2019

**electronic Persistent Pain Outcomes Collaboration Annual Data Report 2018**

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electronic Persistent Pain Outcomes Collaboration Annual Data Report 2018

Abstract

ePPOC is a program that aims to improve services and outcomes for people experiencing persistent pain. It involves specialist pain services collecting a standard set of information to measure outcomes for their patients as a result of treatment. Pain services use the information to triage, monitor and plan treatment for individual clients, and also send non-identifiable information to ePPOC for analysis. The results of these analyses are fed back to participating services every six months, allowing pain management services to assess their results, and compare their patients, services and outcomes to other pain management services. ePPOC also uses the information collected by services for national benchmarking and to develop a coordinated approach to research into the management of chronic pain in Australasia.

ePPOC is an initiative of the Faculty of Pain Medicine, established with funding from the New South Wales Ministry of Health, and supported by key stakeholder bodies. It was launched in 2013 with a small number of pain management services trialling the measures and processes. All other pain management services throughout Australia and New Zealand are now able to participate.

PaedePPOC addresses the differing needs of the paediatric pain management sector. This program allows collection of data items and assessment tools specific to the needs of children, adolescents and their parents.

This report presents data collected by participating pain management units during 2018. Sixty seven adult and nine paediatric pain management services contributed data for this report.

Keywords

pain, annual, 2018, outcomes, collaboration, report, electronic, persistent, data

Publication Details


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Annual Data Report

2018
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DISCLAIMER
ePPOC has made every effort to ensure that the data used in this report are accurate. Data submitted to ePPOC are checked for anomalies and services asked to resubmit information where relevant.

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SUGGESTED CITATION
2018 Snapshot
Adults seeking pain management

67 pain services in Australia and NZ participated in ePPOC and contributed information about

31,530 adults referred for specialist pain management

At referral

40% had experienced their pain for over 5 years

60% were using opioid medication

40% were severely or extremely severely depressed

More than 1 in 3 people were unable to work due to pain

After treatment

3 in 4 people reported overall improvement following treatment

45% of people were able to reduce their opioid dose by at least half

A large proportion of people made clinically meaningful improvement in

- Pain severity: 33%
- Pain interference: 65%
- Depression: 62%
- Anxiety: 47%
- Stress: 63%
- Catastrophising: 58%
- Self-efficacy: 53%
2018 Snapshot

Children and adolescents referred for pain management

9 paediatric pain services in Australia and NZ participated in ePPOC and contributed information about

803 children and adolescents referred for specialist pain management

At referral

60% had experienced their pain for more than 1 year

1 in 3 said they lived with severe pain

Adolescents missed 30% of school hours due to pain

After treatment

A large proportion of children and adolescents reported **clinically meaningful improvement** following treatment

**Physical function** improved in two thirds of children and adolescents

**Sleep** improved in 45%

2 in 3 reported significantly reduced pain

Quality of life improved in 76%
The electronic Persistent Pain Outcomes Collaboration (ePPOC)

ePPOC is a program that aims to improve services and outcomes for people experiencing persistent pain. It involves specialist pain services collecting a standard set of information to measure outcomes for their patients as a result of treatment. Pain services use the information to triage, monitor and plan treatment for individual clients, and also send non-identifiable information to ePPOC for analysis. The results of these analyses are fed back to participating services every six months, allowing pain management services to assess their results, and compare their patients, services and outcomes to other pain management services. ePPOC also uses the information collected by services for national benchmarking and to develop a coordinated approach to research into the management of chronic pain in Australasia.

ePPOC is an initiative of the Faculty of Pain Medicine, established with funding from the New South Wales Ministry of Health, and supported by key stakeholder bodies. It was launched in 2013 with a small number of pain management services trialling the measures and processes. All other pain management services throughout Australia and New Zealand are now able to participate.

PaedePPOC addresses the differing needs of the paediatric pain management sector. This program allows collection of data items and assessment tools specific to the needs of children, adolescents and their parents.

This report

This report presents data collected by participating pain management units during 2018. Sixty seven adult and nine paediatric pain management services contributed data for this report (see Appendix A). The map below shows the locations of these services.

This report includes;

- Information on over 30,000 patients
- Information on patients’ demographic and clinical characteristics and the care they received
- Outcomes for adult and paediatric patients who completed an episode of treatment
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Pain management services participating in ePPOC

The services submitting data for this report were both public and private services located in:

- New South Wales (18 adult and 3 paediatric services)
- Victoria (17 adult and 2 paediatric services)
- Queensland (6 adult and 2 paediatric services)
- Western Australia (3 adult services)
- South Australia (3 adult and 1 paediatric services)
- New Zealand (20 adult and 1 paediatric services).

Since the first ePPOC report in 2014, the number of data-submitting services has increased from 12 to 76.

Figure 1 – Number of data submitting services, 2014-2018
Adults referred for pain management

Demographic profile

Adult pain management services contributed data for 31,530 patients during 2018. Of these patients, 57% were female, with an average age of 51 years at the time of referral. Males were slightly younger on average at 50 years. The distribution by gender and age is shown in Figure 2.

Figure 2 – Age at referral and gender distribution of patients

Most patients were born in Australia (53%) or New Zealand (22%) and 4% identified as being of Aboriginal and/or Torres Strait Islander origin. A relatively small proportion (4%) required an interpreter and 8% required assistance with written or spoken communication. Most patients were referred to the pain management service by a general practitioner or nurse practitioner (53%).

The majority of patients were unable to work, either due to pain (39%) or another condition (12%). 18% of episodes involved a compensation claim. Figure 3 shows the work status of patients at referral to the pain management service.

Figure 3 – Work status of patients at referral
Clinical characteristics at referral

Most patients referred to pain management services completed a questionnaire prior to their first appointment with the service. These questionnaires asked patients about their pain, medication and health care utilisation, and included standard assessment tools which examined mood, cognition, physical function and pain interference. More detailed information regarding these tools is provided in Appendix B.

21,364 of these initial questionnaires were completed, providing a picture of the health and clinical characteristics of patients referred for specialist pain management.

Pain

40% of patients had experienced their pain for more than five years, and most (86%) described their pain as ‘always present’. The events that led to the patients’ pain are shown in Table 1.

The regions where pain is at its worst are shown in Figure 4, with the back being the most common (43% of patients identified this as the most painful site). 14% of patients had pain in one region only, with the remainder identifying multiple regions, as shown in Figure 5.

<table>
<thead>
<tr>
<th>Precipitating event</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury at work/school</td>
<td>25.1</td>
</tr>
<tr>
<td>No obvious cause</td>
<td>14.3</td>
</tr>
<tr>
<td>Injury at home</td>
<td>11.1</td>
</tr>
<tr>
<td>Related to another illness</td>
<td>10.5</td>
</tr>
<tr>
<td>Motor vehicle crash</td>
<td>10.4</td>
</tr>
<tr>
<td>Injury in another setting</td>
<td>9.4</td>
</tr>
<tr>
<td>After surgery</td>
<td>8.4</td>
</tr>
<tr>
<td>Related to cancer</td>
<td>1.2</td>
</tr>
<tr>
<td>Other</td>
<td>9.8</td>
</tr>
</tbody>
</table>

Table 1 – Patient-reported cause of pain

Figure 4 – Site of patient’s main pain

<table>
<thead>
<tr>
<th>Region</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Back</td>
<td>43%</td>
</tr>
<tr>
<td>Arm/shoulder</td>
<td>12%</td>
</tr>
<tr>
<td>Neck</td>
<td>8%</td>
</tr>
<tr>
<td>Hip</td>
<td>7%</td>
</tr>
<tr>
<td>Leg</td>
<td>6%</td>
</tr>
<tr>
<td>Head</td>
<td>5%</td>
</tr>
<tr>
<td>Knee</td>
<td>5%</td>
</tr>
<tr>
<td>Feet</td>
<td>4%</td>
</tr>
<tr>
<td>Abdomen</td>
<td>3%</td>
</tr>
<tr>
<td>Hands</td>
<td>2%</td>
</tr>
<tr>
<td>Pelvic/genital</td>
<td>2%</td>
</tr>
<tr>
<td>Chest</td>
<td>2%</td>
</tr>
</tbody>
</table>

Figure 5 – Number of pain sites

<table>
<thead>
<tr>
<th>Number of pain sites</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>14%</td>
</tr>
<tr>
<td>2-3</td>
<td>34%</td>
</tr>
<tr>
<td>4-6</td>
<td>37%</td>
</tr>
<tr>
<td>7-9</td>
<td>13%</td>
</tr>
<tr>
<td>10+</td>
<td>2%</td>
</tr>
</tbody>
</table>
The Brief Pain Inventory (BPI) was used to assess the intensity of pain and its interference in activities of daily living over the past week. Figure 6 shows that at referral, nearly 1 in 2 people rated their pain as severe, and over 60% reported that it severely interfered with daily activities.

**Figure 6 - Proportion of people with severe, moderate and mild pain and pain interference**

The patient questionnaires included a list of medical conditions, and asked patients to indicate which (if any) they experienced in addition to their pain. 39% of patients reported that they had a mental health condition, with the majority of these people experiencing depression. The percent of patients with each of these conditions is shown in Table 2.

The clinical complexity of people referred to pain management services is further illustrated in Figure 7, which shows that most people experience at least one other condition in addition to their pain.

**Table 2 - Comorbid conditions**

<table>
<thead>
<tr>
<th>Medical condition</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health condition</td>
<td>38.8</td>
</tr>
<tr>
<td>Depression</td>
<td>32.7</td>
</tr>
<tr>
<td>Anxiety</td>
<td>18.3</td>
</tr>
<tr>
<td>PTSD</td>
<td>6.1</td>
</tr>
<tr>
<td>Arthritis</td>
<td>30.5</td>
</tr>
<tr>
<td>Heart and circulation problems</td>
<td>23.5</td>
</tr>
<tr>
<td><em>High blood pressure</em></td>
<td>15.3</td>
</tr>
<tr>
<td><em>High cholesterol</em></td>
<td>4.4</td>
</tr>
<tr>
<td>Muscle, bone and joint problems other than arthritis</td>
<td>20.8</td>
</tr>
<tr>
<td>Digestive problems</td>
<td>17.9</td>
</tr>
<tr>
<td>Respiratory problems</td>
<td>15.8</td>
</tr>
<tr>
<td>Diabetes</td>
<td>7.3</td>
</tr>
<tr>
<td>Neurological problems</td>
<td>6.3</td>
</tr>
<tr>
<td>Liver, kidney and pancreas problems</td>
<td>5.3</td>
</tr>
<tr>
<td>Thyroid problems</td>
<td>5.1</td>
</tr>
<tr>
<td>Cancer</td>
<td>3.6</td>
</tr>
<tr>
<td>Other medical problems</td>
<td>14.5</td>
</tr>
</tbody>
</table>
Figure 7 – Distribution of patients by number of comorbidities

- 21% of patients had 0 comorbidities
- 18% had 1 comorbidity
- 17% had 2 comorbidities
- 14% had 3 comorbidities
- 11% had 4 comorbidities
- 8% had 5 comorbidities
- 12% had 6 or more comorbidities

**Body Mass Index**

Figure 8 – Patient BMI

- 2% are Underweight (<18.5)
- 39% are Normal weight (18.5 to 24.99)
- 26% are Overweight (25 to 29.99)
- 32% are Obese (>=30)

The average Body Mass Index (BMI) of patients at referral was 29.5 (SD=7.6) which lies in the Overweight category, but bordering on Obese. The percentage of patients in each BMI category is show in Figure 8.

**Mood**

The Depression Anxiety and Stress Subscale (short form) was used to assess the mental health of people referred for specialist pain management. Figure 9 shows that 40% of people were experiencing extremely severe or severe depression, and over one third reported severe or extremely severe anxiety and/or stress.
The Pain Self-Efficacy Questionnaire (PSEQ) assesses a patient’s belief that he or she can perform a range of activities despite their pain.

The average score on the PSEQ following referral to the pain services was 21.4 (SD=13.0), a score classified as ‘Moderate’ but bordering on severe impairment (identified by scores less than 20). Figure 10 shows that one in two people reported that pain severely impaired their belief that they could perform these daily activities.

Patients also completed the Pain Catastrophising Scale (PCS), which measures thoughts and feelings related to pain. The average score on the PCS at referral was 27.5 (SD=13.9), a score classified as ‘Moderate’, but with just under 50% of people reporting severe pain catastrophising (Figure 11).
**Medication use**

At referral to the service, 59% of patients were taking opioid medication on more than two days per week. The average daily oral morphine equivalent for patients using opioid medication was 62.9mg. On average, patients were using medications from two of the seven major drug groups, identified by the Faculty of Pain Medicine as of particular interest in pain management. The percentage of patients using each of the drug groups is show in Figure 12.

Figure 12 – Percent of patients using each drug group at referral

**Health service utilisation**

Patients reported how many times in the past three months they used various health services and had diagnostic tests performed because of their pain (Table 3). These equate to, on average, one visit every week for pain-related reasons.

Table 3 – Patient use of health services

<table>
<thead>
<tr>
<th>Health service</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>4.7</td>
</tr>
<tr>
<td>Medical specialist</td>
<td>1.4</td>
</tr>
<tr>
<td>Health professionals other than doctors</td>
<td>4.7</td>
</tr>
<tr>
<td>Hospital emergency department</td>
<td>0.5</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>0.3</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>1.4</td>
</tr>
</tbody>
</table>

1 These are opioids, paracetamol, NSAIDS, antidepressants, anticonvulsants, benzodiazepines and medicinal cannabinoids.
The episode of care

The median wait time for a patient to start an episode of care at a pain management service was 55 days (average = 92 days). This reflects the time from when the pain service receives a referral, to the patient’s first clinical contact. Over two thirds of people were seen within 3 months of the service receiving the referral.

Most episodes of care extended from 1 to 6 months (median = 134 days) and patients typically received an average of 25 hours of treatment during that period.

Patient outcomes

Pain management units provided information on the outcomes of 5,408 patients who completed their episode of care during 2018.

At the end of the episode, patients were asked to compare how they would describe themselves now (overall and physical abilities) compared to before receiving treatment. Patients responded using a Likert scale which ranged from -3 (very much worse) to +3 (very much better). Responses are shown in Figure 13, with almost 3 in 4 patients reporting that they had improved following pain management. Approximately 1 in 5 reported no change, and 8-9% rated themselves as worse.

Figure 13 – Global rating of change at episode end – overall and physical

Pain, mood and cognitions

After receiving pain management, a large proportion of people reported clinically significant improvement\(^2\) in the severity of their pain and its interference in their daily activities, as well as improved mood and pain-related cognitions (see Table 4).

\(^2\) In assessing outcomes using the standard assessment tools, ePPOC has adopted guidelines for determining whether a change is **clinically significant**, that is, what change in score represents a meaningful difference to the patient. These guidelines are detailed in Appendix B.
Table 4 - Proportion of people who made clinically significant improvement (CSI) from referral to episode end

<table>
<thead>
<tr>
<th>Domain</th>
<th>People who report CSI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td></td>
</tr>
<tr>
<td>- Pain severity</td>
<td>33%</td>
</tr>
<tr>
<td>- Pain interference</td>
<td>65%</td>
</tr>
<tr>
<td>Mood</td>
<td></td>
</tr>
<tr>
<td>- Depression</td>
<td>62%</td>
</tr>
<tr>
<td>- Anxiety</td>
<td>47%</td>
</tr>
<tr>
<td>- Stress</td>
<td>63%</td>
</tr>
<tr>
<td>Cognitions</td>
<td></td>
</tr>
<tr>
<td>- Pain catastrophising</td>
<td>58%</td>
</tr>
<tr>
<td>- Pain self-efficacy</td>
<td>53%</td>
</tr>
</tbody>
</table>

Over time, the proportion of people who report clinically significant improvement has increased across all domains. This is shown in Figure 14, which displays improvement in 2018 compared to 2015.

**Figure 14 – Percentage of patients reporting clinically significant improvement, 2015 vs. 2018**

<table>
<thead>
<tr>
<th>Domain</th>
<th>2015</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average pain</td>
<td>29%</td>
<td>33%</td>
</tr>
<tr>
<td>Pain interference</td>
<td>33%</td>
<td>65%</td>
</tr>
<tr>
<td>Depression</td>
<td>39%</td>
<td>62%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>34%</td>
<td>47%</td>
</tr>
<tr>
<td>Stress</td>
<td>34%</td>
<td>63%</td>
</tr>
<tr>
<td>Pain catastrophising</td>
<td>38%</td>
<td>58%</td>
</tr>
<tr>
<td>Pain self-efficacy</td>
<td>43%</td>
<td>53%</td>
</tr>
</tbody>
</table>

**Medication use**

Following treatment at a pain management service, many people made improvements in their use of medications. In particular, of the people who were using opioid medication at referral:

- 29% no longer used opioid medication frequently (more than two days per week)
- The average daily morphine equivalent reduced from 57mg to 42mg per day
- 45% of people were able to at least halve their opioid dose
- 41% of people who were using high doses of opioid at referral (>40mg per day) were able to reduce their dose by at least half following pain management.
Employment and work productivity

Almost one half (42%) of patients who completed an episode of care were unemployed due to pain at referral. While the majority were still unemployed due to pain at the end of the episode, 1 in 3 people no longer classified themselves in this way – they were either employed (full time or part time), seeking employment, not working by choice or unable to work for a reason other than pain (see Figure 15).

Figure 15 – Work status at episode end for patients who were ‘unemployed due to pain’ at referral

For those people who were working at referral, absenteeism and productivity improved following pain management. Figure 16 shows that at referral, workers missed over 30% of their usual hours because of pain, and rated impairment while working at 56%. After treatment this decreased to 19% missed hours and 41% impairment.

Figure 16 - Absenteeism and productivity at referral compared to episode end

Overall work impairment, taking into account absenteeism and impairment while at work, decreased from 63% at referral to 46% following treatment at a pain management service.
Children and adolescents referred for pain management

Demographic profile

Participating paediatric pain management services contributed data for 803 patients during 2018. Of these patients, 71% were female, with an average age of 12.8 years at the time of referral. Males were younger on average at 11.6 years. The distribution by gender and age is shown in Figure 17.

![Figure 17 – Age and gender distribution of patients](image)

Most patients were born in Australia (87%) and 5% identified as being of Aboriginal and/or Torres Strait Islander origin. Patients were generally referred to the pain management service by a specialist practitioner (66%).

Clinical characteristics at referral

Most children and their parents completed a questionnaire prior to their first appointment with the service. These questionnaires asked children and parents about pain, medication and use of health care services, and included standard assessment tools which examined pain severity, quality of life, disability, pain-related worries and the impact of the child’s pain on the parent. More detailed information regarding these tools is provided in Appendix C.

868 of these initial questionnaires were completed (427 completed by the child, 441 by the parent), providing a picture of the health and clinical characteristics of patients following their referral to a specialist paediatric pain management service. All information in this section is based on patient and/or parent report.
Pain

Parents were asked how long their child’s pain had been present, and 60% responded that their child had experienced the pain for more than 12 months. Most (67%) described the pain as ‘always present’. The events thought to have caused the child’s pain are shown in Table 6. 40% of parent’s reported that the cause of their child’s pain was unknown.

Regions where the main pain was experienced are shown in Figure 18, with the back and head the most common (17% each) followed by the abdomen (16%). Just over one in four patients had pain in one region only, with the remainder identifying multiple regions (see Figure 19).

Table 5 – Event precipitating the patient’s pain

<table>
<thead>
<tr>
<th>Precipitating event</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No known cause</td>
<td>39.9</td>
</tr>
<tr>
<td>Injury</td>
<td>21.2</td>
</tr>
<tr>
<td>Illness</td>
<td>15.1</td>
</tr>
<tr>
<td>After surgery</td>
<td>7.7</td>
</tr>
<tr>
<td>Other</td>
<td>16.0</td>
</tr>
</tbody>
</table>

Pain severity was assessed using the Brief Pain Inventory (BPI) in children aged eight years and above. Young children aged 5-7 completed the Faces Pain Scale – Revised. Parents also rated their child’s pain using the BPI. The average pain rating reported by child and parent at referral was 5.5 and 5.4 (moderate severity), respectively, with one in three children and parents rating the pain as severe.

Figure 18 – Site of patient’s main pain

Figure 19 – Number of pain sites

Figure 20 – Patient and parent ratings of pain severity
Comorbid conditions

Parents were asked whether their child had a disability and/or other medical condition in addition to their pain. The responses are shown in Table 6 below.

Table 6 - Percent of parents reporting disabilities and comorbidities

<table>
<thead>
<tr>
<th>Disabilities and comorbid conditions</th>
<th>% of patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disabilities</td>
<td></td>
</tr>
<tr>
<td>Sight impairment</td>
<td>5.8</td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>2.4</td>
</tr>
<tr>
<td>Intellectual disability</td>
<td>3.5</td>
</tr>
<tr>
<td>Physical disability</td>
<td>9.3</td>
</tr>
<tr>
<td>Comorbid conditions</td>
<td></td>
</tr>
<tr>
<td>Chronic disease</td>
<td>21.4</td>
</tr>
<tr>
<td>Mental health condition</td>
<td>24.0</td>
</tr>
<tr>
<td>Cancer</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Role functioning

The number of school days children missed in the previous fortnight (10 school days) as a result of their pain increased with age, as shown in Figure 21.

Figure 21 – Days of school missed by age group

Quality of Life

Quality of life was assessed using the Paediatric Quality of Life Inventory (PedsQL) with both children and parents rating the child’s quality of life. Total and subscale average scores at referral are shown in Table 8, with higher scores reflecting greater quality of life. Total scores below 69.7 and 65.4 for the child and parent, respectively, indicate ‘at risk’ status for impaired quality of life. Over 85% of both parents and children rated the child’s quality of life in this ‘at risk’ range.

Table 7 – Patient and parent quality of life scores

<table>
<thead>
<tr>
<th>Domain</th>
<th>Child</th>
<th>Parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial</td>
<td>53.7</td>
<td>51.0</td>
</tr>
<tr>
<td>Physical</td>
<td>38.9</td>
<td>38.4</td>
</tr>
<tr>
<td>Total score</td>
<td>48.4</td>
<td>46.5</td>
</tr>
</tbody>
</table>
**Disability**

Children aged eight and older completed the Functional Disability Inventory (FDI) to assess the impact of pain on the ability to complete 15 regular physical activities (such as walking, going to school, getting to sleep). The average score for children was 23.1, reflecting moderate disability. The distribution of scores by severity category is shown in Figure 22, indicating that over 4 in 5 children rated their functional disability as either moderate or severe.

![Figure 22 – Disability at referral by severity category](image)

**Pain-related anxiety**

Children aged 13 and older completed the pain-specific anxiety section of the Bath Adolescent Pain Questionnaire. This asks questions assessing pain-related worries, such as “I avoid activities that cause pain” and “When I have pain, I think something harmful is happening”. Responses range from Never to Always, with higher scores indicating greater severity. Children scored an average of 15.9 in pain-specific anxiety. The distribution of scores on this tool is shown below in Figure 23.

![Figure 23 – Distribution of pain-related worry scores](image)
**Medication use**

Parents provided information regarding the medication their child was taking for pain and how frequently each was used. The percent of patients taking each medication type daily or often is shown in Figure 24 below.

![Figure 24 – Percentage of patients using medication daily or often by medication type](image)

**Health service utilisation**

Parents reported how many times in the past three months their child had used various health services and had diagnostic tests performed because of their pain, shown in Table 8. These equate to, on average, more than one visit every week for pain-related reasons.

**Table 8 – Paediatric patient use of health services**

<table>
<thead>
<tr>
<th>Health service</th>
<th>Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner</td>
<td>3.3</td>
</tr>
<tr>
<td>Medical specialist</td>
<td>2.9</td>
</tr>
<tr>
<td>Allied health professionals</td>
<td>3.1</td>
</tr>
<tr>
<td>Other therapist</td>
<td>1.4</td>
</tr>
<tr>
<td>Hospital emergency department</td>
<td>1.3</td>
</tr>
<tr>
<td>Hospital admission</td>
<td>0.4</td>
</tr>
<tr>
<td>Diagnostic tests</td>
<td>2.0</td>
</tr>
</tbody>
</table>
The episode of care

In paediatric services, the median wait time was 49 days (average = 65 days). This reflects the time from when the pain service receives a referral, to the first clinical contact. 85% of people were seen within 3 months of the service receiving the referral.

Episodes of care tended to be longer in paediatric services (compared to adult pain services), with a median episode length of 183 days.

Patient outcomes

Pain management units provided information on outcomes reported by 101 patients and 94 parents for episodes that ended during 2018.

Pain and quality of life

Although the volume of outcomes is relatively small, a large proportion of children and adolescents (and their parents) reported clinically significant improvement after receiving pain management at specialist services (see Table 9).

Table 9 – Paediatric patient outcomes

<table>
<thead>
<tr>
<th>Percent of patients reporting a clinically significant improvement</th>
<th>Patient rated</th>
<th>Parent rated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain Severity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average pain</td>
<td>62%</td>
<td>65%</td>
</tr>
<tr>
<td>Worst pain</td>
<td>42%</td>
<td>53%</td>
</tr>
<tr>
<td>Health-related quality of life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sleep</td>
<td>45%</td>
<td>39%</td>
</tr>
<tr>
<td>Overall</td>
<td>76%</td>
<td>75%</td>
</tr>
<tr>
<td>Functional disability</td>
<td>61%</td>
<td>na</td>
</tr>
</tbody>
</table>

Average pain improved in around 2 in 3 children, as did functional ability. An even higher proportion of patients and parents reported clinically significant improvement in overall health-related quality of life, with over 3 in 4 children improving.

There was also a reduction in the percentage of children whose scores on the PedsQL indicated impaired quality of life: at referral 84% of children were classified as having impaired quality of life, however at the end of the episode of care this proportion was 55%.

One in two adolescents reported an improvement of 30% or more in their pain-related anxiety.

3 In assessing outcomes using the standard assessment tools, ePPOC has adopted guidelines for determining whether a change is **clinically significant**, that is, what change in score represents a meaningful difference to the patient. These guidelines are detailed in Appendix C.
Medication use

The change in frequent use of medications from referral to episode end is shown in Figure 25. With the exception of opioids not containing codeine, there was a reduction in the use of medications used daily or often.

Figure 25 – Medications used daily or often at referral compared to episode end
Appendix A – Data submitting services

Adult pain management services

**New South Wales**
- Central Coast Integrated Pain Service
- Concord Repatriation Hospital Pain Clinic
- Greenwich Hospital Pain Management Service
- Hunter Integrated Pain Service
- Illawarra-Shoalhaven Chronic Pain Service
- Lismore Hospital Pain Management Clinic
- Liverpool Hospital Chronic Pain Service
- Nepean Hospital Pain Management Unit
- Orange Base Hospital Chronic Pain Clinic
- Port Macquarie Chronic Pain Service
- Prince of Wales Pain Management Department
- Royal North Shore Hospital Pain Service
- Royal Prince Alfred Pain Management Service
- St George Pain Management Unit
- St Vincent’s Hospital Pain Clinic
- Sydney Spine and Pain Rehab
- Tamworth Integrated Pain Service
- Westmead Hospital Pain Service

**Queensland**
- Interventus Pain Specialists
- North Queensland Persistent Pain Management Service (Townsville Hospital)
- Princess Alexandra Hospital – Metro South Health Persistent Pain Management Service
- St Vincent’s Private Hospital Brisbane
- Sunshine Coast Persistent Pain Management Service (Nambour Hospital)
- The Wesley Hospital Brisbane

**South Australia**
- Central Adelaide Local Health Network
- Flinders Medical Centre Pain Management Unit
- Northern Pain Rehabilitation Service

**Western Australia**
- Fiona Stanley Hospital
- PainCare
- Sir Charles Gairdner Hospital

**Victoria**
- Advance Healthcare
- Austin Health
- Barbara Walker Centre for Pain Management
- Caulfield Pain Management and Research Centre
- Dorset Rehabilitation Centre
- Eastern Health Pain Management Service
- Empower Rehab
- Epworth Hospital
- Goulburn Valley Chronic Pain Service
- Latrobe Regional Hospital
- Melbourne Health – Pain Management Services
- Monash Health Pain Management
- Northern Health Pain Assessment & Management Service
- Peninsula Health Chronic Pain Management Service
- Precision Ascend Rehabilitation Centre
- The Victorian Rehabilitation Centre
- Western Health Pain Management

**New Zealand**
- Active Plus
- Advantage South
- APM Workcare
- Body in Motion
- Canterbury DHB (Burwood Hospital)
- Capital and Coast DHB (Wellington)
- Fit For Work
- Futureproof Rehab
- Habit Group
- Hutt Valley DHB
- Integrative Pain Care
- Nelson Nursing Service
- Occupational Health Canterbury
- Pain Management and Rehabilitation Services Ltd
- Pain Rehabilitation Christchurch Ltd
- Proactive Health
- QE Health
- Southern Rehab
- Taranaki DHB
- TBI Health
Paediatric pain management services

**New South Wales**
Children’s Hospital at Westmead
John Hunter Children’s Hospital
Sydney Children’s Hospital Randwick

**Queensland**
Queensland Children’s Hospital
St Vincent’s Private Hospital Brisbane

**South Australia**
Women’s and Children’s Hospital Adelaide

**Victoria**
Monash Children’s Hospital
Royal Children’s Hospital Melbourne

**New Zealand**
Starship Children’s Hospital Auckland
Appendix B – ePPOC assessment tools

The assessment tools used in ePPOC are:

- Brief Pain Inventory (BPI)
- Depression, Anxiety, Stress Scale (DASS)
- Pain Catastrophising Scale (PCS)
- Pain Self-Efficacy Questionnaire (PSEQ)
- Global Rating of Change (GRC)
- Work Productivity and Impairment (WPAI)
- CARRA Body Chart.

Each of these assessment tools are briefly described below.

**Brief Pain Inventory**

The BPI items used in the ePPOC dataset measure the severity of pain and the degree to which the pain interferes with common activities of daily living. There are four pain severity questions, rated on a scale of 0 to 10, where 0 = ‘No pain’ and 10 = ‘Pain as bad as you can imagine’. Patients are asked to rate their average, worst and least pain over the last week, and their pain right now. Pain severity is calculated as an average of these four items.

Severity bands for these items are:

- 0-4 = mild pain
- 5-6 = moderate pain
- 7-10 = severe pain

The IMMPACT group’s recommendations for assessing clinical significance for 0-10 numeric pain scales are that a change of:

- ≥ 10% represents minimally important change
- ≥ 30% represents moderate clinically important change (ePPOC uses this category to identify clinically significant improvement for average and worst pain)
- ≥ 50% represents substantial clinically important change.

The interference questions are rated on a scale of 0 to 10, where 0 = ‘Does not interfere’ and 10 = ‘Completely interferes’. The interference subscale is an average of the seven interference questions. At least 4 of 7 questions must be completed for this subscale to be valid. The IMMPACT recommendation for assessment of clinically significant change on the BPI interference scale is a change of 1 point over the average of the 7 items.

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4 Modified Brief Pain Inventory, reproduced with acknowledgement of the Pain Research Group, University of Texas, MD Anderson Cancer Centre, USA

**Depression Anxiety Stress Scales (DASS)**

The DASS measures the negative emotional states of depression, anxiety and stress. Due to the large number of questions in the full DASS (42 questions), the DASS21 is administered. This comprises 21 questions which are rated on a scale of 0 to 3, where 0 = ‘did not apply to me at all’, 1 = ‘applied to me to some degree, or some of the time’, 2 = ‘applied to me to a considerable degree, or a good part of the time’, or 3 = ‘applied to me very much, or most of the time’. Scores are multiplied by 2 to enable comparison with the full-scale DASS42 for which norms exist.

For each subscale (Depression, Anxiety and Stress), the 7 items are summed and then multiplied by 2. The test developers suggest that at least 6 of 7 items should be complete for each subscale to be considered valid. Table 10 shows the range of scores associated with severity categories for each subscale.

<table>
<thead>
<tr>
<th>Table 10 DASS severity categories</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
</tr>
<tr>
<td>Normal</td>
</tr>
<tr>
<td>Mild</td>
</tr>
<tr>
<td>Moderate</td>
</tr>
<tr>
<td>Severe</td>
</tr>
<tr>
<td>Extremely Severe</td>
</tr>
</tbody>
</table>

Clinical significance on each of the DASS subscales is defined as a change of 5 or more points coupled with a move to a different severity category.

**Pain Catastrophising Scale (PCS)**

The PCS measures a patient’s thoughts and feelings related to their pain. This includes three subscales measuring the dimensions of Rumination, Magnification and Helplessness. The PCS comprises 13 questions (Rumination – 4 items, Magnification – 3 items, Helplessness – 6 items) which are rated on a scale of 0 to 4, where 0 = ‘not at all’, 1 = ‘to a slight degree’, 2 = ‘to a moderate degree’, 3 = ‘to a great degree’ and 4 = ‘all the time’. For each subscale, all items must be completed to be valid. For the total to be valid, at least 12 of 13 items must be completed.

Severity bands for the PCS are:
- <20 = mild
- 20 to 30 = high
- >30 = severe.

Clinically significant change requires a change in score of 6 or more points, combined with movement to a different severity category.


8 Sullivan, MJL, personal communication with Nicholas, MK July 2014.
**Pain Self-Efficacy Questionnaire (PSEQ)**

The PSEQ measures how confident a patient is that he or she can do a range of activities despite their pain. The PSEQ Total is a sum of scores from 10 questions which are rated on a scale from 0 = ‘Not confident at all’ to 6 = ‘Completely confident’. At least 9 of 10 items must be complete for the PSEQ Total to be valid. Higher scores represent greater pain self-efficacy.

Severity bands for the PSEQ are:
- <20 = severe
- 20 to 30 = moderate
- 31 to 40 = mild
- >40 = minimal impairment.

Clinically significant change is defined as a change in score of 7 or more points, combined with movement to a different severity category.

**Global Rating of Change**

The Global Rating of Change questions were included as part of the ePPOC dataset in 2018. They are asked in follow-up questionnaires only. The two questions are “Compared with before receiving treatment at this pain management service, how would you describe yourself now overall?” and “Compared with before receiving treatment at this pain management service, how would you describe your physical abilities now?” Participants answer by indicating their response on a Likert scale from -3 (very much worse) to +3 (very much better).

**Work Productivity and Impairment (WPAI)**

WPAI outcomes are expressed as impairment percentages, with higher numbers indicating greater impairment and less productivity. The work status of all patients is collected, based on the International Consortium for Health Outcomes Measurement (ICHOM) categories. For patients who are employed, the WPAI items allow calculation of the following outcomes:

- % of time missed from work due to pain (absenteeism)
- % work impairment while working due to pain (lost productivity)
- % overall work impairment due to pain (taking into account absenteeism and lost productivity).

For more information on the calculations used please see the ePPOC Australian and New Zealand Data Dictionaries on the ePPOC website [https://ahsri.uow.edu.au/eppoc/forms](https://ahsri.uow.edu.au/eppoc/forms).

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10 Nicholas, MK, personal communication, July 2014.


**CARRA Body Chart**\(^{13}\)

Patients identify the site/s they feel pain using body maps. For reporting, pain sites are categorised into pain areas as follows:

<table>
<thead>
<tr>
<th>Pain sites</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td>head and face</td>
</tr>
<tr>
<td>Neck</td>
<td>neck</td>
</tr>
<tr>
<td>Chest</td>
<td>chest</td>
</tr>
<tr>
<td>Back</td>
<td>upper back, mid back and low back</td>
</tr>
<tr>
<td>Leg</td>
<td>left and right thighs, left and right calves, left and right ankles</td>
</tr>
<tr>
<td>Arm/shoulder</td>
<td>left and right shoulders, left and right upper arms, left and right elbows, left and right forearms, left and right wrists</td>
</tr>
<tr>
<td>Abdomen</td>
<td>abdomen</td>
</tr>
<tr>
<td>Hands</td>
<td>left and right hands</td>
</tr>
<tr>
<td>Feet</td>
<td>left and right feet</td>
</tr>
<tr>
<td>Pelvic</td>
<td>groin</td>
</tr>
<tr>
<td>Knee</td>
<td>left and right knees</td>
</tr>
<tr>
<td>Hip</td>
<td>left and right hips</td>
</tr>
</tbody>
</table>

Appendix C – PaedePPOC assessment tools

Six standardised assessment tools have been chosen to measure patient outcomes and the impact of the child’s pain on the parent/parent:

- Modified Brief Pain Inventory - Pain severity questions
- Faces of Pain Scale – Revised
- Paediatric Quality of Life Inventory (PedsQL)
- Functional Disability Inventory (FDI)
- Bath Adolescent Pain – Pain-specific anxiety
- Bath Adolescent Pain – Parent Impact Questionnaire (BAP-PIQ)

**Pain Severity**

The tool used to capture pain severity is dependent on the patient’s age. Children aged eight and above use the Modified Brief Pain Inventory\(^{14}\), whereas those aged 5-7 use the Faces of Pain Scale-Revised\(^{15}\).

**MODIFIED BRIEF PAIN INVENTORY (BPI)** - Modified versions of the questions in the standard BPI are used to assess pain in children aged eight and over, and obtain a parent proxy rating of the child’s pain for all age groups.

**FACES PAIN SCALE – REVISED** - Children choose one of six faces showing increasing levels of pain, from ‘no pain’ to ‘very much pain’ which correspond numerically to 0, 2, 4, 6, 8, 10.

For both tools, questions are rated on a scale of 0 (‘No pain’) to 10 (‘Pain as bad as you can imagine’), with patients asked their average, worst and least pain over the last week, and their pain right now. Severity bands for these items are:

- 0-4 = mild pain
- 5-6 = moderate pain
- 7-10 = severe pain

The IMMPACT group’s recommendations for assessing clinical significance for 0-10 numeric pain scales are that a change of:

\( \geq 10\% \) represents minimally important change

\( \geq 30\% \) represents moderate clinically important change

\( \geq 50\% \) represents substantial clinically important change.

To determine whether the change experienced by patients at referral is clinically significant, the improvement must be at least moderately clinically important, i.e. at least a 30% improvement.

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\(^{14}\) Modified Brief Pain Inventory, reproduced with acknowledgement of the Pain Research Group, University of Texas, MD Anderson Cancer Centre, USA

**Paediatric Quality of Life Inventory (PedsQL)**\(^{16}\)

PaedPePOC uses the PedsQL Generic Core Scales to measure health-related quality of life. Parents and all patients complete the age-appropriate version. Items are rated on a five point scale where 0='Never' [a problem] and 4='Almost always' [a problem]. For 5-7 year olds the scale is clinician administered and rated on a three point scale where 0='Never' [a problem], 2='Sometimes' [a problem] and 4='Almost always' [a problem].

Results are reported as four scale scores (physical, emotional, social and school functioning) and two summary scores (psychosocial and physical health), with higher scores indicating better health-related quality of life.

Minimal clinically meaningful difference on the PedsQL is measured as a:
- 4.4 change in the child self-report total score
- 4.5 change in adult proxy-report total score.

For the PedsQL ‘Sleep’ item, clinically significant improvement is reported for patients with trouble sleeping at least sometimes (sleep item score = 2). The improvement is classed as clinically significant if the score for sleep is reduced by at least 50%.

**Functional Disability Inventory (FDI)**\(^{17}\)

The FDI is a 15 item assessment tool which asks patients whether they have had any physical trouble or difficulty doing specified activities. Items are rated on a five point scale where 0='No trouble' and 4='Impossible'.

Severity bands for the FDI are:
- 0-12 = No/minimal disability
- 13-29 = Moderate disability
- >29 = Severe disability

Clinically significant change is defined as a change of 5 or more points coupled with a change to a different severity category.


**Bath Adolescent Pain Questionnaire – Pain-specific anxiety**\(^{18}\)

Section 5 of the BAPQ asks patients about specific worries or concerns they have about their pain. There are seven items rated on a five point scale of ‘Never’ to ‘Always’.

**Bath Adolescent Pain – Parent Impact Questionnaire**\(^{19}\)

The impact of the child’s pain on the parent is measured over eight subscales: depression, anxiety, child-related catastrophising, self-blame and helplessness, partner relationship, leisure functioning, parental behaviour and parental strain. All items are rated on a 5 point scale, ranging from 0 (never) to 4 (always).
