NATIONAL QUALITY FORUM

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 #: 0559
Corresponding Measures:
De.2. Measure Title: Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer
Co.1.1. Measure Steward: Commission on Cancer, American College of Surgeons
De.3. Brief Description of Measure: Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage T1cN0M0 (tumor greater than 1 cm), or Stage IB -III, whose primary tumor is progesterone and estrogen receptor negative recommended for multiagent chemotherapy (recommended or administered) within 4 months (120 days) of diagnosis.
1b.1. Developer Rationale: Improve the utilization of chemotherapy in women with hormone receptor negative breast cancer.

S.4. Numerator Statement: Combination chemotherapy is administered within 4 months (120 days) of the date of diagnosis or it is recommended and not received.
S.6. Denominator Statement: Women under the age of 70 with AJCC T1cN0M0, or Stage IB-III hormone receptor negative breast cancer:
- Women
- Age 18-69 at time of diagnosis
- Known or assumed first or only cancer diagnosis
- Primary tumors of the breast
- Epithelial invasive malignancy only stageable by AJCC 7th edition
- AJCC T1cN0M0, or Stage IB to III
- Primary tumor is estrogen receptor negative and progesterone receptor negative
- All or part of first course of treatment performed at the reporting facility
- Known to be alive within 4 months (120 days) of diagnosis

S.8. Denominator Exclusions: Exclude, if any of the following characteristics are identified:
Men;
Age <18 and >=70;
not a first or only cancer diagnosis;
non-epithelial and non-invasive tumors;
phyllodes tumor histology;
rare histology not supported by clinical trials: 8940 - Mixed tumor, malignant, NOS, 8950 - Mullerian mixed tumor, 8980 – Carcinosarcoma, 8981 - Carcinosarcoma, embryonal
Tumor size <=1cm and AJCC pN=0;
ERA positive;
PRA positive;
Evidence of in situ or metastatic disease;
Not treated surgically;
Died within 4 months (120 days) of diagnosis;
Participation in a clinical trial which directly impacts the delivery of the standard of care

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
0559_Evidence_MSF5.0_Data.doc,MAC_0559_Evidence_2016-635953599729162351.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.
Improve the utilization of chemotherapy in women with hormone receptor negative breast cancer.

1b.2. **Provide performance scores on the measure as specified (<u>current and over time</u>) at the specified level of analysis**. *(<u>This is required for maintenance of endorsement</u>. 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 30 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 and is included in this applications.

The mean performance rate for this measure has increased from 85.1% (95% CI: 84.5-85.6) IQR=88-100% n= 16,263 in 2008 to 89.4% (88.9-89.9) IQR=92-100% n=14,331 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.**

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, facility type, and education and income at the zip code level.

Race/ethnicity
Race/ethnicity was defined as non-Hispanic white, non-Hispanic black, Hispanic, Asian/Pacific Island or other race/ethnicity. Between 2008 and 2012, performance rates increased in all ethnic groups. Non-hispanic whites had the highest performance rates in 2013 at 91.5% (95% CI: 91.0-92.1) n=9271 in 2013, followed by Asian Pacific Islanders 90.2% (87.3-93.1) n=410, Blacks 85.2% (83.9-86.4) n=2981, and Hispanics 83.6% (81.3-85.9) n=991. Between 2008 and 2012, performance rates increased in all ethnic groups.

Age
Age groups were defined as, 18-49, 50-59, 60-69. Since 2008, each age group saw a relatively equal gain in performance with the measure. Patients under the age of 50 at diagnosis had marginally higher performance rates in 2013 at 91.2% (90.4-91.9) n=5119, compared to patients 50 to 59 89.3% (88.5-90.2) n=5043, and 87.2% (86.2-88.2) n=4169.

Insurance Status
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 gain in performance. Uninsured and Medicaid patients had the lowest performance rates in 2013 at 85.0% (83.3-86.6) n=1875, Medicare at 86.0% (84.6-87.4) n=2246, Other Government 88.5% (84.7-92.4), with private insurance having the highest performance rates at 91.0% (90.4-91.6).

Median 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 lower performance in 2013 than patients from communities with a median income above $36,000. In 2008, the mean performance rate for <$36K was 83.1% (81.5-84.6) n=2246 and increased only 2.2% by 2013 to 85.3% (83.7-86.8) n=2009. In contrast, patients that resided in communities with median incomes above $36K experienced a 5% gain in performance between 2008 and 2013 from 85.0% to 90.0%.

SES – Proportion of population with no high school degree in patient zip code
The proportion of the population with no high school degree at the zip code level were assessed based on the 2012 American Community Survey. 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 91.5% (90.6-92.4) n=3534) than patients from communities with the highest proportion of patients with no high school degree (>21%) 85.3% (83.9-86.7) n=2535. Likewise, the performance increase from 2008 was smaller for patients from communities with the lowest proportion of no high school degree (<7%) 3.4% gain compared to zip codes with great proportions of residents without a high school degree.

Facility Type
Facility type was assessed by CoC-accreditation status; facility types include Comprehensive Community Cancer Programs, Integrated Network Cancer Programs,   Community Cancer Programs and by Teaching/Research programs. Patients that were treated at teaching/research hospitals experienced similar performance rates 89.3% (88.4-90.1) n=5087 to those treated at

comprehensive community centers 89.8% (89.0-90.5) n=6382 in 2013. Patients treated at smaller community hospitals had only slightly lower performance rates at 87.1% (85.4-88.7) n=1529. Since 2008, patients at academic hospitals experienced the largest gain in performance (+8.7%), whereas the performance rate in 2008 for patients at community centers was 87.3% (86.5-88.0), representing only a 2.5% gain. The same trend is true for community hospitals, with performance at 85.4% (83.8-87.0) in 2008 representing a 1.7% gain.

Census region
Performance rates increased in all census regions between 2008 to 2013. Patients that resided in the Northeast Census Region at time of diagnosis experienced the largest gain in performance between 2008 and 2013 compared to all other Census regions. In 2008, the average performance rate for the Northeast was 77.7% (76.2-79.2) n=3039 in contrast to 2013 where it had risen 11% to 88.7% (87.6-89.9) n=2865. In 2013, patients residing in the Midwest at time of diagnosis had the highest performance rate at 91.6% (90.7-92.5%) n=3539. The West had a 2013 performance rate of 89.9% (87.4-92.3%) n=595, the South had a 2013 performance rate of 89.0% (88.1-89.8) n=5775, the Pacific had a 2013 performance rate of 87.4% (85.7-89.0) n=1508.

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**

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2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, <u>as specified</u>, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. ***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 : Breast

De.6. **Non-Condition Specific***(check all the areas that apply):*
Care Coordination, Disparities Sensitive

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.)*
https://www.facs.org/~/media/files/quality programs/cancer/ncdb/measure specs breast.ashx

S.2a. <u>**If this is an eMeasure**</u>, 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.

No, this is not an instrument-based measure **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.
Not an instrument-based measure

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

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 maintenance minor changes to this measure have been instituted.

The word considered has been replaced in the numerator statement with recommended to be more consistent with the registry codes used to assess this measure.

Rare histologies which are not supported by clinical evidence were removed from inclusion:
8200 - adenoid cystic carcinoma,
8940 - Mixed tumor, malignant, NOS
8950 - Mullerian mixed tumor
8980 - Carcinosarcoma
8981 - Carcinosarcoma, embryonal
9020- phyllodes tumor

Based on changes in SEER coding of chemotherapy and immunotherapy patients with HER2 positive disease diagnosed after 2013 are compliant with the standard if they receive chemotherapy plus Her2 targeted therapy (immunotherapy), or if these treatments are recommended and not received.

An exclusion to remove patients in which participation in a clinical trial which directly impacts the delivery of the standard of care.

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).
Combination chemotherapy is administered within 4 months (120 days) of the date of diagnosis or it is recommended and not received.

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).
Chemotherapy [NAACCR Item#1390]=3, and Date Chemotherapy Started (NAACCR Item#1220) <=120 days following Date of Diagnosis [NAACCR Item# 340]
OR
Chemotherapy recommended and not received [NAACCR Item#1390]=82-87 (82:not recommended/administered because it was contraindicated due to patient risk factors, 85:not administered because the patient died prior to planned or recommended therapy,86:It was recommended by the patient´s physician, but was not administered as part of first-course therapy. No reason was stated in the patient record. 87: it was recommended by the patient´s physician, but this treatment was refused by the patient, the patient´s family member, or the patient´s guardian. The refusal was noted in the patient record);
OR

For patients ER/PR negative; Her2 Positive disease

Chemotherapy [NAACCR Item#1390]=2,3 and Date Chemotherapy Started (NAACCR Item#1220] <=120 days following Date of Diagnosis [NAACCR Item# 340]

AND

Immunotherapy/BRM recommended and not received [NAACCR Item#1410]=82-87 (82:not recommended/administered because it was contraindicated due to patient risk factors, 85:not administered because the patient died prior to planned or recommended therapy,86: recommended by the patient´s physician, but was not administered as part of first-course therapy. No reason was stated in the patient record. 87: recommended by the patient´s physician, but this treatment was refused by the patient, the patient´s family member, or the patient´s guardian. The refusal was noted in the patient record)

OR;

Immunotherapy/BRM [NAACCR Item#1410]=1 and Date Immunotherapy Started (NAACCR Item#1240] <=120 days following Date of Diagnosis [NAACCR Item# 340]

S.6. **Denominator Statement** *(Brief, narrative description of the target population being measured)*
Women under the age of 70 with AJCC T1cN0M0, or Stage IB-III hormone receptor negative breast cancer:
• Women
• Age 18-69 at time of diagnosis
• Known or assumed first or only cancer diagnosis
• Primary tumors of the breast
• Epithelial invasive malignancy only stageable by AJCC 7th edition
• AJCC T1cN0M0, or Stage IB to III
• Primary tumor is estrogen receptor negative and progesterone receptor negative
• All or part of first course of treatment performed at the reporting facility
• Known to be alive within 4 months (120 days) of diagnosis

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).
Sex [NAACCR Item#220]=2; Age at Diagnosis [NAACCR Item#230]=18-69; Sequence number [NAACCR Item # 560]=00-01; Tumor Size [NAACCR Item#2800]=011-898, 992-995 and AJCC pN [NAACCR Item#890]=0,0i-,0I+,0M-,0M+; OR AJCC pN [NAACCR Item#890]=1,1a,1b,1c,2,2a,2b, or 3,3a,3b,3c; AND CS SSF1 (ERA) [NAACCR Item#2880]=020,30; AND CS SSF2 (PRA) [NAACCR Item#2890]=020 or 030; AND Surgical Procedure of the Primary Site [NAACCR Item#1290]=20–90

S.8. **Denominator Exclusions** *(Brief narrative description of exclusions from the target population)*
Exclude, if any of the following characteristics are identified:
Men;
Age <18 and >=70;
not a first or only cancer diagnosis;
non-epithelial and non-invasive tumors;
phyllodes tumor histology;
rare histology not supported by clinical trials: 8940 - Mixed tumor, malignant, NOS, 8950 - Mullerian mixed tumor, 8980 – Carcinosarcoma, 8981 - Carcinosarcoma, embryonal
Tumor size <=1cm and AJCC pN=0;
ERA positive;
PRA positive;
Evidence of in situ or metastatic disease;
Not treated surgically;
Died within 4 months (120 days) of diagnosis;
Participation in a clinical trial which directly impacts the delivery of the standard of care

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%20programs/cancer/ncdb/measure%20specs%20breast.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:
- Include breast cancer case
- Exclude patients enrolled in a clinical trial that directly impacts the delivery of the standard of care.
- Include female patients only
- Include patients aged 18-69
- Include epithelial tumors which can be staged according to the AJCC 7th Ed (8000-8199, 8201-5876, 8941-8949)
- Include invasive tumors only
- Exclude patients with pathologic evidence of in situ or metastatic disease
- Exclude patients with clinical evidence of in situ or metastatic disease
- Include cases where all or part of the first course of treatment was performed at the reporting facility
- Include only surgically treated cases
- Includes patients reported living withing 120 days from diagnosis
- Include AJCC T1cN0M0 or AJCC Stage IB -III tumor
- Hormone receptor negative cases

Numerator cases are then assessed from denominator eligible cases:
- Cases with HER2 negative disease: Combination chemotherapy administered within 120 following diagnosis or Chemotherapy recommended but not administered
- Cases with HER2 positive disease: Chemotherapy and Her2 targeted therapy (immunotherapy) both administered within 120 days following diagnosis or chemotherapy administered within 120 days and Her 2 targeted therapy (immunotherapy) recommended

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

See: https://www.facs.org/~/media/files/quality%20programs/cancer/quality%20breast.ashx

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.
NA

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.
Data is collected in accordance with the North American Association of Central Cancer Registries (NAACCR) coding
http://www.naaccr.org/Applications/ContentReader/Default.aspx

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
0559_MeasureTesting_MSF5.0_Data.doc,0559_MeasureTesting_MAC_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.
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 1030 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 do not produce an undue burden on the data collection network. Utilization of these tools increases the completeness of adjuvant therapy information captured by the cancer registry.

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. Registries have demonstrated the ability to identify gaps in data collection and to correctly identify therapy in the majority of cases. 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

a) Public Reporting
Pennsylvania Health Care Quality Alliance
Purpose: The Pennsylvania Health Care Quality Alliance (PHCQA) is a voluntary group of health care organizations collaboratively working together to improve the quality of health care for the people of Pennsylvania. The PHCQA allows for voluntary reporting of compliance with CoC Measures by accredited programs in the state, currently 60 of 71 eligible programs participate.

f) Quality Improvement with Benchmarking

Commission on Cancer, National Cancer Data Base
Purpose: The National Cancer Data Base (NCDB) provides a venue for 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 National Quality Forum (NQF)-endorsed quality of cancer care measures for breast and colorectal cancers - See more at: 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 (adapted):
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.

QOPI® Certification Program (adapted):
The QOPI® Certification Program provides a three-year certification for outpatient hematology-oncology practices. To obtain Certification, a practice must achieve an aggregate score above 75% adherence on 26 measures that count toward the overall Quality Score. Please see a description of the QOPI® program above for details.

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 breast measure was developed by national experts in the field of breast 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, breast 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 Breast Site Specific Leaders (SSLs), who are renown clinical experts on breast 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 or 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 breast 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.

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 susceptible to under-reporting of the adjuvant chemotherapy component appearing in the measure numerator. Due to referral of services, access to patient clinical follow-up with radiation oncology may initially be limited or unavailable. Programs use of the CoC data quality tools has demonstrated through retrospective case and chart reviews that significant additional and accurate information regarding treatment provided to patients can be ascertained, resulting in more accurate reflections of the care provided or coordinated through their centers. Additionally, the CoC´s Program Standards require direct review and oversight of quality measures be monitored by an attending physician (Cancer Liaison Physician) on staff at the center on a quarterly basis.

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 <u>and</u> 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

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): Commission on Cancer, American College of Surgeons
Co.2 Point of Contact: Bryan, Palis, bpalis@facs.org, 312-202-5439-
Co.3 Measure Developer if different from Measure Steward: Commission on Cancer, American College of Surgeons
Co.4 Point of Contact: Erica, McNamera, emcnamara@facs.org, 302-202-5194-

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.
Original developers:
Christopher 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); David Winchester, MD, FACS (Northshore University Health System, Evanston IL); Diana Dickson-Witmer, MD, FACS (Chistiana Health Care System, Wilmington DE); Kelly Hunt, MD, FACS (MD Anderson Cancer Center, Houston TX); Marilyn Leitch, MD, FACS (University of Texas – Southwestern, Dallas TX);

Katherine Virgo, PhD (American Cancer Society)

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)

This panel meets at least once annually to review quality measures currently supported and implemented by the ACoS Commission on Caner and to investigate and consider/review development of possible new measures.

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: 11, 2015
Ad.4 What is your frequency for review/update of this measure? Annual
Ad.5 When is the next scheduled review/update for this measure? 11, 2016

Ad.6 Copyright statement:
Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: