IN ASSOCIATION WITH eu2013.ie

Working Document

Date of working status: 14 May 2013
Outcome after discussion during SIP Focus Group 1
Renaissance Hotel, Brussels, 14 May 2013

SIP Recommendations on the European Implementation of Quality Indicators in Chronic Non-Malignant Pain Management

Under the supervision of:
Professor Pedro J. Saturno, Medical Faculty, University of Murcia, Spain

Draft version as proposed by SIP Expert working group:
Professor Anne Berquin, Consultation de la Douleur Chronique, Cliniques Universitaires Saint-Luc, Belgium
Dr Maria Alice Cardoso, Centro Hospitalar de Lisboa Central, Portugal
Professor Björn Gerdle, Faculty of Health Sciences, Linköping University, Sweden
Dr Wolfgang Habacher, Joanneum Research Forschungsgesellschaft mbH, Austria
Dr Virginie Piano, Hôpital la Timone, Centre Douleur Chronique, France
Dr Cathy Price, Clinical Director at Southampton City CCG, UK
Professor William Raffaeli, Fondazione ISAI, Institute for Research on Pain, Italy
Professor Pedro J. Saturno, Medical Faculty, University of Murcia, Spain
Professor Dr Rolf-Detlef Treede, Medical Faculty Mannheim, Heidelberg University, Germany
Prof Dr Kris C. P. Vissers, UMC St. Radboud, Netherlands

GRÜNENTHAL

The scientific framework of the SIP platform is under the responsibility of the European Federation of IASP® Chapters (EFIC®). The pharmaceutical company Grünenthal GmbH is responsible for funding and non-financial support (e.g. logistical support). The scientific aims of the SIP annual events have been endorsed by a large number of pain advocacy and scientific organisations.

EFIC EUROPE AGAINST PAIN

List of Contents

1. Introduction to the Societal Impact of Pain (SIP)

The European, multi-stakeholder platform Societal Impact of Pain (SIP) was created in 2010 as a joint initiative of the European Federation of IASP® Chapters (EFIC®) and the pharmaceutical company Grünenthal GmbH. The aims are to

- raise awareness of the relevance of the impact that pain has on our societies, health and economic systems;
- exchange information and share best-practices across all member states of the European Union;
- develop and foster European-wide policy strategies & activities for improved pain care in Europe.

As a multi-stakeholder platform SIP provides discussion opportunities for health care professionals, pain advocacy groups, politicians, insurances, representatives of health authorities, regulators and budget holders. The scientific framework of the SIP platform is under the responsibility of EFIC®. Grünenthal is responsible for funding and non-financial support (e.g. logistical support).

In the past three years EFIC® and Grünenthal have organized three European scientific symposia on the societal impact of chronic pain in Europe.

The first symposium SIP 2010 established the multi-stakeholder network thus creating a platform for sharing best practices of pain management throughout Europe.

The second symposium SIP 2011 took place in the European Parliament and was supported by all three European institutions: Members of the EU Parliament, the EU Commissioner for Health & Consumer Policy, as well as the Hungarian Presidency holding the EU Presidency from Jan-Jun 2011. Furthermore, it was endorsed by more than 85 international and national patient advocacy groups, scientific organisations and health authorities. Key result from SIP 2011 was the SIP Road Map for Action outlining seven policy dimensions on how the EU institutions and member states can effectively address the societal impact of pain at EU level.

The third symposium SIP 2012 took place in Copenhagen, Denmark. More than 400 stakeholders from more than 30 countries participated in the meeting, which was officially held under the high patronage of the Italian Prime Minister and the Italian Ministry of Health and Welfare, and was endorsed by more than 161 organisations. For the first time concrete national policies on pain management were shared with the participants reflecting how EU Member States succeeded in implementing the SIP Road Map for Action on national level.

Following these national examples from SIP 2012 and the general SIP stakeholders' feedback to intensify the work on concrete projects to leverage outcomes for EU level, the *SIP Programme Committee* decided to implement the so-called *SIP Focus Groups*. In contrast to the past three European symposia, the SIP 2013 Focus Groups would concentrate on two concrete policy topics, which follow closely one of the seven policy dimensions of the SIP Road Map for Action.

The topic for the SIP 2013 Focus Group 1 as chosen by the SIP Programme Committee was "Quality Indicators in Chronic Pain Management". This follows policy dimension No 7 of the SIP Road Map for Action: "*7. Use the EU*

platform to monitor trends in pain management, services, and outcomes and provide guidelines to harmonize effective levels of pain management to improve the quality of life of European Citizens[1]."

The topic of quality indicators for pain is based on the Spanish pilot project by Plataforma SinDolor on "Good practice indicators for pain management" (IPM)[2], coordinated by FUINSA (Health Research Foundation) and Grünenthal Foundation, and under the technical supervision of Professor Pedro J. Saturno (University of Murcia, Spain). The IPM project developed indicators for chronic malignant pain, chronic non-malignant pain and acute pain, which have been successfully validated and/or pilot-tested in the Spanish Health Care System so far by 10 out of 17 Spanish regions.

Rationale for the SIP Programme Committee for selecting this topic was the commonly agreed need for developing and implementing instruments for monitoring the quality of pain management in Europe. Adequate pain management has started to become a priority for health care services and providers across Europe; epidemiological data, the high prevalence and significant direct and indirect costs for the health care systems have been noted. However, health care providers and budget holders still struggle to measure the quality of pain management and thus to defend the required allocation of monetary resources. Furthermore, due to the differentiation of health care systems in Europe, a harmonization of monitoring instruments across EU Member States remains a challenge.

Learning from the Spanish pilot, the objective of the SIP 2013 Focus Group 1 was to develop and agree on a set of indicators for chronic pain which could be most-commonly shared among EU member states and adopted, sequentially validated and/or implemented by EU Member States following SIP 2013.

The final set of indicators and recommendations for a European implementation will be summarized in this SIP Recommendations report. It was drafted by a working group of international experts between 22 February and 06 May 2013. The working group members are:

- Prof. Anne Berquin, Consultation de la Douleur Chronique, Cliniques Universitaires Saint-Luc, Belgium
- Dr Maria Alice Cardoso, Centro Hospitalar de Lisboa Central, Portugal
- Professor Björn Gerdle, Faculty of Health Sciences, Linköping University, Sweden
- Dr Wolfgang Habacher, Joanneum Research Forschungsgesellschaft mbH, Austria
- Dr Virginie Piano, Hôpital la Timone, Centre Douleur Chronique, France
- Dr Cathy Price, University Hospital Southampton FT, UK
- Professor William Raffaeli, Fondazione ISAl, Institute for Research on Pain, Italy
- Professor Pedro J. Saturno, Medical Faculty, University of Murcia, Spain
- Professor Dr Rolf-Detlef Treede, Medical Faculty of Mannheim, Heidelberg University, Germany
- Professor Dr Kris C. P. Vissers , UMC St. Radboud, Netherlands

The draft version was distributed to all SIP 2013 Focus Group 1 participants on 06 May 2013 for optimal preparation. The SIP 2013 Focus Group 1 took place in the Renaissance Hotel, Brussels, Belgium on 14 May 2013. The Focus Group was chaired by Ms Waltraud Klasnic, Austrian Member of the European Economic and Social Committee. The draft version was discussed and finally agreed upon during the working session by all SIP Focus Group participants. The final report was published and made available for download on the SIP website[3] on 17 May 2013.

---

[1] SIP – A Road Map for Action, 2011: http://www.efic.org/userfiles/file/THE%20SOCIETAL%20IMPACT%20OF%20PAIN%20%20A%20ROAD%20MAP%20FOR%20ACTION%20%20document%2026%2005%202011.pdf

[2] "Good Practice Indicators for Pain Management – Final Summary Report", April 2012, English translation: February 2013. comunicacion@plataformasindolor.com

[3] www.sip-platform.eu

2. Chronic Pain in Europe – Epidemiology and Societal Costs

Looking at current literature and epidemiological data, chronic, non-malignant pain affects 20% of adults – or 80 million Europeans[4]; almost 9% of the adult population suffer from daily pain.

According to a 2007 Eurobarometer survey on "Health in the European Union"[5], one third of respondents had muscle, joint, neck or back pain that affected their daily activities and 25% of them experienced chronic pain, i.e. pain that lasted for 3 months or more. However, it usually takes several years before a chronic pain patient gets appropriate chronic pain treatment[6].

According to the pan-European Health and Wellness Survey 2008[7], which interviewed patients from five EU countries (UK, France, Italy, Germany, and Spain), a total of 51.8 million (20.9%), i.e. over one in five respondents, aged 18 years and over reported living with pain. The survey noted that the most frequently reported conditions causing pain are back pain (66%), joint pain (52%), neck pain (32%), and headache (31%).

Chronic pain is frequently accompanied by other symptoms, such as depression, anxiety, reduced physical mobility, and social isolation. It therefore has a significant impact on both the quality of life of individuals, as well as the different levels of resources across society and the health care system[8]. According to a 2010 Special Eurobarometer survey on "Mental Health"[9], 16% of respondents took antidepressants due to chronic pain. The National Pain Audit[10] in England and Wales found patients reported a very low quality of life on a par with severe neurological disorders.

Whilst the prevalence of chronic pain is high, it poses a severe burden on EU citizens and governments, not only in increasing health care costs but also other indirect costs such as reduced/lost productivity in the workplace, reduced income, and increased government support. In 2005 it was estimated that chronic pain results in more than 500 million sick days in Europe – costing the European economy more than €34 billion[11].

---

[4] Reid K. J. et al., *Epidemiology of chronic non-cancer pain in Europe: narrative review of prevalence, pain treatments and pain impact*, Current Medical Research & Opinion, Vol. 27, No. 2, 2011, 449-462 (https://lirias.kuleuven.be/bitstream/123456789/300711/1/pain.pdf)https://lirias.kuleuven.be/bitstream/123456789/300711/1/pain.pdf)))https://lirias.kuleuven.be/bitstream/123456789/300711/1/pain.pdf))

[5] EUROBAROMETER 66.201, Health in the European Union, Special Eurobarometer 272e, 2007 (http://ec.europa.eu/health/ph_publication/eb_health_en.pdfhttp://ec.europa.eu/health/ph_publication/eb_health_en.pdfhttp://ec.europa.eu/health/ph_publication/eb_health_en.pdfhttp://ec.europa.eu/health/ph_publication/eb_health_en.pdfhttp://ec.europa.eu/health/ph_publication/eb_health_en.pdf)) EUROBAROMETER 66.201, Health in the European Union, Special Eurobarometer 272e, 2007 (http://ec.europa.eu/health/ph_publication/eb_health_en.pdfhttp://ec.europa.eu/health/ph_publication/eb_health_en.pdf)

[6] Berufsverband der Ärzte und Psychologischen Psychotherapeuten in der Schmerz- und Palliatvmedizin in Deutschland e.V (BVSD): Whitebook Pain Medicine, June 2012. http://www.bv-schmerz.de/http://www.bv-schmerz.de/http://www.bv-schmerz.de/http://www.bv-schmerz.de/http://www.bv-schmerz.de/ http://www.bv-schmerz.de/

[7] P.C. Langley et al., *The prevalence, correlates and treatment of pain in the European Union*, Current Medical Research & Opinion, Vol. 27, no.2, 2011, 463-480.

[8] Phillips C, Main C, Buck R, Aylward M, Whynne-Jones G, Farr A., *Prioritising pain in policy making: The need for a whole systems perspective*, Health Policy 88, 2008, 166-175

[9] EUROBAROMETER 73.2, *Mental Health*, Special Eurobarometer 345, 2010 ()http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdfhttp://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf(http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf(http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdfhttp://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf)(http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf)(http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf))(http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf)

[10] C. Price, et all: *National Pain Audit*, 2010-2012.

[11] Hill L. et al., *Recent advances in the pharmaceutical management of pain*, Expert Rev. Clin. Pharmacol. 2(5), 2009, 543-557

Chronic pain is one of the major reasons why people exit the labour market prematurely[12]. In fact, the risk of pain patients having to give up their occupation due to their health status has been calculated to be seven times greater than for the healthy population[13].

3. Good Practice Indicators for Pain Management (IPM) – the Spanish Pilot Project

As described above in chapter 3, due to the high prevalence of chronic pain and the inevitable societal costs, EU governments and health care providers have started to recognise the need for allocating budgets and implementing instruments and service processes for quality pain management. The National Institute for Clinical Excellence (NICE) has been given the task of developing quality indicators for the management of people with pain in the UK which need to be evidence based. NICE Guidance on chronic pain is scattered over a number of areas e.g. osteoarthritis, returning people to work, low back pain, neuropathic pain and long-term conditions. This has led to considerable challenges when establishing overarching quality indicators.

Additionally , until recently there was still lacking proof of successful usage of monitoring systems in order to effectively measure good clinical practice and ensure efficient use of resources. Both Spanish and UK projects have recently completed methodologies in this area. The objective of the Spanish pilot project by Plataforma SinDolor on Good Practice Indicators for Pain Management (IPM) was to develop, pilot-test and evaluate a comprehensive set of evidence-based indicators which may be used for quality management in the assessment, treatment and control of pain, primarily for quality improvement initiatives at health care organization level, even though some of them may be used at more aggregate levels to monitor quality management practices.

Based upon the report by the World Health Organisation (WHO) on "Normative Guidelines on Pain Management"[14], the review of existing guidelines and scientific publications, the multi-disciplinary research team under the supervision of Professor Pedro J. Saturno (University of Murcia, Spain) compiled a set of indicators for the management of acute, chronic malignant, as well as chronic non-malignant pain. All indicators were proven to be valid in terms of the scientific evidence. Empirical tests regarding reliability, feasibility of measurement and ability to identify quality issues in pain management were run by using pilot schemes in real-life health care settings.

The methodological set-up of the project underwent four sets of action which were sequentially conducted:

> *"1. Agree/adopt a working classification of types of pain, and review and organise on that basis the existing evidence concerning its assessment, initial treatment, prevention and control.*
>
> *2. Review and organise the existing evidence and indicators underpinning the evidence-based recommendations contained in practice guidelines and the scientific literature consulted.*
>
> *3. Construct new indicators when necessary.*
>
> *4. Design measurement tools and run pilot tests with the proposed indicators, to produce a final version of the indicators, and draw up a manual of recommended methods for measuring them."*[15]

---

[12] Phillips C, Main C, Buck R, Aylward M, Whynne-Jones G, Farr A., *Prioritising pain in policy making: The need for a whole systems perspective*, Health Policy 88, 2008, 166-175

[13] Jonsson E., *Back pain, neck pain*, Swedish Council on Technology Assessment in Health Care Report, NoP: 145: Stockholm, 2000 (http://www.sbu.se/en/Published/Yellow/Back-and-neck-pain/)

[14] „Normative Guidelines on Pain Management", WHO, Geneva, 2007.

[15] „Good Practice Indicators for Pain Management – Final Summary Report", April 2012, English translation: February 2013. comunicacion@plataformasindolor.com

As result the research team presented 122 indicators in total: 54 for acute pain, 22 for chronic malignant pain, and 46 for chronic non-malignant pain. All of these indicators were tested for reliability, feasibility of measurement and capacity for identifying quality problems, and ranked by general to more specific applicability. General applicability or high-priority use-indicators include 4 for acute pain, 7 for chronic malignant pain and 9 for chronic non-malignant pain.

As the approach by the SIP 2013 Focus Group will concentrate on the development of a set of indicators for chronic, non-malignant pain exclusively, this report will not include the description of results for acute pain indicators and chronic malignant pain indicators, as brought forth by the Spanish pilot-projects. Hence, the following sub-chapter gives an overview of the construction, testing and evaluation of chronic non-malignant pain indicators exclusively.

The Spanish Pilot – Project: Good Practice Indicators for the Management of Chronic Non-Malignant Pain

46 indicators[16] for the management of chronic non-malignant pain were developed and pilot-tested at three test sites, i.e. two hospitals and one health centre:

- 1 large hospital (>500 beds)
- 1 medium size hospital (200-500 beds), with computerized clinical records
- 1 primary health care centre staffed by 20 physicians and 16 nurses

The indicators were measured at centre level, taking a sample of patients with the condition for which they apply, regardless of the clinical department where they were treated as different centres were having different structures. The Clinical Departments eventually included in the assessment were:

- Neurology
- Rheumatology
- Traumatology
- Urology
- Internal Medicine
- Pain Unit
- Gynecology
- Rehabilitation
- plus primary Health Care Centres.

A detailed description of the pilot testing process can be found in the full report of the project[17].

As described by the Spanish pilot project, good practice indicators were developed for “general chronic non-malignant pain conditions” and the following “specific chronic non-malignant pain conditions”: headache, chronic pelvic pain, non-specific low back pain, osteoarthritis, rheumatoid arthritis, fibromyalgia, and neuropathic pain. Taking all those indicators that were applicable to at least one test site into consideration, the final list consists of 32 indicators (see 8. Appendix).

[16] For a detailed describtion/definition of each of the 46 chronic non-malignant pain indicators, please see additional document “Fichas estandarizadas de los indicators de buenas prácticas porpuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013): www.sip-platform.eu

[17] „Good Practice Indicators for Pain Management – Final Summary Report“, April 2012, English translation: February 2013. comunicacion@plataformasindolor.com

In the context where they were pilot-tested, full feasibility of measurement was shown in all types of facilities for only 8 of the 46 indicators, thereby 4 being applicable to any type of chronic non-malignant pain patient ("general"), 1 applicable to patients with osteoarthritis ("OA") and 3 applicable to patients with fibromyalgia ("FM"):

1. Full pain-oriented clinical assessment ("general")[18]
2. Multimodal approach to treating chronic pain ("general")
3. Treatment of chronic pain sufferers over 65 years old with age-adjusted doses ("general")
4. Treatment of chronic pain sufferers over 65 years old with concomitant treatment to prevent side effects of analgesics ("general")
5. Therapeutic exercise treatment for patients with osteoarthritis ("OA")
6. Assessment of disease impact in patients with fibromyalgia ("FM")
7. Aerobic exercise treatment for patients with fibromyalgia ("FM")
8. Treatment with antidepressants for patients with fibromyalgia ("FM")

4. The European Approach: Quality Indicators in Chronic Non-Malignant Pain Management

Based on the Spanish pilot project as described above, the objective of the SIP 2013 Focus Group was to develop and agree upon a set of indicators for pain management of chronic non-malignant pain, which are most-commonly shared among EU member states and which shall be adopted according to national health care requirements and sequentially validated and/or implemented by EU Member States following SIP 2013.

A set of indicators is an essential instrument to measure the performance of a system and the quality of care. It is not the step which needs to be taken to improve the care itstelf. When looking for indicators to monitor the quality of pain management in different health care systems, the international Expert Group suggested clustering three types of indicators based on currently available literature[19,20] to measure the quality of pain management:

- **Structural Indicators**
  Structural indicators inform about what kind of infrastructure, tool, service, etc. is available to be used in order to provide health care services.
  e.g. numbers of inhabitants per inpatient pain service/per outpatient pain service, pain education programmes for physicians/psychologists/physiotherapists, board certification for pain medicine possible, national pain plan, national guidelines for neuropathic pain, back pain, headache, cancer pain

- **Process Indicators**
  Process indicators inform about what kind of action is being taken to provide health care services.

[18] „Full pain-oriented clinical assessment" consisting of 14 sub-indicators, i.e. pain intensity (scale), timing, distribution, course, accompanying symptoms, neurological examination, musculoskeletal examination, anxiety / depression, sleep, allergies, drug abuse, social / family status, occupational status and history, and diagnosis.

[19] Donabedian A.: Basic Approacches to Assessment: Structure, Process and Outcome. In: Explorations in Quality Assessment and Monitoring, Volume I. The Definition of Quality and Approaches to its Assessment. Chapter 3, Pp 79-128. Health Administration Press, Ann Arbor, 1980.

[20] C Eccles, M Wensing and R GroI: Improving patient care: the implementation of change of in clinical practice, Elsevier Health Sciences, 2005.

e.g. measuring pain as 5th vital sign, implementing & using pain registries, measurement of patient activity after pain assessment, educating patients

- **Outcome Indicators**
  Outcome indicators inform about the result from delivering the health care service. This type of indicator is of particular relevance to patients, as they give information on whether or not a specific health care service was successful.
  e.g. pain relief, quality of life, return-to-work

As discussed by the 10 experts and agreed upon during SIP Focus Group 1, for this Recommendations paper it will not be possible to only focus on one category of indicators, as they are all inter-correlating, e.g. structure indicators are *necessary* instruments, but not *sufficient* ones to improve the quality of pain management; e.g. care indicators show the result of the application of a process indicator (whether or not this process brought forth successful outcomes for the patient), but it does not give any information on what needs to be done in order to improve the delivery of pain management.

The suggestion made by the SIP Focus Group therefore is that if EU policy makers, health care authorities, insurers etc. intend to implement quality indicators for improving chronic pain management, this Recommendations paper would be the appropriate set to choose from to adapt and implement in their respective member state.

While there are different methods on how to construct indicators in general (e.g. by literature review, Delphi rounds, etc.), the methodology of how the following European set of indicators was generated can be described as follows:

1. Expert Rating
   All 10 experts were asked to rate the list of all 32 evidence-based indicators for chronic, non-malignant pain management derived from the Spanish Pilot Project (see Chapter 4) by applying the following rating values: 1 = not relevant, 2 = of low relevance, 3 = relevant, 4 = very relevant, 5 = most relevant (complete agreement).
2. Suggestion of additional indicators
   All 10 experts had the option to nominate additional indicators to be included in the list. Following their suggestions, these additional indicators were again rated as described above.
3. Ratings & Selection of indicators
   Following all experts' ratings, the results were consolidated: Those indicators with an average rating score of ≥ 4.0 were selected. All indicators were allocated in one of the three categories of indicators (as described above).
4. Consolidation phase
   In the consolidation phase, the existing levels of evidence/references were collected (partially coming from the Spanish Pilot Project, partially coming from other evidence-based projects or references) and allocated to each indicator.

In the following table, the SIP Focus Group will present their conclusions for proposing EU quality indicators in chronic non-malignant pain management:

Recommendations for quality indicators in chronic non-malignant pain management			
Category	**Name of Indicator**	**Average score by Experts**	**Existing evidence**
I. STRUCTURE INDICATORS			
	A. GENERAL		
A.1	Existence of a national pain strategy	=4,125	IASP[21] Italy – Law 38/10 on Pain and Palliative Care 19b[22, 23]
A.2	Existence of evidence based high quality guidelines for diagnosis and treatment of different chronic pain disorders (define disorders)	= 4,375 = 4,625	Robert A. Moore, et all 2013[24]
A.3	Availability of professionally endorsed programmes for certified and registered pain-treating specialists (list to be defined)		
A.4	Education of principals of pain for all health care professionals		
A.5	Accessibility of pain treatment for patients (to be discussed and defined)		
A.6	Existence of quality measuring programmes for pain treatment		
II. PROCESS INDICATORS			
	B. GENERAL		
B.1	Multimodal approach to treating chronic pain	~4,77	Royal College of Anaesthetists 2011[25] IASP Declaration of Montreal[26]

[21] "Desirable Characteristics of National Pain Strategies: Recommendations by the International Association for the Study of Pain", November 2011.

[22] www.salute.gov.it/curePalliativeTerapiaDolore/curePalliativeTerapiaDolore.jsp Directive 2010 15/03/2010, n. 38; G.U. Serie Generale, n. 65, 19 March 2010). This directive provides a series of important measures including the requirement to report pain in the patient's medical records, the development of a national network of palliative care and pain therapy centres.

[23] Fanelli G, Gensini G, Canonico PL, Delle Fave G, Lora Aprile P, Mandelli A, Nicolosi G. Pain in Italy . background examination . Operative proposals Recenti Prog Med. 2012 Apr;103(4):133-41.

[24] Robert A. Moore et al.: "The costs and Consequences of Adequately Managed Chronic Non-Cancer Pain and Chronic Neuropathic Pain", Pain Practice, World Institute of Pain, 1530-7085/13, 2013.

[25] The Royal College of Anaesthetists: Guidelines for the Provision of Anaesthetic Services", Chapter 7, Chronic pain services, revised July 2011.

[26] http://www.iasp-pain.org/Content/NavigationMenu/Advocacy/DeclarationofMontr233al/default.htm

B.2	Multidimensional (bio-psycho-social) pain-oriented clinical assessment (including quality of life scale)	4 / 5 / 4.77 = 4,59	Spanish Pilot Project[27] Turk DC, Monarch ES.[28] Guilford, 2002.[29] Engel GL, 1987.[30] Shorter E., 2005.[31]
B.3	Utilization of evidence based high quality guidelines for diagnosis and treatment of different chronic pain disorders		
B.4	Communication with other health care providers and patients: A letter summarizing result of the full pain-oriented assessment, as well as multi-modal treatment proposals, to be sent to GP, patient and other caregivers involved.	=4,25	HAS 2008[32]
B.5	Time between onset of pain and commencement of adequate treatment is according to IASP guidelines	~4,1	IASP guidelines[33]
	C. HEADACHES		
C.1.	Screening substance misuse and anxiety and depression.	~4,22	Spanish Pilot Project[34] NICE CG 150[35]
	D. NON-SPECIFIC LOW BACK PAIN		
D.1	Education is provided for patients with non-specific low back pain on return to normal activity.	5/4.62 = 4,81	Spanish Pilot Project[36]
D.2	Patients with non-specific low back pain with appropriate analgesic treatment	=4,25	Spanish Pilot Project[37]
	E. RHEUMATOID ARTHRITIS		

[27] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 – page 4.

[28] Turk DC, Monarch ES Biopsychosocial perspective on chronic pain, in: Turk DC, Gatchel RJ, editors.

[29] Psychological approaches to pain management: a practitioner's handbook . New York: Guilford; 2002.

[30] Engel GL. The biopsychosocial model and the education of health professionals. Ann N Y Acad Sci 1978; 310: 169– 87.

[31] Shorter E. The history of the biopsychosocial approach in medicine: before and after. Engel. In Biopsychosocial Medicine: An Integrated Approach to Understanding Illness (ed P White): 1– 19. Oxford University Press, 2005.

[32] Haute Autorité de Santé: "Recommendations professionnelles. Douleur chronique : reconnaître le syndrome douloureux chronique, l'évaluer et orienter le patient". Arugumentaire, Décembre 2008.

[33] International Association for the Study of Pain: Task Force on Wait-times. Summary and Recommendations. 2009.

[34] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 – page 16.

[35] Headaches: diagnosis and management of headaches in young people and adults. www.nice.org.uk

[36] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 - page 32.

[37] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 - page 35.

E.1.	Assessment of disease activity in patients with rheumatoid arthritis.	~4,05	Spanish Pilot Project[38]
E.2	Analgesic treatment in patients with rheumatoid arthritis.	=4,26	Spanish Pilot Project[39]
	F. FIBROMYALGIA		
F.1.	Assessment of disease impact (i.e. social, family, work, psychological impairment) in patients with fibromyalgia	~4,56	Spanish Pilot Project[40]
F.2	Aerobic exercise treatment for patients with fibromyalgia	~4.02	Spanish Pilot Project[41] Eccleston C, Williams AC, Morley S., 2009.[42]
	G. NEUROPATHIC PAIN		
G.1	Analgesic treatment in patients with neuropathic pain for different indications: 1. diabetic neuropathy 2. post-herpetic neuralgia 3. trigeminal neuralgia 4. post-amputation pain	Combined from 4 neuropathic pain indicators all rated >4.0	Spanish Pilot Project[43]
	H. PREVENTION of CHRONIC PAIN and ASSOCIATED DISABILITY		
H.1	Screening for risk factors for disability using a structured questionnaire	Not rated	Main CJ, Sowden G, Hill JC et al. [44] Kendall NAS, Lington SJ, Main CJ, 2004.[45]

[38] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 - page 42.

[39] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 - page 46.

[40] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 - page 47.

[41] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 - page 48.

[42] Eccleston C, Williams AC, Morley S. Psychological therapies for the management of chronic pain (excluding headache) in adults. Cochrane Database Syst Rev 2009; CD007407. Available from: http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD007407.pub2/pdf/standard

[43] Fichas estandarizadas de los indicatores de buenas prácticas propuestos para el manejo del dolor no oncológico (revised version, January 2013, English translation: March 2013 - page 51-56.

[44] Main CJ, Sowden G, Hill JC et al. Integrating physical and psychological approaches to treatment in low back pain: the development and content of the STarT Back trial's 'high-risk' intervention (StarT Back; ISRCTN 37113406). Physiotherapy 2012; 98: 110-7. Available from: http://www.ncbi.nlm.nih.gov/pubmed/22507360

[45] Kendall NAS, Lington SJ, Main CJ. Guide to Assessing Psycho-social Yellow Flags in Acute Low Back Pain: Risk Factors for Long-Term Disability and Work Loss. Wellington, NZ: Accident Compensation Corporation and the New Zealand Guidelines Group; 2004. Available from: http://www.acc.co.nz/PRD_EXT_CSMP/groups/external_communications/documents/guide/prd_ctrb112930.pdf

III: OUTCOMES INDICATORS *REQUIRED: FURTHER DEFINITION OF INDICATORS FOR MEASUREMENT!*			
I.1.	Pain Relief	~4,42	Dworkin et al. 2009.[46]
I.2.	Quality of life (e.g. to be measured by SF 12, SF 36)	~4,3	
I.3	Emotional factors		
I.4	Physical functioning		
I.5	Patient satisfaction		
I.6	Safety of care		
I.7	"Return to work" (maybe related to I.4)		
I.8	Early retirement (maybe related to I.4)		

5. SIP Recommendations for Validation and Implementation of Quality Indicators in Chronic Non-Malignant Pain Management in EU Member States

Due to large discrepancies between structure, processes and priorities of health care systems across EU Members States, a unified, holistic European approach to validate and implement the proposed European set of quality indicators in chronic non-malignant pain management is rather unlikely and unrealistic. The SIP Platforms clearly distinguish between the development of ideal models for improving health care settings and the process of the required adaptation and "nationalization" according to national, regional or even local health care set-ups.

Two scenarios for approximating the desired transition from theory to reality which would bring the proposed set of indicators into real-life settings, the SIP Platform would therefore like to propose:

1. General European SIP Recommendations based on EU-wide commonly shared success factors
2. Specific national SIP Recommendations based on national expertise by SIP experts and SIP Focus Group

[46] Dworkin RH, Turk DC, McDermott MP, Peirce-Sand¬ner S, Burke LB, Cowan P, Farrar JT, Hertz S, Raja SN, Rappaport BA, Rauschkolb C, Sampaio C. Interpreting the clinical importance of group differences in chronic pain clinical trials: IMMPACT recommendations. Pain, 2009;146:238–244.

General European SIP Recommendations

The SIP platform recommends the following key success factors for a European-wide validation and implementation of the above defined European set of quality indicators in chronic non-malignant pain management: Tbd. In future working sessions.

Specific national SIP Recommendations

Based on suggestions made by each national SIP expert and by the participants from the same EU Member State as discussed during the SIP Focus Group, the SIP platform recommends the following items as key success factors for the national, country-specific validation and implementation of the above defined European set of indicators in chronic non-malignant pain management:

Austria

Validation and subsequent pilot testing should take place in a sample of primary care institutions, general hospitals and specialised pain clinics. It is recommended to build an electronic register for participating institutions; implementation requires a general care management and implementation plan supported by legal and political institutions. It needs the inclusion of all care sectors and should contain not only clinical guidelines, but also organisational pathways (e.g. referral criteria). The aim should be to set-up pain care networks within the existing structures by improving communication and co-operation. Focus should be set on primary care setting.

Quality measurement should primarily be implemented on the systematic national level and contain a limited set of indicators. Additionally, there also should be implemented a detailed documentation on the level of each participating centre which is more patient-oriented and that focusses on treatment processes and outcomes. So far there has not yet been implemented any such system in Austria.

Belgium

The complex institutional situation in Belgium (e.g. several languages, health care controlled by several public institutions, coexistence of private/public hospitals) will make the process of a national validation/implementation quite complicated. Therefore, it is suggested that a small number of general indicators will be chosen and tested in a sufficiently large range of health care facilities to be representative of the Belgian situation.

More precisely:

- Selection of one academic hospital and one non-academic hospital (thus a total of 6 hospitals) for testing in each of the three regions (Flanders, Wallonia, Brussels),
- Collaboration with a newly established pilot project in Belgium to take part in the evaluation. The pilot project aims to establish a pain team in each hospital, whose mission would be to evaluate needs and educate caregivers.

- Reach out to general practitioner associations to evaluate if testing is possible in primary care (very heterogeneous settings)

France

1) Three national pain programme have been developed:
    a. The 1st plan (1998-2000) concerned the development of pain consultations and pain networks, education and information of health caregivers and information and specific patients' care concerning pain.
    b. The 2nd plan (2002-2005) concerned the same topics with a special issue on pain provoked by surgery or care, children' pain and migraine management. Best information to health caregivers and patients, a best access to pain consultations, a specific educational programme on pain and the importance of the nurse's play in pain were underlined.
    c. 3rd plan (2006-2010) concerned pain in frail population (elderly, psychiatric disease and children), initial education and continuing education on pain, improvement of pharmacological and non-pharmacological treatment and a best vision of the care network.[47]

2) In France, clinical practice recommendations are on migraine-headache, neuropathic pain, pain in children, pain in elderly patients, pain in cancer, low back pain, osteoarthritis, etc. One of these recommendations, chronic pain for adults, was chosen to elaborate a specific audit on pain quality indicators. Nine were proposed: 1) prepare the pain evaluation of the patient, 2) synthesis of the medical past history, 3) multi-professional evaluation of the pain, 4) synthesis of the pain evaluation done in the pain consultation, 5) patients' view and wish concerning its pain, its treatment, 6) multidisciplinary meeting, 7) personalized therapeutic project, 8) explanation of the therapeutic project to the patient, 9) conclusions sent to the general practitioner.[48,49]

    The content of these SIP Recommendations will change national indicators according the health care system. On the other hand, a too large set of indicators might not be helpful, to describe the level of care of a health care system.

    Recently, the French ministry made the evaluation of each pain centre to give the certification: certified pain team (CPT). The funding, about 61 million Euros, is shared between the 379 CPT.[50]
3) More general indicators are important to evaluate the level of health care system:
    a. Existence of recommendations on pain, neuropathic pain, migraine, etc. and assessment of their quality of development
    b. Existence of specific core curricula on pain

---

[47] Lanteri-Minet M. Pain in France: the involvement in 2011–2012 of French health authorities in partnership with the French Pain Society. *Douleur analg*. 2012. DOI 10.1007/s11724-012-0309-5.

[48] ANAES. Prise en charge de la douleur chronique de l'adulte en ambulatoire, 1999.

[49] HAS. EPP. Evaluation du syndrome douloureux chronique en structure spécialisée.

[50] INSTRUCTION N°DGOS/PF2/2011/188 du 19 mai 2011 relative à l'identification et au cahier des charges 2011 des structures d'étude et de traitement de la douleur chronique.

c. **Number of pain clinics or consultations specifically dedicated on pain thus "certified pain team" according the DGOS 2011**
d. **The number of new patients seen per year in a "certified pain team"**
e. **The number of physicians with a specific diploma on pain (DESC in France)**
f. **The number of hospitalization in hospital with the International Classification of Disease code: "chronic refractory pain"**
g. Existence of a multidisciplinary team (physician, psychologist, nurse, physiotherapist...)

Germany

Quality indicators implemented in Germany include the following:

- National action plan against pain declared by German Pain Society in 2010, not yet supported by government or insurance companies.
- Mandatory education in palliative medicine in medical schools legislation passed 2010.
- Mandatory education in pain medicine in medical schools legislation passed 2012.
- Postgraduate specialization in pain medicine (specialized pain therapy) for physicians introduced in 1996 and last revised 2009 and revision 2014 being prepared. Number of certified doctors: 1027
- Postgraduate specialization in pain medicine (specialized pain therapy) for psychologists introduced in 2006 and last revised 2011. Number of certified psychologists: 237
- Since 1996 Qualitätssicherungsvereinbarung mit KV = certification for out-patient care using multidisciplinary pain therapy
- German version of ICD-10 contains chronic pain code since 2009 (F45.41); major indication for multidisciplinary pain therapy
- Multidisciplinary pain therapy reimbursed for in-patients (OPS 8.918 etc.)
- Deutscher Schmerzfragebogen = nationwide standard assessment tool, last revised 2011
- National guidelines for back pain and diabetic neuropathy pain generated by AWMF, BÄK and KBV.
- Evidence-based multidisciplinary S3 guidelines for acute pain, neuropathic pain, headache, fibromyalgia, opiates in chronic non-cancer pain, etc. collected by AWMF and updated regularly.
- Quality monitoring programs for acute pain: PainOUT, CefrtKom, TÜV, Patientensiegel
- Chronic pain registry KEDOQ-Schmerz.
- Waiting time too long, number of pain centres too low (HTA report 2012).

Italy

In Italy, since March 2010 there has been a law (Law 38/2010 on chronic pain and palliative care[51]) which normatively demands on any health care structure to evaluate "pain intensity" on a daily basis and to describe efficacy of therapy and monitoring procedures in clinical documents (article 7). Therefore, a few general indicators relevant for physicians and health care providers are already in place. After each year, it is the responsibility of the Ministry of Health to control the proper application of the law and to report back to Parliament.

[51] www.salute.gov.it/curePalliativeTerapiaDolore/curePalliativeTerapiaDolore.jsp, www.statoregioni.it/

The Italian "Palliative Care National Program[52]" does by contrast include both a general, as well as a specific group of indicators (78 code).

Within the "Accreditation Hospital Programme", which is valid in the Italian Region of Emilia Romagna where an Accreditation for Pain Unit[53] has been implemented since 2009, there are also some regional indicators. The implementation of a general set of indicators which is applicable to all regions of Italy remains a challenge since each region is being administered by a regional health authority with autonomy on the implementation of different health programmes.

Netherlands

In the Netherlands, a specific (medical) culture for measuring indicators of various diseases is already present and has been operatively implemented for years. The Netherlands do have indicators for the measurement of acute postoperative pain, cancer pain, pressure ulcers, medication safety, etc..

However, until today the measurement of indicators is only possible in large institutions (hospitals and academic centres), but not in primary care situations. In the latter, the lack of supportive personnel is the major reason that indicators cannot be measured in a structural way. Therefore, if one intends to measure indicators at a primary care level, special teams should be planned and foreseen in order to measure these indicators.

Additionally, these indicators can only be measured in the clinical situation and not in the poly-clinical situation (out-patient departments). Therefore, in order to motivate out-patient departments and primary care situations to participate in the measurement of indicators, special travelling teams should be foreseen, otherwise the participation rate in such a project might be rather low.

The proposed indicators in this document are mostly focused on the quality outcome of pain and not on structure and process. Aiming for improving the care for pain patients and their outcome, should include indicators for structure and process (the number of specialized pain teams, centres, special poly-clinics, number of specific trainings and educational initiatives, number of research budgets, number of chairs in pain medicine, organisation of guideline usage).

Portugal

In Portugal the validation/pilot-testing and potential implementation of the proposed indicators could be held in hospitals and primary care but only a few *per* region.

Portugal has some structural measures: National Pain management program, guidelines to record pain as 5th vital sign, guidelines to neuropathic pain, to the prescription of NSAIDs, and opioids to malignant and non-malignant pain. However, it is difficult to obtain evidence about daily use of the guidelines and pain registry.

---

[52] Ministry of Health National Palliative Care program D.G.R. 327/04, Accreditation Model for Palliative Care and Hospice G.U. 06.04.2007, www.salute.gov.it/imgs/C_17_pubblicazioni_378_allegato.pdf

[53] Accreditation for Pain Units and Hospice Law n. 947 del 6 luglio 2009

It would be very important to have outcome indicators to evaluate performance.

Spain

All indicators proposed in the table above are evidence-based and could be used for quality improvement initiatives at centre level. Limitations to implementation of these indicators could be imposed by the feasibility of measurement, mostly due to the limitations of the information system. A selection of them may be used at a more aggregate level to monitor pain management practices at regional or national levels.

The initially proposed set is a menu encompassing the up-to-date *evidence* on what could and should be done to improve pain management. The prioritization/selection in Spain is the one that was provided by the ratings of experts from the different regions, with the constraints of measurement feasibility. Taking into account these two characteristics (feasibility of measurement and high expert ratings) the proposed list is described in the publication with the results of the project, which is currently in press.

Sweden

In 1994, the National Board of Health and Welfare published recommendations for the organisation of pain care within the health care system. However, these recommendations were never implemented. Several quality aspects of the Swedish health care system have been compared across the county councils, which are responsible for all health care in a geographical area. Sweden is divided into 20 such county councils. These quality aspects were summarised in a report “Open comparisons” (in Swedish: “Öppna jämförelser”). However, pain is not included in this report.

Now, the Swedish Pain Society has suggested a national pain strategy focussing on education, clinical activities and development and research.

In order to implement the indicators as proposed in this document it will be necessary to differentiate between:

1) Primary health care
2) Specialized care in hospitals
3) Clinical pain departments

United Kingdom

National Audits are quality improvement programmes in the UK that are government funded and focus on priority areas. Chronic pain was prioritised as a result of the Chief Medical Officer for England’s report 2008 Pain: breaking through the barrier. NHS providers are obliged to take part in National Audits. The audit was led by the British Pain Society and Dr Foster - a health intelligence data company.

The National Pain Audit in the UK did not develop specific indicators for specific conditions. However, using a similar process of review of existing guidelines and the evidence base behind these, it did establish methods to measure the structure, processes and outcomes of care from specialist pain clinics in the UK on a large scale. To provide this over a three-year cycle, the audit was divided into three phases:

Phase one

Pain service registration and completion of a service questionnaire to the registrant based upon key standards. Organisational standards were benchmarked against each other and against national and internationally agreed standards, where they could be ascertained.

Phase two
Case mix information from both the provider clinicians and patients. Information from patients about the patient journey to a pain service.

Phase three
Outcomes of care from a patient perspective using validated standard questionnaires and questions developed specifically for the audit by both clinicians and patients.

The principal indicators developed by the Audit were piloted in 12 centres and feasibility established. They were then disseminated to all NHS clinics in the UK. 161 clinics returned data with 94 completing all three phases. Nearly 10,000 patients replied from these clinics with 4000 sending in outcome data.

The audit established methodologies to capture information over a wide range of standards
Key standards were:

- Multidisciplinary standard established through asking for staff mix - this has been reported in the NHS Atlas of Variation and demonstrates high variation
- Waiting times to less than 18 weeks for planned care (government standard) and patient report on ease of access with level of difficulty set at easy
- Quality of Life using the Brief Pain Inventory and Euroqol 5D. These were case mix adjusted using sophisticated modelling techniques in order to compare centres. A change of a difference of 1 point or half a standard deviation on the BPI interference score was considered a clinically significant change. (Dworkin RH, Turk DC, McDermott MP, Peirce-Sandner S, Burke LB, Cowan P, Farrar JT, Hertz S, Raja SN, Rappaport BA, Rauschkolb C, Sampaio C. Interpreting the clinical importance of group differences in chronic pain clinical trials: IMMPACT recommendations. Pain, 2009; 146:238–244.)
- Information, Advice and Guidance on managing pain - a standard of 80% of patients in a centre who recalled being given this was set

Overall 40% of English Pain clinics and 60% of Welsh clinics (who have a specific government policy on pain) achieved the multidisciplinary standard. 80% of English clinics and 50% of Welsh clinics achieved the waiting time standard although most patients rated it difficult to gain access with many resorting to emergency attendances at the hospital to gain pain relief. 70% of services had patients reporting significant change in quality of life (from a very low baseline). However, overall only 40% of patients rated the quality of information, advice and guidance to manage pain as good or excellent with many not recalling being offered anything specific. A discussion on this suggests that this may be related to patient expectations and the time it can take to adjust to having a long-term condition.

Work is continuing on safety, community care and longer term outcomes from patients. What has been most striking has been the very low quality of life endured by patients with chronic pain and the high health care resource use of patients waiting to be seen by specialist pain clinics. This rapidly comes down with attendance at a pain centre.

The “Good Practice Guides” produced by the Faculty of Pain Medicine in both acute (inpatient) and chronic pain services are of fundamental importance to delivery. Other useful guides include the “Pain Management Programme Good Practice Guide”, the “IASP waiting list guidance” and the “British Pain Society Persistent Pain Pathways”. Medicines management is already an important part of safety culture. General standards of care that can be applied to any health care condition do already exist.

A National Pain Summit was held in 2011. Government policy is not to produce any further service frameworks. A summit brought together patients, policy makers, commissioners, professionals and researchers. This had four key recommendations for improved delivery of pain care:

- Clear standards and criteria must be agreed and implemented nationally for the identification, assessment, and initial management of problematic pain
- An awareness campaign should be run to explain the nature, extent, impact, prevention and treatment of chronic pain to the wider general and NHS community
- Nationally-agreed commissioning guidance must be developed and agreed, describing best value care in chronic pain to reduce unwarranted variation
- A data strategy for chronic pain should be agreed through creation of an epidemiology of chronic pain working group

The next step is for NICE to draw together Quality Standards to be applied across the area of pain management. These are evidence based and a shadow format is initially proposed. Research that explores some of the outcomes from the audit is proposed.

Specific national SIP recommendations from other EU Member States – other than those described above - have not been examined at this stage.

6. Supporting SIP 2013 Recommendations on the European Implementation of Quality Indicators in Chronic Non-Malignant Pain Management

At the end of the discussion of SIP Focus Group 1, all participants were asked the following question:

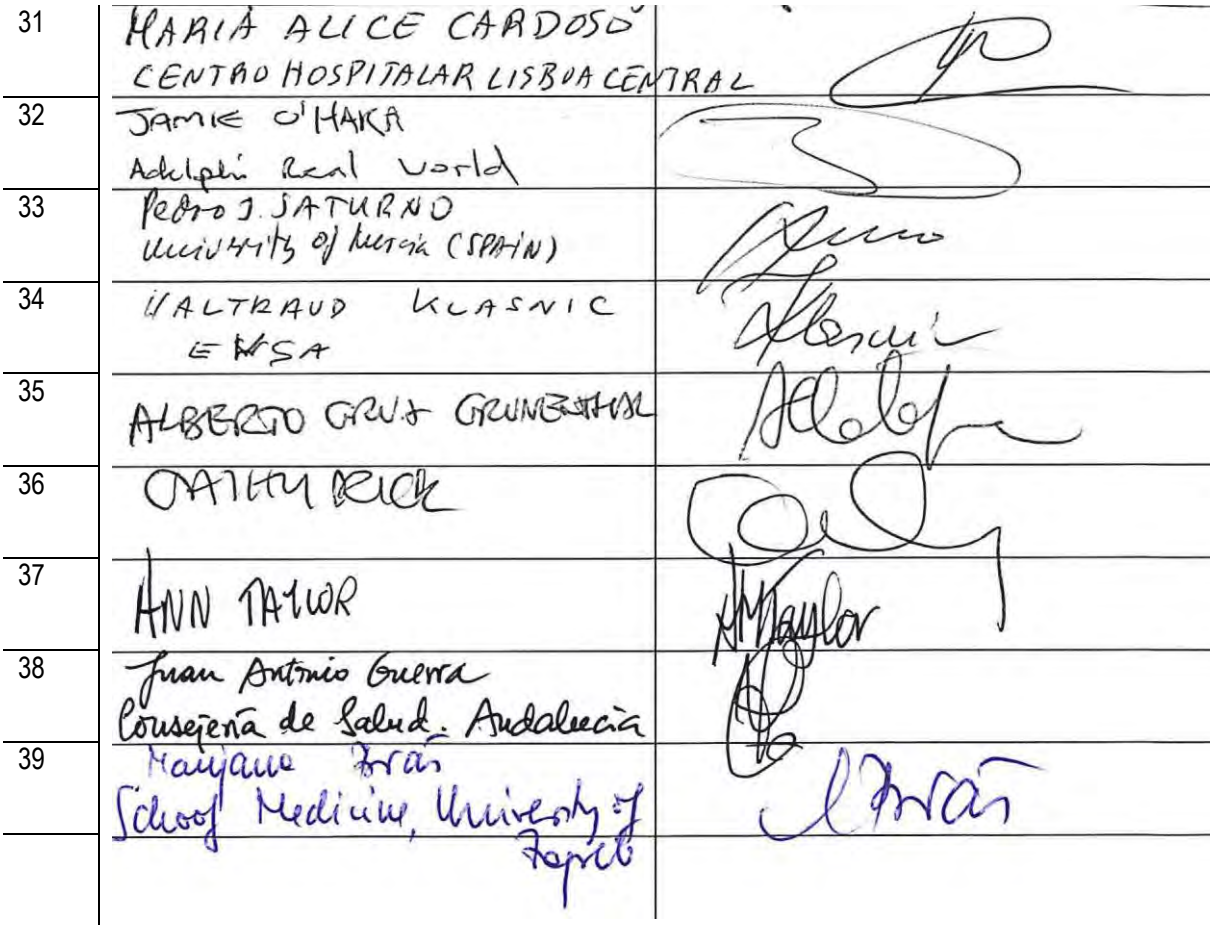
> *"Do you support the process and the outcome of this meeting, defining a draft list of indicators as a starting point for the definition and further formulation of quality indicators for the treatment of patients with chronic non-malignant pain and are you satisfied with the outcome?"*

48 participants answered with "Yes", 1 participant answered with "No".

The following delegates participated at SIP Focus Group 1, which took place in the Renaissance Hotel, Brussels, on 14 May 2013:

	Name of person / organisation / association / institutions	Signature
1	Björn Gerdle Sweden	
2	Roman Hans	
3	Robert Johnston	
4	Nevenka Kregar Velikonja	
5	SIBYLLE KOZIEL	
6	Ma. Eugenia Vega Villegas	
7	Morgan Berg	
8	Jérôme Giwer, Cercle Luxembourgeois d'Algologie Luxembourg	
9	DEBUGNE Thierry. CERCLE LUXEMBOURGEOIS ALGOLOGIE	
10	Anne BERQUIN Belgian Pain Society	
11	Anna VINKOUSKY AUH	
12	Virginie Piano. French Pain Society	

13	EMILIO IGNACIO GARCIA PRESIDENTE SOCIEDAD ESPAÑOLA DE CALIDA ASISTENCIAL	
14	DR ANDRÉ LJUNGQUIST Lecturer Public Health & Epidemiology, Adelphi, LU, Sweden	
15	~~Acela~~ Jamie O'Hara Health economist Adelphi real world	
16	Dr. Pedro J. SATURNO University of Murcia (SPAIN)	
17	Wolfhard Klaiber EFSTA	
18	Hans G. KRESS EFIC	
19	Dolto GRUA GRUNENTHAL	
20	ANN TAYLOR	
21	CATHY PRICE	
22	Juan Guerra de Hoyos	
23	Carlos Blay Pueyo	
24	Manuel Santiñà Vila SCQA	
25	Rolf-Detlef Treede	
26	MATTHIAS MÜLLER GRUNENTHAL	
27	ANTON HERREROS / FUNSAL PLATAF. SIN DOLOR	
28	FRANCISCO LOPEZ SORIANO. HOSPITAL NOROESTE. MURCIA SPAIN	
29	RAFFAELI WILLIAM ISAL Foundation - RIMINI ITALY	
30	FRANCESCO DUARTE CORREIA APED (Associação Portuguesa para o Estudo da Dor)	Portugal



7. Appendix I

7. 1 Table of Good Practice Indicators for Chronic Non-malignant Pain Management, as suggested by "Good Practice Indicators for Pain Management – Final Summary Report", February 2013, Plataforma SinDolor.

GOOD PRACTICE INDICATORS FOR CHRONIC NON-MALIGNANT PAIN MANAGEMENT PRESENTING NO EVALUATION PROBLEMS					
	Name of Indicator	**Large Hospital (non-computerised)**	**Medium-Sized Hospital (computerised)**	**Primary Care**	**All**
A. GENERAL					
A.1. General	A.1.1. Full pain-oriented clinical assessment.	✓	✓	✓	✓
	A.1.2. Pain treatment following the analgesic pain scale, tailored to each individual.	✓	✓		

		A.1.3. Multimodal approach to treating chronic pain.	✓	✓	✓	✓
A.2. Patients > 65 years old		A.2.1. Treatment of chronic pain sufferers over 65 years old with age-adjusted doses.	✓	✓	✓	✓
		A.2.2. Treatment of chronic pain sufferers over 65 years old with concomitant treatment to prevent side effects of analgesics.	✓	✓	✓	✓
B. HEADACHES						
B.1. General		Detection of drug abuse in patients with headache of any aetiology.		✓	✓	
B.2. Migraines		Treatment of migraine attack according to pain intensity.		✓	✓	
		Patients with diagnosis of migraine and appropriate prophylactic treatment.		✓	✓	
		Non-drug treatment of migraine.		✓	✓	
		No patient with migraine should be given ergotamine or botulinum toxin as treatment.		✓	✓	
		Inappropriate use of neuroimaging tests in patients with migraine.		✓		
B.4. Migraine with aura in women		Women on treatment for migraine with aura not simultaneously using oral contraceptives.			✓	
B.5. Tension headache		Patients with tension headache who have analgesics prescribed for acute attacks.		✓	✓	

		Patients with tension headache who have prophylactic treatment prescribed.		✓	✓	
C. CHRONIC PELVIC PAIN						
C.1. General		Patients attending consultation with chronic pelvic pain who have appropriate treatment prescribed.		✓	✓	
C.3. Chronic bladder pain		Patients with chronic bladder pain who have appropriate treatment prescribed.			✓	
D. NON-SPECIFIC LOW BACK PAIN						
D.1. Low back pain		Educate patients with non-specific low back pain for a return to normal activity.			✓	
		Give patients with non-specific low back pain therapeutic exercise treatment.			✓	
		Cognitive behaviour programmes with non-specific low back pain.			✓	
		Patients with non-specific low back pain with appropriate analgesic treatment.			✓	
E. OSTEO-ARTHRITIS						
E.1. Osteoarthritis		Therapeutic exercise treatment for patients with osteoarthritis.	✓	✓	✓	✓
		Weight loss treatment in overweight patients with osteoarthritis.		✓	✓	
F. RHEUMATOID ARTHRITIS						

F.1. Rheumatoid arthritis		Assessment of disease activity in patients with rheumatoid arthritis.		✓	✓	
		Low-intensity exercise programmes for patients with rheumatoid arthritis.		✓	✓	
		Appropriate treatment with disease-modifying anti-rheumatic drugs (DMARDs) in patients with rheumatoid arthritis.		✓	✓	
		Combination drug treatment in patients with rheumatoid arthritis who fail to respond to DMARD monotherapy.				
		Analgesic treatment in patients with rheumatoid arthritis.		✓	✓	
G. FIBRO-MYALGIA						
G.1. Fibromyalgia		Assessment of disease impact in patients with fibromyalgia.	✓	✓	✓	✓
		Aerobic exercise treatment for patients with fibromyalgia.	✓	✓	✓	✓
		Treatment with antidepressants for patients with fibromyalgia.	✓	✓	✓	✓
		Pregabalin or cyclobenzaprine treatment for patients with fibromyalgia.		✓		
H. NEUROPATHIC PAIN						
H.1. Diabetic neuropathy		Analgesic treatment in patients with diabetic neuropathy.				

H.2. Post-herpetic neuralgia	Analgesic treatment in patients with post-herpetic neuralgia.		✓		
H.3. Trigeminal neuralgia	Appropriate analgesic treatment in trigeminal neuralgia.		✓		
H.4. Post-amputation neuropathic pain	Appropriate analgesic treatment in patients with post-amputation neuropathic pain.				
H.5. Chronic post-surgical pain	Appropriate analgesic treatment in chronic post-surgical pain.		✓		