Original Article

Evaluation of Pain Management Documentation

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Objectives: Accurate and consistent documentation of pain management, including patient responses regarding improvement in pain scores, is essential for improving patient care. The objective of the project was to evaluate the current prescribing patterns and to review the current documentation for opioid-managed, chronic pain patients in an academic continuity of care medicine clinic.

Methods: Retrospective data were extracted from currently managed adult, opioid patients to evaluate prescribing patterns and to review documentation processes.

Results: Results reveal inconsistent to absent documentation with most patients receiving prescriptions from multiple providers. Oxycodone/acetaminophen was the most frequently prescribed analgesic.

Conclusion: The results of this evaluation highlight the opportunity for educational intervention and the development of a structured, institution-specific guideline for prescribing and documenting pain management.

Key Words: Chronic pain, documentation, opioid, pain management

Chronic pain is a challenging condition to diagnose, evaluate, and manage. By definition, chronic pain is pain persisting longer than three to six months, beyond the time that healing normally occurs.[1,2] The etiology of chronic pain can be nociceptive, neuropathic, mechanical (compressional), inflammatory, or mixed in origin. Changes in the chronic pain pathways are usually permanent, may be present in the absence of an identifiable source, and have varying response to conventional analgesic medications.[2,3] These characteristics make successful management of chronic pain a difficult task. Acute pain is generally nociceptive (result of direct stimulation of nerve receptor), transient, and responsive to conventional analgesic therapy.[2,4] Thus, treatment strategies differ depending on the type of pain present. The subjective nature of symptoms, wide range of causative etiologies, and the various ways patients present contribute to the complexity of managing this disease state. Further misconceptions of chronic pain patients as "drug-seekers" may also complicate management and can lead to under treatment of the patients' pain. In some cases, nurses with clinical experience may negatively affect the pain management documentation scores unintentionally by influencing patient responses.[5] Even educated, experienced medical professionals may rely on past personal experiences, outdated teachings, and be more resistant to incorporating new practice pain management guidelines which can directly affect the degree of documentation completed.[5] Therefore, consistency in application of evidenced-based pain management practice is the primary means to combat undertreatment of pain. The role of documentation has previously been studied and has shown a lack of consensus between medical documentation and patient self reports. In one study, patients more frequently report having addressed pain needs than was evident by the associated documentation.[6] However, documentation of the pharmaceutical pain management plan is the primary method used by healthcare professionals to communicate effectively and accurately

Key Points

- Chronic pain management continues to challenge prescribers not only in choice of therapy but also in documentation processes.
- Identification of type of pain is essential for target of therapy for chronic pain treatment.
- Nationally recognized groups, American Pain Society and the American Academy of Pain Medicine have provided consensus statements providing general recommendations for pain management, including expectations for documentation.

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among multiple caregivers.[7,8] This emphasizes the need for detailed and thorough care plans which include monitoring goals and timelines for reassessment of current therapy.

While physicians are aware of the different treatment strategies for acute and chronic pain, the amount of standardized training in chronic pain management varies widely among medical programs. Literature stressing the importance of medical documentation is scarce. In one study, physicians expressed much more discomfort in managing chronic pain-related issues compared to most other chronic disease states.[3] Lack of training leading to perceived inadequacies among physicians, in addition to the fear of investigation, legal sanction, and the addictive potential associated with the controlled substances commonly used to manage these patients may all contribute to the under treatment of chronic pain.[3,4,9] An example of this commonly observed by the authors would be monotherapy with short-acting opioids for treatment of chronic pain. Short-acting agents alone do not sufficiently address the needs of chronic pain patients (by lacking around-the-clock analgesia) but are one of the most commonly prescribed pharmacological treatment strategies observed resulting in undertreatment of chronic pain. Suboptimal treatment results in needless suffering for the patient, enormous economic costs through lost productivity, and excessive healthcare expenditures due to undertreated pain conditions.[4,10] Many of these concerns could be minimized with improved medical documentation to alleviate legal sanction concerns. This would also improve continuity of care among the continuum of practitioners providing pain management care for an individual patient.

Improvement in pain management practices and provision of better pain therapy options are a high priority in the United States.[3,4,10] Clinical practice guidelines for management of acute and cancer pain have been released by the U.S. Department of Health and Human Services, but nationally accepted guidelines are lacking for management of chronic pain. Multiple pain organizations have published recommended guidelines for chronic pain management and recently two national advocacy groups, the American Pain Society (APS) and the American Academy of Pain Medicine (AAPM) have released a consensus statement providing general recommendations.[10] The APS/AAPM consensus statement focuses on many aspects of pain management such as documentation, written long-term plans, and periodic reassessment. Individual organizations such as the American Society of Interventional Pain Physicians (ASIPP) and the American Pain Society (APS) have published guidelines; however, clinical practice strategies can still vary greatly among individuals, specialties, and disciplines.[3] As a result, the APS/AAPM statement stresses the importance of documentation both to ensure optimal care of patients among multiple providers while still facilitating continuity of care.[10]

Opioids remain the most common drug class used for treatment of chronic pain. However, a wide degree of variability exists in prescribing patterns among physicians.[3,11] As discussed previously, under treatment of chronic pain has become a focus of many pain advocacy groups and other healthcare professionals. The Drug Enforcement Agency (DEA) has acknowledged the undertreatment of pain, making the statement that "clinicians should not withhold use of controlled substances, including opioids, in patients when they represent the best clinical choice of treatment."[3] The DEA stresses that the best and safest way to protect against legal scrutiny is by the provision of adequate documentation. The attention placed on the importance of documentation led to the conception of this project to determine the current pain management documentation processes being utilized and identify possible areas for improvement in an academic continuity of care medicine clinic (CCC) at our institution. The primary objectives of this study were to evaluate the current prescribing patterns of opioids for the management of chronic pain and review the level of documentation. Secondary objectives were to list the pain treatment medication choices and adjustments made corresponding to the type of pain found in the documentation.

Methods

This project is part of the Medical College of Georgia Health Medication Use Evaluation (MUE) and Improvement Program which has been approved by the Institutional Review Board. To establish the documentation and prescribing practices of our CCC physicians, a data collection sheet was developed based on the ASIPP recommended guidelines (Appendix 1). Inclusion criteria were patients 18 years or older, active patient in the CCC clinic with a current opioid contract, and opioid analgesic prescriptions from a clinic physician. Patients were excluded if they did not have a pain contract despite receiving opioid medication. Opioid contracts were written documents signed by both prescribing physician and patient agreeing that only a prescriber within a single practice site of the institution (ie, all physicians authorized to practice in the CCC) would authorize opioid medications for that patient and if violated, would result in the termination of care. Additionally, patients were encouraged to have opioid prescriptions filled at only one pharmacy to aid in the tracking of misuse. Medical records were manually reviewed to identify patients from an electronically generated list who received prescriptions for pain medications from a clinic physician for at least 6 consecutive months.

Data collected included type of chronic pain, duration, severity, as well as current and past opioid use. The medical record was evaluated for documentation of a comprehensive history and physical evaluation at the initial visit, written long-term plan for the patient's pain management, and periodic reassessment of the efficacy/adequacy of chronic pain control. Additionally, the assessment included the number of different prescribing physicians, any history of narcotic abuse, quantity and type of opioid prescriptions dispensed. Data from each identified patient were then collected through retrospective

electronic chart review. Patient management and documentation processes were compared to current guidelines.

Results

A total of 86 patients were identified to be active patients in the CCC with a current opioid contract and opioid prescriptions. Nineteen patients were randomly selected and evaluated. Fifteen patients (15/19, 79%) had a mixed origin of chronic pain. Nine patients (9/19, 47%) had low back pain or pain from failed back surgery. Eleven patients (11/19, 58%) had a neuropathic component to the diagnosis of chronic pain. Arthritis was identified as a component in six patients. Forty-seven percent (9/19, 47%) of patients presented on medications for chronic pain at their initial visit to the CCC. Oxycodone/acetaminophen was the most commonly prescribed agent, used as monotherapy in 37% (7/19, 37%) of patients and in combination with a long-acting agent in 42% (8/19, 42%) patients (Fig. 1). The majority (15/19, 79%) of patients were prescribed regimens scheduled around the clock (basal pain control), but only 42% (8/19, 42%) had rescue prescriptions for breakthrough pain (Fig. 2). Ninety-five percent (18/19, 95%) of patients received prescriptions from multiple practitioners within the CCC. A comprehensive written, long-term plan was documented in only seven (7/19, 37%) patients. Due to the design of the CCC at the time, pain prescriptions were commonly written by multiple providers without direct patient contact. Periodic reassessments were performed in 89% (17/19, 89%) of patients but were performed erratically, with limited detail and quality of the progress note in terms of facilitating communication between practitioners (Fig. 3). During the time of actual patient visits, the pain management documentation in progress notes were significantly limited to such phrases as: "pain-stable," "pain-no change," and/or just "continue current medications." These responses were included as a "completed reassessment" in our results; however, the limited communication left much to be interpreted by the receiving physician. Further complicating and challenging the pain management

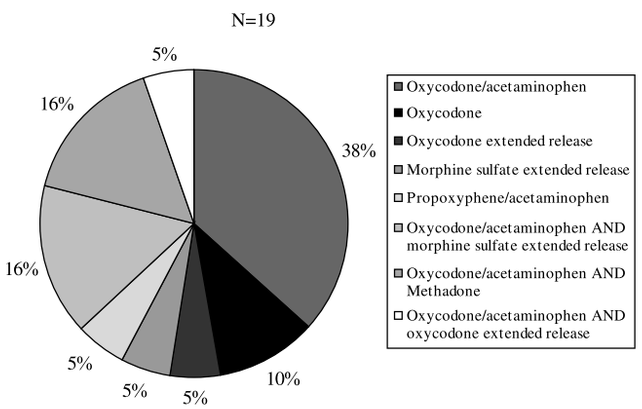

Fig. 1 **Opioid agents prescribed.**

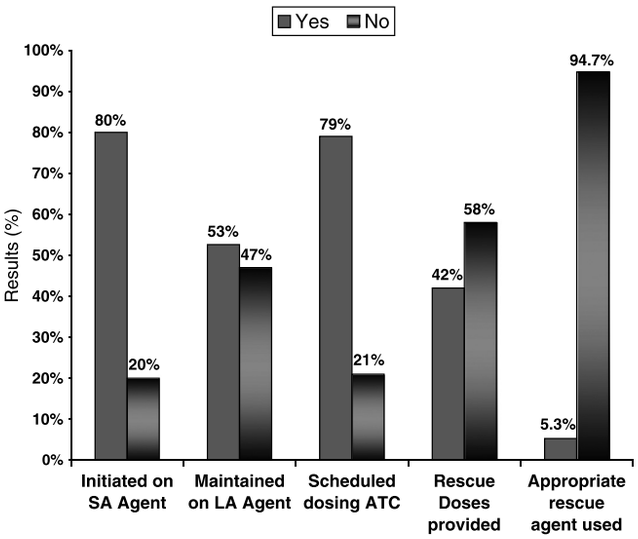

Fig. 2 **Compliance with ASIPP guidelines.**

care, patients were receiving prescriptions without physical assessment and those who were seen in the CCC resulted in limited to no qualitative documentation. Questions regarding the use of adjuvant therapy remain a concern. Seventy-nine percent (15/19) of patients had a mixed origin of chronic pain and 58% (11/19) had a diagnosed neuropathic component, but few therapies commonly used for these specific pain conditions were identified. In many cases where the medication regimens were changed,

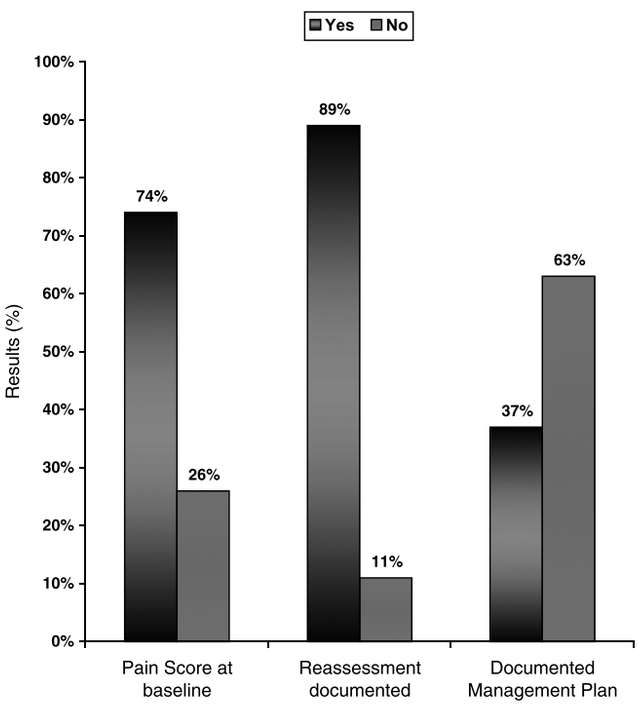

Fig. 3 **Documentation of assessment of plan.**

there was little if any explanation of the adjustment, making prescribing patterns even harder to evaluate - again providing a challenge for the receiving practitioner to understand and follow the care plan of a given patient.

Discussion

During this project, the limited documentation in physicians' notes made evaluation of prescribing patterns challenging. At the time of data collection, there was not an established standard process for progress note documentation in regard to initial evaluation or periodic reassessment of chronic pain patients at the CCC. The importance of the content of documentation was highlighted by Bergen-Jackson and colleagues as a means for communication among providers.[12] These records remain a resource for coordination and continuity of care between multiple providers, as well as a resource for reimbursement needs, meeting accrediting bodies' requirements, and providing data for research.[12] An approach incorporated into practice by nursing homes and home care industries has been the use of mandatory electronic documentation systems to ensure the completion of legally required information.[12] With regard to fear of legal sanction, adequate documentation is paramount in the management of chronic pain with opioids.[9] Even when thorough documentation is present in medical records (including a history, physical exam, studies, and even physician consultations), investigations could still occur but adequate records will ensure appropriate action taken by the prescriber with regards to management of chronic pain with opioids.[9] Prescribing of opioids will continue to remain a challenging venture for prescribers as long as there are illicit abuse and illegal monetary gains from their obtainment. It has been outlined in prior publications that legal action normally occurs when prescribing is done outside the "usual course of medical practice".[13] The definition of this can be just as difficult to determine; therefore thorough documentation highlighting reason of use, monitoring, and follow-up plans is prescribing in good faith.[13]

In direct response to the identified need to improve documentation at our institution in an effort to enhance communication and tracking of care, the procedure for evaluation of chronic pain patients has been changed. In a new policy, established patients with opioid contracts (as a part of the permanent medical record) are to only have chronic pain needs addressed by their assigned provider at a scheduled appointment. This occurrence consequently results in a documented evaluation and assessment in the note of each chronic pain patient along with the action taking regarding medications or alternative therapies. If the assigned provider is unavailable, further stipulations have been put in place to maintain the continuity of care by scheduling patients to follow-up for chronic pain needs on the same day as they normally see their assigned provider. This environment of continuity will increase the likelihood that an attending physician would be involved with the prior management of chronic pain and thus be better equipped to assess and monitor the patient's progress. Having a baseline knowledge of the patient will ideally lead to more complete and detailed documentation concerning his or her care and any changes made. A final step implemented to decrease the prescribing concerns has been the implementation and utilization of eScribe, a web-based electronic medical record prescription system that allows for multiple pharmacy use monitoring, ease of tracking distributed prescriptions, and thorough documentation of provided opioid prescriptions to patients.

Our study had several limitations. We performed a retrospective medical chart review on a small number of patients over a relatively short time period. As with all retrospective studies which rely on historical information, the quality of the data collected was dependent on a number of factors beyond our control. These factors include the accuracy of the information originally written in the medical record, lack of important information (due to limited or incomplete documentation), inability to control for potentially confounding variables (difficulty establishing cause and effect), a less well-defined patient population (versus a prospectively-designed study), and lack of randomization and/or a control group.[14] However, based on the data collected in our review, we believe that the results can safely serve as the baseline for documentation practices by our clinic physicians for patients on chronic opioid therapy and that these data provide us with an impetus to drive change at our institution. These data will also provide a benchmark for comparison after changes have been put in place to improve documentation practices in the future.

Conclusion

Based on the documentation practices discovered during our retrospective review, our results suggest that education regarding prescribing habits and improved documentation are needed. The CCC addressed these issues by integrating changes to facilitate more consistent documentation such as new methods for scheduling appointments and a new, more reliable system for thorough tracking of dispensed prescriptions. It would be the opinion of the authors that in this era of electronic tools that aid in medical documentation, the use of an electronic prescribing system represents an advancement in care. As our ultimate objective is to improve the prescribing patterns of pain medication therapies, enhance documentation and prescription tracking, we believe that an electronic system will aid providers in maintaining a more consistent chronic pain management care plan. Ideally this will lead to improved patient outcomes. Utilization of electronic forms as opposed to paper charting would be a future proposed methodology to improve medical documentation with regard to management of chronic pain. This remains an area of opportunity

and growth for our practice site, with pending opportunities to create an electronic chronic pain assessment template that would standardize the level of documentation for all providers.

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