Interdisciplinary collaborative practice intervention to improve pain control for all patients in a community cancer center

Authors: Jeanne Elnadry MD, Tina Duarte MA LAC, Gregory Yang MD, Ambuga Badari MD

Results
Initial data: Identification of distress, 274 patients
- Number of patients with distress
- Total patients, 207
- Number of domains of distress, 274 pts

Follow up data, 207 patients
- Characteristics of pain in 71 patients who self-identified presence of pain
- Pain management plan by provider

Lessons learned
- Implementation of new processes is challenging at best, and is often quite difficult. During this process improvement study, the community cancer center moved to a new building, leading to a number of processes being changed simply because of geography – key staff were no longer co-located.
- Identification of neuropathic pain is important because use of specific medication directed toward neuropathic pain may be more effective than opioids alone.
- The new data allows us to analyze pain management practices of individual clinicians, and to develop targeted education, skill building and process improvement activities.

Recommendations and next steps
- Develop capacity to use tablet-based pain and distress screening prior to physician visits and at specific times during cancer care (such as time of diagnosis, midway through chemotherapy or radiation, completion of treatment).
- Identification of disease progression, significant change in condition.
- Use electronic medical record, in collaboration with physicians, to develop templates that facilitate documentation of pain intensity, character, response to medications, and plan for management.
- Migrate pain and distress screening information into EMR in real time, to be available for clinic visits.
- Standardize processes for pain assessment and management, with focus on best practices.
- Train clinic triage nurse in use of Pain Management Algorithm for collaborative practice with the physicians.
- Initiate integrated Supportive Care Clinic at the community cancer center – beginning October 21, 2014.

Background
In rural Yuma AZ, there are too few palliative care specialists to meet the needs of the population. This report presents a unique approach to interdisciplinary care for pain management beginning early in cancer care.

Purpose
To address this need, a palliative care specialist collaborated with the entire clinical staff of the community cancer center, including physicians, nurses, social worker, pharmacist, and medical assistants, to initiate a new distress screening tool and develop an interdisciplinary collaborative practice model for pain management.

Methods
Baseline data collection 3/2014
- 274 community cancer center clinic patients were given the clinic standard review of systems form with new distress screening elements, prior to physician visit.

Comparison of clinic pain data to end-of-life pain data
- End of life data for 55 cancer clinic patients referred to home hospice showed that nearly all advanced cancer patients with moderate to severe pain could have pain control to pain scores 0-3.
- Patients undergoing treatment should be able to have a similar level of pain control but did not.

Process improvement project
- Work group included physicians, nurses, medical assistants and social worker.
- Work group identified pain as a major element of distress and a priority for action.
- Developed a Pain Assessment Tool for use by medical assistants and social worker.
- Developed a pain management algorithm to be used by clinic nurses and physicians.

Follow up data collection 8/2014
- 207 clinic patients were given new Pain Assessment Tool.

Follow up data results
- 207 patients were given the new Pain Assessment Tool.
- 71 (34%) self-identified pain.
- 43 (61% of patients with pain) had moderate to severe pain.
- 21 (30% of patients with pain) had symptoms suggesting neuropathic pain.
- Of the patients with pain, the percent who had a documented pain management plan varied among individual physicians from 17% to 65%.

Pain management plan by provider

Recommendations and next steps
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