NATIONAL QUALITY FORUM

Measure Submission and Evaluation Worksheet 5.0

This form contains the information submitted by measure developers/stewards, organized according to NQF's measure evaluation criteria and process. The evaluation criteria, evaluation guidance documents, and a blank online submission form are available on the submitting standards web page.

NQF #: 0384 NQF Project: Cancer Project
(for Endorsement Maintenance Review) Original Endorsement Date: Jul 31, 2008 Most Recent Endorsement Date: Jul 31, 2008
BRIEF MEASURE INFORMATION
De.1 Measure Title: Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Co.1.1 Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
De.2 Brief Description of Measure: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified
2a1.1 Numerator Statement: Patient visits in which pain intensity is quantified* * Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale
2a1.4 Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy
2a1.8 Denominator Exclusions: None
1.1 Measure Type: Process 2a1. 25-26 Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records 2a1.33 Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team 1.2-1.4 Is this measure paired with another measure? No De.3 If included in a composite, please identify the composite measure (*title and NQF number if endorsed*): This measure is paired with NQF #0383 - Oncology: Plan of Care for Pain - Medical Oncology and Radiation Oncology.

STAFF NOTES (*issues or questions regarding any criteria*)
Comments on Conditions for Consideration:
Is the measure untested? Yes☐ No☐ If untested, explain how it meets criteria for consideration for time-limited endorsement:
1a. Specific national health goal/priority identified by DHHS or NPP addressed by the measure (*check De.5*): 5. Similar/related endorsed or submitted measures (*check 5.1*): Other Criteria:
Staff Reviewer Name(s):

1. IMPACT, OPPORTUITY, EVIDENCE - IMPORTANCE TO MEASURE AND REPORT
Importance to Measure and Report is a threshold criterion that must be met in order to recommend a measure for endorsement. All three subcriteria must be met to pass this criterion. See guidance on evidence.

Measures must be judged to be important to measure and report in order to be evaluated against the remaining criteria. (evaluation criteria)

1a. High Impact: H☐ M☐ L☐ I ☐
(*The measure directly addresses a specific national health goal/priority identified by DHHS or NPP, or some other high impact aspect of healthcare.*)

De.4 Subject/Topic Areas *(Check all the areas that apply)*: Cancer
De.5 Cross Cutting Areas (*Check all the areas that apply)*: Patient and Family Engagement

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, A leading cause of morbidity/mortality, Patient/societal consequences of poor quality, Severity of illness

1a.2 If "Other," please describe:

1a.3 Summary of Evidence of High Impact *(Provide epidemiologic or resource use data)*:
About 1,596,670 new cancer cases are expected to be diagnosed in 2011. (1) On January 1, 2008, in the United States there were approximately 11,957,599 men and women alive who had a history of cancer of all sites -- 5,505,862 men and 6,451,737 women, [including both persons with active disease and those who are cured of their disease.] (2) Nearly two-thirds of all cancer patients will receive radiation therapy during their illness. (3) In 2011, about 571,950 Americans are expected to die of cancer, more than 1,500 people a day. Cancer is the second most common cause of death in the US, exceeded only by heart disease. In the US, cancer accounts for nearly 1 of every 4 deaths. (1) The 5-year relative survival rate for all cancers diagnosed between 1999 and 2006 is 68%, up from 50% in 1975-1977 (1). Based on rates from 2006-2008, 41.21% of men and women born today will be diagnosed with cancer of all sites at some time during their lifetime. (2) The National Institutes of Health estimates overall costs of canc er in 2010 at $263.8 billion: $102.8 billion for direct medical costs (total of all health expenditures); $20.9 billion for indirect morbidity costs (cost of lost productivity due to illness); and $140.1 billion for indirect mortality costs (cost of lost productivity due to premature death). (1) Pain is one of the most common symptoms associated with cancer. Pain occurs in approximately one quarter of patients with newly diagnosed malignancies, one third of patients undergoing treatment, and three quarters of patients with advanced disease.(3)

1a.4 Citations for Evidence of High Impact cited in 1a.3: Quoted verbatim from the following sources:

(1) American Cancer Society. Cancer Facts & Figures 2011. Atlanta, GA: American Cancer Society; 2011.
(2) Howlader N, Noone AM, Krapcho M, Neyman N, Aminou R, Waldron W, Altekruse SF, Kosary CL, Ruhl J, Tatalovich Z, Cho H, Mariotto A, Eisner MP, Lewis DR, Chen HS, Feuer EJ, Cronin KA, Edwards BK (eds). SEER Cancer Statistics Review, 1975-2008, National Cancer Institute. Bethesda, MD, http://seer.cancer.gov/csr/1975_2008/, based on November 2010 SEER data submission, posted to the SEER web site, 2011.
(3) National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Adult Cancer Pain. Version 2, 2011. Available at: http://www.nccn.org.

1b. Opportunity for Improvement: H☐ M☐ L☐ I ☐
(*There is a demonstrated performance gap - variability or overall less than optimal performance*)

1b.1 Briefly explain the benefits (improvements in quality) envisioned by use of this measure:
The frequent assessment and quantification of pain is critical to ensure proper pain management. "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.

1b.2 Summary of Data Demonstrating Performance Gap *(Variation or overall less than optimal performance across providers)*:
[*For Maintenance – Descriptive statistics for performance results for this measure - distribution of scores for measured entities by quartile/decile, mean, median, SD, min, max, etc.*]
ASCO´s Quality Oncology Practice Initiative (QOPI®) includes an adaptation of this measure in two separate components - pain assessed by second office visit and pain intensity quantified by second office visit. Among 389 self-selected participating practices, an average performance rate of 89.49% was found for the assessment of pain component with variation among practices ranging

from 6.67% to 100% (N charts=24295). An average performance rate of 87.51% was found for thw quantification of pain component with variation among practices ranging from 23.08% to 100%. (N sites=387, N charts=21732). QOPI is a physician-led, voluntary, practice-based, quality-improvement program using performance measurement and benchmarking among oncology practices across the United States. (1)
(Includes documentation of no pain)

Among physicians participating in ASTRO's Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program, an average performance rate of 57% was reported for this measure with variation among physicians ranging from 0-100%. PAAROT is a practice improvement program that enables a physician to analyze their practice and evaluate their strengths and areas for improvement.

The measure has been in use in the CMS PQRS program since 2009. The mean performance rate for 2009 was reported as 66.83%. Unfortunately, data regarding the variability in performance rates across reporting eligible professionals is not available at this time.(3)

1b.3 Citations for Data on Performance Gap: [*For Maintenance – Description of the data or sample for measure results reported in 1b.2 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

(1) American Society of Clinical Oncology. Quality Oncology Practice Initiative. Unpublished data, fall 2011.
(2) American Society for Radiation Oncology. Performance Assessment for the Advancement of Radiation Oncology Treatment program (PAAROT). Unpublished data, 2010.
(3) CMS. 2009 Reporting Experience Including Trends (2007 – 2010): Physician Quality Reporting System and Electronic Prescribing (eRx) Incentive Program
4/4/2011. Available at: https://www.cms.gov/PQRS. Accessed 1/10/2012.

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]

A number of studies have documented disparities in pain assessment for cancer and other conditions among racial and ethnic groups, the poor, those who are less well-educated, and older adults.(1-5)

1b.5 Citations for Data on Disparities Cited in 1b.4: [*For Maintenance – Description of the data or sample for measure results reported in 1b.4 including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included*]

(1) 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.
(2) 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.
(3) Bonham V. Race, ethnicity and pain treatment: Striving to understand the causes and solutions to the disparities in pain treatment. Journal of Law, Medicine and Ethics. 2001; 29, 52–68.
(4) Herr K., Titler MG, Schilling ML, March JL, Xie X, Ardery G, et al. Evidence-based assessment of acute pain in older adults: Current nursing practices and perceived barriers. Clinical Journal of Pain. 2004; 20, 331–340.
(5)Tait RC, Chibnall JT. Racial and ethnic disparities in the evaluation and treatment of pain: Psychological perspectives. Professional Psychology: Treatment and Practice. 2005; 36, 595–601.

1c. Evidence (*Measure focus is a health outcome OR meets the criteria for quantity, quality, consistency of the body of evidence.*)
Is the measure focus a health outcome? Yes☐ No☐ If not a health outcome, rate the body of evidence.

Quantity: H☐ M☐ L☐ I☐ Quality: H☐ M☐ L☐ I☐ Consistency: H☐ M☐ L☐ I☐

Quantity	Quality	Consistency	Does the measure pass subcriterion1c?
M-H	M-H	M-H	Yes☐

L	M-H	M	Yes☐ IF additional research unlikely to change conclusion that benefits to patients outweigh harms: otherwise No☐
M-H	L	M-H	Yes☐ IF potential benefits to patients clearly outweigh potential harms: otherwise No☐
L-M-H	L-M-H	L	No ☐

Health outcome – rationale supports relationship to at least one healthcare structure, process, intervention, or service	Does the measure pass subcriterion1c? Yes☐ IF rationale supports relationship

1c.1 Structure-Process-Outcome Relationship *(Briefly state the measure focus, e.g., health outcome, intermediate clinical outcome, process, structure; then identify the appropriate links, e.g., structure-process-health outcome; process- health outcome; intermediate clinical outcome-health outcome)*:
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.

1c.2-3 Type of Evidence *(Check all that apply)*:
Clinical Practice Guideline

1c.4 Directness of Evidence to the Specified Measure *(State the central topic, population, and outcomes addressed in the body of evidence and identify any differences from the measure focus and measure target population)*:
The NCCN guidelines for adult cancer pain recommend the screening and quantification of pain for all patients with cancer.

The American Pain Society (APS) guidelines for improving the quality of acute and cancer pain management recommend routine screening for pain and a recording of intensity when present. Unlike the NCCN guidelines, the APS guidelines are not specific to adults.

The measure focus is on the quantification of pain in all patients with cancer, regardless of age, receiving chemotherapy or radiation therapy. The measure focuses on a smaller subset of patients recommended by the guidelines by also requiring that the patient be receiving chemotherapy or radiation therapy.

1c.5 Quantity of Studies in the Body of Evidence *(Total number of studies, not articles)*: 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.

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.

1c.6 Quality of Body of Evidence (*Summarize the certainty or confidence in the estimates of benefits and harms to patients across studies in the body of evidence resulting from study factors. Please address: a) study design/flaws; b) directness/indirectness of the evidence to this measure (e.g., interventions, comparisons, outcomes assessed, population included in the evidence); and c) imprecision/wide confidence intervals due to few patients or events*): 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.

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect):* 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.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:
Initial and ongoing pain assessments are essential to ensure proper pain management.

1c.9 Grading of Strength/Quality of the Body of Evidence. Has the body of evidence been graded? Yes

1c.10 If body of evidence graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: A panel of experts with members from each of the NCCN Member Institutions develops the NCCN Guidelines. Specialties that must be included on a particular panel are identified before that panel is convened but also evolve as the standard of care changes over time. This multidisciplinary representation varies from panel to panel. The NCCN Guidelines Panel Chairs are charged with ensuring that representatives of all treatment strategies are included. Many of the panels also include a patient representative, especially when issues of long-term care and patient preference are paramount in the panel´s considerations.

The following individuals were listed as panel members for the 2011 NCCN adult cancer pain guidelines cited in this submission: Amy P. Abernethy, MD; Doralina L. Anghelescu, MD; Costantino Benedetti, MD; Barry Boston, MD; Sorin Buga, MD; Charles Cleeland, PhD; Oscar A. deLeon-Casasola, MD; Mary Dwyer, MS; June G. Eilers, PhD, APRN, BC; Betty Ferrell, RN, PhD, MA, FAAN, FPCN; Kristina M. Gregory, RN, MSN, OCN; Nora A Janjan, MD, MPSA, MBA; Mihir M. Kamdar, MD; Rashmi Kumar, PhD; Michael H. Levy, MD, PhD; Maureen Lynch, MS, APRN, BC, PCM, AOCN; Joan S. McClure, MS; Natalie Moryl, MD; Suzanne A. Nesbit, PharmD, BCPS; Linda Oakes, RN, MSN; Judith A. Paice, PhD, RN, FAAN; Michael W. Rabow, MD; Robert A. Swarm, MD; Karen L. Syrjala, PhD; Susan G. Urba, MD; Sharon M. Weinstein, MD, FAAHPM

NCCN publishes individual disclosures of potential conflicts of interest for panel members, NCCN Guidelines staff, and NCCN senior management. Relationships disclosed include research funding, participation in advisory groups, participation in speakers' bureaus, employment, and equity or patent ownership. Beginning in 2010, the NCCN Board of Directors has directed that panel members compensation from external sources be less than published thresholds. These thresholds are <= $20,000 from a single entity and <= $50,000 in aggregate from any source.

Although the body of evidence in the APS guideline has not been graded, the following eleven multidisciplinary members of the APS with expertise in quality improvement or measurement participated in the update: Debra B. Gordon, RN, MS; June L. Dahl, PhD; Christine Miaskowski, RN, PhD; Bill McCarberg, MD;
Knox H. Todd, MD, MPH; Judith A. Paice, RN, PhD; Arthur G. Lipman, PharmD; Marilyn Bookbinder, RN, PhD; Steve H. Sanders, PhD; Dennis C. Turk, PhD; Daniel B. Carr, MD.

1c.11 System Used for Grading the Body of Evidence: Other

1c.12 If other, identify and describe the grading scale with definitions: NCCN Categories of Evidence and Consensus Panel members identify the level of evidence supporting each recommendation. These categories are:

•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.

1c.13 Grade Assigned to the Body of Evidence: Category 2A

1c.14 Summary of Controversy/Contradictory Evidence: No controversy or contradictory evidence reported.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:

1c.16 Quote verbatim, the specific guideline recommendation *(Including guideline # and/or page #)*:
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. (1)

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.(2)

1c.17 Clinical Practice Guideline Citation: (1) National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Adult Cancer Pain. Version 2, 2011. Available at: http://www.nccn.org.
(2)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;165:1574-1580.

1c.18 National Guideline Clearinghouse or other URL: www.nccn.org

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? Yes

1c.20 If guideline recommendation graded, identify the entity that graded the evidence including balance of representation and any disclosures regarding bias: Same as in 1c.10 above

1c.21 System Used for Grading the Strength of Guideline Recommendation: Other

1c.22 If other, identify and describe the grading scale with definitions: NCCN Categories of Evidence and Consensus Panel members identify the level of evidence supporting each recommendation. These categories are:

•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 APS guidelines recommendations are not graded.

1c.23 Grade Assigned to the Recommendation: Category 2A

1c.24 Rationale for Using this Guideline Over Others: It is the PCPI policy to use guidelines, which are evidence-based, applicable to physicians and other health-care providers, and developed by a national specialty organization or government agency. In addition, the PCPI has now expanded what is acceptable as the evidence base for measures to include documented quality improvement (QI) initiatives or implementation projects that have demonstrated improvement in quality of care.

Based on the NQF descriptions for rating the evidence, what was the developer's assessment of the quantity, quality, and consistency of the body of evidence?
1c.25 Quantity: Moderate 1c.26 Quality: Moderate1c.27 Consistency: Moderate

Was the threshold criterion, *Importance to Measure and Report*, met?
(*1a & 1b must be rated moderate or high and 1c yes*) Yes☐ No☐
Provide rationale based on specific subcriteria:

For a new measure if the Committee votes NO, then STOP.
For a measure undergoing endorsement maintenance, if the Committee votes NO because of 1b. (no opportunity for

improvement), it may be considered for continued endorsement and all criteria need to be evaluated.

2. RELIABILITY & 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. (evaluation criteria)
Measure testing must demonstrate adequate reliability and validity in order to be recommended for endorsement. Testing may be conducted for data elements and/or the computed measure score. Testing information and results should be entered in the appropriate field. Supplemental materials may be referenced or attached in item 2.1. See guidance on measure testing.

S.1 Measure Web Page *(In the future, NQF will require measure stewards to provide a URL link to a web page where current detailed specifications can be obtained*). Do you have a web page where current detailed specifications for this measure can be obtained? Yes

S.2 If yes, provide web page URL: www.physicianconsortium.org

2a. RELIABILITY. Precise Specifications and Reliability Testing: H☐ M☐ L☐ I ☐

2a1. Precise Measure Specifications. (*The measure specifications precise and unambiguous.*)

2a1.1 Numerator Statement *(Brief, narrative description of the measure focus or what is being measured about the target population, e.g., cases from the target population with the target process, condition, event, or outcome)*:
Patient visits in which pain intensity is quantified*

* Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale

2a1.2 Numerator Time Window *(The time period in which the target process, condition, event, or outcome is eligible for inclusion)*:
At each visit within the measurement period

2a1.3 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, codes with descriptors, and/or specific data collection items/responses*:
For EHR:
eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A).

For Claims/Administrative Data:
To submit the numerator option for number of patient visits in which pain intensity was quantified, report one of the following CPT Category II codes:

1125F – Pain severity quantified; pain present
OR
1126F – Pain severity quantified; no pain present

2a1.4 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

2a1.5 Target Population Category *(Check all the populations for which the measure is specified and tested if any)*: Adult/Elderly Care, Children's Health

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
12 consecutive months

2a1.7 Denominator Details (*All information required to identify and calculate the target population/denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:

For EHR:
eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A).

For Claims/Administrative Data:
All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy
Eligible patients for this measure are identified by:
ICD-9-CM diagnosis codes:
PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-9-CM CODES
ICD-10-CM diagnosis codes:
PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-10-CM CODES

AND either option 1 or 2

1. Chemotherapy
- CPT codes:
  - 99201, 99202, 99203, 99204, 99205,
  - 99212, 99213, 99214, 99215

AND
- CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration)

OR

2. Radiation therapy
- CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
None

2a1.9 Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, codes with descriptors, and/or specific data collection items/responses)*:
There are no exceptions for this measure.

2a1.10 Stratification Details/Variables *(All information required to stratify the measure results including the stratification variables, codes with descriptors, definitions, and/or specific data collection items/responses)*:
We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

2a1.11 Risk Adjustment Type *(Select type. Provide specifications for risk stratification in 2a1.10 and for statistical model in 2a1.13)*: No risk adjustment or risk stratification 2a1.12 If "Other," please describe:

2a1.13 Statistical Risk Model and Variables *(Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development should be addressed in 2b4.)*:
None

2a1.14-16 Detailed Risk Model Available at Web page URL (or attachment). Include coefficients, equations, codes with descriptors, definitions, and/or specific data collection items/responses. Attach documents only if they are not available on a webpage and keep attached file to 5 MB or less. NQF strongly prefers you make documents available at a Web page URL. Please supply login/password if needed:

2a1.17-18. Type of Score: Rate/proportion

2a1.19 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

2a1.20 Calculation Algorithm/Measure Logic*(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; aggregating data; risk adjustment; etc.)*:
To calculate performance rates:
1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address).
2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical.
3) From the patients within the denominator, find the patients who qualify for the Numerator (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
4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI.

If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure.

See calculation algorithm in attachment 2a1.21.

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:
Attachment
AMA-PCPI_Measure Calculation-Standard Measures-634620671516608159.pdf

2a1.24 Sampling (Survey) Methodology. If measure is based on a sample (or survey), provide instructions for obtaining the sample, conducting the survey and guidance on minimum sample size (response rate):
Not applicable. The measure does not require sampling or a survey.

2a1.25 Data Source *(Check all the sources for which the measure is specified and tested*). If other, please describe:
Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records

2a1.26 Data Source/Data Collection Instrument (*Identify the specific data source/data collection instrument, e.g. name of database, clinical registry, collection instrument, etc.*): Not Applicable

2a1.27-29 Data Source/data Collection Instrument Reference Web Page URL or Attachment:

2a1.30-32 Data Dictionary/Code Table Web Page URL or Attachment:
Attachment
NQF_0384_DataElements_AppendixA.pdf

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested)*: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

2a1.34-35 Care Setting *(Check all the settings for which the measure is specified and tested)*: Ambulatory Care : Clinician Office, Other:Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic

2a. Reliability Testing. (*Reliability testing was conducted with appropriate method, scope, and adequate demonstration of reliability*.)

2a2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
PCPI Testing Project
Five practice sites representing various types, locations and sizes were identified to participate in testing the PCPI/ASCO/ASTRO-developed measures.
- Site A: hospital, multi-practice sites in urban, rural and suburban settings; 21 physicians; average 9600 oncology/prostate cancer patient visits per month for MD/NP assessment, chemotherapy; submitted PQRS claims for one measure and utilized a full-fledged EHR.
- Site B: physician owned private practice, suburban setting; 4 physicians; average 48 oncology/prostate cancer patients seen per day; submitted PQRS claims for one measure and utilized paper medical records.
- Site C: physician owned private practice, urban setting; 41 physicians; average 2500 oncology/prostate cancer patients seen per month; submitted PQRS claims for two measures and utilized a full-fledged EHR.
- Site D: academic, suburban setting; 9 physicians; average 240 oncology/prostate cancer patients seen per month; submitted PQRS claims for one measure and utilized paper and EHR.
- Site E: academic, urban setting; 14 physicians; average 250 oncology/prostate cancer patients seen per month; collected PQRS data on 3 measures and utilized a full-fledged EHR.

- The measurement period (data collected from patients seen) was 1/1/2010 through 12/31/2010.
- Chart abstraction was performed between 8/8/2011 and 11/3/2011.

2a2.2 Analytic Method *(Describe method of reliability testing & rationale)*:
PCPI Testing Project
Data abstracted from patient records were used to calculate inter-rater reliability for the measure.
862 patient visits were reviewed.

Data analysis included:
- Percent agreement; and
- Kappa statistic to adjust for chance agreement.

2a2.3 Testing Results *(Reliability statistics, assessment of adequacy in the context of norms for the test conducted)*:
PCPI Testing Project
N, % Agreement, Kappa (95% Confidence Interval)
Overall Reliability: 862, 99.9%, 0.990 (0.970-1.000)
Denominator Reliability: 862, 100.0%, Kappa is noncalculable*
Numerator Reliability: 862, 99.9%, 0.990 (0.970-1.000)

This measure demonstrates almost perfect reliability, as shown in results from the above analysis.

*Kappa Statistics cannot be calculated because of complete agreement. Confidence intervals cannot be calculated because to do so would involve dividing by zero which cannot be done.

2b. VALIDITY. Validity, Testing, including all Threats to Validity: H☐ M☐ L☐ I ☐

2b1.1 Describe how the measure specifications *(measure focus, target population, and exclusions)* are consistent with the evidence cited in support of the measure focus (*criterion 1c)* and identify any differences from the evidence:
The NCCN guidelines for adult cancer pain recommend the screening and quantification of pain for all patients with cancer.

The American Pain Society (APS) guidelines for improving the quality of acute and cancer pain management recommend routine

screening for pain and a recording of intensity when present. Unlike the NCCN guidelines, the APS guidelines are not specific to adults.

The measure focus is on the quantification of pain in all patients with cancer, regardless of age, receiving chemotherapy or radiation therapy. The measure focuses on a smaller subset of patients recommended by the guidelines by also requiring that the patient be receiving chemotherapy or radiation therapy.

2b2. Validity Testing. (*Validity testing was conducted with appropriate method, scope, and adequate demonstration of validity.)*

2b2.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
An expert panel was used to assess face validity of the measure. This panel consisted of the following 31 members, with representation from a number of specialties including oncology, radiation oncology, surgical oncology, urology, gastroenterology, hematology, pathology, colon and rectal surgery, otolaryngology, and pain medicine.

Patricia Ganz, MD (Co-Chair)
James Hayman, MD (Co-Chair)
Joseph Bailes, MD
Nancy Baxter, MD, PhD
Joel V. Brill, MD
Steven B. Clauser, PhD
Charles Cleeland, PhD
J. Thomas Cross, Jr. MD, MPH
Chaitanya R. Divgi, MD
Stephen B. Edge, MD
Patrick L. Fitzgibbons, MD
Myron Goldsmith, MD
Joel W. Goldwein, MD
Alecia Hathaway, MD, MPH
Kevin P. Hubbard, DO
Nora Janjan, MD, MPSA
Maria Kelly, MB, BCh
Wayne Koch, MD
Andre Konski, MD
Len Lichtenfeld, MD
Norman J. Marcus, MD
Catherine Miyamoto, RN, BSN
Michael Neuss, MD
David F. Penson, MD, MPH
Louis Potters, MD
John M. Rainey, MD
Christopher M. Rose, MD
Lee Smith, MD
Lawrence A. Solberg, MD, PhD
Paul E. Wallner, MD
J. Frank Wilson, MD

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
All PCPI performance measures are assessed for content validity by a panel of expert work group members during the development process. Additional input on the content validity of draft measures is obtained through a 30-day public comment period and by also soliciting comments from a panel of consumer, purchaser, and patient representatives convened by the PCPI specifically for this purpose. All comments received are reviewed by the expert work group and the measures adjusted as needed. Other external review groups (eg, focus groups) may be convened if there are any remaining concerns related to the content validity of the measures.

The expert panel was used to assess face validity of the measure. This panel consisted of 31 members, with representation from the following specialties: oncology, radiation oncology, surgical oncology, urology, gastroenterology, hematology, pathology, colon and rectal surgery, otolaryngology, and pain medicine.

The aforementioned panel was asked to rate their agreement with the following statement:

The scores obtained from the measure as specified will accurately differentiate quality across providers.

Scale 1-5, where 1=Strongly Disagree; 3=Neither Disagree nor Agree; 5=Strongly Agree

2b2.3 Testing Results *(Statistical results, assessment of adequacy in the context of norms for the test conducted; if face validity, describe results of systematic assessment)*:
The results of the expert panel rating of the validity statement were as follows: N = 19; Mean rating = 4.32.

Percentage in the top two categories (4 and 5): 84.21%

Frequency Distribution of Ratings
1- 0
2- 1
3- 2
4- 6
5- 10

POTENTIAL THREATS TO VALIDITY. (*All potential threats to validity were appropriately tested with adequate results.*)

2b3. Measure Exclusions. (*Exclusions were supported by the clinical evidence in 1c or appropriately tested with results demonstrating the need to specify them.*)

2b3.1 Data/Sample for analysis of exclusions *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
This measure has no exceptions.

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)*:
This measure has no exceptions.

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*
This measure has no exceptions.

2b4. Risk Adjustment Strategy. (*For outcome measures, adjustment for differences in case mix (severity) across measured entities was appropriately tested with adequate results.*)

2b4.1 Data/Sample *(Description of the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
This measure is not risk adjusted.

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)*:
This measure is not risk adjusted.

2b4.3 Testing Results *(Statistical risk model: Provide quantitative assessment of relative contribution of model risk factors; risk model performance metrics including cross-validation discrimination and calibration statistics, calibration curve and risk decile plot, and assessment of adequacy in the context of norms for risk models. Risk stratification: Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)*:
Not applicable

2b4.4 If outcome or resource use measure is not risk adjusted, provide rationale and analyses to justify lack of adjustment: Not applicable

2b5. Identification of Meaningful Differences in Performance. (*The performance measure scores were appropriately analyzed and discriminated meaningful differences in quality.*)

2b5.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
PCPI Testing Project
- 862 patient visits were reviewed for this measure.
- The measurement period (data collected from patients seen) was 1/1/2010 through 12/31/2010.
- Chart abstraction was performed between 8/8/2011 and 11/3/2011.

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:
PCPI Testing Project
Data analysis performed on the measure included:
Average measure performance rate overall and by site, performance rate range by site and overall standard deviation for the measure.

2b5.3 Results *(Provide measure performance results/scores, e.g., distribution by quartile, mean, median, SD, etc.; identification of statistically significant and meaningfully differences in performance)*:
PCPI Testing Project
Measure rate without exceptions: N= 862 Mean = 94.0% Standard Deviation= 0.2382
The performance rate by site is as follows, where n is the number of performance events by site:

A	0.9780	n=183
B	0.9740	n=189
C	0.9730	n=186
D	0.9730	n=188
E	0.7160	n=116

The performance rate range is .2620. Although this study captured performance on 862 events, the data were not captured at the physician level, restricting reporting of variation in performance to the organization level only. Additionally, we are unable to present a meaningful calculation of variation in performance across organizations due to the small sample size of sites (n=5) in this study.

2b6. Comparability of Multiple Data Sources/Methods. (*If specified for more than one data source, the various approaches result in comparable scores.*)

2b6.1 Data/Sample *(Describe the data or sample including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included)*:
This test was not performed for this measure.

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the measure)*:
This test was not performed for this measure.

2b6.3 Testing Results *(Provide statistical results, e.g., correlation statistics, comparison of rankings; assessment of adequacy in the context of norms for the test conducted)*:
This test was not performed for this measure.

2c. Disparities in Care: H☐ M☐ L☐ I☐ NA☐ (*If applicable, the measure specifications allow identification of disparities.*)

2c.1 If measure is stratified for disparities, provide stratified results *(Scores by stratified categories/cohorts)*: We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:
The PCPI advocates that performance measure data should, where possible, be stratified by race, ethnicity, and primary language to assess disparities and initiate subsequent quality improvement activities addressing identified disparities, consistent with recent national efforts to standardize the collection of race and ethnicity data. A 2008 NQF report endorsed 45 practices including stratification by the aforementioned variables.(1) A 2009 IOM report "recommends collection of the existing Office of Management and Budget (OMB) race and Hispanic ethnicity categories as well as more fine-grained categories of ethnicity(referred to as granular ethnicity and based on one's ancestry) and language need (a rating of spoken English language proficiency of less than very well and one's preferred language for health-related encounters)."(2)

References:
(1)National Quality Forum Issue Brief (No.10). Closing the Disparities Gap in Healthcare Quality with Performance Measurement and Public Reporting. Washington, DC: NQF, August 2008.

(2)Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. March 2010. AHRQ Publication No. 10-0058-EF. Agency for Healthcare Research and Quality, Rockville, MD. Available at: http://www.ahrq.gov/research/iomracereport. Accessed May 25, 2010.

2.1-2.3 Supplemental Testing Methodology Information:

Steering Committee: Overall, was the criterion, *Scientific Acceptability of Measure Properties*, met?
(*Reliability and Validity must be rated moderate or high*) Yes☐ No☐
Provide rationale based on specific subcriteria:

If the Committee votes No, STOP

3. USABILITY

Extent to which intended audiences (e.g., consumers, purchasers, providers, policy makers) can understand the results of the measure and are likely to find them useful for decision making. (evaluation criteria)

C.1 Intended Purpose/ Use *(Check all the purposes and/or uses for which the measure is intended)*: Professional Certification or Recognition Program, Public Reporting, Quality Improvement (Internal to the specific organization), Quality Improvement with Benchmarking (external benchmarking to multiple organizations)

3.1 Current Use *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: Public Reporting, Professional Certification or Recognition Program, Quality Improvement with Benchmarking (external benchmarking to multiple organizations), Quality Improvement (Internal to the specific organization)

3a. Usefulness for Public Reporting: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for public reporting.*)

3a.1. Use in Public Reporting - disclosure of performance results to the public at large *(If used in a public reporting program, provide name of program(s), locations, Web page URL(s)).* If not publicly reported in a national or community program, state the reason AND plans to achieve public reporting, potential reporting programs or commitments, and timeline, e.g., within 3 years of endorsement: [*For Maintenance – If not publicly reported, describe progress made toward achieving disclosure of performance results to the public at large and expected date for public reporting; provide rationale why continued endorsement should be considered.*]
This measure was used in the CMS Physician Quality Reporting System program from 2009-2011 and is currently in use in PQRS 2012. Information on the PQRS program can be found at https://www.cms.gov/PQRS.

The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has

been validated. Continued NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

3a.2.Provide a rationale for why the measure performance results are meaningful, understandable, and useful for public reporting. If usefulness was demonstrated (e.g., focus group, cognitive testing), describe the data, method, and results: The PCPI believes that the reporting of participation information is a beneficial first step on a trajectory toward the public reporting of performance results, which is appropriate since the measure has been tested and the reliability of the performance data has been validated. Continued NQF endorsement will facilitate our ongoing progress toward this public reporting objective.

3.2 Use for other Accountability Functions (payment, certification, accreditation). If used in a public accountability program, provide name of program(s), locations, Web page URL(s): This measure may be used in a Maintenance of Certification program.

QOPI data can be used to meet the ABIM's practice Performance Improvement Module (PIM) requirement for Maintenance of Certification.

PAAROT is ASTRO´s Maintenance of Certification program that is recognized by the American Board of Radiology (ABR) as a Type 2 PQI project in partial fulfillment of the MOC requirements.

3b. Usefulness for Quality Improvement: H☐ M☐ L☐ I ☐
(*The measure is meaningful, understandable and useful for quality improvement.*)

3b.1. Use in QI. If used in quality improvement program, provide name of program(s), locations, Web page URL(s):
[*For Maintenance – If not used for QI, indicate the reasons and describe progress toward using performance results for improvement*].
A slight adaptation of this measure is currently being used in ASCO´s Quality Oncology Practice Initiative (QOPI®) program. QOPI is a physician-led, voluntary, practice-based, quality-improvement program using performance measurement and benchmarking among oncology practices across the United States. QOPI´s goal is to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. The process employed for improving cancer care includes measurement, feedback and improvement tools for hematology-oncology practices.

This measure is also currently being used in ASTRO's Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program. PAAROT is a practice improvement program that enables a physician to analyze their practice and evaluate their strengths and areas for improvement. The data is collected at the physician level and involves periodic chart review of the measures included in the program.

All PCPI measures are suitable for use in quality improvement initiatives and are made freely available on the PCPI website and through the implementation efforts of medical specialty societies and other PCPI members. The PCPI strongly encourages the use of its measures in QI initiatives and seeks to provide information on such initiatives to PCPI members.

3b.2. Provide rationale for why the measure performance results are meaningful, understandable, and useful for quality improvement. If usefulness was demonstrated *(e.g., QI initiative),* describe the data, method and results:
The PCPI believes that the use of PCPI measures in quality improvement initiatives is a beneficial way to gather scientific data with which to improve physician performance. This is appropriate since the measure has been tested and the reliability of the performance data has been validated. NQF endorsement will facilitate our ongoing progress toward this quality improvement objective.

Overall, to what extent was the criterion, *Usability*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

4. FEASIBILITY

Extent to which the required data are readily available, retrievable without undue burden, and can be implemented for performance measurement. (evaluation criteria)

4a. Data Generated as a Byproduct of Care Processes: H☐ M☐ L☐ I ☐

4a.1-2 How are the data elements needed to compute measure scores generated? *(Check all that apply).*

Data used in the measure are:
generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

4b. Electronic Sources: H☐ M☐ L☐ I ☐

4b.1 Are the data elements needed for the measure as specified available electronically *(Elements that are needed to compute measure scores are in defined, computer-readable fields)*: ALL data elements in electronic health records (EHRs)

4b.2 If ALL data elements are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources:

4c. Susceptibility to Inaccuracies, Errors, or Unintended Consequences: H☐ M☐ L☐ I ☐

4c.1 Identify susceptibility to inaccuracies, errors, or unintended consequences of the measurement identified during testing and/or operational use and strategies to prevent, minimize, or detect. If audited, provide results:
We are not aware of any unintended consequences related to this measurement.

4d. Data Collection Strategy/Implementation: H☐ M☐ L☐ I ☐

A.2 Please check if either of the following apply (*regarding proprietary measures*):
4d.1 Describe what you have learned/modified 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 *(e.g., fees for use of proprietary measures)*:
This measure was found to be reliable and feasible for implementation.

Overall, to what extent was the criterion, *Feasibility*, met? H☐ M☐ L☐ I ☐
Provide rationale based on specific subcriteria:

OVERALL SUITABILITY FOR ENDORSEMENT

Does the measure meet all the NQF criteria for endorsement? Yes☐ No☐
Rationale:

If the Committee votes No, STOP.
If the Committee votes Yes, the final recommendation is contingent on comparison to related and competing measures.

5. COMPARISON TO RELATED AND 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 before a final recommendation is made.

5.1 If there are related measures *(either same measure focus or target population)* or competing measures *(both the same measure focus and same target population*), list the NQF # and title of all related and/or competing measures:
0341 : PICU Pain Assessment on Admission
0342 : PICU Periodic Pain Assessment
0420 : Pain Assessment Prior to Initiation of Patient Therapy
0523 : Pain Assessment Conducted

5a. Harmonization

5a.1 If this measure has EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized? No

5a.2 If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden:
There are a number of NQF-endorsed measure focusing on the assessment of pain in a variety of unique settings and circumstances. Several of these measures (0523 and 0420) refer to conducting the assessment using a standardized tool.

Similarly, our measure suggests that pain should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale. Two of the measures are specific to the pediatric intensive care unit and do not require use of a standardized instrument.

5b. Competing Measure(s)

5b.1 If this measure has 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)*:

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), 515 N. State St, Chicago, Illinois, 60654

Co.2 Point of Contact: Mark S., Antman, DDS, MBA, Director, Measure Development Operations Performance Improvement, mark.antman@ama-assn.org, 312-464-5056-

Co.3 Measure Developer if different from Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI), 515 N. State St, Chicago, Illinois, 60654

Co.4 Point of Contact: Samantha, Tierney, MPH, samantha.tierney@ama-assn.org, 312-464-5524-

Co.5 Submitter: Mark S., Antman, DDS, MBA, Director, Measure Development Operations Performance Improvement, mark.antman@ama-assn.org, 312-464-5056-, American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

Co.6 Additional organizations that sponsored/participated in measure development:
This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Co.7 Public Contact: Mark S., Antman, DDS, MBA, Director, Measure Development Operations Performance Improvement, mark.antman@ama-assn.org, 312-464-5056-, American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)

ADDITIONAL INFORMATION

Workgroup/Expert Panel involved in measure development
Ad.1 Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.
Patricia Ganz, MD (Co-Chair)
James Hayman, MD (Co-Chair)
Joseph Bailes, MD
Nancy Baxter, MD, PhD
Joel V. Brill, MD
Steven B. Clauser, PhD
Charles Cleeland, PhD
J. Thomas Cross, Jr. MD, MPH
Chaitanya R. Divgi, MD
Stephen B. Edge, MD
Patrick L. Fitzgibbons, MD
Myron Goldsmith, MD
Joel W. Goldwein, MD
Alecia Hathaway, MD, MPH
Kevin P. Hubbard, DO

Nora Janjan, MD, MPSA
Maria Kelly, MB, BCh
Wayne Koch, MD
Andre Konski, MD
Len Lichtenfeld, MD
Norman J. Marcus, MD
Catherine Miyamoto, RN, BSN
Michael Neuss, MD
David F. Penson, MD, MPH
Louis Potters, MD
John M. Rainey, MD
Christopher M. Rose, MD
Lee Smith, MD
Lawrence A. Solberg, MD, PhD
Paul E. Wallner, MD
J. Frank Wilson, MD
Rodger Winn, MD

PCPI measures are developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process. In addition, the PCPI strives to include on its work groups individuals representing the perspectives of patients, consumers, private health plans, and employers. This broad-based approach to measure development ensures buy-in on the measures from all stakeholders and minimizes bias toward any individual specialty or stakeholder group. All work groups have at least two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Ad.2 If adapted, provide title of original measure, NQF # if endorsed, and measure steward. Briefly describe the reasons for adapting the original measure and any work with the original measure steward:

Measure Developer/Steward Updates and Ongoing Maintenance
Ad.3 Year the measure was first released: 2007
Ad.4 Month and Year of most recent revision: 12, 2011
Ad.5 What is your frequency for review/update of this measure? Coding/Specifications updates occur annually. See additional information below.
Ad.6 When is the next scheduled review/update for this measure? 2012

Ad.8 Disclaimers: See copyright statement above.

Ad.9 Additional Information/Comments: The PCPI has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.

Date of Submission (*MM/DD/YY*): 10/03/2011

Measure #0084: ONCOLOGY: PAIN INTENSITY QUANTIFIED - MEDICAL ONCOLOGY AND RADIATION ONCOLOGY

QDM* Standard Category	QDM* Data Type	Standard Terminology	Constraints	Value Set Name	Value of Data Element	Data Source	Comments/Rationale
N/A	N/A	TBD by measure implementer	Measurement Start Date				
N/A	N/A	TBD by measure implementer	Measurement End Date				
Individual Characteristic	Patient Characteristic	Gender HL7 Value Set (2.16.840.1.113883.1.11.1)	during measurement period	Gender		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Race CDC Value Set (2.16.840.1.114222.4.11.836)	during measurement period	Race		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Ethnicity CDC Value Set (2.16.840.1.114222.4.11.837)	during measurement period	Ethnicity		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Payer Source of Payment Typology Value Set (2.16.840.1.113883.3.221.5)	during measurement period	Payer		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	Primary spoken language (2.16.840.1.114222.4.11.831)	during measurement period	Preferred Language		• Electronic Health Record (EHR)	This data element is collected for the purpose of stratifying results in an effort to highlight disparities.
Individual Characteristic	Patient Characteristic	LOINC (2.16.840.1.113883.3.560.100.4)	starts before the start of measurement period	Birth date		• Electronic Health Record (EHR)	
Individual Characteristic	Patient Characteristic	Calculated	starts before the start of measurement period	Age	All ages	• Electronic Health Record (EHR)	For this measure, there are no restrictions on age for denominator inclusion. Collected for possible stratification of data.
Encounter	Encounter, Performed	CPT (2.16.840.1.113883.3.464.0003.01.02.0001)	during measurement period	Office Visit		• Electronic Health Record (EHR)	
Encounter	Encounter, Performed	SNOMED-CT (2.16.840.1.113883.3.526.03.1012)	during measurement period	Patient Provider Interaction		• Electronic Health Record (EHR)	
Procedure	Procedure, Performed	CPT, SNOMED-CT (TBD)	during measurement period	Chemotherapy Administration		• Electronic Health Record (EHR)	
Procedure	Procedure, Performed	CPT, SNOMED-CT (TBD)	during measurement period	Radiation Therapy II		• Electronic Health Record (EHR)	
Diagnosis	Diagnosis, Active	ICD-9-CM, ICD-10-CM, SNOMED-CT (TBD)	starts before or during measurement period	Cancer		• Electronic Health Record (EHR)	
Risk Category	Risk Category/Assessment	LOINC, SNOMED-CT (TBD)	during encounter	Standardized Pain Assessment Tool	Result	• Electronic Health Record (EHR)	

*The Quality Data Model (QDM), Version 2.1, was developed by National Quality Forum (NQF).

ICD-9-CM Codes	ICD-10-CM Codes
140.0	C00.0
140.1	C00.1
140.3	C00.2
140.4	C00.3
140.5	C00.4
140.6	C00.5
140.8	C00.6
140.9	C00.8
141.0	C00.9
141.1	C01
141.2	C02.0
141.3	C02.1
141.4	C02.2
141.5	C02.3
141.6	C02.4
141.8	C02.8
141.9	C02.9
142.0	C03.0
142.1	C03.1
142.2	C03.9
142.8	C04.0
142.9	C04.1
143.0	C04.8
143.1	C04.9
143.8	C05.0
143.9	C05.1
144.0	C05.2
144.1	C05.8
144.8	C05.9
144.9	C06.0
145.0	C06.1
145.1	C06.2
145.2	C06.80
145.3	C06.89
145.4	C06.9
145.5	C07
145.6	C08.0
145.8	C08.1
145.9	C08.9
146.0	C09.0
146.1	C09.1
146.2	C09.8
146.3	C09.9
146.4	C10.0
146.5	C10.1
146.6	C10.2
146.7	C10.3
146.8	C10.4
146.9	C10.8
147.0	C10.9

147.1	C11.0
147.2	C11.1
147.3	C11.2
147.8	C11.3
147.9	C11.8
148.0	C11.9
148.1	C12
148.2	C13.0
148.3	C13.1
148.8	C13.2
148.9	C13.8
149.0	C13.9
149.1	C14.0
149.8	C14.2
149.9	C14.8
150.0	C15.3
150.1	C15.4
150.2	C15.5
150.3	C15.8
150.4	C15.9
150.5	C16.0
150.8	C16.1
150.9	C16.2
151.0	C16.3
151.1	C16.4
151.2	C16.5
151.3	C16.6
151.4	C16.8
151.5	C16.9
151.6	C17.0
151.8	C17.1
151.9	C17.2
152.0	C17.3
152.1	C17.8
152.2	C17.9
152.3	C18.0
152.8	C18.1
152.9	C18.2
153.0	C18.3
153.1	C18.4
153.2	C18.5
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