0-3: low risk, 4-7: moderate risk, > 8: high risk

| FACTOR | MALE PATIENTS | FEMALE PATIENTS |
|---|---|---|
| Family history of substance abuse | | |
| • Alcohol | ❑ 3 points | ❑ 1 point |
| • Illegal drugs | ❑ 3 points | ❑ 2 points |
| • Prescription drugs | ❑ 4 points | ❑ 4 points |
| Personal history of substance abuse | | |
| • Alcohol | ❑ 3 points | ❑ 3 points |
| • Illegal drugs | ❑ 4 points | ❑ 4 points |
| • Prescription drugs | ❑ 5 points | ❑ 5 points |
| Age between 16 and 45 | ❑ 1 point | ❑ 1 point |
| History of preadolescent sexual abuse | ❑ 0 points | ❑ 3 points |
| Psychiatric disease | | |
| • Attention deficit disorder, obsessive-compulsive disorder, bipolar disorder, schizophrenia | ❑ 2 points | ❑ 2 points |
| • Depression | ❑ 1 point | ❑ 1 point |

Notes

Opioid risk assessment tools can be used to screen patients prior to initiating opioids or patients already on chronic opioid therapy OR to supplement the clinical interview.

Prior to initiating prescription opioids

- ORT (Opioid Risk Tool)
- DIRE (Diagnosis, Intractability, Risk, Efficacy)
- SOAPP-R® (Screener and Opioid Assessment for Patients with Pain – Revised)

Taking prescription opioids

- COMM ™ (Current Opioid Misuse Measure)

The ORT scores patients in 5 domains that are risk factors for opioid misuse:

1. family history of substance abuse
2. personal history of substance abuse
3. Age
4. History of preadolescent sexual abuse
5. Psychological disorders

Scores are weighted differently for males and females.

The ORT may be a more appropriate initial screening tool for clinics with a higher volume of low risk patients while the SOAPP-R® may be more appropriate as an initial screening tool in higher risk patient populations.

ORT

Brief, 5-question survey

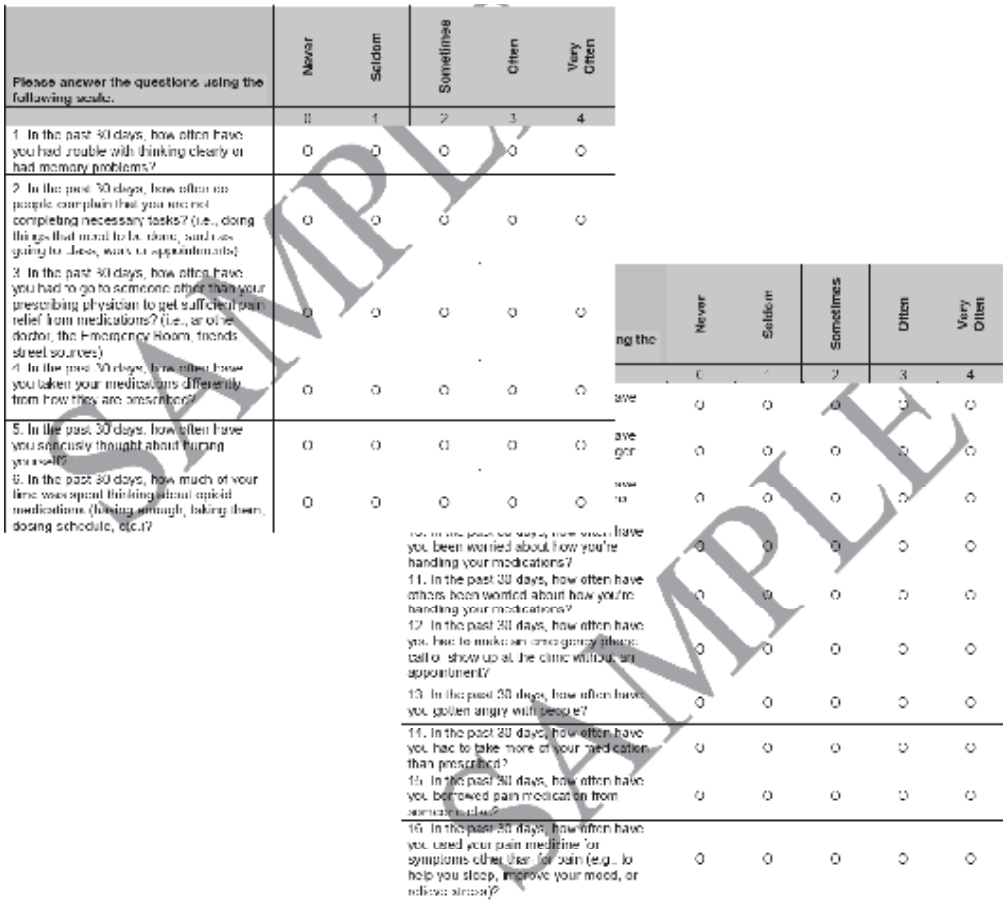
Self-report to assess risk of

- ADRB prior to initiating COT

Strengths include being widely accessible, brief, and easy to administer.

Primary limitation is a low sensitivity for predicting ADRB (0.18-0.45)

## Many other screening tools (SOAPP®, COMM™) are more extensive & proprietary suitable for high risk patients on chronic opioid treatment.



| Please answer the questions using the following scale: | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| 1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems? | O | O | O | O | O |
| 2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments) | O | O | O | O | O |
| 3. 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 medications? (i.e., another doctor, the Emergency Room, friends, street sources) | O | O | O | O | O |
| 4. In the past 30 days, how often have you taken your medications differently from how they are prescribed? | O | O | O | O | O |
| 5. In the past 30 days, how often have you seriously thought about hurting yourself? | O | O | O | O | O |
| 6. In the past 30 days, how much of your time was spent thinking about opioid medications (timing, amount, taking them, dosing schedule, etc.)? | O | O | O | O | O |

| ng the | Never | Seldom | Sometimes | Often | Very Often |
|---|---|---|---|---|---|
| | 0 | 1 | 2 | 3 | 4 |
| ave | O | O | O | O | O |
| ave ger | O | O | O | O | O |
| ave re | O | O | O | O | O |
| you, been worried about how you're handing your medications? | O | O | O | O | O |
| 11. In the past 30 days, how often have others been worried about how you're handing your medications? | O | O | O | O | O |
| 12. In the past 30 days, how often have you had to make an unscheduled phone call or show up at the clinic without an appointment? | O | O | O | O | O |
| 13. In the past 30 days, how often have you gotten angry with people? | O | O | O | O | O |
| 14. In the past 30 days, how often have you had to take more of your medication than prescribed? | O | O | O | O | O |
| 15. In the past 30 days, how often have you borrowed pain medication from someone else? | O | O | O | O | O |
| 16. 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)? | O | O | O | O | O |



Notes

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

- Self report to assess risk of ADRB prior to initiating COT
- More extensive (24 items)
- Higher sensitivity for predicting ADRB (0.41-0.81)

Current Opioid Misuse Measure (COMM ™)

- 17 item self-report survey
- Designed to identify ADRB associated with opioid misuse in patients who are currently using COT
- A COMM score of ≥ 13 sensitivity of 77% and a specificity of 77% for identifying primary care patients with DSM IV prescription opioid abuse or dependence

The COMM ™ a 17-item self-report survey that is designed to identify ADRB that may be associated with opioid misuse in patients who are currently on chronic opioid therapy.

Patients determined to be high risk by either the ORT or the SOAPP® require more rigorous evaluation, treatment structure, and monitoring. Appropriate consultation with psychiatric, SUD, behavioral health, or pain specialty services should be considered. It may not be appropriate to prescribe COT for high risk patients in the primary care setting.

# Topic Two

## Monitoring and Adjusting Treatment

### Assess the effectiveness of your treatment using 4 (+2) A's at every patient visit:

Check 4 A's

- Activity
- Analgesia
- Aberrant drug related behavior
- Adverse effects

Consider 2 A's

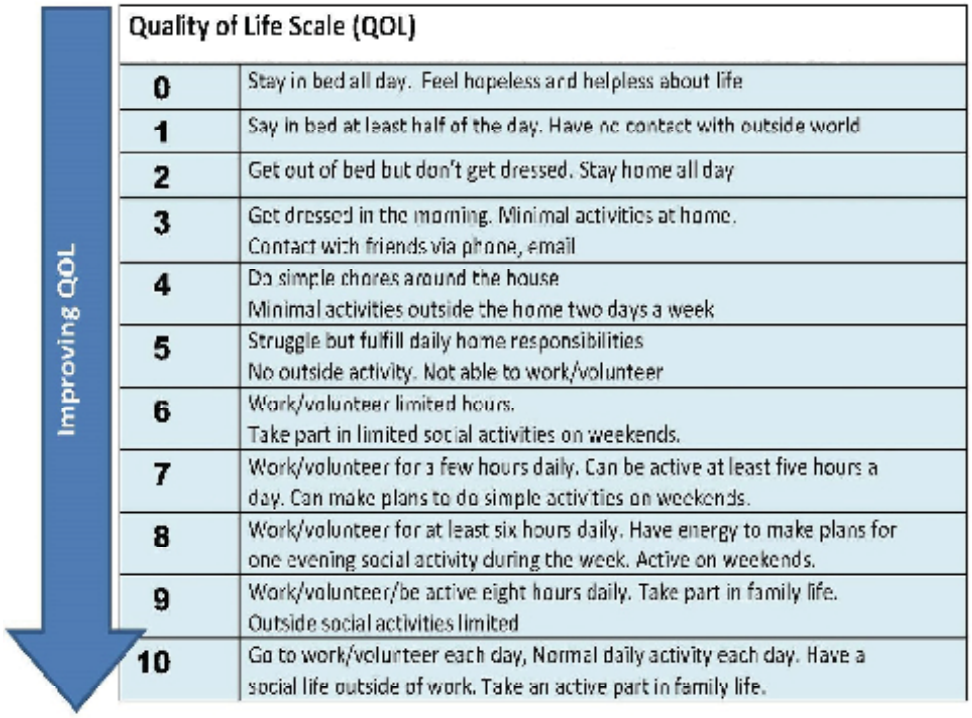
- Affect
- Adjuncts

Notes

At every patient visit always ask the following:

- Activity: Has your activity increased following treatment?
- Analgesia: Has your pain been somewhat relieved?
- Aberrant behavior: Are your taking/seeking other drugs?
- Adverse effects: Do you have constipation, drowsiness, low sexual desire?
- Affect: Are you sad, worried, or frustrated?
- Adjunct: Are you doing other things like exercise, relaxation, and/or yoga to improve your health?

## Assess the patient's quality of life using the QoL scale.




| Quality of Life Scale (QOL) | |
|---|---|
| 0 | Stay in bed all day. Feel hopeless and helpless about life |
| 1 | Say in bed at least half of the day. Have no contact with outside world |
| 2 | Get out of bed but don't get dressed. Stay home all day |
| 3 | Get dressed in the morning. Minimal activities at home.<br>Contact with friends via phone, email |
| 4 | Do simple chores around the house<br>Minimal activities outside the home two days a week |
| 5 | Struggle but fulfill daily home responsibilities<br>No outside activity. Not able to work/volunteer |
| 6 | Work/volunteer limited hours.<br>Take part in limited social activities on weekends. |
| 7 | Work/volunteer for a few hours daily. Can be active at least five hours a day. Can make plans to do simple activities on weekends. |
| 8 | Work/volunteer for at least six hours daily. Have energy to make plans for one evening social activity during the week. Active on weekends. |
| 9 | Work/volunteer/be active eight hours daily. Take part in family life.<br>Outside social activities limited |
| 10 | Go to work/volunteer each day, Normal daily activity each day. Have a social life outside of work. Take an active part in family life. |

Notes

Quality of Life scale from the American Chronic Pain Association

## Knowledge Check

In primary care settings, providers can use _____ and _____ as brief multidimensional pain assessment tools.

a. MMPI; DVPRS
b. PEG; PC-PTSD
c. PC-PTSD; SOAPP
d. DVPRS; PEG
e. PC-PTSD; PEG

## Knowledge Check – Answer

In primary care settings, providers can use _____ and _____ as brief multidimensional pain assessment tools.

a. MMPI; DVPRS
b. PEG; PC-PTSD
c. PC-PTSD; SOAPP
d. DVPRS; PEG
e. PC-PTSD; PEG

Notes

Read the question and correct answer allowed to the class

Rationale for Answer D:

The PEG is a 3 item multidimensional pain assessment tool derived from the BPI.

The DVPRS is a 5-item multidimensional pain assessment tool.

The MMPI (Minnesota Multiphasic Personality Inventory) has 566 questions and is commonly used in spinal cord stimulator assessments.

PC-PTSD is a brief 4 questions screen for PSTD designed for use in primary care.

# Summary

Recall that assessment tools provide a brief and validated way to identify important psychiatric and medical comorbidities, as well as the risk of addiction and pain-related life interference.

Remember that brief screening tools can identify the need for additional evaluation or prompt the use of more extensive assessment tools.

Use regular assessment tools at every clinical encounter in order to monitor treatment effectiveness and plan any necessary changes.

# Resources

Current Opioid Misuse Measure (COMM™)
http://www.painedu.org/soapp.asp

Diagnosis, Intractability, Risk, Efficacy tool (DIRE)
http://integratedcare-nw.org/DIRE_score.pdf

Defense & Veterans Pain Rating Scale (DVPRS)
http://www.dvcipm.org/clinical-resources/pain-rating-scale

Opioid Risk Tool (ORT)
http://www.partnersagainstpain.com/printouts/Opioid_Risk_Tool.pdf

Pain Catastrophizing Scale (PCS)
http://sullivan-painresearch.mcgill.ca/pcs1.php

American Chronic Pain Association Quality of Life Scale (ACPA-QOL)
http://www.theacpa.org/uploads/documents/Quality_of_Life_Scale.pdf

Sheehan Disability Scale
http://calmhsa.org/wp-content/uploads/2013/06/SheehanDisabilityScaleEnglish.pdf

Screener and Opioid Assessment for Patients in Pain (SOAPP) ®
http://www.painedu.org/soapp.asp

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# JPEP

Joint Pain Education Program