



PPS-Exempt Cancer Hospital Quality Reporting Program

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

Presentation Transcript

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Matt McDonough: All right. Good afternoon everybody, and thank you for joining us for this afternoon's webinar. My name is Matt McDonough, and I'm going to be your virtual training host for today's event. Before we begin today's event, I'd like to cover some brief housekeeping items with you, so that you understand how today's event is going to work, and how you can interact with our subject matter experts that are on the line today. As you can see on this slide, we are providing streaming audio over your ReadyTalk service. What that means is that, there's no telephone line that's required, but we do have computer speakers or headphones as required to hear that streaming audio feed. Now, if for some reason you're not able to stream or you may have a situation where your speaker stopped working. You can request a dial-in line, we do have a limited number of those available. So

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please do send us a chat message, if you need one of those and we'll get that number out to you quickly. Also, as a standard procedure, this event is being recorded.

Now, for our audio streamers, we do have some trouble shooting tips that may help you resolve common issues. For example, if the audio from your computer speakers begins breaking up, becomes choppy or if it stops completely all of a sudden, you can resolve that usually on your own. As shown on this slide here, click the Pause button that is illustrated here, it's located in the upper left side of your screen. Wait about five seconds, that Pause button should turn into a Play button, as shown in Step 2 here, and then click that Play button. Your audio feed should resume and it should be re-synchronized with our speakers.

Now, if you're on the call today and I sound like I'm echoing very badly right now, it usually means you're connected to our event in more than one browser tab, which means you're hearing more than one audio feed. So, what you want to do to resolve that is to close all but one of those browsers or tabs. That will reduce the number of audio feeds you're hearing down to one and that will clear up the echo that you may be hearing.

Now, all of our attendees are in a Listen Only Mode today, but that doesn't mean that you can't submit your questions to our subject matter experts that are on the line today. On the left side of your screen, you'll see a Chat with Presenter box; it's located at the bottom left side of your screen. Simply type your question into that box, and click the gray Send button that's located to the right. Your question will be sent to all of our panelist today. And, if time and as resources allow, we'll answer as many questions as we can. Please do keep in mind though that all of our questions are being achieved to be address in a future Q&A document.

That's going to do it from my brief introduction. So, without further ado, I would like to hand things over to our first speaker of the day.

Henrietta Hight: Thank you Matt. Hello, my name is Henrietta Hight, project coordinator on the PPS-Exempt Cancer Hospital Quality

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Reporting team. We would like to welcome everyone to today's webinar entitled, *NQF #0384 and #0383 Sampling, Assessment, and Lessons Learned*. This webinar will be discussing the following two Clinical Process Oncology Care Measures: Pain Intensity Quantified, NQF #0384, and Plan of Care for Pain, NQF #0383. This webinar is part of the educational series focused on the hospitals participating in the CMS PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program. Our presenters today are Tom Ross, PCHQR Program lead at the Inpatient Value, Incentive and Quality Reporting (VIQR) Outreach and Education Support Contractor.

And two guest presenters, who are well-known to the PCHQR participants, Sarah Thirlwell, Nursing Director in support of care medicine at the H. Lee Moffitt Cancer Center and Research Institute. And, Stephen Flaherty, Program Manager for Quality Measures at the Dana-Farber Cancer Institute.

One last reminder before we get started, looking at the list of participants today, we see that a number of you are perhaps involved in other CMS quality reporting programs and are not associated with one of the PPS-Exempt Cancer Hospital[s]. We appreciate your interest in today's webinar. The information provided today could be very helpful in your work with patients who are reporting pain, even if they do not have the diagnosis of cancer. However, during the webinar, we will only be able to answer questions submitted by PPS-Exempt Cancer Hospital Quality Reporting Program participants.

So now, let's go to slide number six to review the purpose of today's webinar.

As the slide indicates, the purpose of today's webinar is to discuss the two, National Quality Forum, NQF measures #0384, Pain Intensity Quantified and #383, Plan of Care for Pain. There has been a lot of discussion among the PCHQR participants regarding these two measures. And, this webinar has been developed to review the relationship between the two measures in order to quote: assist in proper sampling; communicate the prevalence of pain in the PPS-Exempt Cancer Hospitals, based on the rates that were reported for first quarter 2015, and then look

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at the rates reported in the literature; and finally, to share and learn from our two guest presenters their lessons learned with a goal of quality improvement. We will look at the objectives for today's webinar on the next slide.

Learner Objectives for today's webinar – by the end of today's webinar, participants will be able to do the following: first, state the reporting requirement for the first two – for the two measures, NQF #0384, Pain Intensity Quantified and NQF #0383, Plan of Care for Pain; second, understand and implement a sampling strategy for these paired measures; third, discuss the incident for pain present reported by the PPS-Exempt Cancer Hospital in the first quarter 2015, and compare these rates with rates reported in the literature; and lastly, apply lessons learned to improve the assessment of pain in the cancer hospital setting, and assure that patient's with pain have a plan of care to address the pain. And now, I would like to ask Tom to continue with the next slide.

Tom Ross:

Thank you, Henrietta. These metrics were first introduced to the PCHQR in the Fiscal Year 2014 Final Rule. It was noted in the Final Rule that these are paired metrics. The patients identified with having pain in NQF #0384, Pain Intensity Quantified are then used in NQF #383, Plan of Care for Pain. As always, there was the intent to align the PCH Program Metrics with national priorities; in this case, the national quality strategy domain of patient and family engagement. These metrics were added for the Fiscal Year 2016 Program and subsequent years. As you're all aware and have submitted data already, these metrics were effective for patient visits starting on January 1, 2015. During the period of 7/1 to 8/15 this past summer, the data for quarter one 2015 was submitted. Next year, during the same time period, the data for quarters two, three, and four of 2015 will be submitted. Then each year, all four quarters will be submitted once a year. The next slide will show us the changes to these metrics as outlined in the 2015 Final Rule.

There were two significant points to know about NQF #384 and 383 in the Fiscal Year 2015 Rule. The first is that, all of the clinical process oncology care measures, all five, were made, quote, all-patient, quote,

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data. This removes the need to stratify the Medicare versus non-Medicare patients. The purpose of using all patient data is twofold: one, the reason is to ensure the high quality care is delivered to Medicare beneficiaries in the PCH setting, the second is to provide the public with information about the quality of care in the PCH setting. The other concept introduced, to relieve data burden to the PCH, was to introduce the sampling methodology, as outlined on the table on this slide. Note that the right hand column states the minimum required sample size. Also, remember that this is random sampling. Slide number 10, Next slide, please...

outlines the comments in these metrics from the Fiscal Year 2016 Rule. In the Fiscal Year of 2016 Final Rule, it was announced that the pain metrics NQF 384 and 383 would be publicly reported in 2016 and subsequent years. There were comments and responses to these metrics in the Final Rule as well. One of these comments was to ask CMS to clarify the sampling protocol, the NQF 383 and 384, quote, because it appears that the sampling protocol may require over sampling for NQF 384, end quote. (And, I think we are one slide ahead here, Deb. If you can back up one please. Thank you.) CMS responded, as stated in the Fiscal Year 2014 Rule, that these are paired metrics, they further specify that cancer patients that are sampled for the Pain Intensity Quantified measure for the numerator case count for 384 are also sampled to come to the NQF 383 measure denominator case count. Next slide, please.

This also means that for any cancer patients that are reporting pain and the pain is quantified, for example assessed for severity on a scale of one to 10, these cancer patient should have a care of plan for pain management. CMS' perspective is that, this is not quote over sampling, quote, but rather a step toward improving the quality of care. The CMS response also noted the availability of the Help Desk, resource materials, and working with us as the Support Contractor, in providing additional educational material, such as webinars such as this one, on sampling these measures. So, let's take a look at each measure and how [they are] are they tie[d] together. Next slide, please.

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So, the NQF #384 specifics: (And we want to go back one slide please, Deb. There we go.) The denominator is all outpatient visits during the data collection period, regardless of age with a diagnosis of cancer who are receiving chemo therapy or radiation therapy. Steve will later go into the specific codes and date ranges. It is an outpatient metric, as the patients are identified by the CPT code, as will be discussed later. The numerator includes both patients for which pain is assessed as no pain present or, if pain is present, it is quantified using a standardized instrument. The patients who would be non-concordant in this measure are those patients who do have pain present, and is not quantified using a standardize instrument. Obviously, a higher score, or concordance, indicates better quality. On the next slide, we will look at the new revised algorithm for this metric. And we want to go ahead so slide number 12, please.

I would like to thank the many professionals of the different PPS-Exempt Cancer Hospitals who worked with me over the past 12 months in refining this algorithm and explanation; particularly, Denise Morse from the City of Hope and Sara Berger from Memorial Sloan-Kettering Cancer Center, for refining the final version of this metric. There were some interesting phone calls [that] took place. We'll first look at identifying the denominator for 384. Note in the Blue box, it also says this is a paired metric. If pain is present and quantified in 384, the patient should also be reported and measured in NQF 383. So, the algorithm starts with a diagnosis of cancer, as indicated by the ICD-9, or soon ICD-10, code. If the cancer diagnosis is not present, the patient is excluded from the denominator of population. Next, we identify the patients who are receiving either chemotherapy or radiation therapy. If they are not receiving either chemotherapy or radiation therapy, they are excluded from the metric. For the chemotherapy patients, we used a CPT code for a patient/provider encounter. As Steve will address later, these are one of the nine 90,000 level encounter codes. This is the encounter that must occur during the measurement period, and during which pain is to be assessed and, if present, be quantified. The definition of receiving chemotherapy is defined by the presence of a CPT procedure code for the chemotherapy. The chemotherapy must be received within 30 days prior

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to the encounter and, excuse me, also been administered within 30 days after the encounter. I think of this classically, as the patient receiving chemo in the infusion center then a week or two later seeing the medical oncologist in a clinic or office, this is the encounter, then getting chemo again with the 30 days in infusion center. Note, also that the CPT procedure code is for injectable chemotherapy. On the radiation side, there is only a procedure CPT code. These are the five 77,000 codes that Steve will list. As we have learned, radiation therapy drops this procedure code as infrequently as every five fractions. During these periods of treatment, the patient and provider will have a face-to-face encounter, but there are often not a specific CPT code associated with this encounter. Therefore, for patients identified by the radiation treatment management, current procedural terminology or CPT code would date 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 and should be used. Once the initial patient population for the measurement period is identified, you may sample based upon the sample size box in the flow chart which most of which you're familiar with. Remember that this is a minimum required sample size. You can certainly sample more patients, if you wish, or even all patients in initial population. On the next slide, slide 13, we'll look at the numerator for 384.

This is a much simpler portion of the flow chart. In the clinical recommendation statements in the PCR's measure descriptors, they state the following, quote, the algorithm begins with the premise that all patients with cancer should be screened for pain. If pain is present on a screen evaluation, the pain intensity must be quantified by the patient whenever possible. Intensity of pain should be quantified using a zero to ten numerical rating scale, a categorical scale or pictorial scale. To reflect this in the algorithm, we first ask the question, is pain present?. If no, and it's documented "no pain present," then the patient may be considered concordant and in the numerator. If pain is present the intensity must be quantified using a standardize instrument. If it is, the patient is also considered concordant and included in the numerator. If pain is present,

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but is not quantified using a standardize instrument, then the episode is considered to be non-concordant and the patient is not included in the numerator. Lastly, and this is key, the patients in NQF 384 who have pain present and it is quantified using a standardized instrument are in the patient denominator for NQF 383, as is indicated in the blue parallelogram in the flowchart. I should note that the PQRS manual lists CPT-2 codes for use in identifying patients in the numerator, but we are currently not aware of any PCH's that are using CPT-2 codes for documentation at this time. In informal conversations with many of the PCH's, we have found that there are different assessments strategies. And, speaking with seven different PCH's we found the following: Two PCH's require a numerical score of zero to ten for all pain assessments. So, if the patient has no pain, they documented zero, and that's certainly appropriate. Four PCH's screen with a question similar to: "are you currently experiencing pain?" They accept the documentation of "no pain present" as acceptable, but as Sara reminded me, we need the documentation that no pain is present. A total lack of being silent to the issue is not acceptable. One PCH has a combination of some clinics recording zero for no pain and other screening and accepting, quote, no pain present. The key, as always, is to be consistent in your methodology. Next slide, please.

Over the past 12 to 18 months, there have been a number of frequently asked questions that have been asked and addressed pertaining to NQF 384. First of all, pain includes all pain, not just pain specific to cancer. Secondly, if a patient sees multiple practitioners in one day, pain only needs to be assessed once. I saw there was a question earlier about: what if a physician assesses as no pain and a nurse assess as pain? I would say, and I would listen to Steve later on, but his recommendation was, in their institution at Dana-Farber, they took the highest available pain assessment for that day as the approach. But, once again, make a decision within the organization and stay consistent. This measure applies to all types of providers. If a patient would say, see a surgeon for a post-op visit, while receiving chemotherapy, pain should be assessed in the surgeon encounter. We've already discussed the fact that for radiation therapy patients, the pain assessment during the clinician encounter, during a course of

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radiation therapy, may be used and many times will not correspond to the date the CPT code drops. Then lastly, the numerator is patients for whom it is documented that they do not have pain or they have pain and the intensity is quantified using a standardized instrument. And, of course, in a paired metric, the patients in 384, who have pain and it is quantified, form the denominator population for 383. So, speaking of 383, let's take a look at the measure specifics on the next slide.

383 obviously builds on 384. When the information is updated on the Internet, you will see a comprehensive flow chart. But, for simplicity, we broke it down in this presentation. The denominator is patients from 384 who reported having pain, the pain intensity was quantified, the numerator is simply those patients from the document plan of care to address the pain. Next slide, please.

Once again, depending upon the number of patients you identified with pain that the intensity was quantified for, you may apply the sampling instructions in the table above. However, as many PCHs have been concerned about having a low denominator in 383, remember that you do not have to sample. The sampling strata provides a minimum number of patients to sample depending upon the overall number of patients in the overall population. The only decision point in this algorithm is, is there a plan of care to address pain documented in the visit. If there is, the patient is concordant and included in the numerator. If there is not, the patient is not included in the numerator. However, as we'll see in the next slide, this is not always straightforward and oftentimes requires extensive chart review. Next slide, please.

Remember, a plan for pain is required for any documented pain of any intensity. Being a pharmacist by background, I have to say, drugs are always an option. However, the plan is not limited to medication but can include other interventions, such as what is listed in the slide, including but not limited to psychological support, referrals, reassessments and other interventions, such as heat or cold, elevation, compression and/or positioning. Next slide, please.

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Once again, these are paired metrics. The patients for 384, who have pain and the pain intensity is quantified, make up the denominator in 383. And, depending upon your initial population for 384 and 383, you can choose the sample, if you wish. This really comes down to what I call a risk/benefit/data burden decision. You want to minimize your burden for collecting the data. However, you do not want to have a small patient population in 383 that can result in one or two non-concordant patients, resulting in a very low concordance rate that is not reflective of your actual performance. As long as the minimum sample requirements are met, it is up to each PCH to determine where this balance lies in deciding how many patients to include in 384 in order to generate what is felt to be a reflective sample size for 383. On our next slide, we graphically show our 384 and 383 are related.

So here, Henrietta noted my oh-so-clever title of “Drawing It All Together So It Flows.” First, we identify the total population for the denominator of NQF 384. Then, a sample size ensuring this minimum is met is selected for 384. From this sample, the patients for whom pain is present and is quantified generate the patient population for NQF 383. Once again, depending upon the population in the denominator of 383, you may (if you so choose) sample based upon CMS guidelines. Then, review of the records will identify those patients in 383 for whom the plan of care for pain is present and are therefore considered concordant. Slide 20, our next slide, shows some various sampling strategies.

In all three scenarios, there are 2100 eligible patients for the quarter; patients with a diagnosis of cancer who are receiving chemotherapy or a radiation therapy. In scenario number one, the minimal allowable sample size, 25 were selected. Of these 25 patients, five have pain and the intensity was quantified, thus creating a population of five for 383. Since this is less than 10 for the sampling instruction, all five will be sampled to 383. While this is a minimum data burden, the risk here is that if one or two patients are not concordant, you’re looking at a compliance of 80 or even 60 percent. In scenarios number two and three, a larger random sample of 125 was selected for 384, yielding 25 eligible patients for 383.

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In scenario number two, no sampling was performed for 383, allowing all 25 patients to be included. In scenario number three, the minimum sample for a patient population of 25, which will be ten patients were selected for auditing in 383. Candidly, scenario number three does not make a lot of sense, as you did all of the extra work to find the 383 eligible patients from the population of 384. So, why wouldn't you want to include that in 383 to have a more reflective sample. But, it would reduce your chart review data burden. The next slide, slide 21 reviews our discussion of sampling.

So, basically, breaking it down, there are three options. The first is to increase your sampling of 384, remember that it is random sampling, in order to find more patients eligible for 383, this will give you a more robust population but will increase the data burden. The second option is to select a minimum number of patients for 384, which will decrease the data burden but give you a smaller eligible population of 383. A third option, I may suggest, is to better capture a document pain of 384, thus decreasing the number of patients to have to assess in order to have a good population with 383. Next slide, please.

So, as Henrietta promised, we're going to discuss the data submission found from first quarter patients 2015. During the period of 7/1/15 to 8/15/15, the PCHs were required to submit quarter one data for these two metrics. For the 11 participating PCH's the patient denominator averaged 105, excuse me, 104 with a median of 116 for the denominator of 384. The range was from a low of 28 to a high of 126. For NQF 383, the average and median were both 25 with a range of 13 to 44. This means, assuming the proper methodology was followed, that 23.6 percent of patient's reported pain and the pain intensity was quantified. So, how does this compare to the literature rates? We'll find out in the next page.

You can see that the rates of cancer patients reporting pain varies greatly. Sarah will discuss these numbers in some detail in a bit. But, for the intent of NQF 384 and 383, we are looking at cancer patients undergoing treatment with chemotherapy or radiation. From the meta-analysis cited above – are you ready for this Henrietta? – by MHJ van den Beuken-van

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Everdingen (yes, I practiced) this would correspond to an incidence of 59 percent. Once again, I want to stress that these numbers are widely variable. However, it does appear that with a rate of 23.6 percent of patients reporting pain, there may be under recording and/or, this is a real possibility, that the PCH is maybe doing a better job of controlling pain in their patient population. All that being said, why is it important to quantify pain and have a plan to address it. Next slide, please.

Version 2.2015 of the NCCM, Adult Cancer Pain Guidelines states that pain is one of the most feared symptoms, is one of the most common symptoms, obviously has a significant impact on quality of life, and may actually be a factor in survival. Pain is also, not surprisingly, associated with anxiety and depression. The NIH states that, quote, cancer pain can be effectively managed through relatively simple means for up to 90 percent of the eight million Americans who have cancer or a history of cancer. Simply stated, pain treatment is actionable. Next slide, please.

At this point, I'm going to turn the presentation over to Henrietta Hight, also known as double H or H squared for a look at the actual pain assessment process. HH?

Henrietta Hight: OK. Thank you Tom and you're not going to make me repeat that person's name, right?

Tom Ross: Absolutely not.

Henrietta Hight: OK. The next question is: who should they ask when conducting a pain assessment? As the slide indicates, the main stay of pain assessment is self-reported pain. The literature states that, since pain is a subjective experience, self-reporting is the single most reliable indicator of pain. Also, as the slide indicates, the "patient's self-report of pain is the current standard of care for assessment." Now, on the slide there is a statement, quote, family members acting as proxies typically report higher levels of pain than patients self-report. And, that made me kind of curious, so I started looking at the literature. And, there are studies that have been done regarding reasons for the differences in pain reporting by patients versus

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family members. Possible reasons provided indicate or suggests the following: family caregivers are more familiar with, and therefore rely more heavily on observation of, the patient's non-verbal pain behaviors (for instance, facial expressions, body positioning, mood, or communication changes); or, family members are aware of other issues that might be causing pain, such as arthritis that the patient doesn't think as appropriate or related to their complaints of cancer pain. So, they don't want to talk about it to the doctor. The American Cancer Society in one of their patient centered documents states the following to the cancer patient: "only you know how much pain you are in." And, I was wondering, what have been your experiences with patient self-reporting and family proxy reporting of pain? Now, we'll look on the next slide as an example of pain assessment tools.

And, some of these are very probably familiar to you. This slide illustrates three examples – samples of pain assessment tool: the Wong-Baker FACES® pain rating scale; a zero to ten numeric pain rating scale from the National Initiative on Pain Control™; and, a numeric pain scale that also includes descriptions with ranges and colors from the American Cancer Society. And, then there are also many other different pain assessment tools available. The literature now– the literature makes some of the following points about the use of pain assessment tools used for self-assessment or self-reporting of pain. First, the patient needs to be able to understand the instructions. And, I found this as an interesting fact: that the Wong-Baker FACES® pain rating scale is available in 50 languages in addition to English. In addition to – next point is, in addition to pain intensity, the patients should also be asked to describe the characteristics of the pain, duration or timing, and the measure of pain interference or impact on daily activities. In regard to pain assessment tools, including the ones on the slide, one article cautioned that pain measurement tools that rely on numbers or any kind of linear pattern format, such as a face – a roll of faces will not work equally well across cultures. The reason given is that people in some cultures attached strong beliefs to certain numbers or colors. And also, smiling faces do not suggest good feeling– good feelings in all cultures, since in some cultures people tend to smile when they are

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embarrassed or angry. So now, let's look at some of the barriers associated with effective pain management during the assessment phase.

And these are just a few, but just to give us— look at a few of the barriers to effective pain management based on the assessment based, whether it's the healthcare professional, the patient, or the healthcare system. Here are some. For instance, for the healthcare professional, there may be stereotyping or biases based on the cultural identity of the patient; or underestimating or overestimating the patient's pain relative to the patient's self-assessment. And then [there's] concern about regulation of controlled substances. For the patient, there may be the reluctance to report pain. The patient may have been taught, quote, a positive acceptance of pain; that pain is a meaningful quality of aging and not a problem to be solved. There may be concern about being respectful to a patient's authority or time, or as it says, they may be fearful that pain means that their disease is worse. Or, they are fearful of addiction or being thought as an addict. And then, there are the potential financial barriers. From the point of view of the healthcare system and again, these are just a few, most appropriate treatment may not be reimbursed or may be too costly for patients and families. And, then there may be differing states' or jurisdictional regulations regarding controlled substances and other modalities. And then, there may be problems with availability of, or access to, treatment. All of you probably experience additional barriers on a frequent basis. So, let's look on the next slide, at the individual aspects of pain.

As the slide says, each patient's pain must be viewed from their individual perspective. Pain is an individual experience. Those – one of the bullets says, you know, makes the difference between stoic and emotive. A patient's responses to the pain are often divided into two categories. You got the stoic expresser and the emotive expresser, based on the patient and/or the caregiver. The stoic patient may be perceived as easy or a good patient. And then, the emotive patient may be viewed by either a patient or the family member or even the caregiver as being demanding or difficult. And then, there are the different expectations. The patient and the

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healthcare professional may have different goals for comfort and functions. Studies show that there are differences in the way people express their pain and how they expect others, whether it's a family member or healthcare professional, to respond to their discomfort. Another individual aspect of pain is the way – the different ways in which people described the pain. Not all countries described pain in the same way. Different words or descriptions might be used to describe pain. And then, these differing ways of describing pain can add to any already existing language limitations or barriers. And then, depending on the person's culture or personal background, they may have differing meanings for pain in regard to the meaning of pain. Some patients may describe their suffering as a punishment reckoned by a higher power, or in some cultures the acceptance or suffering leads to spiritual growth. And then, among patients and caregivers, there may be some differing attitudes about pain medication, and there may be cultural or religious reasons that may inhibit someone from asking for pain medication. Or, depending on the culture, they may have a preference for a certain type of medication. It must be remembered that a patient may display their experience of pain in the emotional and behavior responses particular to their culture but also based on that patient's individual personal history. Lived experiences and unique perceptions of life and in this case, pain. Therefore, it's important to avoid making assumptions based on the patient's culture or socio-economic background.

And now, I would like to turn the presentation over to Sarah Thirlwell. Who will share her PCH's experience? Sarah?

Sarah Thirlwell: Thank you Henrietta. I'm Sarah Thirlwell and good afternoon to everyone online. I appreciate this opportunity to speak about Moffitt's experience with measures 383 and 384. And, just before I begin, I like just to thank my colleague, pharmacist, David Craig who assisted in the development of these slides and will be participating with us in the question section.

So, for my section of today's webinar, I will be dealing and sharing with you my information around the evidence of both the prevalence of pain for our cancer patients, share Moffitt's experience of how we screen for pain

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and assess pain, and also certainly address some of the challenges and potential solutions for helping to meet the measures of 383 and 384.

I'd like to begin by discussing the prevalence of pain among outpatients with cancer. So, our most— knowledge that we have in the evidence that exists related to prevalence of pain really comes from a meta-analysis conducted by van den Beuken-van Everdingen and colleagues in 2007. And, they did a very rigorous approach to looking at the data among cancer patients, and studied – look to a meta-analysis study – to look at the studies – conducted from 1966 to 2005, and found that for those undergoing cancer treatment, there's about 59 percent prevalence of patients with cancer pain. And then, more recently, a study was conducted, this is a single study, but published in 2008, and looked– by Dr. Ragg in a center which is probably is more like our cancer centers. So, opportunity to look at, in this setting, it was a tertiary cancer clinic within Denmark in which patients were being seen as all comers to the outpatient clinic and looking to their pain prevalence. So, in this population, 80 percent were receiving active chemotherapy and radiation treatments and found that prevalence of pain in this population was 22 percent. So, if we look to this evidence, there can be a range of 22 percent but maybe up to 60 percent of patients who are undergoing cancer treatment with chemotherapy or radiation that are experiencing pain. So, if we think about this back to our sampling that Tom already referred to, we can expect maybe about five to 15 patients in every group of 25 to be experiencing pain while receiving outpatient care and treatment, whether that be, again, chemotherapy or radiation therapy.

So, if we now share what Moffitt's experience then is– to be able to look at – how do we capture those five to 15 patients who are above – every 25 that come to Moffitt? How do we capture that and understand their pain experience. And, within the extra challenge of – with these every 25 within 350,000 that do come to our outpatient clinics here at Moffitt every year. So, there is a great breath, number of patients, but how do we truly capture every patient – the patient experience of pain for each of these visits? So amongst that, the challenge is then, for such a large number, if

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we think of our clinics, many coming in and many challenges, the focus of our own culture, for the most part in very many busy oncology practices was thinking of the primary focus of the patient's treatment plan, factors that may delay or prevent treatments, such as blood counts, and the reality of the focus there is, there's more, can be more difficulties to give attention to other symptoms including pain, having pain and other parts of the patient's cancer experience. So, what's been successful in our center is really to establish a rigorous screening process, and within our institution, the screening process begins with every patient registration. We have a medical assistant that asks every patient a standardized questionnaire and this questionnaire reflects, you'll see, some other list – within this list a number of extremely important regulatory requirement that we meet to this questionnaire and then related to this webinar of course, the one in pain. So, it's a tiered question process that the medicals can ask first if the patient is experiencing pain, yes or no. And then, if yes, ask the patient to rate it on a scale of zero to 10 whereas zero is the worst and – excuse me, zero is the best pain and 10 is the worst experience of pain. And then, if yes, a third question also is whether this pain is new or changed from the last visit. So, these questions were devised, of course, to understand who has pain and then also to give an understanding to the patient's provider and clinicians whether this is the same pain that they've had since their last visit or the concern is to something new that needs to be addressed perhaps in a different way. One important piece for many patients, we do have many patients who have multiple appointments in a day, we do have a process in place that those with multiple appointments would first go to our blood draw area, and then go see their medical oncologist, and then may go to see a radiation oncologist or a fourth treatment you know, appointment in our infusion center, we do have a process in place that the patient is only asked this once per day not at every single encounter, so we have that process in place to help with screening and not overload the patient or any providers inappropriately.

We have a description now of the next steps in Moffitt's process. So, after the screening, there's, of course a process in place to have to respond to that screening. So, for every process, that is every patient who says yes for

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pain, the medical assistant has the process for flagging the chart. And, that's flagging for the next step in the patient's experience for which clinician they will see. So, among our 20 plus different clinics at Moffitt, every clinic does identify, within their workflow, the best way to flag. So, in some clinics, this flag occurs with a literal flag of a printing the Moffitt for clinic screening note from our electronic health record, and then highlighting and placing the highlighted value of concern for this case would be pain on to a clipboard, and put outside the patient's room, you know, identified where the patient has been roomed. And, a nurse would come in and perform the comprehensive assessment based on seeing that flag. Other clinics actually used an electronic tracking board and would include, you know, a virtual flag on a tracking board that the patient has pain, so that, perhaps and as practitioners going to the room would do the full comprehensive assessment. So, that's that response to training – important piece of screening being done and then flagged appropriately. So, then comes step three in our process that the clinician conducts a comprehensive pain assessment. I encourage everyone to – within the organizations and with all their teams to look to the National Comprehensive Cancer Network guidelines, the Adult Cancer Pain Guidelines, most recent version for 2015, and it gives a wonderful framework to really understand, certainly the screening process, the assessment process, and also ways to address pain that I'm alluding to in this webinar. And at minimum, the NCCN guideline do recommend that if someone's pain is assessed, both related to their current pain as well as worse usual or least pain in the past 24 hour period. So, that's a minimal comprehensive assessment, but for true pain control, truly to reach the 70 to 90 percent possibility for relieving pain, as Tom referred to earlier, if we can truly help patients with their pain we really need to do a comprehensive pain assessment that goes beyond just the experience in the past 24 hours. And, I'd like to remind everyone, there's many different ways to do a comprehensive assessment, but one of the simplest acronyms that I like to use is the one of OLD CART, the comprehensive pain assessment that speaks to onset, when the pain begins, location, where's the pain, duration, how long it's been lasting, when it comes on, when – how long does it last? how long they've had it, and then the key element

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of assessment for character. So, character being of course, whether it's constant – it's burning sharp, stinging, tingling and that's an extremely important part, the assessment helps to determine the type of pain, whether it be somatic, visceral, neuropathic or mixed. And, based on that critical assessment, understanding really what the best pain management options are for the patient. And, then beyond that part of the acronym, moving on to aggravating– or also, so aggravating, meaning what activities maybe making the pain worse. Or, if not only aggravating another way to think of the A is also activities. What activities are being– in patient's standard activities are being interfered by the pain? And, then finishing up the comprehensive assessment with relieving, what helps the patient, you know, asking them what their home remedies are for relieving that pain, or what current medications they're taking to help relieve that pain? And then, certainly the timing, is it at night, during the day, constant, or episodic. So, those are examples, some – just the brief description of the comprehensive pain assessment that's helpful. And then of course, based on this assessment the final step in the Moffitt process for addressing, you know, in our pain for addressing 0383 and 0384 to lead of course for the person to address that pain based on a comprehensive assessment and finally to document accordingly.

I'd like to take some time to stress the barriers to addressing pain. So earlier, Henrietta spoke to some of the individual aspects and differences in the expression of pain, so that concept of the challenges and barriers that may exist to assessment of pain, and led us to go a little bit further to discuss some of the overall barriers to helping patients who are experiencing pain. And, these barriers certainly fall across both for the patient and also the oncologist or healthcare system at large and in the three domains of lack knowledge, beliefs and fears, and access to pain management. I encourage you to look at to the NCCN care guidelines I referred to, and they do have discussion of these barriers and in other work by Pasero and McCaffrey who are gurus in the pain field, they really described these pain management barriers and have a wonderful questionnaire that can be used to help identify these. And, I'll speak to this in a little bit more detail. So, we have looked at lack of knowledge,

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obviously, if you don't have the knowledge of how to help patients with pain, then the pain cannot be truly addressed. But, they do – this knowledge really falls into different areas. So, for a patient, they may not even understand that or be aware that there's a possibility of their pain being controlled. And then, the pain regimen, they may not – they literally need the guidance to understand the difference between short acting and long acting medications or even different types of medications whether they be opioid or others such as adjuvants that can help. To be truly helping patients with the pain, they need good education and guidance around the side effects to expect, guidance to understand the sleepiness feeling at first with their pain management will go away, encourage them to keep going with their pain medications. But, a clear conversation also on constipation that will not go away as they are beginning opioids and that they really need them to – in order to continue on opioids, they really need to successfully have their pain controlled and help them know what laxatives they need and how to address their constipation because so many patients do say, I won't – I've heard so often, I don't want anymore opioids. I don't want to be constipated again. So, we need some important education to help the patients really have good pain relief, and then, certainly addressing misconceptions and myths around addiction. But, clarification you know, that tolerance does occur. So, helping patient to understand that addiction will not – you know, rarely occurs when someone is truly taking their medications for pain control. If you're seeking medication for the high, well that's addiction, but if you are receiving the medication for the true control of pain that won't be addiction. But, the reality with time, they will require additional doses because their body does become tolerant to opioid doses. But, increasing dosage because of tolerance, physiological tolerance is not the same as psychological addiction. And that type of knowledge does sometimes, is discussed by oncologist in some of those areas, but in particular one is – I'd like the call attentions of the challenges (inaudible) really to understanding the care of special populations within our ambulatory cancer patients. So, we have the ambulatory cancer patient who do have substantive – excuse me, substance abuse disorders. We have cancer patients who have painful co-morbid conditions, whether it be

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fibromyalgia, lupus, degenerative disk disease. And then also, the cancer patient that serve the experience in the content of total pain. So, pain beyond just the fiscal, pain in their cycle, you know, within the psychological domains, pain within spiritual domains, pain within their financial concern. So, those pains also need to be addressed in order for true success in addressing patient or ambulatory care patients. So, certainly there can be a lack of knowledge in those areas to really truly help our patients decrease their pain experience. Onto the next domain of belief and fears, there are many things listed here, but just to certainly begin with calling attention to patient's role and their beliefs, they need to be good patients, they are seeing the oncologist, the oncologist is there to hear about the cancer plan and concerns on whether communication is good with the cancer treatment, get their next dose or hold it, and related to their blood counts, the patients themselves may not report pain for fear of being the bad patient or taking up the oncologist's time, so that concept of the world of patient. And, in terms of role, that type of understanding and belief or fears about the role of oncology team is the oncologist perceived that their role is only to deal with the cancer treatment plan and not the – it's not the oncologist role to look at symptoms of the cancer or even beyond that also even not – it's not the oncologist role to look at pain other than from their cancer. So, considering, it wouldn't be their roll to assess the degenerative disk pain. So, that's at least the myths around the roles, it's a significant barrier to addressing pain and fear certainly is on the patient side that the increased pain is a sign of progression. Increased pain means, they won't get their next treatment, and then certainly that meaning of pain, suffering can exist for the patient that prevents them from reporting fully and prevents them for instance from having their pain addressed. From other beliefs and fears amongst – they exist amongst oncologist and other prescribers, are the fears and misconceptions are a legal risk of actually prescribing opioids, concern that they may be under greater scrutiny for prescribing opioid. And then, the worries about opioid diversion and so beliefs and fears among the – with the area that prevent them from prescribing but certainly there are many ways of our companies, these fears and beliefs and concerns of our practice and use of many states do have prescription drug monitoring programs and certainly

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within Florida and within our institution, if there's any suspicion or – for many actually it's part of their standard practice is to look to our prescription drug monitoring programs prior to prescriptions to see if patients are receiving opioids from multiple providers and then what frequency and what type. So, there's that opportunity to look to prescription drug monitoring program to assist and to mitigate the risk of opioid diversion or fears of opioid prescription. And then of course, the opportunity for care within care, and using of urine drug screening to look for patients that are misusing or abusing their opioid or other illicit drugs. So, that can be an approach that's possible. And then, the third domain to address certainly that there are barriers to addressing pain because of a patient's insurance coverage and then, or within the organization and healthcare systems, what are the options that exist on formulary for medication. So, for example, within Florida, there are some opioids that are approved for use within Medicaid, but not others. So, there can be limits to how we can successfully address pain depending on what the patient – what is truly helpful and working for patient's pain control. And then again, extending within the healthcare system, as I mentioned, the special patient populations – so, it's the substance use disorders, both of painful co-morbid conditions or patients with total pain beyond just the physical pain. You know, there's – it's really, the barriers that exist to access for pain specialist, for to care for the patient's populations. So, in terms of patient of total pain, access to – easy access to palliative care teams and then for other special patients, how do we collaborate with other experts in substantive disorders or other co-morbid conditions? So, given this, there's certainly this overall table of various ways for addressing pain. There are – there exist barriers, but there's some opportunities within this to look at how we can partner with patients and families and look to how to help build knowledge and address beliefs and fears to help patients have their pain be addressed.

This is my last – to close, I'd like to address a final issue concerning how we successfully meet measures 0383 and 0384. And that is, in order to truly, effectively screen, assess and address, we need to ensure that it's of course, properly documented and that documentation of course, promotes

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compliance, but it also, with the right templates and support documentation standards and hyperlinks, can actually support good assessment and facilitate intervention to address that pain.

So, if we look to how to promote compliance with both pain assessment and addressing it through intervention, it's really both increasing the accessibility and visibility of the documentation for our providers. So, within the EHR it can be paper based, but for most of us now in electronic health records, it's really – it's really using standard templates that actually provide a structure including comprehensive assessments.

The NCCN guidelines of course, if we know within the last 24 hours, as I mentioned earlier, is the actual recent experience of pain or an actual template with acronyms, such as OLD CART, that we have an opportunity to have all those aspects of pains fully addressed and assessed. Another way that it does– is helpful within the electronic health record is the existence of shortcuts whether that be boxes to check, and of course that could be on paper too, but, another piece that many programs have and I know we have access to at Moffitt through Cerner is the concept of macros, and these are little key strokes shortcuts that you can build commonly used sentences, and have them, with that shortcut key, actually populate your – the provider can populate their note very easily. So, if – you know, someone can be using terms of intervention for pain, and for providers commonly referring to palliative care, for complex refractory pain management and addressing total pain concerns that can be a sentence that if commonly typed, can be a sentence that could be a shortcut that can be dropped into any note very easily, or educate patient on proper use of long acting payment occasions and breakthrough dosage and laxative. Or, alternatively another type of sentence, you know, contacted primary care provider to report chronic pain, encourage and educated patient to reach out to their pain specialist in the community, those can be standard sentences that are commonly used, can actually be built into what we call at Moffitt, macros. So, that – those are some of the documentation solutions that can make life easier for documentation of

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assessment and the interventions that are used. I encourage that, that's been very successful for us here at Moffitt. And finally, certainly the opportunity to – we really need to educate all oncology team members of the value, of course, of addressing each patient's pain level whatever the source, whatever the cost. And, in addition, to that certainly, how do we partner with patient's to help them be educated and empowered to report their pain and of course, any symptom and concern, but certainly when we look to 0383 and 0384, how do we give them the opportunity that they feel comfortable and that is important for them to report their pain?. So, thank you so much to everyone for their attention and again, finally, just to close, remember please entertain pain guidelines, [they are] just something that can be very helpful, you're probably also very familiar with them, but I certainly wanted to highlight those as a very important resource. And now, I'll turn the microphone over to Stephen Flaherty.

Stephen Flaherty: Thank you. This is Steve Flaherty from the Dana-Farber Cancer Institute. I will be presenting on some of the lessons learned with the pain measures.

As you can see with my first slide, we hoped that by the end of my portion of the presentation, that you'll be able to more readily identify the appropriate codes and ways in which we identify the populations that are needed for the NQF 0383 and 0384 measure. And also, the fun part of the presentation, I think, is to talk about some of the common interpretations and variations that we encountered when we were abstracting cases that were eligible for NQF 0383 and 0384.

For the initial case selection of eligible patients for our August 15th, 2015, submission, the first submission of the NQF 0383 and 0384 measures, we were looking at the time period of the first quarter 2015. Patients that were seen during that time period were eligible for the pain measures and the eligibility of those patients was based upon having an ICD-9 code that was a cancer ICD-9 code. And, you can see on the small table, we have here, all the aggregated ICD-9 codes that are applicable for cancer, 140 through 239.9. Some of these numbers may change as we switch to ICD-10 codes, and that could be something to talk about in the future. We also needed to look at treatment codes. And, the treatment codes here are broken down as

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aggregated CPT codes. In fact, there are two buckets within that group, the service codes, all those that have a 99 prefix in front of them, so the 99,000 series here. Those are actual service codes for visits to a physician or a provider. So, we're looking at the provider visit when we look at the 99,000 codes, and it has to be someone who had a visit, and we're also looking at radiation therapy or chemotherapy. And, those are all of the other codes in here, that 51720, all the way up through the 96,000 series of codes that are listed on this table. So, we're looking at those two types of codes, which is a service code, as well as the procedure type of code, linked into the CPT. That's how we ran our data and were able to find our eligible population. For each one of these measures we're looking at cancer patients that were seen by a physician or provider and were receiving chemotherapy within 30 days of that visit, previous to or post that visits. So, we're looking at that time frame. That might mean that we're looking at patients that actually received chemo a little before the first quarter period or a little after, but did have a visit during that time period; so, that's the real piece that we view in order to figure out who we're looking at.

We're going to now look at the 0384 and 0383 lessons learned. 0384, we look at that metric first, even though numerically it's the second metric because that actually allows us to whittle down our population. The 0384 metric is assessment of pain. We all went through the algorithm I'm sure, and determined what patients were available for this measure. Once we determined what patients are available for this measure, I started to look at the data that was involved; and, to me, I'm used to looking at adult patient populations, which are very defined. For this metric though, we have pediatric patients and adult patients. We have patients that are seen multiple times. Sometimes, these patients are seen multiple times in one day. So, for us at Dana-Farber, and for some of my colleagues who I spoke with on the phone, we had to figure out ways in which we could better abstract those or correctly inconsistently abstract those. That included us determining what counted as a visit and how we're able to pull that data internally. We also needed to look at multiple data sources, multiple different electronic medical records. For instance, at Dana-

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Farber, there is a different electronic medical record for pediatric patients than there is for our ambulatory and inpatients. There's also a different electronic medical record for our radiation oncology visits. So, radiation oncology patients, as well as pediatric patients, weren't part of the normal pull that I look at when I look at the patients. We had to have an opportunity to include them. We ended up using our billing data system, which captures all of that information as oppose to one of our clinical databases in order to pull this. That allows us to have a broader sample and everyone collected in one area, but it didn't allow for me, at Dana-Farber for instance, to add in any of the downstream factor that I have had to abstract for, which were things like pain scores. The goal in the future for me is to be able to build in some of those pieces, so I don't have to go into every patient's medical record and pull out something like a pain score. So, we learned a lot of lessons when we were looking at these patients. We learned that if they have multiple visits in one day, I erred on the side of caution, and instead of automatically taking the lowest score, which is hopefully a zero and remove them from eligibility for the 0383 measure, we went with the highest score for their pain visits for that day to make sure that we were actually following through in looking at things. We looked at the facts that there are multiple tools. The pediatric scale, it might be your smiley face scale, your classic sad face to happy face, and we had some zero to ten scales. Luckily, many of those scales, and actually for us, all of the scales are turned into a zero to ten scale, even though there are multiple different tools that are used. We also, when looking at the 0384 measure, saw that we had to make sure it was documented as a numerical value in the record, as opposed to just stated. One of our concerns when we initially began looking at medical records, and I think that some of our colleagues had as well and have expressed, is that, there may be a statement that there was no pain present, but we do need to have an actual scale because no pain for some patients might mean a one, whereas for this measure, and in general, a zero is what's considered no pain. Luckily, for our patients, I did not find any that had no numerical value, and we were able to, in this case, look at a sample size of a 124 patients and those 124 patients, all of them had a score, which was

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very helpful. We had to look at 124 patients in order to meet our sampling for 0383.

For NQF 0383, we see that we had multiple systems needed to abstract this metric. In order to abstract this metric, we really needed to go into the patient chart and determine if they met any of the criteria for the documented plan of care to address their pain. In order to find out if they had a documented plan of care, we needed to know what was eligible for that documented plan of care, and that includes use of opioids or non-opioid for treating of the pain, psychological support, patient and family education, patient or family education, a referral to a clinic, or reassessment in an appropriate time interval. All of these things are eligible, if they are recorded in the medical record. They all make this patient compliance with this metric. We, at Dana-Farber, went into the 25 patient charts and looked specifically for these pieces. In doing so, I noticed that I found four or five patients who did not meet the criteria for compliance of this metric. I then had other colleagues at Dana-Farber review those charts, as well as others, to see if their rating or an abstraction of that patient matched mine. We learned that through using inter-rater reliability, or in this slide you'll see that as IRR, that there were interpretative differences in this metric in particular. There were none for 0384, the prior metric, which was a good thing. But for 0383, we sat down after talking about what our differences were to see if we could come up with a solution. We were able to discuss the interpretation of this metric and meeting the inclusion criteria for compliance. We also spoke with some of our colleagues at other cancer centers who are probably on the phone today and asked how they would have abstracted certain types of cases. One of the things that we noticed was that, quite, frequently, there might a pain score, and if there was not plan of care for pain entered, which included a current active medication for pain, there may be a social work consult or other consult later that day. If there is no documentation of that social work consult or other consult or visit later on in the day as specific to in referencing that pain, then that was not counted as a concordant case. Some of my colleague at Dana-Farber had originally quoted this as compliant because there was a follow up consult; but,

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because there is no documentation or mention of the fact of that [the] consult is specific to the pain that was measured that day, we finally determined that those were not compliant. And, that happened in the case of all four or five of our non-compliant cases, that there were other consults that day, but they in fact weren't in reference to that pain. We also found that sometimes you would see a physician mentions pain, but the score might be zero. They might be talking about chronic pain. So, we had to look at the tool to make sure that when the mention of pain was there, if they were still a zero that there was not a need to look into abstracting further and determining if there was a plan of care for that pain. Many of our patients were currently on medications for their pain. This was a discussion that we have had with a number of cancer centers. I believe that the intent of the measure is to make sure that when pain is assessed on any day that it is spoken about and dealt with on that day. I believe that the measure is constructed in such a way that we can infer, if you are currently on a medication for pain, if you are on oxycodone for a long term pain due to – due your illness, if that medication is current and active on the day of your visit, we do meet the measure and we are not going to be discordant. But, I believe that in the future we should look further to make sure that anyone who has pain on a specific or given day, is actually talked about in the record, and the medication is referenced for that pain, for that day. The way that we abstracted was, at Dana-Farber, if a patient had medication for pain and it was active than we allow them to be considered compliant for the metric for that day as it meets the standard. But again, I believe that the intent of the metric is to have them discussed and talk about that medication on that day and have it addressed to the pain. Things like medical marijuana came up with one of your patients someone who had a medical marijuana prescription and that was referenced by a physician in their notes. They did not in fact reference medical marijuana was for the pain that they had experienced that day. So, in that particular example, we had to look to further notation and see if the medical marijuana was prescribed for pain, and we did not have any documentation of that, so that was considered a discordant to case. We also found that we had to look in multiple areas to make sure that, if there was a consultation note or if there was further assessment of pain in that

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day because of the fact that they had pain earlier in the day, if that was our case, we had to look at other notes to try to find that and to follow through. So, this metric, 0383, took a little bit more abstraction, a little bit more time to really go through, especially those cases that did not immediately have medications. I would think that the majority of our institutions have medications prescribed for most of our patients and anyone who has pain probably automatically falls into that first category of using opioid or non-opioid analgesics. Those do not are the ones that we spend a lot more time abstracting and looking into. Thank you very much for my part of the presentation. And, I will pass it back to our host.

Tom Ross:

Thank you, Steve and Sarah. As Steve's case emphasizes, each PCH is unique in their processes and policies, even patient population. I trust that today's webinar is giving you a framework to help you understand, sample, and most importantly, improve your processes related to NQF 384 and 383, with end goals of improving patient care. On this slide, we can see the information that some of you have been requesting: the ICD-9 to ICD-10 crosswalk for one of the other PCH metrics, NQF 1822, external beam radiation therapy for boney metastatic disease. In ICD-9, this included patients with ICD-9 198.5. For ICD-10, this will now include both C79.51 and C79.52. This information was provided to us by the measure steward, ASTRO. So, with this I'm going to turn things over to the always fabulous Deb Price for our continued education information. Deb?

Deb Price:

Well, thank you, Tom, that was a great introduction. Well, today's webinar has been approved – the slide has one credit but it's actually been approved for 1.5 continuing education credits by the boards listed on this slide. We now are a nationally accredited nursing provider. And as such, all nurses will record their own credit to the board by using the number on this slide, on the last bullet: Provider #16578.

We now have an online CE certificate process. And, you can receive your certificates in two separate ways. If you registered through ReadyTalk®, as soon as the slides close out, you'll have a survey, and then you'll take the survey, and then you'll be sent to another site for the certificate. If

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however, you're in a room with other people, in 48 hours we're going to send another survey around and that is the one you can forward to the other people in your room. After completion of the survey, click "Done" at the bottom of the screen where another page opens up where you can register onto our learning management center. It is a completely separate registration from the one you registered in for the webinar. Please use a personal email on this registration because healthcare facilities sometimes have firewalls up and those firewalls change from week to week and they seem to block our links.

This is what the bottom of the survey will look like; it will pop up as soon as this webinar is over. You see in the bottom in the little gray box, you see the word "Done." As soon as you click done, this page will open up.

This page has two links on it: new user link and existing user link. If you have not registered a personal email to get a certificate, I would highly recommend using the new user link and register a personal email. If however, you have been getting our certificates, go ahead and click on the existing user link and then we'll see what that looks like. This is what the new user link will take you to. You put your first name, your last name; put your personal email there and a phone number.

This is what the existing user page looks like. The username is always your entire email, not the first part of the email before the @ sign. The entire email is your user name and whatever password you registered.

And now, I am going to pass the ball to Matt, our virtual host. He's going to help us with a couple of additional slides. Matt, take it away.

Matt McDonough: Thank you, Deb. And before we wrap this up, today, we'd like to just do a little interactive exercise, if you will. So, I'm going to go ahead and advance to the next slide. It's just actually a – I don't want to say a test question, but a knowledge check question, if you will. What we'd like you to do here is read this question and provide an answer by clicking on the screen.

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And, the question is: at a minimum, the patient sample for NQF 383 should contain at least 25 patients. Is that a true statement or is that a false statement? So, the answer to that question again, click either true or false, and then click the submit button, and I know we've got a few people online today, we still have some answers coming in here. We want to make sure that when you leave here, you understand the parameters around this measurement. So, we're going to leave it open for just a little bit more. We've got one or two more questions we'd like to ask you. So, if you haven't answered yet, please do so. All right, we'll go ahead and we'll close this one down, looks like we had 13 answers here, 14. They are still coming in, maybe I'll leave it open for a second more. All right, Tom we'll go ahead and close our first knowledge check, if you will. Let's take a look at that, looks like we had 10 trues and four falses.

Tom Ross: Well Matt, remember that the population for 383 is dependent upon the number of patients in 384 who said yes, I'm experiencing pain and it was quantified using a standardized instrument. So, many of the PCHs chose to sample more people in 384 until they reached up to 25 patients in 383, but there is no requirement to do so. So, the answer to this would be, False. There's no requirement that they have to contain at least 25 patients, although they may sample more in 384, until you reach whatever numbers you feel is reflective of your performance. Does that sound correct, Henrietta?

Henrietta Hight: Sounds good to me.

Tom Ross: OK. Thanks, Matt, let's do one more.

Matt McDonough: All right. Thank you. Yea, let's do one more. We've got one more question here. This one is a multiple choice question as well and it's a – what's the percentage of patient undergoing cancer treatment that report pain for the meta-analysis done by van den Beuken-van Everdingen and colleagues, did I get that right, Tom?

Tom Ross: Perfect.

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Matt McDonough: All right. And your choices are 33 percent, 59 percent, 64 percent, 53 percent, or greater than 90 percent. And again, to answer this one, similar to our last question, just simply click result or click an answer and then click that submit button. And, just so you know, these questions are not being graded on. In fact the responses are anonymous; it's just a knowledge check. We like to make sure that again, when you leave, you do have the knowledge related to the topic that we were covering today. I see a few more coming in Tom, so I'll leave it open for about another 10 or 15 seconds.

Tom Ross: That's OK, Matt. I'm actually looking for my notes so I can answer my own question.

Henrietta Hight: Here Tom, I've got the cheat sheet.

Matt McDonough: I'll leave it open a little longer than Tom, like that. All right. It looks like we've...

Sarah Thirlwell: Hi, Tom it's Sarah. I've got the paper in front of me. So 59 percent is the answer.

Matt McDonough: There you go, 59 percent was the answer and here is the results Tom, from our audience today.

Tom Ross: They did better than I did. It was interesting to me Sarah that the 33 percent was for patients after curative treatment. So, a lot of that was actually probably the neuropathies, and the pain induced by the treatment, if they were actually having curative treatment, which I thought indicated the need for survivorship, certainly. And, I was surprised that it was as low as 64 percent in people with advanced or metastatic and terminal disease and then 53 percent of patients in all diseases that, as both you and I discussed, you know, the rates really vary from anywhere from 24 to 86 percent, which shows the difficulty in pain assessment. I'm not sure if there is anything you want to add to that.

Sarah Thirlwell: Well, just the – you know, the timeframe from that meta-analysis starting from 1986, I mean, the oncology treatment has changed so radically from

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then. So, that's some of the – you need to, obviously, very rigorous study but we have to think of context of the – you know, all of the different oncology medications or radiation therapy techniques, that's so different now.

Tom Ross:

Very good. I want to wrap up with just a couple of questions that weren't answered today. One of them was: how do you address these assessments between nursing-physicians, specifically when the physician documents no pain and the nurse documents pain?

The measure steward and the standard are silent to this issue. You heard from our various case studies: at Moffitt they take the first pain assessment performed that day, Steve said at Dana-Farber they take the highest pain assessment found during the day. The advice that I'd give on this is to take a stance on one or the other – decide on what your organization's policy is for this and then stay with that. The measure is silent as to that question in particular. So, that would be up to the institution.

Another question received is: which facilities does this presentation applied to, does it include acute care hospitals with oncology units, or is it for just cancer stand alone hospitals? Just want to be clear. The presentation today and the question and answers are specific to the participants in the PPS-Exempt Cancer Hospital Quality Reporting Program. These are hospitals that are reimbursed by CMS as PPS-Exempt Cancer Hospitals and are required to report 383 and 384 as a metric. However, the metric is very valid, and in fact a related measure is used in the ASCO QOPI Program. The measure 384 is used as one of the measures you can select for PQRS. And also, I think these are excellent measures for use in any quality improvement program in the hospital or clinic that provide care to cancer patients.

And, the last question that we have from today's presentation, as I scroll down here is, give me just one second: is this for all providers or all oncologists? If it's for all providers, how is this any different than PQRS reporting for pain?

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Once again, the measure is not specific to the type of provider. The measure definition requires a diagnosis, by ICD-9 or ICD-10 code, of a cancer patient who has an encounter and receives chemotherapy within 30 days prior to or including 30 days after the encounter for chemotherapy or received radiation therapy during the treatment period. So, it really is not specific to an oncologist. If they saw another person and pain was assessed and they were under those treatments, they should be included in the patient population. So really, it is the same as the PQRS measure in 384. In fact, the specifications are drawn from the PQRS manual.

So with that, I would like to thank you for your time. I appreciate the extra 30 minutes. We had so much good content today. We didn't want to shorten anything, especially the insights from Steve and Sarah. I hope that today's presentation was helpful to you. And, as always, we thank you for the care that you provide to our patients. Thanks and have a great afternoon. Bye-bye.

Operator: Ladies and gentleman, this does concludes today's conference call, you may now disconnect. Presenters please hold.