Performance Measurement Coordination Strategy for PPS-Exempt Cancer Hospitals

Executive Summary

Eleven hospitals in the United States that specialize in treating people with cancer are exempt from the Medicare Prospective Payment System (PPS) because their focus on cancer care is too narrow for the PPS to work. Subsequently, these hospitals have not participated in quality reporting programs that now apply to most other hospitals, such as the Hospital Inpatient Quality Reporting and Outpatient Quality Reporting Programs.

The Patient Protection and Affordable Care Act (ACA) changes that, establishing the PPS-Exempt Cancer Hospital Quality Reporting Program. Beginning in 2014, the 11 cancer hospitals must report quality data to the Department of Health and Human Services (HHS). This shift is part of a broader effort to push measurement-driven quality improvement into every corner of healthcare.

With the creation of this new quality reporting program, HHS turned to the Measure Applications Partnership (MAP) to help develop a quality measurement strategy for the 11 PPS-exempt cancer hospitals. MAP is comprised of 60 organizations representing diverse stakeholder interests. It was convened in 2011 by the National Quality Forum (NQF) for the purpose of providing guidance on measures for use in public reporting, performance-based payment, and other performance measurement programs in both the public and private sectors.

In this report, MAP identifies priorities for PPS-exempt cancer hospital quality reporting and presents an initial core set of 22 existing measures. However, MAP emphasizes that critical concerns for cancer patients and their families are not yet fully captured in available quality measures. MAP recommends these gaps in measurement be addressed for PPS-exempt hospitals, as well as for other facilities and settings where cancer patients receive care. Priority measure gaps include:

- Survival associated with cancer diagnoses, including information broken out by the stage and/or sub-type of cancer – to inform decision-making about providers and treatments;
- Experience of care and quality of life, including patients' assessments of their functional status, pain management, and other symptoms;
- Coordination of care and care planning, especially when people transition from one setting of care to another (hospital to nursing home, for example);
- Cost of care, including measures that gauge potential overuse or underuse of treatments; and
- Assessment of palliative and hospice care, emphasizing team-based care coordinated across settings.

MAP recognizes that measuring performance of PPS-exempt cancer hospitals can pose technical problems. Chief among these is that the number of patients with less common forms of cancer may be

so small that it may become difficult to draw meaningful conclusions from performance scores. To combat this challenge, MAP suggests greater use of cross-cutting measures looking at broader aspects of care such as patient safety, care transitions, and patient-reported experience of care, in addition to diagnosis-specific measures.

The report discusses several private-sector efforts that have laid groundwork for measuring cancer care quality. MAP acknowledges, for example, the important role played by cancer registries in promoting higher quality cancer care – notably, registries associated with the American Society of Clinical Oncology's Quality Oncology Practice Initiative and the American College of Surgeon's National Cancer Data Base. However, MAP notes that these and other registries were not designed to provide real-time tracking of unique patients across the continuum of cancer care. Therefore, they may be missing data on outpatient care, often have insufficient detail about specific treatments, and lack timely reporting of data to providers and the public. To improve the data infrastructure, MAP urges standardized data collection and transmission mechanisms for performance measurement.

MAP continues to emphasize the importance of alignment across settings and levels of care. This is especially important for people with cancer since they receive care in multiple settings – ambulatory sites, local community hospitals, PPS-exempt cancer hospitals, post-acute care and long-term care facilities, hospice programs, and at home – and often move back and forth among those settings over extended episodes of illness and treatment. Aligned performance measurement among all providers offering cancer care services promotes coordination of care around the patient and more efficient data collection for providers.

Specialty cancer hospitals have an important niche in clinical care, frequently treating people with the most difficult forms of cancer. These hospitals are also often on the forefront of pioneering innovations. Given the complexity and cost of cancer care, prevalence of the disease, and care coordination and patient preference issues that can arise in treating cancer, quality reporting by PPS-exempt cancer hospitals represents a valuable opportunity to stir innovations in measure development; currently, there are scant nationally-endorsed measures of outcomes and patient- and family-centered care with respect to cancer.[i] Better measures and greater alignment in cancer care quality measurement across all providers offering cancer services will support movement toward achieving the goals of the NQS.

Background

MAP is a public-private partnership convened by the National Quality Forum (NQF) for the primary purpose of providing input to HHS on selecting performance measures for public reporting, performance-based payment, and other programs (Appendix A—MAP Background). The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with a consensus-based entity (i.e., NQF) to "convene multistakeholder groups to provide input on the selection of quality measures" for various uses.[ii]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—is designed to provide HHS with thoughtful input on performance measure selection from a broad array of affected stakeholders (Appendix B—

Coordinating Committee Roster). Particularly, MAP has been charged with developing a measurement strategy for PPS-exempt cancer hospital performance measurement.

Previously, PPS-exempt cancer hospitals had been measuring and reporting on their performance for accreditation purposes, but had not been required to participate in federal quality data reporting programs such as the Hospital Inpatient Quality Reporting (IQR) and Outpatient Quality Reporting (OQR) Programs. However, the Affordable Care Act established the PPS-Exempt Cancer Hospital Quality Reporting Program, requiring the 11 PPS-exempt cancer hospitals to publicly report quality data. The statute requires that measures of process, structure, outcomes, patients' perspective on care, efficiency, and cost of care be included in the reporting program. Beginning in FY 2014, these cancer hospitals must report quality data to CMS, with no Medicare payment penalty or incentive.

Table 1. PPS-Exempt Cancer Hospitals

PPS-Exempt Cancer Hospitals
American Oncologic Hospital (Fox Chase) (Philadelphia, PA)
Arthur G. James Cancer Center Hospital and Research Institute (Columbus, OH)
City of Hope National Medical Center (Duarte, CA)
Dana Farber Cancer Institute (Boston, MA)
Fred Hutchinson Cancer Research Center (Seattle, WA)
H. Lee Moffitt Cancer and Research Institute Hospital, Inc. (Tampa, FL)
Memorial Hospital for Cancer and Allied Disease (New York, NY)
Roswell Park Memorial Institute (Buffalo, NY)
The University of Texas M.D. Anderson Cancer Center (Houston, TX)
University of Miami Hospital and Clinics (Miami, FL)
USC Kenneth Norris Jr. Cancer Hospital (Los Angeles, CA)

PPS-Exempt Cancer Hospital Services

PPS-exempt cancer hospitals function as health systems offering comprehensive cancer services. These institutions are dedicated to deepening the understanding of the causes and cures for cancer; developing new treatments for cancer; and disseminating this knowledge to the provider community at large.[iii] While focusing on specialized multi-disciplinary inpatient and outpatient cancer treatment, including diagnostic, surgical, medical, chemotherapy and radiation treatment, they also provide preventive and screening services as well as palliative and end-of-life care.

These hospitals treat common cancers as well as rare cancers that are not treated at other facilities and offer new and experimental treatments through extensive clinical trials programs.[iv] The resulting patient population is often medically complex and undergoing extensive treatment regimens not affording these institutions a broad enough mix of patients to allow the PPS system to work.[v,vi,vii] Consequently, the PPS exemption was created for these cancer hospitals. To qualify for this exemption, a cancer hospital must be:

- recognized by the National Cancer Institute as a comprehensive cancer center or a clinical cancer research center as of April 20, 1983;
- recognized by the Health Care Financing Administration (now the Centers for Medicare & Medicaid Services) as a cancer hospital on or before December 31, 1990; and
- organized primarily for cancer research or treatment, with at least 50% of total discharges having a principal diagnosis of neoplastic disease.[viii]

Beyond cancer-specific treatment, these systems also monitor and treat patients' co-morbid conditions to manage the impact of the disease and effects of the cancer treatment. This approach to providing wide-ranging patient care services enables the PPS-exempt cancer hospitals treat the whole patient, not just cancer diagnoses.

Approach

The MAP Hospital Workgroup advised the Coordinating Committee on developing the performance measurement coordination strategy for PPS-exempt cancer hospitals. The MAP Hospital Workgroup is a 25-member, multistakeholder group (Appendix C – Hospital Workgroup Roster). The agenda and materials for the Hospital Workgroup meeting focused on completion of this task can be found on the NQF website.

This task involved identification of priorities for PPS-exempt cancer hospital measurement and review of available performance measures for cancer care to construct a core set of measures for quality reporting for those entities. NQF staff compiled a table of NQF-endorsed® measures for cancer care (Appendix D – Endorsed Measures Table). The tables included measure attributes such as endorsement status, description, steward, numerator, denominator, data sources, and type, as well as the corresponding settings and programs in which the measure is used. Further, each measure within the table was mapped to the relevant National Quality Strategy (NQS) priorities. MAP also identified opportunities for alignment of measurement efforts as well as for measure development and endorsement needed to fill performance measurement gaps.

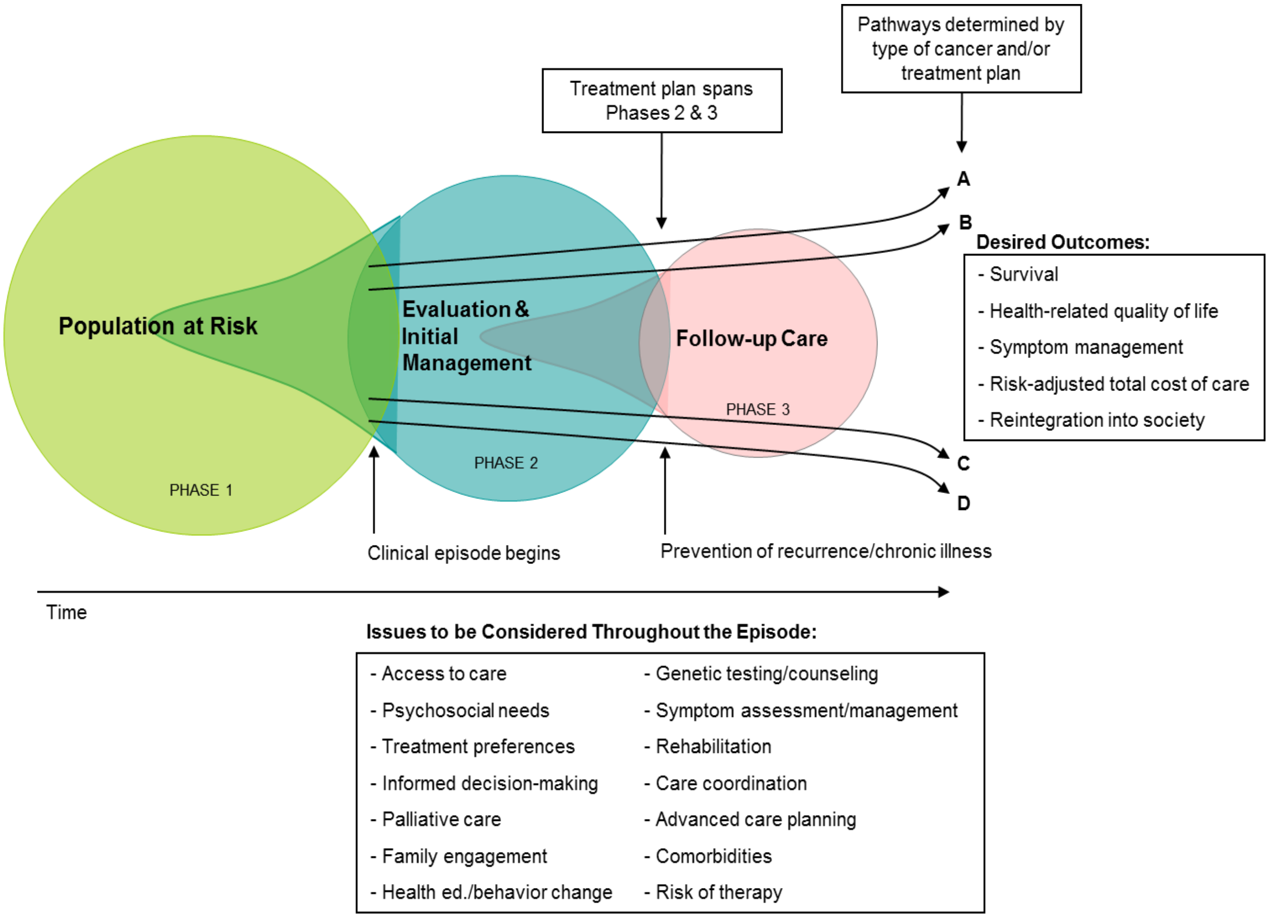
Additionally, the workgroup built on the data platform principles outlined in MAP's Coordination Strategy for Clinician Performance Measurement by adding considerations specific to PPS-exempt cancer hospital measurement. Current data sources and data collection efforts, specifically existing cancer registries, were reviewed and discussed. Promising practices were identified and the workgroup discussed PPS-exempt cancer hospitals' adoption of health IT as a way to reduce data collection burden.

Patient-Centered Cancer Care

MAP stresses the importance of establishing an approach in PPS-exempt cancer hospitals to measurement that is person-centric and aligned across various levels of care. Cancer is a chronic illness that afflicts people of all ages, from very young children to elderly individuals. Cancer care is provided in both acute and outpatient settings within these health systems. Additionally, patients with cancer diagnoses often have co-morbid conditions resulting from their cancer or treatment, or entirely unrelated to their cancer. Consequently, the provision of healthcare services in PPS-exempt cancer hospitals is not limited to cancer care. MAP determined that a measurement strategy for PPS-exempt cancer hospitals should address the whole patient across the entire patient episode.

In further developing a strategy for PPS-exempt cancer hospital quality measurement, MAP sought to build on prior NQF work addressing cancer care quality measurement. MAP preferred NQF-endorsed measures for inclusion within a PPS-exempt cancer hospital core measure set. In addition, MAP built on recommendations from the Value-Based Episodes of Care project for cancer quality measurement, which applied the NQF-endorsed Patient-Focused Episodes of Care model to cancer care. The major recommendations from this project include taking a person-centered approach to measurement and prioritizing outcomes and cross-cutting issues such as symptom management, clear communication, shared decision making, and end-of-life care with specific attention being given to psychosocial care needs of patients and families. The figure below illustrates a trajectory of cancer care from prevention through remission aligned with corresponding patient-centered issues for consideration, demonstrating key opportunities for performance measurement and quality improvement and identifying desired patient outcomes.[ix]

Figure 1. Patient-Focused Episode of Care Model for Cancer Care



The first phase, cancer screening and prevention, comes prior to diagnosis. Though this initial phase of care does not usually occur within PPS-exempt cancer hospitals, these systems do offer preventive services and, as such, those services are important to consider when developing a measurement strategy for PPS-exempt cancer hospitals. Once patients receive a cancer diagnosis, there are four typical pathways they may follow based on their type of cancer and treatment plan. The patient may move across phases of care from treatment, then to maintenance, and on to a surveillance phase once in remission (depicted in Figure 1 as pathways A and B, roughly related to stage I and II respectively). The surveillance phase could include measures looking at late effects of treatment, continued screening, and health-related quality of life. The trajectory for other patients may progress to palliative and end-of-life phases (depicted in Figure 1 as pathways C and D, roughly related to stages III and IV respectively).

Pathways A through D are based on tumor type and are built upon evidence-based guidelines, illustrating the various ways (and corresponding timeframes) by which a patient with cancer navigates diagnosis, evaluation, treatment, and follow-up care. Using colorectal cancer as an example, pathway A could represent a patient undergoing surgical treatment only (Stage I and some Stage II disease) while pathway D could represent a patient with advanced metastatic disease receiving minimal life-prolonging treatments and predominantly palliative care.

MAP noted that the cyclical nature of cancer treatment requires a unique approach to quality measurement. Within the treatment phase, the patient often receives frequently recurring doses of therapy over a discrete period of time. Additionally, patients' health status and care expectations can vary greatly depending on their phase of care. Measurement should reflect changing expectations throughout the course of treatment as patients repeatedly return to their providers for care. This approach also applies to the surveillance phase following remission as many survivors go on to live long, productive lives.

Using the Patient-Focused Episodes of Care model as a guide, MAP began its work to identify priorities for PPS-exempt cancer hospital measurement, establish a set of core measures and measurement gaps, and outline unique data and health IT considerations.

Priorities for PPS-Exempt Cancer Hospital Measurement

MAP continues to use the priorities outlined in the NQS to drive toward greater alignment by promoting the use of cross-cutting measures in all aspects of its work. The current cancer care measurement landscape consists of predominantly provider-focused disease-specific process of care measures. While those measures are important for making operational improvements in care, they do not cross various patients and settings to afford a better understanding of healthcare quality. The well-being and experience of patients should be the primary focus of measurement, helping to ensure that patients remain central to measuring and improving the overall quality of care in PPS-exempt cancer hospitals.

The quality measurement priorities for PPS-exempt cancer hospitals are not entirely dissimilar from other settings where cancer care is provided. As noted, these hospitals provide the full range of cancer care services spanning the entire patient-focused episode, as well as treatment for co-morbid conditions and complications. However, there are unique qualities of these hospitals that require a specialized approach to measurement. While PPS-exempt cancer hospitals provide preventive and screening services, the majority of their patients are referred following a diagnosis made elsewhere. Additionally, these facilities focus on specialized cancer care, including the care of rarer cancers, as well as recurrences of more common forms, leading to more specific priorities for measurement. MAP proposes that a measurement strategy for PPS-exempt cancer hospitals, including measurement priorities, a core measure set, and identified gaps, should focus on cross-cutting measures that align with the NQS aims and priorities, as well as disease-specific measures of survival.

MAP identified a number of measurement priorities for PPS-exempt cancer hospitals (Table 2), many of which are currently measure gap areas (see measure gaps discussion).

Table 2. Priorities for PPS-Exempt Cancer Hospital Measurement

Priority Areas
Survival
Patient-reported outcomes (e.g., experience of care, functional status, quality of life)
Care planning, reflecting individualized goals
Shared decision making
Patient and family engagement
Care coordination
Safety
Palliative and end-of-life care
Cost of care

Survival is an important outcome to patients, and as such, measures of patient survivorship are a high priority for PPS-exempt cancer hospital measurement. Measurement and public reporting on survival should include cancer type and sub-type as well as cancer-specific, stage-for-stage survival curves. There are many factors that contribute to variation in survival curves by stage, and only by measuring by stage can providers begin to define those determinants and establish which ones to target for improvement. Additionally, survival information should be made publically available to help patients and families make informed decisions regarding providers and treatments, as well as gain a better overall understanding of their illness. Members of MAP identified a list of cancer diagnoses that they believed should be addressed in the initial core measure set, expanding slightly beyond the Medicare High-Impact Conditions,[x] to include breast, colon, lung, prostate, gynecological, and pediatric cancers. As the measure set continues to evolve, MAP suggested that other types of cancers, such as esophageal, pancreatic, multiple myeloma, leukemia, melanoma and other skin cancers, brain, and adrenal, should be included as measures become available. However, it is important to balance the use of cross-cutting measures that may be more feasible to collect in the near term with the development and use of diagnosis-specific measures addressing the many cancer types treated at PPS-exempt cancer hospitals.

A core set should also include patient-reported outcomes, such as experience of care, psychosocial health, and quality of life. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are examples of patient experience of care measures currently used within federal programs. These surveys, developed by the Agency for Healthcare Research and Quality (AHRQ), have been adapted for multiple levels of care including hospitals, clinician and group practices, and home health. Further adaptation of these surveys for PPS-exempt cancer hospitals could be considered in addition to other work currently underway to develop cancer-specific measures of patient experience.

Given the stress and emotional aspects of receiving a cancer diagnosis and undergoing treatment, MAP emphasized the importance of measuring a patient's overall quality of life. Following diagnosis and throughout treatment, patients are continually receiving new information related to their illness, treatment regimen, and self-care programs. Further, as a result of their illness and treatment, patients often require additional assistance with such things as transportation, managing work and family life, and financial matters. All of these factors often cause mental health problems, such as depression and anxiety disorders, requiring additional support for cancer patients to help cope with their illness.[xi] An example of an existing tool that begins to capture patient perspectives is the Functional Assessment of Cancer Therapy-General (FACT-G) questionnaire, part of the Functional Assessment of Chronic Illness Therapy measurement system. The FACT-G is a quality-of-life questionnaire that evaluates a patient's physical, social, emotional, and functional well-being. This is a well-validated tool for assessing an individual patient's experience; however, the tool has not been used to measure the quality of care at a clinician or practice level.[xii] MAP suggests that it could be modified for facility-level performance measurement. A standardized, easy-to-use tool for collecting patient-reported information should be implemented across providers to enable comparisons and progress in improving patient experience.

MAP also emphasized the importance of cross-cutting measures that address shared decision making and patient and family engagement. Painting an overall picture for patients, including diagnosis, survival rates, treatment options, and the experiences of other patients leads to more informed decision making by patients and families. Coupling this information with patients' values and preferences for their care enables a patient-provider relationship involving true shared decision-making. The presence and effectiveness of shared decision making should be monitored as well.

Two additional areas of importance for PPS-exempt cancer hospital measurement are care coordination and patient safety. Navigating the health care system and intricate cancer treatment protocols can be overwhelming for patients and caregivers, particularly those who have to travel to a specialized center to receive treatment. Patients need a solid understanding of the risks and side effects of treatment to stay as safe as possible through the course of care. Medication reconciliation is particularly relevant to cancer care as patients are frequently receiving chemotherapeutic agents as well as a number of medications to manage the side effects of treatment as well as to manage other chronic conditions, some of which may be affected by the treatment of the cancer or side effects. As patients transition across settings and providers, effective communication and coordination are essential to safe cancer care and a positive patient experience.

MAP's *Performance Measurement Coordination Strategy for Hospice Care*[xiii] report contains specific information about measures for hospice and palliative care. Considering the continuum of hospice and palliative care, MAP noted that performance measures must be aligned across settings where these types of care are delivered and address a holistic, team-based, and patient- and family-centered approach to care. Patient and family engagement and care coordination are recognized as the highest priorities for measurement in these areas. When reviewing existing measures for this work, MAP determined that a number of measures currently available for hospice and palliative care are specified for the cancer population (noted in Appendix D). While continuing to refine measurement in both areas, these available measures could be expanded more broadly.

Cost of care is an important consideration for the cancer population with its often complex and expensive treatment regimens and increased susceptibility to complications. Access to necessary cancer treatment can be very costly and patients may have difficulty obtaining these services based on their ability to pay. Measures of initial diagnosis and treatment should ensure patients receive the correct diagnosis, including staging, followed by the most appropriate evidence-based treatment in the context of patients' preferences. Cancer care often requires resource intensive services, particularly at the end of life, which can lead to unwanted treatment if care is misaligned with patients' goals. Monitoring for appropriateness of care, considering under treatment, over treatment (e.g., imaging and chemotherapy), total cost of care by episode, and symptom management, is also a key component to ensuring care is provided in a safe and effective manner.

Defining a PPS-Exempt Cancer Hospital Core Measure Set

When establishing the core set of measures, MAP continued to emphasize the importance of taking an aligned, person-centric approach to measurement. In creating an initial core measure set, MAP aimed to focus on PPS-exempt cancer hospital care through inclusion of disease-specific measures, but also to address patient-centered care overall, incorporating cross-cutting measures.

There are currently 47 NQF-endorsed measures (Appendix D–Endorsed Measures Table) related to cancer covering a range of topic areas, including breast, colorectal, and blood cancers, as well as symptom management and end-of-life care. NQF is currently conducting an endorsement maintenance review that began in October 2011 where new measures will be reviewed.

In 2010, the Centers for Medicare & Medicaid Services (CMS) contracted with Mathematica and National Committee for Quality Assurance (NCQA) to identify possible measures for the new PPS-Exempt Cancer Hospital Quality Reporting Program. This contract included an environmental scan that identified cancer-specific and cross-cutting measures—specifically excluding measures of prevention, screening, and diagnosis—followed by the convening of a technical expert panel (TEP) to review and prioritize the measures. The TEP evaluated measures on the basis of relevance to a Medicare population, focusing on the four most common cancers found in the Medicare population (lung, breast, colorectal, and prostate), application to both inpatient and outpatient care, and promotion of evidence-based treatment. The TEP favored measures that are NQF-endorsed, already reported or collected by hospitals, available through claims or registry data, and appropriate for reporting by all hospitals that treat cancer patients, not just PPS-exempt cancer hospitals. Based on this analysis, including consultation with the contractor's TEP, CMS' contractor recommended to CMS three chemotherapy/hormone therapy for breast and colon measures developed by the Commission on Cancer and two hospital-acquired condition (HAC) measures developed by the Centers for Disease Control and Prevention (CDC) (Table 3).

Table 3. Measure Starter Set for PPS-Exempt Cancer Hospital Quality Reporting Recommended by CMS' Contractor

Condition/Area	Measure Name	NQF Measure Number and Status
Safety	Catheter-associated urinary tract infection	0138 Endorsed
Safety	Central line associated bloodstream infection	0139 Endorsed
Breast	Adjuvant hormonal therapy	0220 Endorsed
Breast	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	0559 Endorsed
Colon	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	0223 Endorsed

These five measures were then proposed for consideration by MAP during its 2012 pre-rulemaking activities as the initial set of measures for the PPS-Exempt Cancer Hospital Quality Reporting Program. In its *Pre-Rulemaking Report: Input on Measures Under Consideration by HHS for 2012 Rulemaking*, MAP supported the inclusion of these measures within the program while recognizing they are a good, albeit limited, starter set. MAP encouraged swift expansion beyond these measures in the coming years for more comprehensive assessment of the quality of care provided in PPS-exempt cancer hospitals.

Consistent with other MAP recommendations, MAP supported the use of NQF-endorsed measures within the PPS-Exempt Cancer Hospital Quality Reporting Program. MAP focused on the cancer types identified as priorities in the list of Medicare High-Impact Conditions[xiv] and the priorities of the National Quality Strategy. MAP developed the following list of existing measures to serve as an initial PPS-exempt cancer hospital core measure set (Table 4).

Table 4. PPS-Exempt Cancer Hospital Initial Core Measures List

Condition / Area	Measure Name	NQF Measure Number & Status
Patient & Family Engagement	Family evaluation of hospice care	0208 Endorsed
Symptom Management	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	0209 Endorsed
Symptom Management	Oncology: plan of care for pain—medical oncology and radiation oncology (paired with 0384)	0383 Endorsed
Symptom Management	Oncology: pain intensity quantified—medical oncology and radiation oncology (paired with 0383)	0384 Endorsed
Safety	Catheter-associated urinary tract Infection	0138 Endorsed*
Safety	Central line associated bloodstream infection	0139 Endorsed*
Safety	Oncology: radiation dose limits to normal tissues	0382 Endorsed
Breast	Post breast conserving surgery irradiation	0219 Endorsed
Breast	Adjuvant hormonal therapy	0220 Endorsed*
Breast	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	0221 Endorsed
Breast	Patients with early stage breast cancer who have evaluation of the axilla	0222 Endorsed
Breast	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	0559 Endorsed*
Breast, Colon	Oncology: cancer stage documented	0386 Endorsed
Colon	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	0223 Endorsed*
Colon	Completeness of pathology reporting	0224 Endorsed
Colon	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	0225 Endorsed
Colon	Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	0572 Endorsed
Lung	Risk-adjusted morbidity after lobectomy for lung cancer	0459 Endorsed
Prostate	Prostate cancer: avoidance of overuse measure—isotope bone scan for staging low-risk patients	0389 Endorsed
Prostate	Prostate Cancer: adjuvant hormonal therapy for high-risk patients	0390 Endorsed
Other cancers	Multiple myeloma—treatment with bisphosphonates	0380 Endorsed
Other cancers	Risk-adjusted morbidity and mortality for esophagectomy for cancer	0460 Endorsed

** Measures supported in MAP Pre-rulemaking input on the PPS-Exempt Cancer Hospital Quality Reporting Program*

MAP wrestled with whether to include existing screening measures in the core set, as PPS-exempt cancer hospitals provide those services, but determined that those services, though important, are not core to the specialized function of these systems. Ultimately, MAP identified the measures in Table 4 as an initial core set recognizing that these available measures are not broad enough to comprehensively assess quality of care.

In addition to these measures, MAP identified priority performance measurement gaps. It is necessary to develop, test, endorse, and implement measures in these identified gap areas to create a comprehensive core measure set. The highest priority gap areas identified by MAP, and also noted within the 2012 MAP pre-rulemaking report, include the following:

- Patient outcomes, particularly measures of cancer- and stage-specific survival as well as patient-reported measures
- Cost and efficiency of care, including measures of total cost, underuse, and overuse
- Appropriateness of care, considering the relationship between expected clinical benefit and expected clinical risk
- Health and well-being measures addressing quality of life, social, and emotional health
- Safety, in particular complications such as febrile neutropenia and surgical site infection
- Person- and family-centered care, including shared decision making and patient experience
- Care coordination, including transition communication between providers and medication reconciliation
- Prevention, such as public outreach and education
- Disparities measures, such as risk-stratified process and outcome measures, as well as access measures
- Pediatrics measures, including hematologic cancers and transitions to adult care
- Treatment of lung, prostate, and gynecological cancers

The initial measure set is not static, but should evolve over time as performance measurement improves and shortfalls in quality of care are identified. The set should be reevaluated periodically to obtain multi-stakeholder input on measures that should be added and removed as new, better measures become available, with an eye toward greater alignment across settings and programs. MAP continues to support the minimization of data collection burden while maximizing efficiencies in performance measurement among providers.

Data Source and Health Information Technology Implications

Unique characteristics of cancer care, such as the various sites and providers of treatment, cyclical nature of treatment, and presence across the lifespan, pose a number of operational challenges for data collection and public reporting. In previous reports discussing clinician and safety performance measurement coordination strategies, MAP identified a pressing need for common data collection and reporting practices to support performance measurement across the quality measurement enterprise. A common approach would allow for collection of the data needed to efficiently calculate quality measures. Data entered by a single provider at the point of care could flow from electronic health records (EHR), using common data collection principles and health information exchange (HIE) networks, to be combined with patient data of other providers for aggregation, analysis, reporting, and mining for research. Given the unique characteristics of PPS-exempt cancer hospitals, making this information available to other providers who are jointly involved in patients' care is of particular importance.

For this report, MAP reviewed the current collection and reporting processes for several cancer-related registries as a starting place to highlight potential opportunities and concerns for measurement in this area. Particular challenges include difficulty in collecting detailed patient-level data, delays in the availability of performance scores, concerns regarding the impact of small patient sample sizes, and challenges in collecting patient-reported measures. While noting a number of obstacles for measuring PPS-exempt cancer hospitals performance, MAP did identify promising practices that could demonstrate the feasibility of providing patient-level quality improvement data in a timely manner.

Currently, much of the information captured regarding the quality of cancer care is done through registries such as the American Society of Clinical Oncology's (ASCO's) Quality Oncology Practice Initiative (QOPI)[xv] and the American College of Surgeon's (ACS) National Cancer Data Base (NCDB).[xvi] QOPI provides registry abstracted data for physician practices for quality improvement focusing on care processes and covers steps in care from diagnosis through end of life. The NCDB collects cancer registry data from all Commission on Cancer[xvii] accredited programs to be used for comparative effectiveness research, retrospective quality monitoring and reporting, and active quality management. Registries such as these are very useful to providers and currently serve as the most common mechanism for cancer performance measurement and reporting. MAP encourages registries to also make this information available for public reporting and educational initiatives.

While registries play an important role in quality measurement and improvement, current cancer databases are limited in their ability to provide specific and timely data. The aggregate level at which data is currently being collected lacks specificity and is not conducive to providing an overall picture of the patient's care across the continuum. Existing cancer data registries are not designed to track unique patients across healthcare providers, leading to missing data on outpatient care and insufficient detail about specific therapies. Additionally, more patient-level detail is needed for identifying disparities in care while implementing controls to ensure data is captured in a uniform manner. It will be important to ensure that patient privacy is maintained while collecting this additional information. The greater use of EHRs by providers could increase standardization in data collection and documentation and lead to greater sharing of information across the continuum; however, challenges to the widespread adoption of EHRs still exist, including the cost of implementation and variation between systems developed by different vendors.

Another major concern about registries is timely availability of data. MAP recognized that providers need performance information as close to real time as possible to support better care decisions. When information is funneled through a registry, the delay in the accessibility of this data can be significant. In some instances there is a 2-to-3-year lag time in reporting data. A long lapse in time between the provision of care and the availability of performance scores can decrease provider accountability for the quality of their care. However, the development of new systems such as the Commission on Cancer Rapid Quality Reporting System[xviii] could allow for ongoing reporting of quality metrics and more proactive care management. This system allows providers to see performance at the individual patient level and receive alerts if a patient's care is not meeting quality measures, supporting proactive improvement in patient care.

MAP acknowledges that the issue of small sample sizes can be a major measurement challenge in the context of public reporting for PPS-exempt cancer hospitals. As providers try to measure the quality of care for patients with less common forms or more specific types of cancer, the number of appropriate patients to include within the denominator shrinks rapidly. Very small denominators adversely impact the ability of providers to reach meaningful clinical conclusions regarding quality of care. With a small data set, outliers can disproportionately skew results, reflecting an inaccurate representation of a provider's performance. The small numbers problem is particularly applicable to PPS-exempt cancer hospitals as these facilities often provide treatment for the rarest forms of cancers. As this information begins to be publicly reported, it should be used judiciously with appropriate context where concerns regarding small sample sizes may exist. Concerns about small denominators could be mitigated by reporting results over a longer timeframe or at health system, state, or regional levels. These concerns also support the need to report cross-cutting and structural measures, as well as clinical quality measures, when assessing the overall quality of care provided within a facility. These types of measures are applicable to the majority, if not all, patients receiving healthcare services, affording more accurate performance scores.

Although necessary to ensuring a person-centered measurement approach, the cyclical nature of cancer treatment can make the collection of patient-reported measures difficult. Accurately capturing the quality of patients' care and their experiences can be challenging when patients are returning repeatedly for treatments. Continually assessing patient experience through surveys and questionnaires poses additional burden on patients who are already working to manage a difficult illness and complex treatment regimen. Additionally, data-gathering processes and mechanisms currently used by providers are not designed to support efficient data collection and measure calculation of patient-reported information, placing additional strains on providers.

While PPS-exempt cancer hospital quality measurement presents a number of data issues, the United Healthcare Oncology Analysis Program is an example of a private sector program that demonstrates the feasibility of quality measurement for cancer care. This database of clinical and claims data creates a record for each patient that compares the care a patient is receiving against the National Comprehensive Cancer Network (NCCN) treatment guidelines. Participating oncologists receive aggregate national results in addition to results on their specific patients, along with guideline data. United Healthcare is also working with tumor registries to share data on tumors and treatment. However, issues of privacy around data sharing and the cost of data collection and reporting need to be more fully examined before a wide-scale adoption of a similar system would be possible.

Implications for Cancer Care Beyond PPS-Exempt Cancer Hospitals

Though this specific task focused on a performance measurement strategy for PPS-exempt cancer hospitals, MAP sought a more person-centered view to assess care provided across settings to people at risk for and diagnosed with cancer. As MAP noted in previous performance measurement coordination strategies, setting-specific silos can inhibit effective care coordination and aligned performance measurement. It is important to use consistent measures to ensure that high standards for the quality of cancer care are maintained across all settings and levels of care.

As outlined earlier in this report, cancer care spans the entire continuum, extending upstream and downstream beyond treatment and management received in a hospital setting. Cancer care begins with screening and prevention. There are existing NQF-endorsed measures that address screening for cervical, breast and colorectal cancers as well as surveillance and follow-up for melanoma, breast, and prostate cancers (see Appendix D). Successful inpatient and outpatient treatment leads to the need for follow-up care and surveillance. These services are typically provided in the ambulatory setting, and related or harmonized measures addressing these concepts should be included in associated measurement programs. Moreover, surveillance and palliative care can extend to post-acute care, long-term care, and hospice settings, so applicable cancer measures should be integrated into those related programs as well. Additional work is needed to promote alignment of cancer care measurement across programs in different settings, particularly exploring opportunities to harmonize existing measures as well as developing measures that span settings and provider types.

Patients with cancer may move back and forth between local community hospitals, ambulatory practices, and PPS-exempt cancer centers throughout their treatment. It is important to have consistent measures across differing acute care facilities. Specifically, MAP advises that cancer care measures should be included within the IQR measure set and that appropriate IQR measures should be applied to PPS-exempt cancer hospitals as a first step to aligning cancer care quality measurement. The initial starter set of measures for the Medicare PPS-Exempt Cancer Hospital Quality Reporting Program (Table 3) begins to address this issue by including two general patient safety measures. During MAP's discussion of these measures, a specific concern was raised regarding appropriate specifications for the central line-associated bloodstream infection (CLABSI) measure to differentiate between temporary and permanent central lines, the latter commonly found in cancer patients. Evidence-based protocols for the placement and care of permanent central lines differ from those of temporary central lines, particularly for cancer patients who, by the nature of their treatment, may be more prone to infections. As this example illustrates, inclusion of IQR measures within the PPS-Exempt Cancer Hospital Quality Reporting Program requires deliberate measure-by-measure consideration.

Finally, current federal quality measurement programs for both PPS-exempt cancer hospitals and general acute care hospitals focus on Medicare patients. However, cancer care measurement should extend across the lifespan from childhood to older adulthood. Recognizing the unique needs of pediatric cancer patients, MAP advises that measures focused on this population be considered in a broader performance measurement coordination strategy for cancer care. Transition measures related to the management of care as children grow are especially needed as the effects of cancer and treatment on children can differ greatly from the effects on adults. Inclusion of pediatric measures would encourage alignment across programs, beyond Medicare to include Medicaid and private payer programs.

Path Forward

The core measure set put forth in this report can serve as a fundamental initial list to benchmark cancer care across the 11 PPS-exempt cancer hospitals. MAP suggests that these hospitals could be measured by their results on the core set of measures to inform consumer and purchaser decision-making. Moving forward, MAP believes it is important that quality measurement for PPS-exempt cancer hospitals be patient-centered and align with measurement in other settings where patients with cancer receive care. This core set begins to aim toward a national core set for measuring cancer care across settings and levels of care.

Although data collection and reporting present a number of challenges to measurement by these hospitals, systems such as the Commission on Cancer Rapid Quality Reporting System and the United Healthcare Oncology Analysis Program show the feasibility and potential of providing quality data at an individual patient level and in real time. Additionally, with the increased use and integration of EHRs by providers, more accurate and timely data will become available to uncover opportunities for improvement. While small numbers can make quality measurement for rare cancers difficult, the use of expanded timeframes and geographic populations, as well as cross-cutting and structural measures, can allow for more accurate measurement.

The guidance MAP offers through this report serves as a starting place to better coordinate performance measurement efforts for cancer care. Applying this core measure set for PPS-exempt cancer hospitals and other cancer care providers will promote a more person-centered approach to better prevention and treatment of this disease.

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Appendix A—MAP Background

Purpose

The Measure Applications Partnership (MAP) is a public-private partnership convened by the National Quality Forum (NQF) for providing input to the Department of Health and Human Services (HHS) on selecting performance measures for public reporting, performance-based payment programs, and other purposes. The statutory authority for MAP is the Affordable Care Act (ACA), which requires HHS to contract with NQF (as the consensus-based entity) to "convene multi-stakeholder groups to provide input on the selection of quality measures" for various uses.[xix]

MAP's careful balance of interests—across consumers, businesses and purchasers, labor, health plans, clinicians, providers, communities and states, and suppliers—ensures HHS will receive varied and thoughtful input on performance measure selection. In particular, the ACA-mandated annual publication of measures under consideration for future federal rulemaking allows MAP to evaluate and provide upstream input to HHS in a more global and strategic way.

MAP is designed to facilitate alignment of public- and private-sector uses of performance measures to further the National Quality Strategy's (NQS's) three-part aim of creating better, more affordable care, and healthier people.[xx] Anticipated outcomes from MAP's work include:

- A more cohesive system of care delivery;
- Better and more information for consumer decision making;
- Heightened accountability for clinicians and providers;
- Higher value for spending by aligning payment with performance;
- Reduced data collection and reporting burden through harmonizing measurement activities across public and private sectors; and
- Improvement in the consistent provision of evidence-based care.

Coordination with Other Quality Efforts

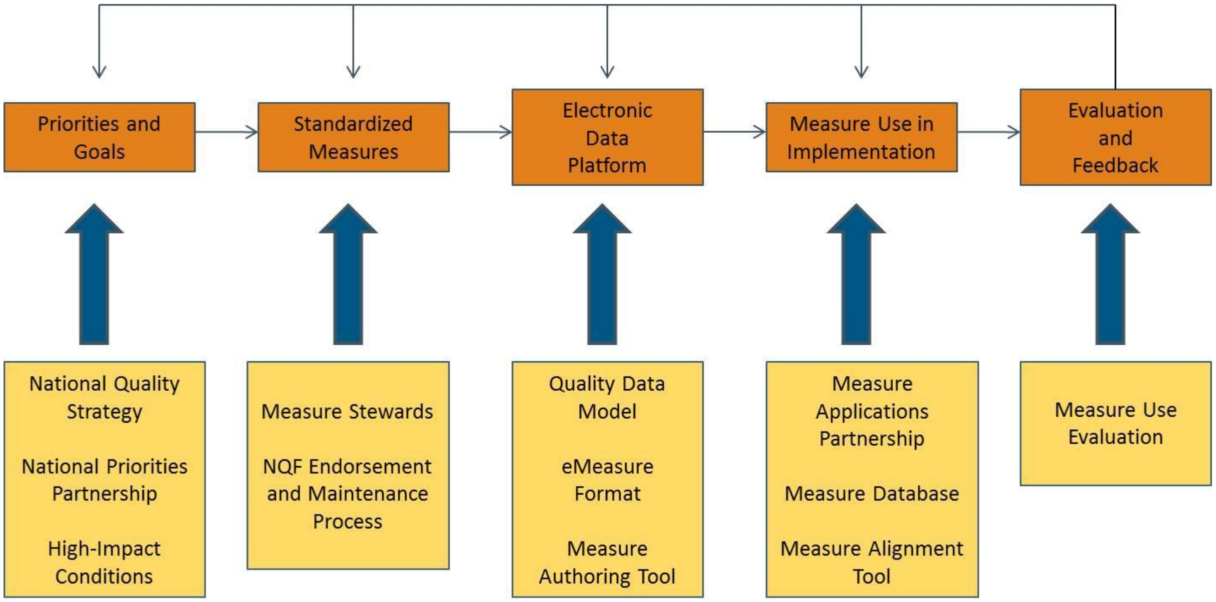
MAP's activities are designed to coordinate with and reinforce other efforts for improving health outcomes and healthcare quality. Key strategies for reforming healthcare delivery and financing include publicly reporting performance results for transparency; aligning payment with value; rewarding providers and professionals for using health information technology (health IT) to improve patient care; and providing knowledge and tools to healthcare providers and professionals to help them improve performance. Many public- and private-sector organizations have important responsibilities in implementing these strategies, including federal and state agencies, private purchasers, measure developers, groups convened by NQF, accreditation and certification entities, various quality alliances at the national and community levels, as well as the professionals and providers of healthcare.

Foundational to the success of all of these efforts is a robust "quality measurement enterprise" (Figure A-1) that includes:

- Setting priorities and goals for improvement;

- Standardizing performance measures;
- Constructing a common data platform that supports measurement and improvement;
- Applying measures to public reporting, performance-based payment, health IT meaningful use programs, and other areas; and
- Promoting performance improvement in all healthcare settings.

Figure A-1. Functions of the Quality Measurement Enterprise



The National Priorities Partnership (NPP), a multi-stakeholder group convened by NQF to provide input to HHS on the NQS, by identifying priorities, goals, and global measures of progress.[xxi] Another NQF-convened group, the Measure Prioritization Advisory Committee, has defined high-impact conditions for the Medicare and child health populations.[xxii] Cross-cutting priorities and high-impact conditions provide the foundation for all of the subsequent work within the quality measurement enterprise.

Measure development and standardization of measures are necessary to assess the baseline relative to the NQS priorities and goals, determine the current state and opportunities for improvement, and monitor progress. The NQF endorsement process meets certain statutory requirements for setting consensus standards and also provides the resources and expertise necessary to accomplish the task. A platform of data sources, with increasing emphasis on electronic collection and transmission, provides the data needed to calculate measures for use in accountability programs and to provide immediate feedback and clinical decision support to providers for performance improvement.

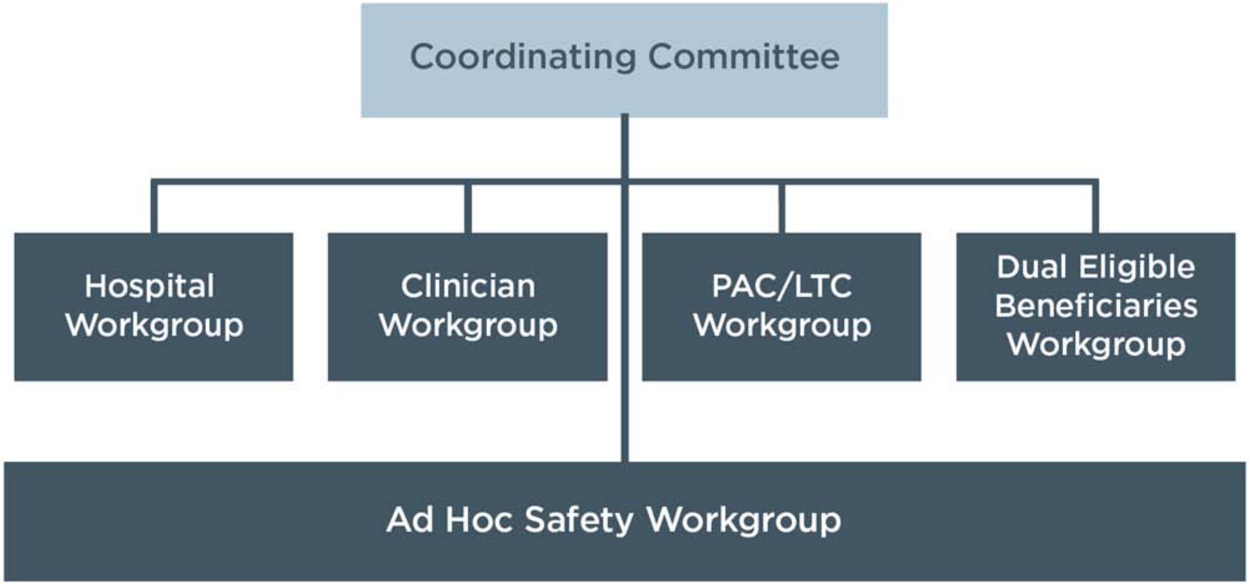
Alignment around environmental drivers, such as public reporting and performance-based payment, is MAP's role in the quality measurement enterprise. By considering and recommending measures for use in specific applications, MAP will facilitate the alignment of public- and private-sector programs and harmonization of measurement efforts under the NQS.

Finally, evaluation and feedback loops for each of the functions of the quality measurement enterprise ensure that each of the various activities is driving desired improvements.[xxiii,xxiv] Further, the evaluation function monitors for potential unintended consequences that may result.

Function

Composed of a two-tiered structure, MAP's overall strategy is set by the Coordinating Committee, which provides final input to HHS. Working directly under the Coordinating Committee are five advisory workgroups responsible for advising the Committee on using measures to encourage performance improvement in specific care settings, providers, and patient populations (Figure A-2). More than 60 organizations representing major stakeholder groups, 40 individual experts, and 9 federal agencies (*ex officio* members) are represented on the Coordinating Committee and workgroups.

Figure A-2. MAP Structure



The NQF Board of Directors oversees MAP. The board will review any procedural questions and periodically evaluate MAP's structure, function, and effectiveness, but will not review the Coordinating Committee's input to HHS. The board selected the Coordinating Committee and workgroups based on board-adopted selection criteria. Balance among stakeholder groups was paramount. Because MAP's tasks are so complex, including individual subject matter experts in the groups also was imperative.

All MAP activities are conducted in an open and transparent manner. The appointment process included open nominations and a public commenting period. MAP meetings are broadcast, materials and summaries are posted on the NQF website, and public comments are solicited on recommendations.

MAP decision making is based on a foundation of established guiding frameworks. The NQS is the primary basis for the overall MAP strategy. Additional frameworks include the high-impact conditions determined by the NQF-convened Measure Prioritization Advisory Committee, the NQF-endorsed Patient-Focused Episodes of Care framework,[xxv] the HHS Partnership for Patients safety initiative,[xxvi] the HHS Prevention and Health Promotion Strategy,[xxvii] the HHS Disparities Strategy,[xxviii] and the HHS Multiple Chronic Conditions Measurement Framework.[xxix] Additionally, the MAP Coordinating Committee has developed measure selection criteria to help guide MAP decision making.

Timeline and Deliverables

MAP's initial work included performance measurement coordination strategies on the selection of measures for public reporting and performance-based payment programs. Each of the coordination strategies addresses:

- Measures and measurement issues, including measure gaps;
- Data sources and health information technology (health it) implications, including the need for a common data platform;
- Alignment across settings and across public- and private-sector programs;
- Special considerations for dual eligible beneficiaries; and
- Path forward for improving measure applications.

On October 1, 2011, three coordination strategies were issued. The report on coordinating readmissions and healthcare-acquired conditions focused on alignment of measurement, data collection, and other efforts to address these safety issues across public and private payers.[xxx] The report on coordinating clinician performance measurement identified the characteristics of an ideal measure set for assessing clinician performance, advances measure selection criteria as a tool, and provides input on a recommended measure set and priority gaps for clinician public reporting and performance-based payment programs.[xxxi] An interim report on performance measurement for dual eligible beneficiaries offered a strategic approach that includes a vision, guiding principles, characteristics of high-need subgroups, and high-leverage opportunities for improvement, all of which will inform the next phase of work to identify specific measures most relevant to improving the quality of care for dual eligible beneficiaries.[xxxii]

On February 1, 2012, MAP submitted the *Pre-Rulemaking Final Report* and the *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement Report*. The *Pre-Rulemaking Final Report* provided input on more than 350 performance measures under consideration for use in nearly 20 federal healthcare programs. The report is part of MAP's annual analysis of measures under consideration for use in federal public reporting and performance-based payment programs, in addition to efforts for alignment of measures with those in the private sector. The *Coordination Strategy for Post-Acute Care and Long-Term Care Performance Measurement* report made recommendations on aligning measurement, promoting common goals for PAC and LTC providers, filling priority measure gaps, and standardizing care planning tools.

Appendix B—Coordinating Committee Roster

Measure Applications Partnership (MAP)

Roster for the MAP Coordinating Committee

Co-Chairs (voting)
George Isham, MD, MS
Elizabeth McGlynn, PhD, MPP

Organizational Members (voting)	Representatives
AARP	Joyce Dubow, MUP
Academy of Managed Care Pharmacy	Marissa Schlaifer, RPh, MS
AdvaMed	Steven Brotman, MD, JD
AFL-CIO	Gerald Shea
America's Health Insurance Plans	Aparna Higgins, MA
American College of Physicians	David Baker, MD, MPH, FACP
American College of Surgeons	Frank Opelka, MD, FACS
American Hospital Association	Rhonda Anderson, RN, DNSc, FAAN
American Medical Association	Carl Sirio, MD
American Medical Group Association	Sam Lin, MD, PhD, MBA
American Nurses Association	Marla Weston, PhD, RN
Catalyst for Payment Reform	Suzanne Delbanco, PhD
Consumers Union	Doris Peter, PhD
Federation of American Hospitals	Chip N. Kahn
LeadingAge (formerly AAHSA)	Cheryl Phillips, MD, AGSF
Maine Health Management Coalition	Elizabeth Mitchell
National Association of Medicaid Directors	Foster Gesten, MD
National Partnership for Women and Families	Christine Bechtel, MA
Pacific Business Group on Health	William Kramer, MBA

Expertise	Individual Subject Matter Expert Members (voting)
Child Health	Richard Antonelli, MD, MS
Population Health	Bobbie Berkowitz, PhD, RN, CNAA, FAAN
Disparities	Joseph Betancourt, MD, MPH
Rural Health	Ira Moscovice, PhD
Mental Health	Harold Pincus, MD
Post-Acute Care/ Home Health/ Hospice	Carol Raphael, MPA

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Nancy Wilson, MD, MPH
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH
Centers for Medicare & Medicaid Services (CMS)	Patrick Conway, MD MSc
Health Resources and Services Administration (HRSA)	Ahmed Calvo, MD, MPH
Office of Personnel Management/FEHBP (OPM)	John O’Brien
Office of the National Coordinator for HIT (ONC)	Kevin Larsen, MD

Accreditation/Certification Liaisons (non-voting)	Representatives
American Board of Medical Specialties	Christine Cassel, MD
National Committee for Quality Assurance	Peggy O’Kane, MPH
The Joint Commission	Mark Chassin, MD, FACP, MPP, MPH

Appendix C—Hospital Workgroup Roster

Measure Applications Partnership (MAP)

Roster for the MAP Hospital Workgroup

Chair (voting
Frank G. Opelka, MD, FACS

Organizational Members (voting)	Representatives
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS
American Hospital Association	Richard Umbdenstock
American Organization of Nurse Executives	Patricia Conway-Morana, RN
American Society of Health-System Pharmacists	Shekhar Mehta, PharmD, MS
Blue Cross Blue Shield of Massachusetts	Jane Franke, RN, MHA, CPHQ
Building Services 32BJ Health Fund	Barbara Caress
Iowa Healthcare Collaborative	Lance Roberts, PhD
Memphis Business Group on Health	Cristie Upshaw Travis, MSHA
Mothers Against Medical Error	Helen Haskell, MA
National Association of Children's Hospitals and Related Institutions	Andrea Benin, MD
National Rural Health Association	Brock Slabach, MPH, FACHE
Premier, Inc.	Richard Bankowitz, MD, MBA, FACP

Expertise	Individual Subject Matter Expert Members (voting)
Patient Safety	Mitchell Levy, MD, FCCM, FCCP
Palliative Care	R. Sean Morrison, MD
State Policy	Dolores Mitchell
Health IT	Brandon Savage, MD
Patient Experience	Dale Shaller, MPA
Safety Net	Bruce Siegel, MD, MPH
Mental Health	Ann Marie Sullivan, MD

Federal Government Members (non-voting, ex officio)	Representatives
Agency for Healthcare Research and Quality (AHRQ)	Mamatha Pancholi, MS
Centers for Disease Control and Prevention (CDC)	Chesley Richards, MD, MPH, FACP
Centers for Medicare & Medicaid Services (CMS)	Shaheen Halim, PhD, CPC-A
Office of the National Coordinator for HIT (ONC)	Leah Marcotte
Veterans Health Administration (VHA)	Michael Kelley, MD

MAP Coordinating Committee Co-Chairs (non-voting, ex officio)
George J. Isham, MD, MS
Elizabeth A. McGlynn, PhD, MPP

Appendix D. NQF-Endorsed Measures Related to Cancer Care

NQF Measure # and Status	Measure Name	Description
0031 Endorsed[†]	Breast cancer screening	Percentage of eligible women 40-69 who receive a mammogram in a two year period
0032 Endorsed[†]	Cervical cancer screening	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer
0034 Endorsed[†]	Colorectal cancer screening	The percentage of members 50–75 years of age who had appropriate screening for colorectal cancer
0208 Endorsed	Family evaluation of hospice care	Composite Score: Derived from responses to 17 items on the Family Evaluation of Hospice Care (FEHC) survey presented as a single score ranging from 0 to 100. Global Score: Percentage of best possible response (Excellent) to the overall rating question on the FEHC survey Target Population: The FEHC survey is an after-death survey administered to bereaved family caregivers of individuals who died while enrolled in hospice. Timeframe: The survey measures family members perception of the quality of hospice care for the entire enrollment period, regardless of length of service
0209 Endorsed	Comfortable dying: pain brought to a comfortable level within 48 hours of initial assessment	Number of patients who report being uncomfortable because of pain at the initial assessment (after admission to hospice services) who report pain was brought to a comfortable level within 48 hours
0210 Endorsed	Proportion receiving chemotherapy in the last 14 days of life	Patients who died from cancer and received chemotherapy in the last 14 days of life
0211 Endorsed*	Proportion with more than one emergency room visit in the last days of life	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life
0212 Endorsed*	Proportion with more than one hospitalization in the last 30 days of life	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life
0213 Endorsed*	Proportion admitted to the ICU in the last 30 days of life	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life
0214 Endorsed*	Proportion dying from cancer in an acute care setting	Percentage of patients who died from cancer dying in an acute care setting
0215 Endorsed*	Proportion not admitted to hospice	Percentage of patients who died from cancer not admitted to hospice
0216 Endorsed*	Proportion admitted to hospice for less than 3 days	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there

NQF Measure # and Status	Measure Name	Description
0219 Endorsed	Post breast conserving surgery irradiation	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
0220 Endorsed	Adjuvant hormonal therapy	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 (No Suggestions) or third generation aromatase inhibitor (considered or administered) within 1 year (365 days) of diagnosis
0221 Endorsed	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	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
0222 Endorsed	Patients with early stage breast cancer who have evaluation of the axilla	Percentage of women with Stage I-IIb breast cancer that received either axillary node dissection or Sentinel Lymph Node Biopsy (SLNB) at the time of surgery (lumpectomy or mastectomy)
0223 Endorsed	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	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
0224 Endorsed	Completeness of pathology reporting	Percentage of patients with audited colorectal cancer resection pathology complete reports
0225 Endorsed	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	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
0377 Endorsed	Myelodysplastic syndrome (MDS) and acute leukemias – baseline cytogenetic testing performed on bone marrow	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
0378 Endorsed	Documentation of iron stores in patients receiving erythropoietin therapy	Percentage of patients aged 18 years and older with a diagnosis of MDS who are receiving erythropoietin therapy with documentation of iron stores prior to initiating erythropoietin therapy
0379 Endorsed	Chronic lymphocytic leukemia (CLL) – baseline flow cytometry	Percentage of patients aged 18 years and older with a diagnosis of CLL who had baseline flow cytometry studies performed

NQF Measure # and Status	Measure Name	Description
0380 Endorsed	Multiple myeloma – treatment with bisphosphonates	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
0381 Endorsed	Oncology: treatment summary documented and communicated – radiation oncology	Percentage of patients 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 within one month of completing treatment
0382 Endorsed	Oncology: radiation dose limits to normal tissues	Percentage of patients with a diagnosis of cancer receiving 3D conformal radiation therapy with documentation in medical record that normal tissue dose constraints were established within five treatment days for a minimum of one tissue
0383 Endorsed	Oncology: plan of care for pain – medical oncology and radiation oncology (paired with 0384)	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain
0384 Endorsed	Oncology: pain intensity quantified – medical oncology and radiation oncology (paired with 0383)	Percentage of visits for patients with a diagnosis of cancer currently receiving intravenous chemotherapy or radiation therapy in which pain intensity is quantified
0385 Endorsed	Oncology: chemotherapy for stage IIIA through IIIC colon cancer patients	Percentage of patients aged 18 years and older with Stage IIIA through IIIC colon cancer who are prescribed or who have received adjuvant chemotherapy within the 12 month reporting period
0386 Endorsed	Oncology: cancer stage documented	Percentage of patients with a diagnosis of breast, colon, or rectal cancer 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
0387 Endorsed	Oncology: hormonal therapy for stage IC through IIIC, ER/PR positive breast cancer	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 (No Suggestions) or aromatase inhibitor (AI) within the 12-month reporting period
0388 Endorsed	Prostate cancer: three-dimensional radiotherapy	Percentage of patients with prostate cancer receiving external beam radiotherapy to the prostate only who receive 3D-CRT (three-dimensional conformal radiotherapy) or IMRT (intensity modulated radiation therapy)

NQF Measure # and Status	Measure Name	Description
0389 Endorsed	Prostate cancer: avoidance of overuse measure – isotope bone scan for staging low-risk patients	Percentage of 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 who did not have a bone scan performed at any time since diagnosis of prostate cancer
0390 Endorsed	Prostate cancer: adjuvant hormonal therapy for high-risk patients	Percentage of patients 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)
0391 Endorsed	Breast cancer resection pathology reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	Percentage of breast cancer resection pathology reports that include the pT category (primary tumor), the pN category (regional lymph nodes) and the histologic grade
0392 Endorsed	Colorectal cancer resection pathology reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	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
0455 Endorsed	Recording of clinical stage for lung cancer and esophageal cancer resection	Percentage of all surgical patients undergoing treatment procedures for lung or esophageal cancer that have clinical TNM staging provided
0457 Endorsed	Recording of performance status (Zubrod, Karnofsky, WHO, or ECOG Performance Status) prior to lung or esophageal cancer resection	Percentage of patients undergoing resection of a lung or esophageal cancer who had their performance status recorded within two weeks of the surgery date
0459 Endorsed	Risk-adjusted morbidity after lobectomy for lung cancer	Percentage of patients undergoing elective lobectomy for lung cancer that have a prolonged length of stay (>14 days)
0460 Endorsed	Risk-adjusted morbidity and mortality for esophagectomy for cancer	The percentage of patients undergoing elective esophagectomy for cancer that had a prolonged length of stay (>14 days)
0559 Endorsed	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	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 and estrogen receptor negative recommended for multiagent chemotherapy (considered or administered) within 4 months (120 days) of diagnosis
0561 Endorsed	Melanoma coordination of care	Percentage of patients 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

NQF Measure # and Status	Measure Name	Description
0562 Endorsed	Over-utilization of imaging studies in stage 0-IA melanoma	Percentage of patients with stage 0 or IA melanoma, without signs or symptoms, for whom no diagnostic imaging studies were ordered
0572 Endorsed	Follow-up after initial diagnosis and treatment of colorectal cancer: colonoscopy	To ensure that all eligible members who have been newly diagnosed and resected with colorectal cancer receive a follow-up colonoscopy within 15 months of resection
0579 Endorsed‡	Annual cervical cancer screening for high-risk patients	This measure identifies women age 12 to 65 diagnosed with cervical dysplasia (CIN 2), cervical carcinoma-in-situ, or HIV/AIDS prior to the measurement year, and who still have a cervix, who had a cervical CA screen during the measurement year
0623 Endorsed ‡	Breast cancer - cancer surveillance	Percentage of female patients with breast cancer who had breast cancer surveillance in the past 12 months
0625 Endorsed ‡	Prostate cancer - cancer surveillance	Percentage of males with prostate cancer that have had their PSA monitored in the past 12 months
0650 Endorsed ‡	Melanoma continuity of care – recall system	Percentage of patients with a current diagnosis of melanoma or a history of melanoma who were entered into a recall system with the date for the next complete physical skin exam specified, at least once within the 12 month reporting period

* *NQF-endorsed hospice and palliative care measures specified for the cancer population*

‡ *NQF-endorsed screening and surveillance measures specified for the cancer population*

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