



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0383

Corresponding Measures:

De.2. Measure Title: Oncology: Medical and Radiation - Plan of Care for Pain

Co.1.1. Measure Steward: American Society of Clinical Oncology

De.3. Brief Description of Measure: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.

1b.1. Developer Rationale: 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 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).

This measure aims to improve attention to pain management and requires a plan of care for cancer patients be documented who report having pain to allow for individualized treatment based on clinical circumstances and patient wishes and focuses on early documentation of a pain plan of care.

Citations:

1. IASP. 2008-2009 Global Year Against Cancer Pain 2008. Available at: <https://www.iasp-pain.org/GlobalYear/CancerPain>. Accessed February 10, 2015.
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. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Adult Cancer Pain. Version 2, 2017. Available at: <http://www.nccn.org>.
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.
<p>S.4. Numerator Statement: Patient visits that include a documented plan of care* to address pain. *A documented plan of care may include: use of non-opioid analgesics, opioids, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.</p> <p>S.6. Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain</p> <p>S.8. Denominator Exclusions: None</p>
<p>De.1. Measure Type: Process</p> <p>S.17. Data Source: Paper Medical Records, Registry Data</p> <p>S.20. Level of Analysis: Clinician : Group/Practice</p>
IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 Most Recent Endorsement Date: Jul 31, 2020
<p>IF this measure is included in a composite, NQF Composite#/title:</p> <p>IF this measure is paired/grouped, NQF#/title: 2100:Paired Measure 0383 and 0384</p> <p>De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? 2100:Paired Measure 0383 and 0384</p> <p>This measure is paired with NQF #0384 Oncology: Medical and Radiation - Pain Intensity Quantified, which assesses whether there is documentation of a clinical assessment for the presence or absence of pain using a standardized tool. These measures together represent a stepwise approach to attenuating pain that commonly results from cancer therapy. This measure requires the initial and ongoing assessment and quantification of pain which are required to formulate the most appropriate plan with the intent of improving patient outcomes.</p>

<p>1. Evidence, Performance Gap, Priority – Importance to Measure and Report</p> <p>Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. <i>Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.</i></p>
<p>1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form 383_NQF_EvidenceAttachment_1.23.17.docx, NQF_evidence_attachment_0383_110819_FINAL-637091624174224446.docx</p> <p>1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission? Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence. No</p>
<p>1b. Performance Gap Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:</p> <ul style="list-style-type: none"> considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or Disparities in care across population groups. <p>1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure) <i>If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.</i></p> <p>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 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</p>

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).

This measure aims to improve attention to pain management and requires a plan of care for cancer patients be documented who report having pain to allow for individualized treatment based on clinical circumstances and patient wishes and focuses on early documentation of a pain plan of care.

Citations:

1. IASP. 2008-2009 Global Year Against Cancer Pain 2008. Available at: [https://www.iasp-pain.org/GlobalYear/Cancer Pain](https://www.iasp-pain.org/GlobalYear/CancerPain). Accessed February 10, 2015.
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. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Adult Cancer Pain. Version 2, 2017. Available at: <http://www.nccn.org>.
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.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*
Data from 2015-2017 for this measure from the CMS Physician Quality Reporting System (PQRS) and the Merit-based Incentive Payment System (MIPS) demonstrate a continued opportunity for improvement.

2015:

88 eligible groups

4,643 patients

Mean: 83.43%

Confidence Interval for mean: (0.78, 0.89)

Minimum: 0.00%

Maximum: 100.00%

25th percentile: 77.60%

75th percentile: 100.00%

2016:

106 eligible groups

15,268 patients

Mean: 89.11%

Confidence Interval for mean: (0.85, 0.93)

Minimum: 25.55%
Maximum: 100.00%
25th percentile: 89.72%
75th percentile: 100.00%

2017:
244 eligible groups
88,854 patients
Mean: 75.24%
Confidence Interval for mean: (0.71, 0.80)
Minimum: 0.00%
Maximum: 100.00%
25th percentile: 64.25%
75th percentile: 100.00%

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. (*This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.*) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

While this measure is included in the MIPS program, this program has not yet made disparities data available for us to analyze and report.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

Studies and analyses of existing data demonstrate that patients with cancer continue to receive disparate treatment for pain. These differences demonstrate a continued need to evaluate the extent to which patients are adequately treated to address their pain. Examples of these disparities are highlight below.

Patients with cancer treated in centers with primarily minority populations have been shown to be three times more likely to have inadequately controlled pain than Caucasian, more affluent patients (1-3).

A study of 116 women in two programs with the aim of advocating, assisting, and supporting women with cancer in an urban area of northern California (4) found that being of low socioeconomic status, being Latino, and having a mastectomy followed by chemotherapy were important indicators for increased symptoms and poor pain management.

A recent study examined data from 4707 cancer survivors who reported experiencing pain from their cancer (5). A multilevel, socioecological, conceptual framework was used to generate a list of 15 barriers to pain management, representing patient, provider, and system levels. The study included separate multivariable logistic regressions for each barrier identified sociodemographic and health-related inequalities in cancer pain management, controlling for years since diagnosis, disease stage, and cancer treatment. The study found that two-thirds of survivors reported at least 1 barrier to pain management. While patient-related barriers were most common, the greatest disparities were noted in provider- and system-level barriers. Inequalities by race/ethnicity, education, age, and physical and mental health comorbidities were observed. Additionally, researchers found that survivors who were nonwhite, less educated, older, and/or burdened by comorbidities were most adversely affected.

Another study examined patterns of disparities in cancer pain by evaluating differences by race/ethnicity in the odds of reporting pain and in pain severity, controlling for key patient-level covariates (6). This study used data from a nationally representative cohort of colorectal and lung cancer patients. The study included 5761 individuals (14% black, 7% Hispanic/Latino, 6% Asian or Pacific

Islander, and 3% multiracial), among whom 48% reported pain. The adjusted odds of reporting differed only for multiracial patients, who were more likely to report pain than whites (odds ratio: 1.54; $P = 0.036$). However, among those with pain, severity was higher for black patients ($\beta = 6.6$; $P = 0.001$) and multiracial patients ($\beta = 4.5$; $P = 0.036$) relative to white patients. Lower educational attainment, depressed affect, and lower levels of wealth also were associated with higher pain severity. The researchers concluded that sociodemographic status, health status, and depression were associated with severity but did not explain the disparity. Interventions to address these disparities will need to focus on reported severity and patient-level factors.

One study set out to see what factors are associated with unmet needs for symptom management in patients with lung and colorectal cancer (7). This study found that 15% (791 of 5,422) of patients had at least one unmet need for symptom management. Adjusting for sociodemographic and clinical factors, African American race, being uninsured or poor, having early-stage lung cancer, and the presence of moderate to severe symptoms were associated with unmet need (all $P < .05$). Furthermore, patients who rated their physician's communication score < 80 (on a 0 to 100 scale) had adjusted rates of an unmet need for symptom management that were more than twice as high as patients who rated their physicians with a perfect communication score (23.1% v 10.0%; $P < .001$). The researchers concluded that a significant minority of patients with newly diagnosed lung and colorectal cancer report unmet needs for symptom management. Interventions to improve symptom management should consider the importance of physician communication to the patient's experience of disease.

The Outpatient Pain Clinics at Memorial Sloan Kettering Cancer Center participated in developing a pain registry to gain insight on the referral and management of cancer pain as related to demographic information, cancer history, prescription records, and interventional pain procedures stored in the institutional database. Five cohorts (subsets of one another) were defined and compared to describe demographics and differences in management and outcomes by age, race, sex, and cancer type. Clinic patients were compared with the entire institution to determine factors associated with better pain relief and reduced side effects. Researchers found that a small percentage of patients were referred to a pain specialist. A total of 1,043 patients completed 3,544 surveys. Compared with the institution, there were higher proportions of patients age 51 to 60 years, nonwhites, and patients with thoracic, abdominal, and head and neck cancers. Medical management-controlled pain with three drug categories in 40% of visits. Short-acting opioids were the only category that statistically provided good pain relief with fewer side effects. Pain scores were improved with increasing opioid dose. Management differed by sex, age, and race; women consistently had lower doses of opioids, poorer pain control, more side effects, and were prescribed a greater variety of medications.

McNeill JA, Reynolds J, Ney ML. Unequal quality of cancer pain management: disparity in perceived control and proposed solutions. *Oncol Nurs Forum*. 2007 Nov;34(6):1121-8. citing:

1. Anderson KO, Mendoza TR, Valero V, Richman SP, Russell C, Hurley J, et al. Minority cancer patients and their providers: Pain management attitudes and practice. *Cancer*. 2000; 88, 1929–1938.
2. Cleeland C, Gonin R, Hatfield A, Edmonson J, Blum R, Stewart J, et al. Pain and its treatment in outpatients with metastatic cancer. *New England Journal of Medicine*. 1994; 330, 592–596.
3. Vallerand A, Hasenau S, Templin T, Collins-Bohler D. Disparities between black and white patients with cancer pain: The effect of perception of control over pain. *Pain Medicine*. 2005; 6, 242–250.
4. Eversley R, Estrin D, Dibble S, Wardlaw L, Pedrosa M, Favila-Penney W. Post-treatment symptoms among ethnic minority breast cancer survivors. *Oncology Nursing Forum*. 2005; 32, 250–256.

Additional Citations:

5. Stein KD, Alcaraz KI, Kamson C, Fallon EA, Smith TG. Sociodemographic inequalities in barriers to cancer pain management: a report from the American Cancer Society's Study of Cancer Survivors-II (SCS-II). *Psychooncology*. 2016 Oct;25(10):1212-1221. doi: 10.1002/pon.4218. Epub 2016 Aug 12.
6. Martinez KA, Snyder CF, Malin JL, Dy SM. Is race/ethnicity related to the presence or severity of pain in colorectal and lung cancer? *Pain Symptom Manage*. 2014 Dec;48(6):1050-9. doi: 10.1016/j.jpainsymman.2014.02.005. Epub 2014 Apr 18.
7. Walling AM, Keating NL, Kahn KL, Dy S, Mack JW, Malin J, Arora NK, Adams JL, Antonio AL, Tisnado D. Lower Patient Ratings of Physician Communication Are Associated With Unmet Need for Symptom Management in Patients With Lung and Colorectal Cancer. *J Oncol Pract*. 2016 Jun;12(6):e654-69. doi: 10.1200/JOP.2015.005538. Epub 2016 May 24.
8. VT Malhotra, P Glare, KS Tan, J Wills, A Gulati, V Puttanniah, J Hung, K Cubert, C Inturrisi; The Tri-Institutional Pain Registry—Analysis of Outpatient Pain Management at a Specialized Cancer Center, *Pain Medicine*, Volume 18, Issue 12, 1 December 2017, Pages 2474–2484, <https://doi.org/10.1093/pm/pnx136>.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when

implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Cancer

De.6. Non-Condition Specific(check all the areas that apply):

Person-and Family-Centered Care

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

The updated specifications for this measure are included with this form.

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment: [NQF_evidence_attachment_0383_110819_FINAL.docx](#)

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

Attachment Attachment: [0383_NQF_PlanofCarePain_CodeSet_07312019.xlsx](#)

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment: [NQFScaleInstrument.pdf](#)

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

The measure title has been modified from Oncology: Care Plan for Pain – Medical Oncology and Radiation Oncology to Oncology: Medical and Radiation – Care Plan for Pain to align with the title of the paired measure NQF 0384.

Beginning with 2019 implementation, the measure was revised to have two populations: 1) All patient visits for patients with a diagnosis of cancer currently receiving chemotherapy OR 2) All patient visits for patients with a diagnosis of cancer currently receiving radiation therapy. This change was made to more clearly delineate the denominator requirements to promote accurate implementation. Based on feedback we heard regarding how users have implemented the measure, there was an inconsistent approach to applying the measure criteria. Therefore, we decided to split this measure out into two populations, based on the type of treatment the patient is receiving. Though the measure is split into two, the measure still requires only one performance rate for reporting.

The ICD9 diagnosis codes have been removed and the ICD10 codes remain.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patient visits that include a documented plan of care* to address pain.

*A documented plan of care may include: use of non-opioid analgesics, opioids, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patient visits that included a documented plan of care to address pain.

Time Period for Data Collection: At each visit within the measurement period for patients with a diagnosis of cancer and in which pain is present.

Guidance: A documented outline of care for a positive pain assessment is required. May include: use of non-opioid analgesics, opioids, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Time Period for Data Collection: 12 consecutive months

Denominator Criteria (Eligible Cases):

For all eligible patient encounters when pain severity quantified and pain is present (e.g., CPT II: 1125F is submitted in the numerator for NQF 0384) for patients regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy.

Guidance: This measure is an episode-of-care measure; the level of analysis for this measure is every visit for patients with a diagnosis of cancer who are also currently receiving chemotherapy or radiation therapy and a positive pain assessment during the measurement period. For patients receiving radiation therapy, pain intensity should be quantified at each radiation treatment management encounter. For patients receiving chemotherapy, pain intensity should be quantified at each face-to-face encounter with the physician while the patient is currently receiving chemotherapy.

All visits for patients, regardless of age

AND

Diagnosis of cancer

AND

Patient encounter during the performance period

AND

Patient reported pain was present
AND
Radiation treatment management encounter
OR
Face-to-face encounter with the physician while the patient is currently receiving chemotherapy

S.8. Denominator Exclusions (Brief narrative description of exclusions from the target population)
None

S.9. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)
N/A, no denominator exclusion

S.10. Stratification Information (Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)
N/A, no risk stratification

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)
No risk adjustment or risk stratification
If other:

S.12. Type of score:
Rate/proportion
If other:

S.13. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)
Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic (Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)
This measure is comprised of two populations but is intended to result in one reporting rate. The reporting rate is the aggregate of Population 1 and Population 2, resulting in a single performance rate. For the purposes of this measure, the single performance rate can be calculated as follows:
$$\text{Performance Rate} = (\text{Numerator 1} + \text{Numerator 2}) / (\text{Denominator 1} + \text{Denominator 2})$$

Calculation algorithm for Population 1: Patient visits for patients with a diagnosis of cancer currently receiving chemotherapy
1. Find the patients who meet the initial population (i.e., the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases, the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
If the patient does not meet the numerator, this case represents a quality failure.

Calculation algorithm for Population 2: Patient visits for patients with a diagnosis of cancer currently receiving radiation therapy
1. Find the patients who meet the initial population (i.e., the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases, the initial population and

denominator are identical.

3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator.

If the patient does not meet the numerator, this case represents a quality failure.

S.15. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.

Measure is not based on a sample

S.16. Survey/Patient-reported data (If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)

Specify calculation of response rates to be reported with performance measure results.

N/A, measure is not based on a survey or instrument

S.17. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.18.

Paper Medical Records, Registry Data

S.18. Data Source or Collection Instrument (Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)

IF instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.

N/A, measure is not instrument-based

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Outpatient Services

If other:

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

N/A

2. Validity – See attached Measure Testing Submission Form

0383_NQF_testing_attachment_073019_Final.docx

2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields) Update this field for **maintenance of endorsement**.

Some data elements are in defined fields in electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

All the data elements needed for this measure are collected through electronic data or through the use of keyword searches. ASCO is in the process of assessing the feasibility of developing an electronic clinical quality measure.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

If instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

Apart from the lack of availability of disparities data for analyses, we have not identified any areas of concern or made any modifications as a result of testing and operational use of the measures in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (e.g., value/code set, risk model, programming code, algorithm).

ASCO requests interested parties seek a licensing agreement prior to commercial use of this measure.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

Merit-based Incentive Payment System (MIPS)-Sponsored by the Centers for Medicare and Medicaid Services (CMS) ?Prior to 2016, this measure was used for Eligible Providers (EPs) in the Physician Quality Reporting System (PQRS). As of 2017, MIPS replaced the PQRS program. MIPS is a national performance-based payment program that uses performance scores across several categories to determine payment rates for EPs. MIPS takes a comprehensive approach to payment by basing consideration of quality on a set of evidence-based measures that were primarily developed by clinicians, thus encouraging improvement in clinical practice and supporting advances in technology that allow for easy exchange of information. Data on geographic area and number and percentage of accountable entities and patients, including level of measurement and setting, are unavailable for analysis.

QOPI® Qualified Clinical Data Registry

This measure has been reported to CMS by the registry as a Qualified Clinical Data Registry. The Quality Oncology Practice Initiative (QOPI®) was deemed as a registry for oncology measures group reporting and as a QCDR to report to PQRS in 2015 and 2016 and to report to MIPS in 2017, 2018 and 2019. Eligible professionals will be considered to have satisfactorily participated in MIPS if they submit quality measures data or results to CMS via a qualified clinical data registry. In 2017 and 2018, a total of 19 practices representing approximately 50,000 patient charts submitted to MIPS through QOPI. CMS has implemented a phased approach to public reporting performance information on the Physician Compare website.

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

According to the CY 2019 Quality Payment Program final rule, Physician Compare has continued to pursue a phased approach to public reporting under MACRA. CMS intends to make all measures under MIPS quality performance category available for public reporting on Physician Compare. These measures include those reported via all available submission methods for MIPS-eligible clinicians and groups. Because this measure has been in use for at least one year and meets the minimum sample size requirement for reliability, this measure meets criteria for public reporting but has not yet been included in Physician Compare.

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for

implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (*Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.*)

Despite not yet being included in Physician Compare, this measure meets criteria for public reporting because it has been in use for at least one year and meets the minimum sample size requirement for reliability, this measure meets criteria for public reporting

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

ASCO's measure development process is rigorous, evidence-based, and utilizes the clinical expertise of multiple standing multi-disciplinary Technical Expert Panels (TEPs) dedicated to development and maintenance of measures across the cancer continuum. During measure maintenance, TEP members are provided with full measure specifications, applicable evidence, historical measure performance data, and any external feedback or requests for clarification or updates that have been received for the measure.

Staff on ASCO's measure development team are available to receive comments and questions from measure implementers and clinicians reporting the measures. As comments and questions are received, they are shared with appropriate staff for follow up. If comments or questions require expert input, these are shared with ASCO's TEPs to determine if measure modifications may be warranted. Additionally, for ASCO measures included in federal reporting programs, there is a system that has been established to elicit timely feedback and responses from ASCO staff in consultation with TEP members, as appropriate.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

See description in 4a2.1.1 above.

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

See description in 4a2.1.1 above.

4a2.2.2. Summarize the feedback obtained from those being measured.

In addition to the feedback obtained from a multi-disciplinary technical expert panel during the measure development and maintenance process, ASCO obtains feedback and receives measure inquiries from implementers and reporters via email. No specific feedback has been received by ASCO on this measure other than recommendations to clarify the denominator population.

4a2.2.3. Summarize the feedback obtained from other users

No additional feedback has been received by ASCO on this measure. However, we will continue to solicit feedback as we perform maintenance on this measure.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

Feedback received on how users have implemented the measure indicated there was an inconsistent approach to applying the measure criteria. To address this feedback, this measure was modified in 2019 to have two populations based on the type of treatment the patient is receiving. This change was made to more clearly delineate the denominator requirements to promote accurate implementation.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

Analysis of the MIPS data from 2015 to 2017 demonstrates that practices continue to improve in the frequency with which patients who report pain have a plan of care in place. For example, the highest average (mean) performance rate was in 2016 with just under 90% performance and the third quartile (75th) was consistently reported at 100% across the three years. Interestingly, the average score was 75% in 2017 with double the number of practices and more than 70,000 additional patients, indicating that improvement in this process is possible but still needed.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

At this time, we are not aware of any unintended consequences related to this measure. We take unintended consequences very seriously and therefore continuously monitor to identify actions that can be taken to mitigate them.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

We have not observed any unexpected benefits associated with implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.
Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

0420 : Pain Assessment and Follow-Up

1628 : Patients with Advanced Cancer Screened for Pain at Outpatient Visits

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

Yes

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

Measure #420 is broadly applicable to any patients 18 years of age and older using claims. Measure #383 examines whether a plan of care is present and maintained for a population who frequently experience pain – a population in which adequate pain management is crucial. In addition, it uses registry data in addition to paper medical records. Measure #1628 targets only patients with Stage IV cancer. Our measure looks at any stage of cancer for purposes of managing pain for which chemotherapy or radiation

may be appropriate.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

[An environmental scan did not identify competing measures.](#)

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

[No appendix Attachment:](#)

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): [American Society of Clinical Oncology](#)

Co.2 Point of Contact: [Angela, Kennedy, angela.kennedy@asco.org, 571-483-1656-](#)

Co.3 Measure Developer if different from Measure Steward: [American Society of Clinical Oncology](#)

Co.4 Point of Contact: [Angela, Kennedy, angela.kennedy@asco.org, 571-483-1656-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

[Michael Hassett, MD, MPH; Measure Panel Chair;](#)

[Dana Farber Cancer Institute Boston, MA](#)

[Laura Chow, MD; Panel Member;](#)

[University of Texas; Austin, TX](#)

[Kristen Fessele, PhD, RN, ANP-BC, AOCN;](#)

[Panel Member; Memorial Sloan Kettering Cancer Center NYC, NY](#)

[Jennifer J. Griggs, MD, MPH, FASCO;](#)

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[Bonnie Labdi, PharmD, BCOP, RPh;](#)

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[Panel Member; University of Florida Gainesville, FL](#)

[Michael Soble, MD; Panel Member;](#)

[North Shore Oncology Chicago, IL](#)

[Jessica Zerillo, MD, MPH; Panel Member;](#)

[Beth Israel Deaconess Medical Center Boston, MA](#)

Caitlin Drumheller; Measure Development Specialist;
American Society of Clinical Oncology Alexandria, VA

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 04, 2019

Ad.4 What is your frequency for review/update of this measure? Annually

Ad.5 When is the next scheduled review/update for this measure? 04, 2020

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Ad.8 Additional Information/Comments: