Cancer Endorsement Maintenance 2011

FINAL REPORT

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NATIONAL QUALITY FORUM

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Cancer Endorsement Maintenance 2011

TECHNICAL REPORT

Introduction

Cancer refers to a group of more than 100 diseases characterized by uncontrolled cellular growth, proliferation, and spread.[1] This group of diseases has an enormous impact on health in the US. As the second leading cause of death, cancer was responsible for an estimated 569,490 deaths among adults and children in 2010.[2] The National Cancer Institute estimates that half of all men and one-third of all women in the US will develop cancer during their lifetimes. Diagnosis and treatment of cancer also has great economic impact as well. In 2010, the estimated total annual costs of cancer reached $263.8 billion: $102.8 billion in direct medical costs; $20.9 billion in loss of productivity from illness; and $140.1 billion in lost productivity from premature death.[3] Despite enormous focus on prevention and treatment of disease, inconsistencies in cancer care exist, with many patients not receiving care that follows clinical practice guidelines.[4] Studies demonstrate persistent socioeconomic disparities in treatment and survival for many different types of cancer, including gastric, breast, prostate, and lung cancers.[5,6,7,8]

Cancer care is complicated for many reasons: treatment regimens are complex, often involving multiple providers, settings of care, and levels of treatment; patients with cancer often require individualized therapies; an evolving evidence base for treatment exists; and care can be hampered by a sometimes limited supply of highly specialized personnel or technologies. There is a need for measures that address the quality of cancer care, taking into account the nuances mentioned.

The Cancer Endorsement Maintenance Project sought to evaluate for endorsement measures for accountability and quality improvement that address breast, colorectal, lung, prostate, hematologic and skin cancers, as well as symptom management and end of life care. Cancer care consensus standards that have been endorsed by NQF before 2009 awere evaluated under the maintenance process. Endorsement maintenance ensures the currency of NQF's portfolio of voluntary consensus standards, provides the opportunity to harmonize specifications, and ensures that endorsed measures represent the best in class. Measures that address specific aspects of the National Quality Strategy (NQS)—particularly those focused on person and family engagement, communication, coordination and safety were a priority.

Measure Evaluation

To facilitate the evaluation the project was divided into two phases. For the first phase the Cancer Endorsement Maintenance Steering Committee reviewed candidate standards relating to hematologic, lung, esophageal, skin, prostate, and colon cancer as well as palliative care. Committee members were divided into 4 workgroups. The workgroups conducted a preliminary review of measures against the evaluation sub-criteria prior to consideration by the entire Steering Committee. At its in-person meeting on March 13-14, 2012 the Committee evaluated 4 new measures and 22 measures undergoing maintenance review against NQF's measure evaluation criteria. For phase two of this project the Steering Committee met on May 23-24, 2012. During this second phase the Cancer Steering Committee evaluated 6 new measures and 12 measures undergoing maintenance review against NQF's standard

evaluation criteria. To facilitate the evaluation, the committee and candidate standards were divided into 3 workgroups for preliminary review of the measures against the sub-criteria prior to consideration by the entire steering committee. The Committee's discussion and rating of the criteria are summarized in the evaluation tables beginning on page 13.

CANCER ENDORSEMENT MAINTENACE SUMMARY 2011

	MAINTENANCE	NEW	TOTAL
Measures under consideration	38	10*	48
Measures withdrawn from consideration	4	0	4
Measures Recommended	28	10	38
Not recommended	6	0	6
Reasons for Not Recommending	Importance – 5 Scientific Acceptability – 1	N/A	

*Includes two untested measures eligible for time-limited endorsement

Overarching Issues

During the Steering Committee's discussion of the measures, several overarching issues emerged that were factored into the Committee's ratings and recommendations for multiple measures and are not repeated in detail with each individual measure:

Palliative Measures

During the first phase the Steering Committee noted that several of the events covered by the palliative care measures including receipt of chemotherapy (#0210), having more than one emergency room visit (#0211) and admission to the ICU in the last days of life (#0213) can and should happen in some cases. The Committee agreed that the measures would be useful for detecting patterns in practice, variation in performance and identifying outliers when comparing similar practices with similar patient populations; addressing patient preference and overtreatment at the end of life; and, reflecting disparities in access to care and the capacity of the local healthcare system to treat patients appropriately at the end of life. The Committee also noted that two measures related to admission to hospice and hospice length of stay were important as they could indicate a need for more hospice facilities or a need for greater physician and patient education around using this resource, leading to improved patient-centered quality of care. The Committee also noted that the area of palliative care and the concept of hospice and the settings in which hospice care is given are evolving and that future measures should consider that palliative care may be provided in the home, special facility, or in a hospital.

Harmonization of Related Measures

During the first phase the Steering Committee recommended that the developer harmonize measures #0384 with currently endorsed measures #1628 and #1634, which are also related to pain assessment and pain treatment. The measures differ in the following ways:

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits (RAND)	1634 Hospice and Palliative Care -- Pain Screening (UNC-Chapel Hill)	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383) (AMA-PCPI)
Data Source	Registry, paper records.	EHR, structured medical record abstraction tool.	Administrative claims, EHR, registry paper records.
Level of Analysis	Facility, health plan, integrated delivery system	Group practice, facility	Group practice, facility, individual clinician, team
Patient Population	Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit.	Patients enrolled in hospice for 7 or more days OR patients receiving hospital-based palliative care for 1 or more days. The Pain Screening quality measure is intended for patients with serious illness who are enrolled in hospice care OR receive palliative care in an acute hospital setting. Conditions may include, but are not limited to: cancer, heart disease, pulmonary disease, dementia and other progressive neurodegenerative diseases, stroke, HIV/AIDS, and advanced renal or hepatic failure. [NOTE: Measure should be paired with the Pain Assessment quality measure to ensure that all patients who report pain are clinically assessed.]	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy, within a 12 month period. [NOTE: Measure is paired with #0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology]
Exclusions	None, other than patients who did not survive at least 30 days after cancer diagnosis.	Patients with length of stay < 7 days in hospice, or < 1 day in palliative care. Calculation of length of stay; discharge date - date of initial encounter.	None

The Committee noted the burden on providers but agreed that there is a preference for a standardized quantitative pain tool that could be used across measures. It was also suggested that in the future, the developers of measures #0383 and #0383 eliminate specifications for documenting a care plan for patients with mild pain, in order to focus on patients who most need an intervention (patients with moderate to severe pain), and further define what constitutes a plan of care to clarify the measures. The Committee suggested that care plans for pain should be broadly specified to include all patients regardless of the type of modality of treatment but also be more precise as to what may be included as an acceptable plan of care as additional data collection methods become more common, including registry reporting and EHR reporting. The related measure comparison table is in Appendix D.

Electronic Health Record Specifications

One measure recommended for endorsement in the first phase was submitted with additional electronic specifications: #0389 Prostate Cancer: Avoidance of Overuse Measure - Bone Scan for Staging Low Risk Patients (AMA-PCPI). This was one of the measures retooled in 2010 and updated in 2011. The submitted e-specifications were reviewed by NQF Health IT staff for accuracy.

Gaps in Care

During the first phase Steering Committee members expressed concern that several measures had high rates of performance, indicating a small gap in performance; however, the developer clarified that the performance gap data came from the American Society for Clinical Oncology's Quality Oncology Practice Initiative (QOPI), which included self-selecting practices voluntarily reporting on measures. As such, the developer stated that it is likely that there is more variation in performance than was demonstrated through QOPI.

- #1857 Trastuzumab not administered to breast cancer patients when human epidermal growth factor receptor 2 (HER2) is negative or undocumented,
- #1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III, human epidermal growth factor receptor 2 (HER2) positive breast cancer, and
- #1878 Human epidermal growth factor receptor 2 (HER2) testing in breast cancer.

Steering Committee discussion for all three measures focused on whether the criterion for opportunity for improvement was met. The Steering Committee agreed with the developer that it is likely that there is greater variation in use of trastuzumab and in HER2 testing, than indicated by the self-selected practices participating with QOPI. Taken in conjunction with several published and unpublished studies suggesting overuse of trastuzumab, the Steering Committee recommended the measures for endorsement.

Harmonization of Related Measures

Related measures identified within Phase 2 of this project include those measuring hormonal therapy for patients with breast cancer, and those measuring chemotherapy for patients with colon cancer. Please see the related measure comparison tables in Appendix C.

The Steering Committee evaluated two measures related to hormonal therapy for patients with breast cancer:

- #0220 Adjuvant hormonal therapy (ACS), and
- #0387 Oncology: Hormonal Therapy for Stage IC through IIIC, ER/PR Positive Breast Cancer (AMA-PCPI).

The Committee noted the two measures were related, but did not have recommendations for further harmonization. The measures addressed similar patient populations but at different levels of analysis; consequently, the specifications of the measures were slightly different to account for the data sources used in calculating the measures at the different levels of analysis.

	#0220 ADJUVANT HORMONAL THERAPY (ACS)	#0387 ONCOLOGY: HORMONAL THERAPY FOR STAGE IC THROUGH IIIC, ER/PR POSITIVE BREAST CANCER (AMA-PCPI)
Level of Analysis	Specified at the facility level.	Specified at the clinician level for group practices, individuals or teams.
Patient Population	Women 18 years or older at the time of diagnosis of breast cancer, • known or assumed to be first or only cancer diagnosis • epithelial malignancy only • primary tumors of the breast • AJCC T1c or Stage II or III • primary tumor is ER or PR positive • all or part of the first course of treatment performed at the reporting facility, and • known to be alive within 365 days of data of diagnosis.	Women 18 years and older with Stage IC through IIIC ER or PR positive breast cancer.
Exclusions	Men, women under the age of 18 at time of diagnosis, second or subsequent cancer diagnosis, tumor not in originating in the breast, Stage 0, in-situ tumor, primary tumor is estrogen receptor negative and progesterone receptor negative, none of the first course therapy is performed at the reporting facility, or died within 365 days of diagnosis.	Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was >= 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period) Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient refusal) Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient is currently enrolled in a clinical trial)
Data Source	Registry and paper records.	Administrative claims, EHR, registry, paper records

The Steering committee evaluated two measures related to chemotherapy for patients with colon cancer:

- #0223 Adjuvant chemotherapy is considered or administered within 4 months (120) days of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer (ACS), and

- #0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients (AMA-PCPI).

The Committee requested that the developers harmonize the age cut-off for the measures at 80 years of age, as the National Comprehensive Cancer Network (NCCN) guidelines do not recommend the intervention for patients older than that due to diminishing benefits to the patient associated with increasing age. The AMA-PCPI will consider modifying its measure in the future as requested.

	#0223 ADJUVANT CHEMOTHERAPY IS CONSIDERED OR ADMINISTERED WITHIN 4 MONTHS (120) DAYS OF DIAGNOSIS TO PATIENTS UNDER THE AGE OF 80 WITH AJCC III (LYMPH NODE POSITIVE) COLON CANCER (ACS),	#0385 ONCOLOGY: CHEMOTHERAPY FOR STAGE IIIA THROUGH IIIC COLON CANCER PATIENTS (AMA-PCPI).
Level of Analysis	Specified at the facility level,	Specified at the clinician level for group practices, individuals or teams.
Patient Population	Patients age 18-79 at time of diagnosis • Known or assumed to be first or only cancer diagnosis • Primary tumors of the colon • Epithelial malignancy only • At least one pathologically examined regional lymph node positive for cancer (AJCC Stage III) • All or part of 1st course of treatment performed at the reporting facility2 • Known to be alive within 4 months (120 days) of diagnosis	Patients aged 18 years and older with Stage IIIA through IIIC colon cancer.
Exclusions	Patients age <18 and >=80; not a first or only cancer diagnosis; • non-epithelial and non-invasive tumors; • no regional • lymph nodes pathologically examined; • metastatic disease (AJCC Stage IV); not treated surgically; • died • within 4 months (120 days) of diagnosis	• Documentation of medical reason(s) for not referring for or prescribing • adjuvant chemotherapy (e.g., medical comorbidities, patient over the age of 80, diagnosis date more than 5 • years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting • period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status) • Documentation of patient reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient • refusal) • Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient is • currently enrolled in a clinical trial that precludes prescription of chemotherapy

	#0223 ADJUVANT CHEMOTHERAPY IS CONSIDERED OR ADMINISTERED WITHIN 4 MONTHS (120) DAYS OF DIAGNOSIS TO PATIENTS UNDER THE AGE OF 80 WITH AJCC III (LYMPH NODE POSITIVE) COLON CANCER (ACS),	#0385 ONCOLOGY: CHEMOTHERAPY FOR STAGE IIIA THROUGH IIIC COLON CANCER PATIENTS (AMA-PCPI).
Data Source	Registry and paper records.	Administrative claims, EHR, registry, paper records

Measure Specific Issues

0031 Breast Cancer Screening

Changing guidelines in the area of screening for breast cancer influenced evaluation of the maintenance measure #0031 Breast Cancer Screening (National Committee for Quality Assurance), during phase 1 of the project which captures women age 40 to 69 years who have had a biennial mammogram to screen for breast cancer. In 2009, the U.S. Preventive Services Task Force (USPSTF) issued the following recommendations related to screening for breast cancer:

- The USPSTF recommends biennial screening mammography for women aged 50 to 74 years.
    - Grade: B recommendation.
- The decision to start regular, biennial screening mammography before the age of 50 years should be an individual one and take patient context into account, including the patient's values regarding specific benefits and harms.
    - Grade: C recommendation.
- The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of screening mammography in women 75 years or older.
    - Grade: I Statement.
- The USPSTF recommends against teaching breast self-examination (BSE).
    - Grade: D recommendation.
- The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of clinical breast examination (CBE) beyond screening mammography in women 40 years or older.
    - Grade: I Statement.
- The USPSTF concludes that the current evidence is insufficient to assess the additional benefits and harms of either digital mammography or magnetic resonance imaging (MRI) instead of film mammography as screening modalities for breast cancer.
    - Grade: I Statement.[9]

However, other national guidelines (e.g., American Cancer Society, American College of Obstetricians and Gynecologists) continue to recommend screening at earlier ages. The Steering Committee did not reach clear consensus on measure #0031 due to concerns about the rationale for the age specified in the measure, given the USPSTF recommendations and conflicting recommendations from national societies. The Steering Committee agreed that the measure addresses an important topic where there is potential for improvement in breast cancer screenings; however, the Steering Committee was concerned that evolving evidence for breast cancer screenings may lessen the impact of this metric for the patient populations that would most benefit from the screenings. The NCQA is currently evaluating the guidelines to determine if and how measure #0031 should be changed. One possibility is that the developer might stratify the measure by different age groups.

Since the Steering Committee was unable to reach consensus on this measure, the Committee requested additional input from the membership and the public on an endorsement recommendation. After considering member and public comment, as well as information presented by the developer on a follow up conference call, the Steering Committee voted against continued endorsement of the measure as it is currently specified.

Comment on the measures provided both support and concern with the measure and the relation to the USPSTF breast cancer screening guidelines. One commenter suggested that the measure might be stratified by women aged 40 to 49, and women aged 50 and older as a way to address concerns about conflicting guideline recommendations regarding the appropriate age to begin biennial screening mammograms. NCQA noted that many professional organizations, including American Congress of Obstetricians and Gynecologists, American Cancer Society, American College of Radiology, American Society of Breast Surgeons, and the Society of Breast Imaging continued to recommend biennial mammography screening for women aged 40 to 49. NCQA is currently reevaluating the measure and exploring potential changes to the measure, including the possibility of stratifying the measure by age. The measure would remain in use in HEDIS while modifications are made, and changes to the measure are expected to be finalized in spring of 2013. Committee members agreed that measures of accountability must be supported by consistent, high-level evidence supporting the measure focus. The Committee was concerned that stratification of the measure by age groups may not address the issue of conflicting evidence as results on the younger age group may not be meaningful and may be confusing to users of the measure. Steering Committee members suggested that two separate measures addressing these age groups may be the most appropriate action given the need to incorporate patient's family history and preferences for screening for women aged 40 to 49.

NQF would be pleased to review the revised NCQA measure when it is finalized and an appropriate endorsement project is available.

Recommendations for Future Measure Development

During their discussions the Committee identified numerous areas where additional measure development is needed:

Disease Specific Gaps

- PSA screenings for patients diagnosed with prostate cancer
- Measures addressing hematological malignancies, particularly first line therapies
- Measures addressing targeted therapies for kidney and lung cancer, as well as other solid tumor cancers
- Measures capturing deviations in care for the CMS priority areas of prostate, lung, breast, and colon cancers
- Measures addressing management of complications such as febrile neutropenia (FN)
- Measures for pediatric patients, including measures in cross cutting areas such as pain assessment and palliative care

Pathology and Treatment Reports

- Measures ensuring that reporting details in pathology reports are standardized across all tumor types

- Measures ensuring that treatment summaries are standardized across medical and radiation oncologists

Appropriateness of Care

- Measures capturing enrollment of patients in clinical trials at appropriate times
- Measures addressing whether appropriate patients are offered enrollment in clinical trials
- Measures capturing access of patients to high quality hospice care facilities
- Measures addressing readmissions and value-based care
- Measures of care coordination

Patient Outcomes

- Measures capturing Patient Reported Outcomes
- Measures capturing cancer survival rate curve measures that can be reported by stage, identified as both overall survival (OS) and disease free survival (DFS).
- Measures applicable to patients with:
    - lung, pancreas, liver, esophagus and colon cancer: 5-year survival rates
    - breast cancer: 10 year survival rates
    - thyroid cancer: 20-25 year survival rates

Surgical Care

- Measures capturing operating room procedures or processes that need to take place in the surgical theater

Next Generation Measures

- Measures capturing patient adherence to prescribed medications or therapies, including oral chemotherapies
- Measures capturing treatment of negative side effects from prescribed medications or therapies
- Measures capturing gene mutations and appropriate therapies
- Measures capturing use of biological therapies
- Outcome measures rather than process measures

Quality of Care

- Measures capturing surgical outcomes
- Measures capturing surgical processes linked to outcomes
- Measures assessing the quality of laboratory methodologies
- Measures assessing the quality of laboratory reports
- Measures addressing maintenance of nutritional status throughout the course of treatment
- Measures capturing smoking cessation for patients with lung cancers
- Evidence-based measures related to surveillance of cancer survivors in order to minimize the probability of recurrence
- Measures related to cancer survival in specific areas, e.g., smoking cessation for lung cancer patients; maintaining nutritional status
- Measures related to the quality, value and effectiveness of surgical, radiation and medical therapies in cancer care over the course of treatment
- Measures related to predictive laboratory testing

Unique Patient Populations

- Measures addressing pediatric patients with cancer
- Measures addressing hematological cancers separately from other cancers
- Measures addressing disparities stratified by race/ethnicity, gender, and language

Other Measures

- Measures submitted by patient advocacy groups or other multidisciplinary stakeholders
- Prevention measures
- Screening measures
- Combined measures to be used in “toolkits” to ensure a process is associated with an improved outcome

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Measures Recommended

Hematology and Melanoma Measures

0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenic testing performed on bone marrow.

Numerator Statement: Patients who had baseline cytogenetic testing* performed on bone marrow

Definition: *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or within three years prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis.

Denominator Statement: All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia

Exclusions: Documentation of medical reason(s) for not performing baseline cytogenetic testing

Documentation of patient reason(s) for not performing baseline cytogenetic testing

Denominator Exclusions: Documentation of system reason(s) for not performing baseline cytogenetic testing

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data : Laboratory

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** The American Society of Hematology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-9; M-8; L-0; I-0; **1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-13, N-1, I-3**

Rationale:

- Myelodysplastic Syndrome (MDS) is increasingly common in an aging population and associated with high morbidity and mortality; baseline cytogenic testing performed on bone marrow is important to measure and report due to its role in evaluating and managing this patient population.
- There is a striking performance gap: 48% non-compliance was demonstrated in the CMS 2008 Physician Quality Reporting System (PQRS).
- Measurement of cytogenetics at the time of diagnosis or prior to treatment has become the standard of care since therapies are stratified based on the cytogenetic profile.
- There was concern that the literature cited and rationale provided by measure authors focuses mainly on the use of cytogenetics in MDS and its evolution to acute myelogenous leukemia (AML) and does not include much information on *de novo* AML. Although much of the literature presented in the application is based on retrospective reviews, there is some prospective randomized literature in AML that is stratified based on prognostic factors (including cytogenetics) to indicate that cytogenetic abnormalities predict outcome. However, this measure is based mainly on a consensus guideline from the National Comprehensive Cancer Network (NCCN). The authors grade the literature as 2A based on lower level evidence.

0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-9; L-1; I-0; 2b. Validity: H-8; M-9; L-0; I-0

Rationale:

- The PCPI Testing Project shows interobserver variability is minimal.
- Face validity is well demonstrated.
- The measure directs that the data be gathered in the ambulatory setting. For acute leukemia, much of the care is in the hospital setting. The Steering Committee recommended reporting the measure with a CPT procedure code or CPT-2 code in order to capture the inpatient setting.
- Extraction of data from separate EHRs was not addressed. The number of patients analyzed for these measures was small, and the sample needed to be extended beyond the scope of the measure to achieve an adequate sample for analysis.

3. Usability: H-10; M-6; L-1; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure has been in use in the CMS Physician Quality Reporting System (PQRS) since 2007
- The data presented demonstrate a high failure rate to meet the measure, and since treatment is stratified based on the presence of cytogenetic information prior to initiating therapy this measure represents a highly useful measure for quality improvement.

4. Feasibility: H-5; M-11; L-1; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Collection of this data is a routine part of care.
- Data can be extracted, but may exist in different EHRs.

Steering Committee Recommendation for Endorsement: Y-17 ; N-0

Rationale:

- The measure represents standard of care measure that is useful to stratify treatments, possibly decrease toxicities and costs and assure appropriate therapies. The measure appears to be reliable, valid, useful and feasible.

RECOMMENDATIONS:

- This measure is becoming outdated, as diagnostic panels for MDS and acute leukemias rely heavily upon molecular panels and FISH in addition to standard cytogenetics. The responsibility for these assays is also divided between pathologists (who have no ongoing relationship with patients) and hematologists, who provide ongoing care. The Steering Committee recommended that the measure developer consider specifying this measure in the future to capture FISH and other tests.
- The Steering Committee recommended the measure developer consider specifying the measure to capture patients with MDS, acute myelogenous leukemia and acute lymphoblastic leukemia. The Committee believed that karyotypic data, stratified appropriately, might provide a way to make major therapeutic decisions with respect to the patient population.

0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow

Public and Member Comment

Comments included:

- Commenters suggested the time window be further defined to specify the look back period for the measure.
- Commenters suggested that in the future, the developer specify measure to capture FISH and other tests.

Developer Response:

- The developer will look to address these concerns in future iterations of the measure.

0378 Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy

Numerator Statement: Patients with documentation* of iron stores within 60 days prior to initiating erythropoietin therapy *Definition: documentation of iron stores which includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC

Denominator Statement: All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy

Exclusions: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy

Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Society of Hematology

Steering Committee In-Person March 13-14, 2012

0378 Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-3 ; M-11 ; L-1 ; I-0; 1b. Performance Gap: H-5 ; M-7 ; L-3 ; I-0 ; 1c. Evidence: Y-15 , N-0 , I-0

<u>Rationale</u>:

- This is an increasingly common condition, with diagnosis rising as the population continues to age.
- There is a significant performance gap; 58% of patients did not meet the measure as demonstrated in the PQRS testing information.
- The measure is based on a National Comprehensive Cancer Network (NCCN) consensus guideline.
- The measure only requires that iron stores be checked, not that an intervention as a result of the iron level occur (it would be far more important to document and supplement iron in patients receiving erythropoietin therapy). This is an area for future measure development.
- This patient population falls outside of FDA regulations for testing of iron stores; this may make this measure more important.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-4 ; M-10 ; L-0 ; I-1 ; 2b**. Validity: H-5 ; M-9 ; L-0 ; I-1**

<u>Rationale</u>:

- Numerator and denominator are precisely specified; clarification of the definition of "iron stores" in the numerator statement and specification of a 60-day time window the denominator allow for the measure to be precisely captured.
- Reliability data supports that the measure is reliable.
- Face validity has been demonstrated.

3. Usability: <u>H-5; M-8; L-2; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure has been in use in PQRS since 2007.
- The measure should be moderately understandable for public reporting.

4. Feasibility: <u>H-7; M-8; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale:</u>

- Collection of this data is a routine part of care.
- Data can be extracted but may exist in different EHRs.

0378 Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy

Steering Committee Recommendation for Endorsement:

Rationale: Y-14; N-1

- The Committee's initial evaluation supported endorsement with clarification of iron measurements, which were addressed by the developer. The Committee noted that erythropoietin works sub optimally without adequate iron stores, and that the measure reflects FDA recommendations.
- The measure was improved with the addition of a testing time window, as the diagnosis of MDS may precede decision to use erythropoietin by many months if not years.
- This measure does not carry a high risk of unintended consequences.

RECOMMENDATIONS: The measure was not voted on at the in-person meeting due to ambiguity in the measure specifications. The Steering Committee asked the developer to clarify the definition of "iron stores" in the numerator statement and to specify time window the denominator. On a follow up call, the Steering Committee reviewed the measure with the clarified numerator and the addition of a 60-day time window to the denominator for the documentation of iron stores prior to the initiation of erythropoietin therapy. The Committee agreed with the changes and recommended the measure for endorsement.

Public & Member Comment

- Commenters indicated support for the measure.

0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

Numerator Statement: Patients who had baseline flow cytometry* studies performed

Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy.

Denominator Statement: All patients aged 18 years and older seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period

Exclusions: Documentation of medical reason(s) for not performing baseline flow cytometry

Documentation of patient reason(s) for not performing baseline flow cytometry

Documentation of system reason(s) for not performing baseline flow cytometry

Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Society of Hematology

0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-7; M-5; L-3; I-0; **1b. Performance Gap: H-2; M-10; L-2; I-1; 1c. Evidence: Y-14, N-0, I-1**

<u>Rationale</u>:

- This is the most common leukemia and involves high resource use.
- There is a performance gap: a 38% failure to perform shown in PQRS testing.
- Flow cytometry is important in diagnosis and treatment planning, but the data provided do not provide adequate rationale for measure. They discuss delays in diagnosis but measure is for flow cytometry following diagnosis or before treatment. So it is unclear how this would shorten time to diagnosis.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-5; M-9; L-0; I-1; 2b. Validity: H-5 ; M-9 ; L-0 ; I-1

<u>Rationale</u>:

- The measure is confusing. It specifies a 12-month reporting period in which all patients with CLL are captured in the denominator. However, flow cytometry may have been performed years prior to the initiation of treatment and reporting event. The numerator therefore may not correspond to the same reporting period as the denominator. The measure may be relying upon interventions done many years earlier. Per the Steering Committee's recommendation, the developer will clarify the time window for flow cytometry studies to be performed.
- The Steering Committee noted that the clarification that flow cytometry baseline studies should take place at the time of diagnosis or prior to initiating treatment, and not necessarily within the time window for the measure, adds the necessary clarity to the measure specifications to make it easily captured.

3. Usability: <u>H-5; M-7; L-2; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale:</u>

- The measure has been in use in PQRS since 2007.
- The measure should be moderately understandable for public reporting.

4. Feasibility: <u>H-3; M-11; L-1; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Collection of this data is a routine part of care.
- Data can be extracted but may exist in different EHRs.

0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry

Steering Committee Recommendation for Endorsement

Rationale: Y-13; N-2

- The measure is improved with clarification of numerator/denominator.
- There is some concern about use as a quality measure as diagnosis is made based on flow cytometry results.
- Flow cytometry is sensitive and specific for diagnosis, impacts prognosis and decisions regarding follow-up; questions about time frames have been addressed.
- Even with the caveats discussed, the measure provides a reasonable assessment of quality care.
- Important to measure, and developer clarified numerator and denominator for more reliable measurement.

RECOMMENDATIONS: The Steering Committee did not recommend the measure at the in-person meeting; voting ended at 2.a Reliability. The Committee noted that the numerator should be clarified to identify patients who had documentation of the study having been performed, and that the denominator should be clarified regarding the time window. On a follow up call, the developer provided clarifications to the numerator and denominator for review and consideration by the Committee. The Committee agreed with the changes presented and recommended the measure for endorsement.

Public and Member Comment

Comments included:

- Commenters were concerned that because the diagnosis of CLL is based on the results of flow cytometry, nearly all patients with the diagnosis will be expected to have had flow cytometry.
- Commenters suggested that the measurement time period should be clarified.

Developer Response:

- We have received comments regarding clarifying the time period as well as the possibility that the flow cytometry would have taken place previously. We have incorporated these updates and comments into the measure language.

Steering Committee Response:

- The Steering Committee agrees with the developer's response, which is in line with discussions that occurred at the in-person meeting and on related conference calls.

0380 Multiple Myeloma – Treatment with Bisphosphonates

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period

Numerator Statement: Patients who were prescribed or received intravenous bisphosphonate therapy* within the 12 month reporting period.

Definition: *Bisphosphonate Therapy: Includes the following medications: pamidronate and zoledronate

Denominator Statement: All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission

Exclusions: Documentation of medical reason(s) for not prescribing bisphosphonates (e.g., patients who do not have bone disease, patients with dental disease, patients with renal insufficiency)

Documentation of patient reason(s) for not prescribing bisphosphonates

Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Society of Hematology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-9; M-8; L-0; I-0; **1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-13, N-1, I-3**

Rationale:

- The measure developer cites an American Cancer Society publication to show that this is an issue of high impact that affects large numbers of patients (approximately 20,000 patients diagnosed annually)
- The gap in care for prescribing bisphosphonates for patients in the measure was striking, with 47.4% of patients reported on not meeting the measure.
- Supporting literature is of moderate to high quality and quantity.
- Use of bisphosphonates increases quality of life, though it does not decrease mortality.
- Intervention should occur more often; however, reporting annually on the measure is acceptable.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-9; L-1; I-0; 2b. Validity: H-8; M-9; L-0; I-0

Rationale:

- Previously endorsed measure; interval study data demonstrated a high degree of reliability (100%)
- Face validity of the measure was well demonstrated.
- The measure is well specified and will be easy to extract.

0380 Multiple Myeloma – Treatment with Bisphosphonates
3. Usability: H-7; M-10; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* **Rationale:** • The measure will be useful for QI, particularly given the performance gap. • The measure should be moderately understandable for public reporting.
4. Feasibility: H-5; M-12; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* **Rationale:** • Data easily extracted from EHR or paper chart
Steering Committee Recommendation for Endorsement: Y-17; N-0 **Rationale:** The Steering Committee found the intervention addressed by this measure affects a large patient population and is important in improving patient quality of life. There is a significant performance gap in meeting the measure, allowing room for improvement in patient care.
Public & Member Comment • Commenters indicated support for the measure.

0562 Overutilization of Imaging Studies in Melanoma

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered

Numerator Statement: Patients for whom no diagnostic imaging studies* were ordered

Denominator Statement: All patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period

Exclusions: Documentation of medical reason(s) for ordering diagnostic imaging studies (e.g., patient has comorbid condition that warrants imaging, other medical reasons); Documentation of system reason(s) for ordering diagnostic imaging studies (e.g., requirement for clinical trial enrollment, ordered by another provider, other system reasons)

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Academy of Dermatology and National Committee for Quality Assurance

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report:

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-9; M-4; L-2; I-0; **1b. Performance Gap: H-7; M-7; L-1; I-0; 1c. Evidence: Y-8, N-4, I-3**

Rationale:

- The Steering Committee agreed that there is no question that imaging use and cost are rising; however, it is less clear to what extent that is true for this population.
- The measure is based mainly on consensus guidelines with a high volume of studies cited and limited data presented to specifically support measure. Literature is graded according NCCN guidelines and recommendations are not based solely on literature support.
- The body of evidence as noted above is larger for the general group of all patients when looking at hospital to outpatient settings. If this is restricted to melanoma patients and if it involves outpatient to outpatient settings, the body of evidence is low. However, there is no evidence for harm.
- The Steering Committee discussed that the measure assumes that treatment for metastatic melanoma is futile therapy, but two new agents have been FDA-approved for melanoma since this measure was adopted and future studies may indicate a new role for surveillance in the future.

2. Scientific Acceptability of Measure Properties: The measure does not meet the Scientific Acceptability Criteria

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-2 ; M-4 ; L-6 ; I-2 ; 2b. Validity: H-1; M-4 ; L-5 ; I-2

0562 Overutilization of Imaging Studies in Melanoma

3. Usability: N/A

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

4. Feasibility: N/A

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Steering Committee Recommendation for Endorsement: The measure failed the Scientific Acceptability criteria and will not be recommended for endorsement.

- The Steering Committee expressed concerns regarding the reliability of the measure: the measure does not adequately address the distinction between initial stage and recurrence, and the definitions of these in data sources
- The measure reflects updated NCCN guidelines, impacts large numbers, and is important to address overuse.
- The topic is too narrow; one could argue for this type of measure for every type of primary cancer.
- The Committee disagreed with inclusion of downstream patients in the measure, as they felt it confounds reliability; data presented by the developers appears to show this.

RATIONALE: The Steering Committee did not recommend the measure at the in-person meeting; voting ended at 1.c Evidence. The Committee noted that the denominator should be limited to patients with a new diagnosis and asked the developer for analysis of the data on newly diagnosed patients versus patients with a history of melanoma. The developer presented reliability testing analysis showing an approximately 10% difference in reliability, but the SC noted that the testing was done on a relatively small sample size of 148. On a follow up call, the Committee reviewed the analysis presented by the developer again and discussed the measure. The Committee noted that cancer staging follows patients from the point of diagnosis; the stage should not migrate as the patient's disease changes. Instead the stage carries with notations denoting clinical or pathological observations. Because of this, the testing analysis demonstrating reliability of the measure was not persuasive, as the stage is from diagnosis and thus cannot be easily extracted for measurement. The Committee found that the information provided by developer did not allay concerns about ambiguities in the measure and did not recommend the measure for endorsement.

Public and Member Comment

Importance

- The Steering Committee members stated that there is limited evidence of overuse of imaging in this patient population, as no study has ever been undertaken.
    - The measure developers presented evidence that the measure was based on both the AAD and NCCN guidelines (please reference attached letter, section 1).
    - The developers noted that the measure is supported by evidence based guidelines (AAD and NCCN) that recommend that both newly diagnosed patients with stage 0-IIC melanoma without signs or symptoms suggesting systemic spread and patients with a history of melanoma at any stage without signs or symptoms suggesting systemic spread not receive unnecessary imaging. The developers emphasized that patients with signs or symptoms suggesting systemic spread would not be counted in the denominator and thus would be eligible for imaging, allowing providers to exercise clinical judgment when signs or symptoms are present.

Scientific Acceptability

- Steering Committee members raised concerns that the measure would restrict imaging of patients with recurrence of melanoma, not taking into account patients who are seen many years out for follow up who present with symptoms or signs of illness. Steering Committee members noted that these patients should be followed up with utilizing imaging, in accordance with NCCN guidelines.

  - The measure developers noted that the measure provides explicit denominator exceptions for patients with signs or symptoms of systemic spread to be evaluated using imaging (see denominator exclusion details, section 2a1.9 of the measure submission form and also section 3 of the attached letter). These patients who have a history of melanoma who present with signs or symptoms of systemic spread would not be included in the denominator and would be eligible for imaging.
  - Signs are defined as: "Signs-For the purposes of this measure, signs include tenderness, jaundice, localized neurologic signs such as weakness, or any other sign"
  - Symptoms are defined as: "Symptoms-For the purposes of this measure, symptoms include cough, dyspnea, pain, paresthesia, or any other symptom"
- Steering Committee members questioned whether providers would game the system and create exceptions in order to justify ordering imaging.
  - The developers noted that there have been several studies on exception methodology, with very high concordance between what is documented and what is considered an acceptable exception as defined by a group of experts.
  - With respect to this measure, for patients with newly diagnosed melanoma, the exception agreement was 100%. For patients with existing diagnoses of melanoma, the exception agreement was 74.59%. The developer cautioned that this was calculated using a small sample size (please reference attached letter, section 2).

In light of the information presented on the follow up conference call, Steering Committee members motioned to formally vote on the measure. A SurveyMonkey link was sent to the Steering Committee members along with a summary of the discussion on the conference call. The voting results are presented below:

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-4; M-9; L-1; I-0; 1b. Performance Gap: H-1; M-11; L-1; I-1; 1c. Evidence: Y-11; N-2; I-1

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-2; M-10; L-2; I-0; 2b. Validity: H-2; M-10; L-2; I-0

3. Usability: <u>H-1; M-11; L-2; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

4. Feasibility: <u>H-1; M-13; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Steering Committee Recommendation for Endorsement: <u>Y-9; N-5</u>

<u>Rationale:</u>

- Steering Committee members voted to recommend measure 0562 for endorsement, noting that the evidence presented by the measure developer alleviated concerns regarding the evidence base for overuse of imaging in patients with asymptomatic localized melanoma.
- Steering Committee member concerns that the measure specifications would limit the ability of providers to use clinical judgment when ordering imaging were addressed by the clarifying language regarding signs or symptoms of

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melanoma.

- Steering Committee member concerns that the reliability of the measure was different for patients with a new diagnosis versus patients with a history of melanoma were addressed by the additional stratified reliability testing provided demonstrating that the measure is reliable in both patient populations and that the exception rate is not markedly different between the two patient groups.

0650 Melanoma Continuity of Care – Recall System

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month reporting period into a recall system that includes:

- A target date for the next complete physical skin exam , AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Numerator Statement: Patients whose information is entered, at least once within a 12 month period, into a recall system* that includes:

- A target date for the next complete physical skin exam , AND
- A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment

Denominator Statement: All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma.

Exclusions: Documentation of system reason(s) for not entering patients into a recall system (e.g., melanoma being monitored by another physician provider)

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Structure

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Registry, Other, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Academy of Dermatology and National Committee for Quality Assurance

Steering Committee In-Person March 13-14, 2012

0650 Melanoma Continuity of Care – Recall System

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-9; M-8; L-0; I-0; **1b. Performance Gap: H-4; M-11; L-1; I-1; 1c. Evidence: Y-7, N-1, I-9; Evidence Exception: Y-16, N-1**

<u>Rationale</u>:

- Studies presented do not specifically address the melanoma recall system.
- Measure is likely an opportunity for improvement but data is unclear about performance gap with regard to a recall system. Authors cite that 9% did not meet measure; however, the Steering Committee views this as a "never event."
- The body of evidence as noted above is larger for the general group of all patients when looking at hospital to outpatient settings. If this is restricted to melanoma patients and if it involves outpatient to outpatient settings, the body of evidence is low. However, there is no evidence for harm.
- Steering Committee members stated that the link between the process of utilizing a recall system and increased screening/examination of patients can be inferred.
- Steering Committee members stated that this is a valuable intervention because of the prevalence of the diagnosis, the increasing incidence of melanoma and the opportunity for impacting the outcome of patients by early diagnosis of a new primary melanoma, and chose to invoke the exception to empirical evidence rule because of this.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-9; L-0; I-1; 2b. Validity: H-4; M-12; L-0; I-1

<u>Rationale</u>:

- The measure developer reports moderate reliability regarding a diagnosis of melanoma but high reliability for all other data elements including documentation of enrollment in a recall system
- Measure specifications are reasonably precise.
- Face validity was demonstrated.

3. Usability: <u>H-4; M-12; L-1; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- Measure is currently in use for PQRS.
- Measure is easily understood.

4. Feasibility: <u>H-6; M-11; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- Data elements relate to office procedures, not directly to care.
- Recall procedure may not be in EHR, may be in practice management software, other tracking software, or non-electronic.
- All criteria should be feasible within an EHR, but extracting information may be difficult.

Steering Committee Recommendation for Endorsement: Y-15; N-2

<u>Rationale:</u> The Steering Committee found that the intervention addressed by this measure affects a large patient population and is important in ensuring continuity of care.

0650 Melanoma Continuity of Care – Recall System
Public and Member Comment Comments included: • Commenters suggested the measure be expanded to capture data regarding multiple types of skin cancers so that continuity of care can be achieved. • It was suggested that the measure capture how many patients had a follow-up appointment rather than how many patients were entered into a recall system. **Developer Response:** • The Work Group will consider expanding the measure population, when the measure undergoes formal review and maintenance, according to the AMA-PCPI measure development/maintenance methodology, in the future. **Steering Committee Response:** • The Steering Committee agrees with the developer's response, which is in line with discussions that occurred at the in-person meeting and on related conference calls.

Oncology Measures

0381 Oncology: Treatment Summary Communication – Radiation Oncology

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment

Numerator Statement: Patients who have a treatment summary* report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment

Definition: *Treatment Summary: a report that includes mention of all of the following components: 1) dose delivered; 2) relevant assessment of tolerance to and progress towards the treatment goals; and 3)subsequent care plans

Numerator Instructions: This measure should be reported once per course of radiation treatment – less than or equal to 30 days from the end of treatment.

Denominator Statement: All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy

Exclusions: Documentation of a patient reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (e.g., patient requests that report not be sent) and to the patient within one month of completing treatment

Documentation of a system reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (e.g., patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** The measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

0381 Oncology: Treatment Summary Communication – Radiation Oncology

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-7; M-10; L-0; I-0; **1b. Performance Gap: H-4; M-10; L-1; I-2; 1c. Evidence: Y-9, N-1, I-7**

<u>Rationale</u>:

- Radiation therapy treatment summaries have been a routine practice for years and are a requirement for payment.
- Many radiation therapy treatment summaries currently lack critical information, such as the site of radiation.
- Summary of evidence of impact is not specific to the focus of the measure. Most evidence is related to incidence, cancer-related death rates, and cancer costs. The most closely related statistic is that two-thirds of all cancer patients will receive radiation. However, there is no data on outcomes associated with the lack of a treatment summary.
- Steering Committee members noted that the information from a treatment summary is very important to disseminate amongst providers caring for the patient receiving radiation therapy.
- The measure affects a large number of patients, and there is demonstrated evidence of a performance gap.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-10; L-0; I-0; 2b. Validity: H-1; M-14; L-1; I-1

<u>Rationale</u>:

- Inter-rater reliability is described as 100% accurate.
- Measure addresses an important priority area: coordination of care. The proximal relationship between performance on the measure and desired outcome is not addressed by available data, however, face validity was demonstrated.

3. Usability: <u>H-6; M-10; L-1; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is being used in a QI program with plans for use in PQRS.

4. Feasibility: <u>H-5; M-10; L-2; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- Data elements are available in an EHR and generated during the provision of care.

Steering Committee Recommendation for Endorsement: Y-14; N-3

<u>Rationale:</u> The intervention addressed by this measure affects a large patient population and is important in ensuring continuity of care.

<u>RECOMMENDATIONS:</u>

The Steering Committee recommended the measure developer consider including the site and stage in the measure in the future.

0381 Oncology: Treatment Summary Communication – Radiation Oncology

Public and Member Comment

Comments included:

- Commenters were concerned that the measure only assesses standard practice that should be occurring routinely.

Developer Response:

- The radiation oncology treatment summary should include many details regarding the treatment course and follow-up plan, which is critical to ensuring proper coordination of care among patient's current and future physicians, including oncologists and primary care physicians. This is especially important for radiation oncology given that cancer patients treated with radiation typically receive multimodality treatment and many patients receive care that is fragmented among several facilities. Unfortunately, as indicated by performance rates for this measure and medical literature on the topic, adherence remains suboptimal demonstrating a significant opportunity to improve the care provided to cancer patients. Specifically, results of the National Initiative for Cancer Care Quality indicated that across five metropolitan statistical areas, only 50% of radiation therapy medical records for patients with breast cancer included information regarding the total dose of radiation, dose per fraction, number of fractions, and the site treated. While this data does not speak to the existence of the report itself, it does speak to the completeness of the report which is a secondary component to the measure. Additionally, among physicians participating in ASTRO's Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program, an average performance rate of 92% was reported for this measure with variation among physicians ranging from 0-100%. PAAROT is a practice improvement program that enables a physician to analyze their practice and evaluate their strengths and areas for improvement.

Steering Committee Response:

- The Steering Committee agrees with the developer's response, which is in line with discussions that occurred at the in-person meeting and on related conference calls.

0382 Oncology: Radiation Dose Limits to Normal Tissues

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Numerator Statement: Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues

Denominator Statement: All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

0382 Oncology: Radiation Dose Limits to Normal Tissues

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-12; M-4; L-0; I-0; **1b. Performance Gap: H-2; M-12; L-2; I-0; 1c. Evidence: Y-14, N-2, I-0**

Rationale:

- The measure applies to lung and pancreatic cancer, with lung especially being a prevalent cancer with high morbidity and mortality. Radiation is a commonly used treatment.
- There was evidence cited showing 89% compliance with the PQRS measure, which highlights some, but not much room for improvement. The Steering Committee considered this a "never event" and felt compliance should be 100%.
- The Steering Committee stated the importance of calculating dose limits when giving radiation to a patient and noted that there is evidence to support this practice.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-11; M-5; L-0; I-0; 2b. Validity: H-7; M-9; L-0; I-0

Rationale:

- The measure contains specifications that allow for reliable ascertainment and data on reliability.
- The measure includes data on face validity from an expert panel.

0382 Oncology: Radiation Dose Limits to Normal Tissues

3. Usability: H-10; M-6; L-0; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure has been successfully implemented in PQRS.
- The measure should be easily understood for public reporting.

4. Feasibility: H-11; M-5; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The data elements are all feasibly extracted from an EHR and generated during routine care delivery.

Steering Committee Recommendation for Endorsement: Y-16; N-0

Rationale: The Steering Committee noted that there is near universal concordance from an expert panel, excellent reliability, usability, and feasibility, and the target population comprises large numbers. There is no contradictory evidence for the measure.

Public and Member Comment

Comments included:

- Commenters were concerned that the measure only assesses standard practice that should be occurring routinely.

Developer Response:

- Identifying normal tissue dose constraints is an important step in the process of care for patients receiving radiation therapy treatments with significant impact on outcomes including reducing the toxic effects of radiation to normal tissues and subsequently reducing the long term potential for late carcinogenesis and a second malignancy, while delivering the desired dose distribution of radiation to target tissue. Unfortunately, as indicated by performance rates for this measure noted in the submission form, adherence remains suboptimal demonstrating a significant opportunity to improve the care provided to cancer patients.

Steering Committee Response:

- The Steering Committee agrees with the developer's response, which is in line with discussions that occurred at the in-person meeting and on related conference calls.

0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain

Numerator Statement: Patient visits that included a documented plan of care* to address pain

Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.

Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-15; M-2; L-0; I-0; **1b. Performance Gap: H-12; M-5; L-0; I-0; 1c. Evidence: Y-15, N-0, I-2**

Rationale:

- It is well documented that many cancer patients will experience pain during the course of treatment. The measure affects a large patient population.
- A performance gap was demonstrated, with performance in the ASCO QOPI study achieving the measure at 78.29% and in PQRS for 2009 at 91.24%.
- Concern that including any report of pain, even mild, may dilute the impact of this measure. However, the Steering Committee stated that simply noting that the patient was experiencing mild pain and the need to follow up on it would be sufficient to meet this measure, alleviating concerns.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-4; M-12; L-1; I-0; 2b. Validity: H-3; M-12; L-1; I-1

Rationale:

- Reliability was adequately demonstrated, albeit with a small sample size.
- Face validity was demonstrated.

0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
3. Usability: H-6; M-9; L-2; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* **Rationale:** • The measure is currently being used in PQRS 2012; also used from 2009-2011. • The measure is currently in use in ASCO's Quality Oncology Practice Initiative (QOPI ®) program and ASTRO's Performance Assessment for the Advancement of Radiation Oncology Treatment (PAAROT) program.
4. Feasibility: H-4; M-13; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* **Rationale:** • Data elements are available in an EHR and generated during the provision of care.
Steering Committee Recommendation for Endorsement: Y-16; N-1 **Rationale:** The Steering Committee found that the intervention addressed by this measure affects a large patient population. There is room for improvement in performance of this measure.

0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)

Public and Member Comment

Comments included:

- Commenters recommended the measure be harmonized with other measures of pain management, including QOPI and ASSIST which specify that a plan of care be required for moderate to severe pain.
- Commenters were concerned about the burden on providers to provide a documented plan of care for pain that is insignificant, and were concerned about potential problems differentiating quality of care for moderate to severe pain patients.
- Commenters were concerned that the measure only assesses standard practice that should be occurring routinely.

Developer Response:

- The NCCN guideline recommendations for the management of cancer related pain in adults, upon which this measure is based, are categorized according to three levels of pain intensity - mild pain (1-3); moderate pain (4-6); and severe pain (7-10). Therefore, the plan of care for pain should be initiated at the lowest level of pain intensity. It is also important to recognize that the scope of the plan is broad and may include use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval. Consistent with NCCN guidelines, the specific plan of care for an individual patient's pain required by the measure is at the discretion of the individual clinician based on the needs and preferences of that specific patient.
- Pain is one of the most common symptoms associated with cancer. Pain occurs in approximately one quarter of patients with newly diagnosed malignancies, one third of patients undergoing treatment, and three quarters of patients with advanced disease. Proper pain management is critical to achieving pain control. This measure aims to improve attention to pain management and requires a plan of care for cancer patients who report having pain to allow for individualized treatment based on clinical circumstances and patient wishes. Unfortunately, as indicated by performance rates for this measure noted in the submission form and medical literature on the topic, adherence remains suboptimal demonstrating a significant opportunity to improve the care provided to cancer patients.

Steering Committee Response:

- The Steering Committee agreed with the commenter that patients with mild pain likely do not require documented care plans for addressing the pain. The Steering Committee stated that documentation of a care plan for patients with mild pain in this patient population may very well present a substantial burden to the provider, as many patients being actively treated with chemotherapy or radiation therapy for cancer have mild pain.
- The Steering Committee questioned whether there are other measures that address pain for this patient population in the NQF portfolio. NQF staff stated that there are measures that may overlap with patients in this population that address moderate to severe pain; however, there are no measures that target the entirety of the patient population (patients with cancer being treated at an outpatient facility) addressed by this measure. Consequently, the Steering Committee determined that they would like to move this measure forward with a recommendation for endorsement; however, the Steering Committee made several recommendations for future iterations of the measure. Those recommendations are as follows:
    - Remove specifications for documenting a care plan for patients with mild pain, in order to focus on patients who most need an intervention (patients with moderate to severe pain).
    - Further define what constitutes a plan of care, to remove ambiguity about what "counts" for the measure. This will move the measure away from being a "check the box" measure and further assist in defining the measure as we move toward integration into electronic health records.

0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

Numerator Statement: Patient visits in which pain intensity is quantified*

* Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale

Denominator Statement: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Other, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-16; M-1; L-0; I-0; **1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-16, N-1, I-0**

Rationale:

- Measure developer presented good evidence showing the prevalence of pain; the measure will impact a large number of patients.
- Performance was documented at 89.49% in the ASCO QOPI study, 57% in ASTRO's PAAROT program, and 66.83% in PQRS. There is an opportunity for improvement.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-10; L-0; I-0; 2b. Validity: H-6; M-11; L-0; I-0

Rationale:

- The measure is precisely specified.
- Reliability testing demonstrates almost perfect reliability.
- Face validity is demonstrated.

3. Usability: H-10; M-7; L-0; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure is currently in use in PQRS.

0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)

4. Feasibility: H-9; M-8; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Data elements are available in an EHR and generated during the provision of care..

Steering Committee Recommendation for Endorsement: Y-17; N-0

Rationale: The Steering Committee found that the intervention addressed by this measure affects a large patient population. There is room for improvement in performance of this measure.

RECOMMENDATIONS: The Steering Committee recommended that the developer harmonize the definition of a standardized quantitative pain tool with that used in measure 1628: Patients with Advanced Cancer Screened for Pain at Outpatient Visits and measure 1634: Hospice and Palliative Care – Pain Screening. The definition used by those measures is as follows: Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.

Public and Member Comment

Comments included:

- With regard to harmonizing pain measures, a commenter noted that pain measures are appropriate for all populations, noting that measure 1628 is specific to adult patients, while measures 1634 and 0384 appear to apply to all ages. The commenter noted that the discussion on harmonization under measure 0384 notes that the PICU pain assessment measures "do not require use of a standardized instrument," and stated that the PICU pain measure calls for use of a nationally recognized pain assessment scale that is age and developmentally appropriate. The commenter was supportive of the inclusion of a pictorial in the measure.
- A commenter was concerned that the measure only assesses standard practice that should be occurring routinely.

Developer Response:

- As the commenter noted, there are a number of NQF-endorsed measures focusing on the assessment of pain in a variety of unique settings and circumstances. With the clarification regarding measures 0341 and 0342 in the PICU setting, it appears that all of these measures refer to conducting the assessment using a standardized tool. Similarly, measure 0384 suggests that pain should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale.
- Initial and ongoing pain assessments, the focus of the measure, are essential to ensure proper pain management among patients with cancer. As noted in the NCCN cancer pain guidelines, failure to adequately assess pain frequently leads to poor control. Unrelieved pain denies [patients] comfort and greatly affects their activities, motivation, interactions with family and friends, and overall quality of life. Unfortunately, as indicated by performance rates for this measure and medical literature on the topic, adherence remains suboptimal demonstrating a significant opportunity to improve the care provided to cancer patients.

Steering Committee Response:

- The Steering Committee agrees with the developer's response, which is in line with discussions that occurred at the in-person meeting and on related conference calls.

0386 Oncology: Cancer Stage Documented

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period

Numerator Statement: Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period

Numerator Instructions: *Cancer stage refers to stage at diagnosis

Denominator Statement: All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure is jointly copyrighted by the AMA-PCPI and American Society of Clinical Oncology. The measure set was also developed in collaboration with the American Society for Radiation Oncology.

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-14; M-2; L-1; I-0; **1b. Performance Gap: H-13; M-4; L-0; I-0; 1c. Evidence: Y-12, N-2, I-3**

Rationale:

- Breast and colorectal cancer affect large numbers of patients and are leading causes of morbidity/mortality.
- Information presented related to the impact of the measure is specific to the general topic area (breast and colorectal cancer) rather than specific to importance of documenting stage of disease or to the consequences of poor quality in this area. Steering Committee agreed that documentation of stage is essential for any treatment planning in oncology, representing a “floor” for improvement, however.
- The developer provided data from the QOPI measure showing an average performance rate of 83%, with a range of 35% to 100%. Data was also presented from ASTRO’s PAAROT program, which has an average performance rate of 87% with a range of 10% to 100%.
- Evidence for the measure is exclusively based on clinical practice guidelines; however, there is uniform NCCN consensus that the intervention is appropriate.

0386 Oncology: Cancer Stage Documented

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-5; M-9; L-1; I-2; 2b. Validity: H-2; M-13; L-1; I-1

<u>Rationale</u>:

- Staging is critical for any cancer diagnosis; the measure specifications should be broadened to include all patients with a cancer diagnosis.
- The Steering Committee was concerned that while it is important to know the stage of cancer at diagnosis, it is also important to know the stage over the course of treatment.
- The Steering Committee agreed that it is important to include clinical and pathological stage wherever possible.
- The measure is clearly specified.
- Reliability testing was adequate.
- Face validity was demonstrated.

3. Usability: <u>H-10; M-7; L-0; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure developer has collected performance data; however, the measure has not been publicly reported.
- The measure is currently only being used in QI initiatives.
- The Steering Committee was concerned that patients do not always understand the concept of staging, which could limit use of the measure for public reporting.

4. Feasibility: <u>H-7; M-9; L-1; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- Data is generated during the provision of care and all data elements are found in an EHR.

Steering Committee Recommendation for Endorsement: Y-17; N-0

<u>Rationale:</u> The Steering Committee found that the intervention addressed by this measure affects a large patient population and is important in ensuring that patients are treated appropriately based on diagnosis. This measure is important for treatment planning.

<u>RECOMMENDATIONS:</u>

The Steering Committee recommended the developer consider broadening measure specifications to include all patients with a cancer diagnosis. Additional experience with the measure should begin to show stronger evidence related to important outcomes.

0386 Oncology: Cancer Stage Documented

Public and Member Comment

Comments included:

- A commenter was concerned that the measure only assesses standard practice that should be occurring routinely.

Developer Response:

- Cancer stage is key to the implementation of therapeutic interventions demonstrated to improve survival and decrease the risk of recurrence. The documentation of cancer stage is therefore critical as it provides a means by which this information can readily be communicated to others, to assist in therapeutic decisions, and to help estimate prognosis. Unfortunately, as indicated by performance rates for this measure and medical literature on the topic, adherence remains suboptimal demonstrating a significant opportunity to improve the care provided to cancer patients.

Steering Committee Response:

- The Steering Committee agrees with the developer's response, which is in line with discussions that occurred at the in-person meeting and on related conference calls.

1854 Barrett´s Esophagus (Eligible for Time-Limited Endorsement)

New Measure

Measure Evaluation and Specifications

Description: Percentage of patients with esophageal biopsy reports for Barrett's esophagus that contain a statement about dysplasia.

Numerator Statement: Numerator: Esophageal biopsy reports with the histologic finding of Barrett's mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.)

3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite)

Denominator Statement: Denominator (Eligible Population): All esophageal biopsy reports that document the presence of Barrett's mucosa.

CPT codes:

• 88305 Level IV – Surgical pathology, gross and microscopic examination

AND

ICD-9 codes:

• 530.85 Barrett's esophagus

Exclusions: Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (e.g., malignant neoplasm or absence of intestinal metaplasia).

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable Not applicable

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Type of Measure: Process

Data Source: Administrative claims, Other, Paper Records

Measure Steward: College of American Pathologists

Steering Committee In-Person March 13-14, 2012

1854 Barrett´s Esophagus (Eligible for Time-Limited Endorsement)

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-6; M-10; L-1; I-0; **1b. Performance Gap: H-2; M-12; L-1; I-2; 1c. Evidence: Y-11, N-2, I-4**

<u>Rationale</u>:

- A clear link between Barrett's Esophagus and esophageal adenocarcinoma was demonstrated. Identifying those at risk could allow for appropriate screening of high risk patients.
- This measure will have a substantial impact for a smaller patient population (those diagnosed with Barrett's Esophagus).

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability requirement for untested measures.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

Precise Specifications: Y-16; N-1

<u>Rationale</u>:

- The measure is well specified; however, the Steering Committee noted the importance of reporting not only the presence or absence of dysplasia, but also the grade of dysplasia. The measure developer addressed this recommendation and modified the numerator.
- Plans for reliability and validity testing are in process.

3. Usability: <u>H-3; M-14; L-0; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure has been included in the 2012 PQRS program with plans to publicly report performance results.

4. Feasibility: <u>H-8; M-9; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The data elements are generated during patient care; the measure should be feasible to implement.

Steering Committee Recommendation for Time-Limited Endorsement: Y-15; N-2

<u>Rationale:</u> The Steering Committee found that the intervention addressed by this measure will greatly impact the target patient population, albeit a smaller population. The link between dysplasia in Barrett's Esophagus patients and incidence of esophageal adenocarcinoma is well substantiated.

<u>RECOMMENDATIONS:</u> The Steering Committee asked the developer to require reporting of the grade of dysplasia (high or low) as part of the numerator. The measure developer addressed this recommendation and provided updated the numerator to capture this information. The Steering Committee agreed with the changes and recommended the measure for time limited endorsement.

The measure has not yet been tested for reliability and validity and is being considered for **time limited endorsement.** The measure developer will have 12 months to provide testing data if time limited endorsement is granted.

1854 Barrett´s Esophagus (Eligible for Time-Limited Endorsement)
Public & Member Comment • Commenters indicated support for the measure.

Prostate and Lung Measures

0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Maintenance Measure **Measure Evaluation and Specifications** **Description:** Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer **Numerator Statement:** Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer **Denominator Statement:** All patients, regardless of age, with a diagnosis of prostate cancer, at low risk* of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy **Exclusions:** Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons) Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician) **Adjustment/Stratification:** No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected. **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Clinician : Team **Type of Measure:** Process **Data Source:** Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records **Measure Steward:** American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Urological Association and American Society for Therapeutic Radiology & Oncology
0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Steering Committee In-Person March 13-14, 2012
1. Importance to Measure and Report: The measure meets the Importance criteria. (1a. High Impact; 1b. Performance Gap; 1c. Evidence) **1a. Impact: H-8; M-8; L-0; I-0**; **1b. Performance Gap: H-7; M-9; L-0; I-0; 1c. Evidence: Y-14, N-2, I-0** **Rationale:** • The measure affects a high number of patients: those with low-risk prostate cancer, and the evidence presented shows the intervention is unnecessary for these patients. • Data submitted demonstrates significant overuse of bone scans (84.31% of patients from 2008 PQRS did not meet this measure). There is an opportunity for improvement.

0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-9; M-6; L-1; I-0; 2b. Validity: H-7; M-8; L-1; I-0

Rationale:

- The measure is specified with ICD-9 and CPT codes that can be ascertained consistently.
- Reliability testing presented was appropriate and demonstrated reliability of the measure.
- Validity was shown using results from an expert panel, and demonstrated strong face validity.

3. Usability: H-6; M-8; L-2; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- This measure has been included in the CMS Physician Quality Reporting System (PQRS) from 2008 through 2011. The measure is also included in PQRS 2012.
- A plan for public reporting has been outlined by the measure developer.

4. Feasibility: H-6; M-8; L-2; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Data is generated during the provision of care and all data elements are found in an EHR.

Steering Committee Recommendation for Endorsement: Y-15; N-1

Rationale: The Steering Committee found that the measure addresses an intervention that is currently overused for the target patient population; improved performance on this measure will likely reduce the use of unnecessary bone scans and decrease overall costs.

0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients

Public & Member Comment

Comments included:

- Commenters indicated that the Steering Committee should consider clarifying 'low risk' status for the measure population and that classification for measurement purposes should be based on staging information available at the time of decision making regarding whether or not to order a bone scan.
- Commenters believed that the measure should clearly articulate that even those patients with a positive bone scan remain in the denominator of this measure, even though the bone scan ultimately demonstrates that they are not actually low risk.
- Comments reflected questions on the measure specifications, specifically:
    - It is unclear how treatment interplays with this measure.
    - The numerator captures patients who did not have a 'bone scan performed prior to initiation of treatment nor at any time since diagnosis.
    - Patient eligibility for the denominator should be based on criteria known before the decision to deliver the service (the bone scan) is considered.
    - Exclusion criteria (i.e. treatment planned for future, patient preference, vulnerable health status, and poor access to care)
- Several commenters supported this measure.

Developer Response:

- The AUA/AMA-PCPI Prostate Cancer Work Group appreciates your comment. The Work Group will consider your feedback about the risk stratification, when the measure undergoes formal review and maintenance, according to the AMA-PCPI measure development/maintenance methodology, in the future. Additionally, the measure contains a medical exception, which allows physicians to use clinical judgment in order to have a bone scan performed on those low-risk prostate cancer patients who have a medical reason documented.
- The denominator was constructed so any patient that has already been stratified as a low risk patient and is being treated according to the low risk strata would be captured in the measure. The measure is aiming to reduce the use of bone scans that are clinically unnecessary, in low risk patients who generally have no indication for imaging studies. Additionally, the measure contains a medical exception, which allows physicians to use clinical judgment in order to have a bone scan performed on those low-risk prostate cancer patients who have a medical reason documented.

Steering Committee Response:

- The Steering Committee agrees with the measure developer's response. The response is in line with discussions that occurred at the in-person meeting and on related conference calls.

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)

Numerator Statement: Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

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

Note: Only patients with prostate cancer with high risk of recurrence will be counted in the denominator of this measure

Exclusions: Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (e.g., salvage therapy)

Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Urological Association and American Society for Therapeutic Radiology & Oncology

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-12; M-4; L-0; I-0; **1b. Performance Gap: H-9; M-7; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0**

Rationale:

- The measure addresses appropriateness of care for patients with high-risk prostate cancer, a prevalent condition affecting a large number of patients.
- The evidence provided is high level and supportive of the measure focus.
- The Steering Committee noted that the survival benefit has been better documented than the evidence submitted suggests.
- Adherence is low: 83.41% of patients from 2008 PQRS did not meet this measure; there is an opportunity for improvement.

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-8; L-1; I-0; 2b. Validity: H-4; M-11; L-1; I-0

Rationale:

- The specifications are clear. The time window for reporting the measure is at each time adjuvant hormonal therapy occurs.
- The Steering Committee agreed it is important that proton beam therapy is included in the denominator for this measure.
- The reliability testing presented was appropriate and demonstrated the reliability of the measure.
- Face validity was confirmed with near universal agreement from an expert panel.

3. Usability: H-11; M-4; L-1; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- This measure has been included in the PQRS from 2008 through 2011. The measure is also included in PQRS 2012.
- A plan for public reporting has been outlined by the measure developer.

4. Feasibility: H-6; M-9; L-1; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Steering Committee was concerned that the low number of patients meeting the measure in 2008 PQRS may be a result of difficulties reporting the measure rather than low performance of the measure intervention. The developer agreed that as the denominator requires both ICD codes and CPT category 2 codes, it likely complicated reporting for some providers reporting on the measure. The developer expects reporting to improve as providers become more familiar with the reporting requirements.
- The information in the measure can be abstracted from EHRs.

Steering Committee Recommendation for Endorsement: Y-15; N-1

Rationale: The Steering Committee found that this is a prevalent condition with a level of mortality that renders it a public health priority. The measure is supported by two randomized controlled trials, bolstered by expert opinion. The measure should be able to be reliably ascertained with EHR inputs.

0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients

Public & Member Comment

Comments included:

- For quality improvement purposes, commenters felt that the measure population should be defined more specifically in order to avoid use of resources to identify the denominator population; as specified it may include cases that are exceedingly rare or non-occurring for hospitals that care for children.
- Commenters referenced NCCN guidelines that suggest hormonal therapy for patients with advanced prostate cancer. They noted that the evidence for this measure is supported by a variety of articles that range from complete support to lack of efficacy of hormonal therapy and felt that developers need to reconsider this measure based on the variation in clinical evidence in support of hormonal therapy.

Developer Response:

- The AUA/AMA-PCPI Prostate Cancer Work Group appreciates your comment. The Work Group will reconsider the measure population, when the measure undergoes formal review and maintenance, according to the AMA-PCPI measure development/maintenance methodology, in the future.
- The PQRS data included in the measure submission and the medical literature clearly indicate a remaining performance gap, with respect to adjuvant hormonal therapy in high risk prostate cancer patients. Therefore, the measure is still being put forth for accountability and quality improvement. Additionally, both the AUA and NCCN guidelines recommend adjuvant hormonal therapy with radiotherapy for high risk prostate cancer patients, for prolonged survival.

Steering Committee Response:

- The Steering Committee agrees with the measure developer's response. The response is in line with discussions that occurred at the in-person meeting and on related conference calls.

1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

New Measure

Measure Evaluation and Specifications

Description: Percentage of patients ≥ 18 years of age undergoing elective lung resection (Open or VATS wedge resection, segmentectomy, lobectomy, bilobectomy, sleeve lobectomy, pneumonectomy) for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.

Numerator Statement: Number of patients ≥ 18 years of age undergoing elective lung resection for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.

Denominator Statement: Number of patients ≥ 18 years of age undergoing elective lung resection for lung cancer.

Exclusions: Emergency procedures

Adjustment/Stratification: Statistical risk model Bayesian hierarchical modeling was used to assess the statistical reliability of hospital-specific standardized incidence ratio (SIR) estimates derived from the January 1, 2008 – December 31, 2010 STS data. All hospitals regardless of sample size were included in the estimation of model parameters. Reliability measures were initially calculated including all the hospitals and were subsequently calculated in subsets of hospitals having at least 10, 20, 30, 50, 100, or 200 eligible cases.

Three separate multivariable risk models were constructed (mortality, major morbidity, and composite mortality or major morbidity). The risk-adjustment models created for this measure and study have excellent performance characteristics and identify important predictors of mortality and major morbidity for lung cancer resections. These models may be used to inform clinical decisions and to compare risk-adjusted outcomes for quality improvement purposes. For additional information see the attachment:

Kozower BD, Sheng S, O'Brien SM, Liptay MJ, Lau CL, Jones DR, Shahian DM, Wright CD. STS Database Risk Models: Predictors of Mortality and Major Morbidity for Lung Cancer Resection. Ann Thorac Surg. 2010;90:875–83. n/a

Level of Analysis: Clinician : Group/Practice, Clinician : Team, Facility

Type of Measure: Outcome

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

Measure Steward: Society of Thoracic Surgeons

1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-17; M-0; L-0; I-0; **1b. Performance Gap: H-11; M-6; L-0; I-0; 1c. Evidence: Y-17, N-0, I-0**

Rationale:

- Developer presented solid evidence for importance of the measure.
- The measure provides a good look at the spectrum of procedures done across a spectrum of hospitals, and a wide range of morbidities/mortalities.
- Evidence was submitted demonstrating substantial variation in morbidity and mortality after lung cancer surgery.
- The measure is a first step in developing a measure capturing long term survival rates.

1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-8; M-9; L-0; I-0; 2b. Validity: H-9; M-8; L-0; I-0

<u>Rationale</u>:

- The measure is clearly defined and well specified.
- Reliability of the measure was well demonstrated with a signal to noise ratio.
- Validity was demonstrated through testing, as well as having face validity assessed by an expert panel.
- The Steering Committee noted that many of these surgeries are performed by non-thoracic surgeons, a population this measure may not capture.

3. Usability: <u>H-15; M-1; L-0; I-1</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The developer has provided a detailed plan for representation of measure results, usability for QI, and public reporting of the measure within the next 2-3 years.

4. Feasibility: <u>H-10; M-7; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee noted that this is somewhat arduous to capture, but the data add significant value

Steering Committee Recommendation for Endorsement: Y-17; N-0

<u>Rationale</u>: The Steering Committee found that the measure will capture the spectrum of procedures done in a spectrum of hospitals-wide range of morbidities/mortalities. The evidence for the measure is high level, and capturing the measure will allow for development of an outcome measure in the future.

Public & Member Comment

- Commenters indicated support for the measure.

1853 Radical Prostatectomy Pathology Reporting (Eligible for Time-Limited Endorsement)

New Measure

Measure Evaluation and Specifications

Description: Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.

Numerator Statement: Numerator: Radical prostatectomy pathology reports that include the pT category, the pN category, Gleason score and a statement about margin status

Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F –pathology report

Denominator Statement: All radical prostatectomy pathology reports

Exclusions: Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, and transurethral resections of the prostate (TURP)

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable Not applicable

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Type of Measure: Process

Data Source: Administrative claims, Other, Paper Records

Measure Steward: College of American Pathologists

1853 Radical Prostatectomy Pathology Reporting

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-9; M-7; L-0; I-0; **1b. Performance Gap: H-3; M-12; L-1; I-0; 1c. Evidence: Y-15, N-1, I-0**

Rationale:

- The Steering Committee agreed the measure would have a high impact as a large number of men are affected by this disease; this is a major health issue with significant mortality.
- The measure developer presented two studies that showed a performance gap of 11.6% noncompliance. The Steering Committee agreed compliance should be 100% on the measure, and so there is an opportunity for improvement.
- The measure developer presented consistent evidence that a variation exists in pathological reporting that impacts the quality of care provided to patients.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability requirement for untested measures.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

Precise Specifications: Y-16; N-0

Rationale:

- The measure is precisely specified.
- The Steering Committee agreed that it is highly likely that testing of the measure will demonstrate a high rate of reliability and validity.

1853 Radical Prostatectomy Pathology Reporting (Eligible for Time-Limited Endorsement)
3. Usability: H-9; M-7; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* **Rationale:** • Usability has not yet been demonstrated; however, the Steering Committee believes that the measure will be useful for QI. • The measure is useful for public reporting: there is high interest, and there is ongoing active surveillance
4. Feasibility: H-12; M-4; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* **Rationale:** • The data elements are all available and may be implemented using an EHR. • Steering Committee members agreed that the measure will be feasible due to the availability of this information in tumor registries and pathology reports.
Steering Committee Recommendation for Time-Limited Endorsement: Y-16; N-0 **Rationale:** Steering Committee noted that staging information and a Gleason score are very important for patients with prostate cancer. There is a strong evidence base for this measure. There is a performance gap in meeting the measure and a need for improvement. **RECOMMENDATIONS:** The measure has not yet been tested for reliability and validity and is being considered for **time limited endorsement.** The measure developer will have 12 months to provide testing data if time limited endorsement is granted.
Public & Member Comment • Commenters indicated support for the measure.

Palliative Measures

0210 Proportion receiving chemotherapy in the last 14 days of life

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life

Numerator Statement: Patients who died from cancer and received chemotherapy in the last 14 days of life

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None

Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry, Management Data, Paper Records

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-12; M-4; L-0; I-1; **1b. Performance Gap: H-9; M-8; L-0; I-0; 1c. Evidence: Y-13, N-3, I-1**

Rationale:

- The measure affects a large number of patients and will have a high impact.
- The Steering Committee noted that in some cases it is appropriate for a patient to receive chemotherapy in the last 14 days of life. The measure is useful for detecting variation in performance and identifying outliers when comparing similar practices with similar patient populations.
- The measure is important because it addresses patient preferences and over-treatment at the end of life.
- The struggle between aggressive care and futile care often plays out in the amount of chemotherapy delivered to patients with advanced disease and poor performance status.
- The measure also reflects disparities in access to care and the capacity of a local healthcare system to treat patients appropriately at the end of life.

0210 Proportion receiving chemotherapy in the last 14 days of life

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-9; M-6; L-2; I-0; 2b. Validity: H-4; M-9; L-3; I-1

<u>Rationale</u>:

- Steering Committee members agreed that the measure was well specified.
- The Steering Committee members raised concerns about how case mix would be accounted for in the measure. The also questioned whether facilities with a high number of patients enrolled in clinical trials would skew the measure results, so that those facilities would appear not to do as well on the measure. It was explained that the measure is intended for use in comparing like facilities, such as major cancer centers to other major cancer centers, where the case mix would be expected to be very similar.
- The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure was demonstrated.

3. Usability: <u>H-6; M-7; L-2; I-2</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The Steering Committee agreed the measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure.
- The measure is easily understandable for public reporting.
- The measure is currently in use in ASCO's QOPI program.

4. Feasibility: <u>H-7; M-6; L-2; I-2</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The measure is reported using claims data and is feasible to implement.

Steering Committee Recommendation for Endorsement: Y-15; N-2

<u>Rationale</u>: The Steering Committee found that the measure is important because it addresses patient preferences and over-treatment at the end of life.

0210 Proportion receiving chemotherapy in the last 14 days of life

Public & Member Comment

Comments included:

- Commenters noted that while overtreatment of terminally ill patients is an important area for study and measurement, there are concerns that the measures imply that patients receiving such treatments as chemotherapy in the last 14 days of life, or patients with more than one ER visit in the last days of life, are receiving poor care.
- The commenters expressed concern that grouping all patient populations together in these measures results in patients who are appropriately receiving said treatments being counted in the numerator against the reporting facility.
- Further, commenters indicated that prognostication of death is limited; in addition to being unable to determine accurately in advance a patient's expected death, the measures do not distinguish between patients who were terminally ill and those who died suddenly.
- Commenters also indicated that it was unclear by the description provided how the measure of chemotherapy received in the last 14 days of life would 'reflect disparities in access to care.' Commenters felt, that for palliative care, measuring disparities in its access should be evaluated more directly than through assessing chemotherapy use for terminally ill patients and suggested that terminally ill patients receiving chemotherapy may have greater access to medical care in general.
- Several comments supported the use of these measures in order to reduce inappropriate end-of-life care.

Developer Response:

- The measures are not intended to imply that any single incidence of these care processes is wrong, but rather to identify consistently outlying practice which could raise a 'red flag' about either practice style (not having realistic discussions about the end-of-life in a timely fashion) or access to palliative or hospice care (lack of access has been consistently shown to be associated with more acute and aggressive care near the end of life). Lastly, while it is true that prognostication is difficult, if a provider's practice is an outlier because they are particularly poor at prognostication, which may be a problem as well.
- Identifying the end of life phase prospectively in administrative data is challenging as the definition always creates a biased sub cohort (a particular stage at diagnosis, using particular services, etc.).
- Users may make adjustments to the numerator and denominator definitions as they see fit.
- The access issue is that these measures of potentially aggressive care near the end of life are associated with less availability of hospice.

Steering Committee Response:

- These issues were discussed extensively during the Cancer Steering Committee in-person meeting. In that discussion, the measure developer noted that at times the interventions can and should occur for many patients. The measures are intended to compare similar providers who have similar patient mixes and identify outlying patterns of care. Consequently, relative incidence of the situations should be similar. For example, grouping patients receiving palliative chemotherapies at the end of life with those receiving curative chemotherapies should not result in markedly different performance rates between two facilities with a similar case mix. This reasoning may also be applied to grouping patients who are terminally ill and those who died suddenly.
- Further, the Steering Committee respectfully disagreed with the statement that prognostication of death is limited, and believed that taking this stance would severely limit measures of this type, which are very important quality indicators for patient preference and the availability of resources at the end of life.
- The Steering Committee also noted that though there are a limited number of studies, it has been demonstrated that patients who receive palliative care earlier have lower rates of chemotherapy at the end of life, lending credence to the importance of palliative interventions in reducing overtreatment.

0211 Proportion with more than one emergency room visit in the last days of life

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer with more than one emergency room visit in the last days of life

Numerator Statement: Patients who died from cancer and had >1 ER visit in the last 30 days of life

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered.

No risk adjustment is necessary. The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting 'Cancer' as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate. No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992)to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.

Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-10; M-4; L-1; I-1; **1b. Performance Gap: H-10; M-3; L-3; I-0; 1c. Evidence: Y-11, N-3, I-2**

Rationale:

- The Steering Committee agreed the measure affects a large number of patients and is high impact.
- In most cases, overutilization of emergency department services for the actively dying is inappropriate and distressing for patients.
- The Steering Committee noted that in some cases more than one visit to the ER during the last days of life is appropriate. The measure is useful for detecting variations in performance and identifying outliers when comparing similar practices with similar patient populations.
- The measure is important because it addresses patient preferences and overtreatment at the end of life.
- The measure also reflects disparities in access to care and the capacity of a local healthcare system to treat patients appropriately at the end of life.

0211 Proportion with more than one emergency room visit in the last days of life

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-3; L-5; I-1; 2b. Validity: H-5; M-5; L-5; I-1

<u>Rationale</u>:

- Steering Committee members raised concerns about use of the measure given the current systemic issues with access to quality hospice facilities. The Committee believed patients may utilize emergency department services when good hospice care is not available. In areas where performance of the measure is poor, it will call attention to a lack of resources available for patients at the end of life.
- The measure is well specified.
- The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure is demonstrated.

3. Usability: <u>H-5; M-4; L-6; I-1</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is usable for public reporting, as it captures the preference of patients to die in a setting other than the emergency department, or to avoid distressing ER visits at the end of life.
- The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure.
- The measure is in use in Cancer Care Ontario´s Cancer System Quality Index.

4. Feasibility: <u>H-6; M-7; L-3; I-1</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The measure is reported using claims data and is feasible to implement.

Steering Committee Recommendation for Endorsement: Y-10; N-6

<u>Rationale</u>: The Steering Committee found that the measure is important because it addresses patient preferences and overtreatment at the end of life.

0211 Proportion with more than one emergency room visit in the last days of life

Public & Member Comment

Comments included:

- Commenters noted that while overtreatment of terminally ill patients is an important area for study and measurement, there are concerns that the measures imply that patients receiving such treatments as chemotherapy in the last 14 days of life, or patients with more than one ER visit in the last days of life, are receiving poor care.
- The commenters expressed concern that grouping all patient populations together in these measures results in patients who are appropriately receiving said treatments being counted in the numerator against the reporting facility.
- Further, commenters indicated that prognostication of death is limited; in addition to being unable to determine accurately in advance a patient's expected death, the measures do not distinguish between patients who were terminally ill and those who died suddenly.
- For the measures of chemotherapy, ER and ICU use in the last days before death, eligibility for the denominator is defined as 'patients who died from cancer.' All types and stages of cancer are combined, ranging from those that are highly treatable to those that are functionally incurable. At the extremes, the measure makes no distinction between a patient who has a benign skin condition (code 216) and a patient with pancreatic cancer (code 157). If interested in capturing service utilization for terminally ill patients, the measures should focus on pre-specified patient populations with poor prognosis.
- Several comments supported the use of these measures in order to reduce inappropriate end-of-life care and patient-centered care.

Developer Response:

- The measures are not intended to imply that any single incidence of these care processes is wrong, but rather to identify consistently outlying practice which could raise a 'red flag' about either practice style (not having realistic discussions about the end-of-life in a timely fashion) or access to palliative or hospice care (lack of access has been consistently shown to be associated with more acute and aggressive care near the end of life). Lastly, while it is true that prognostication is difficult, if a provider's practice is an outlier because they are particularly poor at prognostication, which may be a problem as well.
- Identifying the end of life phase prospectively in administrative data is challenging as the definition always creates a biased sub cohort (a particular stage at diagnosis, using particular services, etc.).
- Users may make adjustments to the numerator and denominator definitions as they see fit.
- The access issue is that these measures of potentially aggressive care near the end of life are associated with less availability of hospice.

Steering Committee Response:

- These issues were discussed extensively during the Cancer Steering Committee in-person meeting. In that discussion, the measure developer noted that at times the interventions can and should occur for many patients. The measures are intended to compare similar providers who have similar patient mixes and identify outlying patterns of care. Consequently, relative incidence of the situations should be similar. For example, grouping patients receiving palliative chemotherapies at the end of life with those receiving curative chemotherapies should not result in markedly different performance rates between two facilities with a similar case mix. This reasoning may also be applied to grouping patients who are terminally ill and those who died suddenly.
- Further, the Steering Committee respectfully disagreed with the statement that prognostication of death is limited, and believed that taking this stance would severely limit measures of this type, which are very important quality indicators for patient preference and the availability of resources at the end of life.
- The Steering Committee also noted that though there are a limited number of studies, it has been demonstrated that patients who receive palliative care earlier have lower rates of chemotherapy at the end of life, lending credence to the importance of palliative interventions in reducing overtreatment.

0213 Proportion admitted to the ICU in the last 30 days of life

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life

Numerator Statement: Patients who died from cancer and were admitted to the ICU in the last 30 days of life

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered.

The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting 'Cancer' as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate. No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992)to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.

Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-14; M-2; L-0; I-0; **1b. Performance Gap: H-8; M-8; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0**

Rationale:

- The Steering Committee agreed the measure affects a large number of patients and will have a high impact.
- Patients overwhelmingly would prefer to not die in the ICU; it is distressing for the patient and the patient's family.
- The Steering Committee noted that in some cases occurrence of this event is appropriate. The measure is useful for detecting variation in performance and identifying outliers when comparing similar practices with similar patient populations.
- The measure is important because it addresses patient preferences and over-treatment at the end of life.
- The measure also reflects disparities in access to care and the capacity of a local healthcare system to treat patients appropriately at the end of life.

0213 Proportion admitted to the ICU in the last 30 days of life

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-12; M-4; L-0; I-0; 2b. Validity: H-11; M-5; L-0; I-0

<u>Rationale</u>:

- Steering Committee members were concerned about use of the measure given current issues related to access to quality hospice facilities. Patients may utilize ICU at the end of life when quality hospice care is not available. In areas where performance of the measure is poor, it will call attention to the lack of resources available for patients at the end of life.
- The measure is well specified.
- The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure was demonstrated.

3. Usability: <u>H-9; M-7; L-0; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is usable for public reporting, as it captures the preference of patients to die in a setting other than the emergency department, or to avoid distressing ER visits at the end of life.
- The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving the measure.
- The measure is in use in Cancer Care Ontario´s Cancer System Quality Index.

4. Feasibility: <u>H-13; M-3; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The measure is reported using claims data and is feasible to implement.

Steering Committee Recommendation for Endorsement: Y-16; N-0

<u>Rationale</u>: The Steering Committee strongly agreed that patients generally do not wish to die in the ICU and believe this intervention should be avoided if at all possible. The measure captures patient preference as well as disparities in access to quality hospice care at the end of life.

0213 Proportion admitted to the ICU in the last 30 days of life

Public & Member Comment

Comments included:

- Commenters noted that while overtreatment of terminally ill patients is an important area for study and measurement, there are concerns that the measures imply that patients receiving such treatments as chemotherapy in the last 14 days of life, or patients with more than one ER visit in the last days of life, are receiving poor care.
- The commenters expressed concern that grouping all patient populations together in these measures results in patients who are appropriately receiving said treatments being counted in the numerator against the reporting facility.
- Further, commenters indicated that prognostication of death is limited; in addition to being unable to determine accurately in advance a patient's expected death, the measures do not distinguish between patients who were terminally ill and those who died suddenly.
- For the measures of chemotherapy, ER and ICU use in the last days before death, eligibility for the denominator is defined as 'patients who died from cancer.' All types and stages of cancer are combined, ranging from those that are highly treatable to those that are functionally incurable. At the extremes, the measure makes no distinction between a patient who has a benign skin condition (code 216) and a patient with pancreatic cancer (code 157). If interested in capturing service utilization for terminally ill patients, the measures should focus on pre-specified patient populations with poor prognosis.
- Several comments supported the use of these measures in order to reduce inappropriate end-of-life care and patient-centered care.

Developer Response:

- The measures are not intended to imply that any single incidence of these care processes is wrong, but rather to identify consistently outlying practice which could raise a 'red flag' about either practice style (not having realistic discussions about the end-of-life in a timely fashion) or access to palliative or hospice care (lack of access has been consistently shown to be associated with more acute and aggressive care near the end of life). Lastly, while it is true that prognostication is difficult, if a provider's practice is an outlier because they are particularly poor at prognostication, which may be a problem as well.
- Identifying the end of life phase prospectively in administrative data is challenging as the definition always creates a biased sub cohort (a particular stage at diagnosis, using particular services, etc.).
- Users may make adjustments to the numerator and denominator definitions as they see fit.
- The access issue is that these measures of potentially aggressive care near the end of life are associated with less availability of hospice.

Steering Committee Response:

- These issues were discussed extensively during the Cancer Steering Committee in-person meeting. In that discussion, the measure developer noted that at times the interventions can and should occur for many patients. The measures are intended to compare similar providers who have similar patient mixes and identify outlying patterns of care. Consequently, relative incidence of the situations should be similar. For example, grouping patients receiving palliative chemotherapies at the end of life with those receiving curative chemotherapies should not result in markedly different performance rates between two facilities with a similar case mix. This reasoning may also be applied to grouping patients who are terminally ill and those who died suddenly.
- Further, the Steering Committee respectfully disagreed with the statement that prognostication of death is limited, and believed that taking this stance would severely limit measures of this type, which are very important quality indicators for patient preference and the availability of resources at the end of life.
- The Steering Committee also noted that though there are a limited number of studies, it has been demonstrated that patients who receive palliative care earlier have lower rates of chemotherapy at the end of life, lending credence to the importance of palliative interventions in reducing overtreatment.

0215 Proportion not admitted to hospice

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer not admitted to hospice

Numerator Statement: Patients who died from cancer without being admitted to hospice

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification. No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None

Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-10; M-3; L-2; I-1; **1b. Performance Gap: H-9; M-5; L-1; I-2; 1c. Evidence: Y-10, N-2, I-5**

Rationale:

- The Steering Committee agreed the measure affects a large number of patients and has a high impact.
- Many cancer patients die in a hospital receiving futile care until the end. Referring patients to hospice, when appropriate, addresses patient preferences, improves quality of care, and reduces cost of care.
- The Steering Committee noted that poor performance on the measure would indicate that providers may be failing to have direct conversations with patients about the futility of further treatment and the benefits of hospice care.
- The Committee agreed the measure developer provided good evidence to support that hospice referral would mean increased quality of care.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-4; M-9; L-3; I-1; 2b. Validity: H-6; M-7; L-3; I-1

Rationale:

- The measure is well specified.
- The reliability testing presented for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure is demonstrated.

3. Usability: H-6; M-5; L-3; I-3

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure is usable for public reporting, as it captures the use of hospice for appropriate patients.
- The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving this measure.
- The measure is in use through ASCO's QOPI program.

4. Feasibility: H-6; M-8; L-2; I-1

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The measure is reported using claims data and is feasible to implement.
- Steering Committee members noted that this measure—in conjunction with measure #0216: Proportion admitted to hospice for less than 3 days—would prevent providers from making patient care decisions about sending patients to hospice based on measure performance.

Steering Committee Recommendation for Endorsement: Y-11; N-6

Rationale: The Steering Committee noted that the measure affects a large patient population and will help identify when facilities are providing overly aggressive, futile care to patients rather than referring patients to hospice.

RECOMMENDATIONS: Steering Committee members recommended that the developer consider stratifying patients with hematologic cancers, as the patient population is different from most other cancer patient populations and their responsiveness to therapies varies.

Public & Member Comment

- Commenters indicated support for the measure.

0216 Proportion admitted to hospice for less than 3 days

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there

Numerator Statement: Patients who died from cancer and spent fewer than three days in hospice.

Denominator Statement: Patients who died from cancer who were admitted to hospice

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care. None

Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records

Measure Steward: American Society of Clinical Oncology

Workgroup Preliminary Evaluations

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-14; M-3; L-0; I-0; **1b. Performance Gap: H-13; M-3; L-1; I-0; 1c. Evidence: Y-16, N-1, I-0**

Rationale:

- It is well documented that short lengths of stay in hospice compromises patients' quality of care and that there is a substantial portion of hospice patients that are referred within 1-3 days of death.
- The measure affects a large number of patients and is high impact.
- Many cancer patients die in a hospital receiving futile care until the end. Referring patients to hospice, when appropriate, addresses patient preferences, improves quality of care, and reduces health care costs.
- The Steering Committee noted that poor performance on this measure would indicate that providers are failing to have direct conversations with their patients about the futility of further treatment and the benefits of hospice care.
- The committee felt the measure developer provided good evidence to support that the concept that hospice referral would mean increased quality of care.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-14; M-3; L-1; I-0; 2b. Validity: H-13; M-4; L-0; I-0

Rationale:

- Steering Committee members questioned why three days was selected as the numerator. The developer noted that three days is the minimum lowest bar; seven days may be a better indicator of quality of care. Also, data was more easily obtained with the three day threshold than the seven day threshold.
- The measure is well specified.
- The reliability testing for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure was demonstrated.

0216 Proportion admitted to hospice for less than 3 days
3. Usability: H-11; M-6; L-0; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* **Rationale:** • The measure is usable for public reporting, as it captures the use of hospice for appropriate patients. • The measure is useful for QI, particularly when comparing facilities with similar patient populations to see if there are irregularities in achieving this measure. • The measure is in use through ASCO's QOPI program.
4. Feasibility: H-12; M-5; L-0; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* **Rationale:** • The measure is reported using claims data and is feasible to implement. • Steering Committee members noted that this measure in conjunction with measure #0215 would prevent providers from not sending patients to hospice because of the fear that the patient would die in the next 3 days and prevents providers from making patient care decisions about sending patients to hospice based on measure performance.
Steering Committee Recommendation for Endorsement: Y-17; N-0 **Rationale:** The Steering Committee found that the measure affects a large patient population and will help identify when facilities are providing overly aggressive, futile care to patients rather than referring them to hospice.
Public & Member Comment • Commenters indicated support for the measure.

1822 External Beam Radiotherapy for Bone Metastases

New Measure

Measure Evaluation and Specifications

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

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

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

Exclusions: The medical reasons for denominator exclusions are:

1) Previous radiation treatment to the same anatomic site;

2) Patients with femoral axis cortical involvement greater than 3 cm in length;

3) Patients who have undergone a surgical stabilization procedure; and

4) Patients with spinal cord compression, cauda equina compression or radicular pain

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable Stratification of the measure is not required.

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

Type of Measure: Process

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

Measure Steward: American Society for Radiation Oncology (ASTRO) **Other organizations:** None

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure meets the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-15; M-1; L-0; I-0; **1b. Performance Gap: H-13; M-3; L-0; I-0; 1c. Evidence: Y-16, N-0, I-0**

Rationale:

- The measure has high impact**.**
- There is a high opportunity for improvement, with nearly a 20% performance gap noted.
- The measure represents quality care.
- There is a strong supportive evidence base for this intervention.

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-13; M-3; L-0; I-0; 2b. Validity: H-11 ; M-5 ; L-0 ; I-0

Rationale:

- The measure is well specified and exclusions are appropriate, except the patient reason exclusions. The Steering Committee asked the developer to remove those exclusions, and the developer agreed to do so.
- The reliability testing for the measure is appropriate and demonstrates the reliability of the measure.
- Face validity of the measure was demonstrated.

1822 External Beam Radiotherapy for Bone Metastases

3. Usability: H-13; M-3; L-0; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The developer has provided a detailed plan for representation of measure results, usability for QI, and public reporting of the measure through PQRS.

4. Feasibility: H-14; M-2; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Data elements are in EHR and generated during the provision of care.

Steering Committee Recommendation for Endorsement: Y-16; N-0

Rationale: The Steering Committee stated that this measure represents good care with a strong evidence base supporting the focus of the measure. The patients affected by this measure suffer from severe pain and the intervention will help alleviate their discomfort.

RECOMMENDATIONS: The Steering Committee asked the developer to remove the patient reason exclusions from the measure denominator. The developer agreed to do so, and the Steering Committee reviewed the changes on a follow up call. The Committee agreed with the changes and recommended the measure for endorsement.

Public & Member Comment

- While commenters indicated general support for the measure, several issues were raised including the burden of data collection data on whether a case meets exclusion criteria, and patient preference for other types of treatment.

Developer Response:

- ASTRO appreciates your comments and support for the measure. The clinical practice guideline has identified specific exclusion criteria for patients that can receive fractionation schedules other than what is recommended and specified in the measure. Considering that the goal of the measure is to assess appropriate use and prevent overuse of treatment, it is important that the specific exclusions are outlined in the measure specifications. The measure, including its exclusions, was tested for feasibility of data collection and the measure was abstracted without difficulty at the testing sites. The following data sources have been identified for the measure exclusions: 1) Previous radiation treatment to the same anatomic site (Medical Record); Patients with femoral axis cortical involvement greater than 3 cm in length(Imaging Studies); Patients who have undergone a surgical stabilization procedure (Operative Report); Patients with spinal cord compression, cauda equina compression or radicular pain (Diagnosis/Problem list).
- We do recognize that this measure is currently not in use in any quality reporting or public reporting programs. However, ASTRO intends to submit the measure for the upcoming CMS's call for measures for potential inclusion in the proposed set of quality measures in the Physician Quality Reporting System for future rule-making years.
- The measure is specified such that the denominator includes only those patients who have consented to radiation therapy and who are receiving External Beam Radiation Therapy for bone metastases; informed consent includes the risks and benefits of the procedure.

Steering Committee Response:

- The Steering Committee agrees with the measure developer's response. The response is in line with discussions that occurred at the in-person meeting and on related conference calls.

Colon Cancer Measures

0223 Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer

Status: Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Mar 01, 2007

Description: Percentage of patients under the age of 80 with AJCC III (lymph node positive) colon cancer for whom adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis.

Numerator Statement: Chemotherapy is considered or administered within 4 months (120 days) of diagnosis

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

Age 18-79 at time of diagnosis

Known or assumed to be first or only cancer diagnosis

Primary tumors of the colon

Epithelial malignancy only

At least one pathologically examined regional lymph node positive for cancer (AJCC Stage III)

All or part of 1st course of treatment performed at the reporting facility2

Known to be alive within 4 months (120 days) of diagnosis

Exclusions: Exclude, if any of the following characteristics are identified:

Age <18 and >=80; not a first or only cancer diagnosis; non-epithelial and non-invasive tumors; no regional lymph nodes pathologically examined; metastatic disease (AJCC Stage IV); not treated surgically; died within 4 months (120 days) of diagnosis

Adjustment/Stratification: No risk adjustment or risk stratification No stratification applied

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Registry, Paper Records

Measure Steward: Commission on Cancer, American College of Surgeons **Other organizations:** This measure was harmonized with measure development efforts coordinated between the American Society of Clinical Oncology (ASCO) and The National Cancer Care Network (NCCN) prior to NQF's formal review and consideration of measures submitted in response to its call for measures in 2005 as part of its Quality of Cancer Care Performance Measures project (Desch CE, McNiff KK, Schneider EC, et al. American Society of Clinical Oncology / National Comprehensive Cancer Network Quality Measures. J Clin Oncol 2008;26:3631-3637). The measure, as specified here, has not been altered or changed in any way since harmonization of specifications between these three organizations occurred in the fall of 2006.

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-11; M-0; L-0; I-0; **1b. Performance Gap: H-7; M-4; L-0; I-0; 1c. Evidence: Y-11, N-0, I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus demonstrates an area of high potential impact as there could be a potential 25 percent difference in survival for patients.
- Overall poor performance on this measure is concerning, given the very strong level 1 evidence of the impact on patient outcomes. A Committee member questioned whether Stage 2b colon cancers should be included in the measure.
    - The developer explained the ability to identify that subset of Stage 2 colon cancers is not yet routinely possible due to the way the staging systems were designed until 2010, and stated the evidence is not settled regarding the appropriateness of adjuvant chemotherapy for Stage 2b disease.

0223 Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-6; M-5; L-0; I-0; 2b. Validity: H-6; M-5; L-0; I-0

<u>Rationale</u>:

- The Steering Committee stated that reliability testing was sufficient.
- The face validity of the measure was well demonstrated.
- The denominator exclusions are relevant.

3. Usability: <u>H-7; M-4; L-0; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- Reporting the time and administration of chemotherapy is straightforward and easily understood.
- This measure is in use by the Commission on Cancer.

4. Feasibility: <u>H-6; M-5; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- Measure appears feasible whether dealing with abstracting data or from EMRs.
- All data elements are available in cancer registries.

Steering Committee Recommendation for Endorsement: <u>Y-11 ; N-0</u>

Public and Member Comment

Comments included:

- Supportive comments for the measure.
- Commenters suggested that the measure can be improved upon by focusing only on administration of chemotherapy and not consideration of chemotherapy, as “considered” is not a precise term.

Developer Response:

- The developer stated that the Commission on Cancer and the American College of Surgeons use cancer registries to implement this measure; the cancer registries have standard definitions for both “administered” and “considered” therapies. Cancer registries record and report this information if it is documented in the patient chart. Further, a review of data has demonstrated consistency in reporting considered therapies over three years.

Steering Committee Response:

- The Steering Committee agreed with the developer’s response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

0225 At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

Status: Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Mar 01, 2007

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

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

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

Age >=18 at time of diagnosis

Known or assumed to be first or only cancer diagnosis

Primary tumors of the colon

Epithelial malignancy only

AJCC Stage I, II, or III

Surgical resection performed at the reporting facility

Exclusions: Exclude, if any of the following characteristics are identified:

Age <18; not a first or only cancer diagnosis; non-epithelial and non-invasive tumors; metastatic disease (AJCC Stage IV); not treated surgically at the reporting facility

Adjustment/Stratification: No risk adjustment or risk stratification No stratification applied

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Registry, Paper Records

Measure Steward: Commission on Cancer, American College of Surgeons

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-8; M-2; L-1; I-0; **1b. Performance Gap: H-5; M-5; L-0; I-1; 1c. Evidence: Y-7, N-2, I-2**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus demonstrates an area of high potential impact as many patients are diagnosed with colon cancer.
- The Steering Committee noted that lower level quality of evidence was presented. A large body of observational studies was provided in support of the measure, but no RCTs.
- The Steering Committee was concerned that some literature suggests that removal of anywhere from 6 to 17 nodes is the appropriate number.
    - The developer noted that was true; however, NCCN guidelines call for 12 lymph nodes. The developer noted that this will be a moving target, and as the literature on the topic improves, the measure will be updated accordingly.
- The Steering Committee stated that there are few measures focused on the quality of surgical care, and as such this measure will move the field forward.

0225 At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-5; M-6; L-0; I-0; 2b. Validity: H-4; M-5; L-1; I-1

<u>Rationale</u>:

- The Steering Committee stated that reliability testing was sufficient.
- The validity of the measure was well demonstrated, though concern about the evolving guidelines was thought to be a possible threat to validity.
- The denominator exclusions are relevant.

3. Usability: <u>H-5; M-4; L-1; I-1</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The number of lymph nodes removed and pathologically examined is straightforward.
- The measure is currently in use by oncologists for Commission on Cancer.

4. Feasibility: <u>H-6; M-4; L-0; I-1</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- Measure appears feasible whether dealing with abstracting data or from EMRs.
- All data elements are available in cancer registries.

Steering Committee Recommendation for Endorsement: <u>Y-9 ; N-2</u>

Public and Member Comment

No comments were received.

0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients

Status: Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008

Description: Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy or have previously received adjuvant chemotherapy within the 12 month reporting period

Numerator Statement: Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy* within the 12 month reporting period

Definition: Adjuvant Chemotherapy: *According to current NCCN guidelines, the following therapies are recommended: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (Category 1); bolus 5-FU/LV/oxaliplatin (FLOX, Category 1), capecitabine/oxaliplatin (CapeOx, Category 1); or single agent capecitabine (Category 2A) or 5-FU/LV (Category 2A) in patients felt to be inappropriate for oxaliplatin therapy. Due to the leucovorin shortage in the United States, levo-leucovorin used in its place may also satisfy the measure.

Prescribed – may include prescription ordered for the patient for adjuvant chemotherapy at one or more visits in the 12-month period OR patient already receiving adjuvant chemotherapy as documented in the current medication list

Denominator Statement: All patients aged 18 years and older with Stage IIIA through IIIC colon cancer

Exclusions: Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., medical comorbidities, patient over the age of 80, diagnosis date more than 5 years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status)

Documentation of patient reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient refusal)

Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure is jointly copyrighted by the AMA-PCPI, American Society of Clinical Oncology, and Nati

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-11; M-0; L-0; I-0; **1b. Performance Gap: H-6; M-5; L-0; I-0; 1c. Evidence: Y-10, N-1, I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus demonstrates an area of high impact, as many patients are diagnosed with colon cancer.
- There is a demonstrated performance gap on this measure, with 93 percent adherence to the measure in PQRS. The Steering Committee noted that as participants in PQRS are self-selecting and report voluntarily, there is likely greater variation in the field and there is an opportunity for improvement.
- High level evidence was provided to support the measure focus.

0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-5; M-6; L-0; I-0; 2b. Validity: H-4; M-5; L-1; I-1

<u>Rationale</u>:

- The Steering Committee stated that reliability testing was sufficient.
- The Steering Committee questioned use of the NCCN list of drugs for adjuvant chemotherapy.
  - The developer noted that the measure specifications will be updated as timely as possible. The developer also stated that the measure has taken a pragmatic approach; reporting of adjuvant chemotherapy is sufficient to meet the measure. The drugs used are not part of the specifications or coding. Instead, the drugs are listed separately.
  - The Steering Committee noted that this in effect means that to get credit for this measure, the provider does not have to give the patient the "gold standard" chemotherapy drugs.
- The validity of the measure was well demonstrated.
- The denominator exclusions are relevant.

3. Usability: <u>H-8; M-3; L-0; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The Steering Committee stated that use of chemotherapy for patients with Stage IIIA through IIIC colon cancer can be easily understood by both providers and the public.
- The measure is currently in use in PQRS.

4. Feasibility: <u>H-8; M-3; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The measure appears feasible whether dealing with abstracting data or from EMRs.
- All data elements are generated through the process of care.

Steering Committee Recommendation for Endorsement: <u>Y-11 ; N-0</u>

Public and Member Comment

Comments included:

- Commenters suggested that the developer revise the measure numerator to include only patients who have received adjuvant chemotherapy in order to create a more patient-centered measure.

Developer Response:

- The developer stated that as the measure can be reported on at any time between diagnosis and five years past diagnosis, and because any provider involved in the patient's cancer care may report this measure (including providers who do not administer chemotherapy), the numerator includes those who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy within the 12 month reporting period. The goal of the measure is to promote shared responsibility for ensuring that all recommended step for cancer treatment occur, in accordance with patient preference.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

0392 Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

Status: Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008

Description: Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade

Numerator Statement: Reports that include the pT category, the pN category and the histologic grade

Denominator Statement: All colon and rectum cancer resection pathology reports

Exclusions: Denominator Exclusion: Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (e.g.; re-excision without residual tumor; non-carcinomasanal canal)

Adjustment/Stratification: No risk adjustment or risk stratification We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** College of American Pathologists

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-12; M-2; L-0; I-0; **1b. Performance Gap: H-9; M-5; L-1; I-1; 1c. Evidence: Y-14, N-2, I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure addresses a high impact area and provides useful and important pieces of information when making therapeutic decisions about patients with colorectal cancer.
- Accurate pathology reporting is very important for determining adjuvant treatments, staging and discriminating between Stage 2 and Stage 3 cancer and possibly in determining eligibility for clinical trials.
- There is not demonstrated evidence that recording stage leads to improved outcomes; however, this can be reasonably inferred as staging provides the basis for treatment decisions.
- There was a demonstrated performance gap, with 25.82 percent of eligible reports missing at least one of the ten CAP-recommended colorectal cancer elements. The Steering Committee was concerned, however that the data for the performance gap data was several years old and that it is unclear what performance gap exists today.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-10; M-4; L-1; I-1; 2b. Validity: H-4; M-8; L-2; I-1

<u>Rationale</u>:

- The Steering Committee stated that the measure was clearly and precisely specified.
- The Steering Committee stated that reliability of the measure score was high.
- The measure demonstrated validity through queries of an expert panel: 8 out of a 12- member panel agreed the measure was important to report.
- Denominator exclusions, such as recurring cases, are relevant.
- The Steering Committee recommended that margin status and number of lymph nodes evaluated be captured in future iterations of the measure.

0392 Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

3. Usability: H-4; M-8; L-3; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure is currently in use in PQRS.
- Measure demonstrates high usability as it's a way to look at the quality of the pathology reporting that is delivered by a local institution.
- The measure should be moderately understood by the public and by healthcare providers.

4. Feasibility: H-5; M-8; L-2; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The measure testing demonstrates reliable abstraction from paper medical records and from EMRs.
- Steering Committee members questioned whether the information required by the measure would be found in an initial report or an integrated summary report. It was noted that as there are often many reports, it will be difficult for a provider to know which report contains the most significant pathology information.
    - The developer noted that reporting of the measure will be limited to what the pathologist has available-the pathologist may not have information demonstrating metastatic disease, and as such, that would not be included on the report.
- The Steering Committee noted that the data is generated during the processes of clinical care.

Steering Committee Recommendation for Endorsement: Y-12 ; N-2

Public and Member Comment

Comments included:

- Supportive comments for the measure.
- Concern that the measure assesses what is considered standard practice.

Developer Response:

- The developer noted that though this should be standard care, there is a documented gap in care, with 25.82 percent of eligible reports missing at least one of the ten CAP-recommended colorectal cancer elements.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

1859 KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy

Status: New Submission

Description: Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy for whom KRAS gene mutation testing was performed

Numerator Statement: KRAS gene mutation testing performed before initiation of anti-EGFR MoAb

Denominator Statement: Adult patients with metastatic colorectal cancer who receive anti-EGFR monoclonal antibody therapy

Exclusions: Patient transfer to practice after initiation of chemotherapy

Adjustment/Stratification: No risk adjustment or risk stratification n/a

Level of Analysis: Clinician : Group/Practice, Clinician : Team

Type of Measure: Process

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

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-11; M-0; L-0; I-0; **1b. Performance Gap: H-6; M-5; L-0; I-0; 1c. Evidence: Y-10, N-1, I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus demonstrates an area of high impact, as many patients are diagnosed with colorectal cancer.
- There is a demonstrated performance gap on this measure, with 73 percent mean adherence to the measure in Quality Oncology Practice Initiative. The Steering Committee noted that there is a demonstrated opportunity for improvement.
- There is consistent evidence demonstrating a lack of benefit in using this therapy for patients with the KRAS mutation, and the therapy is expensive.
- The measure will be useful for preventing overtreatment of patients who would not benefit from the therapy.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-8; M-3; L-0; I-0; 2b. Validity: H-8; M-3; L-0; I-0

<u>Rationale</u>:

- The reliability testing was sufficient.
- The validity of the measure was well demonstrated.
- The denominator exclusions are relevant.
- The Steering Committee asked the developer to specify where the mutations are found, as in the future there may be mutations in the same gene that will be difficult to correlate and understand.
    - The developer made the following modifications to 2a1.7 which sufficiently addressed the Steering Committee's concerns:
        - KRAS mutation testing: KRAS testing for this measure refers to assays that detect mutations in codons 12 and 13 of KRAS only. Do not include results from mutations at other codons (e.g., codons 61 and 146), or assays for other alterations (e.g., BRAF, PI3K, PTEN genes). The College of American Pathologists (CAP) Perspectives on Emerging Technology (POET) Report on KRAS mutation testing provides additional guidance on testing. If multiple KRAS mutation tests have been performed, refer to the most recent test results.

1859 KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy

3. Usability: H-10; M-1; L-0; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- An expert panel has supported use of this measure for public reporting.
- The Steering Committee suggested the developer revise the title of the measure to clarify. The measure developer did so and received the Steering Committee's approval.

4. Feasibility: H-6; M-5; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Measure appears feasible whether dealing with abstracting data or from EMRs.
- All data elements are generated through the process of care.

Steering Committee Recommendation for Endorsement: Y-11 ; N-0

Public and Member Comment

Comments included:

- Supportive comments for the measure.
- A request for harmonization and combination with measure 1860, which would capture testing and treatment with appropriate exclusions such as patient preference.

Developer Response:

- The developer states that the measures are reported together by ASCO, but ASCO considers the measures to be independently useful. Neither measure assesses whether testing was given to all metastatic colorectal cancer (CRC) patients, as that is not recommended. Likewise, neither measure assesses whether patients with metastatic CRC receive monoclonal antibodies; thus, exclusion for patient preference is not warranted.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

1860 Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies

Status: New Submission

Description: Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-EGFR monoclonal antibodies

Numerator Statement: Anti-EGFR monoclonal antibody therapy not received

Denominator Statement: Adult patients with metastatic colorectal cancer who have a KRAS gene mutation

Exclusions: Patient transfer to practice after initiation of chemotherapy

Receipt of anti-EGFR monoclonal antibody therapy as part of a clinical trial protocol

Adjustment/Stratification: No risk adjustment or risk stratification n/a

Level of Analysis: Clinician : Group/Practice, Clinician : Team

Type of Measure: Process

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

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-10; M-1; L-0; I-0; **1b. Performance Gap: H-6; M-5; L-0; I-0; 1c. Evidence: Y-11, N-0, I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus demonstrates an area of high impact, as many patients are diagnosed with colorectal cancer.
- There is a demonstrated performance gap on this measure, with 85 percent mean adherence to the measure in Quality Oncology Practice Initiative. The Steering Committee noted that there is a demonstrated opportunity for improvement.
- The Steering Committee noted that sparing futile or useless therapy is important, particularly as this therapy is very expensive.
- The measure will be useful for preventing overtreatment of patients who would not benefit from the therapy.

1860 Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-5; M-6; L-0; I-0; 2b. Validity: H-6; M-4; L-0; I-1

<u>Rationale</u>:

- Reliability testing was sufficient.
- The validity of the measure was well demonstrated.
- The denominator exclusions are relevant.
- The Steering Committee questioned whether there was clinical trial exclusion for this measure.
    - The developer noted that there was not and added this exclusion to the measure specifications.
- The Steering Committee stated the need for clarification as to when the testing is to be performed.
    - The developer added clarifying instructional information to the measure.
- The Steering Committee asked the developer to specify where the mutations are found, as in the future there may be mutations in the same gene that will be difficult to correlate and understand.
    - The developer made the following modifications to 2a1.7 which sufficiently addressed the Steering Committee's concerns:
        - KRAS mutation testing: KRAS testing for this measure refers to assays that detect mutations in codons 12 and 13 of KRAS only. Do not include results from mutations at other codons (e.g., codons 61 and 146), or assays for other alterations (e.g., BRAF, PI3K, PTEN genes). The College of American Pathologists (CAP) Perspectives on Emerging Technology (POET) Report on KRAS mutation testing provides additional guidance on testing. If multiple KRAS mutation tests have been performed, refer to the most recent test results.

3. Usability: <u>H-7; M-4; L-0; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- An expert panel has supported use of this measure for public reporting.

4. Feasibility: <u>H-8; M-3; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The measure appears feasible whether dealing with abstracting data or from EMRs.
- All data elements are generated through the process of care.

Steering Committee Recommendation for Endorsement: <u>Y-11 ; N-0</u>

1860 Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies

Public and Member Comment

Comments included:

- Supportive comments for the measure.
- A request for harmonization and combination with measure 1860, which would capture testing and treatment with appropriate exclusions such as patient preference.

Developer Response:

- The developer states that the measures are reported together by ASCO, but ASCO considers the measures to be independently useful. Neither measure assesses whether testing was given to all metastatic CRC patients, as that is not recommended. Likewise, neither measure assesses whether patients with metastatic CRC receive monoclonal antibodies; thus, exclusion for patient preference is not warranted.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

0219 Post breast conservation surgery irradiation

Status: Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Mar 01, 2007

Description: Percentage of female patients, age 18-69, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, receiving breast conserving surgery who receive radiation therapy within 1 year (365 days) of diagnosis.

Numerator Statement: Radiation therapy to the breast is initiated within 1 year (365 days) of the date of diagnosis

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

Women

Age 18-69 at time of diagnosis

Known or assumed to be first or only cancer diagnosis

Primary tumors of the breast

Epithelial malignancy only

AJCC Stage I, II, or III

Surgical treatment by breast conservation surgery (surgical excision less than mastectomy)

All or part of 1st course of treatment performed at the reporting facility

Known to be alive within 1 year (365 days) of diagnosis

Exclusions: Exclude, if any of the following characteristics are identified:

Men

Under age 18 at time of diagnosis

Over age 69 at time of diagnosis

Second or subsequent cancer diagnosis

Tumor not originating in the breast

Non-epithelial malignancies

Stage 0, in-situ tumor

Stage IV, metastatic tumor

None of 1st course therapy performed at reporting facility

Died within 12 months (365 days) of diagnosis

Adjustment/Stratification: No risk adjustment or risk stratification No stratification applied

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Registry, Paper Medical Records

Measure Steward: Commission on Cancer, American College of Surgeons **Other organizations:** This measure was harmonized with measure development efforts coordinated between the American Society of Clinical Oncology (ASCO) and The National Cancer Care Network (NCCN) prior to NQF's formal review and consideration of measures submitted in response to its call for measures in 2005 as part of its Quality of Cancer Care Performance Measures project (Desch CE, McNiff KK, Schneider EC, et al. American Society of Clinical Oncology / National Comprehensive Cancer Network Quality Measures. J Clin Oncol 2008;26:3631-3637). The measure, as specified here, has not been altered or changed in any way since harmonization of specifications between these three organizations occurred in the fall of 2006.

Steering Committee In-Person May 23-24, 2012

0219 Post breast conservation surgery irradiation

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-10; M-4; L-0; I-0; **1b. Performance Gap: H-1; M-12; L-1; I-0; 1c. Evidence: Y-13, N-0, I-1**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus represents an area of high impact, with many women receiving breast conservation surgery.
- There is a demonstrated opportunity for improvement, with demonstrated variation in the use of radiation with breast conservation surgery. Additionally, there are demonstrated disparities on the basis of age, race/ethnicity, and other factors.
- The Steering Committee noted that this measure is important for both ER negative and ER positive patients, as the measure was initially specified to include only ER negative patients.
    - The developer removed hormone receptor status condition from the numerator.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-11; M-3; L-0; I-0; 2b. Validity: H-8; M-5; L-0; I-1

<u>Rationale</u>:

- The Steering Committee had noted in a workgroup call prior to the in-person meeting that there were inconsistencies in the denominator specifications related to the Stage 1 category, and were concerned about the specification of receptor status, noting that the measure is important for both ER negative and ER positive patients.
    - The developer corrected the inconsistencies in the denominator specifications to be inclusive of Stage 1 breast cancers, and removed the hormone receptor status condition.
- The Steering Committee questioned the time window of 1 year for the measure.
    - The developer clarified that the time starts at the index diagnosis date, and that typically most patients have started radiation therapy within 1 year of the index diagnosis date.
- The Steering Committee stated that reliability testing was sufficient.
- The validity of the measure is well demonstrated.

3. Usability: <u>H-5; M-9; L-0; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is currently in use in the American College of Surgeons Commission on Cancer.
- The measure should be easily understood by the public and by healthcare providers.

4. Feasibility: <u>H-8; M-6; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- All data elements are available in cancer registries.

Steering Committee Recommendation for Endorsement: <u>Y-14 ; N-0</u>

0219 Post breast conservation surgery irradiation

Public and Member Comment

Comments included:

- Supportive comments for the measure.
- A request for the evidentiary basis for the time window of one year.

Developer Response:

- The developer stated that the standard of care is to provide radiation after the completion of chemotherapy. The time frame to receive chemotherapy, coupled with the time to complete initial diagnostic and second opinions, surgery and chemotherapy may extend through 8 - 10 months. Therefore, radiation will not be administered until this time. For the purpose of a measure, it was felt best to apply the 365 days to accommodate this variation. When this measure was originally specified, sensitivity analyses were performed to evaluate the effect the timing rule for radiation therapy would have on aggregate performance rates. In this analysis of over 90,000 women who had undergone breast conservation surgery it was determined that just over half of those who eventually received radiation therapy did so within 180 days of diagnosis, and three quarters received radiation therapy within 365 days.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

0220 Adjuvant hormonal therapy

Status: Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Mar 01, 2007

Description: Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who´s primary tumor is progesterone or estrogen receptor positive recommended for tamoxifen or third generation aromatase inhibitor (considered or administered) within 1 year (365 days) of diagnosis.

Numerator Statement: Hormone therapy is considered or administered within 1 year (365 days) of the date of diagnosis

Denominator Statement: Include if all of the following characteristics are identified:

Women

Age >=18 at time of diagnosis

Known or assumed to be first or only cancer diagnosis

Epithelial malignancy only

Primary tumors of the breast

AJCC T1c or Stage II or III

Primary tumor is estrogen receptor positive or progesterone receptor positive

All or part of 1st course of treatment performed at the reporting facility

Known to be alive within 1 year (365 days) of date of diagnosis

Exclusions: Exclude, i f any of the following characteristics are identified:

Men

Under age 18 at time of diagnosis

Second or subsequent cancer diagnosis

Tumor not originating in the breast

Non-epithelial malignancies

Stage 0, in-situ tumor

AJCC T1mic, T1a, or T1b tumor

Stage IV, metastatic tumor

Primary tumor is estrogen receptor negative and progesterone receptor negative

None of 1st course therapy performed at reporting facility

Died within 1 year (365 days) of diagnosis

Adjustment/Stratification: No risk adjustment or risk stratification No stratification applied

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Registry, Paper Records

Measure Steward: Commission on Cancer, American College of Surgeons **Other organizations:** This measure was harmonized with measure development efforts coordinated between the American Society of Clinical Oncology (ASCO) and The National Cancer Care Network (NCCN) prior to NQF's formal review and consideration of measures submitted in response to its call for measures in 2005 as part of its Quality of Cancer Care Performance Measures project (Desch CE, McNiff KK, Schneider EC, et al. American Society of Clinical Oncology / National Comprehensive Cancer Network Quality Measures. J Clin Oncol 2008;26:3631-3637). The measure, as specified here, has not been altered or changed in any way since harmonization of specifications between these three organizations occurred in the fall of 2006.

Steering Committee In-Person May 23-24, 2012

0220 Adjuvant hormonal therapy

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-14; M-3; L-0; I-0; **1b. Performance Gap: H-5; M-10; L-1; I-1; 1c. Evidence: Y-16, N-1, I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus represents an area of high impact, with many women receiving a breast cancer diagnosis.
- Evidence supports the selected patient population, as hormone therapy is indicated in patients with receptor positive disease.
- There is a performance gap for this measure.
- Disparities are demonstrated between African American and white females.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-11; M-6; L-0; I-0; 2b. Validity: H-8; M-9; L-0; I-0

<u>Rationale</u>:

- The Steering Committee questioned why there was no exclusion for pregnancy or planned pregnancy.
    - The developer noted that of the 110,000 women reported on, 63 had a secondary diagnosis code with pregnancy. This equates to one half of one percent. Half of these women did ultimately receive hormonal therapy; it is plausible that those women received the therapy after delivery. Consequently, the number of patients excluded for pregnancy would be extremely minimal. With respect to planned pregnancy, it is not feasible to ascertain planned pregnancy with respect to the measure.
- The Steering Committee stated that reliability testing was sufficient.
- The validity of the measure was well demonstrated.
- The Steering Committee recommended that in future iterations, the measure capture that the patients are receiving the appropriate dose of hormonal therapy.
- The Steering Committee also recommended that the measure capture appropriateness of hormonal therapy based upon menopausal state of the patient.
- The Steering Committee recommended that the measure captured patient adherence to the hormonal therapy through filled prescriptions.

3. Usability: <u>H-10; M-6; L-1; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is currently in use in the American College of Surgeons Commission on Cancer.
- The measure should be easily understood by the public and by healthcare providers.

4. Feasibility: <u>H-7; M-10; L-0; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- All data elements are available in cancer registries.

Steering Committee Recommendation for Endorsement: <u>Y-17 ; N-0</u>

0220 Adjuvant hormonal therapy

Public and Member Comment

Comments included:

- Supportive comments for the measure.
- A request that the measure specifications include race, ethnicity, gender, and language data elements to allow for stratification by these elements.
- A request that the measure have provisions for appropriate hormonal therapy dosage.
- A request for exclusion of small tumors.
- Commenters suggested that the measure can be improved upon by focusing only on administration of chemotherapy and not consideration of chemotherapy, as "considered" is not a precise term.

Developer Response:

- The developer stated that the Commission on Cancer's Rapid Quality Reporting System allows participating programs to generate comparison reports which stratify measure performance rates by race/ethnicity, age, insurance status, and area-based SES measures.
- The developer stated that it is not certain that ascertainment of the prescribed dosage of the hormonal therapy would enhance our understanding of adherence to this clinical standard of care. NCCN Guidelines simply specify the term or period of time for which hormonal agents should be prescribed, and in contrast to their dose specifications for chemotherapy regimens, don't comment specifically with respect to hormone therapy doses. Further, for the hormone agents that are used in the large majority of cases (tamoxifen and aromatase inhibitors) there is a single dose used. These issues, coupled with the high level of added work effort to confirm and record a dose, suggest that the added value to a quality measure of collecting dose would be limited.
- The developer stated that the full definition of this measure specifies that women with AJCC T1cN0M0 or Stage II or III HR+ breast disease are eligible to be included in this measure. This excludes women with small (Tmic, T1a and T1b) tumors.
- The developer stated that the Commission on Cancer and the American College of Surgeons use cancer registries to implement this measure; the cancer registries have standard definitions for both "administered" and "considered" therapies. Cancer registries record and report this information if it is documented in the patient chart. Further, a review of data has demonstrated consistency in reporting considered therapies over three years.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

0221 Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection

Status: Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Mar 01, 2007

Description: Percentage of patients presenting with AJCC Stage Group 0, I, II, or III disease, who undergo surgical excision/resection of a primary breast tumor who undergo a needle biopsy to establish diagnosis of cancer preceding surgical excision/resection.

Numerator Statement: Patient whose date of needle biopsy precedes the date of surgery.

Denominator Statement: Women with AJCC Stage 0, I, II, or II breast cancer undergoing surgery:

- Women
- Age >=18 at time of diagnosis
- Known or assumed first or only cancer diagnosis
- Primary tumors of the breast
- Epithelial invasive malignancy only
- Surgically treated
- Diagnosis and all or part of first course of treatment performed at the reporting facility

Exclusions: Exclusions:

Men; not a first or only cancer diagnosis; non-epithelial tumors; metastatic disease (AJCC Stage IV); not treated surgically; died before surgery

Adjustment/Stratification: No risk adjustment or risk stratification No stratification applied

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Registry, Paper Records

Measure Steward: Commission on Cancer, American College of Surgeons

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-2; M-13; L-1; I-0; **1b. Performance Gap: H-3; M-12; L-1; I-0; 1c. Evidence: Y-14, N-1, I-1**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus represents an area of high impact given the prevalence of the disease and the benefit to patients of fewer surgical procedures.
- The evidence demonstrates similar accuracy of needle biopsy with open surgical biopsy in the diagnosis of breast cancer.
- There are demonstrated disparities in use of needle biopsy prior to excision, with variation in use dependent upon age, race/ethnicity, provider specialty training, etc.
- The measure is important for addressing continuity of care for the patient.

0221 Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-4; M-10; L-2; I-0; 2b. Validity: H-3; M-10; L-3; I-1

<u>Rationale</u>:

- The Steering Committee questioned why cytologic was not separated out from core needle biopsies in the measure.
  - The developer stated that the vast majority of biopsies are core needle; however, the cancer registry confounds these data sets so they cannot be separated out.
  - It was also noted that there are limitations to cytologic testing and it requires very experienced programs to perform this testing.
- The Steering Committee questioned whether the measure was dependent upon obtaining usable diagnostic tissue.
  - The developer clarified that performance of the procedure counts toward the numerator. The measure is not outcome dependent.
- Steering Committee members expressed concern that this technique is not available for use everywhere, given the equipment and training necessary to perform the procedure. In particular, the Steering Committee had concerns about the availability of the technique in rural settings.
  - The developer noted that in the current use of the measure by the Commission on Cancer only has 1 percent of facilities in rural areas, another 12 percent are in urban non metro areas. Of those, 80 percent of the facilities have diagnostic imaging available, and the remaining 20 percent have it available by referral.
- The Steering Committee raised concerns over the issue of attribution with referrals to outside providers for performance of the procedure.
  - The developer clarified that the cancer registries track down the information on the referrals and can determine where the procedures take place. The developer also noted that the denominator specifies that only patients who have all or part of the first course of treatment at the reporting facility are to be counted in the measure.
- The Steering Committee stated that reliability testing was sufficient.
- The validity of the measure was well demonstrated.

3. Usability: <u>H-4; M-10; L-2; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure will be used in the American College of Surgeons Commission on Cancer starting in 2012.
- The measure should be easily understood by the public and by healthcare providers.

4. Feasibility: <u>H-3; M-10; L-3; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- All data elements are available in cancer registries.

Steering Committee Recommendation for Endorsement: <u>Y-12 ; N-4</u>

Public and Member Comment

Comments included:

- Supportive comments for the measure.

0391 Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

Status: Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008

Description: Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade.

Numerator Statement: Reports that include the pT category, the pN category and the histologic grade

Denominator Statement: All breast cancer resection pathology reports (excluding biopsies)

Exclusions: Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (e.g.; re-excision without residual tumor; non-carcinomas)

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** College of American Pathologists

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-12; M-3; L-1; I-0; **1b. Performance Gap: H-9; M-5; L-1; I-1; 1c. Evidence: Y-14, N-2, I-0**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus is high impact and is a useful and important piece of information when making therapeutic decisions about patients with breast cancer, as treatment is dependent upon staging.
- There is not demonstrated evidence that recording stage leads to improved outcomes; however, this can be reasonably inferred from the body of literature.
- The Steering Committee raised the concern that a single pathology report will not provide the physician with all of the information necessary diagnostic information. The information may be contained on several different reports, which weakens the outcome link.
- There is a demonstrated performance gap, with 32 percent of eligible reports missing at least one of the ten CAP-recommended breast cancer elements.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-10; M-4; L-1; I-1; 2b. Validity: H-4; M-8; L-2; I-1

<u>Rationale</u>:

- The Steering Committee stated that the measure was clearly and precisely specified.
- Reliability testing was sufficient.
- The validity of the measure was well demonstrated.
- The Steering Committee stated that there is a need for integrated summary reports containing all available pathological information; if these become available, they should be incorporated in future iterations of the measure.
- The Steering Committee recommended that margin status and number of lymph nodes evaluated be captured in future iterations of the measure.

0391 Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade

3. Usability: H-4; M-8; L-3; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure is currently in use in PQRS.
- The measure should be moderately understood by the public and by healthcare providers.

4. Feasibility: H-5; M-8; L-2; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- Steering Committee members questioned whether the information required by the measure would be found in an initial report or an integrated summary report. It was noted that as there are often many reports, it will be difficult for a provider to know which report contains the most significant pathology information.
    - The developer noted that reporting of the measure will be limited to what the pathologist has available-the pathologist may not have information demonstrating metastatic disease, which would not be included on the report.
- The Steering Committee noted that the data is generated during the processes of clinical care.

Steering Committee Recommendation for Endorsement: Y-12 ; N-2

Public and Member Comment

Comments included:

- Supportive comments for the measure.
- Concern that the measure assesses what is considered standard practice.

Developer Response:

- The developer noted that though this should be standard care, there is a documented gap in care, with 32 percent of eligible reports missing at least one of the ten CAP-recommended breast cancer elements.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.

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.

Status: Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Mar 01, 2007

Description: Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage T1c, or Stage II, or III, who´s primary tumor is progesterone and estrogen receptor negative recommended for multiagent chemotherapy (considered or administered) within 4 months (120 days) of diagnosis.

Numerator Statement: Combination chemotherapy is considered or administered within 4 months (120 days) of the date of diagnosis

Denominator Statement: Women under the age of 70 with AJCC T1cN0M0, or Stage II or 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
- AJCC T1cN0M0, or Stage II or 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

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; tumor size <=1cm and AJCC pN=0; ERA unknown or positive; PRA unknown or positive; metastatic disease (AJCC Stage IV); not treated surgically; died within 4 months (120 days) of diagnosis

Adjustment/Stratification: No risk adjustment or risk stratification No stratification applied

Level of Analysis: Facility

Type of Measure: Process

Data Source: Electronic Clinical Data : Registry, Paper Records

Measure Steward: American College of Surgeons **Other organizations:** This measure was harmonized with measure development efforts coordinated between the American Societ

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-8; M-8; L-1; I-0; **1b. Performance Gap: H-1; M-12; L-3; I-1; 1c. Evidence: Y-12, N-3, I-3**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus represents an area of high impact, with many women receiving a breast cancer diagnosis.
- Evidence supports the selected target age and includes RCTs
- There is a performance gap for this measure.
- Disparities are not well documented in this measure.

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.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-7; M-8; L-2; I-0; 2b. Validity: H-7; M-8; L-2; I-0

<u>Rationale</u>:

- The Steering Committee noted that the measure doesn't specify that the patient receive the gold standard for combination chemotherapy; as such, patients could be getting less mainstream combination chemotherapy and that would still count toward the numerator.
- The Steering Committee questioned how neoadjuvant chemotherapy is captured.
    - The developer clarified that the date of service of the chemotherapy and the clinical and pathological staging are all captured.
- The Steering Committee questioned what an acceptable performance rate for the measure is.
    - The developer stated that the target rate is 90 percent, knowing that there should be some flexibility. It was also noted that this measure captures consideration of or administration of combination chemotherapy, making it somewhat easier to achieve the numerator.
- The Steering Committee stated that reliability testing was sufficient.
- The validity of the measure was well demonstrated.
- The Steering Committee expressed a desire to see a more nuanced iteration of the measure in the future to capture whether the chemotherapy administered was appropriate.

3. Usability: <u>H-6; M-6; L-5; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is currently in use in the American College of Surgeons Commission on Cancer.
- The measure should be easily understood by the public and by healthcare providers.

4. Feasibility: <u>H-3; M-9; L-5; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- All data elements are available in cancer registries.

Steering Committee Recommendation for Endorsement: <u>Y-14 ; N-3</u>

Public and Member Comment

Comments included:

- Supportive comments for the measure.

0387 Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer

Status: Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Jul 31, 2008

Description: Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period

Numerator Statement: Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period

Definition: Prescribed may include prescription given to the patient for tamoxifen or aromatase inhibitor (AI) at one or more visits in the 12-month period OR patient already taking tamoxifen or aromatase inhibitor (AI) as documented in the current medication list.

Denominator Statement: All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

Exclusions: Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was >= 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period)

Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient refusal)

Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient is currently enrolled in a clinical trial)

Adjustment/Stratification: No risk adjustment or risk stratification None We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) **Other organizations:** This measure is jointly copyrighted by the AMA-PCPI, American Society of Clinical Oncology and Natio

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-10; M-1; L-0; I-0; **1b. Performance Gap: H-7; M-4; L-0; I-0; 1c. Evidence: Y-10, N-0, I-1**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus represents an area of high impact, with many women receiving a breast cancer diagnosis.
- The ASCO Quality Oncology Practice Initiative (QOPI) study demonstrated a performance rate of 93.9 percent; however, another study reported an 80 percent performance rate, so there is room for improvement.
- Disparities in measure performance for low income and minority patients were cited and were significant.
- The evidence presented is robust.

0387 Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer

2. Scientific Acceptability of Measure Properties: The measure meets the Scientific Acceptability criteria.

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-10; M-1; L-0; I-0; 2b. Validity: H-11; M-0; L-0; I-0

Rationale:

- The measure was clearly and precisely specified.
- The denominator exclusions are appropriate.
- The Steering Committee stated that reliability of the measure score was high.
- Validity was demonstrated.
- The Steering Committee recommended that in the future, compliance with hormonal therapy be captured through prescription data.

3. Usability: H-11; M-0; L-0; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure is currently in use in PQRS.
- The measure should be moderately understood by the public and by healthcare providers.

4. Feasibility: H-9; M-2; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The measure is feasible as it can be captured through electronic data.
- The Steering Committee noted that the data is generated during the processes of clinical care.

Steering Committee Recommendation for Endorsement: Y-11 ; N-0

Public and Member Comment

Comments included:

- Supportive comments for the measure.

1857 Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab

Status: New Submission

Description: Percentage of adult patients (aged 18 or over) with invasive breast cancer that is HER2/neu negative who are not administered trastuzumab

Numerator Statement: Trastuzumab not administered during the initial course of treatment

Denominator Statement: Adult women with AJCC stage I (T1c) – III breast cancer that is HER-2 negative or HER-2 undocumented/unknown

Exclusions: Patient transfer to practice after initiation of chemotherapy

Adjustment/Stratification: No risk adjustment or risk stratification n/a

Level of Analysis: Clinician : Group/Practice, Clinician : Team

Type of Measure: Process

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

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-9; M-3; L-4; I-0; **1b. Performance Gap: H-2; M-6; L-7; I-1; 1c. Evidence: Y-13, N-2, I-1**

<u>Rationale</u>:

- Steering Committee members expressed concern with the presented performance gap showing concordance of 99 percent with the measure and questioned the opportunity for improvement.
    - The developer stated that the participants on the measure are a self-selected group participating in the quality Oncology Practice Initiative and performance may be higher for this group. The developer also noted that several unpublished studies suggest overuse of trastuzumab.
- The Steering Committee questioned whether this intervention would happen without HER2 testing or with a negative HER2 result.
    - The developer stated that this can and does happen, according to feedback from payers.
- The measure focus represents an area of high impact, with many women receiving a breast cancer diagnosis.
- Evidence supports the selected patient population, as trastuzumab is not indicated in women with HER2 negative disease.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-6; M-7; L-3; I-0; 2b. Validity: H-4; M-8; L-4; I-0

<u>Rationale</u>:

- The Steering Committee stated that the measure was clearly and precisely specified.
- Reliability testing was sufficient.
- The validity of the measure was well demonstrated.
- The Steering Committee recommended that the developer revise the title of the measure to clarify the intent of the measure. The measure developer did so and received the Steering Committee's approval.
- The Steering Committee suggested that future iterations of the measure capture:
    - Whether patients are receiving the appropriate dose of hormonal therapy.
    - the appropriateness of hormonal therapy based upon menopausal state of the patient, and patient adherence to the hormonal therapy through prescription data.

1857 Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab

3. Usability: H-5; M-8; L-3; I-0

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure is planned for use in public reporting.
- The measure should be moderately understood by the public and by healthcare providers.

4. Feasibility: H-6; M-6; L-4; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The Steering Committee raised concerns that extraction of this data may be burdensome as it may require chart abstractions.
- Eventual use of this measure through EHRs will lessen this burden.

Steering Committee Recommendation for Endorsement: Y-9 ; N-7

Rationale:

- Steering Committee members expressed concern that several measures had high rates of performance, indicating a small gap in performance; however, the developer clarified that the performance gap data came from the American Society for Clinical Oncology's Quality Oncology Practice Initiative (QOPI), which included self-selecting practices voluntarily reporting on measures. As such, the developer stated that it is likely that there is more variation in performance than was demonstrated through QOPI.
- The Steering Committee agreed with the developer that it is likely that there is variation in use of trastuzumab and in HER2 testing, given the self-selecting nature of the practices participating with QOPI. Taken in conjunction with several studies suggesting overuse of trastuzumab, the Steering Committee recommended the measure for endorsement.

1857 Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab

Public and Member Comment

Comments included:

- A recommendation that references to the specific therapy, trastuzumab, be changed to "FDA-approved HER2 therapy."
- A recommendation against endorsement of the measure due to limited utility in improving quality, citing a 2009 study where 98 percent of patients had HER2 testing and 100 percent of patients receiving trastuzumab had documented HER2 testing prior to receiving trastuzumab.
- A recommendation that a HER2 composite measure be developed, comprised of measures 1857, 1855, 1858, and 1878.

Developer Response:

- The developer stated that the measure is reviewed and, if necessary, updated every six months. If an alternate therapy is approved and considered appropriate for inclusion in this measure, the measure will be updated.
- The developer stated that the preponderance of available data suggest room for improvement. The developer noted that oncologists need to know the result of HER2 testing that was accomplished prior to oncologist engagement. HER2 status should be captured in a way that can be located/retrieved from the medical record.
  The developer stated that given the large numbers of women affected, modest improvements can have a significant national impact. Lastly, the developer noted that if ongoing use of this measure - or the underuse of trastuzumab measure - reveals in future years that no quality gap exists, ASCO will retire the measure.
- The developer stated that ASCO and CAP, the developers of the referenced measures, have discussed the concept of a composite measure, and neither organization believes that it is advantageous at this time. These measures are designed for different providers and levels of accountability, and have different denominators. Measure 1855 was developed to measure the performance of individual pathologists, while measures 1857, 1858, and 1878 are for medical oncologists/clinical oncology practices. It may be beneficial to implement all of these measures within certain settings, such as accountable care organizations or Cancer Care Centers. ASCO reports measures 1857, 1858, and 1878 together in their quality programs; however, they believe that the measures are independently useful. The developer will consider paired or composite measures in the future.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.
- The Steering Committee noted that currently the evidence demonstrates that trastuzumab is the appropriate therapy for HER2 positive patients and is an inappropriate therapy for HER2 negative patients; as such, it should be explicitly named in the measure. The Steering Committee noted that as ASCO has a review system in place for updating the measure as the evidence evolves, the measure should remain unchanged at this time.
- The Steering Committee agreed that as the measures are currently specified for different levels of analysis, a composite measure would not be feasible. Further, the Steering Committee agreed that the measures capture discrete steps in care.

1855 Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines

Status: New Submission **Time-limited**

Description: Percentage of patients with quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the ASCO/CAP guidelines.

Numerator Statement: Breast cancer patients receiving quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the ASCO/CAP guideline *

Denominator Statement: All breast cancer patients with quantitative breast tumor evaluation by HER2 IHC

ICD-9 diagnosis codes for breast cancer: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.7, 174.8, 174.9, 175.0, 175.9

AND

CPT codes: Quantitative IHC Evaluation – 88360 or 88361 (The CPT descriptor for 88360 and 88361 is, "Morphometric analysis, tumor immunohistochemistry (e.g., Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semi-quantitative, each antibody.")

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification Not applicable Not applicable

Level of Analysis: Clinician : Group/Practice, Clinician : Individual

Type of Measure: Process

Data Source: Administrative claims, Other, Paper Records

Measure Steward: College of American Pathologists

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-11; M-4; L-1; I-0; **1b. Performance Gap: H-5; M-11; L-0; I-0; 1c. Evidence: Y-14, N-2, I-0**

<u>Rationale</u>:

- The Steering Committee agreed high quality evidence was presented.
- The measure is high impact and is a useful and important piece of information when making therapeutic decisions about patients with breast cancer.
- The measure is supported by the ASCO/CAP guidelines, and the quantity, quality and consistency of the evidence was sufficient.
- Regarding the performance gap, the Steering Committee noted that the FDA indications differ from the ASCO/CAP guidelines. Committee members noted ASCO/CAP guidelines currently require that 30 percent of the cells subjected to ImmunoHistoChemistry testing (IHC) test positive; if less than that, fluorescence in situ hybridization (FISH) testing is recommended. It was noted that this may be a reason for the current performance gap, with only 84 percent of laboratories meeting the measure.
- The Steering Committee noted that the current version of the ASCO/CAP scoring system will be updated in 2012.
    - The developer clarified that the cited guideline does not specify which version of the ASCO/CAP scoring system is to be used. It simply requires use of the ASCO/CAP scoring system, so if the scoring system changes, the measure will still be accurate.

1855 Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability requirement for untested measures.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

Precise Specifications: Y-15; N-0

<u>Rationale</u>:

- The measure is eligible for time limited endorsement, as reliability and validity testing have yet to be undertaken.
- The Steering Committee stated that the measure was clearly and precisely specified.
- The Steering Committee recommended that future iterations of the measure capture accuracy of the tests at a facility level (laboratories). This will address whether laboratories are compliant with the ASCO/CAP guideline.

3. Usability: <u>H-6; M-5; L-2; I-2</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is planned for use in PQRS 2012.
- The measure should be moderately understood by the public and by healthcare providers.

4. Feasibility: <u>H-4; M-11; L-1; I-0</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee raised concerns that extraction of this data may be burdensome as it may require chart abstractions.
- Eventual use of this measure through EHRs will lessen this burden.

Steering Committee Recommendation for Endorsement: <u>Y-15 ; N-1</u>

Public and Member Comments

Comments included:

- Supportive comments for the measure.
- A recommendation that a HER2 composite measure be developed comprised of measures 1857, 1855, 1858, and 1878.

Developer Response:

- The developer stated that ASCO and CAP, the developers of the referenced measures, have discussed the concept of a composite measure, and neither organization believes that it is advantageous at this time. These measures are designed for different providers and levels of accountability, and have different denominators. Measure 1855 was developed to measure the performance of individual pathologists, while measures 1857, 1858, and 1878 are for medical oncologists/clinical oncology practices. It may be beneficial to implement all of these measures within certain settings, such as accountable care organizations or Cancer Care Centers.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.
- The Steering Committee agreed that as the measures are currently specified for different levels of analysis, a composite measure would not be feasible. Further, the Steering Committee agreed that the measures capture discrete steps in care.

1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy

Status: New Submission

Description: Percentage of adult patients (aged 18 or over) with invasive breast cancer that is HER2/neu positive who are administered trastuzumab

Numerator Statement: Trastuzumab administered within 12 months of diagnosis

Denominator Statement: Adult women with AJCC stage I (T1c) –III, HER2/neu positive breast cancer who receive chemotherapy

Exclusions: •
- Patient history of metastatic cancer
- Multiple primaries prior to or within the measurement period
- Patient metastatic at diagnosis
- Patient transfer to practice after initiation of chemotherapy
- Patient still receiving anthracycline-based chemotherapy
- Patient declined
- Patient died or transferred within 12 months of diagnosis
- Contraindication or other clinical exclusion

Adjustment/Stratification: No risk adjustment or risk stratification n/a

Level of Analysis: Clinician : Group/Practice, Clinician : Team

Type of Measure: Process

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

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-14; M-2; L-0; I-0; **1b. Performance Gap: H-3; M-9; L-2; I-2; 1c. Evidence: Y-15, N-0, I-1**

<u>Rationale</u>:

- The Steering Committee agreed high quality evidence was presented.
- Steering Committee members expressed concern with the presented performance gap showing concordance of 97 percent with the measure and questioned the opportunity for improvement.
    - The developer stated that the participants on the measure are a self-selected group participating in the Quality Oncology Practice Initiative and performance may be higher for this group.
- The Steering Committee questioned whether this intervention would happen without HER2 testing or with a negative HER2 result.
    - The developer stated that this can and does happen, according to feedback from payers.
- The measure focus represents an area of high impact, with many women being diagnosed with breast cancer.
- Evidence supports the selected patient population, as trastuzumab is only indicated in women with HER2 positive disease.

1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-6; M-8; L-2; I-0; 2b. Validity: H-5; M-7; L-4; I-0

<u>Rationale</u>:

- In a workgroup call prior to the in-person meeting, the Steering Committee asked the developer to clarify that trastuzumab should be administered within one year of diagnosis.
  - The developer had made this change.
- The Steering Committee was raised concerns about a possible cardiac exclusion, as trastuzumab can cause cardiac toxicity.
  - The developer noted that "contraindication or other clinical exclusion" is listed as exclusion to the denominator and would cover a cardiac exclusion.
- The measure was clearly and precisely specified.
- Reliability testing was sufficient.
- The validity of the measure was well demonstrated.
- The Steering Committee suggested the developer revise the title of the measure to clarify the intent of the measure. The measure developer did so and received the Steering Committee's approval.

3. Usability: <u>H-4; M-8; L-4; I-0</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

<u>Rationale</u>:

- The measure is planned for use in public reporting.
- The measure should be moderately understood by the public and by healthcare providers.

4. Feasibility: <u>H-5; M-9; L-1; I-1</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee raised concerns that extraction of this data may be burdensome as it may require chart abstractions.
- Eventual abstraction of this measure through EHRs will lessen this burden.

Steering Committee Recommendation for Endorsement: <u>Y-13 ; N-3</u>

<u>Rationale</u>:

- Steering Committee members expressed concern that several measures had high rates of performance, indicating a small gap in performance; however, the developer clarified that the performance gap data came from the American Society for Clinical Oncology's Quality Oncology Practice Initiative (QOPI), which included self-selecting practices voluntarily reporting on measures. As such, the developer stated that it is likely that there is more variation in performance than was demonstrated through QOPI.
- The Steering Committee agreed with the developer that it is likely that there is variation in use of trastuzumab and in HER2 testing, given the self-selecting nature of the practices participating with QOPI. Taken in conjunction with several studies suggesting overuse of trastuzumab, the Steering Committee recommended the measure for endorsement.

1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy

Public and Member Comment

Comments included:

- A recommendation that references to the specific therapy, trastuzumab, be changed to "FDA-approved HER2 therapy."
- A recommendation that a HER2 composite measure be developed, comprised of measures 1857, 1855, 1858, and 1878.

Developer Response:

- The developer stated that the measure is reviewed and, if necessary, updated every six months. If an alternate therapy is approved and considered appropriate for inclusion in this measure, the measure will be updated.
- The developer stated that ASCO and CAP, the developers of the referenced measures, have discussed the concept of a composite measure, and neither organization believes that it is advantageous at this time. These measures are designed for different providers and levels of accountability, and have different denominators. Measure 1855 was developed to measure the performance of individual pathologists, while measures 1857, 1858, and 1878 are for medical oncologists/clinical oncology practices. It may be beneficial to implement all of these measures within certain settings, such as accountable care organizations or Cancer Care Centers. ASCO reports measures 1857, 1858, and 1878 together in their quality programs; however, they believe that the measures are independently useful. The developer will consider paired or composite measures in the future.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.
- The Steering Committee noted that currently the evidence demonstrates that trastuzumab is the appropriate therapy for HER2 positive patients and is an inappropriate therapy for HER2 negative patients; as such, it should be explicitly named in the measure. The Steering Committee noted that as ASCO has a review system in place for updating the measure as the evidence evolves, the measure should remain unchanged.
- The Steering Committee agreed that as the measures are currently specified for different levels of analysis, a composite measure would not be feasible. Further, the Steering Committee agreed that the measures capture discrete steps in care.

1878 Human epidermal growth factor receptor 2 (HER2) testing in breast cancer

Status: New Submission

Description: Percentage of adult patients (aged 18 or over) with invasive breast cancer who receive human epidermal growth factor receptor 2 (HER2) testing

Numerator Statement: HER2/neu testing performed

Denominator Statement: Adult women with invasive breast cancer

Exclusions: Patient history of metastatic cancer

Multiple primaries prior to or within the measurement period

Adjustment/Stratification: No risk adjustment or risk stratification n/a

Level of Analysis: Clinician : Group/Practice, Clinician : Team

Type of Measure: Process

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

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure meets the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-13; M-3; L-0; I-0; **1b. Performance Gap: H-4; M-7; L-4; I-1; 1c. Evidence: Y-16, N-0, I-0**

<u>Rationale</u>:

- The Steering Committee agreed high quality evidence was presented.
- Steering Committee members expressed concern with the presented performance gap stating concordance of 98 percent with the measure and questioned the opportunity for improvement.
    - The developer noted that the participants on the measure are a self-selected group participating in the Quality Oncology Practice Initiative and performance may be higher for this group; there is likely greater variation in practice outside this group.
- The measure focus represents an area of high impact, with many women receiving a breast cancer diagnosis.
- The Steering Committee noted that HER2 testing is both prognostic and predictive of patient response to treatment therapies.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-10; M-6; L-0; I-0; 2b. Validity: H-9; M-6; L-1; I-0

<u>Rationale</u>:

- Steering Committee members questioned whether patients with small tumor sizes should be excluded from the measure.
    - The developer noted that insufficient sample size, as would result from a small tumor size, is included as a data element within the numerator. Further, the workgroup members agreed that an explicit exclusion of small tumor sizes may wrongly imply that HER2 testing on them is not necessary.
- The measure was clearly and precisely specified.
- Reliability testing was sufficient.
- The validity of the measure was well demonstrated.

1878 Human epidermal growth factor receptor 2 (HER2) testing in breast cancer
3. Usability: H-7; M-8; L-1; I-0 (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)* **Rationale:** • The measure is planned for use in public reporting. • The measure should be moderately understood by the public and by healthcare providers.
4. Feasibility: H-10; M-5; L-1; I-0 *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)* **Rationale:** • The Steering Committee raised concerns that extraction of this data may be burdensome as it may require chart abstractions. • Eventual abstraction of this measure through EHRs will lessen this burden.
Steering Committee Recommendation for Endorsement: Y-15 ; N-1 **Rationale:** • Steering Committee members expressed concern that several measures had high rates of performance, indicating a small gap in performance; however, the developer clarified that the performance gap data came from the American Society for Clinical Oncology's Quality Oncology Practice Initiative (QOPI), which included self-selecting practices voluntarily reporting on measures. As such, the developer stated that it is likely that there is more variation in performance than was demonstrated through QOPI. • The Steering Committee agreed with the developer that it is likely that there is variation in use of trastuzumab and in HER2 testing, given the self-selecting nature of the practices participating with QOPI. Taken in conjunction with several studies suggesting overuse of trastuzumab, the Steering Committee recommended the measure for endorsement.

1878 Human epidermal growth factor receptor 2 (HER2) testing in breast cancer

Public and Member Comment

Comments included:

- A recommendation that a HER2 composite measure be developed, comprised of measures 1857, 1855, 1858, and 1878.
- A recommendation that exclusion of de novo patients from testing to determine HER2 status be removed.

Developer Response:

- The developer stated that ASCO and CAP, the developers of the referenced measures, have discussed the concept of a composite measure, and neither organization believes that it is advantageous at this time. These measures are designed for different providers and levels of accountability, and have different denominators. Measure 1855 was developed to measure the performance of individual pathologists, while measures 1857, 1858, and 1878 are for medical oncologists/clinical oncology practices. It may be beneficial to implement all of these measures within certain settings, such as accountable care organizations or Cancer Care Centers.
  ASCO reports measures 1857, 1858, and 1878 together in their quality programs; however, they believe that the measures are independently useful. The developer will consider paired or composite measures in the future.
- The developer stated that the measure does not recommend against testing among patients who are excluded from the denominator (patients with metastatic disease or multiple primaries prior to or within the measurement period). Future development work could consider measurement to address HER2 re-testing, if supported sufficiently by evidence and if feasibility/burden were considered appropriate.

Steering Committee Response:

- The Steering Committee agreed with the developer's response, which is consistent with discussions that occurred at the in-person meeting and on related conference calls.
- The Steering Committee agreed that as the measures are currently specified for different levels of analysis, a composite measure would not be feasible. Further, the Steering Committee agreed that the measures capture discrete steps in care.

Measures Not Recommended

Hematology and Melanoma Measures

0561 Melanoma Coordination of Care

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patient visits, regardless of age, seen with a new occurrence of melanoma who have a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis.

Numerator Statement: Patient visits with a treatment plan documented in the chart that was communicated to the physician(s) providing continuing care within one month of diagnosis

Denominator Statement: All visits for patients, regardless of age, diagnosed with a new occurrence of melanoma

Exclusions: Documentation of patient reason(s) for not communicating treatment plan (e.g., patient asks that treatment plan not be communicated physician(s) providing continuing care);

Documentation of system reason(s) for not communicating treatment plan to the primary care provider(s) (e.g., patient does not have a primary care provider or referring physician)

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification. We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Clinician : Team

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records

Measure Steward: American Medical Association - Physician Consortium for Performance Improvement **Other organizations:** American Academy of Dermatology and National Committee for Quality Assurance

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure does not meet the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-4; M-7; L-3; I-3; **1b. Performance Gap: H-1; M-10; L-3; I-3; 1c. Evidence: Y-1, N-4, I-10**

Rationale:

- Measure demonstrates good clinical care; however, there was concern that this was not important for devoting resources for performance measurement.
- The measure developers presented data that about 12% of the charts did not have evidence regarding the documentation of treatment plans directed to the primary care physicians. However, there is no supporting evidence that this communication would improve the quality of care of a melanoma patient. This is compounded by the fact that patients are already being seen by a "treating" physician which suggests that they are receiving adequate oncology specific care.
- The Steering Committee agreed communication among providers is important but were not sure that this measure improves quality of care or outcomes, especially based on data provided since primary care provider not likely to be directly involved in the treatment of a patient with melanoma. A better measure would be documentation of follow up by an oncology-specific provider.

0561 Melanoma Coordination of Care
2. Scientific Acceptability of Measure Properties: N/A (2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity) **2a. Reliability: H- ; M- ; L- ; I- ; 2b. Validity: H- ; M- ; L- ; I-** .
3. Usability: N/A (*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*
4. Feasibility: N/A *(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)*
Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.
Public & Member Comment • No comments were received.

Prostate Measures

0625 History of Prostate Cancer - Cancer Surveillance
Maintenance Measure **Measure Evaluation and Specifications** **Description:** The percentage of men with definitively treated localized prostate cancer who had at least one PSA level in the past 12 months. **Numerator Statement:** Men who had at least one PSA level in the past 12 months. **Denominator Statement:** Men with localized prostate cancer who were treated with curative intent. **Exclusions:** 1. Surgical treatment for prostate cancer in the past year 2. Drug treatment for prostate cancer in the past year 3. Radiation therapy for prostate cancer in the past year 4. Prostate MRI in past year 5. Prostate biopsy in the past year 6. Metastatic prostate cancer 7. Provider or patient feedback stating patient does not have a diagnosis of prostate cancer. 8. General exclusions a. Terminal Illness b. Active treatment of malignancy (chemotherapy or radiation therapy) in the past 6 months. c. Patients who were admitted to a skilled nursing facility in the past 3 months. **Adjustment/Stratification:** No risk adjustment or risk stratification No risk adjustment is done with our measures, therefore, we do not have a risk model. This specific measure addresses all men with a history of a diagnosis of prostate cancer who were treated with curative intent, across the entire measured population. Using our highly specific rule algorithms, people with a history of a diagnosis of prostate cancer who were treated with curative intent will be included in the denominator. Therefore, no risk adjustment or risk stratification is necessary for this unique measure. **Level of Analysis:** Clinician : Group/Practice, Clinician : Individual, Facility, Health Plan, Population : County or City, Population : National, Population : State **Type of Measure:** Process **Data Source:** Administrative claims, Electronic Clinical Data, Healthcare Provider Survey, Patient Reported Data/Survey **Measure Steward:** ActiveHealth Management
0625 History of Prostate Cancer - Cancer Surveillance
Steering Committee In-Person March 13-14, 2012

0625 History of Prostate Cancer - Cancer Surveillance

1. Importance to Measure and Report: <u>The measure does not meet the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-2; M-1; L-8; I-5; **1b. Performance Gap: H- ; M- ; L- ; I- ; 1c. Evidence: Y- , N- , I-**

<u>Rationale</u>:

- The Steering Committee agreed prostate cancer is a prevalent disease and surveillance care and survivorship care are important areas for measuring quality, however the presented evidence did not demonstrate a link between process and a prostate cancer specific desired outcome.
- There was no evidence presented that management of recurrence is associated with high resource use.
- There was low level evidence that delay in detection of recurrence was associated with adverse outcomes.
- There was no evidence presented that there is variation or suboptimal performance with regard to PSA testing in these patients.
- The Steering Committee was concerned with unintended harm, as overtreatment of patients with relapses of prostate cancer is a current problem.

2. Scientific Acceptability of Measure Properties: <u>N/A</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H- ; M- ; L- ; I- ; 2b. Validity: H- ; M- ; L- ; I-

<u>Rationale</u>:

- The Steering Committee was concerned about the lack of results data presented on the reliability and validity of the measure. The Steering Committee felt that the testing database was inappropriate for evaluating reliability and validity for prostate cancer, due in part to the young age of the cohort.
- The Steering Committee was concerned about the open-ended time window.
- The Steering Committee was concerned that the exclusions for the measure eliminated the patients who would require more rigorous follow up after a diagnosis of prostate cancer. Although one exclusion was misstated, this concern extended to other exclusions in the measure.
- The Steering Committee stated that patients who are asymptomatic and not eligible for salvage therapies may not need to be followed.

3. Usability: <u>N/A</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

- The Steering Committee was concerned that although the developer indicated that 20 percent of patients lack surveillance PSA levels within one year of their treatment, the developer does not document the lower level of care or worse outcomes for that group.

4. Feasibility: <u>N/A</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

<u>Rationale</u>:

- The Steering Committee was concerned about attribution to a provider following the care of the patient. The developer stated they had a database that would pull the most recent test during a 1-year window and using an algorithm, determine the care provider. The Steering Committee was concerned that users of the measure would not be able to do this without the developer's database.

Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

0625 History of Prostate Cancer - Cancer Surveillance

Public & Member Comment

- No comments were received.

Palliative Measures

0212 Proportion with more than one hospitalization in the last 30 days of life

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life

Numerator Statement: Patients who died from cancer and had >1 hospitalization in the last 30 days of life

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered.

None. No risk adjustment is necessary. The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting 'Cancer' as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate. No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992)to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.

Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

0212 Proportion with more than one hospitalization in the last 30 days of life

1. Importance to Measure and Report: <u>The measure does not meet the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-4; M-10; L-2; I-0; **1b. Performance Gap: H-4; M-8; L-3; I-1; 1c. Evidence: Y-6, N-6, I-4**

<u>Rationale</u>:

- The measure affects a large number of patients and is high impact.
- The Steering Committee noted that repeated hospitalizations for a dying patient are indicative that a trajectory of care to deal with end of life issues has not been established.
- The Steering Committee was concerned that this measure did not take into account the increase in Palliative Care Units in hospitals, which provide appropriate care for dying patients in pain and should be utilized.
- The Steering Committee raised concerns that the evidence base for this measure needs to evolve with the use of palliation in inpatient facilities.
- There was concern that not recommending this measure for endorsement would not allow capture of the full spectrum of hospitalizations for cancer patients at the end of life (emergency department, hospitalization, and ICU).

Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

Public and Member Comment

Comments included:

- Commenters urged endorsement of the measure as complementary to measures 0211 and 0213.
- Commenters indicated that given the variation in the use of emergency room (ER) or direct hospital admissions for patients in advanced stages of illness, as well as variation in the intensity of care provided in diverse health care settings, it will not be possible to understand variations in ER and intensive care unit (ICU) use at the end of life without including the hospital admissions piece represented by measure 0212.
- Commenters suggested excluding patients in inpatient hospice and palliative care units to strengthen the measure.

Developer Response:

- True hospice, as paid for through the hospice benefit, is not included. If inpatient palliative care units can be identified in administrative claims (currently not possible in Medicare), then they should be excluded.
- The user could certainly use these measures as a package when implementing them.
- Inpatient hospice care is not included. A more difficult problem is hospitalization on an inpatient palliative care unit which currently is not generally identifiable in administrative claims. If it was, it should be treated like inpatient hospice.

Steering Committee Response:

- Steering Committee members noted that ER and ICU utilization varies regionally and often by facility, with some facilities utilizing ICUs in circumstances where other facilities would simply admit a patient to the hospital. However, the Committee members stated concerns that without a way to distinguish palliative care units, many patients who were receiving appropriate and necessary care via hospitalization would be counted in this measure.
- The data source for the measure is Medicare claims data, which does not currently distinguish between palliative care units and other hospitalizations. Because of this the Steering Committee agreed the measure would not present a valid depiction of the quality of care provided within a facility.

0214 Proportion dying from Cancer in an acute care setting

Maintenance Measure

Measure Evaluation and Specifications

Description: Percentage of patients who died from cancer dying in an acute care setting

Numerator Statement: Patients who died from cancer in an acute care hospital

Denominator Statement: Patients who died from cancer.

Exclusions: None

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. None

Level of Analysis: Clinician : Group/Practice, Facility, Health Plan, Integrated Delivery System, Population : County or City, Population : National, Population : Regional, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Management Data, Paper Records

Measure Steward: American Society of Clinical Oncology

Steering Committee In-Person March 13-14, 2012

1. Importance to Measure and Report: The measure does not meet the Importance criteria.

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-7; M-8; L-0; I-2; **1b. Performance Gap: H-6; M-7; L-0; I-4; 1c. Evidence: Y-6, N-6, I-4**

Rationale:

- The measure affects a large number of patients and is high impact.
- The Steering Committee noted that most patients prefer to die at home, not in an acute care setting.
- The Steering Committee was concerned that this measure did not take into account the increase in Palliative Care Units in hospitals, which provide appropriate care for dying patients in pain and should be utilized.
- The Steering Committee stated that this measure does not take into account that the majority of patients want to die comfortably, and in many circumstances an acute care setting may be the most appropriate place for that to occur.

Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria and will not be recommended for endorsement.

Public & Member Comment

- This measure received a supportive comment.

Breast Cancer Measures

0031 Breast Cancer Screening

Status: Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: May 24, 2012

Description: Percentage of women 40-69 years of age who had a mammogram to screen for breast cancer

Numerator Statement: One or more mammograms during the measurement year or the year prior to the measurement year

Denominator Statement: Women 42–69 years of age as of Dec 31 of the measurement year (note: this denominator statement captures women age 40-69 years)

Exclusions: Exclusion: Women who had a bilateral mastectomy or for whom there is evidence of two unilateral mastectomies. Look for evidence of a bilateral mastectomy as far back as possible in the member´s history through Dec 31 of the measurement year.

Adjustment/Stratification: No risk adjustment or risk stratification NA None

Level of Analysis: Clinician : Group/Practice, Clinician : Individual, Health Plan, Population : State

Type of Measure: Process

Data Source: Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record

Measure Steward: National Committee for Quality Assurance

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure does not meet the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-8; M-2; L-0; I-1; **1b. Performance Gap: H-4; M-4; L-2; I-1; 1c. Evidence: Y-2, N-1, I-8**

<u>Rationale</u>:

- The Steering Committee agreed the measure focus represents an area of high impact; breast cancer is a leading cause of cancer deaths.
- Data presented showed variability in performance rate particularly in the public plan for lower-income Medicaid plans, which have a somewhat significantly lower rate at 52 percent compared to Medicare and commercial plans; commercial plans are only at a 71 percent performance rate.
- Disparities data presented show some room for improvement.

  The Steering Committee was concerned that currently there are differences in national regarding the age at which breast cancer screening should begin.
  - The Steering Committee stated that screening should be a shared decision between patients and providers.
  - The Steering Committee noted that many commercial plans use the USPSTF guidelines (screenings begin at age 50).
    - The developer noted that this could possibly be addressed by stratifying the reporting by age group.
    - The developer stated that this measure is being reevaluated this summer, but the finalization of the measure won't be complete until the summer of 2013.
    - The developer stated that most oncology societies are endorsing biennial mammograms beginning at age 40, which is in line with this measure.

  The Steering Committee was concerned that the inclusion of the 40 to 50 year old patient population in the measure may distract from the importance of the intervention for the 50 to 70 year old patient population, where there is clear consensus that the screening intervention is warranted and the median age of breast cancer is 65.
- The Steering Committee moved to vote on all criteria for the measure even though it did not meet subcriteria 1c. Evidence for Importance to Measure and Report. The Steering Committee acknowledged that the measure focus is important and the intervention is crucial for many patients in this patient population. Steering Committee concern with the evidence for the measure focused solely on the disparities between guideline recommendations for the age when mammography screening should begin. The Steering Committee wanted to seek input from the NQF members and the public as to what patient population should be captured by this measure.

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

0031 Breast Cancer Screening

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-6; M-3; L-0; I-2; 2b. Validity: H-0; M-6; L-2; I-3

Rationale:

- The Steering Committee agreed the measure is reliable.
- The validity is an issue with respect to the age captured by the measure. The Committee was concerned that if providers are following different guidelines, the measure may not be a valid representation of the quality of care.

3. Usability: H-2; M-5; L-2; I-2

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

Rationale:

- The measure is in use in the Healthcare Effectiveness Data and Information Set (HEDIS).
- The measure is easily understood by the public, although there is some concern that there may be confusion because the measure includes age ranges that differ from the USPSTF recommendation.

4. Feasibility: H-9; M-2; L-0; I-0

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Rationale:

- The measure is in the HEDIS measure set and would be captured easily.

Steering Committee Recommendation for Endorsement: Y-2 ; N-9

The Steering Committee requests NQF Member and Public comment on this measure.

Rationale:

- The measure is high impact and a significant performance gap has been demonstrated. It is not clear which guidelines the measure should be conformed to, but the Steering Committee feels the intervention is very important.
- The measure did not pass subcriteria 1c. Evidence for Importance to Measure and Report. The Steering Committee acknowledged that the measure focus is important and the intervention is crucial for many patients in this patient population. Steering Committee concern with the evidence for the measure focused solely on the disparities between guideline recommendations for the age when mammography screening should begin.
- The measure passed all other major criteria for NQF endorsement.

Public and Member Comment

Comments included:

- While there were relatively few comments on this measure, some were supportive of the measure as specified, while another expressed concern that the measure was not consistent with the U.S. Preventive Services Task Force (USPSTF) cancer screening guidelines.
- One commenter suggested that the measure might be stratified by women aged 40 to 49, and women aged 50 and older as a way to address concerns about conflicting guideline recommendations regarding the appropriate age to begin biennial screening mammograms.

Developer Response:

- The developer stated that NCQA currently is re-evaluating this measure under its HEDIS measures process. Per this

process, they are obtaining feedback from multiple stakeholder groups, including breast cancer experts, practicing physicians, consumers and health plans. The developer is working to understand how the measure can best represent the full picture of evidence-based guidelines, as the current U.S. Preventives Services Task Force guideline recommends biennial screening for women aged 50 to 74, noting that screening before age 50 should be an individual decision that takes into account patient context and values. The developer is cognizant that many organizations currently recommend screening begin at age 40. One option the developer is exploring is to stratify the measure by age. Per the measure developer's process changes to the measure, including stratification by age, would be made available for public comment in spring of 2013.

- The developer stated that many professional organizations, including American Congress of Obstetricians and Gynecologists, American Cancer Society, American College of Radiology, American Society of Breast Surgeons, and the Society of Breast Imaging recommend biennial mammography screening for women aged 40 to 49.

Steering Committee Response:

- Steering Committee members stated that there is incontrovertible evidence regarding the utility of this measure for women aged 50 to 74; however, at present the benefits for women aged 40 to 49 are unclear.
- The Steering Committee agreed that quality measures must be supported by consistent, high-level evidence demonstrating that the focus of the measure is recommended, quality care. At present, there is conflicting evidence for which age range of women should receive biennial mammogram screenings. The Steering Committee stated concern that given the conflicting guidelines, it would be difficult to endorse this measure for use for accountability purposes.
- The Steering Committee noted that there is a difference between a quality measure and good clinical practice; though, many providers still recommend biennial screening for women aged 40 to 49, quality measures (particularly those used for accountability purposes) should be based on consistent evidence rather than the current state of clinical care.
- The Steering Committee raised concerns that stratification of the measure by age, 40 to 49 and 50 to 74, does not address the issue of conflicting evidence. Stratifying the measure will result in the reported measure data on women aged 40 to 49 not being meaningful, and users of the measure will be unclear as to how to use the data. Steering Committee measures suggested that two separate measures addressing these age groups may be the most appropriate action to take, as guidelines indicate that providers for women aged 40 to 49 needs to take into account variables such as the patient's family history and preferences for screening.
    - The developer responded that stratifying the measure would allow programs to choose how to implement the measure, allowing the programs to use the measure for patients aged 50 to 74 for accountability or public reporting purposes while still tracking mammography screening in patients aged 40 to 49.
    - The developer stated that this is a long-standing measure currently used in HEDIS. It will continue to be used in HEDIS while modifications to the measure are being made. These modifications may include stratification by age; however, the developer was unsure that this would be the final outcome. The developer stated that an expert group will be convened to modify the measure in fall 2012; the modifications will be posted for public comment in early 2013. The modifications to the measure will be finalized in spring 2013.
    - NQF would be pleased to review the revised NCQA measure when it is finalized and an appropriate endorsement project is available.

Taking into consideration the information presented on the follow up conference call, Steering Committee members re-voted on the measure. The voting results are presented below:

1. Importance to Measure and Report: <u>The measure does not meet the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

0031 Breast Cancer Screening

1a. Impact: H-9; M-4; L-1; I-1; 1b. Performance Gap: H-3; M-11; L-0; I-1; 1c. Evidence: Y-4; N-3; I-8

2. Scientific Acceptability of Measure Properties: <u>The measure meets the Scientific Acceptability criteria.</u>

(2a. Reliability – precise specifications, testing; 2b. Validity – testing, threats to validity)

2a. Reliability: H-8; M-3; L-1; I-3; 2b. Validity: H-2; M-6; L-4; I-3

3. Usability: <u>H-4; M-9; L-1; I-1</u>

(*Meaningful, understandable, and useful to the intended audiences for 3a. Public Reporting and 3b. Quality Improvement)*

4. Feasibility: <u>H-6; M-5; L-2; I-2</u>

(4a. Clinical data generated during care process; 4b. Electronic data; 4c.Susceptibility to inaccuracies/ unintended consequences identified 4d. Data collection strategy can be implemented)

Steering Committee Recommendation for Endorsement: <u>Y-2; N-13</u>

<u>The measure did not meet the Importance criteria. The Steering Committee did not recommend measure 0031 for endorsement.</u>

0623 History of Breast Cancer - Cancer Surveillance

Status: Maintenance, Original Endorsement: Dec 04, 2009, Most Recent Endorsement: Sep 02, 2011

Description: The percentage of women with a history of breast cancer treated with curative intent who had breast cancer surveillance for local regional recurrence (LRR)annually.

Numerator Statement: Women with a history of breast cancer treated with curative intent who had surveillance for breast LRR annually.

Denominator Statement: Women with a history of non-metastatic invasive breast cancer who have been treated with curative intent more than one year ago.

Exclusions: 1. Bilateral mastectomy

2. Evidence of metastatic disease

3. Provider or patient feedback stating patient does not have a diagnosis of breast cancer

5. General exclusions:

a. Patients who have been in a skilled nursing facility in the past 3 months

b. Patients who are terminally ill

c. Active treatment of malignancy (chemotherapy or radiation therapy) in the last 6 months

Adjustment/Stratification: No risk adjustment or risk stratification No risk adjustment is done with our measure, therefore, we do not have a risk model. This measure addresses all patients with a history of breast cancer who have been treated with curative intent. Using our highly specific algorithms, women with a history of breast cancer treated surgically are included in the denominator. This measure

Level of Analysis: Population : National

Type of Measure: Process

Data Source: Administrative claims, Healthcare Provider Survey, Patient Reported Data/Survey

Measure Steward: ActiveHealth Management

Steering Committee In-Person May 23-24, 2012

1. Importance to Measure and Report: <u>The measure does not meet the Importance criteria.</u>

(1a. High Impact; 1b. Performance Gap; 1c. Evidence)

1a. Impact: H-0; M-4; L-6; I-3; **1b. Performance Gap: H-1; M-4; L-1; I-7; 1c. Evidence: Y-0, N-7, I-6**

<u>Rationale</u>:

- The evidence is unclear whether lumpectomy plus radiation therapy has led to the improved survival, rather than increased surveillance.
- The Steering Committee was concerned that the evidence does not demonstrate improved outcomes from this intervention. Data show the same rate of survival for patients who received surveillance and those who did not.
    - The developer stated that incidence of relapse free survival is not the same, and that early detection leads to salvage therapy.
    - The Steering Committee noted that local recurrence risks are in the low single digits, and the false positive rate is higher in this patient population.
- The vast majority of patients captured by this measure would be captured by other measures for mammography.
- Multiple data sets show that the breast conservation population has a poor prognosis with recurrence.

Steering Committee Recommendation for Endorsement: The measure failed the Importance criteria.

0623 History of Breast Cancer - Cancer Surveillance
Public and Member Comments Comments included: • One supportive comment for the measure.

Measures Withdrawn from consideration

4 measures previously endorsed by NQF have not been re-submitted or withdrawn from maintenance of endorsement. The following measures are being retired from endorsement:

Measure	Reason for retirement
0222 : Patients with early stage breast cancer who have evaluation of the axilla	Measure was withdrawn by NQF staff as there was no steward for the submission.
0224 : Completeness of pathology reporting	Measure was withdrawn by NQF staff as there was no steward for the submission.
0388 : Prostate Cancer: Three-Dimensional Radiotherapy	Measure developer asked to withdraw the measure as the evidence supporting the measure has become outdated.
0572 : Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	Measure developer chose to withdraw the measure, citing a lack of available resources to maintain the measure.

Endnotes

[1] U.S. Department of Health and Human Services (DHHS), National Institutes of Health (NIH), National Cancer Institute (NCI), Defining Cancer. Updated 07/12/2010. Bethesda, MD:NCI, 2010. Available at www.cancer.gov/cancertopics/cancerlibrary/what-is-cancer. Last accessed February 2011.

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[3] Ibid. Available at http://www.cancer.org/Research/CancerFactsFigures/CancerFactsFigures/cancer-facts-and-figures-2010. Last accessed February 2011.

[4] McGlynn EA, Asch SM, Adams J, et al. The quality of health care delivered to adults in the United States. [see comment]. New England Journal of Medicine. 2003;348(26):2635-2645, and Harlan LC, Greene AL, Clegg LX, Mooney M, Stevens JL, Brown ML. Insurance status and the use of guideline therapy in the treatment of selected cancers. [see comment]. Journal of Clinical Oncology. 2005;23(36):9079-9088, as cited in National Quality Forum (NQF). The Current State of Cancer Quality Measurement 2008: A White Paper. Washington, DC: NQF; 2008.

[5] Du XL, Lin CC, Johnson NJ et al., Effects of individual-level socioeconomic factors on racial disparities in cancer treatment and survival: findings from the National Longitudinal Mortality Study, 1979-2003, Cancer, 2011.

[6] Byers T, Two decades of declining cancer mortality: progress with disparity, Annu Rev Public Health, 2010;31:121.132.

[7] Sherr DL, Stessin AM, Demographic disparities in patterns of care and survival outcomes for patients with resected gastric adenocarcinoma. Cancer Epidemiol Biomarkers Prev. 2011 Mar;20(2):223-33.

[8] Slatore CG, Au DH, Gould MK; American Thoracic Society Disparities in Healthcare Group, An official American Thoracic Society systematic review: insurance status and disparities in lung cancer practices and outcomes. Am J Respir Crit Care Med. 2010 Nov 1;182(9):1195-205.

[9] *Screening for Breast Cancer*, Topic Page. July 2010. U.S. Preventive Services Task Force. http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm. Last accessed June 2012.

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	0210 Proportion receiving chemotherapy in the last 14 days of life
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Records, Electronic Clinical Data : Pharmacy, Electronic Clinical Data : Registry Medicare claims and denominator file
Level	Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and received chemotherapy in the last 14 days of life
Numerator Details	Time Window: 14 days prior to death ICD-9: 140 – 239 Chemotherapy administration codes: ICD-9 diagnosis codes: V58.1 OR ICD-9 procedure codes: 99.25 OR CPT codes: 964xx, 965xx OR HCPCS codes: J7150, J85xx, J86xx, J87xx, J8999, J9xxx, Q0083, Q0084, Q0085 OR DRG codes: 410 OR Revenue center codes: 0331, 0332, 0335 OR BETOS codes: O1D OR NDC Brand descriptions: Alkeran, Cytoxan, Methotrexate Sodium, Temodar, VePesid, Xeloda
Denominator Statement	Patients who died from cancer.
Denominator Details	Time Window: None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	N/A

	0210 Proportion receiving chemotherapy in the last 14 days of life
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care.
Stratification	None
Type Score	Rate/proportion better quality = lower score
Algorithm	

	0211 Proportion with more than one emergency room visit in the last days of life
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Records, Electronic Clinical Data : Registry Medicare claims and denominator file
Level	Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and had >1 ER visit in the last 30 days of life
Numerator Details	Time Window: 30 days prior to death ER visits documented in MEDPAR claims
Denominator Statement	Patients who died from cancer.
Denominator Details	Time Window: None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	N/A

	0211 Proportion with more than one emergency room visit in the last days of life
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. No risk adjustment is necessary. The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting 'Cancer' as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate.
Stratification	No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992)to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.
Type Score	Rate/proportion better quality = lower score
Algorithm	

	0213 Proportion admitted to the ICU in the last 30 days of life
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Records, Electronic Clinical Data : Registry Medicare claims and denominator file
Level	Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Hospital/Acute Care Facility
Numerator Statement	Patients who died from cancer and were admitted to the ICU in the last 30 days of life
Numerator Details	Time Window: 30 days before death MEDPAR only: did not include SNF claims did not include pediatric, psychiatric, burn or trauma ICUs (MEDPAR variable increind ne 3,4,7,8) • variable in MEDPAR called incrdays, which is number of ICU days per visit • used hospital admission date variable (admitdate) and then checked if incrdays was >0 for admissions occurring in the last 30 days before death
Denominator Statement	Patients who died from cancer.

	0213 Proportion admitted to the ICU in the last 30 days of life
Denominator Details	Time Window: None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	N/A
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons. Since, however, comorbidity risks could increase the likelihood of experiencing this process of care, stratification or adjustment as described above can be considered. The Deyo modification of the Charlson score can be applied to claims as this measure may be sensitive to comorbidity, omitting 'Cancer' as a comorbid condition in the calculation, and used as an independent variable in a regression model to predict an adjusted rate.
Stratification	No stratification was used in the measure´s development or evaluation, however, it would be reasonable to apply the Deyo modification of the Charlson score (Deyo RA, Cherkin DC, Ciol MA: Adapting a clinical comorbidity index for use with ICD-9-CM administrative databases. J Clin Epidemiol 45:613-619, 1992)to claims and stratifying for comorbidities, e.g., scores of 0, 1, or 2+.
Type Score	Rate/proportion better quality = lower score
Algorithm	

	0215 Proportion not admitted to hospice
Status	Maintenance, Original Endorsement: Aug 10, 2009, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer not admitted to hospice
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Records, Electronic Clinical Data : Registry Medicare claims and denominator file
Level	Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Hospice
Numerator Statement	Patients who died from cancer without being admitted to hospice
Numerator Details	Time Window: None Those without claims in Medicare HOSPICE file. No codes used.
Denominator Statement	Patients who died from cancer.

	0215 Proportion not admitted to hospice
Denominator Details	Time Window: None Medicare patients in the death registry with cancer as their cause of death. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	None
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, i
Stratification	None
Type Score	Rate/proportion better quality = lower score
Algorithm	

	0216 Proportion admitted to hospice for less than 3 days
Status	Maintenance, Original Endorsement: Oct 01, 2007, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Management Data, Paper Records, Electronic Clinical Data : Registry Medicare claims and denominator file
Level	Population : County or City, Facility, Clinician : Group/Practice, Health Plan, Integrated Delivery System, Population : National, Population : Regional, Population : State
Setting	Hospice
Numerator Statement	Patients who died from cancer and spent fewer than three days in hospice.
Numerator Details	Time Window: 3 days Medicare HOSPICE file only: Subtracted hospice admission date (admndate) from death date variable to get hospice length of stay No codes used.
Denominator Statement	Patients who died from cancer who were admitted to hospice

	0216 Proportion admitted to hospice for less than 3 days
Denominator Details	Time Window: None Patients in the death registry with cancer as their cause of death who also appear in the Medicare hospice file. In the cited analyses by the measure submitter, this is a field in the cancer registry or denominator file not requiring specific codes. This may be different in other administrative data sets.
Exclusions	None
Exclusion Details	
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification is necessary because a) the measure is intended to be used for comparison among similar providers; unless there is a reason to believe that one providers' patients have significantly different risks than others, it will not affect relative comparisons, and b) comorbidity risks will if anything decrease the likelihood of experiencing this process of care.
Stratification	None
Type Score	Rate/proportion better quality = lower score
Algorithm	

	0219 Post breast conservation surgery irradiation
Status	Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	Commission on Cancer, American College of Surgeons Other organizations: This measure was harmonized with measure development efforts coordinated between the American Society of Clinical Oncology (ASCO) and The National Cancer Care Network (NCCN) prior to NQF's formal review and consideration of measures submitted in response to its call for measures in 2005 as part of it's Quality of Cancer Care Performance Measures project (Desch CE, McNiff KK, Schneider EC, et al. American Society of Clinical Oncology / National Comprehensive Cancer Network Quality Measures. J Clin Oncol 2008;26:3631-3637). The measure, as specified here, has not been altered or changed in any way since harmonization of specifications between these three organizations occured in the fall of 2006.
Description	Percentage of female patients, age 18-69, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, receiving breast conserving surgery who receive radiation therapy within 1 year (365 days) of diagnosis.
Type	Process
Data Source	Paper Medical Records, Electronic Clinical Data : Registry Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Radiation therapy to the breast is initiated within 1 year (365 days) of the date of diagnosis

	0219 Post breast conservation surgery irradiation
Numerator Details	Time Window: 1 year (365 days) Regional Treatment Modality [NAACCR Item#1570]=20-98, and Date Radiation Started [NAACCR Item#1210] <= 365 days following the Date of Diagnosis [NAACCR Item#340]
Denominator Statement	Include, if all of the following characteristics are identified: Women Age 18-69 at time of diagnosis Known or assumed to be first or only cancer diagnosis Primary tumors of the breast Epithelial malignancy only AJCC Stage I, II, or III Surgical treatment by breast conservation surgery (surgical excision less than mastectomy) All or part of 1st course of treatment performed at the reporting facility Known to be alive within 1 year (365 days) of diagnosis
Denominator Details	Time Window: Typically a 12 month, calendar year, time period Sex [NAACCR Item#220]=2; Age at Diagnosis [NAACCR Item#230] < 70; AND Surgical Procedure of the Primary Site [NAACCR Item#1290] = 20–24
Exclusions	Exclude, if any of the following characteristics are identified: Men Under age 18 at time of diagnosis Over age 69 at time of diagnosis Second or subsequent cancer diagnosis Tumor not originating in the breast Non-epithelial malignancies Stage 0, in-situ tumor Stage IV, metastatic tumor None of 1st course therapy performed at reporting facility Died within 12 months (365 days) of diagnosis
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf
Risk Adjustment	No risk adjustment or risk stratification
Stratification	No stratification applied
Type Score	Rate/proportion better quality = higher score
Algorithm	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf

	0220 Adjuvant hormonal therapy
Status	Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Oct 22, 2012 Time-limited

	0220 Adjuvant hormonal therapy
Steward	Commission on Cancer, American College of Surgeons Other organizations: This measure was harmonized with measure development efforts coordinated between the American Society of Clinical Oncology (ASCO) and The National Cancer Care Network (NCCN) prior to NQF's formal review and consideration of measures submitted in response to its call for measures in 2005 as part of it's Quality of Cancer Care Performance Measures project (Desch CE, McNiff KK, Schneider EC, et al. American Society of Clinical Oncology / National Comprehensive Cancer Network Quality Measures. J Clin Oncol 2008;26:3631-3637). The measure, as specified here, has not been altered or changed in any way since harmonization of specifications between these three organizations occured in the fall of 2006.
Description	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who's primary tumor is progesterone or estrogen receptor positive recommended for tamoxifen or third
Type	Process
Data Source	Paper Records, Electronic Clinical Data : Registry Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Hormone therapy is considered or administered within 1 year (365 days) of the date of diagnosis
Numerator Details	Time Window: 1 year (365 days) Hormone Therapy [NAACCR Item#1400]=82-87 OR; Hormone Therapy [NAACCR Item#1400]=1, AND Date Hormone Therapy Started (NAACCR Item#710] <=365 days following Date of Diagnosis [NAACCR Item# 340]
Denominator Statement	Include if all of the following characteristics are identified: Women Age >=18 at time of diagnosis Known or assumed to be first or only cancer diagnosis Epithelial malignancy only Primary tumors of the breast AJCC T1c or Stage II or III Primary tumor is estrogen receptor positive or progesterone receptor positive All or part of 1st course of treatment performed at the reporting facility Known to be alive within 1 year (365 days) of date of diagnosis
Denominator Details	Time Window: Typically a 12 month, calendar year, time period Sex [NAACCR Item#220]=2; CS Tumor Size [NAACCR Item#2800= 010 and AJCC pN [NAACCR Item#890]=0, OR AJCC pN [NAACCR Item#890]=1, 2, or 3; AND CS SSF1 (ERA) [NAACCR Item#2880]=010 or 030; AND CS SSF2 (PRA) [NAACCR Item#2890]=010 or 030; AND Surgical Procedure of the Primary Site [NAACCR Item#1290] = 20–90

	0220 Adjuvant hormonal therapy
Exclusions	Exclude, if any of the following characteristics are identified: Men Under age 18 at time of diagnosis Second or subsequent cancer diagnosis Tumor not originating in the breast Non-epithelial malignancies Stage 0, in-situ tumor AJCC T1mic, T1a, or T1b tumor Stage IV, metastatic tumor Primary tumor is estrogen receptor negative and progesterone receptor negative None of 1st course therapy performed at reporting facility Died within 1 year (365 days) of diagnosis
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf
Risk Adjustment	No risk adjustment or risk stratification
Stratification	No stratification applied
Type Score	Rate/proportion better quality = higher score
Algorithm	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf

	0221 Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection
Status	Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	Commission on Cancer, American College of Surgeons
Description	Percentage of patients presenting with AJCC Stage Group 0, I, II, or III disease, who undergo surgical excision/resection of a primary breast tumor who undergo a needle biopsy to establish diagnosis of cancer preceding surgical excision/resection.
Type	Process
Data Source	Paper Records, Electronic Clinical Data : Registry Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Patient whose date of needle biopsy precedes the date of surgery.
Numerator Details	Time Window: Prior to, but not including, the day of surgical treatment Surgical Diagnostic And Staging and Procedure [NAACCR Item#1350]=2; AND Date of Surgical Diagnostic And Staging and Procedure [NAACCR Item#1280] < Date of First Surgical Procedure [NAACCR Item#1200]

	0221 Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection
Denominator Statement	Women with AJCC Stage 0, I, II, or II breast cancer undergoing surgery: • Women • Age >=18 at time of diagnosis • Known or assumed first or only cancer diagnosis • Primary tumors of the breast • Epithelial invasive malignancy only • Surgically treated • Diagnosis and all or part of first course of treatment performed at the reporting facility
Denominator Details	Time Window: Typically a 12 month, calendar year, time period Sex [NAACCR Item#220]=2; Pathologic Stage Group [NAACCR Item#910] = IA, IB, IIA, IIB, IIIA, IIIB or IIIC, AND Surgical Procedure of the Primary Site at This Facility [NAACCR Item#670] = 20–90
Exclusions	Exclusions: Men; not a first or only cancer diagnosis; non-epithelial tumors; metastatic disease (AJCC Stage IV); not treated surgically; died before surgery
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf
Risk Adjustment	No risk adjustment or risk stratification
Stratification	No stratification applied
Type Score	Rate/proportion better quality = higher score
Algorithm	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf

	0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
Status	Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	Commission on Cancer, American College of Surgeons Other organizations: This measure was harmonized with measure development efforts coordinated between the American Society of Clinical Oncology (ASCO) and The National Cancer Care Network (NCCN) prior to NQF's formal review and consideration of measures submitted in response to its call for measures in 2005 as part of it's Quality of Cancer Care Performance Measures project (Desch CE, McNiff KK, Schneider EC, et al. American Society of Clinical Oncology / National Comprehensive Cancer Network Quality Measures. J Clin Oncol 2008;26:3631-3637). The measure, as specified here, has not been altered or changed in any way since harmonization of specifications between these three organizations occured in the fall of 2006.
Description	Percentage of patients under the age of 80 with AJCC III (lymph node positive) colon cancer for whom adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis.
Type	Process

	0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
Data Source	Paper Records, Electronic Clinical Data : Registry Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Chemotherapy is considered or administered within 4 months (120 days) of diagnosis
Numerator Details	Time Window: 4 months (120 days) Chemotherapy [NAACCR Item#1390]=82-87 OR; Chemotherapy [NAACCR Item#1390]=3, and Date Chemotherapy Started (NAACCR Item#1220] <=120 days following Date of Diagnosis [NAACCR Item# 340]
Denominator Statement	Include, if all of the following characteristics are identified: Age 18-79 at time of diagnosis Known or assumed to be first or only cancer diagnosis Primary tumors of the colon Epithelial malignancy only At least one pathologically examined regional lymph node positive for cancer (AJCC Stage III) All or part of 1st course of treatment performed at the reporting facility2 Known to be alive within 4 months (120 days) of diagnosis
Denominator Details	Time Window: Typically a 12 month, calendar year, time period Age at Diagnosis [NAACCR Item#230] < 80, AND Surgical Procedure of the Primary Site [NAACCR Item#1290] = 30–90, AND Regional Lymph Nodes Positive [NAACCR Item#820] = 1-90, 95, 97
Exclusions	Exclude, if any of the following characteristics are identified: Age <18 and >=80; not a first or only cancer diagnosis; non-epithelial and non-invasive tumors; no regional lymph nodes pathologically examined; metastatic disease (AJCC Stage IV); not treated surgically; died within 4 months (120 days) of diagnosis
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf
Risk Adjustment	No risk adjustment or risk stratification
Stratification	No stratification applied
Type Score	Rate/proportion better quality = higher score
Algorithm	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf

	0225: At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.
Status	Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Oct 22, 2012 Time-limited

	0225: At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer.
Steward	Commission on Cancer, American College of Surgeons
Description	Percentage of patients >18yrs of age, who have primary colon tumors (epithelial malignancies only), experiencing their first diagnosis, at AJCC stage I, II or III who have at least 12 regional lymph nodes removed and pathologically examined for resected c
Type	Process
Data Source	Paper Records, Electronic Clinical Data : Registry Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	>=12 regional lymph nodes pathologically examined.
Numerator Details	Time Window: Not applicable Regional Lymph Nodes Examined [NAACCR Item#830] = 12-90
Denominator Statement	Include, if all of the following characteristics are identified: Age >=18 at time of diagnosis Known or assumed to be first or only cancer diagnosis Primary tumors of the colon Epithelial malignancy only AJCC Stage I, II, or III Surgical resection performed at the reporting facility
Denominator Details	Time Window: Typically a 12 month, calendar year, time period Surgical Procedure of the Primary Site at This Facility [NAACCR Item#670] = 30-80
Exclusions	Exclude, if any of the following characteristics are identified: Age <18; not a first or only cancer diagnosis; non-epithelial and non-invasive tumors; metastatic disease (AJCC Stage IV); not treated surgically at the reporting facility
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf
Risk Adjustment	No risk adjustment or risk stratification
Stratification	No stratification applied
Type Score	Rate/proportion better quality = higher score
Algorithm	

	0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited

	0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: The American Society of Hematology
Description	Percentage of patients aged 18 years and older with a diagnosis of MDS or an acute leukemia who had baseline cytogenic testing performed on bone marrow.
Type	Process
Data Source	Administrative claims, Electronic Clinical Data : Laboratory Not Applicable Attachment 0377 Cytogenetic Testing Data Eelements_FINAL.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office, Laboratory
Numerator Statement	Patients who had baseline cytogenetic testing* performed on bone marrow Definition: *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis.
Numerator Details	Time Window: At least once during measurement period Definition: *Baseline Cytogenetic Testing- Testing that is performed at time of diagnosis or within three years prior to initiating treatment (transfusion, growth factors, or antineoplastic therapy) for that diagnosis. For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims. Report the CPT Category II code: 3155F – Cytogenetic testing performed on bone marrow at time of diagnosis or prior to initiating treatment
Denominator Statement	All patients aged 18 years and older with a diagnosis of MDS or an acute leukemia
Denominator Details	Time Window: 12 consecutive months For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims data AGE: >= 18 years and older AND Diagnosis: Myelodysplastic Syndrome (MDS) and Acute Leukemias ICD-9-CM diagnosis codes: 204.00, 204.02, 205.00, 205.02, 206.00, 206.02, 207.00, 207.02, 207.20, 207.22, 208.00, 208.02, 238.72, 238.73, 238.74, 238.75 ICD-10-CM diagnosis codes: C91.00, C91.02, C92.00, C92.02, C92.40, C92.42, C92.50, C92.52, C92.60, C92.62, C92.a0, C92.a2, C93.00, C93.02, C94.00, C94.02, C94.20, C94.22, C95.00, C95.02, D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.a, D46.b, D46.c, D46.z AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of medical reason(s) for not performing baseline cytogenetic testing Documentation of patient reason(s) for not performing baseline cytogenetic testing Denominator Exclusions: Documentation of system reason(s) for not performing baseline cytogenetic testing

	0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason, patient or system reason for not performing baseline cytogenetic testing. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: Denominator Exceptions: Documentation of medical reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., no liquid bone marrow or fibrotic marrow) Append modifier to CPT Category II code: 3155F-1P Documentation of patient reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., at time of diagnosis receiving palliative care or not receiving treatment as defined above) Append modifier to CPT Category II code: 3155F-2P Documentation of system reason(s) for not performing baseline cytogenetic testing on bone marrow (e.g., patient previously treated by another physician at the time of cytogenetic testing performed) Append modifier to CPT Category II code: 3155F-3P
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0377 Myelodysplastic Syndrome (MDS) and Acute Leukemias – Baseline Cytogenetic Testing Performed on Bone Marrow
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [e.g., medical, system or patient reason for not performing baseline cytogenetic testing). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment Generic Measure Logic.pdf

	0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Society of Hematology
Description	Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores within 60 days prior to initiating erythropoietin therapy
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory Not Applicable Attachment 0378 MDS_Iron Stores Data Elements_FINAL.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office/Clinic, Laboratory, Ambulatory Care : Urgent Care
Numerator Statement	Patients with documentation* of iron stores within 60 days prior to initiating erythropoietin therapy *Definition: documentation of iron stores which includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC

	0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
Numerator Details	Time Window: At least once during measurement period *Definition: documentation of iron stores which includes either: 1) bone marrow examination including iron stain OR 2) serum iron measurement including ferritin, serum iron and TIBC Definition: Erythropoietin Therapy: Includes the following medications: epoetin and darbepoetin for the purpose of this measure. For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: CPT Category II code: 3160F: Documentation of iron stores prior to initiating erythropoietin therapy
Denominator Statement	All patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy
Denominator Details	Time Window: 12 consecutive months For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: AGE: >= 18 years and older ICD-9-CM diagnosis codes: 238.72, 238.73, 238.74, 238.75 ICD-10-CM diagnosis codes: D46.0, D46.1, D46.20, D46.21, D46.22, D46.4, D46.9, D46.a, D46.b, D46.c, D46.z Diagnosis: MDS AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 AND CPT category II 4090F: Patient receiving erythropoietin therapy
Exclusions	Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy

	0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include system reasons, e.g. for not documenting iron stores prior to initiating erythropoietin therapy. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: Denominator Exceptions: Documentation of system reason(s) for not documenting iron stores prior to initiating erythropoietin therapy Append modifier to CPT Category II code: 3160F-3P
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0378 MDS: Documentation of Iron Stores in Patients Receiving Erythropoietin Therapy
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: or system reason(s) (eg, for not documenting iron stores prior to initiating erythropoietin therapy)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See attached calculation algorithm in 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634631931846113738.pdf

	0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Society of Hematology
Description	Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory Attachment AMA-PCPI_0379_HEM CLLCytometry_DATAELEMENTS.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Laboratory
Numerator Statement	Patients who had baseline flow cytometry studies performed and documented in the chart Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy.

	0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
Numerator Details	Time Window: At least once during the measurement period Definition: *Baseline flow cytometry studies: Refer to testing that is performed at time of diagnosis or prior to initiating treatment for that diagnosis. Treatment may include antineoplastic therapy. For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: CPT Category II code: 3170F – Baseline flow cytometry studies performed
Denominator Statement	All patients aged 18 years and older seen within a 12 month reporting period, with a diagnosis of chronic lymphocytic leukemia (CLL) made at any time during or prior to the reporting period
Denominator Details	Time Window: 12 consecutive months For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. AGE: >= 18 years and older AND Diagnosis: Chronic Lymphocytic Leukemia ICD-9-CM diagnosis codes: 204.10, 204.12 ICD-10-CM diagnosis codes: C91.10, C91.12 AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of medical reason(s) for not performing baseline flow cytometry Documentation of patient reason(s) for not performing baseline flow cytometry Documentation of system reason(s) for not performing baseline flow cytometry

	0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason, e.g. for not performing baseline flow cytometry; patient reason, e.g. for not performing baseline flow cytometry (for example, receiving palliative care or not receiving treatment as defined above) or system reason, e.g. for not performing baseline flow cytometry (for example, patient previously treated by another physician at the time baseline flow cytometry studies were performed). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims Denominator Exceptions: Documentation of medical reason(s) for not performing baseline flow cytometry studies Append modifier to CPT Category II code: 3170F-1P Documentation of patient reason(s) for not performing baseline flow cytometry studies (e.g., receiving palliative care or not receiving treatment as defined above) Append modifier to CPT Category II code: 3170F-2P Documentation of system reason(s) for not performing baseline flow cytometry studies (e.g., patient previously treated by another physician at the time baseline flow cytometry studies were performed) Append modifier to CPT Category II code: 3170F-3P
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0379 Chronic Lymphocytic Leukemia (CLL) – Baseline Flow Cytometry
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [For this measure: exceptions may include medical reason, e.g. for not performing baseline flow cytometry; patient reason, e.g. for not performing baseline flow cytometry (for example, receiving palliative care or not receiving treatment as defined above) or system reason, e.g. for not performing baseline flow cytometry (for example, patient previously treated by another physician at the time baseline flow cytometry studies were performed)]. f the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment Generic Measure Logic-634620664214998929.pdf

	0380 Multiple Myeloma – Treatment with Bisphosphonates
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Society of Hematology
Description	Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records Attachment 0380_multiple myeloma DE.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinic/Urgent Care, Ambulatory Care : Clinician Office

	0380 Multiple Myeloma – Treatment with Bisphosphonates
Numerator Statement	Patients who were prescribed or received intravenous bisphosphonate therapy* within the 12 month reporting period. Definition: *Bisphosphonate Therapy: Includes the following medications: pamidronate and zoledronate
Numerator Details	Time Window: At least once during the measurement period Definition: *Bisphosphonate Therapy: Includes the following medications: pamidronate and zoledronate Definition: Prescribed: Includes patients who are currently receiving medication(s) that follow the treatment plan recommended at an encounter during the reporting period, even if the prescription for that medication was ordered prior to the encounter For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: CPT Category II code: 4100F – Intravenous bisphosphonate therapy prescribed or received
Denominator Statement	All patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission
Denominator Details	Time Window: 12 consecutive months For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. AGE: >=18 years and older AND Diagnosis: Multiple Myeloma ICD-9-CM diagnosis codes: 203.00, 203.02 ICD-10-CM diagnosis codes: C90.00, C90.02 AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) Documentation of patient reason(s) for not prescribing bisphosphonates

	0380 Multiple Myeloma – Treatment with Bisphosphonates
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s), e.g. for not prescribing bisphosphonates (patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) or patient reason(s), e.g. for not prescribing bisphosphonates. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: especification currently under development. Data elements (using Quality Data Model) required for the measure attached. Administrative claims: Denominator Exceptions: Documentation of medical reason(s) for not prescribing bisphosphonates (eg, patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) Append modifier to CPT Category II code: 4100F-1P Documentation of patient reason(s) for not prescribing bisphosphonates Append modifier to CPT Category II code: 4100F-2P
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0380 Multiple Myeloma – Treatment with Bisphosphonates
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: exceptions may include medical reason(s), e.g. for not prescribing bisphosphonates (patients who do not have bone disease, patients with dental disease, patients with renal insufficiency) or patient reason(s), e.g. for not prescribing bisphosphonates]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment Generic Measure Logic-634620584294869354.pdf

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: The measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy who have a treatment summary report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records, Electronic Clinical Data : Registry Not Applicable Attachment AMA-PCPI_0381_DataElements_AppendixA.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
Numerator Statement	Patients who have a treatment summary* report in the chart that was communicated to the physician(s) providing continuing care and to the patient within one month of completing treatment Definition: *Treatment Summary: a report that includes mention of all of the following components: 1) dose delivered; 2) relevant assessment of tolerance to and progress towards the treatment goals; and 3)subsequent care plans Numerator Instructions: This measure should be reported once per course of radiation treatment – less than or equal to 30 days from the end of treatment.
Numerator Details	Time Window: <= one month after completion of therapy during measurement period For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: Report CPT Category II code: 5020F - Treatment summary report communicated to physician(s) managing continuing care and to the patient within one month of completing treatment
Denominator Statement	All patients, regardless of age, with a diagnosis of cancer who have undergone brachytherapy or external beam radiation therapy
Denominator Details	Time Window: Each course of brachytherapy or external beam radiation therapy within 12 consecutive months For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: CPT® codes for external beam radiation therapy, weekly management or brachytherapy: 77427, 77431, 77432, 77435, 77470, 77761, 77762, 77763, 77776, 77777, 77778, 77785, 77786, 77787 AND ICD-9-CM diagnosis codes: See Attached Code List (Appendix A in attachment) ICD-10-CM diagnosis codes: See Attached Code List (Appendix A in attachment)
Exclusions	Documentation of a patient reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient requests that report not be sent) and to the patient within one month of completing treatment Documentation of a system reason(s) for not communicating the treatment summary report to the physician(s) providing continuing care (eg, patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include patient (eg, patient requests that report not be sent) or system reason(s)(eg, patient does not have any physician responsible for providing continuing care) for not communicating the treatment summary report to the physician(s) providing continuing care and to the patient within one month of completing treatment. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: Documentation of patient reason(s) for not having a treatment summary report in the chart that was communicated to the physician(s) providing continuing care (eg, patient requests that report not be sent) and to the patient within one month of completing treatment • Append modifier to CPT Category II code: 5020F-2P Documentation of system reason(s) for not having a treatment summary report in the chart that was communicated to the physician(s) providing continuing care (eg, patient does not have any physician responsible for providing continuing care) and to the patient within one month of completing treatment • Append modifier to CPT Category II code: 5020F-3P
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: patient reason(s) (eg, patient requests that report not be sent) or system reason(s)(eg, patient does not have any physician responsible for providing continuing care)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620643896118889.pdf

	0381 Oncology: Treatment Summary Communication – Radiation Oncology
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	0382 Oncology: Radiation Dose Limits to Normal Tissues
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy with documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records, Electronic Clinical Data : Registry Not Applicable Attachment NQF#0382_DataElements-634620692307678721.xls

	0382 Oncology: Radiation Dose Limits to Normal Tissues
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other
Numerator Statement	Patients who had documentation in medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues
Numerator Details	Time Window: Once, prior to start of 3D conformal radiation therapy For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative Data: To submit the numerator option for patients who had documentation in the medical record that radiation dose limits to normal tissues were established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues, report the following CPT Category II code: 0520F – Radiation dose limits to normal tissues established prior to the initiation of a course of 3D conformal radiation for a minimum of two tissues or organs
Denominator Statement	All patients, regardless of age, with a diagnosis of pancreatic or lung cancer who receive 3D conformal radiation therapy
Denominator Details	Time Window: Each course of 3D conformal radiation therapy within 12 consecutive months For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative Data: ICD-9-CM diagnosis codes: 157.0, 157.1, 157.2, 157.3, 157.4, 157.8, 157.9, 162.0, 162.2, 162.3, 162.4, 162.5, 162.8, 162.9 ICD-10-CM diagnosis codes: C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C33, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92 AND • CPT code for radiation therapy 3D simulation: 77295
Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0382 Oncology: Radiation Dose Limits to Normal Tissues
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620693236747167.pdf

	0382 Oncology: Radiation Dose Limits to Normal Tissues
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	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Other, Paper Records, Electronic Clinical Data : Registry Attachment NQF_0383_DataElements_AppendixA.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team

	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
Setting	Ambulatory Care : Clinician Office, Other
Numerator Statement	Patient visits that included a documented plan of care* to address pain Numerator Instructions: *A documented plan of care may include: use of opioids, nonopioid analgesics, psychological support, patient and/or family education, referral to a pain clinic, or reassessment of pain at an appropriate time interval.
Numerator Details	Time Window: At each visit within the measurement period For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: To submit the numerator option for patient visits that included a documented plan of care to address pain, report the following CPT Category II code: 0521F – Plan of care to address pain documented
Denominator Statement	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain

	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
Denominator Details	Time Window: 12 consecutive months For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy who report having pain Eligible patients for this measure are identified by: ICD-9-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-9-CM CODES ICD-10-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-10-CM CODES AND Report CPT Category II code: 1125F: Pain severity quantified; pain present AND either option 1 or 2: 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215, AND o CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration) OR 2. Radiation therapy • CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470
Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620662541238217.pdf

	0383 Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology (paired with 0384)
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	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure set was developed in collaboration with the American Society of Clinical Oncology and the American Society for Radiation Oncology.
Description	Percentage of visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Other, Paper Records, Electronic Clinical Data : Registry Not Applicable Attachment NQF_0384_DataElements_AppendixA.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team

	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Setting	Ambulatory Care : Clinician Office, Other
Numerator Statement	Patient visits in which pain intensity is quantified* * Pain intensity should be quantified using a standard instrument, such as a 0-10 numerical rating scale, a categorical scale, or the pictorial scale
Numerator Details	Time Window: At each visit within the measurement period For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: To submit the numerator option for number of patient visits in which pain intensity was quantified, report one of the following CPT Category II codes: 1125F – Pain severity quantified; pain present OR 1126F – Pain severity quantified; no pain present
Denominator Statement	All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy

	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Denominator Details	Time Window: 12 consecutive months For EHR: eSpecification and eMeasure are currently under development (expected completion: end of Q1 2012). Data elements (using Quality Data Model) required for the measure attached (please refer to Appendix A). For Claims/Administrative Data: All visits for patients, regardless of age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy Eligible patients for this measure are identified by: ICD-9-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-9-CM CODES ICD-10-CM diagnosis codes: PLEASE REFER TO ATTACHED EXCEL FILE TITLED, APPENDIX A, FOR THE APPLICABLE ICD-10-CM CODES AND either option 1 or 2 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215 AND o CPT procedure codes: 51720, 96401, 96402, 96405, 96406, 96409, 96411, 96413, 96415, 96416, 96417, 96420, 96422, 96423, 96425, 96440, 96445, 96450, 96521, 96522, 96523, 96542, 96549 (chemotherapy administration) OR 2. Radiation therapy • CPT codes for radiation treatment weekly management: 77427, 77431, 77432, 77435, 77470
Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620671516608159.pdf

	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
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	0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure is jointly copyrighted by the AMA-PCPI, American Society of Clinical Oncology, and National Comprehensive Cancer Network. The measure set was also developed in collaboration with the American Society for Radiation Oncology.
Description	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy or have previously received adjuvant chemotherapy within the 12 month reporting period
Type	Process

	0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Electronic Clinical Data : Registry Not applicable. Zip file for data dictionary/code table to be sent separately (cannot be attached to 2a1.30).
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Other
Numerator Statement	Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy* within the 12 month reporting period Definition: Adjuvant Chemotherapy: *According to current NCCN guidelines, the following therapies are recommended: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (Category 1); bolus 5-FU/LV/oxaliplatin (FLOX, Category 1), capecitabine/oxaliplatin (CapeOx, Category 1); or single agent capecitabine (Category 2A) or 5-FU/LV (Category 2A) in patients felt to be inappropriate for oxaliplatin therapy. Due to the leucovorin shortage in the United States, levo-leucovorin used in its place may also satisfy the measure. Prescribed – may include prescription ordered for the patient for adjuvant chemotherapy at one or more visits in the 12-month period OR patient already receiving adjuvant chemotherapy as documented in the current medication list
Numerator Details	Time Window: At least once during the measurement period. For EHR: eMeasure (See attached) Administrative claims Report the CPT Category II code: 4180F - Adjuvant chemotherapy referred, prescribed, or previously received for Stage IIIA through IIIC colon cancer
Denominator Statement	All patients aged 18 years and older with Stage IIIA through IIIC colon cancer
Denominator Details	Time Window: 12 consecutive months. For EHR: eMeasure (See attached) Administrative claims data: AGE: >= 18 years AND Diagnosis: Colon Cancer ICD-9-CM diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.6, 153.7, 153.8, 153.9 (malignant neoplasm of colon). ICD-10-CM diagnosis codes: C18.0, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9 AND CPT® Codes: 99201, 99202, 99203, 99204, 99205 99212, 99213, 99214, 99215

	0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients
Exclusions	Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, medical comorbidities, patient over the age of 80, diagnosis date more than 5 years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status) Documentation of patient reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient refusal) Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, medical comorbidities, patient over the age of 80, diagnosis date more than 5 years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status), patient reason(s) (eg, patient refusal) or system reason(s) for not referring for or prescribing adjuvant chemotherapy (eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eMeasure (See attached) Administrative claims: Denominator Exceptions: Append modifier to CPT Category II code: 4180F-1P Append modifier to CPT Category II code: 4180F-2P Append modifier to CPT Category II code: 4180F-3P
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, medical comorbidities, patient over the age of 80, diagnosis date more than 5 years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status), patient reason(s) (eg, patient refusal) or system reason(s)(eg, patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment Generic Measure Logic-634620633024859689.pdf
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	0386 Oncology: Cancer Stage Documented
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure is jointly copyrighted by the AMA-PCPI and American Society of Clinical Oncology. The measure set was also developed in collaboration with the American Society for Radiation Oncology.

	0386 Oncology: Cancer Stage Documented
Description	Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records, Electronic Clinical Data : Pharmacy Not Applicable Attachment Data_Elements_0386.xls
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Other
Numerator Statement	Patients who have a baseline AJCC cancer stage* or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period Numerator Instructions: *Cancer stage refers to stage at diagnosis
Numerator Details	Time Window: At least once during the measurement period For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: To submit the numerator option for patients who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period, report one of the following CPT Category II codes: 3300F – American Joint Committee on Cancer (AJCC) stage documented and reviewed OR 3301F – Cancer stage documented in medical record as metastatic and reviewed
Denominator Statement	All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting

	0386 Oncology: Cancer Stage Documented
Denominator Details	Time Window: 12 consecutive months For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: All patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting AND ICD-9-CM diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9 (malignant neoplasm of colon), 154.0, 154.1, 154.2, 154.3, 154.8 (malignant neoplasm of rectum and anus), 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 (malignant neoplasm of female breast), V10.3, V10.05, V10.06 ICD-10-CM diagnosis codes: C18.3, C18.4, C18.6, C18.7, C18.0, C18.1, C18.2, C18.5, C18.8, C18.9, C19, C20, C21.1, C21.0, C21.2, C21.8, C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, Z85.3, Z85.038, Z85.048 AND either option 1 or 2 1. Chemotherapy • CPT codes: o 99201, 99202, 99203, 99204, 99205, o 99212, 99213, 99214, 99215, o 99241, 99242, 99243, 99244, 99245, o 99024 OR 2. Radiation therapy • CPT codes for radiation treatment planning: 77261, 77262, 77263
Exclusions	None
Exclusion Details	There are no exceptions for this measure.
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0386 Oncology: Cancer Stage Documented
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) If the measure does not have exceptions, STOP. If the measure does have exceptions, proceed with the following steps. From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception, when exceptions have been specified. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620735019045822.pdf
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	0387 Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: This measure is jointly copyrighted by the AMA-PCPI, American Society of Clinical Oncology and National Comprehensive Cancer Network. The measure set was also developed in collaboration with the American Society for Radiation Oncology.
Description	Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Electronic Clinical Data : Registry Not applicable. Zip file for data dictionary/code table to be sent separately (cannot be attached to 2a1.30).

	0387 Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic, Other
Numerator Statement	Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period Definition: Prescribed may include prescription given to the patient for tamoxifen or aromatase inhibitor (AI) at one or more visits in the 12-month period OR patient already taking tamoxifen or aromatase inhibitor (AI) as documented in the current medication list.
Numerator Details	Time Window: At least once during the measurement period For EHR: eMeasure (see attached). Administrative claims: Report the CPT Category II code: 4179F - Tamoxifen or aromatase inhibitor (AI) prescribed
Denominator Statement	All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer
Denominator Details	Time Window: 12 consecutive months For EHR: eMeasure (see attached). Administrative claims: AGE:>= 18 years and older Gender:>Female Diagnosis: Breast Cancer with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) AND ICD-9-CM diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 (malignant neoplasm of female breast ICD-10-CM diagnosis codes: C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919 AND CPT® Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, AND CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented OR CPT II 3376F: AJCC Breast Cancer Stage II, documented OR CPT II 3378F: AJCC Breast Cancer Stage III, documented AND CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

	0387 Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Exclusions	Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was >= 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period) Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient refusal) Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is currently enrolled in a clinical trial)
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was = 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period), patient reason(s) (eg, patient refusal) or system reason(s) for not prescribing tamoxifen or aromatase inhibitor (eg, patient is currently enrolled in a clinical trial). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eMeasure (see attached). Administrative claims: Append modifier to CPT Category II code: 4179F-1P Append modifier to CPT Category II code: 4179F-2P Append modifier to CPT Category II code: 4179F-3P
Risk Adjustment	No risk adjustment or risk stratification None
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0387 Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) ((eg, patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was = 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period), patient reason(s) (eg, patient refusal), or system reason(s) (eg, patient is currently enrolled in a clinical trial)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620676683828729.pdf
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	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Urological Association and American Society for Therapeutic Radiology & Oncology
Description	Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not
Type	Process

	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records, Electronic Clinical Data : Registry Not applicable.
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office, Other
Numerator Statement	Patients who did not have a bone scan performed at any time since diagnosis of prostate cancer
Numerator Details	Time Window: Once for each procedure for treatment of prostate cancer (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) For EHR: See attached eMeasure For Claims/Administrative Data: To submit the numerator option for patients who did not have a bone scan performed at any time since diagnosis of prostate cancer, report the following CPT Category II code: 3270F – Bone scan not performed prior to initiation of treatment nor at any time since diagnosis of prostate cancer
Denominator Statement	All patients, regardless of age, with a diagnosis of prostate cancer, at low risk* of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy

	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Denominator Details	Time Window: Each procedure for treatment of prostate cancer (i.e., interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy) Risk strata definitions: • Low Risk: PSA =10 mg/dL; AND Gleason score 6 or less; AND clinical stage T1c or T2a2 • Intermediate Risk: PSA >10 to 20 mg/dL; OR Gleason score 7; OR clinical stage T2b, and not qualifying for high risk2 • High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinical stage T2c or greater; and not qualifying for very high risk2 Note: Only patients with prostate cancer with low risk of recurrence will be counted in the denominator of this measure For EHR: See attached eMeasure For Claims/Administrative Data: All patients with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy ICD-9-CM diagnosis code: 185 ICD-10-CM diagnosis code: C61 AND CPT codes: 55810, 55812, 55815 (perineal prostatectomies); 55840, 55842, 55845 (retropubic prostatectomies); 55866 (laparoscopic prostatectomy); 55873 (cryotherapy); 77427 (radiation treatment management); 77776, 77777, 77778, 77787 (brachytherapy) AND Report the following CPT Category II Code to identify the risk of recurrence: • 3271F – Low risk of recurrence, prostate cancer
Exclusions	Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons) Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician)

	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) for having a bone scan performed(eg documented pain, salvage therapy, other medical reasons) or system reason(s) for having a bone scan performed (eg, bone scan ordered by someone other than reporting physician). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: See attached eMeasure For Claims/Administrative Data: Documentation of medical reason(s) for having a bone scan performed (including documented pain, salvage therapy, other medical reasons) Append modifier to CPT Category II code: 3269F-1P – Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer (including documented pain, salvage therapy, other medical reasons) Documentation of system reason(s) for having a bone scan performed (including bone scan ordered by someone other than reporting physician) Append modifier to CPT Category II code: 3269F-3P – Bone scan performed prior to initiation of treatment or at any time since diagnosis of prostate cancer (including bone scan ordered by someone other than reporting physician)
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Algorithm	For measures with exceptions: To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, documented pain, salvage therapy, other medical reasons)or system reason(s) (eg, bone scan ordered by someone other than reporting physician)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment Measure Calculation_0389.pdf

	0389 Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients
Copyright/ Disclaimer	These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures. THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND © 2007 American Medical Association. All Rights Reserved Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

	0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Urological Association and American Society for Therapeutic Radiology & Oncology
Description	Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records, Electronic Clinical Data : Registry Not applicable Attachment NQF_0390_DataElements.xls
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Ambulatory Care : Clinician Office, Other
Numerator Statement	Patients who were prescribed adjuvant hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist)

	0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Numerator Details	Time Window: Once for each procedure for treatment of prostate cancer (i.e., external beam radiotherapy to the prostate) For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: To submit the numerator option for patients who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist), report the following CPT Category II code: 4164F – Adjuvant (ie, in combination with external beam radiotherapy to the prostate for prostate cancer) hormonal therapy (GnRH [gonadotropin-releasing hormone] agonist or antagonist) prescribed/administered
Denominator Statement	All patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate Note: Only patients with prostate cancer with high risk of recurrence will be counted in the denominator of this measure
Denominator Details	Time Window: Each procedure for treatment of prostate cancer (i.e., external beam radiotherapy to the prostate) Risk strata definition: • High Risk: PSA > 20 mg/dL; OR Gleason score 8 to 10; OR clinically localized stage T3a1 For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: All patients with a diagnosis of prostate cancer, at high risk of recurrence receiving external beam radiotherapy to the prostate ICD-9-CM diagnosis code: 185 ICD-10-CM diagnosis code: C61 AND CPT code: 77427 (radiation treatment management) AND Report the following CPT Category II code to identify the risk of recurrence: • 3273F – High risk of recurrence, prostate cancer
Exclusions	Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy) Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy

	0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy)or patient reason(s). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eSpecification currently under development. Data elements (using the Quality Data Model) required for the measure attached. For Claims/Administrative Data: Documentation of medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy) Append modifier to CPT Category II code: 4164F-1P Documentation of patient reason(s) for not prescribing adjuvant hormonal therapy Append modifier to CPT Category II code: 4164F-2P
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) for not prescribing adjuvant hormonal therapy (eg, salvage therapy)or patient reason(s). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment Measure Calculation_0390.pdf

	0390 Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients
Copyright/ Disclaimer	Physician Performance Measures (Measures) and related data specifications, developed by the Physician Consortium for Performance ImprovementTM (the Consortium), are intended to facilitate quality improvement activities by physicians. These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care. The Consortium has not tested its Measures for all potential applications. The Consortium encourages the testing and evaluation of its Measures. Measures are subject to review and may be revised or rescinded at any time by the Consortium. The Measures may not be altered without the prior written approval of the Consortium. Measures developed by the Consortium, while copyrighted, can be reproduced and distributed, without modification, for noncommercial purposes, e.g., use by health care providers in connection with their practices. Commercial use is defined as the sale, license, or distribution of the Measures for commercial gain, or incorporation of the Measures into a product or service that is sold, licensed or distributed for commercial gain. Commercial uses of the Measures require a license agreement between the user and American Medical Association, on behalf of the Consortium. Neither the Consortium nor its members shall be responsible for any use of these Measures. THE MEASURES ARE PROVIDED "AS IS" WITHOUT WARRANTY OF ANY KIND © 2007 American Medical Association. All Rights Reserved Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, the Consortium and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications. THE SPECIFICATIONS ARE PROVIDED “AS IS” WITHOUT WARRANTY OF ANY KIND.

	0391 Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: College of American Pathologists
Description	Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Paper Records, Electronic Clinical Data : Registry Not Applicable Attachment AMA-PCPI_0391_PATH BreastCancerResectionPathologyReporting_DataElements_12012.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Laboratory

	0391 Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Numerator Statement	Reports that include the pT category, the pN category and the histologic grade
Numerator Details	Time Window: Each final report during measurement period For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure attached. For Claims Specifications CPT Category II code: 3260F – pT (primary tumor), pN (regional lymph node), and histologic grade documented in pathology report
Denominator Statement	All breast cancer resection pathology reports (excluding biopsies)
Denominator Details	Time Window: 12 consecutive months For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative: ICD-9-CM diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6 , 174.8, 174.9, 175.0, 175.9 ICD-10-CM diagnosis codes: C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919, C50.021, C50.022, C50.029, C50.121, C50.122, C50.129, C50.221, C50.222, C50.229, C50.321, C50.322, C50.329, C50.421, C50.422, C50.429, C50.521, C50.522, C50.529, C50.621, C50.622, C50.629, C50.821, C50.822, C50.829, C50.921, C50.922, C50.929 AND CPT Codes: 88307, 88309
Exclusions	Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (eg; re-excision without residual tumor; non-carcinomas)

	0391 Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure exceptions may include documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (eg; re-excision without residual tumor). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative: Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (eg; re-excision without residual tumor) Append modifier to CPT Category II code: 3260F-1P OR If the specimen is not primary breast tissue (e.g., liver, lung) report: CPT II 3250F: Specimen site other than anatomic location of primary tumor
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0391 Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: exceptions may include documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (eg; re-excision without residual tumor)].If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm attached in 2a1.21. Attachment AMA-PCPI_Measure Calculation-634626514390218943.pdf
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	0392 Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Status	Maintenance, Original Endorsement: Jul 31, 2008, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: College of American Pathologists
Description	Percentage of colon and rectum cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Laboratory, Paper Records, Electronic Clinical Data : Registry Attachment AMA-PCPI_0392_PATH ColorectalCancerResectionPathology_DataElements_1 2012.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Ambulatory Surgery Center (ASC), Laboratory
Numerator Statement	Reports that include the pT category, the pN category and the histologic grade

	0392 Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Numerator Details	Time Window: Each final report during measurement period For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative: CPT Category II code 3260F: pT (primary tumor), pN (regional lymph node), and histologic grade documented in pathology report
Denominator Statement	All colon and rectum cancer resection pathology reports
Denominator Details	Time Window: 12 consecutive months For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative: ICD-9-CM diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.5, 153.6, 153.7, 153.8, 153.9, 154.0, 154.1, 154.8 ICD-10-CM diagnosis codes: C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.2, C21.8 AND CPT Codes: 88309
Exclusions	Denominator Exclusion: Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade (eg; re-excision without residual tumor; non-carcinomasanal canal)

	0392 Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure exceptions may include Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade. Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eSpecification currently under development. Data elements (using Quality Data Model) required for the measure attached. For Claims/Administrative: Documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade • Append modifier to CPT Category II code: 3260F-1P OR If the specimen is not primary breast tissue (e.g., liver, lung) report: CPT II 3250F: Specimen site other than anatomic location of primary tumor
Risk Adjustment	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	better quality = higher score

	0392 Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [For this measure: documentation of medical reason(s) for not including the pT category, the pN category or the histologic grade]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Calculation algorithm is included in data dictionary/code table attachment 2a1.30. Attachment AMA-PCPI_Measure Calculation.pdf
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	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.
Status	Maintenance, Original Endorsement: Mar 01, 2007, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American College of Surgeons Other organizations: This measure was harmonized with measure development efforts coordinated between the American Society of Clinical Oncology (ASCO) and The National Cancer Care Network (NCCN) prior to NQF's formal review and consideration of measures submitted in response to its call for measures in 2005 as part of it's Quality of Cancer Care Performance Measures project (Desch CE, McNiff KK, Schneider EC, et al. American Society of Clinical Oncology / National Comprehensive Cancer Network Quality Measures. J Clin Oncol 2008;26:3631-3637). The measure, as specified here, has not been altered or changed in any way since harmonization of specifications between these three organizations occured in the fall of 2006.
Description	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage T1c, or Stage II, or III, who's primary tumor is progesterone and estrogen receptor negative recommended for multia
Type	Process

	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.
Data Source	Paper Records, Electronic Clinical Data : Registry Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html
Level	Facility
Setting	Hospital/Acute Care Facility
Numerator Statement	Combination chemotherapy is considered or administered within 4 months (120 days) of the date of diagnosis
Numerator Details	Time Window: 4 months (120 days) Chemotherapy [NAACCR Item#1390]=82-87 OR; Chemotherapy [NAACCR Item#1390]=3, and Date Chemotherapy Started (NAACCR Item#1220] <=120 days following Date of Diagnosis [NAACCR Item# 340]
Denominator Statement	Women under the age of 70 with AJCC T1cN0M0, or Stage II or 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 • AJCC T1cN0M0, or Stage II or 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
Denominator Details	Time Window: Typically a 12 month, calendar year, time period Sex [NAACCR Item#220]=2; Age at Diagnosis [NAACCR Item#230] < 80; CS Tumor Size [NAACCR Item#2800= 010 and AJCC pN [NAACCR Item#890]=0, OR AJCC pN [NAACCR Item#890]=1, 2, or 3; AND CS SSF1 (ERA) [NAACCR Item#2880]=020 or 030; AND CS SSF2 (PRA) [NAACCR Item#2890]=020 or 030; AND Surgical Procedure of the Primary Site [NAACCR Item#1290] = 20–90
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; tumor size <=1cm and AJCC pN=0; ERA unknown or positive; PRA unknown or positive; metastatic disease (AJCC Stage IV); not treated surgically; died within 4 months (120 days) of diagnosis
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf
Risk Adjustment	No risk adjustment or risk stratification
Stratification	No stratification applied
Type Score	Rate/proportion better quality = higher score

	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.
Algorithm	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf

	0562 Overutilization of Imaging Studies in Melanoma
Status	Maintenance, Original Endorsement: Oct 30, 2009, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Academy of Dermatology and National Committee for Quality Assurance
Description	Percentage of patients, regardless of age, with a current diganosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signes or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were ordered
Type	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Imaging/Diagnostic Study, Paper Records, Electronic Clinical Data : Registry Not Applicable Attachment AMA-PCPI_0562_MEL.OveruseImaging_DATAELEMENTS 562.pdf
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office
Numerator Statement	Patients for whom no diagnostic imaging studies* were ordered
Numerator Details	Time Window: Once during measurement period Numerator Definition: *Diagnostic imaging studies include CXR, CT, Ultrasound, MRI, PET, and nuclear medicine scans. Ordering any of these imaging studies during the one year measurement period is considered a failure of the measure, unless a justified reason is documented through use of a medical or system reason for exception. For EHR: eSpecification and eMeasure are currently under development (expected completion end of Q1 2012). Data Elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: Report CPT Category II Code: 3320F - None of the following diagnostic imaging studies ordered: chest x-ray, CT, ultrasound, MRI, PET, and nuclear medicine scans
Denominator Statement	All patients, regardless of age, with a current diagnosis of stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period

	0562 Overutilization of Imaging Studies in Melanoma
Denominator Details	Time Window: 12 consecutive months Denominator Definitions: Signs-For the purposes of this measure, signs include tenderness, jaundice, localized neurologic signs such as weakness, or any other sign Symptoms-For the purposes of this measure, symptoms include cough, dyspnea, pain, paresthesia, or any other symptom For EHR: eSpecification and eMeasure are currently under development (expected completion end of Q1 2012). Data Elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: ICD-9-CM diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 ICD-10-CM diagnosis codes: C41.10, C41.11, C41.12, C43.0, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820 AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245 AND Report one of the following CPT Category II codes to identify signs or symptoms (present or absent) suggestive of systemic spread of Melanoma: 2XXXF (CPT Category II Code in Development) – Signs or symptoms suggestive of systemic spread of melanoma, present OR 2XXXF (CPT Category II Code in Development) -- Signs or symptoms suggestive of systemic spread of melanoma, absent Note: Only patients without signs or symptoms will meet the denominator criteria for inclusion in this measure. AND Report one of the following CPT Category II codes to identify the stage of Melanoma : 3XXXF (CPT Category II Code in Development) – Melanoma Cancer Stage 0 through IIC OR 3XXXF (CPT Category II Code in Development) – Melanoma greater than Stage 0 through IIC Note: Only patients with Melanoma Stage 0 to IIC will meet the denominator criteria for inclusion in this measure.
Exclusions	Documentation of medical reason(s) for ordering diagnostic imaging studies (e.g., patient has comorbid condition that warrants imaging, other medical reasons); Documentation of system reason(s) for ordering diagnostic imaging studies (e.g., requirement for clinical trial enrollment, ordered by another provider, other system reasons)

	0562 Overutilization of Imaging Studies in Melanoma
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (eg, patient has comorbid condition that warrants imaging, other medical reasons)or system reason(s) for ordering diagnostic imaging studies(eg, requirement for clinical trial enrollment, ordered by another provider, other system reasons). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eSpecification and eMeasure are currently under development (expected completion end of Q1 2012). Data Elements (using Quality Data Model) required for the measure are attached. For Claims/Administrative: The CPT Category II Code below is reported when diagnostic imaging study(ies) are performed (failure of measure). 3319F - 1 of the following diagnostic imaging studies ordered; chest x-ray, CT, ultrasound, MRI, PET, or nuclear medicine scans When there is a valid medical reason documented for ordering diagnostic imaging studies • Append modifier to CPT Category II code: 3319F-1P When there is a valid system reason documented for ordering diagnostic imaging studies • Append modifier to CPT Category II code: 3319F-3P
Risk Adjustment	No risk adjustment or risk stratification No risk adjustment or risk stratification.
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0562 Overutilization of Imaging Studies in Melanoma
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (eg, patient has comorbid condition that warrants imaging, other medical reasons), or system reason(s) (eg, requirement for clinical trial enrollment, ordered by another provider, other system reasons)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. -- Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment AMA-PCPI_Measure Calculation-Standard Measures 562.pdf
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	0650 Melanoma Continuity of Care – Recall System
Status	Maintenance, Original Endorsement: May 05, 2010, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI) Other organizations: American Academy of Dermatology and National Committee for Quality Assurance
Description	Percentage of patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma whose information was entered, at least once within a 12 month reporting period into a recall system that includes: • A target date for the next complete physical skin exam , AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment
Type	Structure
Data Source	Administrative claims, Electronic Clinical Data, Other, Paper Medical Records, Electronic Clinical Data : Registry Not Applicable
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Patients whose information is entered, at least once within a 12 month period, into a recall system* that includes: • A target date for the next complete physical skin exam , AND • A process to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment
Numerator Details	Time Window: At least once during measurement period Numerator Instructions: To satisfy this measure, the recall system must be linked to a process to notify patients when their next physical exam is due and to follow up with patients who either did not make an appointment within the specified timeframe or who missed a scheduled appointment and must include the following elements at a minimum; patient identifier, patient contact information, cancer diagnosis(es), date(s) of initial cancer diagnosis (if known), and the target date for the next complete physical exam. For Claims/Administrative: Report CPT Category II code: 7010F -- Patient information entered into a recall system with the target date for the next complete physical skin exam specified For EHR: This measure does not lend itself to a "traditional specification" for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems.
Denominator Statement	All patients, regardless of age, with a current diagnosis of melanoma or a history of melanoma.

	0650 Melanoma Continuity of Care – Recall System
Denominator Details	Time Window: 12 consecutive months For EHR: This measure does not lend itself to a "traditional specification" for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems. For Claims/Administrative: ICD-9-CM diagnosis codes: 172.0, 172.1, 172.2, 172.3, 172.4, 172.5, 172.6, 172.7, 172.8, 172.9, V10.82 ICD-10-CM diagnosis codes: C41.10, C41.11, C41.12, C43.0, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, Z85.820 AND CPT codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, 99241, 99242, 99243, 99244, 99245
Exclusions	Documentation of system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider)
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include system reason(s) for not entering patients into a recall system (eg, melanoma being monitored by another physician provider). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: This measure does not lend itself to a "traditional specification" for EHR reporting. This is a structural measure; each facility may have a different process or software system for tracking and transmitting recalls as well as different appointment tracking systems. For Claims/Administrative: Documentation of system reason exception • Append modifier to CPT Category II code: 7010F-3P
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score

	0650 Melanoma Continuity of Care – Recall System
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (ie, the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (ie, the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (ie, the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: system reason(s) (eg, melanoma being monitored by another physician provider)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. Attachment AMA-PCPI_Measure Calculation-Standard Measures650.pdf
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	1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
Status	Maintenance, Original Endorsement: Aug 09, 2012, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	The Society of Thoracic Surgeons
Description	Percentage of patients greater than or equal to 18 years of age undergoing elective lung resection (Open or VATS wedge resection, segmentectomy, lobectomy, bilobectomy, sleeve lobectomy, pneumonectomy) for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.
Type	Outcome
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records, Electronic Clinical Data : Registry STS General Thoracic Surgery Database, Version 2.2 URL Data Collection Form- http://www.sts.org/sites/default/files/documents/STSThoracicDCF_V2_2_MajorProc_Annotated_0.pdf URL http://www.sts.org/sites/default/files/documents/STSThoracicDataSpecsV2_2.pdf
Level	Facility, Clinician : Group/Practice, Clinician : Team
Setting	Hospital/Acute Care Facility
Numerator Statement	Number of patients greater than or equal to 18 years of age undergoing elective lung resection for lung cancer who developed any of the following postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality.

	1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
Numerator Details	Time Window: During hospitalization regardless of length of stay or within 30 days of surgery if discharged from the hospital. Number of patients undergoing elective lung resection for lung cancer for whom: 1. Postoperative events (POEvents - STS GTS Database, v 2.2, sequence number 1710) is marked "Yes" and one of the following items is marked: a) Reintubation (Reintube - STS GTS Database, v 2.2, sequence number 1850) b) Need for tracheostomy (Trach - STS GTS Database, v 2.2, sequence number 1860) c) Initial ventilator support > 48 hours (Vent- STS GTS Database, v 2.2, sequence number 1840) d) Adult Respiratory Distress Syndrome (ARDS - STS GTS Database, v 2.2, sequence number 1790) e) Pneumonia (Pneumonia - STS GTS Database, v 2.2, sequence number 1780) f) Pulmonary Embolus (PE - STS GTS Database, v 2.2, sequence number 1820) g) Bronchopleural Fistula (Bronchopleural - STS GTS Database, v 2.2, sequence number 1810) h) Myocardial infarction (MI - STS GTS Database, v 2.2, sequence number 1900) Or 2. Unexpected return to the operating room (ReturnOR - STS GTS Database, Version 2.2, sequence number 1720) is marked "yes" and primary reason for return to OR (ReturnORRsn – STS GTS Database, Version 2.2, sequence number 1730) is marked "bleeding" Or 3. One of the following fields is marked "dead" a) Discharge status (MtDCStat - STS GTS Database, Version 2.2, sequence number 2200); b) Status at 30 days after surgery (Mt30Stat - STS GTS Database, Version 2.2, sequence number 2240) Please see STS General Thoracic Surgery Database Data Collection Form, Version 2.2- http://www.sts.org/sites/default/files/documents/STSThoracicDCF_V2_2_MajorProc_Annotated_0.pdf
Denominator Statement	Number of patients greater than or equal to 18 years of age undergoing elective lung resection for lung cancer.

	1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
Denominator Details	Time Window: 36 months 1. Lung cancer (LungCancer - STS GTS Database, v 2.2, sequence number 830) is marked "yes" and Category of Disease – Primary (CategoryPrim - STS GTS Database, v 2.2, sequence number 1300) is marked as one of the following: (ICD-9, ICD-10) Lung cancer, main bronchus, carina (162.2, C34.00) Lung cancer, upper lobe (162.3, C34.10) Lung cancer, middle lobe (162.4, C34.2) Lung cancer, lower lobe (162.5, C34.30) Lung cancer, location unspecified (162.9, C34.90) 2. Patient has lung cancer (as defined in #1 above) and primary procedure is one of the following CPT codes: Thoracoscopy, surgical; with lobectomy (32663) Thoracoscopy with therapeutic wedge resection (eg mass or nodule) initial, unilateral (3266X) Thoracoscopy with therapeutic wedge resection (eg mass or nodule) each additional resection, ipsilateral (3266X1) Thoracoscopy with diagnostic wedge resection followed by anatomic lung resection (3266X2) Thoracoscopy with removal of a single lung segment (segmentectomy) (3266X4) Thoracoscopy with removal of two lobes (bilobectomy) (3266X3) Thoracoscopy with removal of lung, pneumonectomy (3266X5) Thoracotomy with therapeutic wedge resection (eg mass nodule) initial (3250X) Thoracotomy with therapeutic wedge resection (eg mass nodule) each additional resection, ipsilateral (+3250X1) Thoracotomy with diagnostic wedge resection followed by anatomic lung resection (+3250X2) Removal of lung, total pneumonectomy; (32440) Removal of lung, sleeve (carinal) pneumonectomy (32442) Removal of lung, total pneumonectomy; extrapleural (32445) Removal of lung, single lobe (lobectomy) (32480) Removal of lung, two lobes (bilobectomy) (32482) Removal of lung, single segment (segmentectomy) (32484) Removal of lung, sleeve lobectomy (32486) Removal of lung, completion pneumonectomy (32488) Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, without chest wall reconstruction(s) (32503) Resection of apical lung tumor (e.g., Pancoast tumor), including chest wall resection, with chest wall reconstruction (32504) 3. Status of Operation (Status - STS General Thoracic Surgery Database, Version 2.2, sequence number 1420) is marked as "Elective" 4. Only analyze the first operation of the hospitalization meeting criteria 1-3
Exclusions	Emergency procedures
Exclusion Details	n/a

	1790 Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer
Risk Adjustment	Statistical risk model Bayesian hierarchical modeling was used to assess the statistical reliability of hospital-specific standardized incidence ratio (SIR) estimates derived from the January 1, 2008 – December 31, 2010 STS data. All hospitals regardless of sample size were inc Attachment Kozower et al.pdf
Stratification	n/a
Type Score	Rate/proportion better quality = lower score
Algorithm	Target population is patients 18 years of age or older undergoing elective lung resection for lung cancer. Emergency procedures were excluded. Outcome is occurrence of postoperative complications: reintubation, need for tracheostomy, initial ventilator support > 48 hours, ARDS, pneumonia, pulmonary embolus, bronchopleural fistula, bleeding requiring reoperation, myocardial infarction or operative mortality. Analysis considered 22,677 patients with procedures between 01/01/2008 and 12/31/2010 (36 months). Risk adjustment was achieved with a Bayesian hierarchical model with composite of the above postoperative complications as the outcome. The measure score was estimated with this model. For additional information review risk model in attachment.

	1822 External Beam Radiotherapy for Bone Metastases
Status	Maintenance, Original Endorsement: Aug 09, 2012, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	American Society for Radiation Oncology (ASTRO) Other organizations: None
Description	This measure reports the percentage of patients, regardless of age, with a diagnosis of painful bone metastases and no history of previous radiation who receive external beam radiation therapy (EBRT) with an acceptable fractionation scheme as defined by the guideline.
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Records The data sources for this measure include: Radiation oncologist consultation note, physician office progress note, radiation flow sheet, radiology report Attachment bone metastases DATA COLLECTION INSTRUMENT.docx Attachment DATA ELEMENTS.docx
Level	Facility, Clinician : Group/Practice, Health Plan, Clinician : Individual, Clinician : Team
Setting	Ambulatory Care : Clinician Office, Hospital/Acute Care Facility
Numerator Statement	All patients, regardless of age, with painful bone metastases, and no previous radiation to the same anatomic site who receive EBRT with any of the following recommended fractionation schemes: 30Gy/10fxns, 24Gy/6fxns, 20Gy/5fxns, 8Gy/1fxn.
Numerator Details	Time Window: Once per reporting period Bone metastases diagnosis (198.5- Secondary malignant neoplasm of bone and bone marrow) Use of EBRT (Therapeutic radiology treatment planning: CPT 77261; simple, CPT 77262; Intermediate, CPT 77263; complex)

	1822 External Beam Radiotherapy for Bone Metastases
Denominator Statement	All patients with painful bone metastases and no previous radiation to the same anatomic site who receive EBRT
Denominator Details	Time Window: Once per reporting period Bone metastases diagnosis (198.5- Secondary malignant neoplasm of bone and bone marrow) Use of EBRT (Therapeutic radiology treatment planning: CPT 77261; simple, CPT 77262; Intermediate, CPT 77263; complex)
Exclusions	The medical reasons for denominator exclusions are: 1) Previous radiation treatment to the same anatomic site; 2) Patients with femoral axis cortical involvement greater than 3 cm in length; 3) Patients who have undergone a surgical stabilization procedure; and 4) Patients with spinal cord compression, cauda equina compression or radicular pain
Exclusion Details	A. Medical Reasons (Data Source) 1) Previous radiation treatment to the same anatomic site (Medical Record) 2) Patients with femoral axis cortical involvement greater than 3 cm in length(Imaging Studies) 3) Patients who have undergone a surgical stabilization procedure (Operative Report) 4) Patients with spinal cord compression, cauda equina compression or radicular pain (Diagnosis/Problem list)
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Stratification of the measure is not required.
Type Score	Rate/proportion better quality = higher score
Algorithm	Denominator Calculation Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT Step 2: Identify patients with no history of previous radiation therapy to the same anatomic site Step 3: Identify patients with specified exceptions and exclude from denominator calculation Numerator Calculation: Step 1: Identify patients with: (a) diagnosis of bone metastases and (b) a prescription for EBRT Step 2: Identify patients prescribed with one of the recommended fractionation schemes: 30Gy/10fxns or 24Gy/6fxns or 20Gy/5fxns or 8Gy/1fxn

	1853 Radical Prostatectomy Pathology Reporting
Status	Maintenance, Original Endorsement: Aug 09, 2012, Most Recent Endorsement: Aug 09, 2012 Time-limited
Steward	College of American Pathologists
Description	Percentage of radical prostatectomy pathology reports that include the pT category, the pN category, the Gleason score and a statement about margin status.
Type	Process

	1853 Radical Prostatectomy Pathology Reporting
Data Source	Administrative claims, Other, Paper Records Medical records/Pathology Report and Claims forms are used as the specific data sources.
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Laboratory
Numerator Statement	Numerator: Radical prostatectomy pathology reports that include the pT category, the pN category, Gleason score and a statement about margin status ? Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F –pathology report
Numerator Details	Time Window: Each event is reported Report the following CPT Category II code to confirm the inclusion of the designated elements in a radical prostatectomy pathology report: 3267F –pathology report
Denominator Statement	All radical prostatectomy pathology reports
Denominator Details	Time Window: Each event is recorded; measurement time period is not specified and can be determined by program. Denominator (Eligible Population): All radical prostatectomy pathology reports CPT code: 88309 - Level VI - Surgical pathology, gross and microscopic examination AND ICD-9 code: 185 – malignant neoplasm of prostate
Exclusions	Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, and transurethral resections of the prostate (TURP)
Exclusion Details	Documentation of medical reason for exclusion (e.g. specimen originated from other malignant neoplasms, secondary site prostatic carcinomas, or transurethral resections of the prostate (TURP) [For patient with appropriate exclusion criteria, report 3267F with modifier 1P.]
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = higher score
Algorithm	Performance Measure: 3267F/Claims using CPT code 88309 and ICD-9 code 185
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	1854 Barrett's Esophagus
Status	Maintenance, Original Endorsement: Aug 09, 2012, Most Recent Endorsement: Aug 09, 2012 Time-limited

	1854 Barrett's Esophagus
Steward	College of American Pathologists
Description	Percentage of patients with esophageal biopsy reports for Barrett's esophagus that contain a statement about dysplasia.
Type	Process
Data Source	Administrative claims, Other, Paper Records Medical records/pathology report/Claims forms
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Laboratory
Numerator Statement	Numerator: Esophageal biopsy reports with the histologic finding of Barrett's mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.) 3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite)
Numerator Details	Time Window: Report once per patient per date of service Numerator: Esophageal biopsy reports with the histologic finding of Barrett's mucosa that contain a statement about dysplasia (present, absent, or indefinite; and if present, contains appropriate grading.) 3125F Esophageal biopsy report with a statement about dysplasia (present, absent, or indefinite)
Denominator Statement	Denominator (Eligible Population): All esophageal biopsy reports that document the presence of Barrett's mucosa. CPT codes: • 88305 Level IV – Surgical pathology, gross and microscopic examination AND ICD-9 codes: • 530.85 Barrett's esophagus
Denominator Details	Time Window: Once per patient per date of service; time period not specified in the measure and can be determined by the program (typically one year.) The pathology report is needed as well as access to correct coding of claims to identify patients: CPT codes: • 88305 Level IV – Surgical pathology, gross and microscopic examination AND ICD-9 codes: • 530.85 Barrett's esophagus
Exclusions	Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia).
Exclusion Details	Documentation of medical reason for not reporting the histologic finding of Barrett's mucosa (eg, malignant neoplasm or absence of intestinal metaplasia). [For patient with appropriate exclusion criteria, report 3125F with modifier 1P]
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable

	1854 Barrett's Esophagus
Type Score	Rate/proportion better quality = higher score
Algorithm	Performance Measure: 3125F/CPT codes 88305 and ICD-9 codes 530.85
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	1855 Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines
Status	Maintenance, Original Endorsement: Oct 22, 2012, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	College of American Pathologists
Description	Percentage of patients with quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the ASCO/CAP guidelines.
Type	Process
Data Source	Administrative claims, Other, Paper Records Data can be collectected from Pathology Report/Medical Records, Laboratory procedures and claims forms.
Level	Clinician : Group/Practice, Clinician : Individual
Setting	Laboratory
Numerator Statement	Breast cancer patients receiving quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the ASCO/CAP guideline *
Numerator Details	Time Window: Report once per patient per date of service Breast cancer patients receiving quantitative breast tumor HER2 IHC evaluation using the ASCO/CAP recommended manual system or a computer-assisted system consistent with the optimal algorithm for HER2 testing as described in the ASCO/CAP guideline Report one of the following CPT Category II codes to confirm the use of the recommended scoring system: • 3394F –Quantitative HER2 IHC evaluation consistent with scoring system defined in the ASCO/CAP guidelines • 3395F– Quantitative non-HER2 IHC evaluation (eg, testing for estrogen or progesterone receptors, [ER/PR]) performed

	1855 Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines
Denominator Statement	All breast cancer patients with quantitative breast tumor evaluation by HER2 IHC ICD-9 diagnosis codes for breast cancer: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.7, 174.8, 174.9, 175.0, 175.9 AND CPT codes: Quantitative IHC Evaluation – 88360 or 88361 (The CPT descriptor for 88360 and 88361 is, "Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semi-quantitative, each antibody.")
Denominator Details	Time Window: Each Event ICD-9 diagnosis codes for breast cancer: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.7, 174.8, 174.9, 175.0, 175.9 AND CPT codes: Quantitative IHC Evaluation – 88360 or 88361 (The CPT descriptor for 88360 and 88361 is, "Morphometric analysis, tumor immunohistochemistry (eg, Her-2/neu, estrogen receptor/progesterone receptor), quantitative or semi-quantitative, each antibody.") Also, from Wolff, A.C., et al. American Society of Clinical Oncology/College of American Pathologists Guideline Recommendations for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer. Arch Pathol Lab Med. 2007;131:18-43 • Positive HER2 test. (p.25) Based on a literature review of clinical trials, international studies and protocols, expert consensus, and US Food and Drug Administration Panel findings, a positive HER2 test is defined as either IHC result of 3+ cell surface protein expression (defined as uniform intense membrane staining of > 30% of invasive tumor cells) • Equivocal HER2 test. (p.26) The equivocal range for IHC consists of samples scored 2+, and this may include up to 15% of samples. An equivocal result (2+) is complete membrane staining that is either non-uniform or weak in intensity but with obvious circumferential distribution in at least 10% of cells. Very rarely, in the experience of panel members, invasive tumors can show intense, complete membrane staining of 30% or fewer tumor cells. These are also considered to be equivocal in this guideline. • Negative HER2 test. (p.27) A negative HER2 test is defined as either an IHC result of 0 or 1+ for cellular membrane protein expression (no staining or weak, incomplete membrane staining in any proportion of tumor cells),....
Exclusions	None
Exclusion Details	Not applicable
Risk Adjustment	No risk adjustment or risk stratification Not applicable
Stratification	Not applicable
Type Score	Rate/proportion better quality = higher score
Algorithm	Performance Measure: 3394F + 3395F/ Claims identified by CPT code 88360 or 88361 and breast cancer ICD- 9 codes

	1855 Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines
Copyright/ Disclaimer	© 2007 College of American Pathologists. All Rights Reserved Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The College of American Pathologists disclaims all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

	1857 Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab
Status	Maintenance, Original Endorsement: Oct 22, 2012, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of adult patients (aged 18 or over) with invasive breast cancer that is HER2/neu negative who are not administered trastuzumab
Type	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Paper Medical Records QOPI data are entered via a case report form accessed via a secure web portal. The case report form includes logic and data validation. URL http://qopi.asco.org
Level	Clinician : Group/Practice, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Trastuzumab not administered during the initial course of treatment
Numerator Details	Time Window: Initial course of treatment. The initial course of treatment is defined as: The treatment course for the initial diagnosis, which may include elements of chemotherapy (any route), hormonal therapy, radiation, or additional surgery. Do not include treatm Trastuzumab (Herceptin) administered during initial treatment course = Trastuzumab NOT administered OR (Trastuzumab (Herceptin) administered during initial treatment course = Trastuzumab administered AND Trastuzumab administered according to clinical trial protocol = Yes)
Denominator Statement	Adult women with AJCC stage I (T1c) – III breast cancer that is HER-2 negative or HER-2 undocumented/unknown
Denominator Details	Time Window: Implementation in QOPI specifies a time window of less than or equal to two years since diagnosis with invasive cancer; however, shorter time windows (e.g., 12 months) can be specified for individual analyses. Female And 2 or more encounters at the reporting site And

	1857 Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab
	Age at diagnosis greater than or equal to 18 years And Initial breast cancer diagnosis (174.xx) AND (HER-2/neu status = HER2 negative OR HER-2/neu status = Test ordered, results not yet documented OR HER-2/neu status = Test NOT ordered/no documentation OR HER-2/neu status=Test ordered, insufficient sample for results Or HER-2/neu status= HER2 equivocal) Definitions Encounter: new patient visit (CPT 99201 -99205) or established patient (CPT 99211-99215), not consult (CPT 99241-99245 office consult or inpatient consult CPT 99251-99255) HER2 status: Select 'Test ordered, results not yet documented' only if there is documentation in the chart that a test that reports HER-2/neu analyses was ordered. In the absence of any documentation regarding HER-2/neu status, select 'Test not ordered/no documentation.' Enter information from the most recent test report. Patients are classified as having HER-2 positive disease based on positive results with either test. If the most recent report indicates insufficient sample, select 'Test ordered, insufficient sample for results.' If a physician note and the HER-2/neu report differ in results, report the status in the physician note if the note explains the discrepancy. Otherwise, report the status from the HER-2/neu report. Use the following definitions to determine HER-2/neu status: Positive: • IHC 3+ cell surface protein expression (defined as uniform intense membrane staining of >30% of invasive tumor cells) or • FISH ratio >2.2 or • HER2 gene copy >6.0 Equivocal: • Not positive according to any of the criteria above, AND • (IHC with scores 2+ AND FISH ratio 1.8-2.2) or • HER2 gene copy 4.0-6.0 Negative: • Not positive according to any of the criteria above, AND • IHC 0 or 1+ or • FISH ratio 1.8 or • HER2 gene copy <4.0 • If the results indicate 'non-amplified', choose HER-2/neu negative. • If the results indicate 'weakly positive', choose HER-2/neu positive.

	1857 Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab
	New test ordered within 10 days of report of equivocal result: Respond 'Yes' if a new test was ordered within 10 days of oncologist review of the report with inconclusive results. Choose 'N/A' if the patient died or transferred out of the practice within 10 days of review of the report with inconclusive results or fewer than 10 days have passed. If the chart documents that the pathologist has ordered a new test, respond 'Yes.'
Exclusions	Patient transfer to practice after initiation of chemotherapy
Exclusion Details	• Patient transferred to reporting practice during the initial course of medical oncology treatment or • Patient transferred to reporting practice following completion of initial course of medical oncology treatment
Risk Adjustment	No risk adjustment or risk stratification n/a
Stratification	n/a
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is a proportion with exclusions; thus, the calculation algorithm is: Patients meeting the numerator/(Patients in the denominator – Patients with valid exclusions) x 100
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	1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy
Status	Maintenance, Original Endorsement: Oct 22, 2012, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of adult patients (aged 18 or over) with invasive breast cancer that is HER2/neu positive who are administered trastuzumab
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record, Paper Medical Records QOPI data are entered via a case report form accessed via a secure web portal. The case report form includes logic and data validation. URL http://qopi.asco.org/
Level	Clinician : Group/Practice, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Trastuzumab administered within 12 months of diagnosis

	1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy
Numerator Details	Time Window: Within 12 months (365 days) of diagnosis Definition: Date of diagnosis: Refer to the pathology/hemato-pathology or cytology report and record the date of the report (not the date of the specimen). If there are multiple reports, enter the first date. In (Trastuzumab (Herceptin) administered during initial treatment course = Trastuzumab administered AND Trastuzumab administration start date – diagnosis date < = 365 days) OR (Trastuzumab (Herceptin) administered during initial treatment course = Trastuzumab NOT administered AND Alternative treatment according to clinical trial protocol) Numerator definitions: Initial Course of Treatment is defined as the treatment course for the initial diagnosis, which may include elements of chemotherapy (any route), hormonal therapy, radiation, or additional surgery. If a section or item refers to the initial course of treatment, do not abstract data related to treatment provided for recurrence or disease progression. In the absence of any documentation regarding trastuzumab, select 'NOT administered.' Select 'Contraindication or other clinical exclusion documented' only if there is documentation of a medical reason why a patient who would otherwise be recommended trastuzumab is not given that recommendation. Trastuzumab administered according to clinical trial protocol: respond 'Yes', if the patient received trastuzumab according to a clinical trial protocol without documentation of HER-2/neu positive tumor.
Denominator Statement	Adult women with AJCC stage I (T1c) –III, HER2/neu positive breast cancer who receive chemotherapy
Denominator Details	Time Window: Implementation in QOPI specifies a time window of less than or equal to two years since diagnosis with invasive cancer; however, shorter time windows (e.g., 12 months) can be specified for individual analyses. Female And 2 or more encounters at the reporting site And Age at diagnosis greater than or equal to 18 years And Initial breast cancer diagnosis (174.xx) And Breast chemotherapy administered AND HER-2/neu status = Positive AND

	1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy
	[(AJCC stage at breast cancer diagnosis =II or III) OR (AJCC stage at breast cancer diagnosis = I (IA or IB) and T-Stage at breast cancer diagnosis =T1c) OR (T-Stage at breast cancer diagnosis = T1c, T2-T4d and N-Stage at breast cancer diagnosis =N0) OR (N-Stage at breast cancer diagnosis = N1-N3c)] Definitions Encounter: new patient visit (CPT 99201 -99205) or established patient (CPT 99211-99215), not consult (CPT 99241-992450 office consult or inpatient consult CPT 99251-99255) HER2 status: Select 'Test ordered, results not yet documented' only if there is documentation in the chart that a test that reports HER-2/neu analyses was ordered. In the absence of any documentation regarding HER-2/neu status, select 'Test not ordered/no documentation.' Enter information from the most recent test report. Patients are classified as having HER-2 positive disease based on positive results with either test. If the most recent report indicates insufficient sample, select 'Test ordered, insufficient sample for results.' If a physician note and the HER-2/neu report differ in results, report the status in the physician note if the note explains the discrepancy. Otherwise, report the status from the HER-2/neu report. Use the following definitions to determine HER-2/neu status: Positive: • IHC 3+ cell surface protein expression (defined as uniform intense membrane staining of >30% of invasive tumor cells) or • FISH ratio >2.2 or • HER2 gene copy >6.0 Equivocal: • Not positive according to any of the criteria above, AND • (IHC with scores 2+ AND FISH ratio 1.8-2.2) or • HER2 gene copy 4.0-6.0 Negative: • Not positive according to any of the criteria above, AND • IHC 0 or 1+ or • FISH ratio 1.8 or • HER2 gene copy <4.0 • If the results indicate 'non-amplified', choose HER-2/neu negative. • If the results indicate 'weakly positive', choose HER-2/neu positive. New test ordered within 10 days of report of equivocal result: Respond 'Yes' if a new test was ordered within 10 days of oncologist review of the report with inconclusive results. Choose 'N/A' if the patient died or transferred out of the practice within 10 days of review of the report with inconclusive results or fewer than 10 days have passed. If the chart documents that the pathologist has ordered a new test, respond 'Yes.'

	1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy
Exclusions	• Patient history of metastatic cancer • Multiple primaries prior to or within the measurement period • Patient metastatic at diagnosis • Patient transfer to practice after initiation of chemotherapy • Patient still receiving anthracycline-based chemotherapy • Patient declined • Patient died or transferred within 12 months of diagnosis • Contraindication or other clinical exclusion
Exclusion Details	
Risk Adjustment	No risk adjustment or risk stratification n/a
Stratification	n/a
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is a proportion with exclusions; thus, the calculation algorithm is: Patients meeting the numerator / (Patients in the denominator – Patients with valid exclusions) x 100
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	1859 KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy
Status	Maintenance, Original Endorsement: Oct 22, 2012, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy for whom KRAS gene mutation testing was performed
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record, Paper Medical Records QOPI data are entered via a case report form accessed via a secure web portal. The case report form includes logic and data validation. URL http://qopi.asco.org/
Level	Clinician : Group/Practice, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic

	1859 KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy
Numerator Statement	KRAS gene mutation testing performed before initiation of anti-EGFR MoAb
Numerator Details	Time Window: Time period between date of diagnosis with colorectal cancer and date of anti-EGFR MoAb initiation. KRAS gene mutation testing = KRAS mutation detected OR KRAS gene mutation testing = No KRAS mutation detected (wildtype) AND KRAS gene mutation testing date Numerator definitions: In the absence of any documentation regarding testing for the KRAS gene mutation, select 'Test not ordered/no documentation.' Refer to the interpretive report for the KRAS test. The report will indicate if a mutation within codon 12 or 13 of the KRAS gene was detected in the DNA extracted from the colon tumor specimen.
Denominator Statement	Adult patients with metastatic colorectal cancer who receive anti-EGFR monoclonal antibody therapy
Denominator Details	Time Window: Implementation in QOPI specifies a time window of less than or equal to two years since diagnosis with invasive cancer; however, shorter time windows (e.g., 12 months) can be specified for individual analyses. The denominator time window should not extend Age at diagnosis greater than or equal to 18 years AND 2 or more encounters at the reporting site AND Initial colon or rectal cancer diagnosis (153.x, 154.0, 154.0, 154.1, 154.8) AND Presence of metastatic disease documented AND Anti-EGFR monoclonal antibody therapy received Definitions Encounter: new patient visit (CPT 99201-99205) or established patient (CPT 99211-99215), not consult (CPT 99241-99245) office consult or inpatient consult CPT 99251-99255) KRAS mutation testing: KRAS testing for this measure refers to assays that detect mutations in codons 12 and 13 of KRAS only. Do not include results from mutations at other codons (e.g., codons 61 and 146), or assays for other alterations (e.g., BRAF, PI3K, PTEN genes). The College of American Pathologists (CAP) Perspectives on Emerging Technology (POET) Report on KRAS mutation testing provides additional guidance on testing. If multiple KRAS mutation tests have been performed, refer to the most recent test results.
Exclusions	Patient transfer to practice after initiation of chemotherapy
Exclusion Details	n/a

	1859 KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy
Risk Adjustment	No risk adjustment or risk stratification n/a
Stratification	n/a
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is a proportion with exclusions; thus, the calculation algorithm is: Patients meeting the numerator/(Patients in the denominator – Patients with valid exclusions) x 100
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	1860 Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies
Status	Maintenance, Original Endorsement: Oct 22, 2012, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of adult patients (aged 18 or over) with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-EGFR monoclonal antibodies
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record, Paper Medical Records QOPI data are entered via a case report form accessed via a secure web portal. The case report form includes logic and data validation. URL http://qopi.asco/org/
Level	Clinician : Group/Practice, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	Anti-EGFR monoclonal antibody therapy not received
Numerator Details	Time Window: Time period between date of diagnosis with metastatic colorectal cancer (initial metastatic diagnosis or progression to metastatic disease) and (date of data collection or date of death) Anti-EGFR monoclonal antibody therapy status = No Anti-EGFR monoclonal antibody therapy received
Denominator Statement	Adult patients with metastatic colorectal cancer who have a KRAS gene mutation

	1860 Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies
Denominator Details	Time Window: Implementation in QOPI specifies a time window of less than or equal to two years since diagnosis with invasive cancer; however, shorter time windows (e.g., 12 months) can be specified for individual analyses. The denominator time window should not extend Age at diagnosis greater than or equal to 18 years And 2 or more encounters at the reporting site And Initial colon or rectal cancer diagnosis (153.x, 154.0, 154.0, 154.1, 154.8) And Presence of metastatic disease documented And KRAS gene mutation detected Definitions Encounter = new patient visit (CPT 99201 -99205) or established patient (CPT 99211-99215), not consult (CPT 99241-99245 office consult or inpatient consult CPT 99251-99255) KRAS mutation testing: KRAS testing for this measure refers to assays that detect mutations in codons 12 and 13 of KRAS only. Do not include results from mutations at other codons (e.g., codons 61 and 146), or assays for other alterations (e.g., BRAF, PI3K, PTEN genes). The College of American Pathologists (CAP) Perspectives on Emerging Technology (POET) Report on KRAS mutation testing provides additional guidance on testing. If multiple KRAS mutation tests have been performed, refer to the most recent test results.
Exclusions	Patient transfer to practice after initiation of chemotherapy Receipt of anti-EGFR monoclonal antibody therapy as part of a clinical trial protocol
Exclusion Details	n/a
Risk Adjustment	No risk adjustment or risk stratification n/a
Stratification	n/a
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is a proportion with exclusions; thus, the calculation algorithm is: Patients meeting the numerator/(Patients in the denominator – Patients with valid exclusions) x 100
Copyright/ Disclaimer	 These clinical indicators and quality measures are not intended to and should never supplant independent physician judgment with respect to particular patients or clinical situations. Patient care is always subject to the independent professional judgment of the treating physician. Accordingly, QOPI participants' adherence to quality measures contained in this research report is strictly voluntary and discretionary, with the ultimate determination regarding their application to be made by the treating physician in his or her professional judgment and in light of each patient's individual circumstances. ASCO does not endorse the QOPI® measures as guidelines for standards of practice or 'best practices.'

	1878 Human epidermal growth factor receptor 2 (HER2) testing in breast cancer
Status	Maintenance, Original Endorsement: Oct 22, 2012, Most Recent Endorsement: Oct 22, 2012 Time-limited
Steward	American Society of Clinical Oncology
Description	Percentage of adult patients (aged 18 or over) with invasive breast cancer who receive human epidermal growth factor receptor 2 (HER2) testing
Type	Process
Data Source	Electronic Clinical Data : Electronic Health Record, Paper Medical Records QOPI data are entered via a case report form accessed via a secure web portal. The case report form includes logic and data validation. URL http:/qopi.asco.org/
Level	Clinician : Group/Practice, Clinician : Team
Setting	Ambulatory Care : Clinician Office/Clinic
Numerator Statement	HER2/neu testing performed
Numerator Details	Time Window: Within 4 weeks (28 days) of diagnosis Date of diagnosis: [Refer to the pathology/hemato-pathology or cytology report and record the date of the report (not the date of the specimen). If there are multiple reports, enter the first date. In the absence of HER-2/neu status = HER2 positive OR HER-2/neu status = HER2 negative OR HER-2/neu status = Test ordered, results not yet documented OR HER-2/neu status = Test ordered, insufficient sample for results OR (HER-2 equivocal AND New test ordered within 10 days of report = Yes or N/A (patient died or transferred out of practice)) Numerator definitions: Select 'Test ordered, results not yet documented' only if there is documentation in the chart that a test that reports HER-2/neu analyses was ordered. In the absence of any documentation regarding HER-2/neu status, select 'Test not ordered/no documentation.' Enter information from the most recent test report. Patients are classified as having HER-2 positive disease based on positive results with either test. If the most recent report indicates insufficient sample, select 'Test ordered, insufficient sample for results.' If a physician note and the HER-2/neu report differ in results, report the status in the physician note if the note explains the discrepancy. Otherwise, report the status from the HER-2/neu report. Use the following definitions to determine HER-2/neu status: Positive: • IHC 3+ cell surface protein expression (defined as uniform intense membrane staining of >30% of invasive tumor cells) or • FISH ratio >2.2 or

	1878 Human epidermal growth factor receptor 2 (HER2) testing in breast cancer
	• HER2 gene copy >6.0 Equivocal: • Not positive according to any of the criteria above, AND • (IHC with scores 2+ AND FISH ratio 1.8-2.2) or • HER2 gene copy 4.0-6.0 Negative: • Not positive according to any of the criteria above, AND • IHC 0 or 1+ or • FISH ratio 1.8 or • HER2 gene copy <4.0 • If the results indicate 'non-amplified', choose HER-2/neu negative. • If the results indicate 'weakly positive', choose HER-2/neu positive. New test ordered within 10 days of report of equivocal result: Respond 'Yes' if a new test was ordered within 10 days of oncologist review of the report with inconclusive results. Choose 'N/A' if the patient died or transferred out of the practice within 10 days of review of the report with inconclusive results or fewer than 10 days have passed. If the chart documents that the pathologist has ordered a new test, respond 'Yes.'
Denominator Statement	Adult women with invasive breast cancer
Denominator Details	Time Window: None specified; should be specific to the periodicity of analysis. Female And 2 or more encounters at the reporting site And Age at diagnosis greater than or equal to 18 years And Breast cancer diagnosis (174.xx) Definitions Encounter = new patient visit (CPT 99201 -99205) or established patient (CPT 99211-99215), not consult (CPT 99241-99245) office consult or inpatient consult (CPT 99251-99255)
Exclusions	Patient history of metastatic cancer Multiple primaries prior to or within the measurement period
Exclusion Details	'Multiple primaries' is defined as two or more distinct cancer diagnoses. This includes patients with simultaneous bilateral breast cancer or two distinct cancers in one breast.
Risk Adjustment	No risk adjustment or risk stratification n/a
Stratification	n/a
Type Score	Rate/proportion better quality = higher score
Algorithm	This measure is a proportion with exclusions; thus, the calculation algorithm is: Patients meeting the numerator/(Patients in the denominator – Patients with valid exclusions) x 100.

	1878 Human epidermal growth factor receptor 2 (HER2) testing in breast cancer
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Appendix B: Project Steering Committee and NQF Staff

STEERING COMMITTEE

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Appendix C: Measures Endorsed in Cancer Since July 2008

NQF Number	Title	Steward
1628	**Patients with Advanced Cancer Screened for Pain at Outpatient Visits**	RAND Corporation
1626	**Patients Admitted to ICU who Have Care Preferences Documented**	RAND Corporation
1625	**Hospitalized Patients Who Die an Expected Death with an ICD that Has Been Deactivated**	RAND Corporation
1617	**Patients Treated with an Opiod who are Given a Bowel Regimen**	RAND Corporation
0579	**Annual Cervical Cancer Screening for High-Risk Patients**	Resolution Health, Inc.
0460	**Risk-adjusted morbidity and mortality for esophagectomy for cancer**	The Society of Thoracic Surgeons
0459	**Risk-adjusted Morbidity and Lobectomy for Lung cancer**	The Society of Thoracic Surgeons
0457	**Recording of Performance Status (Zubrod, Karnofsky, WHO or ECOG Performance Status) Prior to Lung or Esophageal Cancer Resection**	The Society of Thoracic Surgeons
0455	**Recording of Clinical Stage for Lung Cancer and Esophageal Cancer Resection**	The Society of Thoracic Surgeons
0365	**Pancreatic Resection Mortality Rate (IQI 9) (risk adjusted)**	Agency for Healthcare Research and Quality

NQF Number	Title	Steward
0360	**Esophageal Resection Mortality Rate (IQI 8)**	Agency for Healthcare Research and Quality
0209	**Comfortable Dying: Pain Brought to a Comfortable Level Within 48 Hours of Initial Assessment**	National Hospice and Palliative Care Organization
0208	**Family Evaluation of Hospice Care**	National Hospice and Palliative Care Organization
0139	**National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome**	Centers for Disease Control and Prevention
0138	**National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI)**	Centers for Disease Control and Prevention
0034	**Colorectal Cancer Screening**	National Committee for Quality Assurance
0032	**Cervical Cancer Screening**	National Committee for Quality Assurance

Appendix D: Related and Competing Measures

Comparison of NQF #1628, #1634 and NQF #0384

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care – Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Steward	RAND Corporation	RAND Corporation	RAND Corporation
Description	Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit	Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit	Adult patients with advanced cancer who are screened for pain with a standardized quantitative tool at each outpatient visit
Type	Process	Process	Process
Data Source	Electronic Clinical Data, Electronic Clinical Data : Registry, Paper Records Patients were identified via the testing organizations´ cancer registries. At one institution, outpatient pain vital sign scores were extracted electronically from the patient EHR. At other institutions, quantitative pain scores were collected via medical record abstraction.	Electronic Clinical Data, Electronic Clinical Data : Registry, Paper Records Patients were identified via the testing organizations´ cancer registries. At one institution, outpatient pain vital sign scores were extracted electronically from the patient EHR. At other institutions, quantitative pain scores were collected via medical record abstraction.	Electronic Clinical Data, Electronic Clinical Data : Registry, Paper Records Patients were identified via the testing organizations´ cancer registries. At one institution, outpatient pain vital sign scores were extracted electronically from the patient EHR. At other institutions, quantitative pain scores were collected via medical record abstraction.
Level	Facility, Health Plan, Integrated Delivery System	Facility, Health Plan, Integrated Delivery System	Facility, Health Plan, Integrated Delivery System
Setting	Ambulatory Care : Clinician Office	Ambulatory Care : Clinician Office	Ambulatory Care : Clinician Office
Numerator Statement	Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool	Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool	Outpatient visits from the denominator in which the patient was screened for pain (and if present, severity noted) with a quantitative standardized tool

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care – Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Numerator Details	**Time Window:** At the time of outpatient visit(s) Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.	**Time Window:** At the time of outpatient visit(s) Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.	**Time Window:** At the time of outpatient visit(s) Pain screening with a standardized quantitative tool during the primary care or cancer-related/specialty outpatient visit(s). Screening may be completed using verbal, numeric, visual analog, rating scales designed for use with nonverbal patients, or other standardized tools.
Denominator Statement	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit	Adult patients with advanced cancer who have at least 1 primary care or cancer-related/specialty outpatient visit
Denominator Details	**Time Window:** At the time of outpatient visit(s) Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion	**Time Window:** At the time of outpatient visit(s) Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion	**Time Window:** At the time of outpatient visit(s) Adult patients with Stage IV cancer who are alive 30 days or more after diagnosis and who have had at least 1 primary care visit or cancer-related/specialty outpatient visit. Cancer-related visit = any oncology (medical, surgical, radiation) visit, chemotherapy infusion
Exclusions	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)	None (other than those patients noted in 2a1.7. who did not survive at least 30 days after cancer diagnosis)
Exclusion Details			
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification	No risk adjustment or risk stratification
Stratification			

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care – Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	1. Identify patients at least 18 years of age with Stage IV cancer 2. Identify patients who have had at least 1 primary care or cancer-related visit. Exclude patients who are not alive 30 or more days after diagnosis. 3. For each applicable visit, determine if a screening for pain was performed using a quantitative standardized tool. 4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits	1. Identify patients at least 18 years of age with Stage IV cancer 2. Identify patients who have had at least 1 primary care or cancer-related visit. Exclude patients who are not alive 30 or more days after diagnosis. 3. For each applicable visit, determine if a screening for pain was performed using a quantitative standardized tool. 4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits	1. Identify patients at least 18 years of age with Stage IV cancer 2. Identify patients who have had at least 1 primary care or cancer-related visit. Exclude patients who are not alive 30 or more days after diagnosis. 3. For each applicable visit, determine if a screening for pain was performed using a quantitative standardized tool. 4. Performance score = number of visits with standardized quantitative screening for pain/total number of outpatient visits
Submission items	**5.1 Identified measures:** **5a.1 Are specs completely harmonized?** Yes **5a.2 If not completely harmonized, identify difference, rationale, impact:** **5b.1 If competing, why superior or rationale for additive value:** This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundled measures for description of the selection and harmonization of the Key Palliative Measures Bundle. Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure.	**5.1 Identified measures:** **5a.1 Are specs completely harmonized?** Yes **5a.2 If not completely harmonized, identify difference, rationale, impact:** **5b.1 If competing, why superior or rationale for additive value:** This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundled measures for description of the selection and harmonization of the Key Palliative Measures Bundle. Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health care settings and are, therefore, not competing with the proposed measure.	**5.1 Identified measures:** **5a.1 Are specs completely harmonized?** Yes **5a.2 If not completely harmonized, identify difference, rationale, impact:** **5b.1 If competing, why superior or rationale for additive value:** This measure is part of the NPCRC Key Palliative Measures Bundle. Refer to the NPCRC cover letter and table of bundled measures for description of the selection and harmonization of the Key Palliative Measures Bundle. Measures 0677, 0675, 0523, and 0524 apply to nursing home and home health

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care – Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
	It is unclear exactly what the scope of measure 0420 is, however it appears to be directed at ancillary, non-physician professionals. It is unclear what "initiation of therapy" is referring to. The measure´s endorsement is time limited (endorsed July 31, 2008) Measure 0384 (paired with 0383) also has a time-limited endorsement (endorsed July 31, 2008). This measure targets only patients who are currently receiving chemotherapy or radiation therapy, and by definition, excludes some patients with advanced cancer who are not receiving this type of treatment. The proposed measure targets patients with Stage IV cancer and includes more venues of care than the existing measure where it would be applied (primary care and all cancer-related outpatient visits). This is in keeping with the reality that pain and pain control becomes a central focus for patients with late-stage cancer, and regular pain assessment should occur in multiple outpatient care settings. The developers propose that measure 0383 be limited to patients with Stage I-III cancer and endorse the proposed measure which targets Stage IV cancer patients. Proposed measure 1634: Hospice and Palliative Care - Pain Screening: Proposed measure 1634 targets patients with serious conditions who are entering hospice or hospital-based palliative care. The measure proposed here targets a sub-population (advanced cancer). However, the setting and	It is unclear exactly what the scope of measure 0420 is, however it appears to be directed at ancillary, non-physician professionals. It is unclear what "initiation of therapy" is referring to. The measure´s endorsement is time limited (endorsed July 31, 2008) Measure 0384 (paired with 0383) also has a time-limited endorsement (endorsed July 31, 2008). This measure targets only patients who are currently receiving chemotherapy or radiation therapy, and by definition, excludes some patients with advanced cancer who are not receiving this type of treatment. The proposed measure targets patients with Stage IV cancer and includes more venues of care than the existing measure where it would be applied (primary care and all cancer-related outpatient visits). This is in keeping with the reality that pain and pain control becomes a central focus for patients with late-stage cancer, and regular pain assessment should occur in multiple outpatient care settings. The developers propose that measure 0383 be limited to patients with Stage I-III cancer and endorse the proposed measure which targets Stage IV cancer patients. Proposed measure 1634: Hospice and Palliative Care - Pain Screening: Proposed measure 1634 targets patients with serious conditions who are entering hospice or hospital-based palliative care. The measure proposed here targets a sub-population (advanced cancer). However, the setting and	care settings and are, therefore, not competing with the proposed measure. It is unclear exactly what the scope of measure 0420 is, however it appears to be directed at ancillary, non-physician professionals. It is unclear what "initiation of therapy" is referring to. The measure´s endorsement is time limited (endorsed July 31, 2008) Measure 0384 (paired with 0383) also has a time-limited endorsement (endorsed July 31, 2008). This measure targets only patients who are currently receiving chemotherapy or radiation therapy, and by definition, excludes some patients with advanced cancer who are not receiving this type of treatment. The proposed measure targets patients with Stage IV cancer and includes more venues of care than the existing measure where it would be applied (primary care and all cancer-related outpatient visits). This is in keeping with the reality that pain and pain control becomes a central focus for patients with late-stage cancer, and regular pain assessment should occur in multiple outpatient care settings. The developers propose that measure 0383 be limited to patients with Stage I-III cancer and endorse the proposed measure which targets Stage IV cancer patients. Proposed measure 1634: Hospice and Palliative Care - Pain Screening: Proposed measure 1634 targets patients with serious

	1628 Patients with Advanced Cancer Screened for Pain at Outpatient Visits	1634 Hospice and Palliative Care – Pain Screening	0384 Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology (paired with 0383)
	timing of 1634 is hospice/palliative care admission and is a one-time screen. 1628 focuses on pain screening at all outpatient visits. Although the 2 measures focus on different venues of care (and 1 is a time measure and the other every visit), they are completely harmonized in content.	timing of 1634 is hospice/palliative care admission and is a one-time screen. 1628 focuses on pain screening at all outpatient visits. Although the 2 measures focus on different venues of care (and 1 is a time measure and the other every visit), they are completely harmonized in content.	conditions who are entering hospice or hospital-based palliative care. The measure proposed here targets a sub-population (advanced cancer). However, the setting and timing of 1634 is hospice/palliative care admission and is a one-time screen. 1628 focuses on pain screening at all outpatient visits. Although the 2 measures focus on different venues of care (and 1 is a time measure and the other every visit), they are completely harmonized in content.

Comparison of NQF #0220 and NQF #0387

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Steward	Commission on Cancer, American College of Surgeons	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who´s primary tumor is progesterone or estrogen receptor positive recommended for tamoxifen or third generation aromatase inhibitor (considered or administered) within 1 year (365 days) of diagnosis.	Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period
Type	Process	Process
Data Source	Electronic Clinical Data : Registry, Paper Records Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not applicable. Zip file for data dictionary/code table to be sent separately (cannot be attached to 2a1.30).
Level	Facility	Clinician : Group/Practice, Clinician : Individual, Clinician : Team

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Setting	Hospital/Acute Care Facility	Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic
Numerator Statement	Hormone therapy is considered or administered within 1 year (365 days) of the date of diagnosis	Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period Definition: Prescribed may include prescription given to the patient for tamoxifen or aromatase inhibitor (AI) at one or more visits in the 12-month period OR patient already taking tamoxifen or aromatase inhibitor (AI) as documented in the current medication list.
Numerator Details	**Time Window:** 1 year (365 days) Hormone Therapy [NAACCR Item#1400]=82-87 OR; Hormone Therapy [NAACCR Item#1400]=1, AND Date Hormone Therapy Started (NAACCR Item#710] <=365 days following Date of Diagnosis [NAACCR Item# 340]	**Time Window:** At least once during the measurement period For EHR: eMeasure (see attached). Administrative claims: Report the CPT Category II code: 4179F - Tamoxifen or aromatase inhibitor (AI) prescribed
Denominator Statement	Include if all of the following characteristics are identified: Women Age >=18 at time of diagnosis Known or assumed to be first or only cancer diagnosis Epithelial malignancy only Primary tumors of the breast AJCC T1c or Stage II or III Primary tumor is estrogen receptor positive or progesterone receptor positive All or part of 1st course of treatment performed at the reporting facility Known to be alive within 1 year (365 days) of date of diagnosis	All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Denominator Details	**Time Window:** Typically a 12 month, calendar year, time period Sex [NAACCR Item#220]=2; CS Tumor Size [NAACCR Item#2800= 010 and AJCC pN [NAACCR Item#890]=0, OR AJCC pN [NAACCR Item#890]=1, 2, or 3; AND CS SSF1 (ERA) [NAACCR Item#2880]=010 or 030; AND CS SSF2 (PRA) [NAACCR Item#2890]=010 or 030; AND Surgical Procedure of the Primary Site [NAACCR Item#1290] = 20–90	**Time Window:** 12 consecutive months For EHR: eMeasure (see attached). Administrative claims: AGE:>= 18 years and older Gender:>Female Diagnosis: Breast Cancer with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) AND ICD-9-CM diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 (malignant neoplasm of female breast ICD-10-CM diagnosis codes: C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919 AND CPT® Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, AND CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented OR CPT II 3376F: AJCC Breast Cancer Stage II, documented OR CPT II 3378F: AJCC Breast Cancer Stage III, documented AND CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Exclusions	Exclude, if any of the following characteristics are identified: Men Under age 18 at time of diagnosis Second or subsequent cancer diagnosis Tumor not originating in the breast Non-epithelial malignancies Stage 0, in-situ tumor AJCC T1mic, T1a, or T1b tumor Stage IV, metastatic tumor Primary tumor is estrogen receptor negative and progesterone receptor negative None of 1st course therapy performed at reporting facility Died within 1 year (365 days) of diagnosis	Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was >= 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period) Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient refusal) Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient is currently enrolled in a clinical trial)

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was = 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period), patient reason(s) (e.g., patient refusal) or system reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient is currently enrolled in a clinical trial). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eMeasure (see attached). Administrative claims: Append modifier to CPT Category II code: 4179F-1P Append modifier to CPT Category II code: 4179F-2P Append modifier to CPT Category II code: 4179F-3P

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification None
Stratification	No stratification applied	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf	To calculate performance rates: 1) Find the patients who meet the initial patient population (i.e., the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) ((e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was = 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period), patient reason(s) (e.g., patient refusal), or system reason(s) (e.g., patient is currently enrolled in a clinical trial)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
		removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620676683828729.pdf
Submission items	**5.1 Identified measures:** **5a.1 Are specs completely harmonized?** **5a.2 If not completely harmonized, identify difference, rationale, impact:** **5b.1 If competing, why superior or rationale for additive value:**	**5.1 Identified measures:** 0220 : 0220: Adjuvant hormonal therapy **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** No related measures; See competing measures section below regarding the harmonization of measure specifications. **5b.1 If competing, why superior or rationale for additive value:** Measure 0220 is similarly limited to stage I through III breast cancer patients whose primary tumor is progesterone or estrogen receptor positive. Measure 0220 requires that the agents be considered or administered within 1 year of diagnosis while our measure looks at the receipt of adjuvant endocrine therapy over time, specifically whether the agents were prescribed once within a 12 month reporting period. Since the recommended treatment duration of adjuvant endocrine therapy is 5 years, our measure includes medical reason exceptions to allow physicians to exclude patients who have already received the agents for the recommended duration and for other medical reasons. Our measure assess performance at the individual physician level while measure 0220 was designed to assess performance at the facility level.

Comparison of NQF #0385 and NQF #0223

	Measure 0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Measure 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
Steward	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)	Commission on Cancer, American College of Surgeons
Description	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy or have previously received adjuvant chemotherapy within the 12 month reporting period	Percentage of patients under the age of 80 with AJCC III (lymph node positive) colon cancer for whom adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery.
Type	Process	Process
Data Source	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Medical Records Not applicable. Zip file for data dictionary/code table to be sent separately (cannot be attached to 2a1.30).	Electronic Clinical Data : Registry, Paper Records Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html
Level	Clinician : Group/Practice, Clinician : Individual, Clinician : Team	Facility
Setting	Ambulatory Care : Clinician Office/Clinic, Other Oncology/Outpatient Clinic; Radiation Oncology Dept/Clinic	Hospital/Acute Care Facility

	Measure 0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Measure 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
Numerator Statement	Patients who are referred for adjuvant chemotherapy, prescribed adjuvant chemotherapy, or have previously received adjuvant chemotherapy* within the 12 month reporting period Definition: Adjuvant Chemotherapy: *According to current NCCN guidelines, the following therapies are recommended: 5-FU/LV/oxaliplatin (mFOLFOX6) as the standard of care (Category 1); bolus 5-FU/LV/oxaliplatin (FLOX, Category 1), capecitabine/oxaliplatin (CapeOx, Category 1); or single agent capecitabine (Category 2A) or 5-FU/LV (Category 2A) in patients felt to be inappropriate for oxaliplatin therapy. Due to the leucovorin shortage in the United States, levo-leucovorin used in its place may also satisfy the measure. Prescribed – may include prescription ordered for the patient for adjuvant chemotherapy at one or more visits in the 12-month period OR patient already receiving adjuvant chemotherapy as documented in the current medication list	Chemotherapy is considered or administered within 4 months (120 days) of diagnosis
Numerator Details	**Time Window:** At least once during the measurement period. For EHR: eMeasure (See attached) Administrative claims Report the CPT Category II code: 4180F - Adjuvant chemotherapy referred, prescribed, or previously received for Stage IIIA through IIIC colon cancer	**Time Window:** 4 months (120 days) Chemotherapy [NAACCR Item#1390]=82-87 OR; Chemotherapy [NAACCR Item#1390]=3, and Date Chemotherapy Started (NAACCR Item#1220] <=120 days following Date of Diagnosis [NAACCR Item# 340]

	Measure 0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Measure 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
Denominator Statement	All patients aged 18 years and older with Stage IIIA through IIIC colon cancer	Include, if all of the following characteristics are identified: Age 18-79 at time of diagnosis Known or assumed to be first or only cancer diagnosis Primary tumors of the colon Epithelial malignancy only At least one pathologically examined regional lymph node positive for cancer (AJCC Stage III) All or part of 1st course of treatment performed at the reporting facility2 Known to be alive within 4 months (120 days) of diagnosis
Denominator Details	**Time Window:** 12 consecutive months. For EHR: eMeasure (See attached) Administrative claims data: AGE: >= 18 years AND Diagnosis: Colon Cancer ICD-9-CM diagnosis codes: 153.0, 153.1, 153.2, 153.3, 153.4, 153.6, 153.7, 153.8, 153.9 (malignant neoplasm of colon). ICD-10-CM diagnosis codes: C18.0, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9 AND CPT® Codes: 99201, 99202, 99203, 99204, 99205 99212, 99213, 99214, 99215	**Time Window:** Typically a 12 month, calendar year, time period Age at Diagnosis [NAACCR Item#230] < 80, AND Surgical Procedure of the Primary Site [NAACCR Item#1290] = 30–90, AND Regional Lymph Nodes Positive [NAACCR Item#820] = 1-90, 95, 97

	Measure 0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Measure 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
Exclusions	Documentation of medical reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., medical comorbidities, patient over the age of 80, diagnosis date more than 5 years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status) Documentation of patient reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient refusal) Documentation of system reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy)	Exclude, if any of the following characteristics are identified: Age <18 and >=80; not a first or only cancer diagnosis; non-epithelial and non-invasive tumors; no regional lymph nodes pathologically examined; metastatic disease (AJCC Stage IV); not treated surgically; died within 4 months (120 days) of diagnosis
Exclusion Details	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (e.g., medical comorbidities, patient over the age of 80, diagnosis date more than 5 years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status), patient reason(s) (e.g., patient refusal) or system reason(s) for not referring for or prescribing adjuvant chemotherapy (e.g., patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf

	Measure 0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Measure 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
	reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eMeasure (See attached) Administrative claims: Denominator Exceptions: Append modifier to CPT Category II code: 4180F-1P Append modifier to CPT Category II code: 4180F-2P Append modifier to CPT Category II code: 4180F-3P	
Risk Adjustment	No risk adjustment or risk stratification None	No risk adjustment or risk stratification
Stratification	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.	No stratification applied
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	To calculate performance rates: 1) Find the patients who meet the initial patient population (i.e., the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf

	Measure 0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Measure 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
	identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) (e.g., medical comorbidities, patient over the age of 80, diagnosis date more than 5 years prior to the current visit date, diagnosis date is within 120 days of the end of the 12 month reporting period, patient's cancer has metastasized, medical contraindication/allergy, poor performance status), patient reason(s) (e.g., patient refusal) or system reason(s)(e.g., patient is currently enrolled in a clinical trial that precludes prescription of chemotherapy). If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment Generic Measure Logic-634620633024859689.pdf	

	Measure 0385 Oncology: Chemotherapy for Stage IIIA through IIIC Colon Cancer Patients	Measure 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer
Submission items	**5.1 Identified measures:** 0223 : 0223: Adjuvant chemotherapy is considered or administered within 4 months (120 days) of surgery to patients under the age of 80 with AJCC III (lymph node positive) colon cancer **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** No related measures; See competing measures section below regarding the harmonization of measure specifications. **5b.1 If competing, why superior or rationale for additive value:** Measure 0223 is limited to Stage III colon cancer patients under the age of 80 following surgical treatment. Although our measure focuses on stage III colon cancer patients, it does not focus only on patients following surgical treatment. However, the numerator of the measure allows for current OR PREVIOUS receipt of adjuvant chemotherapy as well as a referral for adjuvant chemotherapy. This approach offers a great likelihood of achieving a sufficient sample size to measure performance at the individual physician level. Additionally, patients over the age of 80 can be excluded from the patient population through the use of a medical reason exception. Our measure assesses performance at the individual physician level while measure 0223 was designed to assess performance at the facility level.	**5.1 Identified measures:** **5a.1 Are specs completely harmonized?** **5a.2 If not completely harmonized, identify difference, rationale, impact:** **5b.1 If competing, why superior or rationale for additive value:**

Comparison of NQF #0220 and NQF #0387

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Steward	Commission on Cancer, American College of Surgeons	American Medical Association - Physician Consortium for Performance Improvement (AMA-PCPI)
Description	Percentage of female patients, age >18 at diagnosis, who have their first diagnosis of breast cancer (epithelial malignancy), at AJCC stage I, II, or III, who´s primary tumor is progesterone or estrogen receptor positive recommended for tamoxifen or third generation aromatase inhibitor (considered or administered) within 1 year (365 days) of diagnosis.	Percentage of female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period
Type	Process	Process
Data Source	Electronic Clinical Data : Registry, Paper Records Hospital cancer registry data, reported to the American College of Surgeons, Commission on Cancer, National Cancer Data Base URL http://www.naaccr.org/StandardsandRegistryOperations/VolumeII.aspx URL http://www.facs.org/cancer/coc/fordsmanual.html	Administrative claims, Electronic Clinical Data, Electronic Clinical Data : Electronic Health Record, Electronic Clinical Data : Registry, Paper Records Not applicable. Zip file for data dictionary/code table to be sent separately (cannot be attached to 2a1.30).
Level	Facility	Clinician : Group/Practice, Clinician : Individual, Clinician : Team
Setting	Hospital/Acute Care Facility	Ambulatory Care : Clinician Office, Other Oncology/Outpatient Clinic
Numerator Statement	Hormone therapy is considered or administered within 1 year (365 days) of the date of diagnosis	Patients who were prescribed tamoxifen or aromatase inhibitor (AI) during the 12 month reporting period Definition: Prescribed may include prescription given to the patient for tamoxifen or aromatase inhibitor (AI) at one or more visits in the 12-month period OR patient already taking tamoxifen or aromatase inhibitor (AI) as documented in the current medication list.
Numerator Details	**Time Window:** 1 year (365 days) Hormone Therapy [NAACCR Item#1400]=82-87 OR; Hormone Therapy [NAACCR Item#1400]=1, AND Date Hormone Therapy Started (NAACCR Item#710] <=365 days following Date of Diagnosis [NAACCR Item# 340]	**Time Window:** At least once during the measurement period For EHR: eMeasure (see attached). Administrative claims: Report the CPT Category II code: 4179F - Tamoxifen or aromatase inhibitor (AI) prescribed

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Denominator Statement	Include if all of the following characteristics are identified: Women Age >=18 at time of diagnosis Known or assumed to be first or only cancer diagnosis Epithelial malignancy only Primary tumors of the breast AJCC T1c or Stage II or III Primary tumor is estrogen receptor positive or progesterone receptor positive All or part of 1st course of treatment performed at the reporting facility Known to be alive within 1 year (365 days) of date of diagnosis	All female patients aged 18 years and older with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Denominator Details	**Time Window:** Typically a 12 month, calendar year, time period Sex [NAACCR Item#220]=2; CS Tumor Size [NAACCR Item#2800= 010 and AJCC pN [NAACCR Item#890]=0, OR AJCC pN [NAACCR Item#890]=1, 2, or 3; AND CS SSF1 (ERA) [NAACCR Item#2880]=010 or 030; AND CS SSF2 (PRA) [NAACCR Item#2890]=010 or 030; AND Surgical Procedure of the Primary Site [NAACCR Item#1290] = 20–90	**Time Window:** 12 consecutive months For EHR: eMeasure (see attached). Administrative claims: AGE:>= 18 years and older Gender:>Female Diagnosis: Breast Cancer with Stage IC through IIIC, estrogen receptor (ER) or progesterone receptor (PR) AND ICD-9-CM diagnosis codes: 174.0, 174.1, 174.2, 174.3, 174.4, 174.5, 174.6, 174.8, 174.9 (malignant neoplasm of female breast ICD-10-CM diagnosis codes: C50.011, C50.012, C50.019, C50.111, C50.112, C50.119, C50.211, C50.212, C50.219, C50.311, C50.312, C50.319, C50.411, C50.412, C50.419, C50.511, C50.512, C50.519, C50.611, C50.612, C50.619, C50.811, C50.812, C50.819, C50.911, C50.912, C50.919 AND CPT® Codes: 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215, AND CPT II 3374F: AJCC Breast Cancer Stage I: TIC (tumor size > 1 cm to 2 cm), documented OR CPT II 3376F: AJCC Breast Cancer Stage II, documented OR CPT II 3378F: AJCC Breast Cancer Stage III, documented AND CPT II 3315F: Estrogen receptor (ER) or progesterone receptor (PR) positive breast cancer

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Exclusions	Exclude, i f any of the following characteristics are identified: Men Under age 18 at time of diagnosis Second or subsequent cancer diagnosis Tumor not originating in the breast Non-epithelial malignancies Stage 0, in-situ tumor AJCC T1mic, T1a, or T1b tumor Stage IV, metastatic tumor Primary tumor is estrogen receptor negative and progesterone receptor negative None of 1st course therapy performed at reporting facility Died within 1 year (365 days) of diagnosis	Documentation of medical reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was >= 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period) Documentation of patient reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient refusal) Documentation of system reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient is currently enrolled in a clinical trial)

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Exclusion Details	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf	The PCPI methodology uses three categories of reasons for which a patient may be excluded from the denominator of an individual measure. These measure exception categories are not uniformly relevant across all measures; for each measure, there must be a clear rationale to permit an exception for a medical, patient, or system reason. Examples are provided in the measure exception language of instances that may constitute an exception and are intended to serve as a guide to clinicians. For this measure, exceptions may include medical reason(s) (e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was = 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period), patient reason(s) (e.g., patient refusal) or system reason(s) for not prescribing tamoxifen or aromatase inhibitor (e.g., patient is currently enrolled in a clinical trial). Where examples of exceptions are included in the measure language, these examples are coded and included in the eSpecifications. Although this methodology does not require the external reporting of more detailed exception data, the PCPI recommends that physicians document the specific reasons for exception in patients' medical records for purposes of optimal patient management and audit-readiness. The PCPI also advocates the systematic review and analysis of each physician's exceptions data to identify practice patterns and opportunities for quality improvement. For example, it is possible for implementers to calculate the percentage of patients that physicians have identified as meeting the criteria for exception. Additional details by data source are as follows: For EHR: eMeasure (see attached). Administrative claims: Append modifier to CPT Category II code: 4179F-1P Append modifier to CPT Category II code: 4179F-2P Append modifier to CPT Category II code: 4179F-3P

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
Risk Adjustment	No risk adjustment or risk stratification	No risk adjustment or risk stratification None
Stratification	No stratification applied	We encourage the results of this measure to be stratified by race, ethnicity, gender, and primary language, and have included these variables as recommended data elements to be collected.
Type Score	Rate/proportion better quality = higher score	Rate/proportion better quality = higher score
Algorithm	See: http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf URL http://www.facs.org/cancer/ncdb/cp3rv2-measurespecs-1211.pdf	To calculate performance rates: 1) Find the patients who meet the initial patient population (i.e., the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the Numerator (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exception when exceptions have been specified [for this measure: medical reason(s) ((e.g., patient's disease has progressed to metastatic, patient is receiving a gonadotropin-releasing hormone analogue, patient has received oophorectomy, patient is currently receiving radiation or chemotherapy, patient's diagnosis date was = 5 years from reporting date, patient's diagnosis date is within 120 days of the end of the 12 month reporting period), patient reason(s) (e.g., patient refusal), or system reason(s) (e.g., patient is currently enrolled in a clinical trial)]. If the patient meets any exception criteria, they should be removed from the denominator for performance calculation. --Although the exception cases are

	Measure 0220: Adjuvant hormonal therapy	Measure 0387: Oncology: Hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer
		removed from the denominator population for the performance calculation, the number of patients with valid exceptions should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exception is not present, this case represents a quality failure. See calculation algorithm in attachment 2a1.21. Attachment AMA-PCPI_Measure Calculation-Standard Measures-634620676683828729.pdf
Submission items	**5.1 Identified measures:** **5a.1 Are specs completely harmonized?** **5a.2 If not completely harmonized, identify difference, rationale, impact:** **5b.1 If competing, why superior or rationale for additive value:**	**5.1 Identified measures:** 0220 : 0220: Adjuvant hormonal therapy **5a.1 Are specs completely harmonized?** No **5a.2 If not completely harmonized, identify difference, rationale, impact:** No related measures; See competing measures section below regarding the harmonization of measure specifications. **5b.1 If competing, why superior or rationale for additive value:** Measure 0220 is similarly limited to stage I through III breast cancer patients whose primary tumor is progesterone or estrogen receptor positive. Measure 0220 requires that the agents be considered or administered within 1 year of diagnosis while our measure looks at the receipt of adjuvant endocrine therapy over time, specifically whether the agents were prescribed once within a 12 month reporting period. Since the recommended treatment duration of adjuvant endocrine therapy is 5 years, our measure includes medical reason exceptions to allow physicians to exclude patients who have already received the agents for the recommended duration and for other medical reasons. Our measure assess performance at the individual physician level while measure 0220 was designed to assess performance at the facility level.

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