2020 QI Project FAQs

What is the rapid improvement cycle?

- Refer to the MSQC Website=-https://msqc.org/wp-content/uploads/2019/12/2020-QI-Webinar-Slides-December-2019.pptx

What should be collected for the ERP variables?

- Refer to the MSQC website= https://msqc.org/wp-content/uploads/2020/01/2020-QI-Implementation-Goals-Measure-6-7-1.pdf

Most sites will not have a baseline for the 4 ERP tab measures from Quarters 2-3 2019, so how will the baseline be determined?

- If the ERP tab measures for the selected procedure groups were not collected during 2019, you can compare your performance to Quarter 4 -2019 and Quarter 1 -2020 (case dates October 1, 2019 - March 31, 2020) for the two chosen procedure groups. MSQC will be distributing this baseline data to each site once the periods lock, and will continue to provide updates in your Box folder throughout the year. Each site will perform their own tracking to determine if their interventions are effective at improving performance and reaching the **80% goal for the project.**

When Toradol is given at the end of the surgery is it included in intraop or postop multimodal pain management?

- **Short answer- No, it counts toward neither intraop or postop.**
- For intraop-- if Toradol is given at the end of the case it is not being used for intraop pain management. It is meant for controlling pain in the post op setting.
- The definition and the QI measure require that *postop medications* be ordered *after "out of room"* time. The **only** exception to this is a regional block or local analgesia wound infiltration placed at the end of the case, which can be included as one type of postop multimodal pain management, as identified within the definition.

How do you decide whether a TAP block or local analgesia wound infiltration is considered for intraop or postop multimodal pain management?

- For this you do need to look at the timing of the block/local analgesia--if given before or near the start of surgery it is included in intraop multimodal. If it is given toward the end (typically near or after closing the incision) it is considered one type of postop multimodal.

Example:

General Anesthetic. Incision start time **1322** Incision close time **1439**

Marcaine 0.5% injected into operative site at 1333 = **Intraop**

Lidocaine 1% with epi injected in operative site at 1420 =**PostOp**

What kind of *pre-op* pain management teaching is acceptable to answer "YES"?

- If there is documentation of preadmission/preoperative pain management teaching, or you know this is occurring, you can answer "YES". The patient teaching needs to include written (pamphlet, booklet and/or handout) and verbal instructions from healthcare personnel.
- Ideally this would take place in the surgeon's office or in a pre-anesthesia testing (PAT) area sometime before the day of surgery, but could also take place on the day of surgery in preop holding if it didn't occur before.
- In addition to determining 'where' preadmission/preop teaching is being done, what is more important is that you know 'what' patients are being taught regarding care and expectations related to the surgery (i.e., preop care, postop care, pain management expectations/goals). Knowing this would mean observing in PAT and learning what the patient is taught while they are there, or touching base with the surgeon's office to know what is covered in their instructions. The documentation of the process/protocol does not need to be explicit. Also, you might be able to obtain this information from the patient at 30 day follow up**. The 2020 MSQC definitions manual (pg. 211) lists acceptable documentation.**
- If you discover that verbal and written preop teaching/counseling specifically about pain management is not being done, you would report 'NO' (and that would be a great place to start for the 2020 QI project).
- If your hospital is using the 'Start Talking Form', a patient signature means someone has educated them about safe opioid use. Just signing the form is not sufficient for this variable due to the fact that this is a state required form that many just have the patients sign as part of their admission paperwork, and it only includes opioid use teaching. This form should be used in addition to other verbal and written instructions.

What kind of *post-op* pain management teaching is acceptable to answer "YES"?

- There is no time frame associated with the measure, so as long as the teaching is post-op before the patient leaves the hospital, and includes written and verbal instruction about how the patient should manage pain and includes multimodal pain management teaching, it is included.
- Verify what the patients are actually taught and what written materials they receive by going to the PACU and inpatient units to observe the process. This will likely be documented in PACU notes (for outpatient) or nursing floor notes (inpatient) and could be part of a standardized plan of care, but if unable to locate where this is being documented, have a conversation with the PACU/inpatient unit staff to ensure it is being documented.
    - For outpatients, if PACU staff are telling patients to take Tylenol and Motrin at home, it needs to be included in the written discharge summary that is given to the patient. Conversely, do not assume that verbal teaching has been done just because Tylenol and Ibuprofen are on the discharge instructions. If the Tylenol and Motrin instructions are on the discharge papers, and it is documented that verbal instructions are given with patient understanding, you can answer 'YES'.
- If no documentation that teaching occurred was available, but in doing follow up with the patient they confirm that they were taught about pain management including multimodal use (with written handouts), enter 'YES'.

- Michigan OPEN offers a brochure that can be customized with your hospital logo and it covers a lot of information on multimodal and safely using opioids after surgery. https://michigan-open.org/wp-content/uploads/2019/05/190192-M-OPEN-Surgical-ToPost.pdf While the brochure is good, it should be used as a "supporting" material, nursing staff should chart that the brochure was given and instructions for pain management were verbally discussed.
- If your hospital is using the 'Start Talking Form', a patient signature means someone has educated them about safe opioid use. Just signing the form is not sufficient for this variable due to the fact that this is a state required form that many just have the patients sign as part of their admission paperwork, and it only includes opioid use teaching. This form should be used in addition to other verbal and written instructions.

How do I capture the order of postop multimodal pain management for outpatient surgeries?

- We understand that patients might not have two postop non-opioid analgesics ordered in the hospital if they go home a few hours after surgery, but these patients would also benefit from multimodal pain medications with only taking opioids as needed. For example, if the patient is instructed to alternate Tylenol and Motrin, and to take oxycodone only as needed, then this should be printed on the discharge instructions sheet that is given to the patient. This example can be captured in the workstation as 'ordered' for multimodal postop pain management.
- It's not necessary that an actual 'script be written for Tylenol/Motrin, and both medications/strategies do not need to be administered before leaving the hospital for this measure. Also remember, regional blocks and local wound infiltration placed at the end of surgery will count as one of the postop multimodal pain strategies.

My surgeons want to prescribe Norco/Tylenol 3/Ultram, is there a penalty for this?

- There is no penalty for prescribing an opioid other than Oxycodone if the OME calculation is at or below the recommended OME amount for that procedure. The total OME of the 'script is calculated in order to determine whether the recommendation was exceeded. Here is a great OME calculator to compare the daily morphine equivalent doses: https://www.oregonpainguidance.org/opioidmedcalculator/

If a PRO email response has "No" to the question "did you have a prescription for a narcotic/opioid based pain medication" but the EMR clearly states the type, dose and amount of the script the patient was given. How should I be answering this?

- The EMR is the source of truth for this question. So you would need to capture the prescription (Opioid Type, Dose, Unit, and Quantity based on the EMR). Since the patient states they did not get a prescription you would answer "NO" to the prescription being filled. For 2020 cases, when you answer 'NO' to the prescription being filled it will disable the remaining questions including 'how many doses were taken', so it will not impact the collaborative-wide measure.

Are the M-OPEN recommendations the same for chronic opioid users?

- M-OPEN does not endorse surgeons overprescribing to treat chronic pain, because the data shows that if patients are prescribed more pills, they will take more pills. In addition, MSQC has not stipulated that chronic pain patients are to be excluded from the 2020 QI Project, instead these patients will be included as part of the overall data analysis, realizing they may fall into the 10% non-compliance allotment when prescribers use their best judgement for the patient. As we do every year, once we evaluate all sites participating in the project, if fewer than half the sites achieve 90% compliance, we will re-evaluate the target goal accordingly to be sure that at least half the collaborative receives full points for the measure.

Can you provide an example of "the practice model for providing intraop pain management"? Would this be a specific pain management pathway?

- For goal #5 we are looking for a document order set and/or the practice model for providing intra-op pain management. This should include the multimodal pain management options that are used at your facility. If you look at the Care Pathways on the MSQC website, they all contain multimodal pain management within them. Also included in the 2019 Opioid Project there is a pain management pathway example. For this measure we are just looking for the intra-op pain management which is part of the pathway. https://msqc.org/wp-content/uploads/2019/02/opioid-sparing-pain-pathway.pdf

Regarding the 100% of ALL procedures with complete discharge prescription measure, is this stating that if there is one case where the amount of pills prescribed was not documented, we will miss all 10 points for this metric or will this be a tiered metric? For example, if our site has a score of 98-99%, would we lose ALL 10 points for this measure?

- In order to have a complete discharge prescription, the prescription needs to contain **all 4 elements:** Opioid name, dose, unit and quantity prescribed. We will assess the scoring measure for all sites including the scoring distribution, then consider tiered scoring for that element if warranted. In 2019, we have a large number of sites who are successfully collecting 100% of the discharge prescriptions.