



PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program

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PCHQR Program Best Practices: Mitigating Outpatient Pain

Presentation Transcript

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July 27, 2017

2 p.m. ET

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Tom Ross:

Thanks, Matt. Good afternoon, my name is Tom Ross and I serve as the Program Lead for the PCHQR Program, and today I will be serving as the moderator and speaker for today's event. I will be joined by Sarah Thirlwell, the Supportive Care Director at the H. Lee Moffitt Cancer Center and Research Institute. Last year, a new measure was added to the PCHQR Program, Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy. There are ten adverse events that are the focus of this measure, with pain being one of them, hence the focus of today's webinar. This measure has also been added to the Hospital Outpatient Quality Reporting Program. Therefore, while today's presentation may have interest and applicability to participants in the OQR Program, as well as other clinicians providing care to cancer patients receiving outpatient chemotherapy, I want to emphasize that the specific contents of today's webinar is only applicable to the participants in the PPS-Exempt Cancer Hospital Quality Reporting Program, as it relates to participation and reporting in CMS Quality Reporting Programs. Please be sure to refer to information regarding this measure provided by the support contractor for your program. And lastly, I want to remind participants that the slides for today's event were posted on [Quality Reporting Center](#) prior to the event. Furthermore, the questions and answers, transcript, and recording of today's event will be posted to the same website in the near future and also on [QualityNet](#). So let's take a look at another of our standard slides that contain the abbreviations that will be used in today's presentation, on slide number six.

These are quite familiar to participants in the Program and regular attendees of our events. There are a couple of new abbreviations I want to highlight for you. Sarah will speak of the use of the Edmonton Symptom Assessment System, or E-S-A-S. You will soon become very familiar with the term F-S-R. This stands for Facility-Specific Report, and is the report prepared for your hospital containing your performance data for claims-based measures. And speaking of the Outpatient Chemotherapy claims-based measure, there are two abbreviations used to display the final results that will be calculated for your hospital, an R-S-A-R, or risk-

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standardized admission rate, and an R-S-E-D-R, or risk-standardized emergency department visit rate. Slide number seven, please.

During today's presentation we will be providing you with an overview of pain management in the ambulatory cancer patient population and then describe effective mitigation strategies to help you minimize the occurrence of admissions and ED visits associated with pain in patients receiving outpatient chemotherapy. Slide number eight, please.

The specific objectives that Sarah and I will hope to achieve include: explaining why pain is a significant clinical concern for cancer patients; summarizing the PCHQR Program measures related to pain management; and to wrap things up, Sarah will assist you in describing effective strategies to identify, assess and manage pain experienced by cancer patients in the outpatient setting. So, with the educational framework set, let's move into the first major section of today's event on slide number nine.

Pain in the cancer patient. Pain is a major fear for many cancer patients and the presence of pain is a reality for many cancer patients. However, the good news is that for the majority of patients is can be effectively managed. Slide ten, please.

In fact, in general, pain control can be achieved in about 90 percent of cancer patients. It is actionable. Effective pain management begins with determining the root cause or source of the pain, most importantly starting with a comprehensive pain assessment. This assessment is essential in providing insight into the underlying cause or causes of pain. And this understanding of the source of pain is essential in developing an effective treatment strategy. For example, neuropathic pain is treated much differently than post-surgical pain. In terms of performance improvement language, you have to assess the current state before you can design and implement an effective corrective action. In fact, Sarah will actually show you a slide that looks very much like a PDCA cycle. Slide number 11, please.

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In determining the intensity of pain, patient reporting is the gold standard. This is really at the heart of NQF 0384. Pain can be furthermore characterized by the type of pain: acute pain, of sudden onset, maybe of a shorter duration. Examples include post-surgical pain, positional pain, or pain from a procedure or infusion. Breakthrough pain is pain that occurs despite the presence of a scheduled pain regimen. Chronic pain is obviously pain of a longer duration. And, lastly, refractory or intractable pain are those cases that do not respond to typical interventions and often require a referral to specialists. Another way to classify pain in a cancer patient is by its source. There are three basic sources of such pain in cancer patients: pain related directly to the cancer, pain associated with the treatment of cancer, and pain unrelated to cancer or its treatments. We will discuss these types of cancer pain more on our next slides beginning on slide number 12.

There are four general categories or sources of pain that are commonly cited. Nociception refers to the process by which information about tissue damage is conveyed to the central nervous system. This could be a good thing. For example, a finger touching a hot stove, one that prevents further tissue damage. Nociceptive pain results through an impact of a tumor upon bones, nerves or body organs. Nociceptive pain can be somatic or visceral. Somatic pain is caused by injury to skin, muscles, bone, joint or connective tissue, and is usually described by the patient as “aching, stabbing or throbbing.” On the other hand, visceral pain results from injury to organs in the hollow viscus. This is often less localized and described as “cramping or gnawing.” However, note that visceral pain can be referred to somatic sites. Neuropathic, as the name implies, suggests injury to the peripheral or central nervous system. Some examples can include post-herpetic neuralgia, nerve entrapment from carpal tunnel syndrome, and neuropathy from some types of chemotherapy. Psychogenic pain is pain predominantly sustained by psychological factors. This can oftentimes be depression or anxiety. A patient with this type of pain may have pain that does not correspond to what is expected from a physical standpoint. And, lastly, there is idiopathic pain, which as

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the name implies, is a pain of unknown cause. On slide 13 we will look at the prevalence of pain in the cancer patient population.

In review of the literature, you will see a wide variety reported for the prevalence of pain from 24 percent to 86 percent of patients. In general, and not surprisingly, pain is a more frequent occurrence in patients with more advanced disease. And the highest prevalence is found in those patients with cancer of the pancreas, bone, brain, lymphoma, lung, and head and neck. For the purposes of today's presentation, I want to drill in a bit on the portion of the slide under "Etiology." You see that 85 percent to 95 percent of cancer pain is cancer related. Then 17 percent to 21 percent of reported pain is related to cancer therapy, and 2 percent to percent is related to comorbidities unrelated to cancer. Note that the percentages' total is greater than 100 percent. Unfortunately, patients may be experiencing pain from one, two or even three of these sources. For the purposes of today's discussion, you can see that patients undergoing cancer treatment, such as outpatient chemotherapy, have a reported incidence of about 59 percent. Focusing even more on pain related to cancer therapy, let's look at slides 14 and 15.

Patients can certainly experience acute, nociceptive pain from procedures and testing. And, obviously, while it may have long-term benefits, surgery itself can cause pain. Specific to chemotherapy, you can see there are a myriad of sources for pain. I will not go into all of these, but a couple to note include mucositis, musculoskeletal pain during infusions, as a result of toxicity, or even with some of the supportive care therapies, such as bone pain with colony-stimulating factors and steroids or pain resulting from osteonecrosis with bisphosphonate therapy. Also many of the chemotherapy agents can result in dermatologic complications, some of which can be quite painful. Slide 15, please.

And here we see some of the pain that can result from radiation therapy, including dermatologic irritation and/or burns, mucositis, organ injury, and even positional injury from immobilization. On our next slide, slide number 16, we emphasize the importance of pain assessment and management in this patient population.

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The NCCN guidelines reinforce the fact that pain is one of the most common symptoms associated with cancer. Patients fear pain and it obviously impacts quality of life and the activities of daily living. Interestingly, effective pain management has been linked to increased survival. The good news is the last bullet, which we discussed earlier, 90 percent of cancer pain can be effectively managed. It is actionable. Slide 17.

With the understanding that pain is a reality for many cancer patients and that it's important to them, it is not surprising that the quality reporting program for the PCHs has three measures that address the topic of pain. We'll take a quick look at these before I turn the presentation over to Sarah, beginning on slide 18.

Two of the measures related to pain, NQF 0384: Pain Intensity Quantified and 0383: Plan of Care for Pain, were added to the Program in the Fiscal Year 2014 rule, and the Admissions and Emergency Department Visits for Patients Receiving Outpatient Chemotherapy measure was added to the Program for the 2017 rule. As NQF 0384 is the measurement of the assessment of pain, we will start there on slide number 19.

The denominator for 0384 begins with a very long list of ICD-10 codes indicating the diagnosis of cancer. Then, you select, through the use of CPT codes, those patients who have received radiation therapy or are on active chemotherapy during the treatment period, which is defined as a patient who has a CPT code for injectable chemotherapy within 30 days prior to and 30 days after the date of a physician office visit. The numerator are those patients who have documentation that no pain is present, or if pain is present, the intensity is quantified using a standardized instrument. Slide 20, please.

And here we see the denominator of the patients. Here we see the first diamond asking, "Does the patient have a diagnosis of cancer?" Then we see the flow chart branch, showing the different inclusion criteria for receiving radiation therapy or chemotherapy. Notice it is receiving chemo or radiation therapy. Those patients meeting the criteria form the

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denominator for NQF 0384. Slide 21 graphically illustrates the numerator component of this measure.

The first step is to assess if pain is present. If it is documented that the – pain is – patient is experiencing no pain they are included in the denominator and numerator for NQF 0384. If they do have pain, you move to the second diamond. Here you ask, “Was the pain intensity quantified using a standardized instrument?” If yes, they are included in the numerator with NQF 0384. If no, they are not included in the numerator. Note that some organizations do the first two steps as one step, documenting no pain as an intensity of zero. Either method is appropriate. If they have no pain or they have pain and the intensity is quantified using a standardized instrument, they meet the intention and are included in the numerator. On the lower right-hand corner of the slide you see a blue parallelogram stating, “Patient denominator population for NQF 0383.” Remember, 0384 and 0383 are paired measures. Those patients in NQF 0384 who have pain present and the intensity is quantified using a standardized instrument form the population for NQF 0383. Slide 22, please.

NQF 0383 is more straightforward. Remember, those patients from NQF 0384 who have pain present and the intensity is quantified using a standardized instrument form the population for NQF 0383. The numerator portion is clear-cut. Those patients who have a plan of care to address the pain present in the medical record are included in the numerator. Remember the plan of care must be to address pain and can consist of many corrective actions including such things as medications, alternative therapies, consults, further monitoring, and so forth. The elements that qualify as a plan of care for pain are not prescribed. Slide 23.

And this slide simply reinforces the information discussed on the previous few slides in relation to the assessment of the numerator for 0383. So, on slide 24, let’s take a look at the PCH’s performance of these two measures to date. Next slide, please.

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I'm sorry, Jamie. I'm not seeing the next slide. OK. So we're going to be on slide 24 please. There we go. You can see the results for NQF 0384 are displayed on the left-hand side of the table, while those for NQF 0383 are on the right-hand column. Data was first reported in August 2015 for quarter one 2015 and then in August 2016 for quarters two through four. I broke the results up between these two submission periods to see if there was any dramatic shift in performance, and the answer is no. You can see that the overall compliance of NQF 0384 has averaged around 92.5 percent for the first year of data that was reported, and for NQF 0383, overall, it was looking about 92.9 percent. While on slide 25 we look what conclusions, if any, we can get from this.

First of all, as I already noted, performance for these two measures has remained relatively consistent for the first year's worth of data reporting. Secondly, looking a bit more closely at the population and sampling data submitted by the PCHs, we note that each PCH had a population of several hundred to several thousand during each quarter. So therefore, not surprisingly, all the PCHs indicated they sampled their data for NQF 0384. And, lastly, knowing that those patients reported having pain and the pain intensity was quantified using a standardized instrument in NQF 0384 form the population for NQF 0383, we can surmise that about one in four patients are reporting pain. This number seems a bit low given what the literature reports, such as by van den Beuken-van Everdingen who noted that 59 percent of patients undergoing anti-cancer treatment report pain. So slide 26, we'll take a quick look at the basics of the Outpatient Chemotherapy measure. Slide 26, please.

I've spent a lot of time talking about this recently so, to save time for Sarah, I'm going to be brief. But, first of all, the full measure is listed on this slide, and for brevity I'm going to refer to it as the Outpatient Chemo measure. It's claims-based; therefore, there is no data submission required on behalf of the PCHs. The CMS contractor responsible for this task will look at a PCH's Medicare billing data to identify cancer patients who received outpatient chemotherapy in a given timeframe. They will also look at the codes to assist in exclusions and risk adjustment. They will

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then look for admissions and emergency department visits associated with one of the ten adverse events most commonly cited as being associated with outpatient chemo.

On slide 27, we see these ten events and note that pain, the focus of today's event, is highlighted in the red. Slide 28, please.

Today's webinar is the first in a series of best practices from PCHs to mitigate these events, and over the next few months, we're going to cover a number of other topics. But, as you can tell, today we're going to look at mitigating outpatient pain. Slide 29, please.

Here, I've provided a number of references to you, notably the June 1, 2014 Journal of Clinical Oncology, which is entirely devoted to the topic. There are also NCCN guidelines on adult cancer pain, and many tools from ONS. However, today you get a first-hand report of their experiences from someone in the field. It's my great pleasure to turn the program over to a friend of mine, and an excellent clinician, Sarah Thirlwell, from Moffitt. Sarah has held numerous positions over her tenure there, currently serving as their Supportive Care Director in the program of the same name. Sarah?

Sarah Thirlwell:

Good afternoon, everyone. Thank you so much for that kind introduction, Tom. I very much appreciate the opportunity to share Moffitt's experience with pain assessment and care planning and how we can with good screening, good assessment, good care planning we can help avoid admissions from adverse events. So as you listen today I hope you'll be able to learn more about the process to screen and quantify pain for all patients in a busy outpatient oncology setting. We're going to describe the elements in a plan of care for pain and also touch on the criteria for referral to speciality palliative care for patients in need. Next slide, please.

So at Moffitt Cancer Center, we're a very busy comprehensive cancer center and we're seeing over 350,000 patient encounters every year. And so it's been very important for us in order to support compliance with 0383 and 0384 that we actually established a standardized process to

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ensure that we're screening for all symptoms, including pain. So within our clinics, what we do is that every medical assistant screens every patient upon their first – I mean, after registration. So patients are registered with a typical front desk and then seen by the medical assistant and we have the standardized Moffitt Clinic Screening Questionnaire. So as you can see these questions, the first one beginning with “Are you currently experiencing pain?” A simple Yes or No. If yes, the medical assistant is prompted to then actually ask about pain intensity with a rating of 0–10. And then followed by, if also if yes, is whether this pain is new or changed since the last visit? Our Moffitt Clinic Screening Questionnaire does actually also include some other screening questions that you can see that obviously helps serve other multiple regulatory compliance purposes. What's very important in terms of standardizing a process it really helps, again as I mentioned, ensure that we're assessing for pain and also that standardization certainly helps maintain good clinic workflow. And on the patient's perspective helps set that expectation, their understanding, that we are attending to their pain, we're concerned about their pain and that that's a part of their regular patient visit. Amidst all the challenges and busyness of an oncology clinic where certainly the main focus of the oncologists is on treatment of the tumor or decisions to continue with chemotherapy or radiation, and monitor those outcomes and communicate them to the patient, it is essential that there is actually a standardized process for screening for symptoms like pain part the clinic workflow. Next slide, please.

Upon screening and then with the importance of describing a process for responding to that screening, our medical assistants flag the chart in a specific way, whether that be a manual flag for those who are still working with paper in some of our clinics or more commonly now an electronic flag. That flag indicates to the nurse or midlevel provider or physician, depending on our clinics, and that flag indicates the need for the clinician to do a more thorough assessment of the patient's experience of pain. So, for us, the flag electronically, we have a patient tracking board. So, within the tracking board a patient has an extra indication level, with a flag, that will indicate to the clinician that, that again, further assessment for pain to

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be conducted. And I'll speak of it more in greater depth a bit later about that assessment process. Next slide, please.

I'd like to just highlight, before I continue with the assessment process, one of our newer processes that we've begun in the radiation oncology clinic. So one of our approaches, sort of building on our experience with standardization of Moffitt clinic screening notes that I just mentioned, we really want to shift our focus and incorporate patients more fully into the process of care and in terms of really hearing the patient voice as they report their symptoms. So we've incorporated a validated tool known as the Edmonton Symptom Assessment System, or, in short form, ESAS. It's a self-report questionnaire for pain and other symptoms, and we've actually incorporated that into our practice here at Moffitt. It was first used and implemented in our palliative care clinic, and secondly now in our radiation clinic which I'll speak to now, but our plans are to really roll this out into other clinics at Moffitt. So our radiation oncology clinic is extremely busy, with over 40,000 treatments a year, and that's over 6,000 encounters with a clinician. And in that clinic, we've established this process with this new ESAS is after patient registration, the medical assistant provides every patient with an iPad. And on this iPad it has this new electronic ESAS application that was actually built by our software engineers here at Moffitt. And the beauty of this electronic process of asking patients directly their symptoms is that we can see, on the next slide, that this information, directly from the patient, flows into our Electronic Health Record.

So, that you can see here. This is a screenshot from our Electronic Health Record, where the patient reported symptoms from ESAS, flows directly into the flow sheet, right beside the vital signs. And so you can see merely clinicians have the opportunity, to real time have increased visibility of this symptom. As you can see we've increased, included some key features of making it red, and having "H" for high when patients have severe pain of 7, 8, 9 or 10. So that certainly increases the visibility of a symptom like pain in our Electronic Health Record. And then further from that we also, with the next slide...

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We've incorporated and developed the process, for ease of documentation, providers can easily incorporate these patient-reported symptoms directly in their clinic notes, as you can see here. This is a section, a screenshot of a clinician's note, where they've actually incorporated the results. And, again, you can see for symptoms, here in this patient situation, the patient didn't have pain, and so this allows for the clinician to directly document those symptoms. So, we have two processes right now at Moffitt. First, that manual process where they, the medical assistant, or MA ask the questions directly to the patient, or now this newer process, that we hope to bring across all our clinics, in which we have the patient-reported outcome, specifically with ESAS, to report their symptoms and they go directly into the Electronic Health Record. Next slide, please.

So on this slide, I'd just, I'd like to pause for a moment and acknowledge the importance of looking beyond just pain score as pain intensity. So patients in our processes are commonly used to the concept of asking patients to describe their pain on a score of 0 to 10. But it's also important to acknowledge that, for some patients, it may be difficult to assign a number to their pain. And actually, there's great value in shifting from assessing not only on scores, but actually for patients who may have difficulty saying the number or if over time you see they're always saying the same number, no matter what your interventions are with the patient. It may be more helpful to also add a qualitative assessment in terms of assessment intensity for if the patient is experiencing no pain, mild pain, moderate pain or severe pain. In general, as you see by the table on this slide, they, those are in general associated with a range of scores, but it's extremely important for every individual to verify a sense of associating those words with the pain, actual pain score. Next slide, please.

Upon screening, once that's occurred, it's really important of course to take it to the next step, if the patient has said yes. It's really, it's important to then conduct a comprehensive pain assessment. It is not sufficient to go from "yes pain" to a plan of care. You must take this important step of conducting a comprehensive pain assessment. Now the National Comprehensive Cancer Network guidelines do speak to what a pain

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assessment is, and it can guide us in our practice in oncology. And it certainly, at a minimum, is to assess the current pain, which is, of course, similar to our screening process. But, it's from assessing current pain. It's actually very important to go another step, which is to also assess what is the patient's worst pain, usual pain, or least pain in the last 24 hours. And, if yes to any of those timeframes, then a further assessment must be done to be able to really capture what that pain experience is for the patient. In terms of then other further assessment of pain, there are many ways, mnemonics, and acronyms that exist to help guide a comprehensive pain assessment. The one that is my favorite and I find most helpful is to use the acronym, OLD CART. And, as the patient says "yes" to current pain, worst, when was their worst pain, their usual pain or what's been their least pain, it's very important then to ask about the onset. When did that pain first begin? Has it been constant in terms of it's been every day for the past week? Did it just start today? Did it just start last night? Did it just occur in the blood draw clinic just, you know, 30 minutes ago when difficulty with the blood draw? Or, has it been there for months or years? If it's like pain that, from a chronic illness, that perhaps began before their cancer diagnosis or onset. And location, where? Where on the body? And this is important, the idea of really paying attention to patients, not just their verbal responses to your questions, but also their non-verbal responses. So when you ask about location, it often will be accompanied by a patient, and especially those in severe pain, to use their hands with a non-verbal cue, with their hand to indicate where it is. And also, location is also important to talk about the concept of where it's radiating. So location... Does it stay in one place or does it move? So, sciatic pain would be starting in the hip and then going down the leg. So those indicators, if the patient answers those questions and perhaps uses their hands, indicated are important for the comprehensive assessment. And then D of OLD, D for Duration, and this very much is how long it lasts and how, similar to Onset in some respect, but very much the idea of how long it lasts. Is it constant or intermittent? Is it continuous? And then that brings us then to OLD CART, C, 'Character. How is it described? Is it cramping? Shooting? Does the pain expand like a punch? Those are important things to be asking about. By aggravating that, what makes the

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pain worse? Does it – is it worse with walking? Is it worse with sitting? Is it worse with lying down? What relieves it? What medications? That's where it's an opportunity, with your comprehensive assessment, to ask what medications or other interventions the patient is already using to help relieve that pain. And then the Timing. And that can certainly be the idea of, if it comes and goes, or if it's relative to an activity. So that reflects the idea of the comprehensive assessment using the OLD CART acronym. And the concept obviously is not just asking, but it's obviously, as the practitioner does this assessment, that's when they begin to discern the type of pain. So, as Tom referred to, is it somatic? Is it neuropathic? It may begin to help a clinician determine what diagnostic tests may be required. What is the next course of action after this assessment in terms of the plan of care? And certainly, also, it will depend on the type of pain. As, you're deciding the plan of care, what's the most appropriate medication is indicated. So assessment is a crucial step. So to be able to do a comprehensive assessment is crucial to be able to do a true plan of care. Next slide, please.

Now on this slide, take another pause to consider the importance of really looking to a patient's total pain. So in our questions, so far in our conversation, we've been talking about physical pain that's caused by the cancer or caused by their treatment, or perhaps again the co-morbidities of pre-existing conditions. But as Dame Cicely Saunders first recognized – she's Saunders, actually – of the modern hospice, palliative care movement, she really helped us recognize the importance of looking to total pain in which a patient who has the physical pain of, from their cancer may be very anxious. So we need to look at the psychological pain that a patient experiences through their physical pain. They may be very anxious of that pain. That new pain may indicate a recurrence of their disease or that their chemotherapy is not working. From that physical pain, patients may also feel a sense of spiritual distress or spiritual pain; that it's a punishment. Or, with that pain, that experience of cancer, they may be angry that this is occurring to them and may be struggling with understanding the meaning, in perhaps, even approaching advice meaning that their life and just the fear of the unknown. So, that physical pain may

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trigger many types of other pain, not least to mention the social impact of physical pain. And to look at a patient who's in pain, who no longer wishes to engage with their family or are no longer able to engage with their family or their normal role as the income earner perhaps in their job, which of course then brings financial concerns and overall worries about their future for themselves and their family. So the importance of recognizing, we talk about, you know, physical pain, it's to acknowledge that that's in the context of total pain. And, when we think of adverse event of pain, it is truly this big picture that can lead to a hospitalization related to the pain. It's all these factors together. So, on the next slide, I'd like to now focus on, once our comprehensive assessment is done of both physical pain and total pain, what is our approach to comprehensive evidence-based pain care?

And we've talked about the assessment in terms of the intensity, whether it be the score or the descriptor "mild, moderate or severe" using OLD CART as a guide, and then the assessment, furthermore, of trying to establish the exact type whether it be somatic, visceral or neuropathic. And, what is the impact of that pain on the patient's life? Are they able to do their normal activities? Are they able to care for themselves? That's an important part of the assessment. And with OLD CART, you may have already assessed some of the relieving factors. But, it's important to do an in-depth assessment of any current or prior interventions. And, again, I refer to that assessment of total pain. First step, absolutely, assessment. But we can't – and then the development of plan of care comes from that. And with interventions, of course, there is the pharmacologic interventions, and non-pharmacologic, and other modalities that I'll speak to further, the importance of documentation, and, of course, the reassessment. And in reassessment, the reassessment of pain, but then reassessment absolutely of any side effects of the interventions you've recommended. So, it's important if a patient, for example, is on opioids. It's extremely common for patients to stop opioids because of constipation so, or you know, avoid them to begin with. So that would be an example of the importance of side effects and how to assess them as you're assessing also the pain, the physical pain. Because, yes, we do have

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admissions related to pain because of constipation from the opioids they were trying to take for that pain. So, on the next slide, you know certainly all the steps, as well as the elements I referred to.

And it's really important to recognize with this, the steps are really a continuous loop, that each element of evidence-based pain care leads to the next. And one has to come back from the assessment, yes, the plan of care. What are your interventions? What have you documented? And then, absolutely the reassessment, in order to see the benefits of your interventions and to reassess completely with all the same depth of the initial assessment to then, to assess if the plan of care was accurate, best for the patient or needs to change. And this assessment is not only the concept of a continuous loop. It's certainly when there is new pain and a new treatment plan, but also at all times if the patient has been on a regimen for medication or other intervention that's been helpful. Perhaps it's time and the pain source, the cause of the pain, is no longer there that you can actually change the intervention, so that the review with medication the patient is still on are really necessary for relief of that pain. And with assessment and reassessment the importance of certainly, again, keep going through this continuous loop. Next slide, please.

So when we talk about a plan of care, and I have to address on this slide a little bit more detail, this concept of we can very easily and very obviously – in oncology we can think of pharmacological interventions that can help for the pain, and as Tom referred to, there's some valuable evidence-based guidelines for how to treat pain, that's important to refer to. But it's not sufficient to just think about the pharmacological. It's really important to also consider the non-pharmacological approaches to relieve that physical pain and distress, maybe some of the non-physical pain that a patient's reporting. And absolutely, how do we plan to monitor the response to the intervention with follow-up? And that must absolutely be about reassessment, as I mentioned in the previous slide. But the concept of assessment and reassessment, also the patient's understanding of their pain, their understanding of their treatment plan this is essential to know if they are adhering to it and why, if there are any barriers to adherence,

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whether it be financial barriers or fears of the interventions, such as opioids. And then if we can truly assess and monitor the response, follow-up in that continuous loop, then we can truly get to successes and improvements in pain, when it's been reported. The next slide, please.

So, for developing that plan of care when non-pharmacological interventions may be appropriate or when pharmacological interventions are appropriate, but through perhaps a speciality service are appropriated, it's extremely important to certainly document that and consider, of course, the speciality services. And, as you're documenting, and really the importance of when you're making the referral, to indicate relative compliance for 0383 and 0384, the importance of actually indicating the reason, as related to pain, for your referral to these speciality services. So for patients with psychosocial concerns and worries about taking their pain medication and its impact, perhaps on their work, they may benefit from a follow-up for social work. For patients who are experiencing those existential concerns or spiritual concerns, religious concerns, looking to your chaplaincy or pastoral care team. For those who are worried about finance and that's what's impacting their ability to actually take their medication that's prescribed or access the other of the speciality services, a financial coordinator can be an appropriate referral. Arts in Medicine, that is one of the services that we do have at Moffitt that can absolutely help in, and in collaboration with, integrative medicine, that look to support positive coping strategies with music, art, yoga, meditation approaches that can actually, or been shown to help, reduce the need for opioids or other pharmacological interventions and certainly other speciality services like palliative care. And I'll speak to that in a little bit more detail next. But certainly physical medicine and rehabilitation with physical therapy and occupational therapy can help with positioning even and improving strength to decrease pain. And then, the last on this list I haven't described yet, is behavioral medicine. So those who require assistance from psychological support or psychiatric support, for those who may have more of some of the perhaps psychogenic reasons for pain, as Tom alluded to. Now certainly not, I acknowledge that maybe all practices don't have access to all of these services, but I do want to stress

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that pain relief does not only come from pharmacological interventions. And it's important to refer and appropriate to refer and document that and include that in your plan of care for relief of pain. The next slide, please.

So on this slide I want to discuss the importance of palliative care for those with uncontrolled pain. So for your patients that have been seen on numerous visits and you've tried as a team with some primary interventions for that pain control, but the relief is not, it is not, the patient, unfortunately, is not achieving pain relief. It's really important to consider the value of adding palliative care speciality services. So palliative care, as we recognize it in this day and age, is truly recognized as an extra layer of support that a speciality team works in collaboration with the primary team. And the American Society of Clinical Oncology, in its most recent guidelines related to palliative care, known as the Guidelines for Integration of Palliative Care (Integration of Palliative Care Into Standard Oncology Care: American Society of Clinical Oncology Clinical Practice Guideline Update) and the standard for oncology care, recognizes that inpatients and outpatients with advanced cancer should receive dedicated palliative care services early in the disease course and concurrent with active treatment. So, it's a big shift in oncology care in recognition that palliative care has value at time of diagnosis with advanced cancer and it's not something that's solely for end-of-life care. But palliative care truly can help with symptom control, avoid, help avoid that hospitalization and actually has been shown in some studies like, for example, Temil et al. in 2010 that actually palliative care and early symptom management and relief of pain can actually help prolong life. So how do we know when a patient needs palliative care? It's not only just a diagnosis of advanced cancer, but within our facilities, where there may or may not be the appropriate resources for all patients in pain to be able to refer to palliative care, it's very important to consider some of the triggers to really focus on palliative care based on the patient's needs. So referral to palliative care, has been as adopted in this list, here on this slide, is adopted from the National Comprehensive Cancer Network Palliative Care Guidelines. So, first one, certainly. Patients who are experiencing significant burden from the disease or from treatment such as, related to this presentation, that

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they've had uncontrolled pain; but, of course, other sources of pain that's significant social or psychosocial; spiritual distress, if they have impaired performance status; if they're uncertain about their goals of care or treatment; and then, most importantly, of course they acknowledge the important role of the patient or family requesting services. So this is a guideline to consider for patients who need palliative care based on these guidelines, and certainly for those with uncontrolled pain. If the primary interventions by the team of the oncologists have not been successful then to look to referral to palliative care as appropriate. Next slide, please.

So up to now we've discussed certainly a screening process, an approach to comprehensive team assessment, how to develop an appropriate plan of care that's evidenced-based and how to help, really help, that patient who's in pain be relieved of their pain. All of these elements have extreme value, but if it's not documented it's not truly been done. So I want to talk now about the idea of how to document this plan of care of pain. And, of extreme importance, I want to certainly stress the idea of, in order to promote good documentation, of plan of care in compliance with measures like 0383 and 0384. It's essential to truly create templates as the starting point, templates in your documentation. So within Electronic Health Records, how to create templates that have fields for all the elements of the comprehensive assessments once the patient has said "Yes", elements to promote reassessment elements in that Electronic Health Record template for actual features of the plan of care. There can be ideas even with this electronic template. There can be shortcuts for using – I know in some institutions they're called macros – that you can actually have terminology linked with the pain descriptors and common interventions for those types of pain that can be used to be able to help promote ease of documentation and efficiency with documentation by creating those templates and some shortcuts of commonly used interventions. And then, extremely important for the documentation, is also in support of realization of the plan of care, is certainly the reviewing within your team the role of all the team members in pain management. That concept of being able to refer to the appropriate primary provider, perhaps in your documentation, refer to the nurse for further education or

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counselling as appropriate for pain control and the idea that all must address the symptom when patients do have pain and educate appropriately and how to document that. And certainly related to that and the value of actually using something like ESAS as a patient reported outcome, there is also importance of value of educating and empowering patients to report their pain and all symptoms to be part of the success in being able to screen, assess, provide care for pain and help relieve that pain. So next slide, please.

In closing, I'd like to just highlight the importance of creating processes to support compliance overall. So I've referred to the importance of standardized processes, including standardized questionnaires, whether it be administered by a clinician or a team member, such as a medical assistant, or ideally, and really best practice, is to ask the patient directly, and using standardized, validated patient report questionnaires can help facilitate that, to support compliance certainly with clear roles and responsibilities with the team of who's screening, who's assessing, where referrals are occurring and how that care is delivered and coordinated. With opportunities to actually assess, screen, and we can leverage our clinical practice guidelines from the NCCN, from ASCO, to help support best practices and interventions and referral, as appropriate, for relief of pain. And certainly, that last and the most important point, is being able to help support documentation with good standardized templates to help again support compliance. And, finally, as all these wonderful measures, such as 0384 and 0383, are being monitored by our teams at our institutions, the value of providing timely feedback to providers so they know how they're doing is of extreme importance. So the value of helping clinicians know they may see now, like with ESAS, that the pain has been screened, the importance of providing the feedback that they've truly assessed appropriately and documented that plan of care to be able to, to be able to support full compliance and then encourage them to improve their compliance over time with that feedback. And with that I conclude my part of the presentation. Thank you so much for your attention. And I'd like to turn it back to Tom.

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Tom Ross:

Thanks, Sarah. Slide 46, please. For our last six minutes I'm going to go over a few important program notes, beginning on slide 47, please.

The subscribers to the PCHQR Program notifications would have received a listserve today outlining the information on the next three slides. There is a dry run of the Outpatient Chemotherapy measure coming up. It will be conducted for the period of August 15–September 14 and the purpose is to familiarize the PCHs with the reporting of the measure we are discussing today in advance of calculating the actual performance on a yearly basis, as was specified in the rule and in the future, when public reporting is finalized for this measure, so that you're prepared for that. So slide 48, please.

So CMS will be providing the facilities with an FSR, one of the abbreviations I mentioned, via the *QualityNet Secure Portal* at the start of the dry run. And so on the listserve you see instructions on that. It will appear, as tested yesterday, in your auto-route mailbox for your Security Administrators. It's important to note that the FSRs will contain patient-level data, in addition to your facility's specific results, and state and national results. The state and national results you see will be specific to the PCHs, but, remembering that these reports contain patient-level data, be sure you adhere to all institutional safeguards on sharing this report. And if you do share the report at all with the measure developer or with us as your support contractor, do not send it via regular email because it contains patient-level data. Be sure you use Secure File Transfer, which is secure. CMS will be holding the National Provider Call and you will see more information on this, but be sure to block your calendars for Wednesday, August 23rd at 1:00 Eastern Time. So next slide, please.

There will be more information about this in the near future on *QualityNet* on the PCHQR Program tab. Under the Measures tab, there will be a new tab for Chemotherapy Measure Dry Run. And CMS encourages you to review the measure results and ask any questions you have about the measure, either your results or the methodology, and to send the questions about the chemotherapy measure to the measure developers at their email

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address. CMSChemotherapyMeasure@yale.edu is on this slide and in the listserv as well. So slide 50, please.

Upcoming events: On August 24th, Caitlin Cromer, your CMS Program Lead and Lisa Vinson, my colleague here at the VIQR Support Contractor, will be presenting the PCHQR impacts from the Fiscal Year 2018 IPPS/LTCH Final Rule. Then, in September and November, we're going to have Best Practices similar to today. So I'll be looking for volunteers from other PCHs for those topics. On October 26, we'll discuss new program measures and then on December 14th we will provide a Look Back and a Look Ahead. Slide 51, please.

As far as upcoming important dates, you're all aware that we're coming up to the August 15th data submission. You'll be using the Web-Based Data Collection Tool for your CST measures, for your OCM and your EBRT data. A couple of PCHs have already submitted data on that, so we know it's working. Thank you. And the CDC will be submitting your quarter one 2017 HAI data. August 31st is the deadline for the Fiscal Year 2018 DACA. There's still a couple of PCHs to complete that, so please be sure you do that. Then you can see the future reporting for HCAHPS and more PCHQR Program data. Next slide, please.

Here we see our upcoming dates for *Hospital Compare*. Yesterday, actually, was the refresh of the data for July. And here you can see what will be refreshed on October and December. October's refresh, the preview period is currently open, and anticipated refreshing is to occur on the October 25th. And then December is in the feature, but will include a lot of new data being refreshed with the refreshing on December 20th. Next slide, please.

We have two EBRT questions we wanted to briefly touch on for you. The first one, one of our providers asked that in the 2016 data abstraction tools for NQF 1822, there is exclusion criteria for "patient reasons." This disappeared in 2017. What happened? Well, if you remember, the original CPT codes were for radiation treatment planning. And those were changed, to help you extract more readily the data, to radiation therapy

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administration. And if the right EBRT was administered, as indicated by the new CPT codes, obviously the patient did not decline the therapy, so therefore the “patient reasons” was removed. And then secondly they asked, there used to be ICD-10 and CPT codes for some of the exclusion criteria, for example, for SBRT, SRS, and spinal cord compression. We removed these because, by using those CPT and ICD-10 codes, you may inadvertently remove a patient from the denominator. So, for example, a patient could have an active diagnosis of spinal cord compression, and currently be getting an EBRT to let’s say their clavicle. Well, the spinal cord compression doesn’t have anything to do with the EBRT to the clavicle, so really you should not use codes for those exclusionary criteria, but rather rely upon chart review. So we’re at the top of the hour. Deb, I’m going to turn it over to you for a brief look at CE and then we’ll wrap up. Deb?

Debbie Price:

Well, thank you, Tom. Since most of the people on this call have already received CEs from us, I’m going to go through the slides very quickly. This webinar has been approved for one continuing education credit by the boards listed on this slide. Please follow the directions on slides 55 and 56, if you have had any problems with the CE process. This is what the survey will look like, as soon as my last slide closes out. In the very bottom right-hand corner is the “Done” button. So as soon as you’re done with the survey hit the “Done” button, and then this page pops up. If you’ve not had any problems getting your certificate, you’re going to click on the green “Existing User” link. But, if you have had issues, please click on the green “New User” link. This is what the “New User” link looks like. You will register your first name, last name. We are asking you to put a personal phone number and a personal email into this particular spot so we don’t have any firewall working.

This is what the “Existing User” link takes you to. The username is your complete email address, including what’s after the @ sign, and, of course, your password. If you forgot your password, click into the box and you will be prompted to create a new password. And now I’m going to turn the ball back to Tom, your Team Lead. Tom?

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Tom Ross:

Thanks, Deb. So honoring everyone's time, I'd like to briefly close and just say thank you for your time and attention today. Thanks for all the care that you provide to our patients. And I hope that today's program gives you some good ideas to share with your teams about effectively mitigating pain in the ambulatory patient population. Thanks and have a great afternoon.