



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 #: 0225

Corresponding Measures:

De.2. Measure Title: At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer

Co.1.1. Measure Steward: Commission on Cancer, American College of Surgeons

De.3. Brief Description of Measure: Percentage of patients >18yrs of age, who have primary colon tumors (epithelial malignancies only), at AJCC stage I, II or III who have at least 12 regional lymph nodes removed and pathologically examined for resected colon cancer.

1b.1. Developer Rationale: Improved survival for patients with a greater number of lymph nodes resected; greater accuracy of staging for patients, and consequently appropriate post-surgical care

S.4. Numerator Statement: >=12 regional lymph nodes pathologically examined.

S.6. Denominator Statement: Include, if all of the following characteristics are identified:

Age >=18 at time of diagnosis

Primary tumors of the colon

Epithelial malignancy only

AJCC Stage I, II, or III

Surgical resection performed at the reporting facility

S.8. Denominator Exclusions: Exclude, if any of the following characteristics are identified:

Age <18; non-epithelial and non-invasive tumors; metastatic disease (AJCC Stage IV); not treated surgically at the reporting facility; perforation of the primary site; acute obstruction

De.1. Measure Type: Process

S.17. Data Source: Paper Medical Records, Registry Data

S.20. Level of Analysis: Facility

IF Endorsement Maintenance – Original Endorsement Date: Mar 01, 2007 **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?

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

0225_Evidence_MSF5.0_Data.doc,12RLN_0225_Evidence_2016_04052016.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.

Improved survival for patients with a greater number of lymph nodes resected; greater accuracy of staging for patients, and consequently appropriate post-surgical care

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.*

The nationally recognized National Cancer Data Base (NCDB), jointly sponsored by the American College of Surgeons and the American Cancer Society, is a clinical oncology database sourced from hospital registry data that are collected in more than 1,500 Commission on Cancer (CoC)-accredited facilities. NCDB data are used to analyze and track patients with malignant neoplastic diseases, their treatments, and outcomes. Data represent approximately 70 percent of newly diagnosed cancer cases nationwide and 33 million historical records. Data from the NCDB was analyzed.

The NCDB collects data from CoC accredited cancer programs on an annual basis; the data we collect is in accordance with standard registry procedures. In January of 2015, 2013 diagnoses were collected. This information was released to accredited cancer programs in the late summer 2015, this data is used in this application.

The mean performance rate for this measure has increased from 81.7% (95% CI: 81.4-82.1) IQR=71-92% n= 39,910 in 2008 to 89.7% (89.4-90.0) IQR=84-97% n=41,546 in 2013 representing a steady improvement in quality. The minimum hospital-level performance rate is 0% with a 100% maximum in all years assessed 2008-2013.

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.

NA

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.*

The data source is described in 1b.1.

Disparities were assessed by race/ethnicity, age, insurance status, sex, facility type, and income at the zip code level.

Race/Ethnicity

Race/ethnicity was defined as non-Hispanic white, non-Hispanic black, Hispanic, Asian/Hawaiian/Pacific Island or other race/ethnicity. Between 2008 and 2012, performance rates increased in all ethnic groups. Non-hispanic whites, Non-hispanic blacks, Asian Pacific Islanders, Hispanics, and Non-hispanic Blacks had similar performance rates in 2013; Non-hispanic whites at

89.9% (95% CI: 89.6-90.3) n=31,698 in 2013, non-Hispanic Blacks at 88.6% (95% CI: 87.7-89.6) n=4752, Asian Pacific Islanders 90.6% (88.9-92.4) n=1064, and Hispanics 89.7% (95% CI: 88.4-90.9) n=2177.

Age

Age groups were defined as, 18-49, 50-59, 60-69, 70-79 and over 79. Since 2008, patient above age 49 saw a relatively equal gain in performance with the measure ~9%. Patients age 18-49 saw only a 5.2% increase given the already high performance 89.3% (88.3-90.4) n=3360 in 2008. Patients under the age of 50 at diagnosis had higher performance rates in 2013 at 94.5% (93.7-95.2) n=3164, compared to patients aged 50 to 59 90.0% (89.3-90.7) n=6776, patients aged 60-69 89.7% (89.1-90.3) n=9762, patients aged 70-79 89.2% (88.7-89.8) n=11,196, and patients aged >79 88.6% (88.0-89.2) n=10,648.

Insurance

Insurance status is defined as insurance at the time of diagnosis. Insurance was stratified into private, Medicare, Medicaid/No insurance. Since 2008, patients with each insurance type saw a relative equal gain in performance of 8-10%. Uninsured and insured including Medicaid patients had similar performance rates in 2013. Uninsured at 91.2% (90.1-92.4) n=2310, private insurance at 90.7% (90.2-91.2) n=13,461, Medicare at 89.0% (88.6-89.4) n=24,792, Other Government 89.7% (86.6-92.9).

Median Zip Code Income Quintile

Income quintiles at the zip code level were assessed based on the 2012 American Community Survey. Patients that resided in communities with a median income of <\$36,000 annually at diagnosis experienced higher performance in 2013 88.2% (87.4-89.1) n=5720 than patients from communities with a median income above \$69,000 91.5% (91.0-92.1) n=10,076. In 2008, the mean performance rate for <\$36K was 79.7% (78.7-80.8) n=5507 and increased by 8.5% by 2013. Patients that resided in communities with median incomes above \$69K experienced a 8.1% gain in performance between 2008 and 2013.

Proportion of residents with no high school degree in zip code

Patients that resided in communities at time of diagnosis with the lowest proportion of no high school degree (<7%) had higher rates of performance in 2013 91.0% (90.4-91.6) n=9771 than patients from communities with the highest proportion of patients with no high school degree (>21%) 89.4% (88.7-90.1) n=7302. Likewise, the performance increase from 2008 was higher for patients from communities with the highest proportion of no high school degree (>21%) 9.5% gain.

Facility Type

Facility type was assessed by programs CoC-accreditation status. Facility types include Comprehensive Community Cancer Programs, Integrated Network Cancer Programs, Community Cancer Programs and by Academic/Research programs. Since 2008, patients at community hospitals experienced the largest gain in performance (+10.8%), whereas the performance rate in 2008 for patients at academic centers was 86.0% (85.3-86.7), representing a 6% gain. Patients that were treated at teaching/research hospitals experienced higher performance rates 92.0% (91.5-92.5) n=11,214 to those treated at comprehensive community centers 89.3% (88.8-89.7) n=21,302 in 2013. Patients treated at smaller community hospitals had lower performance rates at 86.4% (85.5-87.3) n=5902.

Census Region

There was very little regional variation by Census Region in 2013. Patients that resided in the Midwest Census Region had a performance rate of 90.4% (89.8-90.9) n=10,754 in 2013, Pacific 90.2% (89.3-91.0) n=4748, West 90.1% (88.7-91.5) n=1700, South 88.9% (88.4-89.4) n=15,614, and Northeast 89.9% (89.3-90.5) n=8651. Patients that resided in the Pacific Census Region saw the largest performance gain since 2008 79.2% (78.1-80.4) n=4695 representing a 11.2% increase. By contrast, the smallest increase in performance was in the Northeast region, 83.1% (82.3-84.0) n=8036 in 2008.

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

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

<p>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.</p>
<p>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).</p>
<p>De.5. Subject/Topic Area (check all the areas that apply): Cancer, Cancer : Colorectal</p> <p>De.6. Non-Condition Specific(check all the areas that apply): Care Coordination, Disparities Sensitive</p> <p>De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any): Elderly</p>
<p>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.) https://www.facs.org/~media/files/quality_programs/cancer/ncdb/measure_specs_colon.ashx</p> <p>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:</p> <p>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:</p> <p>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. No, this is not an instrument-based measure Attachment:</p> <p>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. Not an instrument-based measure</p> <p>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. Yes</p> <p>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. Since the last endorsement, this measure has been updated to include any tumor diagnosis, no longer limited to first or only malignant primaries. Due to advances in medical oncology, drug development, surgical techniques and radiotherapeutic techniques, more patients are living longer and being cured of their cancer only to develop a subsequent malignancy. For this reason when patients are being operated on for curative intent, we are holding these patients to the standard of care of a threshold minimum lymph node removal established in the Commission on Cancer Quality Measures. We have also allowed for exclusion of cases based on perforation to the primary site and acute obstructions which may lead to emergency interventions and lack of a lymph node yield.</p>
<p>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.</p>

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

>=12 regional lymph nodes pathologically examined.

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).

Regional Lymph Nodes Examined [NAACCR Item#830] = 12-90

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

Include, if all of the following characteristics are identified:

Age >=18 at time of diagnosis

Primary tumors of the colon

Epithelial malignancy only

AJCC Stage I, II, or III

Surgical resection performed at the reporting facility

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).

Surgical Procedure of the Primary Site at This Facility [NAACCR Item#670] = 30-80

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

Exclude, if any of the following characteristics are identified:

Age <18; non-epithelial and non-invasive tumors; metastatic disease (AJCC Stage IV); not treated surgically at the reporting facility; perforation of the primary site; acute obstruction

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.)

See: https://www.facs.org/~media/files/quality_programs/cancer/ncdb/measure_specs_colon.ashx

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.)

No stratification applied

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.)*

This measure score is calculated by dividing the numerator cases by denominator eligible cases.

Denominator eligible cases are assessed in a step-wise fashion:

First include diagnosis of colon cancer,

male or females,

adult patients,

malignant tumors

epithelial tumors based on AJCC 7th edition staging

Exclude clinical or pathologic evidence of in-situ disease

Exclude clinical or pathologic evidence of metastatic disease

All or part of first course of treatment at reporting facility

surgically treated at this facility

These cases are included in the denominator

Then numerator cases are assessed from denominator eligible cases

The number of regional lymph nodes examined are 12-90

The number of nodes examined is greater or equal to the number of positive lymph nodes.

The measure score is calculated by the numerator divided by the denominator.

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.

No sampling

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.

NA

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

If other, please describe in S.18.

Paper Medical Records, 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.

Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base

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)*

Facility

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

Inpatient/Hospital

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.*)

2. Validity – See attached Measure Testing Submission Form

[0225_MeasureTesting_MS5.0_Data.doc,0225_MeasureTesting_12RLN_04012016.doc](#)

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.

[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**.

[Some data elements are in defined fields in 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).

[The ACoS/CoC implementation of this measure is framed around the feasibility of data collection and reporting considerations.](#)

Cancer registries in the United States depend on a multitude of information sources in order to completely abstract case records and be in compliance with State, Federal and private sector accreditation requirements. Commission on Cancer Standards require case abstracting to be performed by a Certified Tumor Registrars (CTRs). CTRs must pass an exam and maintain continuing education. In the past decade, great strides have been made within the cancer registration community in terms of electronic capture of registry data from electronic pathology systems and electronic health records. However, until EHR systems are universally implemented in the US and fully integrated within hospital-level cancer registry systems, registry data will depend upon some level of human review and intervention to ensure data are complete and accurately recorded. Robust data quality edits are applied to the data at all levels of cancer data abstraction and processing. These edits standardize coded information and ensure its accuracy.

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.

1) The infrastructure to monitor compliance with this measure has been in place since 2005 to assess and feed-back to approximately 1,500 Commission on Cancer (CoC) accredited centers performance rates for this measure. CoC accredited cancer programs account for 70-80% of patients affected by this measure. This measure is currently reported to CoC accredited programs through the National Cancer Data Base (NCDB) using the Cancer Program Practice Profile Report (CP3R) web-based audit and feed-back reporting tool. The CP3R is generally described at: <https://www.facs.org/quality-programs/cancer/ncdb/qualitytools/cp3r>. In addition, this measure is also reported to over 1000 cancer programs participating in its "real clinical time" feedback reporting tool through its Rapid Quality Response System (RQRS). An overview of the RQRS is available at: <https://www.facs.org/quality-programs/cancer/ncdb/qualitytools/rqrs>. Both of these reporting tools have been utilized in the cancer registry community and will not produce an undue burden on the data collection network.

2) The data for this measure are key elements already collected in all hospital registries. This measure has been reviewed using cancer registry data. The CoC data demonstrates variation in the measure. The measure is readily implemented.

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.

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

4.1.a Public Reporting

Pennsylvania Health Care Quality Alliance (PHCQA)

About: PHCQA is a voluntary group of health care organizations collaboratively working together to improve the quality of health care for the people of Pennsylvania. This organization works to develop a consensus-driven, statewide approach to hospital quality measurement that is supported by quality of care data from a variety of public data sources. Commission on Cancer (CoC) accredited cancer programs in Pennsylvania may elect to voluntarily report their estimated performance rates through this program. Currently 60 of 73 Pennsylvania programs are participating.

4.1.d Regulatory and Accreditation Programs

Commission on Cancer Accreditation

The CoC standards have a requirement for programs to meet expected estimated performance rates for accountability measures approved through the CoC (Standard 4.5), programs are required to meet 85% compliance with this measure, either through the estimated performance rate point estimate or the 95% confidence interval. If this benchmark was not met then programs were required to develop action plans to address this issue. There are over 1500 CoC-accredited cancer programs representing approximately 70% of newly diagnosed cancer cases annually.

4.1.f Quality Improvement with Benchmarking

Commission on Cancer, National Cancer Data Base

Purpose: The National Cancer Data Base (NCDB) provides a benefit for CoC-accredited programs to benchmark their compliance compared to other CoC-accredited cancer programs through the use of the Cancer Program Practice Profile Reports (CP3R), the Rapid Quality Reporting System (RQRS) and the Cancer Quality Improvement Program (CQIP).

CP3R offers local providers comparative information to assess adherence to and consideration of standard of care therapies for major cancer and is described <https://www.facs.org/quality-programs/cancer/ncdb/qualitytools/cp3r>. This application is available to over 1500 CoC-accredited cancer programs

CQIP reports annual quality and outcomes data to more than 1,500 cancer programs accredited by the American College of Surgeons Commission on Cancer (CoC) and provides the availability for programs to benchmark their performance on quality measures to other CoC-accredited programs. <https://www.facs.org/quality-programs/cancer/ncdb/qualitytools/cqip>

RQRS is a reporting and quality improvement tool which provides real clinical time assessment of hospital level adherence to quality of cancer care measures for breast and colorectal cancers -<https://www.facs.org/quality-programs/cancer/ncdb/qualitytools/rqrs>. Over 1040 CoC-accredited cancer programs across the country are currently participating in this quality tool.

Quality Oncology Practice Initiative

In 2002, the American Society of Clinical Oncology established the Quality Oncology Practice Initiative (QOPI®). QOPI® is a practice-based quality assessment and improvement program designed to foster a culture of self-examination and improvement in oncology. Collection rounds are offered twice per year, in spring and fall, for an eight week period. QOPI® continues to be a successful program in the United States and 12 other countries, with 441, 313, 361 and 256 unique practices participating in Fall 2013, Spring 2014, Spring 2015 and Fall 2015 respectively.

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.

The colon measure was developed by national experts in the field of colon cancer. The measure has been harmonized with NCCN and ASCO. Prior to this update, the measure was again reviewed by a group of nationally recognized, colon cancer specialist designated as the NCDB/CoC Site Specific Leaders.

Cancer data collection through registries is uniform throughout North America. Cancer registries utilize the North American Association of Central Cancer Registries (NAACCR). NAACCR develops and promotes uniform data standards for cancer registration and certifies population-based registries among other important work to reduce the burden of cancer in North America. Data collected through the National Cancer Database (NCDB) utilizes NAACCR standard formats and editing functionality. The CoC-accredited programs file submissions are passed through an edits program to ensure the data meet acceptable quality standards. Cases with errors must be reviewed and resubmitted.

To improve capture of adjuvant therapy reported to the NCDB, the CoC-accredited programs receive individual case information regarding the quality measures supported by the CoC. This notification includes the status of the case (i.e., not eligible, concordant, non-concordant and incomplete) and any potentially missing treatment information needed for calculating the performance rates (PRs). To be compliant with Standards 4.4 and 4.5, cancer programs meet the performance rates specified by the CoC's Quality Integration Committee specified performance rate (PR) reported in the CP3R. If the PR is not met, then the cancer program must establish and implement an action plan that addresses improving performance.

All CoC-accredited facilities (n=1492) receive a report of their performance rates on this measure through the Cancer Program Practice Profile (CP3R) and an estimated performance rate on the Rapid Quality Reporting System (RQRS), a real clinical time decision support system. In 2013, the Commonwealth of Pennsylvania began reporting performance rates on this measure for 72% (52 of 72) of the CoC-accredited hospitals in Pennsylvania. That number of reporting hospitals has risen to 87.5% (63 or 72) of the Commonwealth's hospitals (7/01/2018).

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.

The Web-based Cancer Program Practice Profile Report (CP3R) offers local providers comparative information to assess adherence to and consideration of standard of care therapies for this measure, and provides a platform from which to promote continuous practice improvement aimed to improve quality of patient care at the local level. This tool also permits hospitals to compare their care for these patients relative to that of other providers. The aim is to empower clinicians, administrators, and other staff to work cooperatively and collaboratively to identify problems in practice and delivery and to implement best practices that will diminish disparities in care across Commission on Cancer (CoC)-accredited cancer programs. This tool is updated annually.

The Rapid Quality Reporting System (RQRS) is a reporting and quality improvement tool for this measure. This tool provides real clinical time assessment of hospital-level adherence to measure and provides alerts for upcoming adjuvant therapy for patients affected by this measure. The RQRS has been available to all Commission on Cancer (CoC)-accredited cancer programs beginning September 2011. As of January 2017, RQRS participation is required for all CoC-accredited programs. RQRS is updated every 24 hours.

This measure is critical to the Commission on Cancer's (CoC) accreditation process as performance on this measure is expected to meet a proposed performance rate (PR). The CoC-Accreditation Manual (AM), Standard 4.3 of the AM, requires the Cancer Liaison Physician to monitor, interpret and provide updated reports of the program's performance related to the accountability measures in

the CP3R at least four times a year. A quality related audit is initiated for any of the accountability measures, which this measure is considered. Standard 4.4 (AM) addresses the expected performance rate for facilities and those that fall below the expected performance rates must implement an action plan to address how the program will implement a quality improvement plan to address and reach expected compliance.

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.

Our facilities have fostered the development of the CP3R, commenting on the design of the feedback to facilitate utilization of the tools. The RQRS was developed and based on survey results from alpha and beta testers. Design issues continue to be addressed as to how best to capture forthcoming adjuvant therapy.

As this measure is distributed, if any questions about the calculation of the measure or inquiry regarding the numerator/denominator are asked, programs will submit questions through the NCDB mailbox. The User Support Specialists monitor this mailbox and answer these questions. Content related questions are sent to the Colon Site Specific Leaders (SSLs), who are renown clinical experts on colon cancer.

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

The CP3R: Our registrars and physicians review the measures through phone calls and e-mails. Our surveyors inform the CoC of potential problems that the measure may encounter. As issues are identified, slight modifications will be made; e.g., excluding patients on related clinical trials.

The RQRS: The responses have been positive. For example, a hospital administrator has stated that he had better physician recruiting with the implementation of this clinical data support system that alerts providers of adjuvant therapy for their patients. Further, an often heard comment is that RQRS has “prevented patients from slipping through the cracks” as the first course of treatment can last a year.

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

The Pennsylvania Health Care Alliance (PHCQA) approached the CoC to support voluntary hospital reporting of clinical measures on their website (<http://www.phcqa.org/>). The CoC provides the means for data collection through the annual call for data. Calculations are made and sent to the hospitals, who have stated that they wish to participate in this voluntary reporting of their performance on the measure. Upon agreement by these hospitals, the NCDB sends the Performance Rates to the PHCA for posting on the website. In 2013, the Commonwealth of Pennsylvania began reporting performance rates on this measure for 72% (52 of 72) of the CoC-accredited hospitals in Pennsylvania. That number of reporting hospitals has risen to 87.5% (63 of 72) of the Commonwealth’s hospitals (7/01/2018).

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.

Site-specific leaders, who are expert clinicians in the care of colon cancer patients, are notified of any potential issues that have been identified in the calculation of this measure. They review the measure for current practice and potential impact of any clinical trials that may impact the measure. Identified issues are communicated to the CoC and changes, if needed, are incorporated into the measure logic. The CoC-accredited hospitals are notified if changes are made and why.

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.

NA

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.

This measure, as specified, is unlikely to be systematically susceptible to under-reporting due to the integral dependence of the measure upon information routinely documented and reported following pathologic examination of colon tissue specimens.

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.

No

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.

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?

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

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
<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.</p> <p>Attachment:</p>
Contact Information
<p>Co.1 Measure Steward (Intellectual Property Owner): Commission on Cancer, American College of Surgeons</p> <p>Co.2 Point of Contact: Bryan, Palis, bpalis@facs.org, 312-202-5439-</p> <p>Co.3 Measure Developer if different from Measure Steward: Commission on Cancer, American College of Surgeons</p> <p>Co.4 Point of Contact: Erica, McNamera, emcnamara@facs.org, 302-202-5194-</p>
Additional Information
<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. Original Developers: Christopher (Chris) Pezzi, MD, FACS (Abington Memorial Hospital, Abington PA); Lawrence Shulman, MD (Dana Farber Cancer Institute, Boston MA); Stephen Edge, MD, FACS (Roswell Park Cancer Institute, Buffalo NY); Richard Swanson, MD, FACS (Partners Health Care, Boston MA); Peter Enzinger, MD (Dana Farber Cancer Institute, Boston MA); Elin Sigurdson, MD, FACS (Fox Chase Cancer Center, Philadelphia PA); Mitchell Posner, MD, FACS (University of Chicago, Chicago IL); Anthony Robbins, MD, PhD (American Cancer Society)</p> <p>The current Measure workgroup includes: Charles Cheng MD, FACS (Fox Valley Surgical Associates, Appleton, WI), Daniel McKellar, MD, FACS (Wayne Healthcare, Greenville, OH), David Jason Bentrem, MD (Northwestern Memorial Hospital, Chicago, IL), Karl Bilimoria, MD, FACS (Northwestern Univ/Feinberg Sch of Med, Chicago, IL), Lawrence Shulman MD (University of Pennsylvania, Philadelphia, PA), Matthew A Facktor, MD FACS (Geisinger Medical Center, Danville, PA), Ted James (University of Vermont, Burlington, VT)</p> <p>This panel meets at least once a calendar year to review quality measures currently supported and implemented by the ACoS Commission on Cancer and to investigate and consider/review development of possible new measures.</p>
<p>Measure Developer/Steward Updates and Ongoing Maintenance</p> <p>Ad.2 Year the measure was first released: 2007</p> <p>Ad.3 Month and Year of most recent revision: 06, 2007</p> <p>Ad.4 What is your frequency for review/update of this measure? Annual</p> <p>Ad.5 When is the next scheduled review/update for this measure? 11, 2016</p>
<p>Ad.6 Copyright statement:</p> <p>Ad.7 Disclaimers:</p>
Ad.8 Additional Information/Comments: