# Interdisciplinary pain management programs

Please check with your local ethics service or governing body about the process requirements for auditing your own practice.

<table>
<thead>
<tr>
<th>Background</th>
<th>Interdisciplinary pain management programs (PMPs) based on a cognitive behavioural therapy (CBT) framework can reduce distress and improve physical function in well selected patients with pain more effectively than single modality treatments alone(^1)(^-)(^3). With 20 per cent of the Australian population reporting chronic pain(^4), and less than 400 Fellows of the Faculty of Pain Medicine(^5), the demand for pain management services well outstrips supply. Audit of outcomes of pain management programs can contribute to ensuring appropriate patients(^6) are selected for these intensive interventions and outcomes are assessed. A series of audits may also provide the opportunity to implement and evaluate program changes. Standards (local, national or international) against which to assess many interventions (particularly non-procedural interventions) in the management of persistent pain are lacking. It is hoped that the acquisition of national data through the Electronic Persistent Pain Outcomes Collaboration (ePPOC) will provide a large data set that may be used to generate some comparative data. However it must be remembered that ePPOC is collecting data primarily from adult, tertiary hospital persistent pain services (although paediatric data is also being collected). This does not reflect the practice of all specialist pain medicine physicians (SPMPs). It may also provide a data set based on a patient population that differs from that seen in an individual SPMP’s practice. Provision of numerical or absolute targets or benchmarks is therefore inappropriate at this time.</th>
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<tr>
<td>Aim and objectives</td>
<td>To assess the changes in levels of distress, self efficacy, pain and pain interference in patients undergoing pain management programs.</td>
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<td>Research evidence/ best practice</td>
<td>Pain management programs should be based on psychological principles(^1)(^-)(^2). Team members should include a clinical psychologist, occupational therapist, physiotherapist and a doctor (generally a specialist pain medicine physician)(^2). Other disciplines (such as nursing, social work, exercise physiology) may be included. Functional improvement is the primary goal, not pain relief.</td>
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<td>Suggested indicators</td>
<td>The Initiative on Methods, Measurement, and Pain Assessment in Clinical Trials (IMMPACT) recommends considering clinical important change (as distinct from statistically significant change) on the following basis(^7):</td>
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<td>• Minimal benefit 10-20 per cent change.</td>
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<td>• Moderately important benefit at least 30 per cent change.</td>
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<td>• Substantially important benefit at least 50 per cent change.</td>
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<td>Percentages of patients who are significantly better or worse across the measures should be assessed. Detailed audits of each scale may be undertaken for more detail. Outcome measures from ePPOC have been chosen as a minimum data set to facilitate data collection, minimise the number of questionnaires patients need to fill out (in those units collecting ePPOC data), and enable comparison with data produced by ePPOC. Additional measures can clearly be added. Measures of function (for example, measured activity tolerances, six-minute walk test distance) would probably be of interest to most practitioners and could easily be included if regularly measured as part of the pain management program.</td>
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Standards and criteria for best practice

- Minimal patient non-completion.
- Minimal incomplete follow-up data sets.
- Minimal patients significantly worse on each measure.
- Majority of patients obtaining clinically important change.

Method

Audit of 20 or more sequential patients undertaking a pain management program. With collection of simple demographic and program data as well as data (pre and post program with a minimum three month interval between data sets) regarding changes in:
- Healthcare utilisation.
- Depression/anxiety/stress.
- Pain self efficacy.
- Pain catastrophising.

See data collection form for more details.

Percentage change in individual patients has been suggested (rather than average percentage change across the population audited) as average percentage change is very sensitive to outliers and small audits may therefore be significantly influenced by average percentage change.

References


Acknowledgement

This audit guide is adapted from Makin, R., Moores, L. and Twiddy H. “Audit of pain management programs’ in: Raising the Standard: a compendium of audit recipes, 2012; Royal College of Anaesthetists. pp.322-323. The Royal College has kindly granted ANZCA permission to use this material.

Authors: Dr S Cartwright and Dr C Thomas FFPMANZCA. September 2014

Associated documents:

Pain Management Program Audit Data Collection Form
Pain Management Program Audit Results Summary and Conclusions Form