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Measure Applications Partnership

Hospital Workgroup

In-Person Meeting #1

October 12-13, 2011
Washington, DC

SUPPLEMENTAL SLIDES INCLUDED

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Welcome and Review of Meeting Objectives

Meeting Objectives

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- Provide input to the MAP Coordinating Committee on the draft measure selection criteria
- Evaluate CMS measure sets for the Hospital Inpatient Quality Reporting (IQR), Outpatient Quality Reporting (OQR), and Value-based Purchasing (VBP) programs
- Identify a proposed core set of hospital measures
- Provide input to the Coordinating Committee on the approach to accomplishing the pre-rulemaking input to HHS
- Provide input to the Coordinating Committee on the selection of performance measures for cancer care, particularly PPS-exempt Cancer Hospitals

Meeting Agenda: Day 1

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- Introductions and Disclosures of Interest
- MAP Hospital Workgroup Task
- Proposed Approach for the Pre-Rulemaking Task
- Hospital IQR Measure Set Survey Exercise Results
- Hospital OQR Measure Set Exercise
- Building a Hospital Core Measure Set
- Input into Approach for the Pre-Rulemaking Task
- Summary of Day 1 and Look-Forward to Day 2
- Adjourn for the Day

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Introductions and Disclosures of Interests

Hospital Workgroup Membership

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Chair	Frank G. Opelka, MD, FACS		
Organizational Members	Alliance of Dedicated Cancer Centers	Representatives	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		Kasey Thompson, Pharm.D
	Blue Cross Blue Shield of Massachusetts		Jane Franke, RN, MHA
	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
Coordinating Committee Co-Chairs	George Isham, MD, MS		
	Beth McGlynn, PhD, MPP		

Hospital Workgroup Membership

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	Patient Safety	Subject Matter Experts	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	Agency for Healthcare Research and Quality (AHRQ)	Representatives	Mamatha Pancholi, MS
	Centers for Disease Control and Prevention (CDC)		Chesley Richards, MD, MPH, FACP
	Centers for Medicare & Medicaid Services (CMS)		Shaheen Halim, Ph.D., CPC-A
	Office of the National Coordinator for HIT (ONC)		Leah Marcotte
	Veterans Health Administration (VHA)		Michael Kelley, MD

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MAP Hospital Workgroup Task

MAP Hospital Workgroup Charge

The Hospital Workgroup will advise the Coordinating Committee on measures to be implemented through the rulemaking process for hospital inpatient and outpatient services, cancer hospitals, the value-based purchasing program, and psychiatric hospitals.

The Workgroup will:

- Provide input on measures to be implemented through the Federal rulemaking process, the manner in which quality problems could be improved, and the related measures for encouraging improvement.
- Identify critical hospital measure development and endorsement gaps.
- Identify performance measures for PPS-exempt cancer hospital quality reporting by:
  - Reviewing available performance measures for cancer hospitals, including clinical quality measures and patient-centered cross-cutting measures;
  - Identification of a core set of performance measures for cancer hospital quality reporting; and
  - Identification of measure development and endorsement gaps for cancer hospitals.

Guidance from the Coordinating Committee

- Consider alignment between public and private sectors
- Focus on models of care in addition to individual measures
- Consider cancer care beyond PPS-exempt cancer hospitals.
- Maintain appropriate expectations given the time constraints (e.g., identify work for subsequent phases)

Workgroup Member Terms

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- While NQF's current scope of work with HHS lasts through June 2012; MAP's work is expected to continue.
  - Specific tasks will change over time
  - The workgroup structure is designed to be flexible and groups may shift to align with evolving priorities
- The terms for MAP members are for three years.
- The initial members will serve staggered 1-, 2-, and 3-year terms, determined by random draw.
- There are equal numbers of 1-, 2-, and 3-year terms.
- Members whose terms expire are eligible to re-nominate themselves during the open Call for Nominations.
- There is no term limit for MAP members at this time

Hospital Workgroup Membership

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Chair	Frank G. Opelka, MD, FACS	Term Expires	

Organizational Members	Representatives	Term Expires
Alliance of Dedicated Cancer Centers	Ronald Walters, MD, MBA, MHA, MS	
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Hospital Workgroup Membership

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Proposed Approach for the Pre-Rulemaking Task

Pre-rulemaking Analysis

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Measures to Be Implemented Through the Federal Rulemaking Process

Task Description	Deliverable	Timeline
Provide input to HHS on measures to be implemented through the federal rulemaking process, based on an overview of the quality issues in hospital, clinician office, and post-acute/long-term care settings; the manner in which those problems could be improved; and the metrics for encouraging such improvement.	Final report containing Coordinating Committee framework for decision-making and proposed measures	Draft Report: January 2012 Final Report: February 1, 2012

Coordinating Committee with input from all workgroups

MAP Coordinating Committee Timeline and Processes – February 1, 2012 Pre-Rulemaking Analysis Report

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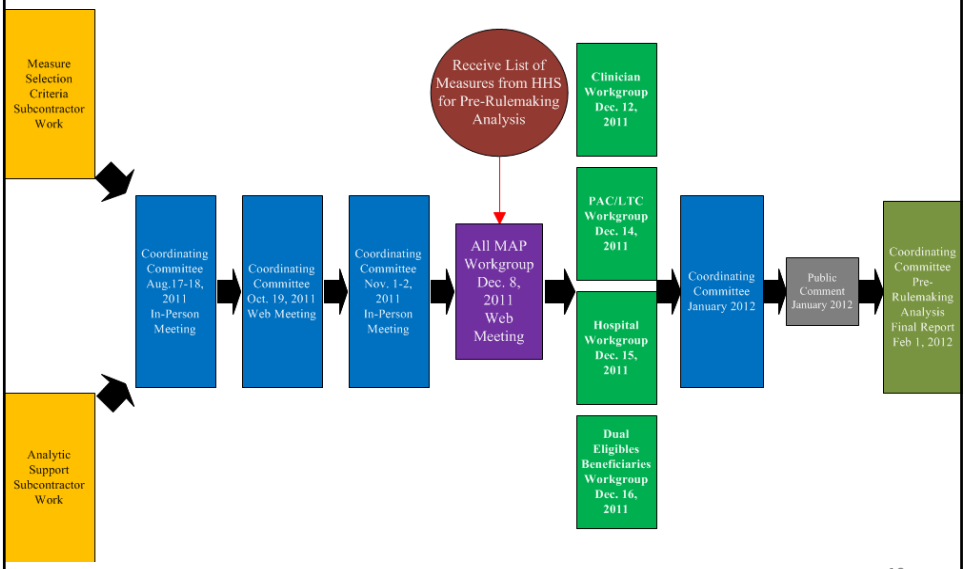

MAP Pre-Rulemaking Proposed Approach

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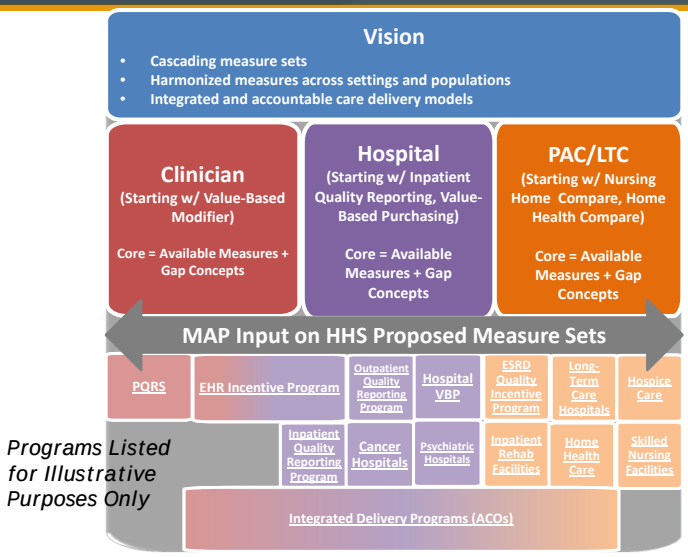

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Pre-Rulemaking Analysis Proposed Process

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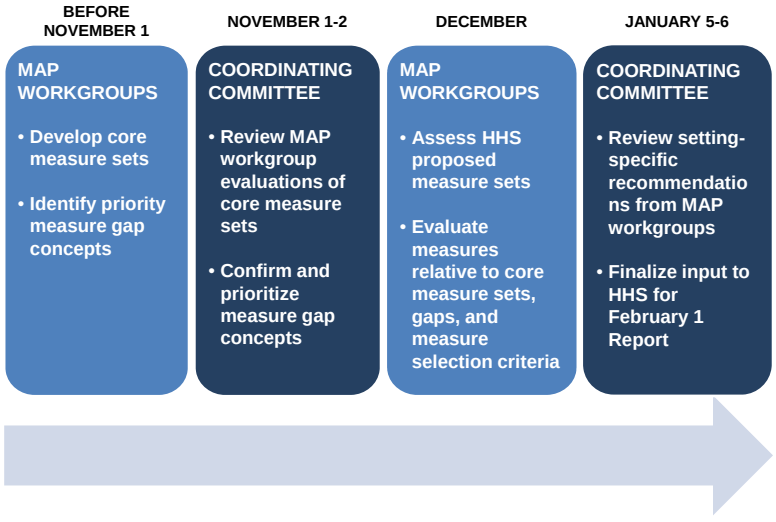

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Before November 1

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MAP WORKGROUPS

- **Develop core measure sets**
- **Identify priority measure gap concepts**

Key Deliverable	• Preliminary core measure sets for each setting (i.e., clinician, hospital, PAC/LTC) that reflect the ideal characteristics of a measure set and identified priority measure gaps concepts
Activity	• Complete evaluation of initial starting point for core measure set, including identification of priority measure gap concepts
Background Materials	• List of measures used in federal programs • Federal program descriptions • Measure selection criteria

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November 1-2

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COORDINATING COMMITTEE

- **Review MAP workgroup evaluations of core measure sets**
- **Confirm and prioritize measure gap concepts**

Key Deliverable	• Finalize core measure sets and prioritized measure gap concepts
Activity	• Review MAP workgroup evaluations of preliminary core measure sets and identified measure gap concepts
Background Materials	• List of measures used in federal programs • Workgroup evaluations of existing measure sets and associated measure concept gaps • Measure selection criteria

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December

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MAP WORKGROUPS

- **Assess HHS proposed measure sets**
- **Evaluate measures relative measure sets, gaps, and measure selection criteria**

Key Deliverable	• Input to MAP Coordinating Committee on HHS proposed measure sets
Activity	• Assess HHS proposed measure sets against MAP core measure sets and prioritized gaps concepts
Background Materials	• HHS proposed measure sets list • Finalized MAP core measure sets and prioritized measure gap concepts • Measure selection criteria

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January 5-6

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COORDINATING COMMITTEE

- **Review the setting-specific recommendations from MAP workgroups**
- **Finalize input to HHS for February 1 Report**

Key Deliverable	• Finalized input to HHS on proposed measure sets
Activity	• Review MAP workgroup input regarding HHS proposed measure sets
Background Materials	• MAP workgroup input to Coordinating Committee on HHS proposed measure sets

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Hospital IQR Measure Set Survey Exercise Results

Experience Applying Measure Selection Criteria

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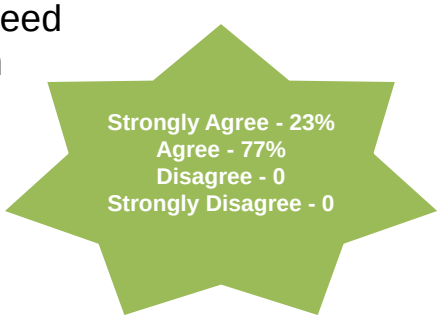
Majority of respondents agreed the MAP measure selection criteria are a good starting place for assessing the adequacy of a measure set for a specific purpose



Criteria would ideally better ascertain if a set contains the best or right measures to address a given criterion.

Experience Applying Measure Selection Criteria

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Hospital WG Feedback:

- Good principles, but difficult to apply; very “all or nothing”
- High-impact conditions have gaps (e.g., child health, cancer care, behavioral health)
- Suggest that criteria include functional health status outcomes for patients
- There is a need to assess individual measures alongside this “set-level” criteria
- Criteria does not address how infrastructure (e.g., data sources, tools, etc.) can be used for improvement purposes
- Overall consensus that the criteria is focused on the right things (e.g., consensus, patient-centeredness, burden)

IQR Measure Set Survey Exercise Results

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Overall, the IQR program measure set is a good starting place. It addresses many of the measure selection criteria.

However, measure gaps were identified, specifically:

- Some priorities of the National Quality Strategy
- Some measure types
- Disparities sensitive measures

IQR Measure Set Survey Exercise Results

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- Nearly all IQR measures are NQF-endorsed or meet requirements for NQF submission (Criterion #1)
  - Some concern expressed about the HAC measures
- The IQR measure set does not address all of the NQS priorities. Does address safety (67% of measures), prevention/treatment, and person/family-centeredness (Criterion #2)
  - Evident gaps include measures for alcohol, tobacco, care coordination, depression, functional health status, and patient-reported outcomes

IQR Measure Set Survey Exercise Results

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- Agreement that the IQR measure set addresses high impact conditions (Criterion #3)
  - Gaps include child health and cancer care
- Agreement that measure set promotes alignment with specific program attributes (Criterion #4)
  - Varying opinion on how well it bridges care from inpatient to outpatient

IQR Measure Set Survey Exercise Results

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- Measure set adequately includes process and experience of care measures (Criterion #5)
  - Gap areas include:
    - Outcome measures
    - Cost/resource use/appropriateness measures
    - Structural measures
- General agreement that the set enables measurement across the patient-focused episode of care for settings and across time (Criterion #6)
  - Some question as to whether or not it's applicable across providers

IQR Measure Set Survey Exercise Results

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- Workgroup felt strongly that the measure set does not have special considerations for health care disparities (Criterion #7)
- General consensus that the measure set promotes parsimony (Criterion #8), although the following concerns were raised:
  - Some measures are "topped out"
  - Measures not e-specified (so not useful for Meaningful Use)
  - Unclear if measure are useful for PQRS

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Opportunity for Public Comment

OQR Measure Set Exercise

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Instructions:

1. Individual evaluation of the OQR program measure set using the MAP measure selection criteria (approximately 15 minutes)
2. Small group discussion regarding results of individual assessments (approximately 30 minutes)
3. Report out of small group findings and discussion (approximately 45 minutes)

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Building a Hospital Core Measure Set

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Input into Approach for Pre-Rulemaking Task

Input into Approach for Pre-Rulemaking Activity

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Hospital WG feedback:

- Use what is currently available in first round; identify gaps as MAP moves forward
- Challenges will include:
  - Data collection
  - Identifying meaningful ways to fill gaps

Feedback to the Coordinating Committee

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MAP Measure Selection Criteria:

- Good principles, but difficult to apply; very “all or nothing”
- High-impact conditions have gaps (e.g., child health, cancer care, behavioral health)
- Suggest that criteria include functional health status outcomes for patients
- There is a need to assess individual measures alongside this “set-level” criteria
- Criteria does not address how infrastructure (e.g., data sources, tools, etc.) can be used for improvement purposes
- Overall consensus that the criteria is focused on the right things (e.g., consensus, patient-centeredness, burden)

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Opportunity for Public Comment

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Summary of Day 1 and Look-Forward to Day 2

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Recap of Day 1 and Review of Day 2 Agenda

Breakfast Activity

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- Please rank the core set and the measure set gaps on the *left side* of the table at your seat.
  - 3= Yes, include in core set
  - 2= Maybe/Not sure
  - 1=No, do not include in core set

Meeting Agenda: Day 2

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- Priorities for Cancer Care Measurement
- Review Work of the CMS Cancer Care Measures Technical Expert Panel
- NQF-endorsed® Cancer Care Measures
- Data Sources and HIT Implications
- Propose a Cancer Care Measurement Strategy
- Adjourn for the Day

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Review Work of the CMS Cancer Care Measures Technical Expert Panel

CMS Technical Expert Panel Work

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- PPS-exempt Cancer Hospital background and statutory requirements
- Prioritization process for selecting measures
- Review the five measures recommended
- Opportunities identified for future measurement

CMS Technical Expert Panel Work

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Five measures selected by the TEP

- Adjuvant chemotherapy for Stage III colon cancer
- Combination chemotherapy for AJCC T1c or Stage II or III hormone receptor-negative breast cancer
- Hormone therapy for AJCC T1c or Stage II or III hormone receptor-positive breast cancer
- Catheter-associated urinary tract infections (CAUTIs)
- Central line-associated bloodstream infections (CLABSIs)

NQF-endorsed® Cancer Care Measures

Angela J. Franklin, JD
Performance Measures
National Quality Forum

Past NQF Work Related to Cancer

- **Cancer Care Phase I – 2002**
  - Focus: Identified priority areas for public reporting & accountability
  - Defined what should be included in a core set for cancer care:
    1. access to care/critical trials/cultural competence;
    2. diagnosis and treatment of breast cancer;
    3. diagnosis and treatment of colorectal cancer;
    4. communication and coordination of care,
    5. including information technology issues;
    6. prevention/screening;
    7. diagnosis and treatment of prostate cancer; and
    8. symptom management/end-of-life care
  - No measures were endorsed during this phase

Past NQF Work Related to Cancer

- **Cancer Care Phase II – 2004**
  - Focus: Public reporting & accountability
  - Endorsed 19 performance measures for gauging the quality of cancer care in the areas of
    - breast cancer
    - colorectal cancer
    - symptom management, and
    - end-of-life care
  - Areas for consideration under this project were selected based on five criteria:
    - alignment with national goals
    - key leverage points
    - addressed variation in care
    - patient centered, and
    - addressed disparities in vulnerable populations

Past NQF Work Related to Cancer

- **Cancer Care Phase II – 2004**
  - One conclusion of the Steering Committee was that because cancer—especially if one type is to be evaluated—is a relatively infrequent disease, most measures for accountability may be at the institutional level rather than at the physician level.
    - Breast cancer: 6 measures
    - Colorectal cancer: 4 measures
    - Symptom management and end-of-life care: 9 measures
  - The 19 endorsed measures do not reflect all the NQF-endorsed measures and practices; these cancer measures can be used with other NQF-endorsed measures to provide a more complete picture of the quality of care provided

Past NQF Work Related to Cancer

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- **Cancer Measure Set: Value-Based Episodes of Care – 2008**
  - Focus: Recommendations for a path forward for cancer quality measurement and a defined research agenda.
  - Building on the previous two projects, this project developed recommendations for a comprehensive cancer measure set to potentially apply the NQF framework for assessing "episode efficiency" for chronic conditions to cancer care.
  - The project:
    - Reviewed the current state of cancer care quality measurement
    - Presented one method of measuring quality care through the episode of care approach and a conceptualization this approach for breast and colorectal cancers
    - Highlighted recognized gaps in measures of cancer care quality, and
    - Offered recommendations for a path forward

Past NQF Work Related to Cancer

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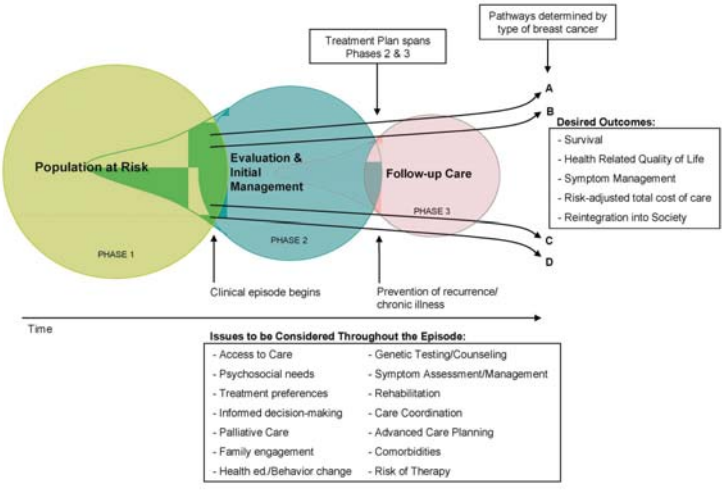
- **Cancer Measure Set: Value-Based Episodes of Care – 2008**

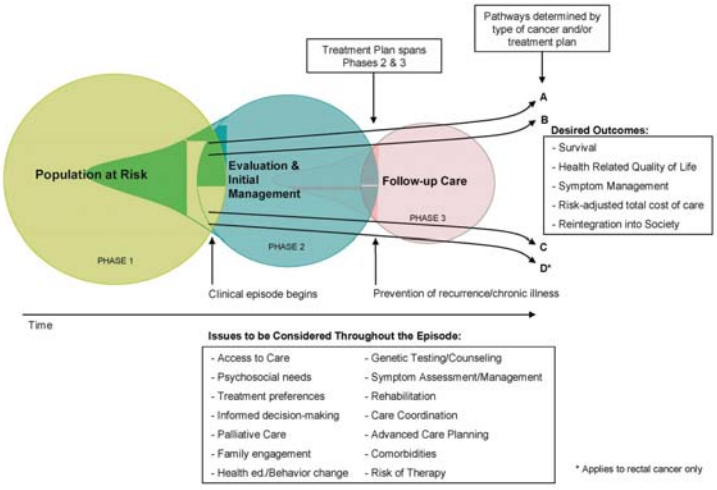
Figure 1: Context for Considering a Breast Cancer Episode of Care



Past NQF Work Related to Cancer

- **Cancer Measure Set: Value-Based Episodes of Care – 2008**

Figure 2: Context for Considering Colon and Rectal Cancers Episodes of Care



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Past NQF Work Related to Cancer

- **Cancer Measure Set: Value-Based Episodes of Care – 2008**
  - **Recommendations and Next Steps in Four categories:**
    - patient-centered measurement
      - Prioritize outcomes and cross-cutting issues (e.g. symptom management, end of life, communication around transitions, psychosocial distress)
      - Focus on shared decision-making and clear communication
    - data and measurement issues
      - Ensure correct and relevant data elements (including those around initial stages and disease status)
      - Expand on current guidelines (e.g. NCCN) and evidence bases
      - Push for outcomes measures
      - Develop a framework and system for all measurement needs
    - models of accountability
      - Focus on multidisciplinary care coordination: shared accountability across health professionals and providers
    - explicit consideration of palliative and psychosocial care needs
      - Assess psychosocial and palliative care needs of the patient and family much earlier in the episode of care, if not at the very start

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Cancer Endorsement Maintenance Project

- Cancer Endorsement Maintenance 2011
  - Focus: to identify and endorse additional cancer care measures for accountability and QI
- Seeking composite, outcome, and process measures proximal to outcomes, applicable to any setting. Will prioritize measures:
  - addressing specific National Quality Strategy areas
  - specified for use with EHRs (eMeasures), and
  - harmonized across settings (e.g., outpatient and hospital)
- Will evaluate measures endorsed before 2009

Cancer Endorsement Maintenance Project

- Cancer Endorsement Maintenance 2011

  Timeline:
  - Nominations: Oct 14th – Nov 11th
  - Measures: Oct 14th – Jan 13th, 2012
  - Implementation Comments: Oct 14th –Nov 11th

Current Set of Endorsed Cancer Measures

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- Thirty-four (34) NQF-endorsed measures directly related to cancer
- Current measures cover a wide range of topic areas including:
  - breast cancer,
  - colorectal cancer,
  - blood cancers,
  - symptom management, and
  - end-of-life care

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Workgroup Discussion and Questions

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Opportunity for Public Comment

Lunch Activity

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- Please rank the NQF-endorsed cancer measures on the *left side* of the table.
  - 3= Yes, include in core set
  - 2= Maybe/Not sure
  - 1=No, do not include in core set

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Data Sources and HIT Implications

Data Sources and HIT Implications

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American College of Surgeons Commission on Cancer

– Stephen B. Edge, MD

American Society of Clinical Oncology

– Michael Nuess, MD

– Kristen McNiff, MPH

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Propose a Cancer Care Measurement Strategy

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	Screening Prevention	Diagnosis Under Treatment Treatment Overtreatment	Survivorship Surveillance Quality of life Palliative Care End of life
Cross cutting measures, NQS priorities: safety, care coordination, patient preferences (including patient outcomes, patient shared decision making, patient experience of care, family engagement)			
Breast			
Colon			
Lung			
Prostate			
Gynecological cancers			
Pediatric Cancers Subgroup: leukemia			
Other cancers (measures: esophagus, pancreas, multiple myeloma, leukemia, melanoma) (no measures: brain, adrenal, other skin)			

Cancer Care Measurement Strategy

- Define a core set of cancer care measures
- Identify priority measure gap concepts
- Consider the relationship to the hospital core measure set
- Review data source and HIT implications
- Synthesis of Hospital Workgroup guidance to the Coordinating Committee

Proposed Cancer Care Measure Set

Five measures selected by the TEP:

- Adjuvant chemotherapy for Stage III colon cancer
- Combination chemotherapy for AJCC T1c or Stage II or III hormone receptor-negative breast cancer
- Hormone therapy for AJCC T1c or Stage II or III hormone receptor-positive breast cancer
- Catheter-associated urinary tract infections (CAUTIs)
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- *Additional measures*

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Opportunity for Public Comment

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Hospital Workgroup Next Steps

Next Steps

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Pre-rulemaking Task:

- Feedback on MAP measure selection criteria to Coordinating Committee – Oct. 19 Coordinating Committee web meeting to finalize criteria
- Pre-rulemaking Task – Hospital Workgroup in-person meeting on Dec. 15

Cancer Care Measures Task:

- Follow-up survey exercise to confirm workgroup recommendations (if needed)
- Draft Report to Coordinating Committee – Mar. 15-16 in-person meeting

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SUPPLEMENTAL MATERIALS

Measure Applications Partnership Meeting: Cancer Measurement

ASCO

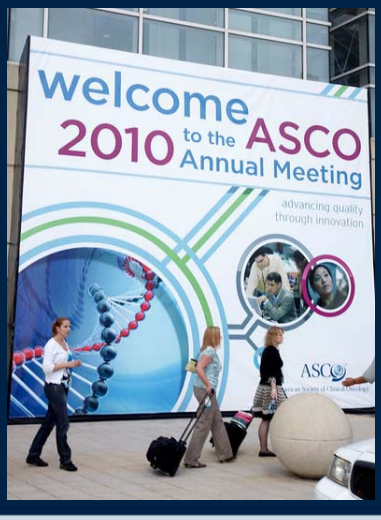
Michael Neuss, MD
Vanderbilt-Ingram Cancer Center
Kristen McNiff, MPH
ASCO

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Who Are We?

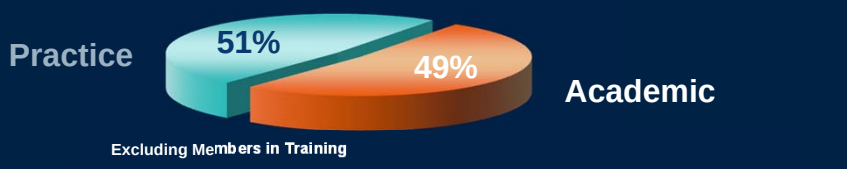
The American Society of Clinical Oncology

- Society for oncology professionals
- 30,000 members
- 115 countries
- Multi-specialty
- Multidisciplinary
- Multi-setting



ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

Our Membership



Excluding Members in Training

All ASCO members

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Quality Oncology Practice Initiative (QOPI)

- Launched in 2006 as free member benefit for outpatient adult Med Onc practices
- Retrospective chart abstraction offered twice/year, secure web-based submission
- Data analyses and confidential practice reporting
- Practice-specific and aggregate comparison data for data-driven QI
- Nearing 50,000 patient year (1,400,000 new cases/year, 3-4%)

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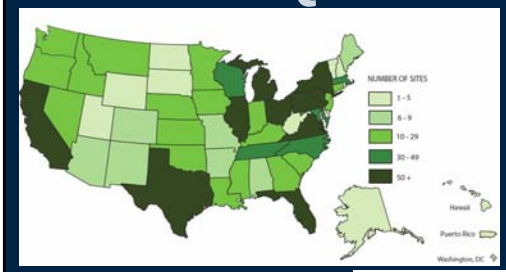
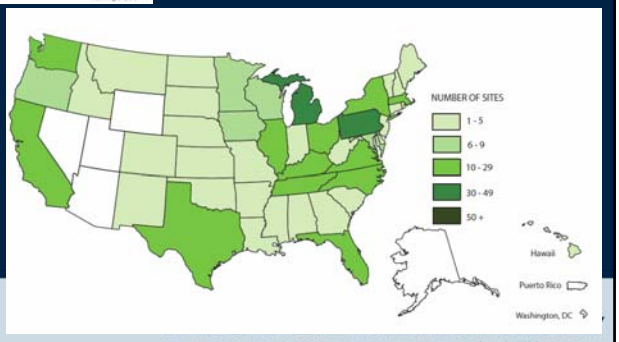
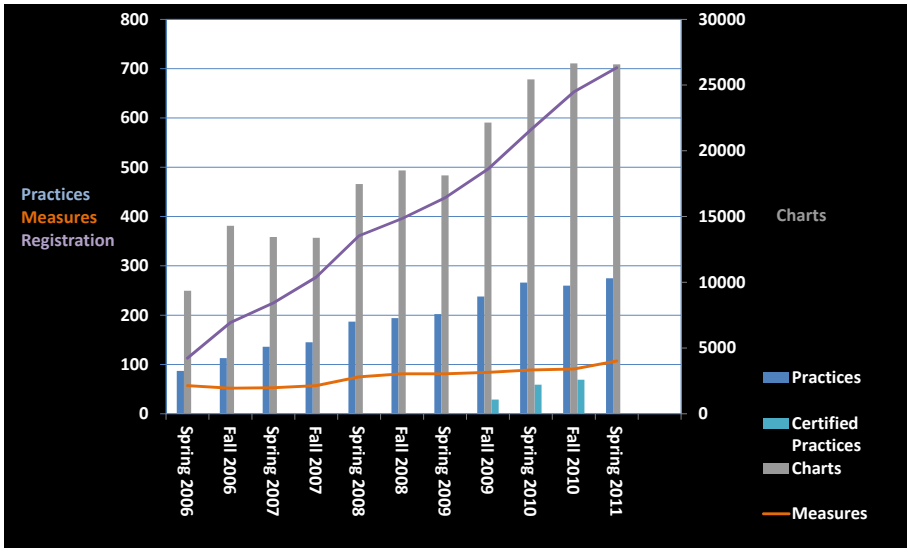
National QOPI Participation



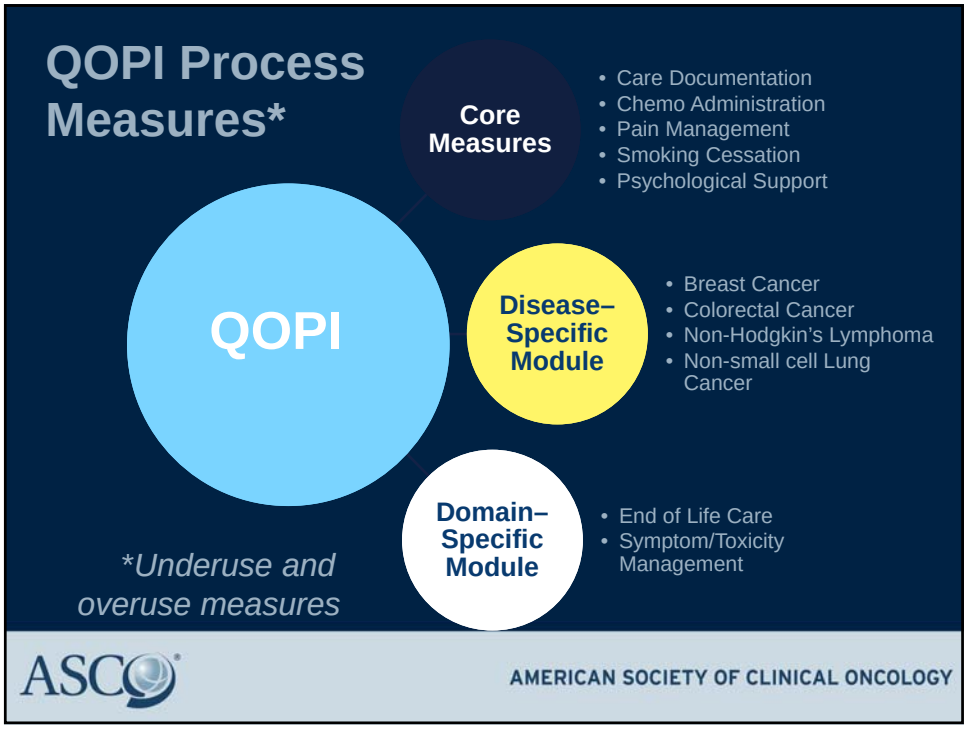


ASCO

Last Updated: 5/2011



QOPI & QCP: Spring 2006 – Spring 2011



Sources for ASCO Measures

- ASCO guidelines, other organizations' guidelines
- ASCO committees (e.g., Cost of Care; Disparities, Survivorship)
- National reports (e.g., IOM reports)
- Suggestions for external organizations (e.g., patient advocacy organizations, other societies)

ASCO AMERICAN SOCIETY OF CLINICAL ONCOLOGY

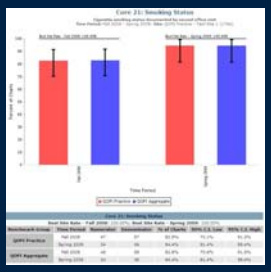
QOPI Rapid Reporting

QOPI Measures Summary Report

QOPI® Fall 2008 Measure Summary Report

#	Measure (%)	Oncology Hematology Care Inc - Blue Ash Medical			QOPI Aggregate Data				
		Num	Denom	Rate	Mean	Min	Max	N Charts	N Sites
	Core								
1	Pathology report confirming malignancy available in the chart	129	129	100.00%	97.53%	71.17%	100.00%	17771	245
2	Explicit statement of staging within one month of first office visit	121	129	93.80%	91.86%	42.22%	100.00%	17662	245
3	Pain assessed by second office visit	113	129	87.60%	83.08%	0.00%	100.00%	17771	245
4	Pain intensity quantified by second office visit	63	63	100.00%	56.76%	0.00%	100.00%	5333	242
5	For patients with severe or moderate pain, documentation that pain was addressed	24	43	55.81%	80.40%	0.00%	100.00%	1379	188
6	Pain addressed appropriately (combined measure, 3, 4, and 5)	94	129	72.87%	68.58%	0.00%	100.00%	17771	245
7	Effectiveness of pain medication assessed on visit following new narcotic prescription	8	19	42.11%	65.59%	0.00%	100.00%	2438	235
8	Constipation assessed at the time of or at the first visit following new narcotic analgesic prescription	13	20	65.00%	50.22%	0.00%	100.00%	2694	235
9	Documented plan for chemotherapy, including dose and time intervals, before chemotherapy started	104	104	100.00%	84.42%	2.63%	100.00%	13699	242
10	Chemotherapy intent (palliative vs. curative) documented	104	104	100.00%	81.54%	0.00%	100.00%	13699	242
11	Chemotherapy intent discussion with patient documented	80	104	76.92%	91.53%	20.00%	100.00%	11170	241
12	Number of chemotherapy cycles documented prior to administration	59	59	100.00%	89.44%	10.00%	100.00%	8043	241
13	Flow sheet for chemotherapy with doses, dates of administration, and blood counts available in the chart	104	104	100.00%	92.52%	0.00%	100.00%	13699	242
14	Signed patient consent for chemotherapy in chart	102	104	98.08%	73.52%	0.00%	100.00%	13699	242
15	Treatment discussion and patient consent for administration of chemotherapy documented	53	104	50.96%	81.93%	7.81%	100.00%	13699	242
16	Some form of patient consent documented (combined measure, 14 or 15)	104	104	100.00%	93.66%	7.84%	100.00%	13699	242
17	Chemotherapy treatment summary documented in chart within 3 months of completion of chemotherapy	0	23	0.00%	42.43%	0.00%	100.00%	4539	235

Graphical Measures Summary Report/ Trend Report



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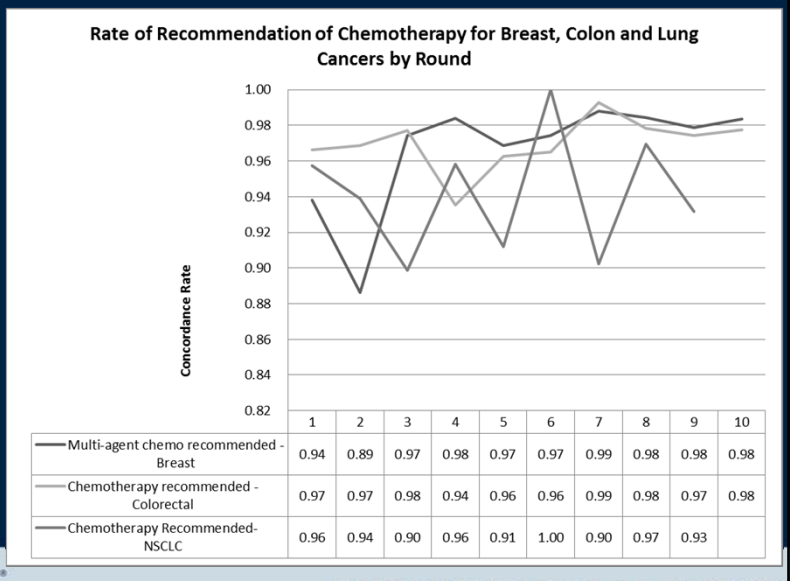
QOPI Measure Examples…



	1	2	3	4	5	6	7	8	9	10
Multi-agent chemo recommended - Breast	0.94	0.89	0.97	0.98	0.97	0.97	0.99	0.98	0.98	0.98
Chemotherapy recommended - Colorectal	0.97	0.97	0.98	0.94	0.96	0.96	0.99	0.98	0.97	0.98
Chemotherapy Recommended- NSCLC	0.96	0.94	0.90	0.96	0.91	1.00	0.90	0.97	0.93	

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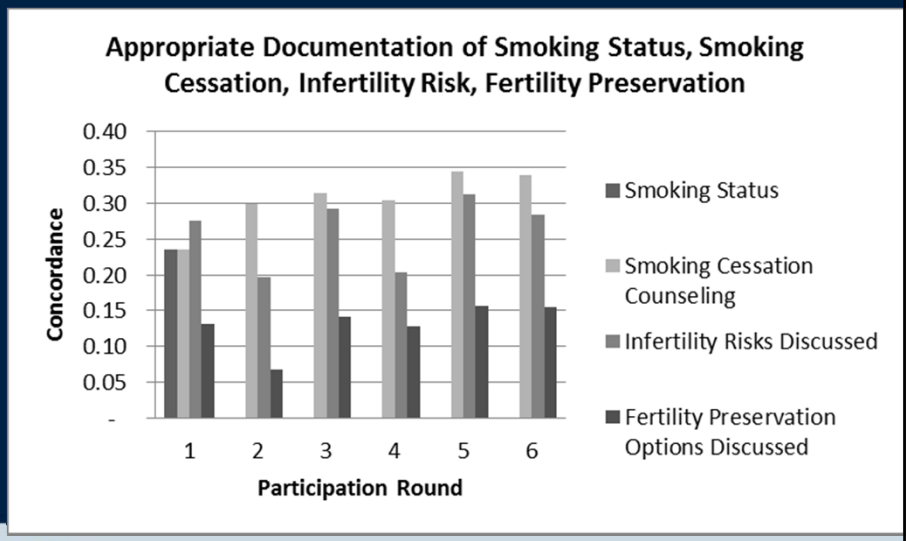
QOPI Measure Examples…



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QOPI is Nimble

- QOPI development cycle is days
- Definition of data elements serves educational function
- New concepts can be introduced easily
- Platform independent

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Next Steps/Identified Needs

- More robust quality measures
  - Including outcome measures, patient experience and outcome measures
- EHR-based, prospective and longitudinal data to populate QOPI
- Ability to meet CMS reporting requirements while participating in more comprehensive quality reporting and improvement initiatives

eMeasures

- ASCO has engaged with AMA PCPI and NQF in 'retooled' cancer measures
- ASCO will develop additional measures for EHR-based reporting
- Major issue: lack of standards to capture staging and state
  - Not captured by ICD-9 codes, ICD-10 codes, or any administrative data
  - Inadequate, incomplete, incorrect SNOMED codes

Future Cancer Quality Measures

Where should we go?

- Existing NQF endorsed measures are important to assess
  - Especially at the system/institution level
- Additional measures are needed
  - More comprehensive and patient-centric measures across specialties and domains
  - Mix of structure, process and outcome measures
  - Measures developed for EHR as unique data source
  - Means to address methodologic issues (risk adjustment, small denominator [especially at provider level])

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Future Cancer Reporting

- Specialty-led registry programs can provide comprehensive data collection and actionable reporting which cannot be replicated by federal reporting programs
- Federal programs should leverage established and proven programs and promote participation

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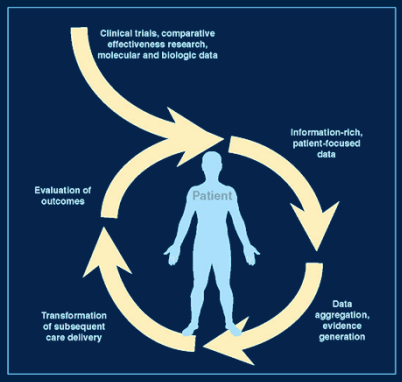
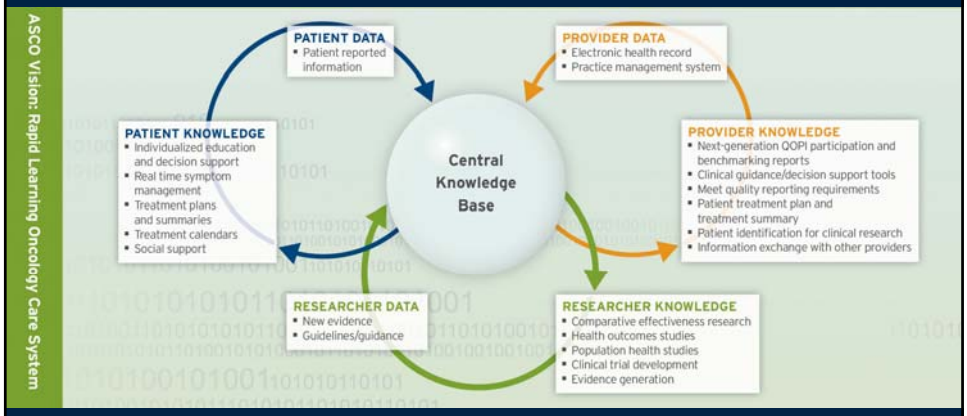
Realizing Potential of HIT: IOM 'Rapid Learning System for Cancer Care'

- "In this framework, routinely collected real-time clinical data drive the process of scientific discovery, which becomes a natural outgrowth of patient care"
  - Abernethy et al, Rapid-Learning System for Cancer Care, JCO 2010





Summary

- Use of existing, proven registries will maximize comprehensive quality measurement and opportunities for improvement
- ASCO has developed and implemented more than 100 quality measures; however, additional measure development and endorsement work is needed for oncology
- Emeasures are needed but there is a requirement for
  - Staging data standards
  - Combined input cross time and location (e.g. tumor registry)
  - Universal reporting
  - Patient input
  - Outcomes

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Cancer Care Measurement

MAP Hospital Workgroup

October 13, 2011

First, some housekeeping…

- Yes, cancer care is complex and involves many types of providers and procedures
- Yes, there are many types and subtypes
- Yes, there is much work to do

- This only means that it is challenging, not impossible

- And, unfortunately, you are not going to hear a "we've done it well" talk. WHY??

Who are the exempt cancer centers?

- The Ohio State Comprehensive Cancer Center – Arthur G. James Cancer Hospital and Solove Research Institute, Columbus, OH
- City of Hope Comprehensive Cancer Center, Duarte, CA
- Dana-Farber Cancer Institute, Boston, MA
- Fox Chase Cancer Center, Philadelphia, PA
- H. Lee Moffitt Cancer Center & Research Institute, Tampa, FL
- The University of Texas MD Anderson Cancer Center, Houston, TX
- Memorial Sloan-Kettering Cancer Center, New York, NY
- Roswell Park Cancer Institute, Buffalo, NY
- Seattle Cancer Care Alliance, Seattle, WA
- Sylvester Comprehensive Cancer Center, Miami, FL
- USC Norris Cancer Hospital, Los Angeles, CA

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

(k) Quality Reporting by Cancer Hospitals-

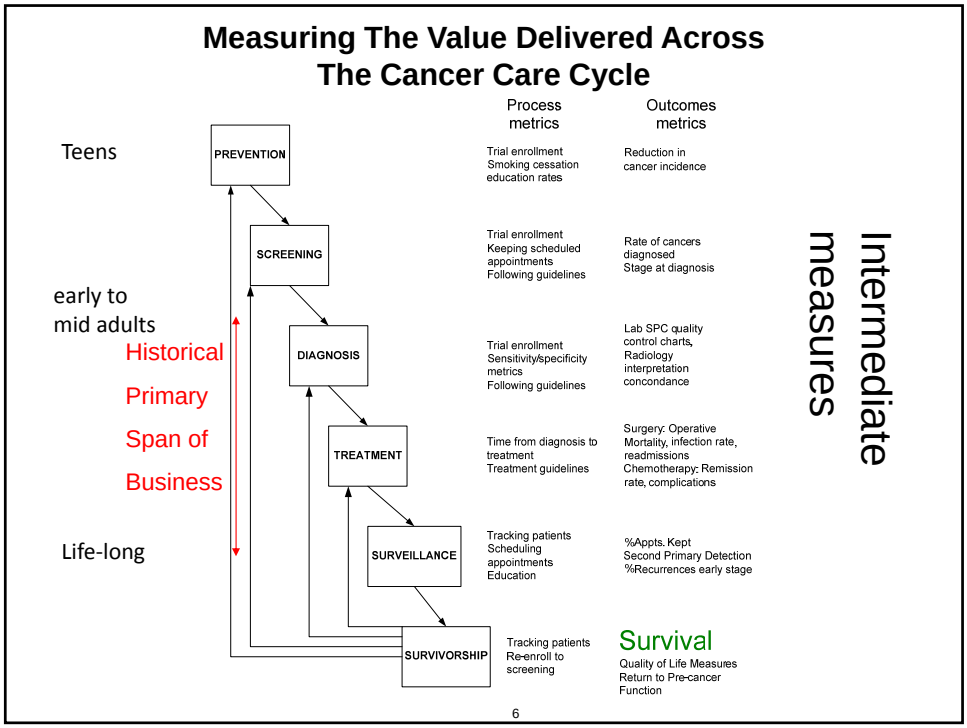
(1) IN GENERAL- For purposes of fiscal year 2014 and each subsequent fiscal year, a hospital described in section 1886(d)(1)(B)(v) shall submit data to the Secretary in accordance with paragraph (2) with respect to such a fiscal year.

(2) SUBMISSION OF QUALITY DATA- **For fiscal year 2014 and each subsequent fiscal year, each hospital described in such section shall submit to the Secretary data on quality measures specified under paragraph** (3). Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

H.R. 3590
Patient Safety and Affordable Healthcare Act

SEC. 3005. QUALITY REPORTING FOR PPS-EXEMPT CANCER HOSPITALS.

"(4) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under paragraph (4) available to the public. Such procedures shall ensure that a hospital described in section 1886(d)(1)(B)(v) has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspective on care, efficiency, and costs of care that relate to services furnished in such hospitals on the Internet website of the Centers for Medicare & Medicaid Services.".



Unique characteristics and measurement needs

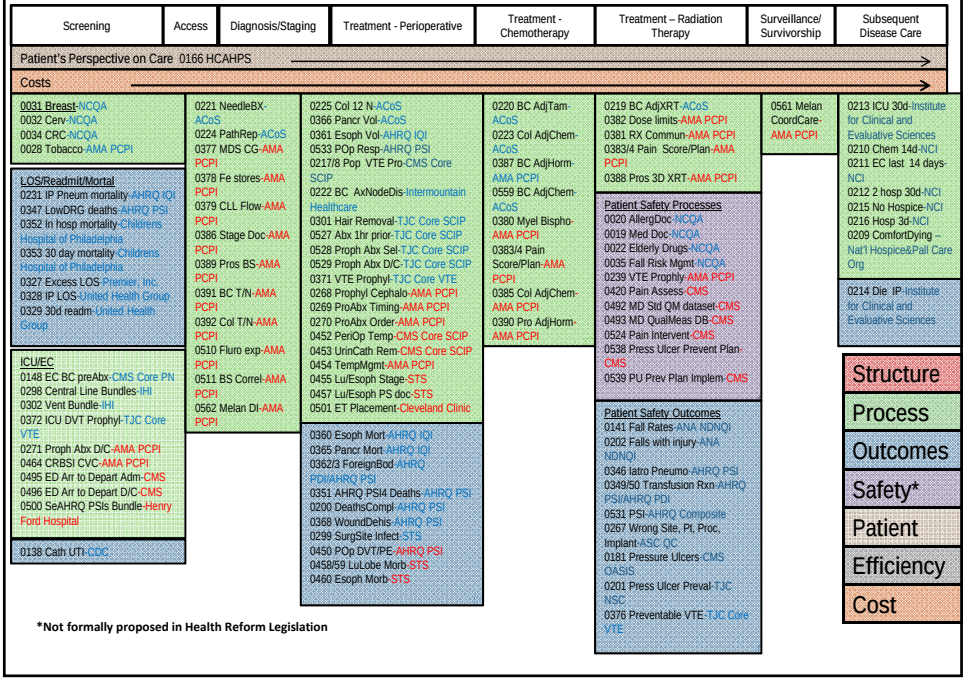
- Short-term (months) and long term (years) focus
- Hospital-outpatient blend
- Longitudinally-patient centered database
- Generally care is across many providers which requires coordinated data systems

Unique characteristics and measurement needs

- Generally across many settings
- Prognostic factors (data elements) very complex
- Significant interplay between disease characteristics and host characteristics
- Risk adjustment methodological limitations

Gap analysis

Current State of NQF Metrics Applied to Cancer Care



*Not formally proposed in Health Reform Legislation

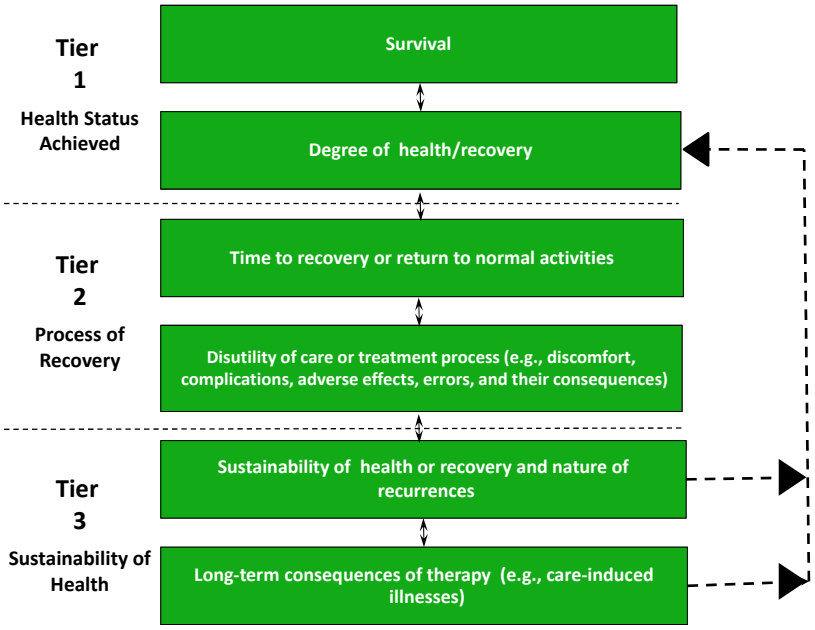
Current NQF-Endorsed Cancer Metrics Across the Continuum of Care

Current State Of Endorsed Quality Measures Applied To Cancer Care

	Measures		Cancer-specific measures	
Cancer care continuum	**Number**	**Percent**	**Number**	**Percent**
OUTCOMES				
Treatment	36	24	4	7
Subsequent disease care	2	1	2	4
Subtotal	38	25	6	11
STRUCTURE				
All stages of care	14	9	2	4
PROCESS				
Treatment	56	37	18	33
Diagnosis/staging	13	9	11	20
Subsequent disease care	12	8	6	11
Screening/prevention	10	7	5	9
Surveillance/survivorship	5	3	5	9
Subtotal	96	64	45	83
EFFICIENCY				
All stages of care	0	0	0	0
COST OF CARE				
All stages of care	0	0	0	0
PATIENTS' PERCEPTION OF CARE				
All stages of care	3	2	1	2
TOTAL				
	151	100	54	100

SOURCE Authors' analysis of measures endorsed by the National Quality Forum. See Note 12 in text. **NOTES** The list of endorsed measures includes measures that are applicable to cancer disease only (for example, National Quality Forum–endorsed measure 0386: documentation of cancer stage) and measures that are applicable to a broad range of diseases (for example, National Quality Forum–endorsed measure 0533: postoperative respiratory failure).

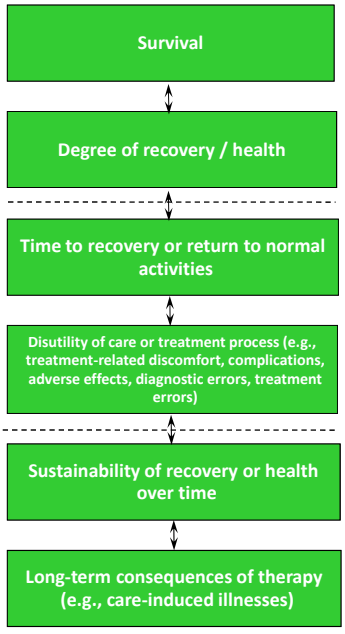
The Outcome Measures Hierarchy



From : Porter, ME, Harvard Business School, 2009

The Outcome Measures Hierarchy

Head and Neck Cancer



- **Survival rate** (Two-year, five -year)
- **Degree of remission**
- **Functional status**
- **Time to remission**
- **Cancer recurrence**
- **Incidence of secondary cancers**

- **Can swallow normally**
- **Can talk normally**
- **Completion of all treatments for cure within 100 days**
- **Postoperative complications**
- **Readmissions**
- **"Time-to's" (referral, appt., treatment,etc)**
- **Disease-free survival**

M Porter, Redefining Healthcare, 2006

Clinical Outcomes

	H&N CA (1st Porter)	Esoph (SLC)	Lung (AHRQ grant)	Breast (AHRQ grant)	ColoRect (AHRQ grant)	Prostr (AHRQ grant)	Gyne (new interest)
Tier 1 - Surv	1,2 yr surv	2 yr surv	1,2 yr surv	5, 10 yr DFS	2,5 yr surv	5, 10 yr surv	2, 5 yr surv
Pt -centered	Swallowing, speaking	Swallowing, weight	Pulm fn	Cosmesis, hormonal	Bladder and bowel fn Stoma rate	Bladder and bowel fn Sexual fn	Bladder and bowel fn
Tier 2 – Normalcy and Disutilities	Time to complete RX System thruput Complications of care	Time to complete RX System thruput Complications of care	Time to complete RX System thruput Complications of care	Time to complete RX System thruput Complications of care	Time to complete RX System thruput Complications of care	Time to complete RX System thruput Complications of care	Time to complete RX System thruput Complications of care
Tier 3 - Sustainability and long term complications	Secondary cancers (lung or upper resp) RX toxicities	Secondary cancers (upper GI) RX toxicities	Secondary cancers (lung or upper resp) RX toxicities	Secondary cancers (arm sarcoma) RX toxicities	Secondary cancers (GI) RX toxicities	Secondary cancers (GU) RX toxicities	Secondary cancers RX toxicities

What are the database prospects?

- Of course, administrative claims data for the usual stuff

ASCO QOPI

- Tested, valid, reliable, usable
- "Registry" type – abstracted data
- Very process-oriented
- Very physician practice oriented
- Covers many steps in the process
  - Diagnosis, staging, lab testing, treatment, symptom management, screening and detection, prevention, followup, end of life care

http://qopi.asco.org/program

ASCO QOPI

- Gaps:
  - Patient preferences
  - Patient satisfaction
  - Complications of care
  - Long-term outcomes
  - Handoffs and care coordination
  - Inpatient care

ACOS NCDB

- Tested, reliable, valid, usable
- “Registry” type – abstracted data
- Heavily weighted towards initial interventions
- Specifically geared to measure survival

Longitudinal measures that span the care continuum
NONE ARE ENDORSED

- SURVIVAL (or, if you wish, more than 30 day mortality)
- Patient perceived quality of life
- Functional status
- Disease status
- Long term consequences of treatment

Patient reported measures

- HCAHPS
  - Inpatient
  - Not cancer specific
  - Halo effects
  - Endorsed

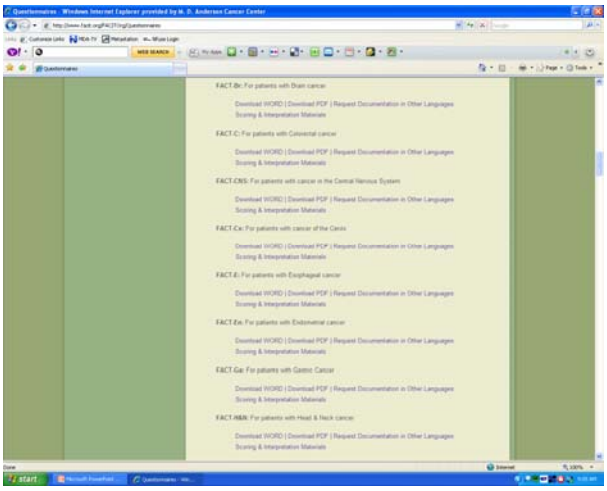
*Summary of HCAHPS Survey Results**
October 2009 to September 2010 Discharges

State	Comm. with Nurses	Comm. with Doctors	Responsiveness of Hospital Staff	Pain Management	Comm. About Medicines	Cleanliness of Hosp. Env.	Quietness of Hosp. Env.	Discharge Information	Overall Hospital Rating	Recommend the Hospital	Publicity Reporting Hospitals	Survey Response Rate**

- Press-Ganey
  - Inpatient and Outpatient
  - Customized for cancer
  - Not endorsed

Patient centered approach to public reporting, i.e. FACIT

- Very cancer specific
- Validated tool
- True patient reported outcomes
- Primarily been used in research
- Need registry or EHR development



For example, ovarian

NCCN-FACT FOSI-18

Below is a list of statements that other people with your illness have said are important. **Please circle or mark one number per line to indicate your response as it applies to the past 7 days.**

		Not at all	A little bit	Some-what	Quite a bit	Very much
GP1	I have a lack of energy	0	1	2	3	4
GP4	I have pain	0	1	2	3	4
GP6	I feel ill	0	1	2	3	4
O3	I have cramps in my stomach area	0	1	2	3	4
H17	I feel fatigued	0	1	2	3	4
Cn5	I am bothered by constipation	0	1	2	3	4
O1	I have swelling in my stomach area	0	1	2	3	4
C3	I have control of my bowels	0	1	2	3	4
GP3	I am sleeping well	0	1	2	3	4
GE6	I worry that my condition will get worse	0	1	2	3	4
GP2	I have nausea	0	1	2	3	4

Palliative and end of life measures

- Administrative data “close”
- Do require human interpretation
- Very important tie to resource utilization

#0210: Proportion receiving chemotherapy in the last 14 days of life	No identified steward	Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life
#0211: Proportion with more than one emergency room visit in the last 30 days of life	No identified steward	Percentage of patients who died from cancer with more than one emergency room visit in the last 30 days of life
#0212: Proportion with more than one hospitalization in the last 30 days of life	No identified steward	Percentage of patients who died from cancer with more than one hospitalization in the last 30 days of life
#0213: Proportion admitted to the ICU in the last 30 days of life	No identified steward	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life
#0214: Proportion dying from Cancer in an acute care setting	No identified steward	Percentage of patients who died from cancer in an acute care setting
#0215: Proportion not admitted to hospice	No identified steward	Percentage of patients who died from cancer not admitted to hospice
#0216: Proportion admitted to hospice for less than 3 days	No identified steward	Percentage of patients who died from cancer, and admitted to hospice and spent less than 3 days there

Note: Some similarities to ASCO QOPI measures

Resource utilization measures

- Initial attempts failed
- VERY KEY! – over-, under-, mis-use
- Very emotional
- Administrative data possible
- Interesting recent NYT article re: surgery

Colon CA	(1583) Episode of care for 21-day period around a colonoscopy	Resource use and costs associated with colonoscopy. Patients undergoing a colonoscopy are identified and the resource use and costs associated with colonoscopy in the 7 days before the procedure and the 14 days following the procedure are measured. For the group of patients with a colectomy that includes a primary diagnosis for colon cancer within the 14-day follow-up period, the episode will be from 7 days preceding the colonoscopy to 2 days preceding the colectomy. Those with a colectomy with a primary diagnosis of colon cancer within 2 days of the colonoscopy will be excluded from the measure.	ABMS-REF
Colon CA	(1584) Episode of care for treatment of localized colon cancer	Resource use and costs associated with colon cancer treatment. Patients undergoing colectomy are identified and the resource use and costs associated with colon cancer care in the 30 days before the procedure and the 11 months following the procedure are measured.	ABMS-REF
Breast CA	(1578) Episode of care for 60-day period preceding breast biopsy	Resource use and costs associated with breast biopsy. Women with a breast biopsy are identified and the resource use and costs associated with the biopsy in the 60 days preceding the biopsy and the seven days following the biopsy are measured.	ABMS-REF
Breast CA	(1579) Episode of care for cases of newly diagnosed breast cancer over a 15 month period	Resource use and costs associated with management of newly diagnosed cases of breast cancer over an 18-month period, three months preceding the diagnosis date and 15 months following the initial diagnosis. Patients are included in the cohort based on identification of new diagnoses of breast cancer using a validated algorithm. Women with a diagnosis code for breast cancer are identified during the measurement year and stratified into high likelihood cases if they have surgical or procedure claims related to breast cancer (mastectomy, lumpectomy, radiation treatment) or have more than two visits with a primary diagnosis of breast cancer. Women are identified as non-high likelihood cases if they do not meet these criteria. These women are included as potential cases if they meet certain criteria related to surgery, multiple claims, other cancers and secondary breast cancer. Patients with a previous diagnosis of breast cancer, metastatic disease and non-melanoma non-skin cancer are excluded. Eligible patients are followed for 15 months following the initial date of their diagnosis during the measurement period and data from the three months preceding the entry date are also captured for identification of breast cancer-related care. Patients are stratified into four mutually exclusive groups: 1) Chemotherapy, with trastuzumab; 2) chemotherapy, no trastuzumab; 3) no chemotherapy; and 4) neoadjuvant chemotherapy. Overall breast cancer-related costs and resource use are calculated for each stratum. Costs of care are calculated at a system level due to the inability to measure important case-mix factors such as stage of disease and estrogen and progesterone receptor status in current administrative datasets.	ABMS-REF

Recommendation

- "The journey starts with….."
- At least start measuring – nothing will be perfect
- Learn the lessons from previous core measures
- Refine and improve over time
- Enhance the data systems for patient reported outcomes

Specifics

- Process measures in QOPI with staged implementation – diagnosis, staging, treatment
- "Re-commission" end of life measures
- Re- invigorate the resource utilization measures around breast and colon cancer
- Utilize cancer-specific patient satisfaction
- Work towards true patient reported outcomes including quality of life and functional outcomes

Specifics

- Can incorporate non-specific measures in the interim, i.e. NHSN, NDNQI, SCIP, PSI's, etc
- Recognize that what matters to cancer patients is LIVING, and with what quality of life
- Acknowledge the true continuum of care

American College of Surgeons Commission on Cancer

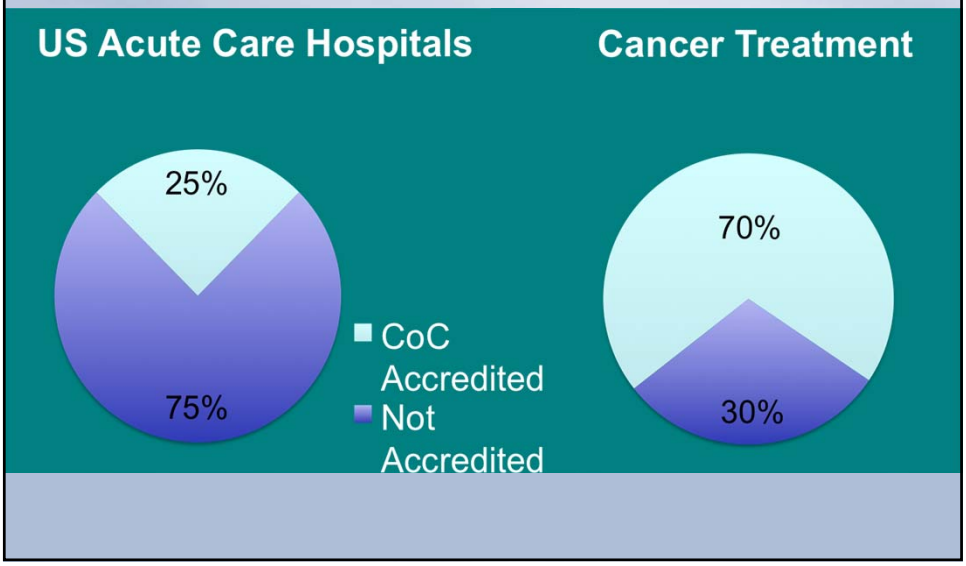
Focus on Quality Measurement and Improvement

Stephen B. Edge, MD, FACS
Chair, Commission on Cancer

American College of Surgeons
Inspiring Quality: Highest Standards, Better Outcomes

Commission on Cancer

Most Cancer Care in America at CoC Programs



CoC Program Accreditation Requirements

- Cancer Program Oversight
  - Administrative
  - Medical
- Community involvement / outreach
- Cancer Care Review
  - Cancer Conferences
  - Cancer Registry
- Report registry data to CoC in Chicago

Updated Accreditation Standards 2011

Promoting the use of quality measurement at at the point of care to improve patient outcomes

- Enhanced use of existing quality metrics with required performance / improvement plan
- Assessing and implement new measures
- Studies of quality and improvements
- Public reporting

Quality Measurement Tools

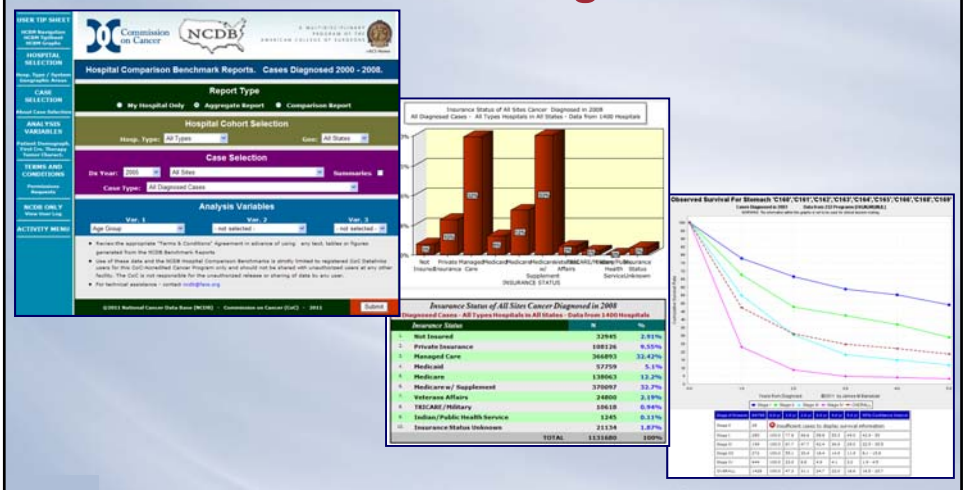
Based on

National Cancer Data Base

National Cancer Data Base

- Cancer registry data from all CoC accredited programs
- Uses of NCDB
  - Comparative Effectiveness Research / Evaluation of patterns of care
  - Retrospective quality monitoring / reporting
  - Active quality management

On Line Reporting Available to All CoC Accredited Programs



Retrospective Reporting of Quality Performance:

NQF Approved Measures

Cancer Program Practice Profile Reports (CP³R): for Breast, Colon and Rectal Cancers

2004 - 2008 Diagnoses

Roswell Park Cancer Institute, Buffalo, NY

Interpreting This Report: The estimated performance rates shown below provides your cancer program with an indication of the proportion of breast and colorectal patients treated according to recognized standards of care by diagnosis year. These proportions are computed based on data directly reported from your registry to the NCDB. This Cancer Program Practice Profile Reports (CP3R) application provides cancer programs with the opportunity to examine data to determine if these performance rates are representative of the care provided at the institution. Cancer programs have the ability to review and modify cases by clicking on "case review" for the measure of interest. Displayed performance rates are immediately updated once modifications via the CP3R are completed by cancer program staff, comparison rates are updated nightly. Note: Any modifications made online should be reflected at the local cancer registry. Cancer programs are encouraged to resubmit reconciled cases to the NCDB.

	Select Breast & Colorectal Measures	Estimated Performance Rates (click rate for comparissons) 2004	2005	2006	2007	2008	Case Review
BREAST	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. **[BCS/RT]**	97.3%	95.3%	94%	94.8%	94.3%	BCS
BREAST	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c N0 M0, or Stage II or III ERA and PRA negative breast cancer. **[MAC]**	90%	97.2%	92.7%	84.6%	82.1%	MAC
BREAST	Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c N0 M0, or Stage II or III ERA and/or PRA positive breast cancer. **[HT]**	93%	93.8%	93.5%	95%	94.7%	HT
COLON	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. **[ACT]**	100%	94.7%	87.5%	100%	100%	ACT
COLON	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. **[12RLN]**	75%	94.7%	90.9%	90.5%	100%	12 RLN
REC	Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer. **[AdjRT]**	90%	100%	92.9%	83.3%	100%	Adj RT

NCDB CP³R

Retrospective Reporting of Quality Performance:

NQF Measures

Center can audit data for completeness

Cancer Program Practice Profile Reports (CP³R): for Breast, Colon and Rectal Cancers
2004 - 2008 Diagnoses
Roswell Park Cancer Institute, Buffalo, NY
Interpreting This Report: The estimated performance rates shown below provides your cancer program with an indication of the proportion of breast and colorectal patients treated according to recognized standards of care by diagnosis year. These proportions are computed based on data directly reported from your registry to the NCDB. This Cancer Program Practice Profile Reports (CP3R) application provides cancer programs with the opportunity to examine data to determine if these performance rates are representative of the care provided at the institution. Cancer programs have the ability to review and modify cases by clicking on "case review" for the measure of interest. Displayed performance rates are immediately updated once modifications via the CP3R are completed by cancer program staff, comparison rates are updated nightly. Note: Any modifications made online should be reflected at the local cancer registry. Cancer programs are encouraged to resubmit reconciled cases to the NCDB.

	Select Breast & Colorectal Measures	Estimated Performance Rates (click rate for comparissons) 2004	2005	2006	2007	2008	Case Review
BREAST	Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer. **[BCS/RT]**	97.3%	95.3%	94%	94.8%	94.3%	BCS
BREAST	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c N0 M0, or Stage II or III ERA and PRA negative breast cancer. **[MAC]**	90%	97.2%	92.7%	84.6%	82.1%	MAC
BREAST	Tamoxifen or third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c N0 M0, or Stage II or III ERA and/or PRA positive breast cancer. **[HT]**	93%	93.8%	93.5%	95%	94.7%	HT
COLON	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer. **[ACT]**	100%	94.7%	87.5%	100%	100%	ACT
COLON	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer. **[12RLN]**	75%	94.7%	90.9%	90.5%	100%	12 RLN
REC	Radiation therapy is considered or administered within 6 months (180 days) of diagnosis for patients under the age of 80 of with clinical or pathologic AJCC T4N0M0 or Stage III receiving surgical resection for rectal cancer. **[AdjRT]**	90%	100%	92.9%	83.3%	100%	Adj RT

NCDB CP³R

Case Count Summary – Chemotherapy with ER Negative Breast Cancer

Drill Down to Case Level Data

Roswell Park Cancer Institute, Buffalo, NY

FACILITY SELECTION ALL MEASURES EPR

Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage II or III hormone receptor negative breast cancer. [MAC]	Performance Rates and Reported Cases					
	2004	2005	2006	2007	2008	All
Estimated Performance Rates	90%	97.2%	92.7%	84.6%	82.1%	89.2%
Performance Rate Numerator / Denominator	36/40	35/36	38/41	33/39	32/39	174/195
Cases eligible for the measure (Denominator) [Comp] + [rRx]	40	36	41	39	39	195
Cases not assessable due to incomplete tumor characteristics [I]	2	1	4	0	2	9
Cases not applicable for this measure by definition [NA]	186	209	198	200	220	1013
Cases not eligible for consideration for any breast measure [NE]	157	151	172	234	264	978
Total number of breast cancer cases reported to NCDB	385	397	415	473	525	2195

NCDB CP'R

Case Level Review: a) Auditing completeness; b) Quality Evaluation

SORT Status	SORT Case #	SORT Meas. Descr.	SORT Last Update	SORT Acc #	SORT Seq #	SORT Site
rRx	edit 2698613	Chemo started more than 120 days following diagnosis (12222)		200801319	00	C504
rRx	edit 1405618	Chemo started more than 120 days following diagnosis (12220)		200802385	00	C504
rRx	edit 1409664	Chemo started more than 120 days following diagnosis (12220)		200801591	00	C508
rRx	edit 2675981	Chemo started more than 120 days following diagnosis (12220)	Sep-29-2010	200803850	00	C502
rRx	edit 2687762	Chemo started more than 120 days following diagnosis (12222)		200803716	00	C508
rRx	edit 1300155	Chemo started more than 120 days following diagnosis (12220)		200803631	00	C505
rRx	edit 2700084	Chemo started more than 120 days following diagnosis (12220)		200800709	00	C504
Consid	edit 2691053	Chemo considered, not administered (12120)	Sep-29-2010	200800940	00	C508
Consid	edit 2691282	Chemo considered, not administered (12122)		200802066	00	C508
Comp	edit 2695463	Chemo started within 120 days following diagnosis (12110)		200803883	01	C504

Use of CoC

Cancer Registry System for

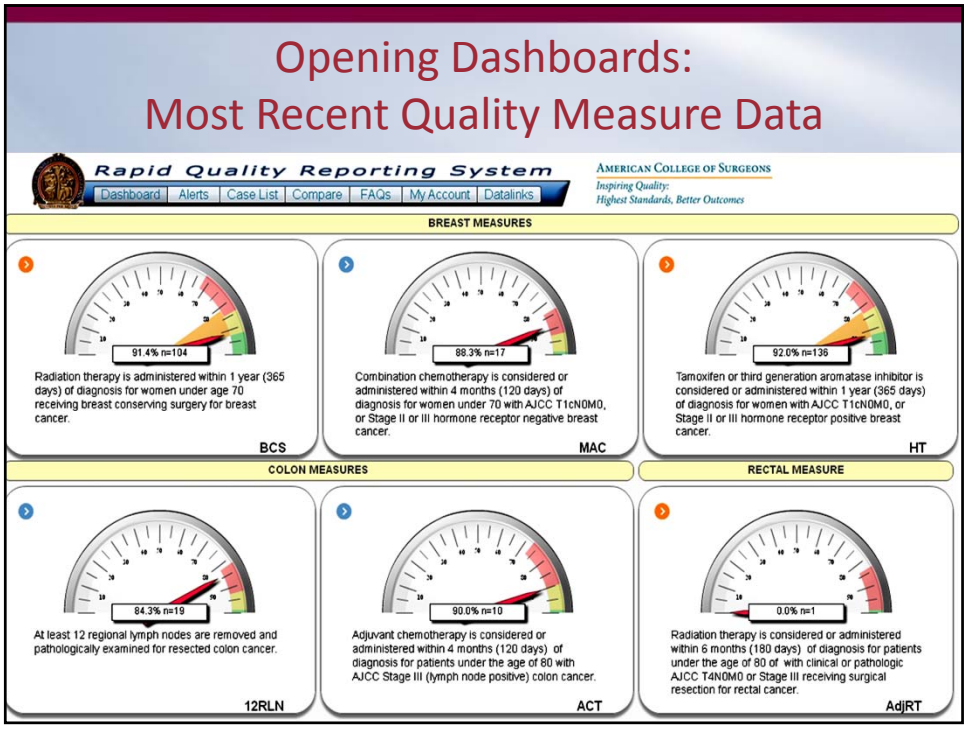
Rapid Quality Monitoring and

Active Care Management

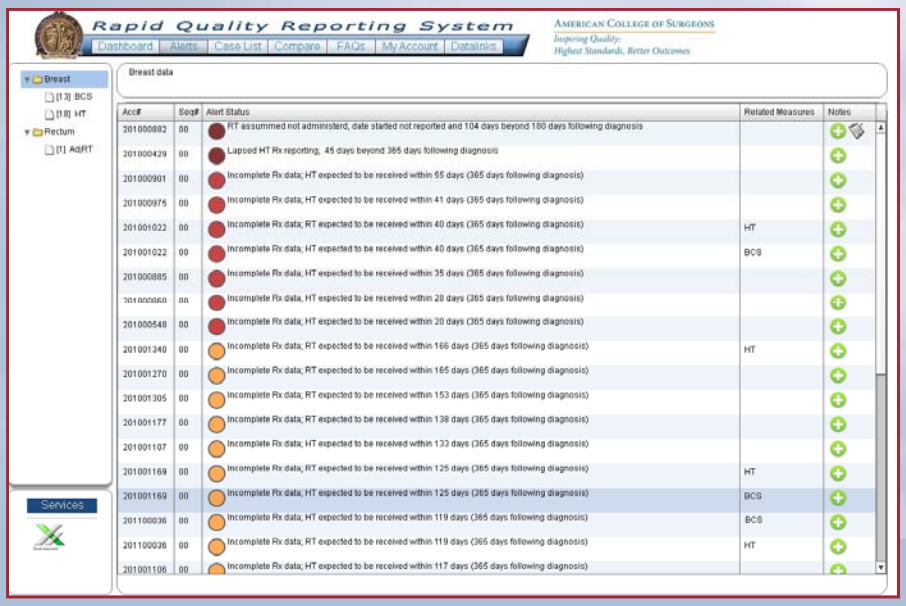
Rapid Quality Reporting System (RQRS)

- Immediate case ascertainment
  - Case tracking to allow active management
  - Ongoing reporting of quality metrics
  - Integration with survivorship plans and patient reported data
- Currently includes 3 breast and 1 colon National Quality Forum-endorsed quality measures
  - New breast measure to be added Fall 2011
  - Plans to expand with additional QI measures in GI and lung
- Piloted last 18 months
- Released September 2011 for all CoC programs

Opening Dashboards: Most Recent Quality Measure Data

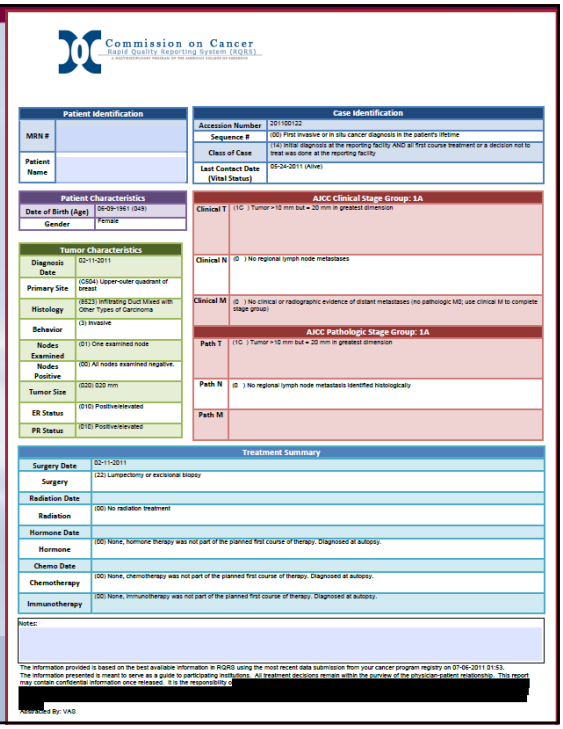


RQRS Monthly e-mail Alerts to Programs



Integration of Treatment Summary for Staff and Patient:

Autocompletion from registry data



Commission on Cancer
Rapid Quality Reporting System (RQRS)

Patient Identification	
MRN #	
Patient Name	

Case Identification	
Accession Number	2011100122
Sequence #	(00) First invasive or in situ cancer diagnosis in the patient's lifetime
Class of Case	(14) Initial diagnosis at the reporting facility AND all first course treatment or a decision not to treat was done at the reporting facility
Last Contact Date (Vital Status)	05-24-2011 (Alive)

Patient Characteristics	
Date of Birth (Age)	09-09-1961 (049)
Gender	Female

Tumor Characteristics	
Diagnosis Date	02-11-2011
Primary Site	(C504) Upper-outer quadrant of breast
Histology	(8523) Infiltrating Duct Mixed with Other Types of Carcinoma
Behavior	(3) Invasive
Nodes Examined	(01) One examined node
Nodes Positive	(00) All nodes examined negative.
Tumor Size	(020) 020 mm
ER Status	(010) Positive/elevated
PR Status	(010) Positive/elevated

AJCC Clinical Stage Group: 1A	
Clinical T	(1C) Tumor >10 mm but ≤ 20 mm in greatest dimension
Clinical N	(0) No regional lymph node metastases
Clinical M	(0) No clinical or radiographic evidence of distant metastases (no pathologic M0; use clinical M to complete stage group)

AJCC Pathologic Stage Group: 1A	
Path T	(1C) Tumor >10 mm but ≤ 20 mm in greatest dimension
Path N	(0) No regional lymph node metastasis identified histologically
Path M	

Treatment Summary	
Surgery Date	02-11-2011
Surgery	(22) Lumpectomy or excisional biopsy
Radiation Date	
Radiation	(00) No radiation treatment
Hormone Date	
Hormone	(00) None, hormone therapy was not part of the planned first course of therapy. Diagnosed at autopsy.
Chemo Date	
Chemotherapy	(00) None, chemotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.
Immunotherapy	(00) None, immunotherapy was not part of the planned first course of therapy. Diagnosed at autopsy.

Notes:

The information provided is based on the best available information in RQRS using the most recent data submission from your cancer program registry on 07-06-2011 01:53.
The information presented is meant to serve as a guide to participating institutions. All treatment decisions remain within the purview of the physician-patient relationship. This report may contain confidential information once released. It is the responsibility of [redacted]

Abstracted By: VAS

Plans for Expansion of NCDB-Based Quality Measurement System

- **National implementation of RQRS**
  - **Voluntary at this point – opened Sept 2011**
- **Collection of patient-reported data**
- **Linkage with administrative data**
  - **Claims; EHR; others**
- **NCDB is fertile ground to identify and test new measures**
  - **Current program to expand measure library**
  - **Multidisciplinary teams identifying measures for "accountability" and "quality improvement"**
    - **Breast; Esophagus; Gastric; Non-small cell lung**

Collaboration in CoC Quality Programs

- **Patient advocacy groups**
  - **American Cancer Society**
  - **NCCS; LiveSTRONG; CSC**
- **ASCO and ASTRO**
  - **Evaluating linkage to ASCO Quality Oncology Practice Initiative, EHR pilot project and Rapid Health Learning System**
- **Continued collaboration with NCQA and NQF**

Concerns on Use of Cancer Registry for Quality Measurement

Issue	NCDB / CoC Solutions
Cancer registry data not available for 2 – 3 years	Implementing Rapid Ascertainment System 2011
Data on outpatient data (e.g. RT and systemic therapy) incomplete	a) Best information is that NCDB fails to capture < 15% of data b) When used for public reporting, centers and CMS likely to apply additional auditing to assure complete case and data capture
Insufficient granularity on specific therapy	Enhancing data set; evaluating linkage to other data sets and oncology practices

Opportunities for Collaboration

- Work with others – e.g. ASCO
- Evaluate NCDB for opportunities for other measures based on Level I evidence in collaboration with experts at CoC; others
- Collaborate with NCQA and NQF on measure development, approval, application

The Future is Now

Commission on Cancer

A multidisciplinary program of the American College of Surgeons