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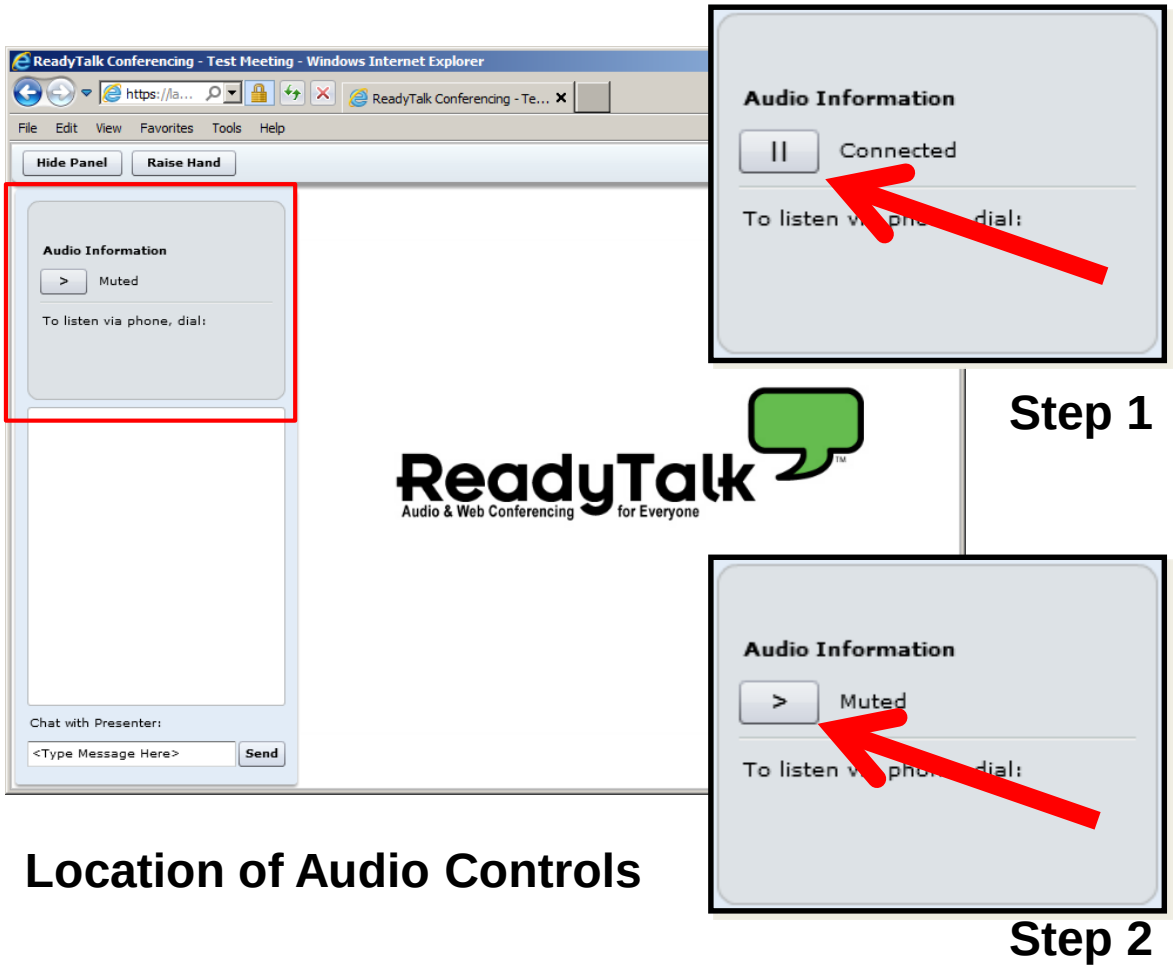

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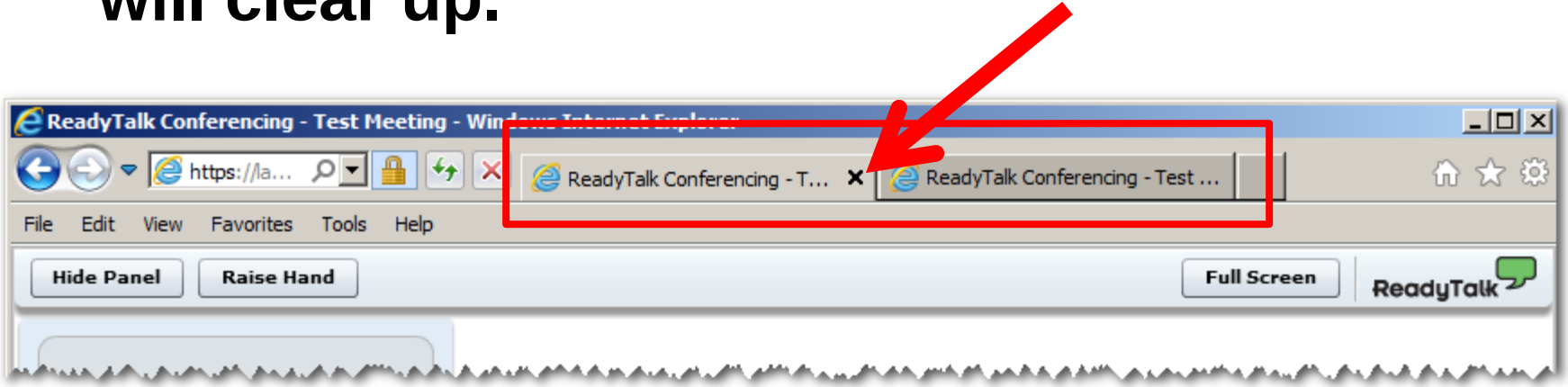

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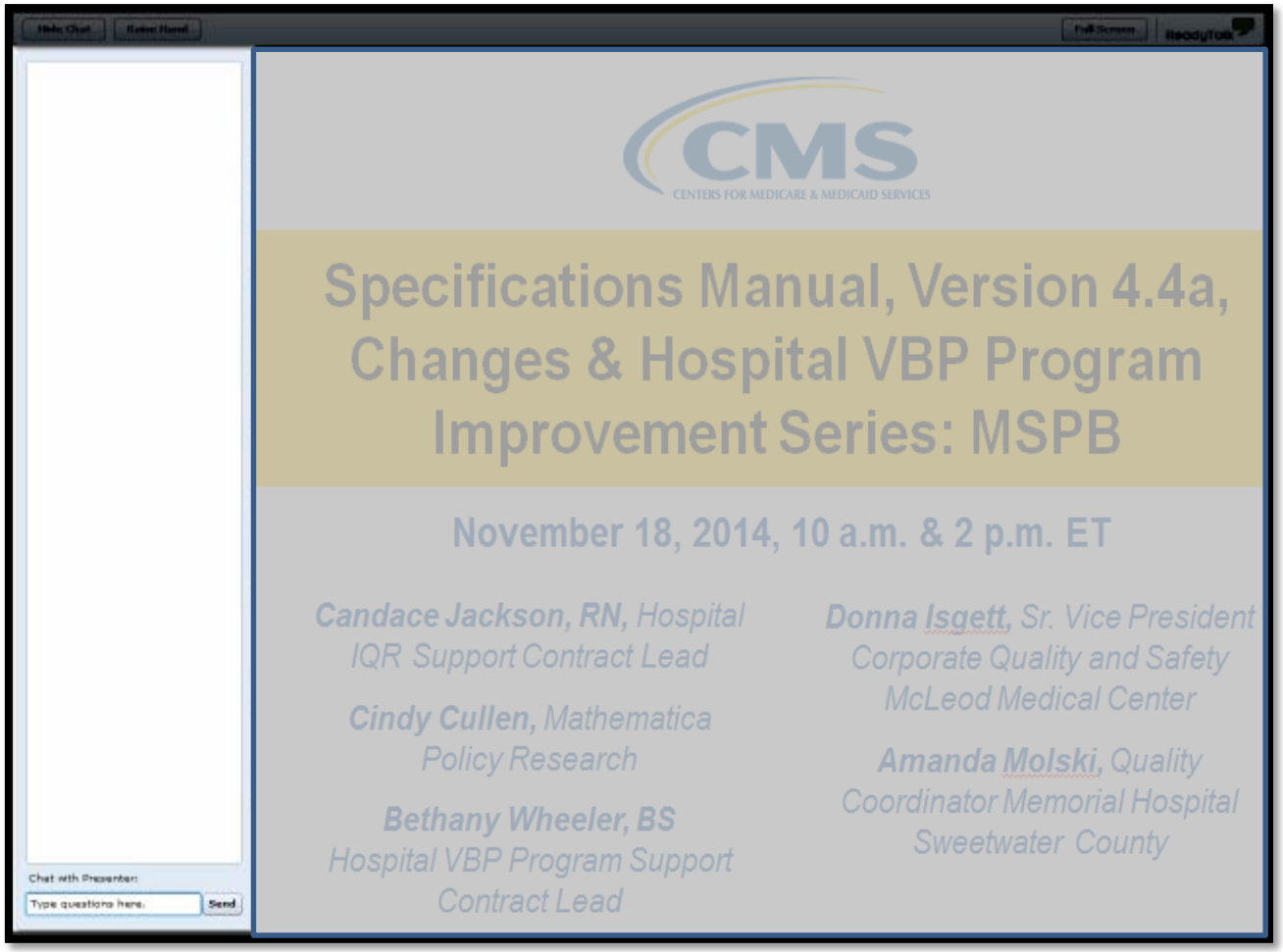

NQF #0384 and #0383 Sampling, Assessment, and Lessons Learned

PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

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September 24, 2015

Purpose

The purpose of this presentation is to discuss National Quality Forum (NQF) measures #0384 and #0383 in the PPS-exempt Cancer Hospital Quality Reporting (PCHQR) Program.

This discussion will explain the relationship between the two measures to:

- Assist in proper sampling
- Communicate the prevalence of pain in the PPS-exempt Cancer Hospitals (PCHs) versus rates reported in the literature
- Share lessons learned for the purpose of quality improvement

Objectives

Upon completion of this program participants will be able to:

- Clearly state the requirements for NQF #0384 and #0383
- Understand and implement a sampling strategy for these paired metrics
- Discuss the incidence of the presence of pain reported in the first quarter 2015 and compare with literature-reported rates
- Apply lessons learned to improve the assessment of pain in the cancer hospital setting and help ensure patients with pain have a plan to address it

FY 2014 Final Rule: Pain Metric Overview

Clinical Process/Oncology Care Measures for Pain Intensity Quantified (NQF #0384) and Plan of Care for Pain (NQF #0383):

- Are “paired metrics”
- Address the National Quality Strategy (NQS) domain of Patient and Family Engagement
- Were added for FY 2016 program and subsequent years
- Will be reported
  - Beginning with patient visits January 1, 2015
  - Once a year in aggregate quarters

FY 2015 Final Rule: Pain Metric Data Collection

- Clinical Process/Oncology Care Measures, including NQF #0384 and NQF #0383, are required to be "all-patient" data in order to:
  - Ensure high quality care is delivered to Medicare beneficiaries in the PCH setting
  - Provide CMS with the data needed to inform the public about the quality of care and outcomes in the PCH setting
- New sampling methodology for the Clinical Process/Oncology Care Measures introduced

Average Quarterly Initial Patient Population Size "N"	Minimum Required Sample Size "N"
>125	25
51–125	20% of Initial Population
10–50	10
<10	No Sampling; 100% of the Initial Patient Population

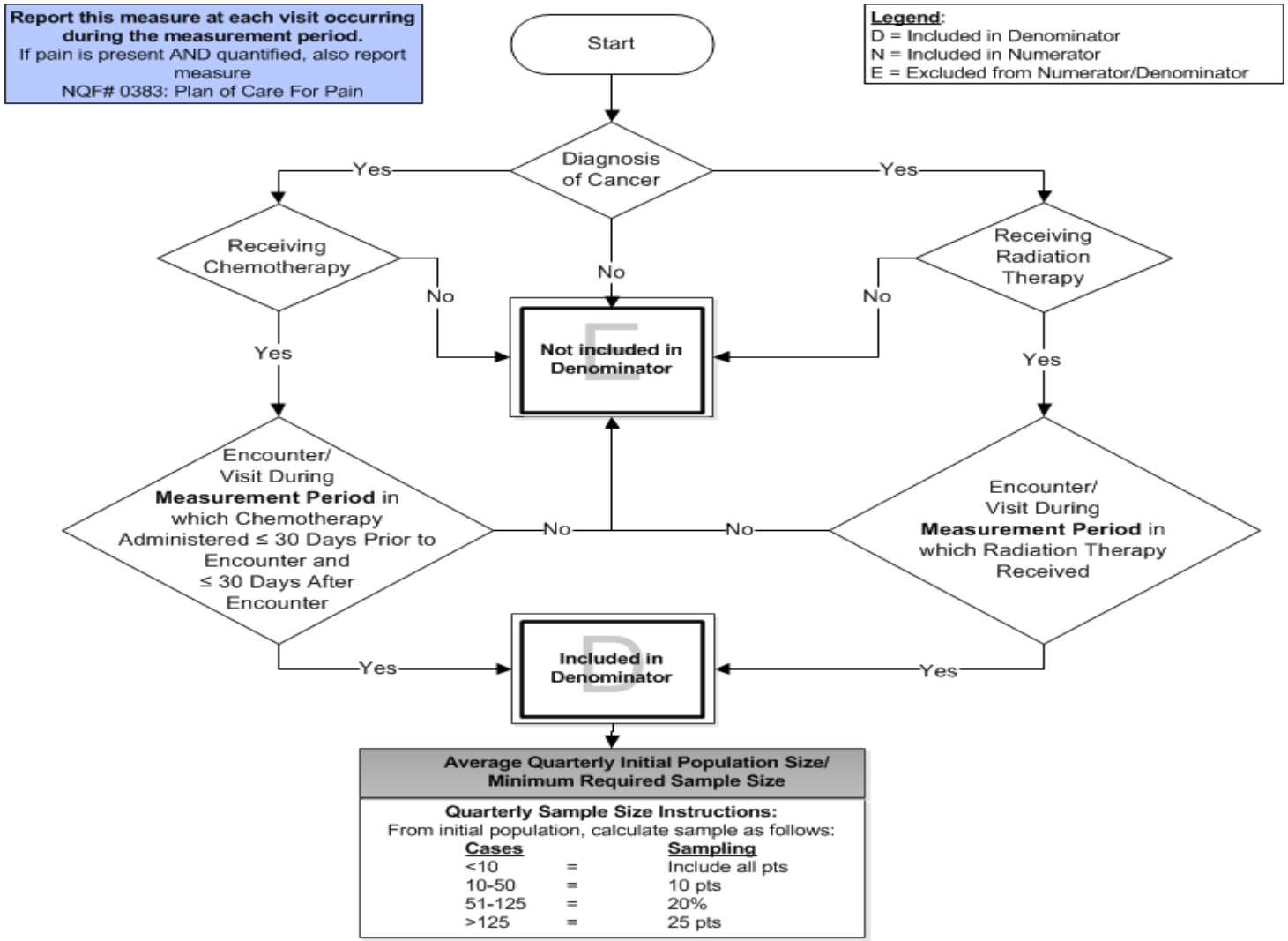
FY 2016 Final Rule: Pain Metrics

- Public Reporting in 2016 and subsequent years
- Comment requesting clarification of sampling protocol for NQF #0383 and #0384
  - These are “paired” measures
  - Cancer patients that are sampled for the Pain Intensity Quantified (NQF 0384) measures for the numerator case count are also sampled to account for the Plan of Care for Pain (NQF 0383) measure (denominator case count)
  - Patients who are reporting pain, and it is quantified, should have a care plan for pain management
  - This is not perceived as “oversampling” but rather a step toward improving quality of care by monitoring, managing, and controlling pain throughout the life cycle of cancer treatment

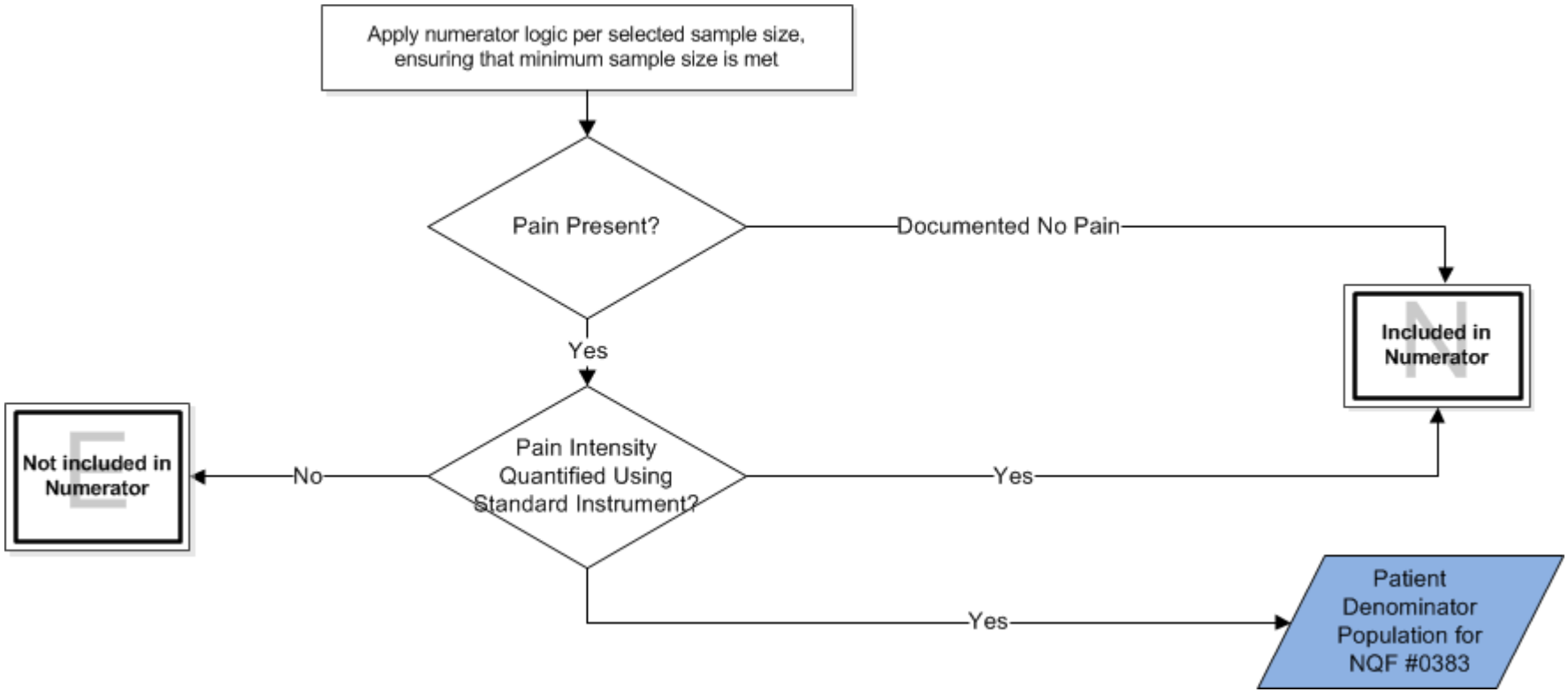
NQF #0384 Specifics

- **Description:** Percentage outpatient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy **OR** radiation therapy in which pain intensity is quantified during the measurement period
- **Denominator Statement:** All outpatient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy **OR** radiation therapy
- **Numerator Statement:** Pain assessed “no pain present” **OR** if “pain is present,” it is quantified using a standardized instrument
- **Type of Measure:** Process
- **Improvement Noted As:** Higher score indicates better quality

NQF #0384 Denominator



Numerator for NQF #0384



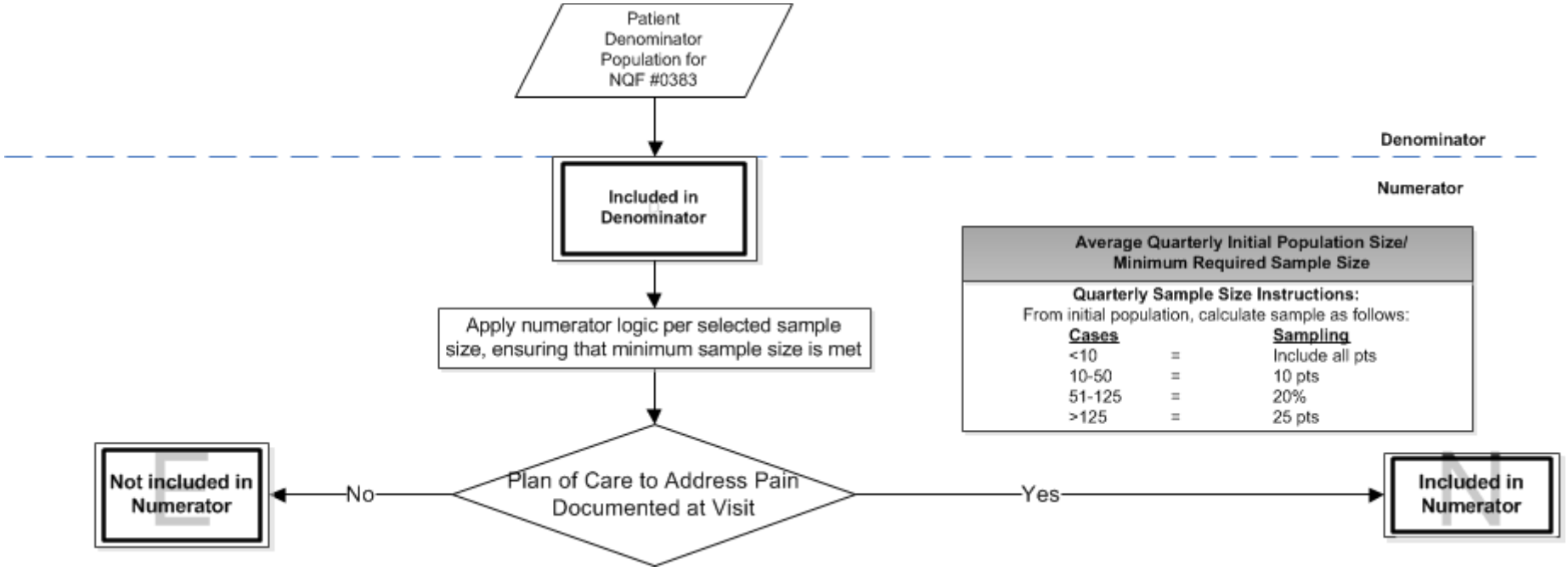
NQF #0384: Responses to Frequently Asked Questions

- Pain includes all pain, not just pain specific to cancer.
- If a patient sees multiple practitioners within one day at a PCH, any pain assessment documented on that day can be used for compliance with the measure.
- This measure is not limited to only medical and radiation oncologists; it applies to all. The inclusion criteria for the denominator is specific for patient selection.
- For patients identified by the radiation treatment management Current Procedural Terminology (CPT) codes, the date of the CPT code may not coincide with the radiation treatment management encounter. The pain assessment during the clinician encounter occurring during the course of radiation therapy can be used.
- The numerator consists of patients for whom it is documented do not have pain AND the patients who do have pain and it is quantified using a standardized instrument.
- The numerator of patients in NQF #0384 who have pain AND it is quantified make up the denominator for NQF #0383.

NQF #0383 Specifics

- **Description:** Percentage outpatient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy **OR** radiation therapy who report having pain and for which the pain intensity was quantified with a documented plan of care to address the pain
- **Denominator Statement:** Patients from NQF #0384 who reported pain for which the intensity of pain was quantified
- **Numerator Statement:** Patient visits that included a documented plan of care to address pain
- **Type of Measure:** Process
- **Improvement Noted As:** Higher score indicates better quality

NQF #0383: Plan of Care for Pain



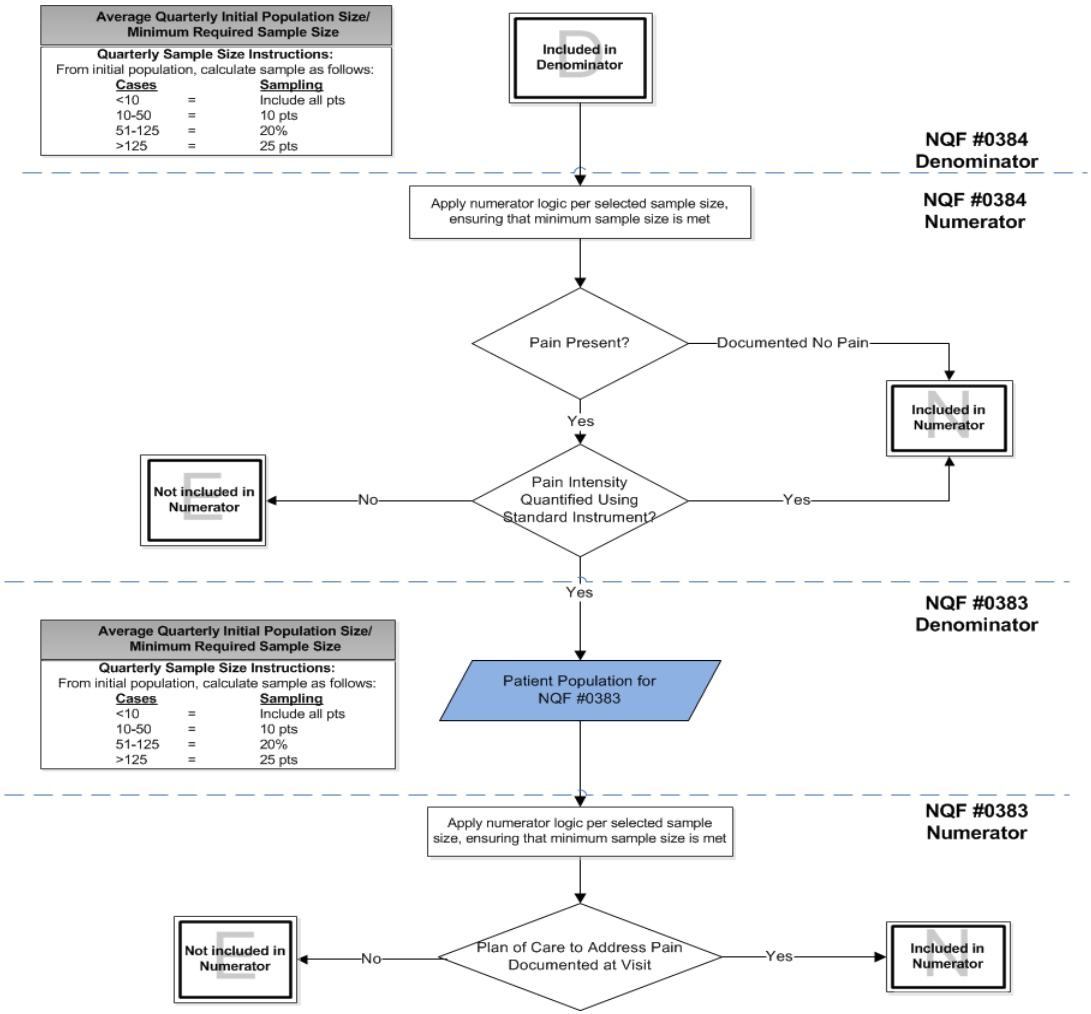
NQF #0383: Responses to Frequently Asked Questions

- A plan for pain is required for any documented pain of any intensity
- A plan may include the use of opiods, non-opiod analgesics, and adjuvant analgesics
- The plan should be appropriate to the type of pain and setting
- The plan is not limited to medications but can include other interventions, including, but not limited to:
  - Psychological support
  - Patient and/or family education
  - Referral to a pain clinic, supportive care, or palliative care
  - Reassessment of pain at an appropriate time interval
  - Other interventions such as relaxation, use of heat or cold, elevation, compression, positioning

Relationship Between NQF #0384 and NQF #0383

- The numerator of patients in NQF #0384 who have pain **AND** the pain is quantified make up the denominator for NQF #0383.
- Dependent upon your initial population size, you **CAN** choose a minimum sample size in either #0384 or #0383.
  - Sampling more than the minimum required sample size in NQF #0384 increases the denominator for NQF #0383.
  - This is a “Risk/Benefit/Burden” decision.

Drawing It All Together
So It Flows



Sampling Strategy Scenarios

	Scenario #1	Scenario #2	Scenario #3
Initial Patient Population #0384	2,100	2,100	2,100
Sample Size Selected #0384	25 (Minimum)	125 (Projected)	125 (Projected)
Numerator #0384 with Pain and Intensity Quantified	5	25	25
Initial Patient Population #0383	5	25	25
Sample Size Selected #0383	5 (Minimum = all)	25 (No Sampling)	10 (Minimum Sample)

Discussion of Sampling Strategies

- Selecting a **larger random sample** than the required minimum in #0384:
  - Will increase patients included in #0383 denominator
    - Is this more reflective of actual performance?
  - Will increase data burden
- Selecting the **smallest possible sample** for #0384 has both pros and cons
- Using an assessment tool/method that better captures the level of patients' pain
  - May be a solution to reducing pain rate variances

NOTE: The sampling of the initial patient population is a **MINIMUM**.

Findings of Quarter 1 2015 Data Submission

11 PCHs submitted data on both measures.

- Denominator #0384
  - Average = 104
  - Median = 116
  - Range = 28–126
- Denominator #0383
  - Average = 25
  - Median = 25
  - Range = 13–44

If the proper methodology was followed, this means that **23.6 percent** of patients reported pain and it was quantified using a standardized instrument.

How Does this Compare to Rates Reported in the Literature?

- Reported rates are highly variable
  - Early rates reported 52–77 percent of cancer patients in pain
  - Recent rates reported 24–86 percent of cancer patients in pain
- 2007 meta-analysis by MHJ van den Beuken-van Everdingen
  - 33 percent of patients after curative treatment
  - 59 percent of patients under anticancer treatment
  - 64 percent of patients with advanced/metastatic/terminal disease
  - 53 percent of patients at all disease stages

Why Is Pain Assessment Essential in the Cancer Patient Population?

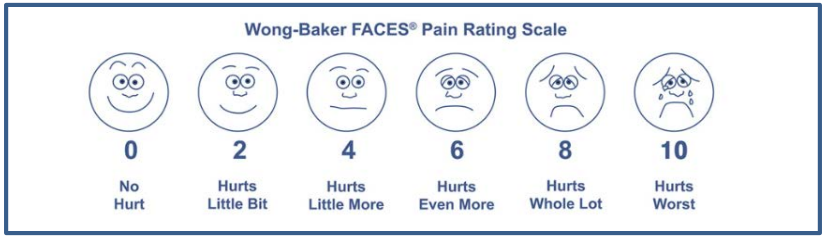
- National Comprehensive Cancer Network (NCCN) Version 2.2015 Adult Cancer Pain Guidelines state, pain:
  - Is one of the most common symptoms associated with cancer
  - Is one of the symptoms patients fear most
  - Denies patients comfort and affects quality of life, interactions, motivation, and activities
  - Is a factor in survival rates
    - Growing evidence links survival to effective pain management
- Mystakidou et al. (2006) reported that pain is a significant predictor of anxiety and depression
- National Institute of Health (NIH) states that, “Cancer pain can be effectively managed through relatively simple means in up to 90 percent of the eight million Americans who have cancer or a history of cancer.”

Who Should Be Asked When Conducting a Pain Assessment?

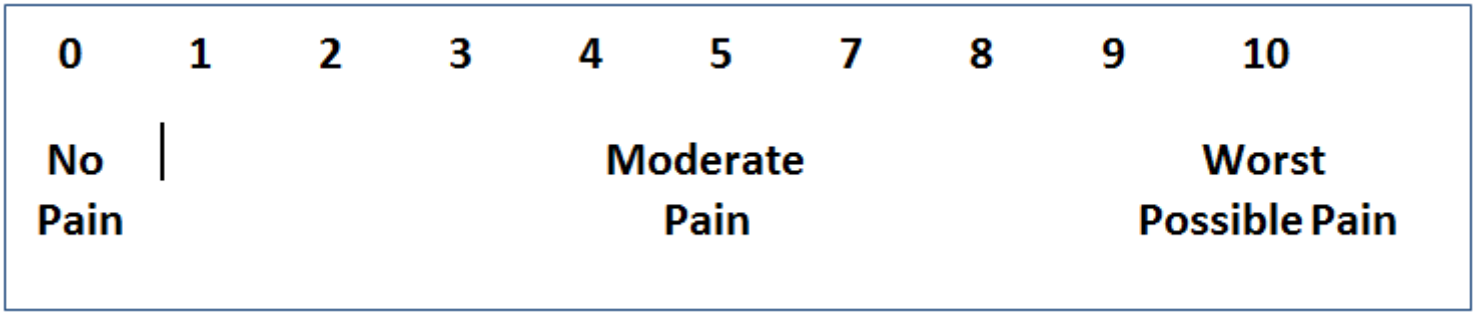
- National Cancer Institute states that, “The mainstay of pain assessment is the patient self-report.”
  - Family members acting as proxies typically report higher levels of pain than patients self-report.
- NQF #0384 states, “Since pain is inherently subjective, patient’s self-report to pain is the current standard of care for assessment.”

Pain Assessment Tools: Examples

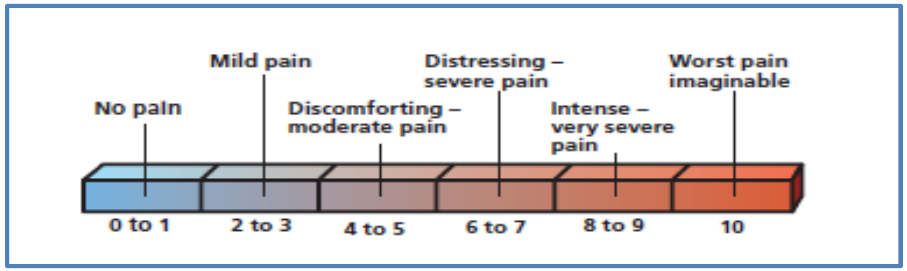
Wong-Baker FACES® Pain Rating Scale



0–10 Numeric Pain Rating Scale (National Initiative on Pain Control™)



Numeric Pain Scale – Descriptions and Use of Colors (American Cancer Society)



Barriers to Effective Pain Management: Assessment

- Healthcare professionals may perform a poor or incomplete assessment of pain
- Patients can contribute to poor assessment by being:
  - Reluctant to report pain
  - Afraid of distracting providers from treatment of underlying disease
  - Fearful that pain means their disease is worse
  - Afraid of not being seen as a “good” patient
- The healthcare system also contributes by:
  - Giving a low priority to cancer pain treatment
  - Providing inadequate reimbursement for pain assessment and treatment
  - Adding pressure through volume and timeliness requirements

Individual Aspects of Pain

- Each patient's pain must be viewed from their individual perspective. Each cancer patient will have:
- Different expressions of pain, expected responses, and support from others
  - Stoic expressers may tend to:
    - Internalize their discomfort and put forth a 'grin and bear it' attitude
    - Withdraw socially
    - Frequently perceived as "easy" or "good" patients
  - Emotive expressers may tend to:
    - Verbalize their discomfort and seek interaction and reaction
    - Frequently perceived as "demanding" patients
- Different expectations, degrees of acceptance, coping styles/mechanisms
- Different cultural descriptions/meanings of pain
- Language limitations/barriers
- Different attitudes regarding pain and pain medication
  - Pertains to both the healthcare professional and patient

PCH EXPERIENCE

Sarah Thirlwell, Msc, Msc(a), RN
H. Lee Moffitt Cancer Center And Research Institute

Objectives

Participants will be able to:

- Describe the prevalence of pain among ambulatory oncology patients
- Describe a process to screen and address pain for all patients in a busy, outpatient oncology setting
- Discuss potential barriers and solutions to addressing pain

Prevalence of Pain Among Outpatients with Cancer

- Meta-analysis of 52 studies from 1966–2005
  - 59 percent of those undergoing cancer treatment
- Single-study of 305 patients in 2008
  - 22 percent of those receiving outpatient care

Expect 5–15 patients in every group of 25 to experience pain while receiving outpatient care/treatment (chemo or radiation therapy).

Process: Moffitt's Example

Moffitt has 350,000 ambulatory encounters per year.

I. Screening: After patient registration, a Medical Assistant screens every patient with the standardized Moffitt Clinic Screening Questionnaire which asks patients about:

   A. Trouble with activities of daily living
   B. Unintentional weight loss
   C. Emotional concerns
   D. Pain
      1. Yes or No
         a. If yes, rate from 0 to 10
            i. If yes, Is pain new or changed since your last visit?
   E. Falls
   F. Tobacco Use

Process: Moffitt's Example

II. Response to Screening: For every positive response, such as "Yes" for Pain, the Medical Assistant "flags" the chart for a registered nurse, mid-level provider, or physician.

III. The clinician conducts a comprehensive pain assessment.
   A. NCCN Adult Cancer Pain Guidelines:
      1. At minimum, assess "current" as well as "worst," "usual," and "least" pain
   B. OLD CART Acronym:
      1. Onset, Location, Duration, Character, Aggravating, Relieving, Timing

IV. The clinician addresses the pain as indicated and documents accordingly.

Barriers to Addressing Pain

Barriers	Patient	Oncologist/Healthcare System
Lack of Knowledge	• Pain management • Pain regimen • Opioid side effects • Addiction • Tolerance	• Pain assessment • Pain management • Care of special populations
Beliefs and Fears	• Role of patient • Sign of progression • Indicator for treatment delay or cancellation • Meaning of pain & suffering	• Role of oncology team versus roles of other providers • Risks of opioid prescription • Risks of opioid diversion
Access to Pain Management	• Insurance coverage	• Medication options • Experts in care of special populations

Documentation to Facilitate Intervention

Promote compliance for pain assessment and intervention with increased accessibility and visibility:

- Use of templates for comprehensive assessment
- Use of shortcuts for commonly used pain descriptors and interventions
- Review of role of oncology team members in pain management with all stakeholders

NQF #0384 and #0383 Sampling, Assessment, and Lessons Learned
PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

PCH EXPERIENCE

Stephen Flaherty, MPH
Dana-Farber Cancer Institute

Objectives

Participants will be able to:

- Identify appropriate codes (ICD9 and CPT) for capturing the eligible populations within each measure
- Describe common interpretation variations that may be encountered when abstracting NQF #0383 and #0384

Initial Data Collection

- Identification of eligible cases
  - Time Period (1Q15)
  - Diagnosis (Cancer ICD9s)
  - Treatment Codes (Chemo/Radiation)

These codes are the only ones needed for inclusion in the submission of NQF 0383 and 0384 for August 2015. Any patient with out one of the following ICD9 or CPT codes should be excluded from the data set.
Aggregate ICD9
140.00- 239.9
Aggregate CPT
51720, 77427, 77431, 77432, 77435, 77470, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415- 96417, 96420, 96422, 96423, 96425, 96440, 96446, 96450, 96521- 96523, 96542, 96549, 99201-99205, 99212 -99215

- Based upon Physician Quality Reporting System (PQRS) measure specifications

Data Collection and Lessons Learned: NQF #0384

- Data collection
  - Eligible population (Pediatric and Adult, multiple visit types)
  - What counts as a visit when data is pulled internally
  - Multiple data sources/Electronic Medical Records
- Lessons learned
  - Multiple visits in one day
  - Multiple tools (Pediatric scales, 0–10 scales)
  - Documentation of value for pain versus statement

Data Collection and Lessons Learned: NQF #0383

- Data collection
  - Access to multiple systems for abstraction
- Lessons learned
  - Inter-rater reliability (IRR) testing showed interpretive differences
  - Social Work consults, medical marijuana, meds in record vs. prescribed that day
  - Access to multiple systems for abstraction

NQF #1822: ICD–9 to ICD–10 Crosswalk

- ICD–9
  - 198.5 – secondary malignant neoplasm of bone and bone marrow
- ICD–10
  - C79.51 – secondary malignant neoplasm of bone
  - C79.52 – secondary malignant neoplasm of bone marrow

Continuing Education Approval

- This program has been approved for 1.0 continuing education (CE) unit for the following professional boards:
  - Florida Board of Clinical Social Work, Marriage and Family Therapy and Mental Health Counseling
  - Florida Board of Nursing Home Administrators
  - Florida Council of Dietetics
  - Florida Board of Pharmacy
  - Board of Registered Nursing (Provider #16578)
    - It is your responsibility to submit this form to your accrediting body for credit.

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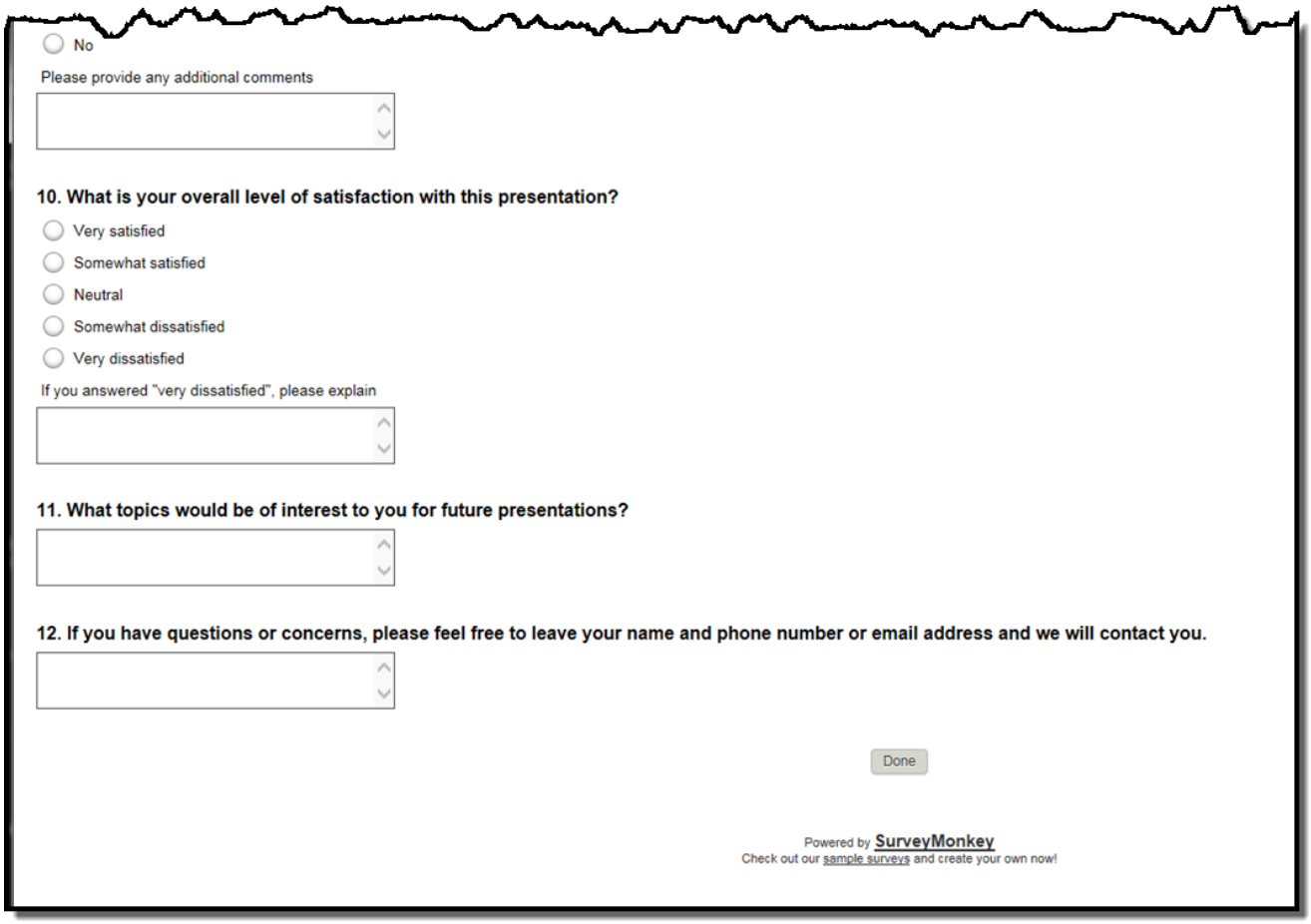

No

Please provide any additional comments

10. What is your overall level of satisfaction with this presentation?

- Very satisfied
- Somewhat satisfied
- Neutral
- Somewhat dissatisfied
- Very dissatisfied

If you answered "very dissatisfied", please explain

11. What topics would be of interest to you for future presentations?

12. If you have questions or concerns, please feel free to leave your name and phone number or email address and we will contact you.

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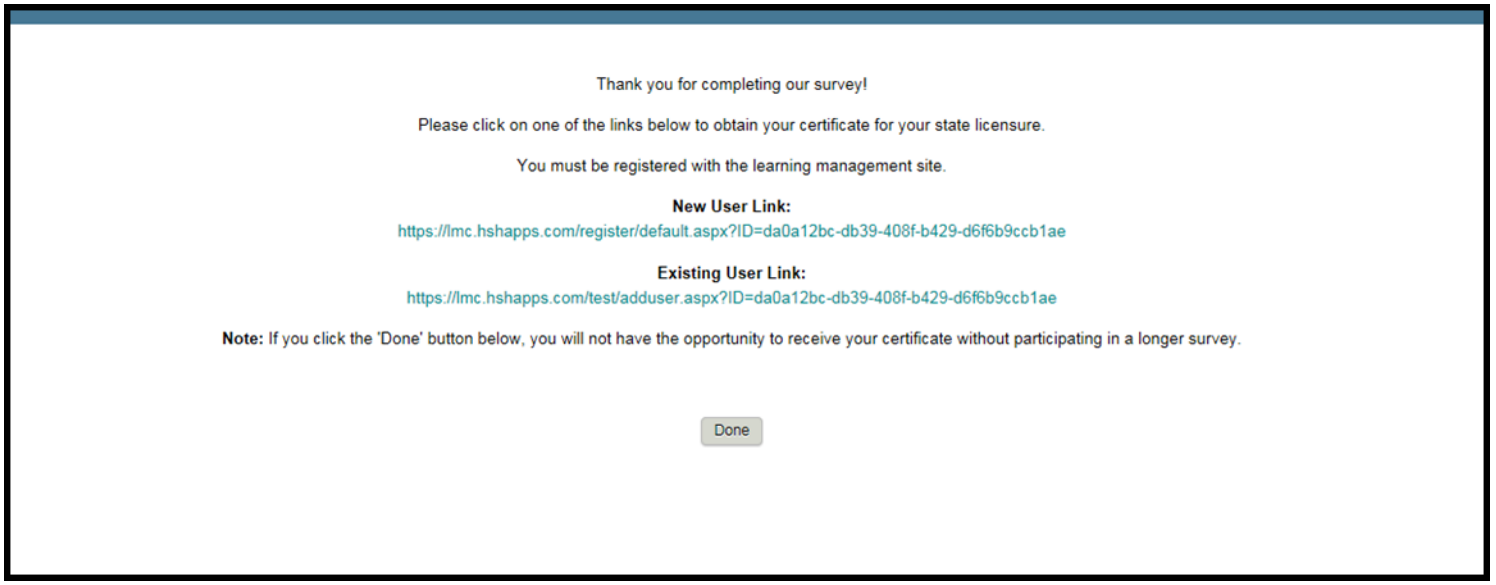
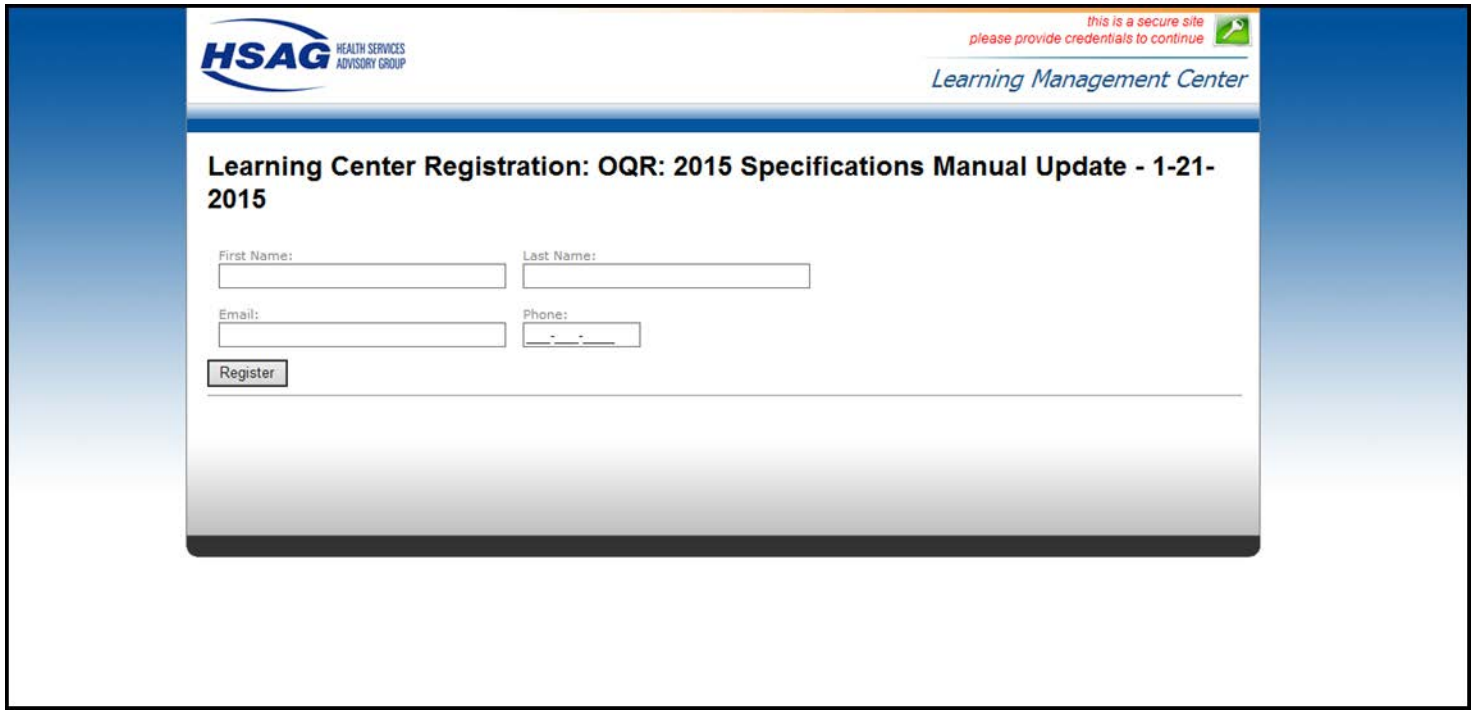


CE Credit Process: New User



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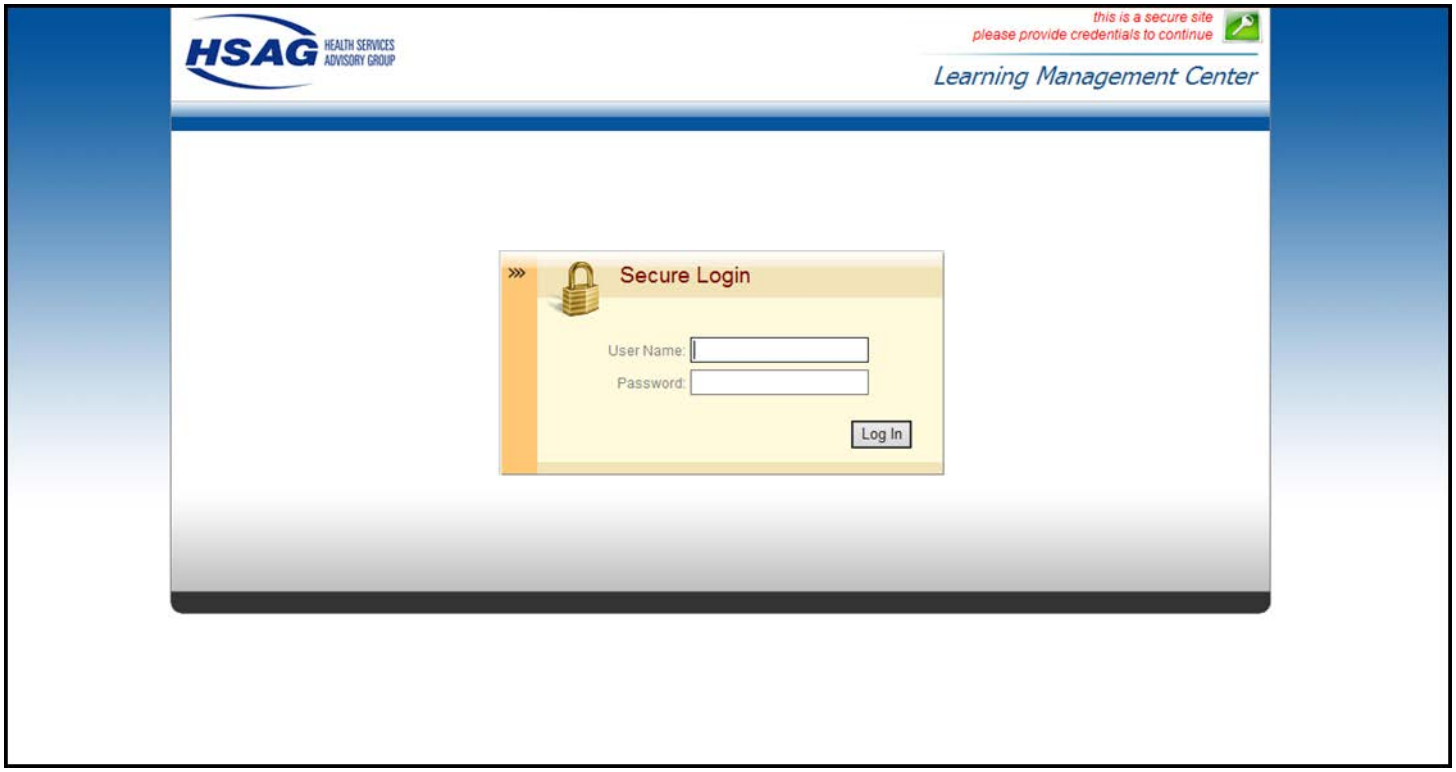

QUESTIONS?