



Measure Information

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

Brief Measure Information

NQF #: 1822

De.2. Measure Title: External Beam Radiotherapy for Bone Metastases

Co.1.1. Measure Steward: American Society for Radiation Oncology

De.3. Brief Description of Measure: This measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme as defined by the guideline.

1b.1. Developer Rationale: Treatment Variation:

Although the role of radiation therapy in palliation of bone metastases has been well established, literature shows widespread variation in the practice patterns for using radiation therapy for palliation. Even though several meta-analysis have shown the efficiency of using lower fractionation schedules, there has been a reluctance to adopt them. A most-recent survey studied international practice variations and found doses commonly prescribed ranging from 3Gy/1 fraction to 60Gy/20 fractions. Single fraction treatment was recommended in only 2-20% of cases presented in United States (4),(5).

Numerous prospective randomized and retrospective trials have shown similar pain relief outcomes with shorter EBRT schedules than with longer courses of palliative radiation therapy (RT).

The clinical practice guideline on "Palliative Radiotherapy for Bone Metastases" reviewed evidence from nine studies. The guideline states: "Although various fractionation schemes can provide good rates of palliation, numerous prospective randomized trials have shown that 30Gy in 10 fractions, 24Gy in 6 fractions, 20Gy in 5 fractions, or 8Gy in a single fraction can provide excellent pain control and minimal side effects. The longer course has the advantage of lower incidence of repeat treatment to the same site, and the single fraction has proved more convenient for patients and care givers."

Patient preferences: Studies assessing patient preferences, demonstrated that patients preferred short course treatments for reasons of convenience and fewer intrinsic costs associated with clinical visits.

This is a process measure intended to close the gap in the demonstrated treatment variation and ensure the use of an appropriate fractionation schedule as well as to prevent the overuse of radiation therapy. The measure also takes into account the effective schedule for relieving pain from bone metastases, patient preferences and time and cost effectiveness.

S.4. Numerator Statement: All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn.

S.7. Denominator Statement: All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT

S.10. Denominator Exclusions: The medical reasons for denominator exclusions are:

- 1) Previous radiation treatment to the same anatomic site;
- 2) Patients with femoral axis cortical involvement greater than 3 cm in length;
- 3) Patients who have undergone a surgical stabilization procedure; and
- 4) Patients with spinal cord compression, cauda equina compression or radicular pain

De.1. Measure Type: Process

S.23. Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

S.26. Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan

IF Endorsement Maintenance – Original Endorsement Date: [Aug 09, 2012](#) Most Recent Endorsement Date: [Aug 09, 2012](#)

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? [This measure is not included in a composite](#)

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. **Measures must be judged to meet all subcriteria to pass this criterion and be evaluated against the remaining criteria.**

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

[1822_Evidence_MSF5.0_Data.doc](#)

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., the benefits or improvements in quality envisioned by use of this measure)

Treatment Variation:

Although the role of radiation therapy in palliation of bone metastases has been well established, literature shows widespread variation in the practice patterns for using radiation therapy for palliation. Even though several meta-analysis have shown the efficiency of using lower fractionation schedules, there has been a reluctance to adopt them. A most-recent survey studied international practice variations and found doses commonly prescribed ranging from 3Gy/1 fraction to 60Gy/20 fractions. Single fraction treatment was recommended in only 2-20% of cases presented in United States (4),(5).

Numerous prospective randomized and retrospective trials have shown similar pain relief outcomes with shorter EBRT schedules than with longer courses of palliative radiation therapy (RT).

The clinical practice guideline on "Palliative Radiotherapy for Bone Metastases" reviewed evidence from nine studies. The guideline states: "Although various fractionation schemes can provide good rates of palliation, numerous prospective randomized trials have shown that 30Gy in 10 fractions, 24Gy in 6 fractions, 20Gy in 5 fractions, or 8Gy in a single fraction can provide excellent pain control and minimal side effects. The longer course has the advantage of lower incidence of repeat treatment to the same site, and the single fraction has proved more convenient for patients and care givers."

Patient preferences: Studies assessing patient preferences, demonstrated that patients preferred short course treatments for reasons of convenience and fewer intrinsic costs associated with clinical visits.

This is a process measure intended to close the gap in the demonstrated treatment variation and ensure the use of an appropriate fractionation schedule as well as to prevent the overuse of radiation therapy. The measure also takes into account the effective schedule for relieving pain from bone metastases, patient preferences and time and cost effectiveness.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (This is required for endorsement maintenance. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

Treatment variation data- Cross-sectional data from a payor represented a sample of 245 physicians from 3 states. The data reported between April 2009 through October 2011 indicates that 1635 cases of patients with bone metastases were treated with EBRT, the range of treatment fractions was between 1-25. 34% of these patients were prescribed more than 10 fractions. The ASTRO guideline recommends fractions between 1-10 fractions for treating bone metastases with EBRT.

The measure was also tested for performance gaps. The information on the testing results for the performance gaps are noted below. The sample included four practices representing various types, locations, specialties, department sizes and patient load. Please see the described information below:

Practice type: One hospital, two academic and one physician-owned private practices specializing in medical oncology, radiation oncology and prostate cancer treatments.

Practice-setting: Two practices were located in a sub-urban setting, one in an urban setting, whereas as one hospital had multiple practice sites in urban, rural and suburban settings.

Number of physicians: The size of the departments ranged from 4- 21 physicians.

Average number of patients: The average number of patient ranged between 250-1000 patients per month.

Data Source: Two sites had EHR and paper records, one site had paper records only and one site had- EHR only.

Sample size: A total of 155 patient charts were abstracted for the measure.

Records review timeframe: Randomly selected patients who received care during the 2010 calendar year.

Period of data collection: August - October 2011

Results: Sample = 155 patients, Exception Rate (1.9%)

Performance Rate without exceptions was 121 of 155 (78.1%)

Performance Rate with exceptions was 121 of 152 (79.6%)

These data demonstrate a sizable performance gap in adherence to the guideline for the use of EBRT to treat bone metastases.

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

1. Van der Linden Y, Roos D, Lutz S, et al. International variations in radiotherapy fractionation for bone metastases: geographic borders define practice patterns? Clin Oncol (R Coll Radiol) 2009;21:655-65
2. Lutz S, Berk L, Chang E, et al. Palliative radiotherapy for bone metastases: An ASTRO evidence-based guideline. Int J Radiat Oncol Biol Phys. 2011;79(4):965-976.
3. Chow E, Zeng L, Salvo N, Dennis K, Tsao M, Lutz S. Update on the systematic review of palliative radiotherapy trials for bone metastases. Clin Oncol (R Coll Radiol). 2011.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for endorsement maintenance. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.*

Data on disparities by population group could not be found in the literature.

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Data on disparities by population group could not be found in the literature.

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or

future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

Affects large numbers, Frequently performed procedure, High resource use, Other

1c.2. If Other: Patient centric

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare.

List citations in 1c.4.

Cancer Incidence and Epidemiology of Bone Metastases:

It is estimated that nearly 1.4 million new cancer cases were diagnosed in 2011 (1). Bone metastases are a common manifestation of malignancy. The incidence of bone metastases differs among the sites of cancer as follows(2):

Tumor type	Prevalence of bone metastases
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Multiple myeloma	70% to 95%
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Prostate cancer	65% to 75%
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Breast cancer	65% to 75%
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Thyroid tumors	60%
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Bladder cancer	40%
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Lung cancer	30% to 40%
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Renal cell carcinoma	20% to 25%
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Impact of bone metastases:

Bone metastases can significantly affect the quality of life for patients by causing debilitating effects including pain, spinal cord compression, hypercalcemia and pathologic fracture(3).

The management of painful bone metastases requires multidisciplinary approaches to care. Evidence shows that radiotherapy (RT) provides successful palliation of painful bone metastases. EBRT can provide significant palliation of painful bone metastases in 50-80% of patients (3).

Resource Use Data:

Although, the role of radiation therapy in palliation of bone metastases has been well established, literature shows widespread variation in the practice patterns for using radiation therapy for palliation. Even though several meta-analysis have shown the efficiency of using lower fractionation schedules, there has been a reluctance to adopt them. A most-recent survey studied international practice variations and found doses commonly prescribed ranging from 3Gy/1 fraction to 60Gy/20 fractions. Single fraction treatment was recommended in only 2-20% of cases presented in United States (4),(5).

Measure Importance:

Bone metastases is a common manifestation of malignancy and the evidence review shows variation in treatment with EBRT and thus a potential gap. This measure will monitor the appropriate use of EBRT for qualified patients and impact the quality of care provided to end of life patients needing palliation.

Patient quality of life:

Pain is an important indicator of quality of life and can be used as one of the indicators to evaluate the quality of supportive and end-of-life care for patients with advanced cancer (6). Alleviation of pain is important to enhance the quality of life for the patient. It is also important to take into consideration the burden of treatment cost, time and convenience to the patient when delivering care. The use of lower fractionation schedules may be preferred for patient convenience without loss of palliative effect. This measure will address concerns of end of life and palliative patients; both groups are identified as priority areas.

1c.4. Citations for data demonstrating high priority provided in 1a.3

(1)American Cancer Society. Cancer Facts & Figures 2011. Atlanta: American Cancer Society; 2011

(2)Coleman RE. Metastatic bone disease: clinical features, pathophysiology and treatment strategies. Cancer Treat Rev. 2001;27:165-176.

(3)Lutz S, Berk L, Chang E, et al. Palliative radiotherapy for bone metastases: An ASTRO evidence-based guideline. Int J Radiat Oncol Biol Phys. 2011;79(4):965-976.

(4)Van der Linden Y, Roos D, Lutz S, et al. International variations in radiotherapy fractionation for bone metastases:geographic borders define practice patterns? Clin Oncol (R Coll Radiol) 2009;21:655-65

(5)Chow E, Zeng L, Salvo N, Dennis K, Tsao M, Lutz S. Update on the systematic review of palliative radiotherapy trials for bone

metastases. Clin Oncol (R Coll Radiol). 2011.

(6)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(13):3267-3275.

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the subcriteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

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

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

Cancer

De.6. Cross Cutting Areas (check all the areas that apply):

Overuse, Palliative Care and End of Life Care, Safety

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

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

Attachment:

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

Attachment Attachment: DATA ELEMENTS.docx

S.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome)

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

All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

Once per reporting period

S.6. 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, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

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

Bone metastases diagnosis (198.5- Secondary malignant neoplasm of bone and bone marrow)

Use of EBRT (Therapeutic radiology treatment planning:

CPT 77261; simple,

CPT 77262; Intermediate,

CPT 77263; complex)

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Senior Care

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

Bone metastases diagnosis (198.5- Secondary malignant neoplasm of bone and bone marrow)

Use of EBRT (Therapeutic radiology treatment planning:

CPT 77261; simple,

CPT 77262; Intermediate,

CPT 77263; complex)

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

The medical reasons for denominator exclusions are:

- 1) Previous radiation treatment to the same anatomic site;
- 2) Patients with femoral axis cortical involvement greater than 3 cm in length;
- 3) Patients who have undergone a surgical stabilization procedure; and
- 4) Patients with spinal cord compression, cauda equina compression or radicular pain

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

A. Medical Reasons (Data Source)

- 1) Previous radiation treatment to the same anatomic site (Medical Record)
- 2) Patients with femoral axis cortical involvement greater than 3 cm in length(Imaging Studies)
- 3) Patients who have undergone a surgical stabilization procedure (Operative Report)
- 4) Patients with spinal cord compression, cauda equina compression or radicular pain (Diagnosis/Problem list)

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b)

Stratification of the measure is not required.

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

Not applicable

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)

Better quality = Higher score

S.18. 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.)

Denominator Calculation

Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT

Step 2: Identify patients with no history of previous radiation therapy to the same anatomic site

Step 3: Identify patients with specified exceptions and exclude from denominator calculation

Numerator Calculation:

Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT

Step 2: Identify patients prescribed with one of the recommended fractionation schemes: 30Gy/10fxns or 24Gy/6fxns or 20Gy/5fxns or 8Gy/1fxn

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

The measure is based on a clinical practice guideline

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

The data sources for this measure include: Radiation oncologist consultation note, physician office progress note, radiation flow

sheet, radiology report

S.25. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

S.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual, Clinician : Team, Facility, Health Plan

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Ambulatory Care : Clinician Office, Hospital/Acute Care Facility

If other:

S.28. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

1822_MeasureTesting_MS5.0_Data.doc

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

generated 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)

If other:

3b. Electronic Sources

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

3b.1. To what extent are the specified data elements available electronically in defined fields? (i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields)

ALL data elements are in defined fields in a combination of electronic sources

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources.

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL.

Attachment:

3c. Data Collection Strategy

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

3c.1. 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.

IF a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

The denominator for the measure includes all patients with a diagnosis of painful bone metastases and no previous radiation to that anatomical site, who were prescribed EBRT. Much of the information was found in consultation, office visit note, outpatient treatment center and other-treatment summaries. This was abstracted without difficulty.

The numerator for this measure includes all patients, regardless of age, with painful bone metastases and no previous radiation to that anatomical site, who were prescribed EBRT with any of the following fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns or 8Gy/1fxn. The data for the numerator was contained in consultation, office visit notes, outpatient treatment center and problem/ diagnosis list. This was also abstracted without any difficulty.

The measure was abstracted without difficulty at four testing sites.

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

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

Planned	Current Use (for current use provide URL)
Public Reporting	
Payment Program	
Quality Improvement with Benchmarking (external benchmarking to multiple organizations)	
Quality Improvement (Internal to the specific organization)	
Not in use	

4a.1. For each CURRENT use, checked above, provide:

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

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

4a.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

4b. Improvement

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

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (trends in performance results, number and percentage of people receiving high-quality healthcare)
- Geographic area and number and percentage of accountable entities and patients included

4b.2. If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4c. Unintended Consequences

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

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

There was no identified susceptibility to inaccuracies, errors, or unintended consequences of measurement identified during testing.

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

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

<p>5a. Harmonization The measure specifications are harmonized with related measures; OR The differences in specifications are justified</p> <p>5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s): Are the measure specifications completely harmonized?</p> <p>5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.</p>
<p>5b. Competing Measures The measure is superior to competing measures (e.g., is a more valid or efficient way to measure); OR Multiple measures are justified.</p> <p>5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s): Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.) No competing or related measures identified</p>

<p>Appendix</p> <p>A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed. Attachment:</p>
<p>Contact Information</p> <p>Co.1 Measure Steward (Intellectual Property Owner): American Society for Radiation Oncology Co.2 Point of Contact: Nadine, Eads, nadinee@astro.org, 703-502-1550- Co.3 Measure Developer if different from Measure Steward: American Society for Radiation Oncology Co.4 Point of Contact: Nadine, Eads, nadinee@astro.org, 703-502-1550-</p>
<p>Additional Information</p> <p>Ad.1 Workgroup/Expert Panel involved in measure development Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development. Anushree Vichare, MBBS MPH, Measures Development Manager, ASTRO: Measure Developer Emily Wilson, Vice-President, Advocacy & Clinical Affairs Division, ASTRO: Measure Developer</p> <p>Measure Developer/Steward Updates and Ongoing Maintenance Ad.2 Year the measure was first released: Ad.3 Month and Year of most recent revision: Ad.4 What is your frequency for review/update of this measure? Ad.5 When is the next scheduled review/update for this measure?</p> <p>Ad.6 Copyright statement: Ad.7 Disclaimers:</p>

Ad.8 Additional Information/Comments: