



Building a Model Pain Management Community Cancer Center

In the last decade, cancer pain guidelines have been published by the World Health Organization (WHO), the U.S. Agency for Health Care Policy and Research, the American Cancer Society (ACS), and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).^{1,2,3} The incidence of pain in cancer patients is estimated at 30 to 50 percent in those undergoing active treatment, and 70 to 90 percent in those with advanced disease.⁴ Nevertheless, cancer pain is still widely undertreated, which results in a diminished quality of life, reduced productivity, increased symptoms, and the disruption of work, leisure, and functional activities for cancer patients.

Effectively treating cancer pain is imperative for several reasons. First, unrelieved pain produces needless suffering and feelings of hopelessness in both patients and their caregivers. Second, pain can prevent patients from accepting vitally needed treatment. Finally, unrelieved pain can lead to hospital readmissions, longer inpatient stays, and increased outpatient visits, which cost the health care system millions of dollars annually.^{5,6}

Establishing the Need for a Pain Management Program

The first step in developing a model pain management program is to conduct a needs assessment and create a "snapshot" of the strengths and weaknesses of the cancer center's current pain management practices. Data collected during a needs assessment can be a good bargaining tool in discussions with the facility's administration, and can also be used as a baseline against which future improvements can be measured.⁶

Before embarking on a needs assessment, find out what survey tools already exist and review them to see whether information on pain management can be added. For example, when our staff learned that a hospital-wide Gallup Poll was going to be conducted at Beth Israel Medical Center, we were able to add two questions on pain management to the survey and were rewarded with information on a large group of patients in a short period of time.

Although the idea of a needs assessment may be overwhelming, a number of published tools are available in the literature that can be administered quickly, efficiently, and inexpensively. Many centers have successfully used the simple Institutional Needs Assessment that asks questions such as:

- Is there an interdisciplinary workgroup that can address pain at the center?
- If not, can you identify individuals who might agree to join such a team?

- Is there a documented common standard for pain assessment and treatment?
- Does your center have written policies and procedures for the use of interventional analgesic administration such as IV PCAs, spinal infusions, and others?
- Does the center staff have access to cancer pain management guidelines and dosing charts?
- Is pain management addressed in your center's public information materials, Patient Bill of Rights, or mission statement?
- Does the center provide staff education on pain management?
- Are pain management outcomes reported through quality assurance and quality improvement programs?^{6,7}

Other approaches to gathering baseline data include chart review, surveys of staff knowledge, analysis of the analgesics dispensed by the pharmacy, and quality improvement (QI) studies related to pain management. Patient and caregiver satisfaction surveys on pain management issues can yield very useful information. In addition, the oncology and pain literature are full of benchmark data, outcome studies, practice guidelines, and other resources that can be helpful in shaping a needs assessment.

Define Your Program Goals and Standards

Program goals and standards are used to determine the minimum level of care to which patients are entitled. The challenge is to select the standards that are right for your program. So many different sets of standards have been published that the selection process can be overwhelming.

At Beth Israel, our staff implemented the Standards for Cancer Patients developed by the American Pain Society.^{8,9} These standards endorse five guidelines: 1) recognize and treat pain promptly, 2) make information about analgesics readily available, 3) promise patients attentive pain management, 4) define explicit policies for the use of advanced and interventional analgesic technologies, and 5) monitor adherence to standards.

More recently, JCAHO published a set of pain management guidelines that include these rules:³

- Patients have the right to the appropriate assessment and management of pain.
- Pain must be assessed in all patients.
- The patient's level of functioning should be assessed so that goals of care and rehabilitation can be individualized to specific patient needs and choices.
- Discharge planning should include ways to manage the patient's pain and other symptoms.

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- Patients should be educated about the integral nature of pain treatment.
- Policies and procedures should support the safe prescription or ordering of pain medications.
- The institution should collect data to monitor its own performance.
- Pain should be aggressively and effectively managed in dying patients.
- Relevant providers should be educated on pain assessment and management.
- The ability of new staff members to competently assess and manage pain should be routinely evaluated when new staff members are oriented to the institution.

Many community cancer centers have adopted a simple, validated, 0-10 numeric rating scale for measuring pain intensity and pain relief. Some medical centers have created new standard forms to address pain, some have integrated a pain section into existing forms, and others have included pain assessment and treatment notes as part of the ongoing medical chart.

Whatever standards are adopted, cancer centers should also develop documentation guidelines to make sure their standards are upheld.

Additional guidelines should be developed for obtaining detailed pain histories, performing psychosocial pain assessments, performing physical and neurological examinations as needed, and performing diagnostic pain evaluations. (see www.Mayday.COH.org).

Developing an Interdisciplinary QI Leadership Team

A successful pain management program will have a quality improvement (QI) leadership group composed of representatives of all the departments involved in pain management, including medicine, nursing, anesthesiology, the pharmacy, and psychology or social work. Other potential members of the leadership group are representatives from administration, public affairs, and development; hospital Board members; key referral sources from other departments; and representatives from the community. Members of this leadership group should be chosen for their expertise in pain medicine, their position within the cancer center, or their ability to implement needed clinical services. The leader should possess expertise in pain medicine, institutional authority, excellent communication skills, and commitment to the goal of adequate pain management for all patients.

Once the leadership team has been assembled, its initial task will be the development of a clear work plan⁶, including a mission statement, a



ILLUSTRATION BY KAREN STOLPER

An outpatient program should also be developed that provides a range of services to identify, prevent, and address the **physical** and **psychological problems** produced by *the experience of pain*.

timeline, specific steps needed to accomplish each goal, and the staff members responsible for carrying out each step. The work plan must identify the members of the new interdisciplinary pain team and their roles in the delivery of pain management services, as well as mechanisms for ensuring accountability for all aspects of the pain management process. Finally, the work plan must include clinical practices for pain management.

Implement Processes for Service Delivery

Some of the issues the leadership team must address before patients are seen include:¹⁰

- Who will take new referrals for the pain program?
- Who will carry the pain beeper?
- How much time can lapse before new referrals are seen (i.e., 4, 12, or 24 hours)?
- Who performs the initial pain assessment (i.e., attending physician, nurse practitioner)?
- Who writes the orders for pain medication?
- Who provides psychological and social support?
- Who takes calls after hours for the pain management service?
- Who is responsible for documenting the results of the pain assessment, treatment plan, and follow-up?
- Who is responsible for billing, maintaining the charts, medication renewals, and other administrative duties?
- Who is responsible for measuring quality indicators and monitoring the progress toward program goals?

Daily rounds of inpatients with cancer pain problems should be established and conducted at a consistent time so that the unit staff knows when to expect the pain team and can participate in rounds. Making the unit staff part of the team ensures that medication orders and treatment plans are carried out reliably.

An outpatient program should also be developed that provides a range of services to identify, prevent, and address the physical and psychological problems produced by the experience of pain. Outpatient programs allow the patient and family to maintain contact with the medical system and facilitate continuity of care.

Although research and planning are essential, the pain committee's timeline should clearly name a date when the new program will be implemented so the planning process does not become an end in itself.

Providers need to have a good understanding of the CPT and E&M codes for pain management services. All new physicians and nurse practitioners should be required to attend training on coding and billing that covers, at a minimum, the codes for new office visit, established office visit, initial hospital visit, subsequent hospital visit, and consultation.

Establish Outcome Measures

Monitoring the outcomes of the pain program is the ongoing responsibility of the interdisciplinary workgroup, which should address clinical, educational, and systems issues.

Periodic surveys of inpatients and outpatients should measure:

- Patient comfort (pain intensity)
- The impact of pain on function
- Patient and family satisfaction with staff responsiveness to pain issues
- The waiting time from pain complaint to visit/appointment by the pain team.

Chart audits and reviews of pharmacy records can measure:

- The documentation of pain assessment
- What delivery systems are available within a particular setting
- How often analgesics are prescribed and administered
- Pain treatment costs (i.e., increased length of stay, unscheduled emergency room visits, and re-hospitalization due to pain).

The following outcomes can be assessed during weekly team discussions, pain rounds, regular follow-up phone calls with patients, during outpatient oncology clinic visits, and during mortality and morbidity conferences:

- The prevalence and severity of side effects associated with pain management
- The number of adverse events associated with pain treatment procedures
- The quality of pain management across points of transition (inpatient, outpatient, home care).

Staff knowledge and competence and patient and family education outcomes can be measured with simple surveys.^{2,6,9}

The Interdisciplinary Pain Management Team

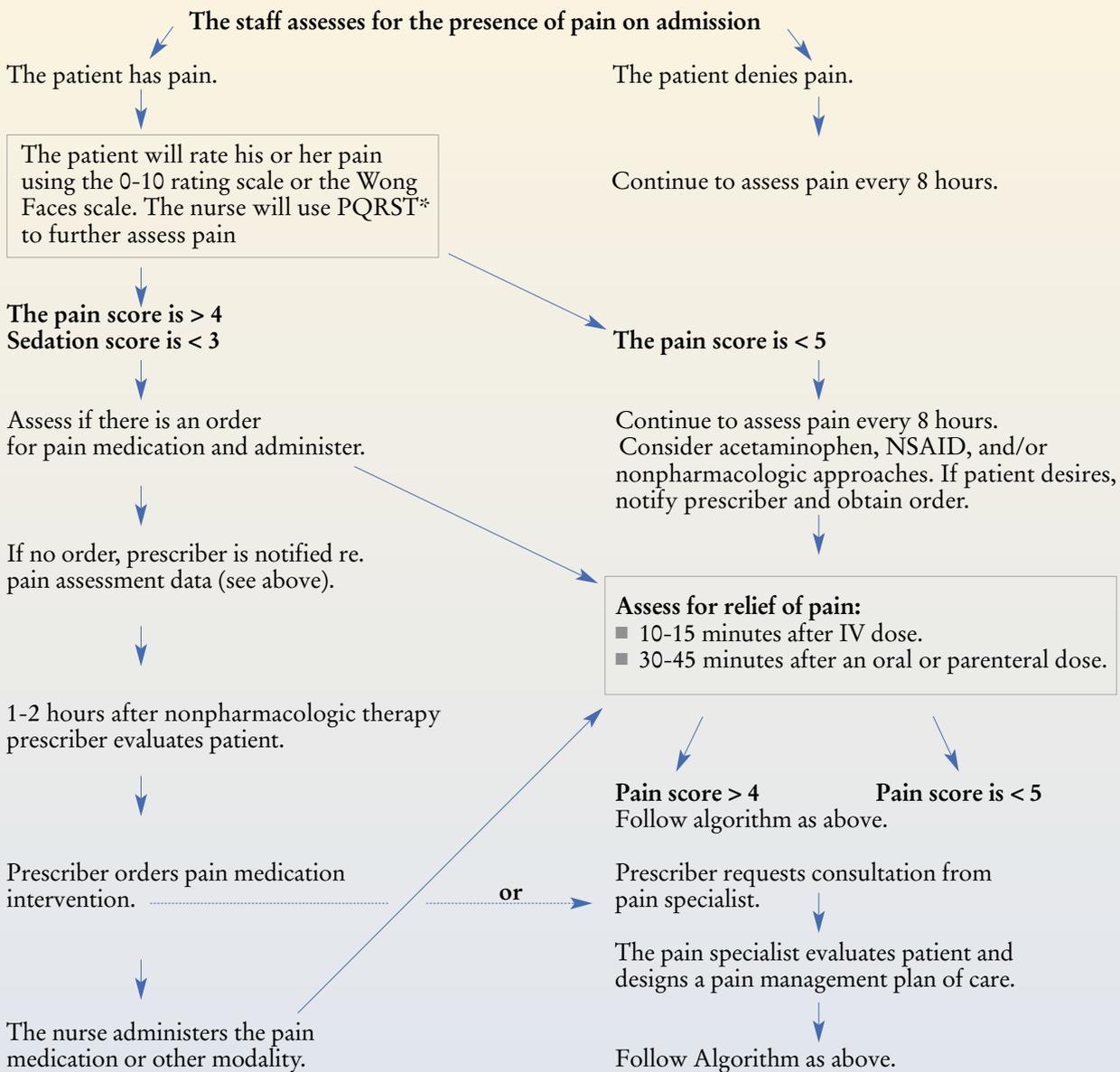
At this juncture, staff education should begin in earnest. The workgroup or leadership team should develop a blueprint for educating the staff about pain management. Core topics should include 1) pain assessment, 2) documentation, 3) pharmacologic management, 4) equianalgesic conversions, 5) the management of side effects, 6) non-pharmacologic approaches (i.e., biofeedback, cognitive behavioral treatment, complementary and alternative approaches, heat and cold), 7) barriers to pain management, and 8) ethical issues.⁶

Many pain courses are available online, such as the

Figure 1: Algorithm for Pain Assessment and Management

JCAHO Standard RL.1.2.8

Patients have the right to appropriate assessment and management of pain.



*PQRST is an acronym for P (palliative/provocative); Q (quality of pain); R (regions/radiation); S (severity of pain); and T (temporal)

problem-based, interactive module on neuropathic pain (www.StopPain.org) and courses through the National Pain Education Council (www.NPECweb.org).

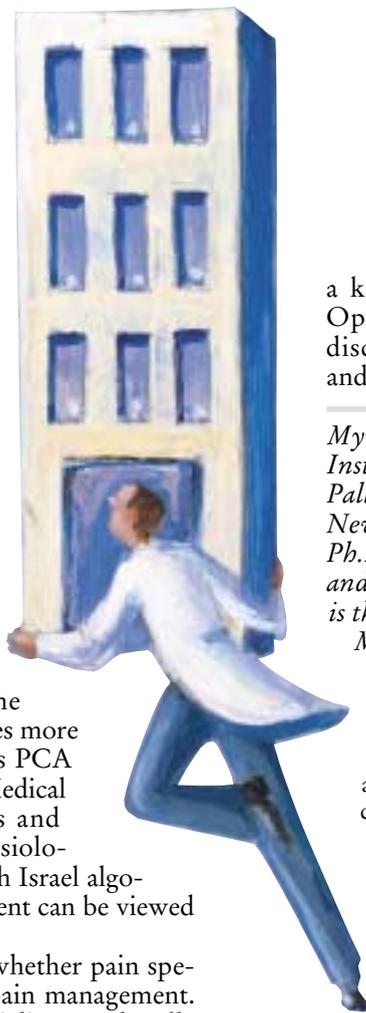
The advantages of having a specialized pain team are numerous. For instance, the team provides expertise in symptom control, can identify unmet needs, and the pain consultation itself can educate other hospital staff members and expose them to new principles and practices.

An interdisciplinary pain team can pool professional

expertise and achieve both a better understanding of client needs and increase its problem-solving options. For example, if the pain team recommends daily physical therapy at the community cancer center, the social worker can point out that the patient lives alone, cannot drive, and cannot manage the three-story walk-up in the building.

Ideally, every pain program should have a full-time physician, advanced practice nurse, psychologist or social

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worker, and administrator. If the resources within your community cancer center are limited, begin with a physician and a nurse and refer the patient to practitioners of other disciplines as needed. Each member of the pain management team should devote at least half of his or her time to pain management activities for the program to run successfully.

Two distinct pain treatment models have evolved. One model is for patients in chronic pain and utilizes pain medication and non-pharmacological treatment approaches. The other is for patients in acute pain and uses more aggressive physical interventions such as PCA pumps and stimulators. At Beth Israel Medical Center, we integrate the two models and make referrals to neurologists, anesthesiologists, or physiatrists, as needed. The Beth Israel algorithm for pain assessment and management can be viewed in Figure 1.

There is an ongoing debate about whether pain specialists or oncologists should provide pain management. We think the answer is both. Pain specialists can handle complex symptoms and multiple needs, but oncologists have a deep understanding of how the patient's disease is likely to progress and develop such intense relationships with their patients that they must be part of the pain management process. Because pain is so widespread among patients with cancer, medical oncologists should master the basics of pain assessment and treatment, then work hand-in-hand with pain specialists, who should provide expert consultation without "taking over" the case from the primary treating physician.

Promoting a Pain Management Program

Once the new pain program has been established, the problem is how to keep the momentum going. Here are some innovative methods¹¹ for making a pain management program more visible within an institution:

- Establish pain as the fifth vital sign.
- Distribute pain brochures to all new patients upon admission and discharge.
- Post pain intensity scales in all patient care areas.
- Provide large-scale and ongoing professional education.
- Partner with local community groups to raise awareness about a patient's right to adequate pain relief.

Finally, your cancer center should capitalize on the appeal of a new program, obtain funding, and organize

a kickoff symposium with outside experts. Open the symposium to as wide a variety of disciplines as possible, including nurses' aides and pharmacists. ◻

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