



Measure Information

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

Brief Measure Information

NQF #: 0390

Corresponding Measures:

De.2. Measure Title: Prostate Cancer: Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer

Co.1.1. Measure Steward: American Urological Association

De.3. Brief Description of Measure: Percentage of patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate who were prescribed androgen deprivation therapy in combination with external beam radiotherapy to the prostate

1b.1. Developer Rationale: The use of adjuvant hormonal therapy following external beam radiotherapy is a well-established standard of care for high-risk prostate cancer patients. Multiple large studies have shown that men who receive adjuvant hormonal therapy following external beam radiotherapy can live longer and have a lower risk of recurrence than men who receive radiotherapy alone. In addition, a cost-analysis conducted found that the use of adjuvant hormonal therapy and external beam radiotherapy is cost-effective and adds quality-adjusted life years for patients (1).

Data from several sources indicates that while utilization rates of adjuvant hormonal therapy and external beam radiotherapy have increased, they still remain suboptimal. One study analyzing the CaPSURE database, a provider-based registry, found that the utilization of adjuvant hormonal therapy and external beam radiotherapy for high-risk patients has increased to 80% throughout the past two decades, yet utilization rates have plateaued since 2000 (2). There is rising concern about undertreatment of high-risk prostate cancer patients (3). This suggests greater outreach and education are needed to improve outcomes in care.

Citation:

1. Satish K, Shelly M, Harrison C, et al. Neo-adjuvant and adjuvant hormone therapy for localised and locally advanced prostate cancer. *Cochrane Database Syst Rev.* 2006; (4): CD006019. DOI: 10.1002/14651858.CD006019.pub2. Accessed at: http://www.cochrane.org/CD006019/PROSTATE_neo-adjuvant-and-adjuvant-hormone-therapy-for-localised-and-locally-advanced-prostate-cancer

2. Cooperberg MR, Janet Cowan, J, Broering JM, et al. High-Risk Prostate Cancer in the United States, 1990-2007. *World J Urol.* 2008; 26(3): 211–218. doi:10.1007/s00345-008-0250-7.

3. Cooperberg MR, Broering JM, Carroll, PR. Time trends and local variation in primary treatment of localized prostate cancer. *J Clin Oncol.* 2010;28(7):1117-1123.

S.4. Numerator Statement: Patients who were prescribed androgen deprivation therapy in combination with external beam radiotherapy to the prostate

S.6. Denominator Statement: All patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate

S.8. Denominator Exclusions: Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (eg, salvage therapy)

Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate

De.1. Measure Type: Process

S.17. Data Source: [Registry Data](#)

S.20. Level of Analysis: [Clinician : Group/Practice, Clinician : Individual](#)

IF Endorsement Maintenance – Original Endorsement Date: [Jul 31, 2008](#) **Most Recent Endorsement Date:** [Oct 26, 2016](#)

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 sub criteria to pass this criterion and be evaluated against the remaining criteria.***

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

[0390_Evidence_MSF5.0_Data-635278494967840120-635932898713011145.doc](#)

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

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., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

The use of adjuvant hormonal therapy following external beam radiotherapy is a well-established standard of care for high-risk prostate cancer patients. Multiple large studies have shown that men who receive adjuvant hormonal therapy following external beam radiotherapy can live longer and have a lower risk of recurrence than men who receive radiotherapy alone. In addition, a cost-analysis conducted found that the use of adjuvant hormonal therapy and external beam radiotherapy is cost-effective and adds quality-adjusted life years for patients (1).

Data from several sources indicates that while utilization rates of adjuvant hormonal therapy and external beam radiotherapy have increased, they still remain suboptimal. One study analyzing the CaPSURE database, a provider-based registry, found that the utilization of adjuvant hormonal therapy and external beam radiotherapy for high-risk patients has increased to 80% throughout the past two decades, yet utilization rates have plateaued since 2000 (2). There is rising concern about undertreatment of high-risk prostate cancer patients (3). This suggests greater outreach and education are needed to improve outcomes in care.

Citation:

1. Satish K, Shelly M, Harrison C, et al. Neo-adjuvant and adjuvant hormone therapy for localised and locally advanced prostate cancer. *Cochrane Database Syst Rev.* 2006; (4): CD006019. DOI: 10.1002/14651858.CD006019.pub2. Accessed at: http://www.cochrane.org/CD006019/PROSTATE_neo-adjuvant-and-adjuvant-hormone-therapy-for-localised-and-locally-advanced-prostate-cancer

2. Cooperberg MR, Janet Cowan, J, Broering JM, et al. High-Risk Prostate Cancer in the United States, 1990-2007. *World J Urol.* 2008; 26(3): 211–218. doi:10.1007/s00345-008-0250-7.

3. Cooperberg MR, Broering JM, Carroll, PR. Time trends and local variation in primary treatment of localized prostate cancer. J Clin Oncol. 2010;28(7):1117-1123.

1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. (*This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.*) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.

Report Title: PQRS Ad Hoc Analysis PQ3394, 2014 PQRS Measure Data for PCPI

Report includes Final Action 2014 EHR data, Final Action 2014 Registry Data and Part B Claims data for services rendered between January 1, 2014 and December 31, 2014 and processed into NCH by February 27, 2015.

01/01/2014 – 12/31/2014 Registry Performance Rate:

Mean: 93.82%

Minimum: 16.67%

Maximum: 100.00%

2013 PQRS Experience Report by Individual Measure:

2013 is the most recent year for which PQRS Experience Report measure data is available. The average performance rates on over Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer Patients the last several years are as follows:

2010: 79.60%

2011: 93.50%

2012: 91.10%

2013: 95.40%

It is important to note that PQRS has been and remains a voluntary reporting program. In the early years of the PQRS program, participants received an incentive for satisfactorily reporting. However, beginning in 2015, the program will impose payment penalties for non-participants based on 2013 performance. For 2013, 18.70% of eligible professionals reported on Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer Patients for claims and registry. As a result, performance rates may not be nationally representative.

Reference: Center for Medicare and Medicaid Services. 2013 Reporting Experience Including Trends. Available:

<https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/pqrs/analysisandpayment.html>

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.

An analysis of data from the CaPSURE database, a provider-based registry, conducted by Cooperberg and colleagues found that the utilization of adjuvant hormonal therapy and external beam radiotherapy for high-risk patients has increased to 80% throughout the past two decades, yet utilization rates have plateaued since 2000.

Citation:

1. Cooperberg MR, Janet Cowan, J, Broering JM, et al. High-Risk Prostate Cancer in the United States, 1990-2007. World J Urol. 2008 June ; 26(3): 211–218. doi:10.1007/s00345-008-0250-7.

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

While this measure is included in federal reporting programs, those programs have not yet made disparities data available for us to analyze and report.

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

African American/black men have the highest incidence rate of prostate cancer in the United States and are more than twice as likely as white men to die from the disease (1). Between 2008-2012, the average annual prostate cancer incidence rate among African American men was 208.7 cases per 100,000 men, which was 70% higher than the rate in white men. Although prostate cancer incidence and mortality rates have been declining in African American and white men since 1991, the incidence, prevalence, and death rates remain comparably higher among African American men as compared to white men (2).

An analysis of data from the CaPSURE database by Moses and colleagues found significant ethnic and racial differences in the treatment of high-risk prostate cancer. African American men are more likely to receive non-surgical treatment than white men.

White men were 25% less likely than African American men to receive radiation therapy and are 48% less likely to receive hormonal therapy (3).

Citations:

1. National Cancer Institute. Cancer health disparities. <http://www.cancer.gov/about-nci/organization/crchd/cancer-health-disparities-fact-sheet>. Accessed February 12, 2016.

2. American Cancer Society Cancer Facts and Figures for African Americans 2016-2018. <http://www.cancer.org/acs/groups/content/@editorial/documents/document/acspc-047403.pdf>. Accessed February 26, 2016.

3. Moses KA, Paciorek AT, Penson DF, et al. Impact of ethnicity on primary treatment choice and mortality in men with prostate cancer: data from CaPSURE. J Clin Oncol. 2010; 28(6): 1069-1074.

2. Reliability and Validity—Scientific Acceptability of Measure Properties

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

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

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

Cancer, Cancer : Prostate

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

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

Elderly

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

The measure specifications are included within this submission. Additional measure details may be found at <http://www.auanet.org/resources/aua-developed-measures.cfm>

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

This is not an eMeasure Attachment:

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)

No data dictionary Attachment:

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

Attachment:

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

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

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

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

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

Patients who were prescribed androgen deprivation therapy in combination with external beam radiotherapy to the prostate

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

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

Time Period for Data Collection: Once per episode of radiation therapy to the prostate cancer (ie, external beam radiotherapy to the prostate) during the 12-month reporting period

Definition:

Prescribed – Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the performance period, even if the prescription for that medication was ordered prior to the encounter.

To submit the numerator option for patients who were prescribed with androgen deprivation therapy in combination with external beam radiotherapy to the prostate, report the following quality data code (G-code):

GXXXX (in development for 2018 implementation): Androgen deprivation therapy prescribed/administered in combination with external beam radiotherapy to the prostate

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

All patients, regardless of age, with a diagnosis of prostate cancer at high or very high risk of recurrence receiving external beam radiotherapy to the prostate

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

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be

described in the calculation algorithm (S.14).

Time Period for Data Collection: 12 consecutive months

Definitions:

Risk Strata - Very Low, Low, Intermediate, High, or Very High—

Very Low Risk – PSA < 10 ng/mL; AND Gleason score 6 or less/Gleason grade group 1; AND clinical stage T1c; AND presence of disease in fewer than 3 biopsy cores; AND = 50% prostate cancer involvement in any core; AND PSA density < 0.15 ng/mL/cm³.

Low Risk – PSA < 10 ng/mL; AND Gleason score 6/Gleason grade group 1; AND clinical stage T1 to T2a.

Intermediate Risk – PSA 10 to 20 ng/mL; OR Gleason score 7/Gleason grade group 2-3; OR clinical stage T2b to T2c.

Note: Patients with multiple adverse factors may be shifted into the high risk category.

High Risk – PSA > 20 ng/mL; OR Gleason score 8 to 10/Gleason grade group 4-5; OR clinically localized stage T3a.

Note: Patients with multiple adverse factors may be shifted into the very high risk category.

Very High Risk – Clinical stage T3b to T4; OR primary Gleason pattern 5; OR more than 4 cores with Gleason score 8 to 10/Gleason grade group 4-5. (NCCN, 2017)

External beam radiotherapy – External beam radiotherapy refers to 3D conformal radiation therapy (3D- CRT), intensity modulated radiation therapy (IMRT), stereotactic body radiotherapy (SBRT), and proton beam therapy.

Any male patient, regardless of age

AND

Diagnosis for prostate cancer (ICD-10-CM): C61

AND

Patient encounter during the performance period (CPT): 77427, 77435

AND

High or very high risk of recurrence of prostate cancer: G8465

AND NOT

Diagnosis for metastatic cancer (ICD-10-CM): C77.0, C77.1, C77.2, C77.3, C77.4, C77.5, C77.8, C77.9, C78.00, C78.01, C78.02, C78.1, C78.2, C78.30, C78.39, C78.4, C78.5, C78.6, C78.7, C78.80, C78.89, C79.00, C79.01, C79.02, C79.10, C79.11, C79.19, C79.2, C79.31, C79.32, C79.40, C79.49, C79.51, C79.52, C79.60, C79.61, C79.62, C79.70, C79.71, C79.72, C79.81, C79.82, C79.89, C79.9

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (eg, salvage therapy)

Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate

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

Time Period for Data Collection: Denominator Exception(s) are determined on the date of the denominator eligible encounter.

Exceptions are used to remove a patient from the denominator of a performance measure when the patient does not receive a therapy or service AND that therapy or service would not be appropriate due to patient-specific reasons. The patient would otherwise meet the denominator criteria. Exceptions are not absolute, and are based on clinical judgment, individual patient characteristics, or patient preferences. The AUA exception methodology uses three categories of reasons for which a patient may be removed from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For measure Combination Androgen Deprivation Therapy for High Risk or Very High Risk Prostate Cancer, exceptions may include medical reason(s) (eg, salvage therapy) or patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate. Although this methodology does not require the external reporting of more detailed exception data, the AUA recommends that physicians document the specific reasons for exception in patients' medical records for the purposes of optimal patient management and audit-readiness. The AUA also

advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement.

Additional details are as follows:

GXXXX (in development for 2018 implementation): Documentation of medical reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate (eg, salvage therapy)

GXXXX (in development for 2018 implementation): Documentation of patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate

S.10. Stratification Information *(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)*

Consistent with CMS' Measures Management System Blueprint and recent national recommendations put forth by the IOM and NQF to standardize the collection of race and ethnicity data, we encourage the results of this measure to be stratified by race, ethnicity, administrative sex, and payer.

S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment)

No risk adjustment or risk stratification

If other:

S.12. Type of score:

Rate/proportion

If other:

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

Better quality = Higher score

S.14. Calculation Algorithm/Measure Logic *(Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)*

To calculate performance rates:

1. Find the patients who meet the initial population (ie, the general group of patients that a set of performance measures is designed to address).
2. From the patients within the initial population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial population and denominator are identical.
3. From the patients within the denominator, find the patients who meet the numerator criteria (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator
4. From the patients who did not meet the numerator criteria, determine if the provider has documented that the patient meets any criteria for exception when denominator exceptions have been specified [for this measure: medical reason(s) (eg, salvage therapy) or patient reason(s) for not prescribing/administering androgen deprivation therapy in combination with external beam radiotherapy to the prostate]. 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 exception rate (ie, percentage 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.

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

IF an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed.
Not applicable. The measure is not based on a sample.

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

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

Not applicable. The measure is not based on a survey.

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

If other, please describe in S.18.

Registry Data

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

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

Not applicable. Not a PRO.

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

No data collection instrument provided

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

Clinician : Group/Practice, Clinician : Individual

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

Clinician Office/Clinic, Other:Radiation Oncology Clinic/Department, Outpatient Services

If other:

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

Not applicable. The measure is not a composite.

2. Validity – See attached Measure Testing Submission Form

NQF_0390_Adjuvant_Hormonal_Therapy_2016_03_28.docx

2.1 For maintenance of endorsement

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

2.2 For maintenance of endorsement

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

2.3 For maintenance of endorsement

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

3. Feasibility

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

3a. Byproduct of Care Processes

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

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

Generated or collected by and used by healthcare personnel during the provision of care (e.g., blood pressure, lab value, diagnosis, depression score), Coded by someone other than person obtaining original information (e.g., DRG, ICD-9 codes on claims), Abstracted from a record by someone other than person obtaining original information (e.g., chart abstraction for quality measure or registry)

If other:

3b. Electronic Sources

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

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

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. For maintenance of endorsement, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

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

Attachment:

3c. Data Collection Strategy

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

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

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

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

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

The AUAER and PCPI jointly hold all rights on the Measure, including copyright, in perpetuity, in all forms and media throughout the world, for the full term of copyright, including renewals. Notwithstanding the foregoing, the Measure will be available to the public free of charge for use in non-commercial endeavors without seeking any permissions (notices on the measures provide this

permission, e.g., use by health care providers in connection with their practices is not a commercial use).

4. Usability and Use

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

4a. Accountability and Transparency

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

4.1. Current and Planned Use

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

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

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

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

1. Physician Quality Reporting System (PQRS)-Sponsored by the Centers for Medicare and Medicaid Services (CMS)

Purpose: PQRS is a national reporting program that uses a combination of incentive payments and payment adjustments to promote reporting of quality information by eligible professionals (EPs). The program provides an incentive payment to practices with EPs (identified on claims by their individual National Provider Identifier [NPI] and Tax Identification Number [TIN]). EPs satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B Fee-for-Service (FFS) beneficiaries (including Railroad Retirement Board and Medicare Secondary Payer). Beginning in 2015, the program also applies a payment adjustment to EPs who do not satisfactorily report data on quality measures for covered professional services in 2013. Source: <http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/index.html> CMS has implemented a phased approach to public reporting performance information on the Physician Compare Web site. CMS announced through rulemaking their plans to make all PQRS individual EP level PQRS measures available for public reporting annually, including making the 2016 PQRS individual EP level data available for public reporting on Physician Compare in late 2017.

2. AQUA Registry – Sponsored by the American Urological Association

Purpose: As part of its ongoing commitment to improving the quality of care for patients with urologic disease, the American Urological Association launched the AUA Quality (AQUA) Registry with a pilot project in June 2014. The AQUA Registry is a national urologic disease registry designed to measure and report healthcare quality and patient outcomes. Through the aggregation and organization of both clinical- and patient-reported data on diagnostic and therapeutic interventions, outcomes and resource utilization, the Registry will provide the urologic community with a definitive resource for informing and advancing urology within the United States. The AQUA Registry currently focuses on prostate cancer, but it will gradually expand to include other urological conditions when it becomes a Qualified Clinical Data Registry (QCDR). It is anticipated that the registry will achieve QCDR status in early 2016. The registry is currently in the early stages of data aggregation and has plans for continued expansion in 2016 and beyond. Beginning in late 2016, CMS will require QCDRs to publicly report on PQRS and non-PQRS measure data at the individual EP level following the first year of reporting by the QCDR.

3. Michigan Urological Surgery Improvement Collaboration (MUSIC)-- Sponsored by Blue Cross and Blue Shield of Michigan as part of the BCBSM Value Partnerships program

Purpose: The overall aims of the collaborative include, among others, evaluating and improving patterns of care in the radiographic staging of men with newly diagnosed prostate cancer, reducing biopsy-related complications and assessing repeat biopsy patterns, improving patient outcomes after radical prostatectomy, enhancing patient-centered decision making among men considering local therapy for early-stage prostate cancer, and understanding and reducing variation in the use of androgen deprivation therapy. Participating practices number 45 and submit data to a clinical registry maintained by the MUSIC Coordinating Center and tri-annual consortium-wide meetings are held each year to discuss data, review risk-adjusted measures of processes of care and patient outcomes, and identify strategies and best practices for quality improvement.

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

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

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

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

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

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

Describe how feedback was obtained.

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

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

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

Improvement

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

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results,

number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

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

While the AUA creates measures with an ultimate goal of improving the quality of care, measurement is a mechanism to drive improvement but does not equate with improvement. Measurement can help identify opportunities for improvement with actual improvement requiring making changes to health care processes and structure. In order to promote improvement, quality measurement systems need to provide feedback to front-line clinical staff in as close to real time as possible and at the point of care whenever possible. (1)

1. Conway PH, Mostashari F, Clancy C. The future of quality measurement for improvement and accountability. JAMA. 2013 Jun 5;309(21):2215-6.

4b2. Unintended Consequences

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

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

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

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

5. Comparison to Related or Competing Measures

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

5. Relation to Other NQF-endorsed Measures

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

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

0220 : Adjuvant hormonal therapy is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor-positive breast cancer
0389 : Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
1853 : Radical Prostatectomy Pathology Reporting

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

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

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

Are the measure specifications harmonized to the extent possible?

No

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

For measure 0220, Adjuvant Hormonal Therapy, the related measure focuses on adjuvant hormonal therapy for breast cancer patients, which is not consistent with the target population addressed in measure 0390. While this is the same action, it is a different drug and target population addressed in each measure. The related measure 0389, Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients addresses the use of bone scan in low-risk prostate cancer patients which is a different quality action from measure 0390. The two measures do not share similar target populations and address different aspects of prostate cancer care. The related measure 1853, Radical Prostatectomy Pathology Reporting, addresses the percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status, which is a different action than measure 0390. The two measures do not share similar target populations and address different aspects of prostate cancer care.

5b. Competing Measures

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

OR

Multiple measures are justified.

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

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

Appendix

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

Attachment:

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Urological Association

Co.2 Point of Contact: Suzanne, Pope, spope@auanet.org, 410-689-4026-

Co.3 Measure Developer if different from Measure Steward: American Urological Association

Co.4 Point of Contact: Suzanne, Pope, spope@auanet.org, 410-464-4904-

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

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

Timothy D. Averch, MD, FACS (urology)

John L. Gore, MD, MS, FACS (urology)

Christopher D. Tessier, MD (urology)

Ian Thompson, MD (Co-Chair, urology)

Steven Clauser, PhD (Co-Chair, methodology)

Peter Albertsen, MD (urology)

Colleen Lawton, MD (radiation oncology)

Charles Bennett, MD, PhD, MPP (clinical oncology)

W. Robert Lee, MD, MS, Med (radiation oncology)

Michael Cookson, MD (urology)
 Peter A. S. Johnstone, MD, FACR (radiation oncology)
 Gregory W. Cotter, MD (radiation oncology)
 David F. Penson, MD, MPH (urology)
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 Howard Sandler, MD (radiation oncology)
 Louis Kavoussi, MD (urology)
 Bill Steirman, MA (consumer representative)
 Eric A. Klein, MD (urology)
 John T. Wei, MD (urology)
 Carol Wilhoit, MD (health plan representative)

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 must be 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.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: 2007

Ad.3 Month and Year of most recent revision: 09, 2015

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

Ad.5 When is the next scheduled review/update for this measure? 09, 2017

Ad.6 Copyright statement: The AUAER and PCPI shall jointly hold all rights on the Measure, including copyright, in perpetuity, in all forms and media throughout the world, for the full term of copyright, including renewals. Notwithstanding the foregoing, the Measure will be available to the public free of charge for use in non-commercial endeavors without seeking any permissions (notices on the measures provide this permission, e.g., use by health care providers in connection with their practices is not a commercial use).

Ad.7 Disclaimers: Please see the copyright statement above in AD.6 for disclaimer information.

Ad.8 Additional Information/Comments: