Assessing and Addressing Pain in Cancer Patients at BIDMC

The Problem

Through the Division of Hematology/Oncology's participation in the Quality Oncology Practice Initiative (QOPI®)*, a national quality assessment and improvement program developed by the American Society of Clinical Oncology (ASCO), we learned that provider documentation of patients' pain scores lagged behind other cancer centers nationwide.

Aim/Goal

Increase rate of assessment of pain for each patient visit and improve documentation of patient pain scores (the "fifth vital sign"). With increased consistency in assessment of pain, an improvement in documentation of addressing the pain (i.e., counseling about narcotic-induced constipation and asking about narcotic effectiveness on follow up visits) is expected.

The Team

- Gregory Britt, MD – Project Lead, Clinical Fellow
- Reed Drews, MD – Faculty Advisor
- 18 Hematology/Oncology Physician Fellows
- Participating Hematology/Oncology Physician Faculty
- Kerry Brown, MBA – Director of Operations
- Susan Meehan – Practice Manager
- Hematology/Oncology Practice Assistants

All the above are members of the Division of Hematology/Oncology, Department of Medicine

- Scot B. Sternberg, MS – QI, Department of Medicine

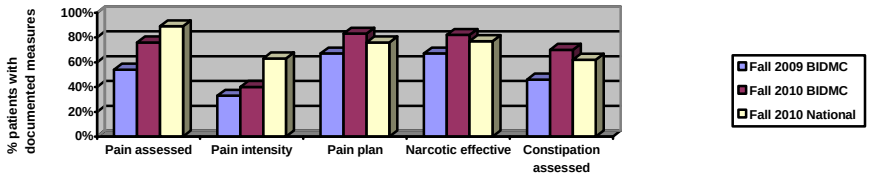
The Interventions

- Assessment and recording of pain scores has become a routine part of obtaining patient vital signs.
- Practice assistants asked patients to provide a pain score using numerical (0-10)/cartoon pain scale at vital sign stations.
- Pain score entered by practice assistants into vital sign section of electronic medical record (EMR) for each patient.
- Pain score also hand-written by practice assistants on patients' vital sign sheet for review by provider.

The Results/Progress to Date

Improvement was demonstrated in all areas related to pain management as compared to previous year's data (Fall 2009 collection, selected sample size = 120 cancer patients).

- Data from Fall 2010 collection (selected sample size = 190 cancer patients) showed improvement in all areas regarding assessment/addressing pain, i.e. pain assessed by 2nd office visit (76% vs 54%), pain intensity documented by 2nd office visit (40% vs 33%), plan for pain recorded (83% vs 67%), effectiveness of narcotics recorded on subsequent visit (82% vs 67%), and constipation assessment noted (70% vs 46%).



- Scores in assessing pain (76%) and documenting pain intensity (40%) by the 2nd office visit still trailed the national QOPI® aggregate (89% and 63%, respectively).
- Documentation of a care plan for pain (83%), assessment of narcotic effectiveness (82%), and counseling/assessment of narcotic-induced constipation (70%) exceeded the national QOPI® aggregate (76%, 77%, 62%, respectively). For more information regarding QOPI®, refer to http://qopi.asco.org.

Lessons Learned

Improvement in documenting patient pain scores is feasible by making it a routine part of obtaining vital signs by practice assistants. The recording of patient pain scores suggests that it brings it to the attention of providers and, by doing so, leads to increased rates of documenting a plan for managing pain and for monitoring pain relief and narcotic-induced constipation.

Next Steps/What Should Happen Next

- Continue to monitor QOPI® scores on these measures on future QOPI® data abstraction (Spring 2011).
- Identify barriers for practice assistants (in recording pain scores) and providers (in managing and documenting pain) and discuss at future faculty meetings.

Beth Israel Deaconess Medical Center | A teaching hospital of Harvard Medical School | The Silverman Institute For Healthcare Quality and Safety

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