**National Quality Forum—Evidence (subcriterion 1a)**

**Measure Number** (*if previously endorsed*)**:** 0383

**Measure Title**: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology

**IF the measure is a component in a composite performance measure, provide the title of the Composite Measure here:** Click here to enter composite measure #/ title

**Date of Submission**: 11/1/2019

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| **Instructions**  *Complete 1a.1 and 1a.2 for all measures. If instrument-based measure, complete 1a.3.*  *Complete* ***EITHER 1a.2, 1a.3 or 1a.4*** *as applicable for the type of measure and evidence.*  *For composite performance measures:*  *A separate evidence form is required for each component measure unless several components were studied together.*  *If a component measure is submitted as an individual performance measure, attach the evidence form to the individual measure submission.*   * All information needed to demonstrate meeting the evidence subcriterion (1a) must be in this form. An appendix of *supplemental* materials may be submitted, but there is no guarantee it will be reviewed. * If you are unable to check a box, please highlight or shade the box for your response. * Contact NQF staff regarding questions. Check for resources at [Submitting Standards webpage](http://www.qualityforum.org/Measuring_Performance/Submitting_Standards.aspx). |

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| **Note: The information provided in this form is intended to aid the Standing Committee and other stakeholders in understanding to what degree the evidence for this measure meets NQF’s evaluation criteria.**   1a. Evidence to Support the Measure Focus The measure focus is evidence-based, demonstrated as follows:   * Outcome: [**3**](#Note3) Empirical data demonstrate a relationship between the outcome and at least one healthcare structure, process, intervention, or service. If not available, wide variation in performance can be used as evidence, assuming the data are from a robust number of providers and results are not subject to systematic bias. * Intermediate clinical outcome: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4)that the measured intermediate clinical outcome leads to a desired health outcome. * Process: [**5**](#Note5) a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured process leads to a desired health outcome. * Structure: a systematic assessment and grading of the quantity, quality, and consistency of the body of evidence [**4**](#Note4) that the measured structure leads to a desired health outcome. * Efficiency: [**6**](#Note6) evidence not required for the resource use component. * For measures derived from patient reports, evidence should demonstrate that the target population values the measured outcome, process, or structure and finds it meaningful. * Process measures incorporating Appropriate Use Criteria: See NQF’s guidance for evidence for measures, in general; guidance for measures specifically based on clinical practice guidelines apply as well.   **Notes**  **3.** Generally, rare event outcomes do not provide adequate information for improvement or discrimination; however, serious reportable events that are compared to zero are appropriate outcomes for public reporting and quality improvement.  **4.** The preferred systems for grading the evidence are the Grading of Recommendations, Assessment, Development and Evaluation [(GRADE) guidelines](http://www.gradeworkinggroup.org) and/or modified GRADE.  **5.** Clinical care processes typically include multiple steps: assess → identify problem/potential problem → choose/plan intervention (with patient input) → provide intervention → evaluate impact on health status. If the measure focus is one step in such a multistep process, the step with the strongest evidence for the link to the desired outcome should be selected as the focus of measurement. Note: A measure focused only on collecting PROM data is not a PRO-PM.  **6.** Measures of efficiency combine the concepts of resource use and quality (see NQF’s [Measurement Framework: Evaluating Efficiency Across Episodes of Care](http://www.qualityforum.org/Publications/2010/01/Measurement_Framework__Evaluating_Efficiency_Across_Patient-Focused_Episodes_of_Care.aspx); [AQA Principles of Efficiency Measures](http://www.aqaalliance.org/files/PrinciplesofEfficiencyMeasurementApril2006.doc)). |

**1a.1.This is a measure of**: (*should be consistent with type of measure entered in De.1*)

Outcome

Outcome: Click here to name the health outcome

Patient-reported outcome (PRO): Click here to name the PRO

*PROs include HRQoL/functional status, symptom/symptom burden, experience with care, health-related behaviors.* (*A PRO-based performance measure is not a survey instrument. Data may be collected using a survey instrument to construct a PRO measure.)*

Intermediate clinical outcome (*e.g., lab value*): Click here to name the intermediate outcome

Process: Plan of care to address pain at each visit for patients receiving chemotherapy or radiation therapy

Appropriate use measure: Click here to name what is being measured

Structure: Click here to name the structure

Composite: Click here to name what is being measured

**1a.2** **LOGIC MODEL** Diagram or briefly describe the steps between the healthcare structures and processes (e.g., interventions, or services) and the patient’s health outcome(s). The relationships in the diagram should be easily understood by general, non-technical audiences. Indicate the structure, process or outcome being measured.

Proper pain management is critical to achieving pain control. Pain has a severe impact on a patient’s quality of life (1). Additionally, cancer pain is associated with numerous psychosocial responses (2-3). One third of patients describe cancer pain as intolerable aspect of cancer (4). Adequate pain treatment results in clinically relevant improvement in health-related quality of life (5). This is reflected in the most recent National Comprehensive Cancer Network (NCCN) guidelines, which stated that “unrelieved pain denies patients comfort and greatly affects their activities, motivation, interactions with family and friends, and overall quality of life” (6). Moreover, the importance of assessing pain in cancer patients is included in European guidelines, which go as far to say that despite published guidelines and education programs on the assessment and treatment of cancer related pain, unrelieved pain continues to be a substantial concern in patients worldwide (7). Given that it is projected that there will be over 15 million cancer patients in 2020 worldwide, this only increased the importance of addressing address patient pain (8).

1. IASP. 2008-2009 Global Year Against Cancer Pain 2008. Available at: https://www.iasp-pain.org/GlobalYear/CancerPain. Accessed October 17, 2019.

2. Kroenke K, Theobald D, Wu J, et al. The association of depression and pain with health-related quality of life, disability, and health care use in cancer patients. J Pain Symptom Manage 2010;40:327e341.

3. Porter LS, Keefe FJ. Psychosocial issues in cancer pain. Curr Pain Headache Rep 2011;15:263e270.

4. Breivik H, Cherny N, Collett B, et al. Cancer-related pain: a pan-European survey of prevalence, treatment, and patient attitudes. Ann Oncol 2009;20:1420e1433.

5. Puetzler J, Feldmann RE Jr, Brascher AK, Gerhardt A, Benrath J. Improvements in health-related quality of life by comprehensive cancer pain therapy: a pilot study with breast cancer outpatients under palliative chemotherapy. Oncol Res Treat 2014;37:456e462.

6. Swarm RA, Paice JA, Anghelescu DL, et al. NCCN Guidelines Panel. NCCN Clinical Practice Guidelines in Oncology – Adult Cancer Pain. Version 3. 2019. June 24, 2019.

<https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf>

7. Management of Cancer Pain: ESMO Clinical Practice Guidelines. C. I. Ripamonti, D. Santini, E. Maranzano, M. Berti, F. Roila . Ann Oncol 2012; 23 (Suppl 7): vii39-vii154.

8. Frankish H. 15 million new cancer cases per year by 2020, says WHO. Lancet 2003; 361: 1278.

**1a.3** **Value and Meaningfulness:**  **IF** this measure is derived from patient report, provide evidence that the target population values the measured ***outcome, process, or structure*** and finds it meaningful. (Describe how and from whom their input was obtained.)

**\*\*RESPOND TO ONLY ONE SECTION BELOW -EITHER 1a.2, 1a.3 or 1a.4) \*\***

**1a.2** **FOR OUTCOME MEASURES including PATIENT REPORTED OUTCOMES - Provide empirical data demonstrating the relationship between the outcome (or PRO) to at least one healthcare structure, process, intervention, or service.**

**1a.3.****SYSTEMATIC REVIEW(SR) OF THE EVIDENCE (for intermediate outcome, PROCESS, or STRUCTURE PERFORMANCE measures, including those that are instrument-based) If the evidence is not based on a systematic review go to section 1a.4) If you wish to include more than one systematic review, add additional tables.**

**What is the source of the systematic review of the body of evidence that supports the performance measure? A systematic review is a scientific investigation that focuses on a specific question and uses explicit, prespecified scientific methods to identify, select, assess, and summarize the findings of similar but separate studies. It may include a quantitative synthesis (meta-analysis), depending on the available data. (IOM)**

⮽ Clinical Practice Guideline recommendation (with evidence review)

☐ US Preventive Services Task Force Recommendation

☐ Other systematic review and grading of the body of evidence (*e.g., Cochrane Collaboration, AHRQ Evidence Practice Center*)

☐ Other

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| **Source of Systematic Review:**   * **Title** * **Author** * **Date** * **Citation, including page number** * **URL** | Swarm RA, Paice JA, Anghelescu DL, et al. NCCN Guidelines Panel. NCCN Clinical Practice Guidelines in Oncology – Adult Cancer Pain. Version 3. 2019. June 24, 2019.  <https://www.nccn.org/professionals/physician_gls/pdf/pain.pdf> |
| Quote the guideline or recommendation verbatim about the process, structure or intermediate outcome being measured. If not a guideline, summarize the conclusions from the SR. | Management of pain in opioid-naïve patients   * Select the most appropriate medication based on the pain diagnosis, comorbid conditions, and potential drug interactions. * Analgesic regimen may include an opioid, acetaminophen, nonsteroidal anti-inflammatory drugs (NSAIDs), and/or adjuvant analgesics. * Anticipate and treat analgesic adverse effects, including opioid-induced constipation. * Provide psychosocial support * Provide patient and family/caregiver education * Optimize integrative interventions * Reevaluate pain at each contact and as needed to meet patient-specific goals for comfort, function and safety.   Management of pain in opioid-tolerant patients   * Select the most appropriate medication based on the pain diagnosis, comorbid conditions, and potential drug interactions * Analgesic regimen may include an opioid, acetaminophen, NSAIDs, and/or adjuvant analgesics. * Anticipate and treat analgesic adverse effects, including opioid-induced constipation. * Provide psychosocial support. * Provide patient and family/caregiver education. * Optimize integrative interventions. * Reevaluate pain at each contact and as needed to meet patient-specific goals for comfort, function and safety.   Goals of treatment  If achieved:   * Continue routine follow-up. * Re-evaluate need for opioids and reduce if appropriate.   If not achieved:   * See Universal Screening and Assessment. * Consider pain management specialty consultation. * Consider interventional strategies or other treatments. * Consider palliative care consultation. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | Category 2A; Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate |
| Provide all other grades and definitions from the evidence grading system | NCCN Categories of Evidence and Consensus:   * Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate. * Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate. * Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate. * Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate. |
| Grade assigned to the **recommendation** with definition of the grade | Category 2A; Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate |
| Provide all other grades and definitions from the recommendation grading system | NCCN Categories of Evidence and Consensus:   * Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate. * Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate. * Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate. * Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate. |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | The NCCN guideline does not include an overview of the body of evidence used for the recommendations specific to the overall management of pain. However, the guideline does provide an in-depth discussion on the evidence, benefits and harms of specific therapies and interventions (e.g., aspirin, opioids, strategies for specific cancer pain syndromes, non-pharmacologic). This analysis includes the following summary (MS-29):   * In most patients, cancer pain can be successfully managed with appropriate techniques and safe drugs. The overall approach to pain management encompassed in these guidelines is multimodal and comprehensive. It is based on routine pain assessments, utilizes both pharmacologic and nonpharmacologic interventions, and requires ongoing reevaluation of the patient. The NCCN Adult Cancer Pain Guidelines Panel advises that cancer pain can be well managed in the vast majority of patients if the algorithms presented are systematically applied, carefully monitored, and tailored to the needs of the individual patient. |
| Estimates of benefit and consistency across studies | See Body of Evidence section. |
| What harms were identified? | See Body of Evidence section. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? | Updated guidelines continue to support this measure. |

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**1a.4 OTHER SOURCE OF EVIDENCE**

*If source of evidence is NOT from a clinical practice guideline, USPSTF, or systematic review, please describe the evidence on which you are basing the performance measure.*

**1a.4.1** **Briefly SYNTHESIZE the evidence that supports the measure.** A list of references without a summary is not acceptable.

**1a.4.2 What process was used to identify the evidence?**

**1a.4.3.** **Provide the citation(s) for the evidence.**