

Patient-Reported Pain Improvement

In this lesson you will learn the required documentation for the **MIPS #PIMSH4 Patient-Reported Pain Improvement** quality measure.

This measure looks at the pain intensity documented within a 30-day episode.


The screenshot shows the patient banner for 'Orange Blossom Flower (43 / F)' with DOB: 07/07/1977 and MRN: zzflowerorange. The 'Nursing Care' tab is selected, and the 'VITAL SIGNS' button is highlighted with a red box and a yellow circle labeled '1'. The 'Ht/Wt/BSA' link in the patient banner is also highlighted with a red box and a yellow circle labeled '2'.

1. To document patient vitals, click on the **VITAL SIGNS** under the **Nursing Care** tab.
2. Clicking on [Ht/Wt/BSA](#) in the patient banner will also open the vitals window. Once in the vitals window, the documentation is the same.

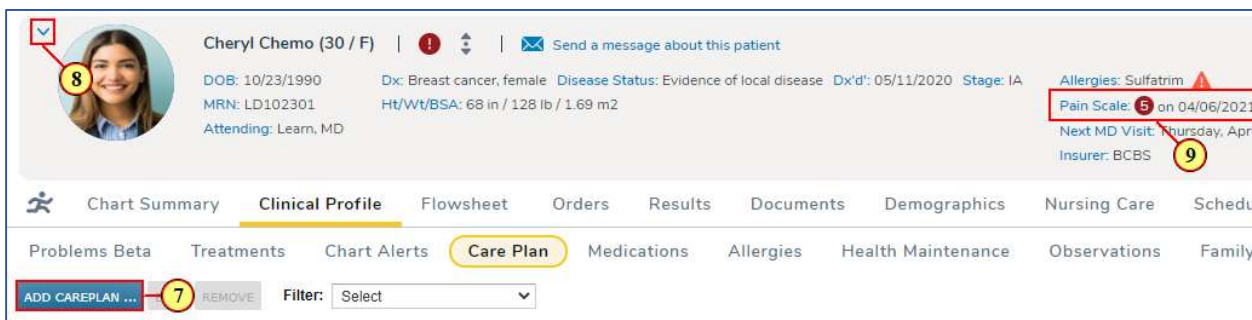
The screenshot shows the 'Pain Scale' form. A dropdown menu is open, showing options from '0-No pain' to '10-The worst pain you can imagine'. The dropdown is highlighted with a red box and a yellow circle labeled '3'. The '0-No pain' option is selected, highlighted with a red box and a yellow circle labeled '4'. The 'Flow rate' section has radio buttons for 'Room air' and 'Nasal cannula', with a text input for 'L/min'. The 'Flow rate' label is highlighted with a red box and a yellow circle labeled '5'. The 'SAVE' button is highlighted with a red box and a yellow circle labeled '6'.

3. **Using the drop-down arrow to select** the number that corresponds with the pain the patient is currently experiencing. 0 = no pain and 10 = the worst pain imaginable.
4. **Select** the number reported by the patient.
5. Click [+ Add comment](#) to add any comments related to the patient's pain score.
6. Click **SAVE**.

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- Patients will be included in the denominator when pain is documented on the date of an office visit and the pain level is > 3.
- Subsequent pain intensity within the 30-day episode does not have to be documented on the same day as a visit.
- If a patient refuses the clinician recommended plan of care for pain, they will be removed from the denominator. The exception can be documented in the **Pain Care Plan**.



7. To add a **Pain Care Plan**, click **ADD CAREPLAN** under **Care Plan** in the patient's **Clinical Profile**.

8. The **Pain Care Plan** is also accessible directly from the **Patient Banner**, when expanded. If the **Patient Banner** is not already expanded, click the arrow next to the patient's photo to expand it.

9. If the patient's pain is documented at a value greater than 0, the value is red. Click **Pain Scale** to go directly to the patient's **Pain Care Plan**.

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▼ Pain Treatment Plan

☐ No pain reported
☐ Use of Opioids
☐ Non-opioid analgesics or techniques
☐ Non-pharmacologic interventions (relaxation techniques, use of heat/cold)
☐ Driving prohibitions discussed
☐ Opioid agreement signed
☐ PDMP reviewed
☐ Patient and/or family education
☒ Patient and/or family education- patient refuses pain management intervention
☐ Psychological Support
☐ Radiation treatment
☐ Reassessment of pain at an appropriate time interval
☐ Referral to a pain clinic
☐ Referral to other provider
☐ Urine drug screen order provided and discussed
☐ Other

▼ Comment

SAVE

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10. **Click** the check box for patient refuses pain management intervention.

11. Click **SAVE**.

This concludes the lesson for the **MIPS #PIMSH4 Patient-Reported Pain Improvement** quality measure.