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

**Measure Number** (*if previously endorsed*)**:** 0384

**Measure Title**: Oncology: Medical and Radiation – Pain Intensity Quantified

**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**: 4/13/2018

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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: Assessment and quantification of pain intensity 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.

Initial and ongoing pain assessments, the focus of the measure, are essential to ensure proper pain

management among patients with cancer. "Failure to adequately assess pain frequently leads to poor

control."(1) "Unrelieved pain denies [patients] comfort and greatly affects their activities, motivation,

interactions with family and friends, and overall quality of life." (1)

(1) National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Adult Cancer Pain. Version 2, 2011. Available at: <http://www.nccn.org>.

Updated guideline: There is mounting evidence in oncology that quality of life and survival are linked to early and effective palliative care, including pain management. Although improvements have been observed, undertreatment of pain remains an issue in a significant subset of patients with cancer and this issue may be exacerbated by the inappropriate application of recommendations against the use of opioids to patients with cancer in the setting of the United States opioid epidemic. A comprehensive evaluation is essential to ensure proper pain management.

National Comprehensive Cancer Network (NCCN). NCCN Clinical Practice Guidelines in Oncology. Adult cancer pain Version 1.2020. April 8, 2020. http://[www.nccn.org](http://www.nccn.org)

**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.)

Not applicable

**\*\*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** | * **Title:** Clinical Practice Guidelines in Oncology: Adult Cancer Pain. Version 2, 2011 * **Author:** National Comprehensive Cancer Network (NCCN). * **Date:** 2011 * **Citation:** National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Adult Cancer Pain. Version 2, 2011. * **URL:** <http://www.nccn.org> * **Title:** American Pain Society Recommendations for Improving the Quality of Acute and Cancer Pain Management * **Author:** Gordon DB; Dahl JL, Miaskowski C, et al * **Date:** July 25, 2005 * **Citation:** Gordon DB; Dahl JL, Miaskowski C, et al. American Pain Society Recommendations for Improving the Quality of Acute and Cancer Pain Management: American Pain Society Quality of Care Task Force. *Arch Intern Med.* 2005;165 (14):1574-1580. * **URL:** <https://jamanetwork.com/journals> /jamainternalmedicine/fullarticle/486669   **Updated 2020 NCCN guideline**   * **Title:** NCCN Clinical Practice Guidelines in Oncology – Adult Cancer Pain * **Author:** Swarm RA, Youngwerth JM, Anghelescu DL, et al; NCCN Guidelines Panel * **Date:** April 8, 2020 * **Citation:** Adult Cancer Pain, Version 1.2020, NCCN Clinical Practice Guidelines in Oncology * **URL:** <http://www.nccn.org> |
| 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. | **2011 Clinical Practice Guidelines in Oncology: Adult**  **Cancer Pain**  This algorithm begins with the premise that all  patients with cancer should be screened for pain  during the initial evaluation, at regular intervals, and  whenever new therapy is initiated. If pain is present  on a screening evaluation, the pain intensity must be  quantified by the patient (whenever possible). Since  pain is inherently subjective, patient’s self-report to  pain is the current standard of care for assessment.  Intensity of pain should be quantified using a 0-10  numerical rating scale, a categorical scale, or a  pictorial scale (e.g., The Faces Pain Rating Scale). The  Faces Pain Rating Scale may be successful with  patients who have difficulty with other scales, for  example, children, the elderly, and patients with  language or cultural differences or other  communication barriers.  **2005 American Pain Society Recommendations for**  **Improving the Quality of Acute and Cancer Pain**  **Management**  All patients should be routinely screened for pain, and  when it is present, pain intensity should be recorded in  highly visible ways that facilitate regular review by  health care providers. A standard for pain assessment  and documentation should be established in each  setting to ensure that pain is recognized, documented,  and treated promptly.  **2020 NCCN Clinical Practice Guidelines in Oncology –**  **Adult Cancer Pain**  This algorithm begins with the premise that all patients with cancer should be screened for pain during the initial evaluation, at each subsequent contact, and whenever new therapy is initiated. If pain is present on a screening evaluation, the pain intensity must be quantified by the patient (whenever possible). Since pain is inherently subjective, patients’ self-reporting of pain is the most current standard of care for assessment.  Although pain is commonly assessed using numerical or categorical ratings, some patients may experience difficulty with these scales. The Face Pain Rating Scale may be successful with patients who have difficulty with other scales, for example, children, the elderly, and patients with language or cultural differences or other communication barriers. If the patient is unable to verbally report pain, an alternative method to obtain pain rating and pain assessment must be utilized. In addition to pain intensity, the patient should be asked to describe the characteristics of his/her pain (ie, aching, burning).   * Screen all patients for pain at each contact. * Routinely quantify and document pain intensity and quality as characterized by the patient (whenever possible). Include patient reporting of breakthrough pain, treatments used and their impact on pain, satisfaction with pain relief, pain interference, provider assessment of impact on function, and any special issues for the patient relevant to pain treatment. If necessary, get additional information from caregiver regarding pain and impact on function. * Perform comprehensive pain assessment if new or worsening pain is present and regularly for persisting pain. * Evaluate for risk factors for opioid abuse/misuse/diversion. |
| Grade assigned to the **evidence** associated with the recommendation with the definition of the grade | **2011 Clinical Practice Guidelines in Oncology: Adult**  **Cancer Pain:** Category 2A; Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.  **2005 American Pain Society Recommendations for**  **Improving the Quality of Acute and Cancer Pain**  **Management:** The body of evidence in the APS guideline has not been graded. However, the APS indicates that recommendations result from literature reviews, expert experience, and consensus.  **2020 NCCN Clinical Practice Guidelines in Oncology –**  **Adult Cancer Pain**  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.   The body of evidence in the APS guideline has not been graded. However, the APS indicates that recommendations result from literature reviews, expert experience, and consensus. |
| Grade assigned to the **recommendation** with definition of the grade | **2011 Clinical Practice Guidelines in Oncology: Adult**  **Cancer Pain:** Category 2A; Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.  **2005 American Pain Society Recommendations for**  **Improving the Quality of Acute and Cancer Pain**  **Management:** The body of evidence in the APS guideline has not been graded. However, the APS indicates that recommendations result from literature reviews, expert experience, and consensus.  **2020 NCCN Clinical Practice Guidelines in Oncology –**  **Adult Cancer Pain**  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.   The body of evidence in the APS guideline has not been graded. However, the APS indicates that recommendations result from literature reviews, expert experience, and consensus. |
| Body of evidence:   * Quantity – how many studies? * Quality – what type of studies? | * **Quantity:** The description of the evidence review in the NCCN guideline did not address the overall quantity of studies in the body of evidence. However, 105 articles are cited.   The 2020 NCCN guideline also does not provide a description of the body of evidence. However, the overview and pain assessment section within the guideline cites 36 articles in support of the pain assessment concept and recommendations.  Similarly, the description of the evidence review in the APS guideline did not address the overall quantity of studies in the body of evidence. However, 82 articles are cited.   * **Quality:** The quality of the body of evidence supporting the NCCN guideline recommendations are summarized according to the NCCN categories of evidence and consensus as being based on "lower-level evidence". Lower-level evidence is later described as evidence that may include non-randomized trials; case series; or when other data are lacking, the clinical experience of expert physicians.   The quality of the body of evidence supporting the APS guideline recommendation is not provided. |
| Estimates of benefit and consistency across studies | Although there is no explicit statement regarding the overall consistency of results across studies in the NCCN guidelines supporting the measure, the recommendation received uniform NCCN consensus that the intervention is appropriate and initial and ongoing pain assessments are essential to ensure proper pain management. |
| What harms were identified? | Initial and ongoing pain assessments are essential to ensure proper pain management.  The NCCN guideline states that “…attempts should be made to determine the underlying pain mechanism and diagnose the pain syndrome.” The selection of analgesic for optimal outcomes will depend on the intensity of pain, current analgesic therapy and concomitant illnesses.  The NCCN Panel recommends monitoring patients for opioid dose reduction, such as situations in which the patient rarely or never needs breakthrough analgesics, the completion of an acute pain event, improvement of pain control through non-opioid or interventional pain management therapies, or well-controlled pain in the setting of stable disease. Additionally, the panel notes that opioid dose reduction may be considered if a patient experiences unmanageable adverse effects and/or significant safety concerns.  The NCCN Panel acknowledges the potential for misuse and abuse of opioids and recommends monitoring for aberrant medication drug-related behaviors over the course of treatment, such as with the use of the COMM (Current Opioid Misuse Measure) which helps clinicians identifying whether patients on long-term opioid therapy is exhibiting aberrant behaviors associated with opioid misuse. |
| Identify any new studies conducted since the SR. Do the new studies change the conclusions from the SR? |  |

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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.**