

Attachment 5: Assessment Instrument

Web Based Training for Pain Management Providers (NIDA)

April 12, 2010

## ASSESSMENT INSTRUMENT

**OMB # 0925-XXX**

Expiration Date xx/xxxx

### BURDEN STATEMENT

Public reporting burden for this collection of information is estimated to average 45 minutes per response each time the assessment is completed, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Each 45 minute experience consists of an Objective Structured Clinical Examination (OSCE) immediately followed by an assessment. The OSCE, which is when the data needed are gathered, takes 15 to 30 minutes and the assessment instrument takes from 15 to 30 minutes. Each time the assessment is completed, it is expected to be completed in a single sitting. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0486). Do not return the completed form to this address.

Medical Record Patient Encounter Note – SOAP Note: Pre-, Post-, Follow-up

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Form will be online, with OMB number added appropriately

Medical Record Patient Encounter Note (SOAP note)

**History**

*Include significant positives and negatives from history of present illness, past medical history, review of system(s), social history and family history.*

**Physical Examination**

*Indicate only pertinent positive and negative findings related to the patient's chief complaint.*

**Differential Diagnosis**

*In order of likelihood, write no more than 5 differential diagnoses for this patient's current problems:*

- 1.
- 2.
- 3.

4.

5.

### **Diagnostic Work Up**

*Immediate plans for no more than 3 further diagnostic studies:*

1.

2.

3.

### *Tentative Treatment Plan*

1.

2.

3.

4.

5.

Learner Self-Assessment Modified Interpersonal Skills Inventory: Pre-, Post-,

Follow-up

– draft

Please rate the following questions on a 5 point Likert Scale:

1=Strongly Disagree, 2=Disagree, 3=Neither Disagree or Agree, 4=Agree, 5=Strongly Agree

1. I (he/she) was warm and friendly throughout the encounter, not abrupt or impatient.
2. I (he/she) listened carefully as the patient described the problem and did not interrupt him or her.
3. I (he/she) encouraged the patient to ask questions.
4. I (he/she) gave the patient adequate time to ask any questions and to express his or her thoughts and concerns.
5. I (he/she) used words that the patient could understand when explaining any technical or medical terms.
6. I (he/she) did not lecture or talk down to the patient.
7. I (he/she) showed interest in the patient as a person, did not act bored, or ignore what the patient had to say.

8. I (he/she) expressed empathy for the patient's suffering when appropriate
9. I (he/she) used an appropriate and polite manner to end the interview.
10. Overall, I felt (he/she seemed) comfortable in the interview.

Knowledge and Competency Measure: Pre-, Post- and Followup

draft

1. Screening questionnaires for risk of opioid addiction in chronic pain patients are best used:

- A. To avoid urine drug testing
- B. Only for patients with a “red flag” in their medical history or physical examination
- \*C. For all chronic pain patients before prescribing opioids
- D. Only when urine drug testing is positive

2. Which of the following is a tool specifically designed to assess risk for substance abuse in pain patients:

- A) AUDIT
- B) CAGE-AID
- C) BPI
- \*D. ORT

3. After patient selection for long term opioid therapy, physicians should triage patients in order to stratify

risk. The following describes a moderate-risk patient:

- A) Current substance use problem
- \*B) Comorbid minor or past major mental health problem
- C) No contributory family history of substance abuse
- D) Major untreated mental health problem

4. To minimize risk for addiction, the best strategy of the following for chronic opioid therapy is:

- \*A) Use long acting opioids on a schedule
- B) Use long acting opioids as needed for pain
- C) Use short acting opioids as needed for pain
- D) Use short acting opioids on a schedule

5. Which of the following is true for the clinical guidelines regarding chronic opioid therapy produced most recently by the professional organizations on pain treatment, APS/AAPM?

- A) Recommendations are weak due to lack of evidence for effectiveness
- \*B) Recommendations are weak due to side effects and variability in effectiveness
- C) Recommendations are strong despite weak evidence due to clinical consensus
- D) Recommendations are strong due to strong evidence for at least modest effectiveness

6. A complete list of the critical outcomes to assess at every visit during the ongoing management of pain patients on controlled substances is:

- A) Pain severity and daily functioning

- B) Breakthrough pain, pill counts, collaborative interviews, and prescription monitoring programs
- \*C) Analgesia, activities, adverse effects, aberrant behaviors, and affect
- D) Behaviors characteristic of addiction: continual use despite harmful effect, craving, compulsive use, and impaired control

7. Aberrant behaviors due to which of the following may resemble addiction?

- A) Pseudoaddiction
- B) Chemical coping
- C) Recreational abuse
- \*D) All of the above

8. Based on the concept of a "medical home" for patients on chronic opioid therapy:

- A) The addiction treatment specialist, if one is needed, is always the one responsible for the patient's overall medical care.
- B) The provider who prescribes the opioids is the one responsible for the patient's overall medical care.
- \*C) A primary care physician could provide the medical home for patients, even if he or she did not prescribe the opioids.
- D) The primary care provider provides the medical home only for patients at low risk for substance use problems.

9. The following statements refer to urine drug testing. All of the following are appropriate uses of urine drug screening EXCEPT:



- A) Use urine drug screening to assess all chronic pain patients before prescribing opioids
- B) Use urine drug screening to monitor patients on chronic opioid therapy
- \*C) Use urine drug screening to detect whether the patient is taking too much of the prescribed opioid
- D) Use more frequent urine drug screening when a patient on chronic opioid therapy shows signs of high risk for addiction

10. All of the following are considered appropriate treatment during chronic opioid therapy of a patient with increased risk for addiction EXCEPT:

- A. Calling the patient the day before an appointment and requiring they bring their medication bottle for a pill count
- B. Testing urine for a medication you did not prescribe
- C. Talk to family members of a patient with permission regarding their habits in using their medication
- \*D. All of the above are appropriate

11. Which of the following is true for treatment agreements used in chronic opioid therapy?

- \*A) May be combined with informed consent process
- B) Must be in writing and signed
- C) Have been replaced with more structured, legal contracts
- D) Are likely to increase malpractice lawsuits

12. Which of the following best describes the severity of chronic pain for which opioids are indicated?

- A. Pain of any severity but must be constant pain

- \*B. Moderate to severe pain
- C. Only severe pain or worse
- D. It varies with the underlying pain condition

13. The evidence for opioid effectiveness is

- A. Similar for most oxycodone, fentanyl, and morphine
- B. Stronger for oxycodone than fentanyl
- \*C. Stronger for fentanyl than oxycodone
- D. Fentanyl and oxycodone have not been studied well enough to draw conclusions about their effectiveness

14. All of the following are assessed at each appointment during ongoing patient monitoring to minimizing risk of addiction in a patient on chronic opioid therapy

- A) Pain
- B) Adverse effects
- \*C) Prescription drug monitoring program
- D) All of the above are assessed at each appointment

15. Which of the following is NOT an appropriate clinical strategy to prevent diversion in your practice?

- A) Conduct thorough patient interviews.
- B) Make a practice of periodic urine screening for illicit substances.
- C) Require patients to fill all prescriptions at one pharmacy.
- \*D) Terminate care of patients whom you believe may be diverting.

16. The age group with the highest rate of diversion is:

- A) 13-19
- \*B) 20-29
- C) 30-39
- D) 40-49

17. Which of the following is true for regulations regarding prescribing opioids?

- A. State regulations always override federal regulations
- B. Federal regulations always override state regulations
- \*C. The strictest rule always overrides the less strict rule
- D. State and Federal drug schedules are identical

18. Barbara, a 47-year-old chronic pain patient has a history of alcoholism and is now in recovery and on no medications. Which of the following is true regarding her risk of opioid addiction?

- A. There is no risk because she was addicted to alcohol not opioids
- B. There is no risk because she is now in recovery
- \*C. There is some increased risk with a history of addiction to any substance
- D. Opioids should not be used due to the high risk of relapse to alcohol use and/or high risk of opioid addiction

19. Scott, a 38-year-old auto mechanic new patient has moderately severe back pain for several weeks that is not responding sufficiently to ibuprofen. What is the next step?

- A. A trial of short acting opioids
- B. A trial of long acting opioids
- C. A trial of long acting opioids with short acting opioids for episodes of increased pain
- \*D. None of the above

20. You suspect that Monica, a 28-year-old chronic pain patient, is misusing her prescription pain medication because she comes back early for refills with stories of losing the drug and repeatedly running out early. You are unable to get more information from her on the reasons for running out early, so the best response of the following is:

- A. This is not sufficient evidence to make any change in treatment.
- \*B. Tighten treatment structure and continue prescribing the opioid
- C. Stop opioids immediately
- D. Refer her to addiction treatment

Participant Attitude Measure: Pre-, Post-, and Follow-up

– draft.

Please rate the following questions on a 5 point Likert Scale:

1= Strongly Disagree, 2=Disagree, 3=Neutral, 4=Agree, 5=Strongly Agree

In my opinion:

1 . It is my role as a primary care provider to prescribe opioids for chronic pain when indicated.

2 . It is my role as a primary care provider to screen for risk of addiction before prescribing opioids.

3 . It is important to monitor regularly chronic pain patients who are on opioids.

4 . It is possible to prescribe opioids for chronic pain without addiction developing.

5 . It is important to have a plan for stopping opioids before starting to prescribe them for a particular patient.

6 . Treatment agreements are important tools in reducing risk of substance misuse in chronic opioid treatment.

7 . Urine drug testing is an important tool for use with all chronic pain patients on opioids.

8 . It is my role as a primary care provider to regularly communicate with specialists in addiction and/or pain treatment who are treating my patients.

