



Measure Information

This document contains the information submitted by measure developers/stewards, but is organized according to NQF's measure evaluation criteria and process. The item numbers refer to those in the submission form but may be in a slightly different order here. In general, the item numbers also reference the related criteria (e.g., item 1b.1 relates to sub criterion 1b).

Brief Measure Information

NQF #: 0386

Corresponding Measures:

De.2. Measure Title: Oncology: Cancer Stage Documented

Co.1.1. Measure Steward: American Society of Clinical Oncology

De.3. Brief Description of Measure: Percentage of patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting who have cancer staging documented using any standardized system or documentation that the cancer is metastatic in the medical record within one month of first office visit

1b.1. Developer Rationale: Cancer stage is a critical component in determining treatment options for patients with cancer. Additionally, documentation of cancer stage in the medical record facilitates communication and care coordination among providers for a disease that is often treated by a multidisciplinary care team (e.g. medical oncology, surgery, and radiation oncology).

Despite its importance, cancer stage is often not documented in the medical record. For example, colon cancer is the third most common cancer in the United States (1), and Abernethy et al. demonstrated in a retrospective review of 499 colorectal cancer patients that only 38 percent of patient records provided TNM stage (which improved to 73 percent when any clinical notation of stage was accepted). Accordingly, Abernethy et al. concluded that assessment of care quality is impeded by the absence of data elements vital to the calculation of performance (2).

In 2015, the Surveillance, Epidemiology, and End Results (SEER) program implemented a field study to determine how often T, N, and M were not available in a total of 280 medical records (56 each for breast, prostate, colon, lung, and ovarian cancer). The authors determined that Pathologic T and N were only available for roughly two-thirds of the medical records examined and concluded that the data elements for TNM staging and stage group were often missing from the medical records (3).

A more recent 2017 study examined how often physician-assigned staging components were documented in the medical records of 282 routine cases at five cancer sites selected from the SEER registries. Noone et al. concluded that the physician-assigned TNM components and stage groups were often not found in the medical record, with pathologic T and N found most frequently at 65percent and 64 percent, respectively (4).

Citations:

1. Haggard, F.A. and R.P. Boushey, Colorectal cancer epidemiology: incidence, mortality, survival, and risk factors. Clin Colon Rectal Surg, 2009. 22(4): p. 191-7.
2. Abernethy, A.P., et al., Poor documentation prevents adequate assessment of quality metrics in colorectal cancer. J Oncol Pract, 2009. 5(4): p. 167-74.
3. Noone, A.M., et al., Availability of TNM Staging Data Elements in the Medical Record and Training Needs Assessment: Results from the 2014 SEER Training Needs Assessment for TNM Study. J Registry Manag, 2015. 42(2): p. 40-7.
4. Noone, A.M., et al., Medical Record-Documented TNM Categories and Stage Group: Feasibility of Use for Cancer Surveillance. J Registry Manag, 2017. 44(2): p. 46-53.

S.4. Numerator Statement: Patients who have cancer staging documented using any standardized system or documentation that the cancer is metastatic in the medical record within one month of the first office visit

S.6. Denominator Statement: All patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting.

S.8. Denominator Exclusions: Patients with a documented case of leukemia, myeloma, or myelodysplastic syndromes (MDS).

De.1. Measure Type: Process

S.17. Data Source: Registry Data

S.20. Level of Analysis: Clinician : Group/Practice, Clinician : Individual

IF Endorsement Maintenance – Original Endorsement Date: Jul 31, 2008 Most Recent Endorsement Date: Aug 09, 2012

IF this measure is included in a composite, NQF Composite#/title:

IF this measure is paired/grouped, NQF#/title:

De.4. IF PAIRED/GROUPED, what is the reason this measure must be reported with other measures to appropriately interpret results? Not Applicable

1. Evidence, Performance Gap, Priority – Importance to Measure and Report

Extent to which the specific measure focus is evidence-based, important to making significant gains in healthcare quality, and improving health outcomes for a specific high-priority (high-impact) aspect of healthcare where there is variation in or overall less-than-optimal performance. ***Measures must be judged to meet all sub criteria to pass this criterion and be evaluated against the remaining criteria.***

1a. Evidence to Support the Measure Focus – See attached Evidence Submission Form

386_NQF_EvidenceAttachment_4.10.2018.docx

1a.1 For Maintenance of Endorsement: Is there new evidence about the measure since the last update/submission?

Do not remove any existing information. If there have been any changes to evidence, the Committee will consider the new evidence. Please use the most current version of the evidence attachment (v7.1). Please use red font to indicate updated evidence.

Yes

1b. Performance Gap

Demonstration of quality problems and opportunity for improvement, i.e., data demonstrating:

- considerable variation, or overall less-than-optimal performance, in the quality of care across providers; and/or
- Disparities in care across population groups.

1b.1. Briefly explain the rationale for this measure (e.g., how the measure will improve the quality of care, the benefits or improvements in quality envisioned by use of this measure)

If a COMPOSITE (e.g., combination of component measure scores, all-or-none, any-or-none), SKIP this question and answer the composite questions.

Cancer stage is a critical component in determining treatment options for patients with cancer. Additionally, documentation of cancer stage in the medical record facilitates communication and care coordination among providers for a disease that is often treated by a multidisciplinary care team (e.g. medical oncology, surgery, and radiation oncology).

Despite its importance, cancer stage is often not documented in the medical record. For example, colon cancer is the third most common cancer in the United States (1), and Abernethy et al. demonstrated in a retrospective review of 499 colorectal cancer patients that only 38 percent of patient records provided TNM stage (which improved to 73 percent when any clinical notation of stage was accepted). Accordingly, Abernethy et al. concluded that assessment of care quality is impeded by the absence of data elements vital to the calculation of performance (2).

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1b.2. Provide performance scores on the measure as specified (current and over time) at the specified level of analysis. *(This is required for maintenance of endorsement. Include mean, std dev, min, max, interquartile range, scores by decile. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities include.) This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

ASCO's Quality Oncology Practice Initiative (QOPI®) includes the Oncology: Cancer Stage Documented measure. The QOPI testing data shows that of 242 facilities analyzed in 2017, the median and mean performance scores were 0.85 and 0.78 respectively. There were 3,660 patient that were included in this analysis. QOPI is a physician-led, voluntary, practice-based, quality-improvement program using performance measurement and benchmarking among oncology practices across the United States.

1b.3. If no or limited performance data on the measure as specified is reported in 1b2, then provide a summary of data from the literature that indicates opportunity for improvement or overall less than optimal performance on the specific focus of measurement.

1b.4. Provide disparities data from the measure as specified (current and over time) by population group, e.g., by race/ethnicity, gender, age, insurance status, socioeconomic status, and/or disability. *(This is required for maintenance of endorsement. Describe the data source including number of measured entities; number of patients; dates of data; if a sample, characteristics of the entities included.) For measures that show high levels of performance, i.e., "topped out", disparities data may demonstrate an opportunity for improvement/gap in care for certain sub-populations. This information also will be used to address the sub-criterion on improvement (4b1) under Usability and Use.*

Disparities data is provided below. The data is broken down by female versus male and then within gender by race (e.g. females who were white).

Female General Performance Rate: 0.865210084

Female Performance Rate by Race:

White: 0.8667

Black: 0.8469

Asian: 0.8956

Native American/Indian: 0.8824

Hawaiian Islander: 0.9091

Race Other: 0.8716

Race Not Reported: 0.8525

Race Unknown: 0.8525

Race Skip: 0.8977

Male General Performance Rate: 0.8568

Male Performance Rate by Race:

White: 0.8576

Black: 0.8402

Asian: 0.8456

Native American/Indian: 0.7647

Hawaiian Islander: 0.8

Race Other: 0.8729

Race Not Reported: 0.8675

Race Unknown: 0.7789

Race Skip: 0.8962

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b.4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations. Not necessary if performance data provided in 1b.4

2. Reliability and Validity—Scientific Acceptability of Measure Properties

Extent to which the measure, as specified, produces consistent (reliable) and credible (valid) results about the quality of care when implemented. **Measures must be judged to meet the sub criteria for both reliability and validity to pass this criterion and be evaluated against the remaining criteria.**

2a.1. Specifications The measure is well defined and precisely specified so it can be implemented consistently within and across organizations and allows for comparability. eMeasures should be specified in the Health Quality Measures Format (HQMF) and the Quality Data Model (QDM).

De.5. Subject/Topic Area (check all the areas that apply):

Cancer, Cancer : Breast, Cancer : Colorectal

De.6. Non-Condition Specific(check all the areas that apply):

De.7. Target Population Category (Check all the populations for which the measure is specified and tested if any):

Elderly

S.1. Measure-specific Web Page (Provide a URL link to a web page specific for this measure that contains current detailed specifications including code lists, risk model details, and supplemental materials. Do not enter a URL linking to a home page or to general information.)

The updated specifications for this measure are attached with this form.

S.2a. If this is an eMeasure, HQMF specifications must be attached. Attach the zipped output from the eMeasure authoring tool (MAT) - if the MAT was not used, contact staff. (Use the specification fields in this online form for the plain-language description of the specifications)

This is not an eMeasure Attachment:

S.2b. Data Dictionary, Code Table, or Value Sets (and risk model codes and coefficients when applicable) must be attached. (Excel or csv file in the suggested format preferred - if not, contact staff)

No data dictionary Attachment:

S.2c. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

No, this is not an instrument-based measure Attachment:

S.2d. Is this an instrument-based measure (i.e., data collected via instruments, surveys, tools, questionnaires, scales, etc.)? Attach copy of instrument if available.

Not an instrument-based measure

S.3.1. For maintenance of endorsement: Are there changes to the specifications since the last updates/submission. If yes, update the specifications for S1-2 and S4-22 and explain reasons for the changes in S3.2.

Yes

S.3.2. For maintenance of endorsement, please briefly describe any important changes to the measure specifications since last measure update and explain the reasons.

This measure has been updated to align with a version of the measure in use in ASCO's Quality Oncology Practice Initiative (QOPI) registry. The numerator has been expanded to include cancer staging documented using any standardized system, and the timing

component of cancer stage documentation within one month of first office visit has also been added. Denominator exclusions have been added to exclude patients with certain non-solid tumor cancer types.

S.4. Numerator Statement (Brief, narrative description of the measure focus or what is being measured about the target population, i.e., cases from the target population with the target process, condition, event, or outcome) DO NOT include the rationale for the measure.

IF an OUTCOME MEASURE, state the outcome being measured. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Patients who have cancer staging documented using any standardized system or documentation that the cancer is metastatic in the medical record within one month of the first office visit

S.5. Numerator Details (All information required to identify and calculate the cases from the target population with the target process, condition, event, or outcome such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b)

IF an OUTCOME MEASURE, describe how the observed outcome is identified/counted. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

Numerator Instructions:

- For certain malignancies, staging or classification systems included in the AJCC Staging Manual would also satisfy the requirements of this measure (e.g., Ann Arbor).
- Cancer stage refers to stage at diagnosis. Documentation that the cancer is metastatic at diagnosis would also satisfy the requirements of the measure.

S.6. Denominator Statement (Brief, narrative description of the target population being measured)

All patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting.

S.7. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)

IF an OUTCOME MEASURE, describe how the target population is identified. Calculation of the risk-adjusted outcome should be described in the calculation algorithm (S.14).

All patients, regardless of age, with a diagnosis of cancer who are seen in the ambulatory setting

Eligible patients for this measure are identified by:

ICD-10-CM diagnosis codes:

C00.0, C00.1, C00.2, C00.3, C00.4, C00.5, C00.6, C00.8, C00.9, C01, C02.0, C02.1, C02.2, C02.3, C02.4, C02.8, C02.9, C03.0, C03.1, C03.9, C04.0, C04.1, C04.8, C04.9, C05.0, C05.1, C05.2, C05.8, C05.9, C06.0, C06.1, C06.2, C06.80, C06.89, C06.9, C07, C08.0, C08.1, C08.9, C09.0, C09.1, C09.8, C09.9, C10.0, C10.1, C10.2, C10.3, C10.4, C10.8, C10.9, C11.0, C11.1, C11.2, C11.3, C11.8, C11.9, C12, C13.0, C13.1, C13.2, C13.8, C13.9, C15.3, C15.4, C15.5, C15.8, C15.9, C16.0, C16.1, C16.2, C16.3, C16.4, C16.5, C16.6, C16.8, C16.9, C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, C18.0, C18.1, C18.2, C18.3, C18.4, C18.5, C18.6, C18.7, C18.8, C18.9, C19, C20, C21.0, C21.1, C21.2, C21.8, C22.0, C22.1, C22.2, C22.3, C22.4, C22.7, C22.8, C22.9, C23, C24.0, C24.1, C25.0, C25.1, C25.2, C25.3, C25.4, C25.7, C25.8, C25.9, C30.0, C31.0, C31.1, C32.0, C32.1, C32.2, C32.3, C32.8, C32.9, C34.00, C34.01, C34.02, C34.10, C34.11, C34.12, C34.2, C34.30, C34.31, C34.32, C34.80, C34.81, C34.82, C34.90, C34.91, C34.92, C37, C38.0, C38.1, C38.2, C38.3, C38.4, C38.8, C40.00, C40.01, C40.02, C40.10, C40.11, C40.12, C40.20, C40.21, C40.22, C40.30, C40.31, C40.32, C40.80, C40.81, C40.82, C40.90, C40.91, C40.92, C41.0, C41.1, C41.2, C41.3, C41.4, C41.9, C43.0, C43.10, C43.11, C43.12, C43.20, C43.21, C43.22, C43.30, C43.31, C43.39, C43.4, C43.51, C43.52, C43.59, C43.60, C43.61, C43.62, C43.70, C43.71, C43.72, C43.8, C43.9, C44.00, C44.01, C44.02, C44.09, C44.101, C44.102, C44.109, C44.111, C44.112, C44.119, C44.121, C44.122, C44.129, C44.191, C44.192, C44.199, C44.201, C44.202, C44.209, C44.211, C44.212, C44.219, C44.221, C44.222, C44.229, C44.291, C44.292, C44.299, C44.300, C44.301, C44.309, C44.310, C44.311, C44.319, C44.320, C44.321, C44.329, C44.390, C44.391, C44.399, C44.40, C44.41, C44.42, C44.49, C44.500, C44.501, C44.509, C44.510, C44.511, C44.519, C44.520, C44.521, C44.529, C44.590, C44.591, C44.599, C44.601, C44.602, C44.609, C44.611, C44.612, C44.619, C44.621, C44.622, C44.629, C44.691, C44.692, C44.699, C44.701, C44.702, C44.709, C44.711, C44.712, C44.719, C44.721, C44.722, C44.729, C44.791, C44.792, C44.799, C44.80, C44.81, C44.82, C44.89, C44.90, C44.91, C44.92, C44.99, C45.0, C45.1, C45.2, C47.0, C47.10, C47.11, C47.12, C47.20, C47.21, C47.22, C47.3, C47.4, C47.5, C47.6, C47.8, C47.9, C48.0, C48.1, C48.2, C48.8, C49.0, C49.10, C49.11, C49.12, C49.20, C49.21, C49.22, C49.3, C49.4, C49.5, C49.6, C49.8, C49.9, C4A.0, C4A.10, C4A.11,

C4A.12, C4A.20, C4A.21, C4A.22, C4A.30, C4A.31, C4A.39, C4A.4, C4A.51, C4A.52, C4A.59, C4A.60, C4A.61, C4A.62, C4A.70, C4A.71, C4A.72, C4A.8, C4A.9, C50.011, C50.012, C50.019, C50.021, C50.022, C50.029, C50.111, C50.112, C50.119, C50.121, C50.122, C50.129, C50.211, C50.212, C50.219, C50.221, C50.222, C50.229, C50.311, C50.312, C50.319, C50.321, C50.322, C50.329, C50.411, C50.412, C50.419, C50.421, C50.422, C50.429, C50.511, C50.512, C50.519, C50.521, C50.522, C50.529, C50.611, C50.612, C50.619, C50.621, C50.622, C50.629, C50.811, C50.812, C50.819, C50.821, C50.822, C50.829, C50.911, C50.912, C50.919, C50.921, C50.922, C50.929, C51.0, C51.1, C51.2, C52, C53.0, C53.1, C53.8, C53.9, C54.0, C54.1, C54.2, C54.3, C54.8, C54.9, C55, C56.1, C56.2, C56.9, C57.00, C57.01, C57.02, C58, C60.0, C60.1, C60.2, C61, C62.00, C62.01, C62.02, C63.00, C63.01, C63.02, C63.10, C63.11, C63.12, C63.2, C64.1, C64.2, C64.9, C65.1, C65.2, C65.9, C66.1, C66.2, C66.9, C67.0, C67.1, C67.2, C67.3, C67.4, C67.5, C67.6, C67.7, C67.8, C67.9, C68.0, C69.00, C69.01, C69.02, C69.50, C69.51, C69.52, C69.60, C69.61, C69.62, C73, C7A.00, C7A.010, C7A.011, C7A.012, C7A.019, C7A.020, C7A.021, C7A.022, C7A.023, C7A.024, C7A.025, C7A.026, C7A.029, C7A.090, C7A.091, C7A.092, C7A.093, C7A.094, C7A.095, C7A.096, C7A.098, C7A.1, C7A.8, C81.00, C81.01, C81.02, C81.03, C81.04, C81.05, C81.06, C81.07, C81.08, C81.09, C81.10, C81.11, C81.12, C81.13, C81.14, C81.15, C81.16, C81.17, C81.18, C81.19, C81.20, C81.21, C81.22, C81.23, C81.24, C81.25, C81.26, C81.27, C81.28, C81.29, C81.30, C81.31, C81.32, C81.33, C81.34, C81.35, C81.36, C81.37, C81.38, C81.39, C81.40, C81.41, C81.42, C81.43, C81.44, C81.45, C81.46, C81.47, C81.48, C81.49, C81.70, C81.71, C81.72, C81.73, C81.74, C81.75, C81.76, C81.77, C81.78, C81.79, C81.90, C81.91, C81.92, C81.93, C81.94, C81.95, C81.96, C81.97, C81.98, C81.99, C82.00, C82.01, C82.02, C82.03, C82.04, C82.05, C82.06, C82.07, C82.08, C82.09, C82.10, C82.11, C82.12, C82.13, C82.14, C82.15, C82.16, C82.17, C82.18, C82.19, C82.20, C82.21, C82.22, C82.23, C82.24, C82.25, C82.26, C82.27, C82.28, C82.29, C82.30, C82.31, C82.32, C82.33, C82.34, C82.35, C82.36, C82.37, C82.38, C82.39, C82.40, C82.41, C82.42, C82.43, C82.44, C82.45, C82.46, C82.47, C82.48, C82.49, C82.50, C82.51, C82.52, C82.53, C82.54, C82.55, C82.56, C82.57, C82.58, C82.59, C82.60, C82.61, C82.62, C82.63, C82.64, C82.65, C82.66, C82.67, C82.68, C82.69, C82.80, C82.81, C82.82, C82.83, C82.84, C82.85, C82.86, C82.87, C82.88, C82.89, C82.90, C82.91, C82.92, C82.93, C82.94, C82.95, C82.96, C82.97, C82.98, C82.99, C83.10, C83.11, C83.12, C83.13, C83.14, C83.15, C83.16, C83.17, C83.18, C83.19, C83.31, C83.32, C83.33, C83.34, C83.35, C83.36, C83.37, C83.38, C83.39, C83.70, C83.71, C83.72, C83.73, C83.74, C83.75, C83.76, C83.77, C83.78, C83.79, C83.80, C83.81, C83.82, C83.83, C83.84, C83.85, C83.86, C83.87, C83.88, C83.89, C84.00, C84.01, C84.02, C84.03, C84.04, C84.05, C84.06, C84.07, C84.08, C84.09, C84.10, C84.11, C84.12, C84.13, C84.14, C84.15, C84.16, C84.17, C84.18, C84.19, C84.40, C84.41, C84.42, C84.43, C84.44, C84.45, C84.46, C84.47, C84.48, C84.49, C84.60, C84.61, C84.62, C84.63, C84.64, C84.65, C84.66, C84.67, C84.68, C84.69, C84.70, C84.71, C84.72, C84.73, C84.74, C84.75, C84.76, C84.77, C84.78, C84.79, C84.90, C84.91, C84.92, C84.93, C84.94, C84.95, C84.96, C84.97, C84.98, C84.99, C84.A0, C84.A1, C84.A2, C84.A3, C84.A4, C84.A5, C84.A6, C84.A7, C84.A8, C84.A9, C84.Z0, C84.Z1, C84.Z2, C84.Z3, C84.Z4, C84.Z5, C84.Z6, C84.Z7, C84.Z8, C84.Z9, C85.10, C85.11, C85.12, C85.13, C85.14, C85.15, C85.16, C85.17, C85.18, C85.19, C85.20, C85.21, C85.22, C85.23, C85.24, C85.25, C85.26, C85.27, C85.28, C85.29, C85.80, C85.81, C85.82, C85.83, C85.84, C85.85, C85.86, C85.87, C85.88, C85.89, C85.90, C85.91, C85.92, C85.93, C85.94, C85.95, C85.96, C85.97, C85.98, C85.99, C86.0, C86.1, C86.2, C86.3, C86.4, C86.5, C86.6, C88.0, C88.2, C88.3, C88.4, C88.8, C88.9, D03.0, D03.10, D03.11, D03.12, D03.20, D03.21, D03.22, D03.30, D03.39, D03.4, D03.51, D03.52, D03.59, D03.60, D03.61, D03.62, D03.70, D03.71, D03.72, D03.8, D03.9, D37.01, D37.02, D37.030, D37.031, D37.032, D37.039, D37.04, D37.05, D37.09, D37.1, D37.2, D37.3, D37.4, D37.5, D37.6, D37.8, D37.9, D38.0, D38.1, D38.2, D38.3, D38.4, D38.5, D38.6, D39.0, D39.10, D39.11, D39.12, D39.2, D39.8, D39.9, D40.0, D40.10, D40.11, D40.12, D40.8, D40.9, D41.00, D41.01, D41.02, D41.10, D41.11, D41.12, D41.20, D41.21, D41.22, D41.3, D41.4, D41.8, D41.9, D42.0, D42.1, D42.9, D43.0, D43.1, D43.2, D43.3, D43.4, D43.8, D43.9, D44.0, D44.10, D44.11, D44.12, D44.2, D44.3, D44.4, D44.5, D44.6, D44.7, D44.9, D48.0, D48.1, D48.2, D48.3, D48.4, D48.5, D48.60, D48.61, D48.62, D48.7, D48.9, D49.0, D49.1, D49.2, D49.3, D49.4, D49.5, D49.511, D49.512, D49.519, D49.59, D49.6, D49.7, D49.81, D49.89, D49.9, Q85.00, Q85.01, Q85.02, Q85.03, Q85.09

AND

CPT® Codes: 77261, 77262, 77263, 99201, 99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215

S.8. Denominator Exclusions *(Brief narrative description of exclusions from the target population)*

Patients with a documented case of leukemia, myeloma, or myelodysplastic syndromes (MDS).

S.9. Denominator Exclusion Details *(All information required to identify and calculate exclusions from the denominator such as definitions, time period for data collection, specific data collection items/responses, code/value sets – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format at S.2b.)*

C90.00, C90.10, C90.1, C90.11, C90.20, C90.2, C90.21, C90.30, C90.3, C90.31, C91.00, C91.0, C91, C91.01, C91.10, C91.1, C91.11, C91.30, C91.3, C91.31, C91.40, C91.4, C91.41, C91.50, C91.5, C91.51, C91.60, C91.6, C91.61, C91.90, C91.9, C91.91, C91.A0, C91.A, C91.A1, C91.Z0, C91.Z, C91.Z1, C92.00, C92, C92.0, C92.01, C92.02, C92.10, C92.1, C92.11, C92.20, C92.2, C92.21, C92.30, C92.3, C92.31, C92.40, C92.4, C92.41, C92.50, C92.5, C92.51, C92.60, C92.6, C92.61, C92.90, C92.9, C92.91, C92.A0, C92.A, C92.A1, C92.Z0, C92.Z, C92.Z1, C93.00, C93.0, C93, C93.01, C93.10, C93.1, C93.11, C93.30, C93.3, C93.31, C93.90, C93.9, C93.91, C93.Z0, C93.Z, C93.Z1, C94.00, C94, C94.0, C94.01, C94.20, C94.2, C94.21, C94.30, C94.3, C94.31, C94.40, C94.4, C94.41, C94.6, C94.60, C94.80, C94.8, C94.81, C95.00, C95.0, C95, C95.01, C95.10, C95.1, C95.11, C95.90, C95.9, C95.91, D46.0, D46.00, D46, D46.1, D46.10,

<p>D46.20, D46.2, D46.21, D46.22, D46.4, D46.9, D46.40, D46.90, D46.A, D46.B, D46.C, D46.Z</p>
<p>S.10. Stratification Information <i>(Provide all information required to stratify the measure results, if necessary, including the stratification variables, definitions, specific data collection items/responses, code/value sets, and the risk-model covariates and coefficients for the clinically-adjusted version of the measure when appropriate – Note: lists of individual codes with descriptors that exceed 1 page should be provided in an Excel or csv file in required format with at S.2b.)</i> We encourage the results of this measure to be stratified by race, ethnicity, primary language, and administrative sex.</p> <p>S.11. Risk Adjustment Type (Select type. Provide specifications for risk stratification in measure testing attachment) No risk adjustment or risk stratification If other:</p>
<p>S.12. Type of score: Rate/proportion If other:</p> <p>S.13. Interpretation of Score <i>(Classifies interpretation of score according to whether better quality is associated with a higher score, a lower score, a score falling within a defined interval, or a passing score)</i> Better quality = Higher score</p> <p>S.14. Calculation Algorithm/Measure Logic <i>(Diagram or describe the calculation of the measure score as an ordered sequence of steps including identifying the target population; exclusions; cases meeting the target process, condition, event, or outcome; time period for data, aggregating data; risk adjustment; etc.)</i> To calculate performance rates: 1) Find the patients who meet the initial patient population (i.e., the general group of patients that the performance measure is designed to address). 2) From the patients within the initial patient population criteria, find the patients who qualify for the denominator (i.e., the specific group of patients for inclusion in a specific performance measure based on defined criteria). Note: in some cases the initial patient population and denominator are identical. 3) From the patients within the denominator, find the patients who qualify for the numerator (i.e., the group of patients in the denominator for whom a process or outcome of care occurs). Validate that the number of patients in the numerator is less than or equal to the number of patients in the denominator. 4) From the patients who did not meet the numerator criteria, determine if the physician has documented that the patient meets any criteria for denominator exclusion when exceptions have been specified. If the patient meets any exclusion criteria, they should be removed from the denominator for performance calculation. –Although exclusion cases are removed from the denominator population for the performance calculation, the number of patients with valid exclusion should be calculated and reported along with performance rates to track variations in care and highlight possible areas of focus for QI. If the patient does not meet the numerator and a valid exclusion is not present, this case represents a quality failure.</p>
<p>S.15. Sampling <i>(If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)</i> If an instrument-based performance measure (e.g., PRO-PM), identify whether (and how) proxy responses are allowed. Not applicable. The measure does not require sampling or a survey.</p> <p>S.16. Survey/Patient-reported data <i>(If measure is based on a survey or instrument, provide instructions for data collection and guidance on minimum response rate.)</i> Specify calculation of response rates to be reported with performance measure results.</p>
<p>S.17. Data Source <i>(Check ONLY the sources for which the measure is SPECIFIED AND TESTED).</i> If other, please describe in S.18. Registry Data</p> <p>S.18. Data Source or Collection Instrument <i>(Identify the specific data source/data collection instrument (e.g. name of database, clinical registry, collection instrument, etc., and describe how data are collected.)</i> If instrument-based, identify the specific instrument(s) and standard methods, modes, and languages of administration.</p>

Not Applicable

S.19. Data Source or Collection Instrument (available at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No data collection instrument provided

S.20. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

Clinician : Group/Practice, Clinician : Individual

S.21. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

Other, Outpatient Services

If other: Oncology/Outpatient Clinic; Radiation Oncology Department/Clinic

S.22. COMPOSITE Performance Measure - Additional Specifications (Use this section as needed for aggregation and weighting rules, or calculation of individual performance measures if not individually endorsed.)

Not Applicable

2. Validity – See attached Measure Testing Submission Form

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2.1 For maintenance of endorsement

Reliability testing: If testing of reliability of the measure score was not presented in prior submission(s), has reliability testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

Yes

2.2 For maintenance of endorsement

Has additional empirical validity testing of the measure score been conducted? If yes, please provide results in the Testing attachment. Please use the most current version of the testing attachment (v7.1). Include information on all testing conducted (prior testing as well as any new testing); use red font to indicate updated testing.

No

2.3 For maintenance of endorsement

Risk adjustment: For outcome, resource use, cost, and some process measures, risk-adjustment that includes social risk factors is not prohibited at present. Please update sections 1.8, 2a2, 2b1,2b4.3 and 2b5 in the Testing attachment and S.140 and S.11 in the online submission form. NOTE: These sections must be updated even if social risk factors are not included in the risk-adjustment strategy. You MUST use the most current version of the Testing Attachment (v7.1) -- older versions of the form will not have all required questions.

No - This measure is not risk-adjusted

3. Feasibility

Extent to which the specifications including measure logic, require data that are readily available or could be captured without undue burden and can be implemented for performance measurement.

3a. Byproduct of Care Processes

For clinical measures, the required data elements are routinely generated and used during care delivery (e.g., blood pressure, lab test, diagnosis, medication order).

3a.1. Data Elements Generated as Byproduct of Care Processes.

generated by and used by healthcare personnel during the provision of care, e.g., blood pressure, lab value, medical condition

If other:

3b. Electronic Sources

The required data elements are available in electronic health records or other electronic sources. If the required data are not in

electronic health records or existing electronic sources, a credible, near-term path to electronic collection is specified.

3b.1. To what extent are the specified data elements available electronically in defined fields (*i.e., data elements that are needed to compute the performance measure score are in defined, computer-readable fields*) Update this field for **maintenance of endorsement**.

ALL data elements are in defined fields in electronic health records (EHRs)

3b.2. If ALL the data elements needed to compute the performance measure score are not from electronic sources, specify a credible, near-term path to electronic capture, OR provide a rationale for using other than electronic sources. For **maintenance of endorsement**, if this measure is not an eMeasure (eCQM), please describe any efforts to develop an eMeasure (eCQM).

All the data elements needed for this measure are collected through electronic data or through the use of keyword searches. ASCO is in the process of assessing the feasibility of developing an electronic clinical quality measure. We will be assessing this during the next year (2019).

3b.3. If this is an eMeasure, provide a summary of the feasibility assessment in an attached file or make available at a measure-specific URL. Please also complete and attach the NQF Feasibility Score Card.

Attachment:

3c. Data Collection Strategy

Demonstration that the data collection strategy (e.g., source, timing, frequency, sampling, patient confidentiality, costs associated with fees/licensing of proprietary measures) can be implemented (e.g., already in operational use, or testing demonstrates that it is ready to put into operational use). For eMeasures, a feasibility assessment addresses the data elements and measure logic and demonstrates the eMeasure can be implemented or feasibility concerns can be adequately addressed.

3c.1. Required for maintenance of endorsement. Describe difficulties (as a result of testing and/or operational use of the measure) regarding data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, other feasibility/implementation issues.

IF instrument-based, consider implications for both individuals providing data (patients, service recipients, respondents) and those whose performance is being measured.

We have not identified any areas of concern or made any modifications as a result of testing, and operational use of the measures in relation to data collection, availability of data, missing data, timing and frequency of data collection, sampling, patient confidentiality, time and cost of data collection, and other feasibility issues unless otherwise noted.

3c.2. Describe any fees, licensing, or other requirements to use any aspect of the measure as specified (*e.g., value/code set, risk model, programming code, algorithm*).

ASCO requests interested parties seek a licensing agreement prior to use of this measure.

4. Usability and Use

Extent to which potential audiences (e.g., consumers, purchasers, providers, policy makers) are using or could use performance results for both accountability and performance improvement to achieve the goal of high-quality, efficient healthcare for individuals or populations.

4a. Accountability and Transparency

Performance results are used in at least one accountability application within three years after initial endorsement and are publicly reported within six years after initial endorsement (or the data on performance results are available). If not in use at the time of initial endorsement, then a credible plan for implementation within the specified timeframes is provided.

4.1. Current and Planned Use

NQF-endorsed measures are expected to be used in at least one accountability application within 3 years and publicly reported within 6 years of initial endorsement in addition to performance improvement.

Specific Plan for Use	Current Use (for current use provide URL)
Public Reporting	Professional Certification or Recognition Program QOPI Certification Program

<https://practice.asco.org/quality-improvement/quality-programs/qopi-certification-program>

Quality Improvement (Internal to the specific organization)

Quality Oncology Practice Initiative

<https://practice.asco.org/quality-improvement/quality-programs/quality-oncology-practice-initiative>

4a1.1 For each CURRENT use, checked above (update for maintenance of endorsement), provide:

- Name of program and sponsor
- Purpose
- Geographic area and number and percentage of accountable entities and patients included
- Level of measurement and setting

The American Society of Clinical Oncology's Quality Oncology Practice Initiative (QOPI®) is an oncologist-led, practice-based quality assessment program designed to promote excellence in cancer care by helping practices create a culture of self-examination and improvement. QOPI provides a standard methodology, robust library of quality metrics for oncology, and a collection tool to reliably and routinely assess care, inform quality improvement activities, and demonstrate quality to patients and external stakeholders.

In the United States QOPI currently has over 650 practices, with over 110 academic practices and over 535 nonacademic practices. QOPI has over 1.3 million new patients annual recorded in the registry. The uses of QOPI include over 28,000 physicians including medical oncologists and radiation oncologists, over 7,100 nurse practitioners, over 5,3000 physician assistants and over 850 fellows represented.

QOPI is used in no only the United States, but also in the following:

o Countries in the European Union

o Australia

o Argentina

o Brazil

o India

o Philippines

o Saudi Arabia

o United Arab Emirates

4a1.2. If not currently publicly reported OR used in at least one other accountability application (e.g., payment program, certification, licensing) what are the reasons? (e.g., Do policies or actions of the developer/steward or accountable entities restrict access to performance results or impede implementation?)

Not Applicable

4a1.3. If not currently publicly reported OR used in at least one other accountability application, provide a credible plan for implementation within the expected timeframes -- any accountability application within 3 years and publicly reported within 6 years of initial endorsement. (Credible plan includes the specific program, purpose, intended audience, and timeline for implementing the measure within the specified timeframes. A plan for accountability applications addresses mechanisms for data aggregation and reporting.)

Not Applicable

4a2.1.1. Describe how performance results, data, and assistance with interpretation have been provided to those being measured or other users during development or implementation.

How many and which types of measured entities and/or others were included? If only a sample of measured entities were included, describe the full population and how the sample was selected.

The results are provided twice within each QOPI round; interim and final reports. Data was provided on each measure abstracted for that QOPI® round. QOPI operates a help desk to assist registry users with any specification or technical questions.

4a2.1.2. Describe the process(es) involved, including when/how often results were provided, what data were provided, what educational/explanatory efforts were made, etc.

The results are provided twice within each QOPI round; interim and final reports. Data was provided on each measure abstracted for

that QOPI® round. Educational efforts include a written guide to interpreting measures and reports, as well as, individual consultation to review report results

4a2.2.1. Summarize the feedback on measure performance and implementation from the measured entities and others described in 4d.1.

Describe how feedback was obtained.

QOPI staff send survey data to all participating practices at the end of each round twice a year. Feedback is also obtained by emailing the QOPI Help Desk.

4a2.2.2. Summarize the feedback obtained from those being measured.

QOPI® allows for participant feedback on a continuous basis via QOPI Help Desk email, which is monitored and triaged for measure-related content. QOPI® also provides opportunity for feedback through a Q&A session for Abstractor Webinars conducted prior to each abstraction round. At the conclusion of each abstraction period, each practice receives a measure summary report delineating the performance score for each measure based on their abstraction of qualified charts. Participants contact QOPI with feedback relative to the reported measures.

Upon review from the QOPI® Clinical Data Manager all measure-specific feedback is forwarded to the ASCO Measures Team and measure analysis commences. The appropriate steering groups are informed of the feedback, measure analysis and recommendations (as warranted).

4a2.2.3. Summarize the feedback obtained from other users

No additional feedback has been received by QOPI staff or ASCO on this measure. However, we will continue to solicit feedback from QOPI users, and from the general public as we perform maintenance on this measure.

4a2.3. Describe how the feedback described in 4a2.2.1 has been considered when developing or revising the measure specifications or implementation, including whether the measure was modified and why or why not.

This measure was revised to ensure that it focuses on cancer staging documented using any standardized system within one month of the first office visit. These changes were initiated based on feedback from measure users.

Improvement

Progress toward achieving the goal of high-quality, efficient healthcare for individuals or populations is demonstrated. If not in use for performance improvement at the time of initial endorsement, then a credible rationale describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

4b1. Refer to data provided in 1b but do not repeat here. Discuss any progress on improvement (trends in performance results, number and percentage of people receiving high-quality healthcare; Geographic area and number and percentage of accountable entities and patients included.)

If no improvement was demonstrated, what are the reasons? If not in use for performance improvement at the time of initial endorsement, provide a credible rationale that describes how the performance results could be used to further the goal of high-quality, efficient healthcare for individuals or populations.

While this measure has shown improvement by physicians participating in QOPI, cancer staging continues to be a performed at varying rates. Additionally, the measure is not topped out, and still shows room for improvement.

4b2. Unintended Consequences

The benefits of the performance measure in facilitating progress toward achieving high-quality, efficient healthcare for individuals or populations outweigh evidence of unintended negative consequences to individuals or populations (if such evidence exists).

4b2.1. Please explain any unexpected findings (positive or negative) during implementation of this measure including unintended impacts on patients.

We are not aware of any unintended consequences related to this measure.

4b2.2. Please explain any unexpected benefits from implementation of this measure.

We have not observed any unexpected benefits associated with implementation of this measure.

5. Comparison to Related or Competing Measures

If a measure meets the above criteria and there are endorsed or new related measures (either the same measure focus or the same target population) or competing measures (both the same measure focus and the same target population), the measures are compared to address harmonization and/or selection of the best measure.

5. Relation to Other NQF-endorsed Measures

Are there related measures (conceptually, either same measure focus or target population) or competing measures (conceptually both the same measure focus and same target population)? If yes, list the NQF # and title of all related and/or competing measures.

Yes

5.1a. List of related or competing measures (selected from NQF-endorsed measures)

5.1b. If related or competing measures are not NQF endorsed please indicate measure title and steward.

Documentation of stage for patients with newly diagnosed cervical cancer (Society of Gynecologic Oncology)

Complete staging for women with invasive stage I-IIIb ovarian, fallopian tube, or peritoneal cancer who have undergone cytoreduction (Society of Gynecologic Oncology)

5a. Harmonization of Related Measures

The measure specifications are harmonized with related measures;

OR

The differences in specifications are justified

5a.1. If this measure conceptually addresses EITHER the same measure focus OR the same target population as NQF-endorsed measure(s):

Are the measure specifications harmonized to the extent possible?

No

5a.2. If the measure specifications are not completely harmonized, identify the differences, rationale, and impact on interpretability and data collection burden.

We believe the measures as distinct enough as to not require harmonization of specifications.

5b. Competing Measures

The measure is superior to competing measures (e.g., is a more valid or efficient way to measure);

OR

Multiple measures are justified.

5b.1. If this measure conceptually addresses both the same measure focus and the same target population as NQF-endorsed measure(s):

Describe why this measure is superior to competing measures (e.g., a more valid or efficient way to measure quality); OR provide a rationale for the additive value of endorsing an additional measure. (Provide analyses when possible.)

No competing measures.

Appendix

A.1 Supplemental materials may be provided in an appendix. All supplemental materials (such as data collection instrument or methodology reports) should be organized in one file with a table of contents or bookmarks. If material pertains to a specific submission form number, that should be indicated. Requested information should be provided in the submission form and required attachments. There is no guarantee that supplemental materials will be reviewed.

Attachment Attachment: 386_Flow.docx

Contact Information

Co.1 Measure Steward (Intellectual Property Owner): American Society of Clinical Oncology

Co.2 Point of Contact: Caitlin, Drumheller, caitlin.drumheller@asco.org, 571-483-1488-

Co.3 Measure Developer if different from Measure Steward: [American Society of Clinical Oncology](#)

Co.4 Point of Contact: [Caitlin, Drumheller, caitlin.drumheller@asco.org, 571-483-1488-](#)

Additional Information

Ad.1 Workgroup/Expert Panel involved in measure development

Provide a list of sponsoring organizations and workgroup/panel members' names and organizations. Describe the members' role in measure development.

[Patricia Ganz, MD \(Co-Chair\)](#)
[James Hayman, MD \(Co-Chair\)](#)
[Joseph Bailes, MD](#)
[Nancy Baxter, MD, PhD](#)
[Joel V. Brill, MD](#)
[Steven B. Clauser, PhD](#)
[Charles Cleeland, PhD](#)
[J. Thomas Cross, Jr. MD, MPH](#)
[Chaitanya R. Divgi, MD](#)
[Stephen B. Edge, MD](#)
[Patrick L. Fitzgibbons, MD](#)
[Myron Goldsmith, MD](#)
[Joel W. Goldwein, MD](#)
[Alecia Hathaway, MD, MPH](#)
[Kevin P. Hubbard, DO](#)
[Nora Janjan, MD, MPSA](#)
[Maria Kelly, MB, BCh](#)
[Wayne Koch, MD](#)
[Andre Konski, MD](#)
[Len Lichtenfeld, MD](#)
[Norman J. Marcus, MD](#)
[Catherine Miyamoto, RN, BSN](#)
[Michael Neuss, MD](#)
[David F. Penson, MD, MPH](#)
[Louis Potters, MD](#)
[John M. Rainey, MD](#)
[Christopher M. Rose, MD](#)
[Lee Smith, MD](#)
[Lawrence A. Solberg, MD, PhD](#)
[Paul E. Wallner, MD](#)
[J. Frank Wilson, MD](#)
[Rodger Winn, MD](#)

This measure was developed through cross-specialty, multi-disciplinary work groups. All medical specialties and other health care professional disciplines participating in patient care for the clinical condition or topic under study are invited to participate as equal contributors to the measure development process.

The workgroup that developed this measure had two co-chairs who have relevant clinical and/or measure development expertise and who are responsible for ensuring that consensus is achieved and that all perspectives are voiced.

Measure Developer/Steward Updates and Ongoing Maintenance

Ad.2 Year the measure was first released: [2007](#)

Ad.3 Month and Year of most recent revision: [12, 2011](#)

Ad.4 What is your frequency for review/update of this measure? [Coding/Specifications updates occur annually. See additional information below.](#)

Ad.5 When is the next scheduled review/update for this measure? [04, 2018](#)

Ad.6 Copyright statement: © 2018 American Medical Association and American Society of Clinical Oncology. All Rights Reserved. Applicable FARS/DFARS Restrictions Apply to Government Use.

Limited proprietary coding is contained in the Measure specifications for convenience. Users of the proprietary code sets should obtain all necessary licenses from the owners of these code sets. The AMA, ASCO, the PCPI and its members disclaim all liability for use or accuracy of any Current Procedural Terminology (CPT®) or other coding contained in the specifications.

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Ad.7 Disclaimers: These Measures are intended to assist physicians in enhancing quality of care. Measures are designed for use by any physician who manages the care of a patient for a specific condition or for prevention. These performance Measures are not clinical guidelines and do not establish a standard of medical care.

Measures are subject to review and may be revised or rescinded at any time. The Measures may not be altered without the prior written approval of PCPI and ASCO.

Ad.8 Additional Information/Comments: ASCO has a formal measurement review process that stipulates regular (usually on a three-year cycle, when feasible) review of the measures. The process can also be activated if there is a major change in scientific evidence, results from testing or other issues are noted that materially affect the integrity of the measure.