NATIONAL QUALITY FORUM

Memo

TO: Cancer Standing Committee
FR: NQF Staff
RE: Post-Comment Call to Discuss Public and Member Comments
DA: August 18, 2016

Purpose of the Call

The Cancer Standing Committee will meet via conference call on Tuesday, August 23, 2016 from 2:00-4:00 pm ET. The purpose of this call is to:

- Review and discuss comments received during the post-evaluation public and member comment period.
- Provide input on proposed responses to the post-evaluation comments.
- Re-vote on criteria where consensus was not reached.
- Determine whether reconsideration of any measures or other courses of action is warranted.

Due to time constraints, during this call we will review comments by exception, in the case the Committee disagrees with the proposed responses.

Standing Committee Actions

1. Review this briefing memo and Draft Report.
2. Review and consider the full text of all comments received and the proposed responses to the post-evaluation comments (see Comment Table and additional documents included with the call materials).
3. Be prepared to provide feedback and input on proposed post-evaluation comment responses.
4. Be prepared to re-vote on the Reliability and/or Validity subcriteria for selected measures (indicated below)

Conference Call Information

Please use the following information to access the conference call line and webinar:
Speaker dial-in #: (844) 870-8188 (*NO CONFERENCE CODE REQUIRED)*
Web link: http://nqf.commpartners.com/se/Rd/Mt.aspx?572472
Registration link: http://nqf.commpartners.com/se/Rd/Rg.aspx?572472

Background

For this project, the 24-member Cancer Standing Committee met during a 2-day in-person meeting to evaluate a total of 18 measures: 15 maintenance measures and 3 newly-submitted measures against NQF's standard evaluation criteria. The Committee evaluated one new eMeasure version of an endorsed claims-based/registry measure. The eMeasure was evaluated separate from its claims-based/registry counterpart. Nine measures were recommended for endorsement and two measures were recommended for continued endorsement with reserve status. The Committee did not reach consensus on six measures and one measure was not recommended for endorsement. Three newly-submitted eMeasures were withdrawn from consideration by the measure developer prior to the in-person meeting.

Comments Received

NQF solicits comments on measures undergoing review in various ways and at various times throughout the evaluation process. First, NQF solicits comments on endorsed measures on an ongoing basis through the Quality Positioning System (QPS). Second, NQF solicits member and public comments prior to the evaluation of the measures via an online tool located on the project webpage. Third, NQF opens a 30-day comment period to both members and the public after measures have been evaluated by the full committee and once a report of the proceedings has been drafted.

Pre-evaluation comments

The pre-evaluation comment period was open from April 13 – April 26, 2016 for all of the 21 measures under review. Three newly-submitted eMeasures were withdrawn from consideration by the measure developer prior to the in-person meeting. Two pre-evaluation comments were received, both of which pertained to, and were supportive of, the prostate cancer measures. The pre-evaluation comments were provided to the Committee prior to their initial deliberations held during the workgroups calls.

Post-evaluation comments

The Draft Report went out for Public and Member comment July 8 – August 8, 2016. During this commenting period, NQF received 15 comments from 4 member organizations:

Consumers – 0	Professional – 3
Purchasers – 0	Health Plans – 0
Providers – 0	QMRI – 0
Supplier and Industry – 1	Public & Community Health - 0

An additional comment not included in the Comment Table was submitted by:
Commission on Cancer

In order to facilitate discussion, the majority of the post-evaluation comments have been categorized into major topic areas or themes. Where possible, NQF staff has proposed draft

responses for the Committee to consider. Although all comments and proposed responses are subject to discussion, we will not necessarily discuss each comment and response on the post-comment call. Instead, we will spend the majority of the time considering the major topics and/or those measures with the most significant issues that arose from the comments. Note that the organization of the comments into major topic areas is not an attempt to limit Committee discussion.

We have included all of the comments that we received (both pre- and post-evaluation) in the Comment Table. This comment table contains the commenter's name, comment, associated measure, topic (if applicable), and—for the post-evaluation comments—draft responses for the Committee's consideration. Please refer to this comment table to view and consider the individual comments received and the proposed responses to each.

Comments and their Disposition

Three major themes were identified in the post-evaluation comments, as follows:

1. Preference for outcome measures
2. Request for changes
3. Reserve status with inactive endorsement

Theme 1 – Preference for outcome measures

Two measures (***2930****: Febrile Neutropenia Risk Assessment Prior to Chemotherapy* and ***0378****: Hematology: Myelodysplastic Syndrome (MDS): Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy*) received two comments noting a preference for outcome measures. For #2930, the commenter noted that an outcome measure will assist in determining more than appropriate use of colony-stimulating factor (CSF), specifically resource utilization related to urgent care due to febrile neutropenia (FN). The commenter also noted the challenges of documenting FN risk assessment in electronic health records (EHR). For #0378, the commenter stated that it is unlikely that this measure will have a performance rate of 100.0%; therefore, an outcome measure based on the patient benefit of ESAs with respect to iron stores may be more appropriate.

> **Developer Response (#2930):** Thank you for your comment. We agree that measuring febrile neutropenia (FN) outcomes is important, but view an outcome measure as a complement to our proposed measure rather than a substitute for two reasons.
>
> First, the process measure is more actionable for oncology clinics which are our intended unit of analysis. With a process measure, clinics can set targets for improvement based on realistic expectations and relevant benchmarks and adopt management practices to reach those targets. On the other hand, an outcome measure would have to be risk-adjusted. So performance targets would have to be based on meaningful differences between expected and actual event rates, and performance could only be measured retrospectively. In addition, the ability to detect performance differences depends on the sample size and the stability of the event rates. Both factors

would make it difficult to use an FN outcome measure to inform management decisions at the clinic level.

Second, the intent of our proposed measure is to encourage appropriate use of CSF prophylaxis, i.e., promote use in patients with an elevated FN risk but discourage use in patients with a low risk, as defined by current guidelines. A standalone outcomes measure might incent clinics to overuse CSF prophylaxis to avoid adverse events and have the unintended consequence of overuse.

Thus, we believe that such a measure concept should be considered for future development, but it should not replace our proposed measure.

Proposed Committee Response (#2930): Thank you for your comment. The Committee agrees that a febrile neutropenia outcome measure would further the goal of high-quality, efficient healthcare rather than this process measure. However, the Committee also recognizes that certain process and structure measures are still useful for assessing quality, especially where outcomes may be difficult to measure. In addition, the Committee suggested incorporating the febrile neutropenia risk assessment into computerized physician order entry (CPOE) and standard orders to increase the feasibility of the measure in the future.

Proposed Committee Response (#0378): Thank you for your comment. The study conducted by Dr. Gregory Abel found that 56.0% of patients had evidence of pre-ESA iron assessment (*Abel, G. A., Cronin, A. M., Odejide, O. O., Uno, H., Stone, R. M. and Steensma, D. P. (2016), Influence of patient and provider characteristics on quality of care for the myelodysplastic syndromes. Br J Haematol, 173: 713–721. doi:10.1111/bjh.13987*).

The Committee agreed that this additional data suggests that a gap in performance exists in the documentation of iron stores in patients receiving erythropoietin therapy.

Action Item: Does the Committee agree with the proposed responses?

Theme 2 – Request for changes

A couple of comments suggested refining the measure description and specifications of two measures (***0559****: 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* and ***0220****: Adjuvant hormonal therapy).* Another comment suggested measuring a different outcome (***0459****: Risk-Adjusted Length of Stay >14 Days after Elective Lobectomy for Lung Cancer).*

Action Item: The Committee should review the recommended changes, developer responses, and then discuss these during the call before re-voting on the criteria where consensus was not reached for these three measures (see measure specific comments below).

Theme 3 – Reserve status with inactive endorsement.

For the two measures that were recommended for reserve status with inactive endorsement (***1857**: HER2 negative or undocumented breast cancer patients spared treatment with HER2-targeted therapies* and ***1878**: HER2 testing for overexpression or gene amplification in patients with breast cancer)*, commenters requested changes to the specifications and/or a preference of outcome measures.

> **Developer Response (#1857):** Thank you for your comments. The focus of this measure is to ensure patients receiving HER2 targeted therapies have documentation of a HER2 mutation. ASCO agrees that determining whether the patient ever received HER2 testing is important and this aspect of care is addressed in NQF endorsed measure #1878 "HER2 testing for overexpression or gene amplification in patients with breast cancer."
>
> **Developer Response (#1857):** Thank you for your comment. ASCO recognizes the importance of outcome measures and efforts are in progress to develop these types of measures within the domains of oncology care.
>
> **Developer Responses (#1878):** Thank you for your response. ASCO continues to develop new measures and will consider developing a new measure to address disparities highlighted by this gap in practice.
>
> **Developer Responses (#1878):** Thank you for your comment. ASCO acknowledges that the data available are based on QOPI® self-selecting practices that voluntarily report data and may not be reflective of care provided outside of the QOPI® program.
>
> **Proposed Committee Response:** Thank you for your comment. The Standing Committee will periodically review measures in reserve status for any change in evidence, evidence of deterioration in performance or unintended consequences, or any other concerns related to the measure. The Standing Committee may remove a measure from inactive endorsement status if the measure no longer meets NQF endorsement criteria. A maintenance review may occur upon a request from the Standing Committee or measure steward to return the measure to active endorsement.
>
> **Action Item:** Does the Committee agree with the proposed response?

Consensus Not Reached Measures

0220: Adjuvant hormonal therapy (American College of Surgeons)

The developer provided national trend data from the National Cancer Data Base (NCDB) from 2008 and 2012. The mean performance rate for 2008 was 78.7% and 85.5% for 2012. The developer stated that the performance rate for 2013 was 90.1%. The most current data were not available at the time of measure submission. However, the developer provided additional performance data from the Rapid Quality Reporting System (RQRS) during the comment period

(see Appendix A). The developer stated that the RQRS performance rates were similar to the performance rates from the NCDB.

Data element validity testing was performed and counted for data element reliability. The Standing Committee noted that the measure specifications for this measure are not consistently implemented due to various patient factors such as the physician recommending hormone therapy, the patient obtaining a prescription, declining hormone therapy, and then possibly starting hormone therapy.

The Standing Committee did not reach consensus on reliability and validity during the in-person meeting. Furthermore, the Standing Committee encouraged the developer to provide updated reliability and validity testing at the next maintenance review of the measure. The developer confirmed that they are planning to update their validity and reliability testing for the five measures submitted in this project (#0219, #0220, #0223, #0225, and #0559) before the next maintenance review.

NQF received one comment for #0220. The commenter stated that it would be beneficial to have the measure stipulate administered vs. prescribed and to address who might not receive the treatment via the exclusions.

> **Developer Response (#0220):** The American College of Surgeons, Commission on Cancer (CoC) thanks you for your comment and review of our measures. These quality measures use the terminology of administered within a specific timeframe or recommended based on the coding from the FORDS manual. This is the nationally standardized coding guideline promulgated by the CoC, and coordinated with several Federal agencies including the NCI and CDC; include specific code values indicating the clinical consideration of chemotherapy and hormone therapy and the choice of the patient and/or guardian to decline recommended therapy. Cancer registries within CoC-accredited cancer programs record and report this information if it is documented in the patient chart. The language of "recommended or administered" in these measures was specifically selected after discussion with clinicians and users and is based directly on the FORDs data item definitions used to calculate these measures.
>
> We agree with that when assessing overall quality, cancer programs should review patients in which treatment is administered and those in which treatment is recommended but not administered. Therefore, in the our reporting systems where compliance with these measures is assessed, cancer programs are able to view cases stratified by if; a) treatment is administered, b) treatment is recommended but not administered and c) the case is non-compliant with the measure. This allows programs to assess patients which cases are compliant with the measure but for which adjuvant therapy was not administered during internal quality improvement efforts.
>
> For 2013 diagnoses cases in which treatment was recommended but not administered represents represented 6% of the numerator cases for measure #0220 changing compliance from 86.2% to 92.3%.

Additional information provided by the Developer: Most recent performance results from the Rapid Quality Reporting System (RQRS) (See Appendix A).

Action Item: The Committee must re-vote on the validity criterion. The validity voting results will also count for reliability.

0559: 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 (American College of Surgeons)

Since the testing provided by the developer for this measure had the same issues as #0220, the Committee considered the same concerns they had for the testing of that measure and agreed to carry forward the votes from the reliability and validity criteria from #0220. Thus, consensus was not reached on reliability and validity. The Committee also suggested monitoring the impact of emerging breast cancer data and new genomic assays that may potentially exclude patients with hormone receptor negative tumors from receiving chemotherapy.

NQF received one comment for #0559. The commenter stated that it would be beneficial to have the measure stipulate administered vs. prescribed and to address who might not receive the treatment via the exclusions.

Developer Response (#0559): The American College of Surgeons, Commission on Cancer (CoC) thanks you for your comment and review of our measures. These quality measures use the terminology of administered within a specific timeframe or recommended based on the coding from the FORDS manual. This is the nationally standardized coding guideline promulgated by the CoC, and coordinated with several Federal agencies including the NCI and CDC; include specific code values indicating the clinical consideration of chemotherapy and hormone therapy and the choice of the patient and/or guardian to decline recommended therapy. Cancer registries within CoC-accredited cancer programs record and report this information if it is documented in the patient chart. The language of "recommended or administered" in these measures was specifically selected after discussion with clinicians and users and is based directly on the FORDs data item definitions used to calculate these measures.

We agree with that when assessing overall quality, cancer programs should review patients in which treatment is administered and those in which treatment is recommended but not administered. Therefore, in the our reporting systems where compliance with these measures is assessed, cancer programs are able to view cases stratified by if; a) treatment is administered, b) treatment is recommended but not administered and c) the case is non-compliant with the measure. This allows programs to assess patients which cases are compliant with the measure but for which adjuvant therapy was not administered during internal quality improvement efforts.

For 2013 diagnoses, cases in which treatment was recommended but not administered represents 4% of the numerator changing overall compliance from 88.6% to 92.6% for measure #0559.

Additional information provided by the Developer: The CoC appreciates the response from the Standing Committee to monitor emerging breast cancer data and new genomic assays which may exclude patients from receive *[sic]* chemotherapy, the CoC is currently reviewing and revising the FORDS manual and plans to update clinically relevant data elements (See Appendix A.)

Action Item: The Committee must re-vote on the validity criterion. The validity voting results will also count for reliability.

2963: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (AMA-PCPI)

The developer provided reliability results from the registry measure (#0389) and stated that once data from the eCQM are available for analysis it is expected that reliability test results will be comparable for the 2 measures. The Committee questioned extrapolating the reliability of the eCQM based on the registry measure without testing results. The Committee also asked the developer if they had tested the correlation of the eCQM and registry measure. The developer clarified that although the eCQM is currently used in Meaningful Use (MU), CMS has not released performance data from MU. The Committee noted their concerns with providers' ability to consistently implement the Health Quality Measure Format (HQMF) specifications for the eCQM and the potential impact on the numerator, denominator, and exceptions.

The Committee did not reach consensus on the reliability of the measure but acknowledged the importance of eMeasures and the challenges associated with respecifying registry and claims measures and encouraged CMS to release MU performance data.

NQF received one comment for #2963 from the developer. The comment has been included below.

Developer Response: PCPI sincerely appreciates the thoughtful comments from the Cancer Steering Committee, with regards to the electronic clinical quality measure (eCQM), Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients. We also appreciate the opportunity to provide comments on this very detailed draft report. In considering this eCQM for potential endorsement, we urge the Steering Committee to consider that this is a legacy measure, as it was recently retooled into an eCQM and is currently included in the PQRS and Meaningful Use programs. Unfortunately, although the measure is included in these programs and data is currently being collected, the data sample from the PQRS program collected through EHR reporting was insufficient and no other statistically significant sample was able to be identified, given that data from the Meaningful Use program is currently unavailable. Thankfully, NQF allows measure developers and stewards to submit simulated patient data, generated within the BONNIE tool, in order to evaluate the feasibility and scientific acceptability of measures, when adequate data is unavailable for analysis. The Bonnie tool enables measure developers to create a simulated patient deck, complete with demographic data, medical history, and encounter information, in order to allow for the evaluation of whether the measure logic performs as expected and whether the measure can reach 100% coverage through the tool. Given that we

have submitted information from the Bonnie tool to NQF, in addition to performing a feasibility assessment and providing face validity data, therefore, meeting the testing requirements for Legacy measures, we urge the Steering Committee to revote in favor of the measure's reliability and to move forward with recommending this measure for potential endorsement, to ensure that the measure remains in use in the national quality reporting programs, allowing more data to be collected for future measure testing.

Action Item: The Committee must revote on the reliability criterion.

0459: Risk-Adjusted Length of Stay >14 Days after Elective Lobectomy for Lung Cancer (Society of Thoracic Surgeons)

The Committee noted several concerns with the performance data provided by the developer and did not reach consensus on performance gap. During the in-person meeting, the Committee noted that the number of patients per region ranged from 2,996 per 40 surgeons to 7,756 patients per 73 surgeons, yet the mean prolonged length of stay (PLOS) was ~4.0% for each region. The Committee was concerned that low-volume providers may affect overall performance rates making it difficult to distinguish high-performers from low-performers and to determine if a gap in care exists based on the data provided. The Committee requested that the developer provide performance data on 10 days vs. 14 days PLOS and the correlation between the number of procedures performed (volume) and PLOS at the next maintenance review of the measure.

NQF received one comment suggesting that a measure addressing the discharge outcomes may provide better insight into variations of care due to low patient volume in the current measure. The commenter also noted the new measure(s) might be similar to measure #0460 with a different surgical procedure/patient diagnostic group.

Developer Response: STS appreciates the comment submitted by the Oncology Nursing Society. Although length of stay is a surrogate for morbidity, measure #0459 is intended to be used to measure health care resource utilization. STS serves as the measure developer and steward for NQF-endorsed measure #1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer, an outcomes measure that addresses the Oncology Nursing Society's suggestion. In addition, STS recently developed a two-domain, outcomes only composite measure for lobectomy for lung cancer. The results of this composite have been distributed to STS General Thoracic Surgery Database participants, and planning is underway to add the lobectomy composite measure to STS's voluntary public reporting program.

Action Item: The Committee must re-vote on the performance gap criterion.

0460: Risk-Adjusted Morbidity and Mortality for Esophagectomy for Cancer (Society of Thoracic Surgeons)

The Standing Committee did not reach consensus on the reliability and validity criteria during the in-person meeting. The Standing Committee noted that more than 55.0% of participants

(94) in the registry did fewer than five procedures a year. The Standing Committee expressed concern with the reliability of this low-volume procedure and that the measure was not specified for ≥5 procedures per year. The reliability of the measure score increased as the volume of minimum procedures per year for participants increased. The reliability scores for all 169 participants and 4,557 operations were 44.4%, 67.9% for ≥5 procedures per year, and 80.6% for ≥20 procedures per year.

The Standing Committee also expressed concern with combining morbidity and mortality and asked the developer if there were plans for differential weighting of these outcomes. (The previous Committee also noted the same concern in 2012.) The developer is developing a new measure that more heavily weighs mortality than morbidity; measurement development is expected to be complete by the next maintenance review.

The Committee determined that the data element validity testing provided was adequate but did not reach consensus on overall validity because low-volume providers was noted as a threat to validity.

NQF did not receive any public or member comments for this measure.

Action Item: The Committee must re-vote on the reliability and validity criteria.

0509: Diagnostic Imaging: Reminder System for Screening Mammograms (American College of Radiology)

The Standing Committee did not reach consensus on the validity criterion due to their concerns about the exclusion, "medical reason documentation." The developer stated that the exclusion allows physicians to report on the measure if a patient's information was not entered into a reminder system because it was determined that they did not need to return for a screening mammogram due to decreased life expectancy, history of a mastectomy, or some other medical reason. The developer further explained that the exclusion should not be a threat to validity because it was only used three times during 2014. The Committee questioned why the exclusions were so low considering that the developer was reporting Medicare data from PQRS and expected the number of exclusions to be higher in the Medicare population. This raised concerns about the exclusion not being used properly by physicians and the need for the exclusion.

NQF did not receive any public or member comments for this measure.

Action Item: The Committee must revote on the validity criterion.

Daniel P. McKellar, MD, FACS | *Chair*
David P. Winchester, MD, FACS | *Medical Director*

Commission on Cancer Response to questions raised by the NQF Cancer Project Standing Committee 0219, 0220, 0559, 0223, 0225

Thank you for your review of the five quality measures submitted for maintenance by The American College of Surgeons, Commission on Cancer.

During the review of the measures, the Standing Committee noted the high level of evidence supporting these measures but requested more current data than was submitted with the measure applications to assess performance gaps. The NQF application included the most current diagnoses from submissions to the NCDB from all CoC-accredited cancer programs. These measures are also reported to CoC-accredited cancer programs through the voluntary Rapid Quality Reporting System (RQRS). This system allows programs to prospectively assess compliance with the measures and report data concurrently, but since it is not required it was not included in the original application. Based on the Committee's request, data for the most recent annual rates for these measures calculated in May 2016 through RQRS are included in the tables below; 1100 CoC-accredited programs were enrolled in RQRS at the time and included in these analyses. These results yield findings similar to the data included in the NQF application reported through the annual NCDB submission cycle. The trends for overall compliance hover around 90%, and the disparities in compliance with race, insurance status and socio-economic data are statistically-significant. This demonstrates the importance of continued measurement with trends in improvement (Table 1, Table 2, Table 3, Table 4, Table 5).

In addition to the sensitivity and specificity reports provided to the NQF for the initial endorsement of these quality measures, additional information on studies reporting the reliability and validity of cancer registry data and, specifically, treatment data within the NCDB compared to insurance data were provided at the time of the in person meeting in May. [1,2] Studies have verified the completeness and accuracy of cancer registry data collected through the CDC National Program of Cancer Registries (NPCR)-Cancer Surveillance System (NPCR-CSS).[2]

To further improve capture of adjuvant therapy reported to the NCDB, the CoC-accredited programs receive individual case information regarding 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 estimated performance rates (EPRs). In addition, the EPRs generated by the NCDB are not static calculations dependent on the initial submission of individual data items. Registrars along with physician leaders are encouraged to review

[1] Mallin, K, Palis, B E, Watroba, N, Stewart, A K, Walczak, D, Singer, J, Edge, SB (2013). Completeness of American Cancer Registry Treatment Data: Implications for Quality of Care Research. *Journal of the American College of Surgeons, 216*(3), 428-437. doi:10.1016/j.jamcollsurg.2012.12.016

[2] Thoburn, KK, German, RR, Lewis, M, Nichols, PJ Nichols, Ahmed, F, Jackson-Thompson, J. Case completeness and data accuracy in the Centers for Disease Control and Prevention's National Program of Cancer Registries. Cancer. 2007;109(8):1607–1616. doi:10.1002/cncr.22566.

non-concordant and incomplete cases in order to ensure the data on which the EPRs are based are accurate. Upon re-submission, the case status is reassessed for eligibility, and EPRs and confidence intervals are updated. As a result, the data are under continuous audit.

The Rapid Quality Reporting System (RQRS) is another effort by the CoC to improve collection of adjuvant treatment data. The RQRS provides participating programs with a prospective alert of expected, forthcoming treatment information. In so doing, improved documentation of adjuvant treatment has occurred. More importantly, this system has a positive impact on the cancer patient as programs are alerted to forthcoming treatment, which has led to fewer persons "slipping through the cracks." Based on these efforts to improve data collection, facilitate patients' receipt of adjuvant care, and the findings of the Surveyors' review of patient records at the facilities, the data supporting the CoC quality measure are reliable and valid and can be readily captured by the cancer registries.

As was stated during the in person meeting the Commission on Cancer will be performing additional empirical tests on the reliability and validity of the submitted quality measures 0220, 0219, 0559, 0223, 0225.

These quality measures are based on a high level of evidence, have been shown to reliably distinguish low performing and high performing hospitals and reporting through Commission on Cancer accredited cancer programs has shown improvements in the quality of care of patients. However, the results indicate that there are still populations with room for improvement which show the importance of continued reporting and NQF endorsement.

Discussion on specific measures:

#0220 Adjuvant hormonal therapy

Receipt of hormonal therapy for estrogen and progesterone positive patients improves survival in patients and adheres to the NCCN guidelines. The Standing Committee noted concern that accredited programs had a difficult time capturing the timing of receipt of adjuvant hormonal therapy. This is a standard data item captured in all cancer registries. Cancer registrars are instructed to review medical records to determine the date in which hormone therapy was administered. One of the benefits of the Rapid Quality Reporting System (RQRS), which will become mandatory for all CoC-accredited cancer programs in 2017, is that it provides prospective alerts for programs to follow-up on patients who meet the criteria of the measure. This allows programs to monitor, track, and document when a patient initiates hormonal therapy, prospectively rather than retrospectively trying to assess when hormone therapy was begun.

Also, #0220 is included in the table on starting on page 147; this is a table shows a comparison of prostate cancer measures so this breast measure should be removed.

#0559 Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer.

The CoC appreciates the response from the Standing Committee to monitor emerging breast cancer data and new genomic assays which may exclude patients from receive chemotherapy, the CoC is currently reviewing and revising the FORDS manual and plans to update clinically relevant data elements.

Rapid Quality Reporting System (RQRS) Measure compliance, overall and stratified

Table 1 BCSRT (NQF #219) Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer

	RQRS	
	2013	**2014**
Overall	**92.3 (92.1 – 92.5)**	**90.5 (90.3 – 90.8)**
Race		
White	93.3 (93.1-93.6)	91.6 (91.3 – 91.9)
Black	88.9 (88.1-89.7)	87.4 (86.6 – 88.2)
Hispanic	86.4 (85.2-87.6)	84.6 (83.4 – 85.9)
API	92.5 (91.2-93.8)	90.1 (88.6 – 91.5)
Other	90.8 (89.2-92.4)	87.9 (86.1 – 89.6)
Age		
30-39	89.0 (87.1-91.0)	86.6 (84.6 – 88.7)
40-49	92.0 (91.4-92.5)	89.8 (89.2– 90.4)
50-59	92.6 (92.3-93.0)	91.4 (91.0– 91.8)
60-69	92.4 (92.0-92.7)	90.3 (89.9– 90.7)
Insurance		
Not Insured	86.8 (84.9-88.8)	83.7 (81.4– 86.1)
Medicaid	87.2 (86.1-88.2)	86.5 (85.4– 87.5)
Private	93.7 (93.4-93.9)	91.8 (81.5– 92.1)
Medicare	90.9 (90.4-91.4)	89.1 (88.6– 89.7)
Other Government	90.6 (88.5-92.6)	90.9 (88.9– 93.0)
Unknown	88.2 (86.1-90.3)	86.7 (84.5– 88.9)
Quartile, No HS degree		
1st quartile (greatest prop no HS degree)	89.9 (89.2-90.6)	86.2 (85.4 – 87.0)
2nd quartile	91.4 (90.8-91.9)	89.6 (89.1– 90.2)
3rd quartile	92.8 (92.4-93.3)	91.0 (90.5 – 91.5)
4th quartile (lowest prop no HS degree)	93.3 (93.0-93.7)	92.2 (91.8– 92.5)
Cancer Program Type		
Community Cancer Program	90.8 (90.1-91.5)	89.2 (88.5– 90.0)
Comp Com Can Program	92.4 (92.1-92.7)	90.3 (89.9– 90.7)
Academic/Research Program	92.2 (91.8-92.7)	90.8 (90.4– 91.3)

Rates include all RQRS participating programs (1100 programs) calculated as of 5/27/2016. Please note: Annual compliance is only available for this measure through 2014 because some patients diagnosed in 2015 are still awaiting treatment. The slight decrease in compliance found in the 2014 annual rate may be due in part to time required for receipt, documentation and submission of adjuvant therapy for cases diagnosed near the end of 2014.

Table 2 (NQF #0559) Combination chemotherapy is considered 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.

	RQRS	
	2014	**2015**
Overall	**91.6 (91.1-92.1)**	**91.1 (90.4-91.7)**
Race		
White	93.3 (92.8-93.9)	93.0 (92.3 – 93.7)
Black	88.9 (87.6-90.1)	88.8 (87.3 – 90.3)
Hispanic	85.8 (83.5-88.0)	83.2 (80.2 – 86.2)
API	89.8 (86.7-92.8)	89.3 (85.4 – 93.2)
Other	92.3 (89.1-95.5)	86.2 (81.7 - 90.7)
Age		
30-39	93.7 (92.1-95.4)	93.9 (92.0-95.9)
40-49	91.1 (91.0-92.9)	91.9 (90.8-93.1)
50-59	91.69 (90.8-92.5)	90.6 (89.6-91.7)
60-69	90.6 (89.6-91.5)	89.8 (88.6-91.0)
Insurance		
Not Insured,	88.8 (85.4-92.2)	86.2 (83.9-88.5)
Medicaid	93.3 (92.8-93.9)	92.9 (92.2-93.6)
Private	88.1 (86.4-89.8)	88.4 (86.6-90.1)
Medicare	88.8 (87.4-90.3)	86.5 (80.9-92.2)
Other Government	87.9 (83.4-92.3)	88.0 (82.8-93.2)
Unknown	85.6 (81.0-90.3)	91.1 (90.4-91.7)
Quartile, No HS degree		
1st quartile (greatest prop no HS degree)	87.4 (86.0-88.8)	86.2 (84.4 -88.1)
2nd quartile	91.2 (90.1-92.4)	90.3 (88.9-91.7)
3rd quartile	92.8 (91.8-93.8)	92.7 (91.5-93.9)
4th quartile (lowest prop no HS degree)	93.6 (92.9-94.4)	92.7 (91.8-93.7)
Cancer Program Type		
Community Cancer Program	90.4 (88.8-92.0)	88.5 (86.4-90.6)
Comp Com Can Program	92.0 (91.2-92.7)	90.4 (89.4-91.4)
Academic/Research Program	91.8 (90.9-92.7)	91.2 (90.1-92.3)

Rates include all RQRS participating programs (1100 programs) calculated as of 5/27/2016. Please note: The slight decrease in compliance found in the 2014 annual rate may be due in part to time required for receipt, documentation and submission of adjuvant therapy for cases diagnosed near the end of 2014.

Table 3 HT (NQF #0220) Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor positive breast cancer.

	RQRS	
	2013	**2014**
Overall	**91.7 (91.5-91.9)**	**90.0 (89.8-90.3)**
Race		
White	93.0 (92.7-93.2)	91.5 (91.2-91.7)
Black	87.2 (86.4-87.9)	84.6 (83.8-85.4)
Hispanic	85.0 (83.9-86.0)	83.0 (81.9-84.1)
API	90.3 (89.0-91.5)	89.4 (84.3-87.6)
Other	88.9 (87.4-90.4)	85.9 (84.3-87.6)
Age		
30-39	87.1 (85.7-88.5)	86.8 (85.5-88.2)
40-49	90.4 (89.9-90.8)	88.6 (88.0-89.1)
50-59	91.3 (90.9-91.7)	89.3 (88.9-89.7)
60-69	92.3 (92.0-92.7)	90.9 (90.5-91.3)
70-79	93.6 (93.2-94.1)	92.0 (91.5-92.5)
80+	92.6 (91.8-93.4)	90.7 (89.8-91.6)
Insurance		
Not Insured	86.9 (85.2-88.6)	85.1 (83.1-87.0)
Medicaid	86.1 (85.2-87.1)	83.7 (82.7-84.7)
Private	92.2 (92.0-92.5)	90.4 (90.1-90.6)
Medicare	92.6 (92.3-93.0)	91.4 (91.1-91.8)
Other Government	87.1 (85.1-89.2)	87.5 (85.4-89.6)
Unknown	88.8 (87.0-90.5)	86.6 (84.6-88.6)
Quartile, No HS degree		
1st quartile (greatest prop no HS degree)	88.7 (88.0-89.3)	85.6 (84.9-86.4)
2nd quartile	91.2 (90.7-91.7)	89.1 (88.6-89.6)
3rd quartile	92.3 (91.8-92.7)	90.8 (90.4-91.2)
4th quartile (lowest prop no HS degree)	92.7 (92.4-93.0)	91.6 (91.2-91.9)
Cancer Program Type		
Community Cancer Program	89.4 (88.8-90.1)	87.6 (87.0-88.3)
Comp Com Can Program	91.5 (91.2–91.8)	89.2 (88.8-89.5)
Academic/Research Program	91.9 (91.5-92.3)	91.5 (91.2-91.9)

Rates include all RQRS participating programs (1100 programs) calculated as of 5/27/2016. Please note: Annual compliance is only available for this measure through 2014 because some patients diagnosed in 2015 are still awaiting treatment. The slight decrease in compliance found in the 2014 annual rate may be due in part to time required for receipt, documentation and submission of adjuvant therapy for cases diagnosed near the end of 2014.

Table 4 ACT (NQF #0223) Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer.

	RQRS	
	2014	**2015**
Overall	**87.0 (86.3-87.7)**	**83.6 (82.8-84.5)**
Race		
White	88.9 (88.1-89.7)	85.2 (84.2-86.2)
Black	84.2 (82.2-86.2)	80.0 (77.6-82.5)
Hispanic	77.5 (74.2-80.8)	76.5 (72.8-80.1)
API	80.6 (76.2-84.9)	81.8 (77.2-86.5)
Other	87.4 (82.5-92.3)	83.4 (77.9-88.9)
Age		
40-49	88.5	88.6 (86.5-90.7)
50-59	87.5 (86.1-89)	85.3 (83.7-87.0)
60-69	85.3 (83.9-86.6)	82.2 (80.6-83.8)
70-79	83.7 (82.1-85.2)	80.5 (78.7-82.2)
Insurance		
Not Insured,	81.7 (77.5-85.8)	82.1 (77.4-86.7)
Medicaid	82.8 (80.0-85.5)	82.7 (79.6-85.7)
Private	89.7 (88.8-90.7)	86.0 (84.8-87.3)
Medicare	85.5 (84.3-86.7)	81.6 (80.2-83.0)
Other Government	88.0 (81.8-94.1)	85.9 (78.5-93.3)
Unknown	85.2 (79.5-90.9)	78.3 (71.0 -85.7)
Quartile, No HS degree		
1st quartile (greatest prop no HS degree)	83.7 (81.9-85.5)	79.0 (76.8-81.2)
2nd quartile	86.3 (84.8-87.8)	82.2 (80.3-84.0)
3rd quartile	88.0 (86.6-89.5)	84.8 (83.1-86.6)
4th quartile (lowest prop no HS degree)	89.5 (88.3-90.6)	86.3 (84.9-87.8)
Cancer Program Type		
Community Cancer Program	86.0 (84.1-88.0)	82.1 (79.7-84.4)
Comp Com Can Program	85.6 (84.5-86.6)	82.5 (81.2-83.8)
Academic/Research Program	88.1 (86.8-89.4)	84.3 (82.7-85.9)
Sex		
Male	87.2 (86.2-88.2)	83.1 (81.9-84.3)
Female	86.9 (85.9-87.9)	84.2 (83.0-85.4)

Rates include all RQRS participating programs (1100 programs) calculated as of 5/27/2016. Please note: The slight decrease in compliance found in the 2015 annual rate may be due in part to time required for receipt, documentation and submission of adjuvant therapy for cases diagnosed near the end of 2015.

Table 5 (NQF #0225) At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

	RQRS	
	2014	**2015**
Overall	**91.0 (90.7-91.3)**	**91.8 (91.5-92.1)**
Race		
White	91.2 (90.9 – 91.6)	92.0 (91.6-92.4)
Black	90.4 (89.5 – 91.4)	90.5 (89.5-91.6)
Hispanic	91.2 (89.9 – 92.6)	92.2 (90.9-93.5)
API	93.6 (91.9 – 95.2)	91.7 (89.8-93.6)
Other	93.1 (91.0 – 95.3)	90.5 (88.0-93.0)
Age		
40-49	95.0 (94.1-95.9)	94.8 (93.7-95.8)
50-59	91.4 (90.7-92.2)	92.1 (91.3-92.9)
60-69	90.5 (89.8-91.1)	92.1 (91.4-92.7)
70-79	90.5 (89.9-91.1)	91.4 (90.8-92.1)
>79	90.7 (90.0-91.4)	90.6 (89.8-91.3)
90+	89.7 (88.0-91.4)	91.1 (89.3-92.8)
Insurance		
Not Insured,	92.0 (90.1-93.9)	91.2 (88.9-93.5)
Medicaid	92.0 (90.7-93.2)	92.1 (90.7-93.4)
Private	91.8 (91.3-92.3)	92.7 (92.1-93.3)
Medicare	90.4 (90.0-90.9)	91.4 (90.9-91.8)
Other Government	93.4 (90.7-96.0)	90.5 (87.0-94.0)
Unknown	92.0 (89.3-94.6)	91.9 (89.1-94.7)
Quartile, No HS degree		
1st quartile (greatest prop no HS degree)	90.2 (89.4-91.0)	90.9 (90.1-91.8)
2nd quartile	90.2 (89.5-90.8)	91.7 (91.0-92.4)
3rd quartile	90.7 (90.0-91.4)	91.5 (90.8-92.2)
4th quartile (lowest prop no HS degree)	92.3 (91.8-92.8)	92.5 (92.0-93.0)
Cancer Program Type		
Community Cancer Program	88.9 (88.0-89.8)	89.8 (88.8-90.7)
Comp Com Can Program	90.7 (90.2-91.1)	91.7 (91.2-92.2)
Academic/Research Program	92.8 (92.3 – 93.4)	93.3 (92.7-93.9)
Sex		
Male	89.9 (89.4-90.4)	91.3 (90.8-91.7)
Female	92.1 (91.7-92.5)	92.3 (91.9-92.8)

Rates include all RQRS participating programs (1100 programs) calculated as of 5/27/2016