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 #: 1628   **NQF Project:** Palliative Care and End-of-Life Care

(for Endorsement Maintenance Review)
Original Endorsement Date: Most Recent Endorsement Date:

BRIEF MEASURE INFORMATION

De.1 Measure Title: Patients with Advanced Cancer Screened for Pain at Outpatient Visits

Co.1.1 Measure Steward: RAND Corporation

De.2 Brief Description of Measure: Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit

2a1.1 Numerator Statement: Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool

2a1.4 Denominator Statement: Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit

2a1.8 Denominator Exclusions: None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)

1.1 Measure Type: Process
2a1. 25-26 Data Source: Electronic Clinical Data, Electronic Clinical Data : Registry, Paper Records
2a1.33 Level of Analysis: Facility, Health Plan, Integrated Delivery System

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*):

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):

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1. IMPACT, OPPORTUNITY, 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*): Palliative Care and End of Life Care

1a.1 Demonstrated High Impact Aspect of Healthcare: Affects large numbers, Patient/societal consequences of poor quality

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

1a.3 Summary of Evidence of High Impact (*Provide epidemiologic or resource use data*):
Although increasing pain assessment has been shown not to be sufficient for improving pain outcomes (Mularski 2006; Morrison 2006), increased routine pain assessment was found to be a key component of RCTs and quality improvement interventions that have been successful for improving pain in a systematic review of cancer pain quality measures and evidence supporting their use. (Lorenz 2006; Dy 2008) Routine pain assessment is recommended by numerous organizations and pain guidelines, including National Comprehensive Cancer Network. (NCCN 2006) Routine measurement of pain is a necessary first step in pain management. Without asking patients, clinicians´ assessments of pain are usually inaccurate, and correlation was worst for patients with severe pain. (Purcell 2003) Discrepancies between patients and physicians in perceptions of pain severity are predictive of inadequate management. (Cleeland 1994) Without regular screening for pain, many patients with significant pain do not have pain documented in the medical record and do not receive analgesia. (Rhodes 2001) A study of 76,759 patients who died of cancer revealed that they made 36,600 emergency department visits in the last 6 months of life, and the most common reason for these visits was abdominal pain. (Barbera 2010)

1a.4 Citations for Evidence of High Impact cited in 1a.3: Barbera L, Taylor C, Dudgeon D. Why do patients with cancer visit the emergency department near the end of life? Can Med Assoc J 2010;182(6):563-569

Cleeland CS, Gonin R, Hatfield AK, et al. Pain and its treatment in outpatients with metastatic cancer. N Engl J Med 1994;330(9):592-596

Dy SM, Asch SM, Naeim A, et al. Evidence-based standards for cancer pain management. J Clin Oncol 2008;26(23):3879-38885

Lorenz KA, Lynn J, Dy S, et al. Quality measures for symptoms and advance care planning in cancer: a systematic review. J Clin Oncol 2006;24(30):4933-4938

Morrison RS, Meler DE, Fischberg D, et al. Improving the management of pain in hospitalized adults. Arch Intern Med 2006;166(9):1033-1039

Mularski RA, White-Chu F, Overbay D, et al. Measuring pain as the 5th vital sign doe not improve quality of pain management. J Gen Intern Med 2006;21(6):607-612

NCCN: Adult Cancer Pain. http://www.nccn.org/professionals/physician_gls/PDF/pain.pdf Accessed December 4, 2006

Purcell W, Grossman S, Carson K. High outpatient pain scores identify patients at high risk for inpatient hospital admission. Proc Am Soc Clin Oncol 2003;22:737

Rhodes DJ, Koshy RC, Waterfield WC, et al. Feasibility of quantitative pain assessment in outpatient oncology practice. J Clin Oncol 2001;19(2):601-508

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:
Routine, ongoing accurate assessment of pain is the basis for guiding providers in developing pain management interventions and adjusting those interventions over time. A quantitative standardized tool allows for consistent and comparable measurements. Adequate pain control is a major factor in maximizing quality of life for advanced cancer patients.

See Guidance for Definitions of Rating Scale: H=High; M=Moderate; L=Low; I=Insufficient; NA=Not Applicable   2

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.*]
N, % performance
Assessing Symptoms Side Effects and Indicators of Supportive Treatment (ASSIST)(Dy 2011): Advanced cancer outpatient encounters at a comprehensive cancer center, N=467, 79%

ASSIST (Malin 2010): Advanced cancer outpatient encounters at VA facility, 36%

Veterans Health Administration (VHA) (VHA unpublished report): Advanced lung cancer outpatient encounters at VA facility: N=9485, 70%

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*]
Dy SM, Asch SM, Lorenz KA, et al. Quality of end-of-life care for patients with advanced cancer in an academic medical center. J Pall Med 2011;14(4):451-457

Malin JL, O´Neill SM, Asch SM, et al. Quality of supportive care for patients with advanced cancer in a VA medical center. J Pall Med 2011;14(5):1-5

VHA, Executive Summary: The Quality of VHA Lung Cancer Care. VHA Office of Quality and Performance Special Study, November 2010. (Unpublished)

1b.4 Summary of Data on Disparities by Population Group: [*For Maintenance –Descriptive statistics for performance results for this measure by population group*]
None available yet

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*]

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*):
This measure focuses on the necessity of a standardized quantitative screen for pain (and if present, severity) with each contact to provide the input required to effectively manage advanced cancer pain over time.

1c.2-3 Type of Evidence *(Check all that apply)*:
Selected individual studies (rather than entire body of evidence), Systematic review of body of evidence (other than within guideline development)

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)*:
A systematic review was conducted of cancer pain management. A central topic of this review focused on the need for regular pain screening as a means of providing information to guide pain management.

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

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*):

1c.7 Consistency of Results across Studies *(Summarize the consistency of the magnitude and direction of the effect)*: Pain screening was a necessary but not sufficient intervention in itself to improve quality of pain care.

1c.8 Net Benefit *(Provide estimates of effect for benefit/outcome; identify harms addressed and estimates of effect; and net benefit - benefit over harms)*:
No harms identified. Consistent benefit is related to effective 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: The body of evidence was graded by the RAND Corporation Evidence-based Practice Center (EPC) ASSIST team.

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

1c.12 If other, identify and describe the grading scale with definitions: Randomized controlled trial; non-randomized controlled trial, cohort or case analysis; multiple time series; textbook, opinion, descriptive study

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

1c.14 Summary of Controversy/Contradictory Evidence: There was no controversy regarding pain screening in itself. Studies that showed increased quality of pain care also included feedback of quantitative pain measurement.

1c.15 Citations for Evidence other than Guidelines*(Guidelines addressed below)*:
Dy SM, Asch SM, Naiem A, et al. Evidence-based standards for cancer pain management. J Clin Oncol 2008;26(23):3879-3885

Lorenz KA, Lynn J, Dy S, et al. Quality measures for symptoms and advance care planning in cancer: a systematic review. J Clin Oncol 2006;24:4933-4938

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

1c.17 Clinical Practice Guideline Citation:

1c.18 National Guideline Clearinghouse or other URL:

1c.19 Grading of Strength of Guideline Recommendation. Has the recommendation been graded? No

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

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

1c.22 If other, identify and describe the grading scale with definitions: Not graded

1c.23 Grade Assigned to the Recommendation:

1c.24 Rationale for Using this Guideline Over Others:

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

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, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. (<u>evaluation criteria</u>)
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 <u>guidance on measure testing</u>.

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 <u>this</u> measure can be obtained? No

S.2 If yes, provide web page URL:

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)*:
Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool

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

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*:
Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.

2a1.4 Denominator Statement *(Brief, narrative description of the target population being measured)*:
Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit

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

2a1.6 Denominator Time Window *(The time period in which cases are eligible for inclusion)*:
At the time of outpatient visit(s)

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)*:
Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion

2a1.8 Denominator Exclusions *(Brief narrative description of exclusions from the target population)*:
None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)

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)*:

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)*:

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.)*:

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.)*:
1. Identify patients at least 18 years of age with Stage IV cancer

2. Identify patients who have had at least 1 primary care or cancer-related visit.   Exclude patients who are not alive 30 or more days after diagnosis.

3. For each applicable visit, determine if a screening for pain was performed using a quantitative standardized tool.

4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits

2a1.21-23 Calculation Algorithm/Measure Logic Diagram URL or attachment:

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):

2a1.25 Data Source (*Check all the sources for which the measure is specified and tested*). If other, please describe:
Electronic Clinical Data, Electronic Clinical Data : Registry, 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.*): Patients were identified via the testing organizations´ cancer registries.
At one institution, outpatient pain vital sign scores were extracted electronically from the patient EHR.
At other institutions, quantitative pain scores were collected via medical record abstraction.

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:

2a1.33 Level of Analysis (*Check the levels of analysis for which the measure is specified and tested*): Facility, Health Plan, Integrated Delivery System

2a1.34-35 Care Setting (*Check all the settings for which the measure is specified and tested*): Ambulatory Care : Clinician Office

2a2. 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*):
See 2a2.3.

2a2.2 Analytic Method (*Describe method of reliability testing & rationale*):
See 2a2.3.

2a2.3 Testing Results (*Reliability statistics, assessment of adequacy in the context of norms for the test conducted*):
ASSIST (Dy 2011) outpatient cancer visits (n=467): Overall eligibility kappa=0.87; overall specific care kappa=0.86

Dy SM, Lorenz KA, O´Neill SM, et al. Cancer quality-ASSIST supportive oncology quality indicator set. Feasibility, reliability, and validity testing. Cancer 2010;116:3267-3275

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:**
See 2b2.2.

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):
See 2b2.2.

2b2.2 Analytic Method *(Describe method of validity testing and rationale; if face validity, describe systematic assessment)*:
Validity of the process-outcome link was explicitly evaluated by the ASSIST and ACOVE expert panels that reviewed the relevant literature and used a modified Delphi panel of voting on the validity of the measure (Lorenz 2009, Etzioni 2007)

Etzioni S, Chodosh J, Ferrell BA, et al. Quality indicators for pain management in vulnerable elders. J Amer Geriatr Soc 2007;55S(S3):5403-5408

Lorenz KA, Dy SM, Naeim A, et al. Quality measures for supportive cancer care: the cancer quality-ASSIST project. J Pain Symptom Manage 2009;37(6):943-964

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)*:

POTENTIAL THREATS TO VALIDITY. (<u>*All*</u> *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)*:
None

2b3.2 Analytic Method (*Describe type of analysis and rationale for examining exclusions, including exclusion related to patient preference)*:

2b3.3 Results *(Provide statistical results for analysis of exclusions, e.g., frequency, variability, sensitivity analyses):*

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)*:
None

2b4.2 Analytic Method (*Describe methods and rationale for development and testing of risk model or risk stratification including selection of factors/variables)*:

2b4.3 Testing Results (<u>*Statistical risk model*</u>: *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.* <u>*Risk stratification*</u>: *Provide quantitative assessment of relationship of risk factors to the outcome and differences in outcomes among the strata)*:

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

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):

2b5.2 Analytic Method *(Describe methods and rationale to identify statistically significant and practically/meaningfully differences in performance)*:

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)*:
 This measure provides a broader range of performance than is typical for pain screening. Performance data revealed many settings of care where routine quantitative pain assessment with a standardized tool is not being done.

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)*:

2b6.2 Analytic Method *(Describe methods and rationale for testing comparability of scores produced by the different data sources specified in the 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)*:

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)*:

2c.2 If disparities have been reported/identified (e.g., in 1b), but measure is not specified to detect disparities, please explain:

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)*:   Public Reporting, Quality Improvement (Internal to the specific organization)

3.1 Current Use *(Check all that apply; for any that are checked, provide the specific program information in the following questions)*: 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.*]

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:

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):

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*].
Used by the VA Cancer Collaborative and VA Office of Quality Performance (OQP)

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:

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, Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

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)*: Some data elements are in electronic sources

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:

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*):

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:**
0383 : Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
0384 : Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383
0420 : Pain Assessment Prior to Initiation of Patient Therapy
0523 : Pain Assessment Conducted
0524 : Pain Interventions Implemented During Short Term Episodes Of Care
0675 : The Percentage of Residents on a Scheduled Pain Medication Regimen on Admission Who Self-Report a Decrease in Pain Intensity or Frequency (Short-stay)
0677 : Percent of Residents Who Self-Report Moderate to Severe Pain (Long-Stay)

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? Yes

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

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*):
This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundled measures for description of the selection and harmonization of the Key Palliative Measures Bundle.

Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure.

It is unclear exactly what the scope of measure 0420 is, however it appears to be directed at ancillary, non-physician professionals.

It is unclear what "initiation of therapy" is referring to. The measure´s endorsement is time limited (endorsed July 31, 2008)

Measure 0384 (paired with 0383) also has a time-limited endorsement (endorsed July 31, 2008). This measure targets only patients who are currently receiving chemotherapy or radiation therapy, and by definition, excludes some patients with advanced cancer who are not receiving this type of treatment. The proposed measure targets patients with Stage IV cancer and includes more venues of care than the existing measure where it would be applied (primary care and all cancer-related outpatient visits). This is in keeping with the reality that pain and pain control becomes a central focus for patients with late-stage cancer, and regular pain assessment should occur in multiple outpatient care settings. The developers propose that measure 0383 be limited to patients with Stage I-III cancer and endorse the proposed measure which targets Stage IV cancer patients.

Proposed measure 1634: Hospice and Palliative Care - Pain Screening: Proposed measure 1634 targets patients with serious conditions who are entering hospice or hospital-based palliative care. The measure proposed here targets a sub-population (advanced cancer). However, the setting and timing of 1634 is hospice/palliative care admission and is a one-time screen. 1628 focuses on pain screening at all outpatient visits. Although the 2 measures focus on different venues of care (and 1 is a time measure and the other every visit), they are completely harmonized in content.

CONTACT INFORMATION

Co.1 Measure Steward (Intellectual Property Owner): RAND Corporation, 1776 Main Street, Santa Monica, California, 90407

Co.2 Point of Contact: Carol, Roth, RN, MPH, roth@rand.org, 310-393-0411-6425

Co.3 Measure Developer if different from Measure Steward: RAND Corporation, 1776 Main Street, Santa Monica, California, 90407

Co.4 Point of Contact: Karl, Lorenz, MD, MSHS, karl.lorenz@va.gov, 310-478-3711-43523

Co.5 Submitter: Carol, Roth, RN, MPH, roth@rand.org, 310-393-0411-6425, RAND Corporation

Co.6 Additional organizations that sponsored/participated in measure development:
VA Greater Los Angeles Healthcare System

Co.7 Public Contact: Carol, Roth, RN, MPH, roth@rand.org, 310-393-0411-6425, RAND Corporation

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.
ACOVE-3 project expert panel members, ACOVE-3 Clinical Committee members, ASSIST project expert panel members and Advisory Board as listed below.

ACOVE-3 project (Panel 2) expert panel members:

Helena Chang, MD
UCLA School of Medicine, Los Angeles, CA

Nick Fitterman, MD
Northshore Medical Group, Huntington, NY

Jean S. Kutner, MD, MSPH
University of Colorado Health Sciences Center, Aurora, CO

Patrick J. Loehrer, Sr., MD
Indiana University School of Medicine, Indianapolis, IN

Thomas Mattimore, MD
University of California at Los Angeles, Los Angeles, CA

Hyman B. Muss, MD
Vermont Cancer Center at University of Vermont, Burlington, VT

James L. Naughton, MD
Alliance Medical Group, Pinole, CA

Cheryl Phillips, MD
Sutter Medical Group, Sacramento, CA

Doron Schneider, MD
Muller Center for Senior Health, Abington Memorial Hospital, Abington, PA

Michael Stamos, MD
University of California, Irvine, CA

Ronald D. Stock, MD
Center for Senior Health, Eugene, OR

May Lin Tao, MD, MSPH
John Wayne Cancer Institute, Saint John´s Health Center, Santa Monica, CA and Valley Radiotherapy Associates Medical Group, El Segundo, CA

Role of ACOVE Expert Panel: Expanded and updated the Assessing Care of Vulnerable Elders (ACOVE) quality indicators via literature review, face-to-face discussion, and 2 rounds of anonymous ratings to evaluate whether the QIs were valid measures of quality of care using a process that is an explicit combination of scientific evidence and professional consensus.

ACOVE-3 CLINICAL COMMITTEE MEMBERS:

Alpesh N. Amin, MD - Hospitalist
University of California, Irvine Medical Center, Irvine, CA

Richard W. Besdine, MD - Geriatrician and Clinical Committee Chair
Brown University Center for Gerontology and Health Care Research, Providence, RI

Dan G. Blazer, MD - Geriatric Psychiatrist
Duke University Medical Center, Durham, NC

Harvey J. Cohen, MD - Geriatric Oncologist
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Terry Fulmer, PhD, RN, FAAN - Nurse
New York University, New York, NY

Patricia A. Ganz, MD - Oncologist
UCLA Schools of Medicine & Public Health, Jonsson Comprehensive Cancer Center, Los Angeles, CA

Mark A. Grunwald, MD - Family Practitioner
Gunderson Lutheran Clinic, Prairie du Chien, WI

William J. Hall, MD, MACP - Geriatrician

Highland Hospital, Rochester, NY

Ira R. Katz, MD, PhD - Psychiatrist
University of Pennsylvania, Philadelphia, PA

Paul R. Katz, MD - Geriatrician
Monroe Community Hospital, Rochester, NY

Dalane W. Kitzman, MD - Geriatric Cardiologist
Wake Forest University School of Medicine, Winston-Salem, NC

Rosanne M. Leipzig, MD, PhD - Geriatrician
Mount Sinai School of Medicine, New York, NY

Ronnie A. Rosenthal, MD - Surgeon
Yale University School of Medicine, New Haven, CT

Role of ACOVE-3 Clinical Committee: Evaluated the coherence of the complete set of QIs that the experts rated as valid as well as determined exclusions for advanced dementia and poor prognosis.

ASSIST project expert panel members:
Kurt Kroenke, MD
Indiana University Cancer Center, Indianapolis, Indiana

Terry Altilio, LCSW
Beth Israel Medical Center, New York, New York

Lodovico Balducci, MD
H. Lee Moffitt Cancer Center & Research Institute, Tampa, Florida

Jeannine M. Brant PhD(c),
St. Vincent Healthcare, Billings, Montana

Eduardo Bruera, MD
UT M. D. Anderson Cancer Center, Houston, Texas

Peter Eisenberg, MD
California Cancer Care, Greenbrae, California

Pr Stein Kaasa
St. Olavs University Hospital HF, Trondheim, Norway

Sean Morrison, MD
Mt. Sinai Medical School, New York, New York

Mary Simmonds, MD
Family practice, New Cumberland, Pennsylvania

Role of ASSIST Expert Panel: Helped to develop and refine the quality indicators for the Addressing Symptoms Side effects and Indicators for Supportive Treatment (ASSIST) project via literature review, face-to-face discussion, and 2 rounds of anonymous ratings to evaluate whether the QIs were valid measures of quality of care using a process that is an explicit combination of scientific evidence and professional consensus.

ASSIST Project Advisory Board:

Neil S. Wenger, MD, MPH
UCLA Division of Gen Internal Med and Health Svcs Research, Los Angeles, CA

Steven B. Clauser, PhD
Chief, Outcomes Research Branch, Applied Research Program, Div of Cancer Control and Pop. Sciences, National Cancer Institute, Bethesda, MD

David Currow, MD
CEO, Cancer Australia, Flinders University, South Australia

Molla S. Donaldson, Dr.PH, MS
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Catherine H. MacLean, MD, PhD
Medical Director, Programs for Clinical Excellence Health Solutions, Wellpoint, Inc., Thousand Oaks, CA

Thomas J. Smith, MD
Division of Hematology/Oncology and Palliative Care, Virginia Commonwealth University, Massey Cancer Center, Richmond, VA

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: 2010 **Ad.4** Month and Year of most recent revision: **Ad.5** What is your frequency for review/update of this measure? Every 3 years **Ad.6** When is the next scheduled review/update for this measure?
Ad.7 Copyright statement:
Ad.8 Disclaimers:
Ad.9 Additional Information/Comments:
Date of Submission (*MM/DD/YY*): 05/18/2011