



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 subcriterion 1b).

Brief Measure Information

NQF #: 1857

Corresponding Measures:

De.2. Measure Title: HER2 negative or undocumented breast cancer patients spared treatment with HER2-targeted therapies

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

De.3. Brief Description of Measure: Proportion of female patients (aged 18 years and older) with breast cancer who are human epidermal growth factor receptor 2 (HER2)/neu negative who are not administered HER2-targeted therapies

1b.1. Developer Rationale: Human epidermal growth factor receptor (HER2) gene is amplified and/or overexpressed in approximately 15% to 20% of primary breast cancers (Giordano, 2014). The ASCO/CAP joint guideline on HER2 testing recommends all patients with invasive breast cancer should be tested for HER2 status and only those who test positive for HER2 status should receive HER2 targeted therapies. Additionally data have shown that the administration of HER2 targeted therapies such as Pertuzumab offer no clinical benefit in patients with HER2 negative metastatic disease (Wolff, 2013).

The contraindicated administration of HER2 targeted therapy to patients with HER2 negative breast cancer can propagate potentially toxic, costly and adverse effects as well as decrease the patient's overall quality of life (Partridge, 2014).

Citations:

Giordano, S.H., Temin, S., et. al., "Systemic Therapy for Patients with Advanced Human Epidermal Growth Factor Receptor 2-Positive Breast Cancer: American Society of Clinical Oncology Clinical Practice Guideline." J Clin Onc 32.19 (2014): 2078-099. Available at:<http://jco.ascopubs.org/content/32/19/2078.full.pdf+html>

Partridge, A.H., Smith, I.E., et. al., "Chemo- and Targeted Therapy for Women with Human Epidermal Growth Factor Receptor 2-Negative (or Unknown) Advanced Breast Cancer: American Society of Clinical Oncology Clinical Practice Guideline." J Onc Pr 11.1 (2014): 3307-3329. Available at: <http://jco.ascopubs.org/content/32/29/3307.full>

Wolff, A.C, Hammond, M.E.H, et.al., "Recommendations for Human Epidermal Growth Factor Receptor 2 Testing in Breast Cancer: American Society of Clinical Oncology/College of American Pathologists Clinical Practice Guideline Update." J Clin Onc 31.31 (2013): 3997-4013. Available at: <http://jco.ascopubs.org/content/31/31/3997.full>

S.4. Numerator Statement: HER2-targeted therapies not administered during the initial course of treatment.

S.7. Denominator Statement: Adult women with breast cancer that are HER2 negative or HER2 undocumented.

S.10. Denominator Exclusions: Patient transfer to practice during or after initial course.

De.1. Measure Type: Process

S.23. Data Source: Registry Data

S.26. Level of Analysis: Clinician : Group/Practice

IF Endorsement Maintenance – Original Endorsement Date: Oct 22, 2012 **Most Recent Endorsement Date:** Oct 26, 2016

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 subcriteria to pass this criterion and be evaluated against the remaining criteria.**

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

[BREAST_1857_MeasSubm_Evidence_2013-08-20-635933068979914314-637262737539327437.docx](#)

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., the benefits or improvements in quality envisioned by use of this measure) Human epidermal growth factor receptor (HER2) gene is amplified and/or overexpressed in approximately 15% to 20% of primary breast cancers (Giordano, 2014). The ASCO/CAP joint guideline on HER2 testing recommends all patients with invasive breast cancer should be tested for HER2 status and only those who test positive for HER2 status should receive HER2 targeted therapies. Additionally data have shown that the administration of HER2 targeted therapies such as Pertuzumab offer no clinical benefit in patients with HER2 negative metastatic disease (Wolff, 2013).

The contraindicated administration of HER2 targeted therapy to patients with HER2 negative breast cancer can propagate potentially toxic, costly and adverse effects as well as decrease the patient's overall quality of life (Partridge, 2014).

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Partridge, A.H., Smith, I.E., et. al., "Chemo- and Targeted Therapy for Women with Human Epidermal Growth Factor Receptor 2-Negative (or Unknown) Advanced Breast Cancer: American Society of Clinical Oncology Clinical Practice Guideline." J Onc Pr 11.1 (2014): 3307-3329. Available at: <http://jco.ascopubs.org/content/32/29/3307.full>

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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 endorsement maintenance. 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 included). This information also will be used to address the subcriterion on improvement (4b.1) under Usability and Use.

This data was produced from the QOPI® registry and data was abstracted for a sample of patients seen with the data collection period. Performance is reported at the clinical practice level.

In 2013, 230 practices were measured, and the total patient population for this measure was 6418. 122 total patients were excluded across all reporting practices.

In 2014, 225 practices were measured, and the total patient population for this measure was 6168. 135 total patients were excluded

across all reporting practices.

In 2015, 265 practices were measured, and the total patient population for this measure was 6917. 98 total patients were excluded across all reporting practices.

		2013	2014	2015
Overall	99.39	99.11	99.47	
Mean	99.25	99.26	99.54	
Minimum	66.7	84	90.91	
Maximum	100	100	100	
Standard Deviation	2.82	2.02	1.38	
Percentiles				
P10	100	100	100	
P25	100	100	100	
P50	100	100	100	
P75	100	100	100	
P90	96.78	96.67	96.97	
P95	95.66	95.66	96.3	

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 endorsement maintenance. 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 subcriterion on improvement (4b.1) under Usability and Use.

This data was produced from the QOPI® registry and data was abstracted for a sample of patients seen with the data collection period. Performance is reported at the chart level.

In 2013, the total patient population for this measure was 6418.

In 2014, the total patient population for this measure was 6168.

In 2015, the total patient population for this measure was 6917.

		2013	2014	2015
Overall	99.39	99.11	99.47	
Hispanic	100	99.26	99.74	
White	99.34	99.20	99.38	
Black	98.84	98.47	99.66	
Other	98.41	99.43	99.59	

1b.5. If no or limited data on disparities from the measure as specified is reported in 1b4, then provide a summary of data from the literature that addresses disparities in care on the specific focus of measurement. Include citations.

Health disparities between patients with breast cancer according to race/ethnicity, age, insurance status, geographic location, education, and other factors are well documented, however literature addressing disparities specific to patients with HER2-positive metastatic breast cancer is scarce. According to some studies, there are not large (although some suggest modest) differences in the prevalence of HER2 positivity between women with breast cancer of different races/ethnicities. The variation by race is smaller among those with HER2-positive breast cancer than for some other subtypes.

HER2 positivity is not necessarily associated with worse treatment outcomes among African American compared with non-African American patients. However, high-quality data on patients with HER2-positive metastatic disease are still needed to reach

conclusions related to outcomes based on ethnicity. Therefore, health disparities may be similar to those faced by patients with metastatic breast cancer generally.

Although ASCO clinical practice guidelines represent expert recommendations the highest level of cancer care, it is important to note that many patients have limited access to medical care. Racial and ethnic disparities in health care contribute significantly to this problem in the United States. Minority racial/ethnic patients with cancer suffer disproportionately from comorbidities, experience more substantial obstacles to receiving care, are more likely to be uninsured, and are at greater risk of receiving care of poor quality than other North Americans. Many other patients lack access to care because of their age, geography, and distance from appropriate treatment facilities. Awareness of these disparities in access to care should be considered in the context of this clinical practice guideline, and health care providers should strive to deliver the highest level of cancer care to these vulnerable populations.

Citations:

Giordano, S.H., Temin, S., et. al., "Systemic Therapy for Patients with Advanced Human Epidermal Growth Factor Receptor 2-Positive Breast Cancer: American Society of Clinical Oncology Clinical Practice Guideline." J Clin Onc 32.19 (2014): 2078-099. Available at:<http://jco.ascopubs.org/content/32/19/2078.full.pdf+html>

1c. High Priority (previously referred to as High Impact)

The measure addresses:

- a specific national health goal/priority identified by DHHS or the National Priorities Partnership convened by NQF; OR
- a demonstrated high-priority (high-impact) aspect of healthcare (e.g., affects large numbers of patients and/or has a substantial impact for a smaller population; leading cause of morbidity/mortality; high resource use (current and/or future); severity of illness; and severity of patient/societal consequences of poor quality).

1c.1. Demonstrated high priority aspect of healthcare

1c.2. If Other:

1c.3. Provide epidemiologic or resource use data that demonstrates the measure addresses a high priority aspect of healthcare. List citations in 1c.4.

1c.4. Citations for data demonstrating high priority provided in 1a.3

1c.5. If a PRO-PM (e.g. HRQoL/functional status, symptom/burden, experience with care, health-related behaviors), provide evidence that the target population values the measured PRO and finds it meaningful. (Describe how and from whom their input was obtained.)

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 subcriteria 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

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

Safety : Overuse

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.)

No webpage available

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.3. For endorsement maintenance, please briefly describe any changes to the measure specifications since last endorsement date and explain the reasons.

"Trastuzumab" has been changed to "HER2 targeted therapies" to reflect updated evidence regarding the expansion of treatment options for HER-2 positive patients.

Changes to the measure were made after the latest measure update of ASCO's Quality Oncology Practice Initiative (QOPI®) measures and therefore the data and testing reflect the previous version of the measure. These changes will be implemented in the Fall of 2016.

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)

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

HER2-targeted therapies not administered during the initial course of treatment.

S.5. Time Period for Data (What is the time period in which data will be aggregated for the measure, e.g., 12 mo, 3 years, look back to August for flu vaccination? Note if there are different time periods for the numerator and denominator.)

The initial course of treatment is defined as: The treatment course for the initial diagnosis, which may include elements of chemotherapy (any route), hormonal therapy, radiation, or additional surgery. Do not include treatment provided for recurrence or disease progression.

S.6. 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, 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.

HER2 targeted therapy administered during initial treatment course = HER2 targeted therapy NOT administered
OR

HER2 targeted therapy administered during initial treatment course = HER2 targeted therapy administered
AND

HER2 targeted therapy administered according to clinical trial protocol = Yes)

'HER2 targeted therapies' include trastuzumab, pertuzumab, T-DM1.

S.7. Denominator Statement (Brief, narrative description of the target population being measured)

Adult women with breast cancer that are HER2 negative or HER2 undocumented.

S.8. Target Population Category (Check all the populations for which the measure is specified and tested if any):

S.9. Denominator Details (All information required to identify and calculate the target population/denominator such as definitions, 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)

Female

And

2 or more encounters at the reporting site

And

Age at diagnosis greater than or equal to 18 years

And

Initial breast cancer diagnosis [C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-]

AND

(HER-2/neu status = HER2 negative

OR

HER-2/neu status = Test ordered, results not yet documented

OR

HER-2/neu status = Test NOT ordered/no documentation

OR

HER-2/neu status=Test ordered, insufficient sample for results

Or

HER-2/neu status= HER2 equivocal)

Definitions

Encounter: Patients must have been first seen in the office by a medical oncology or hematology oncology practitioner for the cancer diagnosis eligible for inclusion within the 1-year time frame of the reporting period. Enter the most recent visit that occurred during the 6-month visit window before the abstraction date. This can include visits to other office sites within the practice only if the practice uses a common medical record and shares management of care for the patient. This does not include visits during which a practitioner wasn't seen (e.g., laboratory testing), inpatient consults/visits, phone or email consults, or visits to a surgeon or radiation oncologist.

HER2 status:

Select 'Test ordered, results not yet documented' only if there is documentation in the chart that a test that included HER2 analyses was ordered.

In the absence of any documentation regarding HER-2/neu status, select 'Test not ordered/no documentation.'

Enter information from the most recent test report. If the most recent report indicates insufficient sample, select 'Test ordered, insufficient sample for results.'

If a physician note and the HER-2/neu report differ in results, report the status in the physician note if the note explains the discrepancy. Otherwise, report the status from the HER-2/neu report.

Use the following definitions to determine HER-2/neu status:

Positive:

IHC 3+ based on circumferential membrane staining that is complete, intense

- ISH positive based on:

- Single-probe average HER2 copy number ≥ 6.0 signals/cell

- Dual-probe HER2/CEP17 ratio ≥ 2.0 with an average HER2 copy number ≥ 4.0 signals/cell

- Dual-probe HER2/CEP17 ratio ≥ 2.0 with an average HER2 copy number < 4.0 signals/cell

- Dual-probe HER2/CEP17 ratio < 2.0 with an average HER2 copy number ≥ 6.0 signals/cell

Equivocal:

- IHC 2+ based on circumferential membrane staining that is incomplete and/or weak/moderate and within > 10% of the invasive tumor cells or complete and circumferential membrane staining that is intense and within = 10% of the invasive tumor cells
- ISH equivocal based on:
 - Single-probe ISH average HER2 copy number = 4.0 and < 6.0 signals/cell
 - Dual-probe HER2/CEP17 ratio < 2.0 with an average HER2 copy number = 4.0 and < 6.0 signals/cell

Negative:

IHC 1+ as defined by incomplete membrane staining that is faint/barely perceptible and within > 10% of the invasive tumor cells or IHC 0 as defined by no staining observed or membrane staining that is incomplete and is faint/barely perceptible and within = 10% of the invasive tumor cells

ISH negative based on:

- Single-probe average HER2 copy number < 4.0 signals/cell
- Dual-probe HER2/CEP17 ratio < 2.0 with an average HER2 copy number < 4.0 signals/cell

Indeterminate:

Indeterminate if technical issues prevent one or both tests (IHC and ISH) from being reported as positive, negative, or equivocal.

Conditions may include:

- Inadequate specimen handling,
- Artifacts (crush or edge artifacts) that make interpretation difficult
- Analytic testing failure.

S.10. Denominator Exclusions (Brief narrative description of exclusions from the target population)

Patient transfer to practice during or after initial course.

S.11. Denominator Exclusion Details (All information required to identify and calculate exclusions from the denominator such as definitions, 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)

Transfer-in Status does not equal Reporting practice has/had primary responsibility for the initial course of the patient's medical oncology care

S.12. Stratification Details/Variables (All information required to stratify the measure results including the stratification variables, definitions, 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 with at S.2b)

Not applicable

S.13. Risk Adjustment Type (Select type. Provide specifications for risk stratification in S.12 and for statistical model in S.14-15)

No risk adjustment or risk stratification

If other:

S.14. Identify the statistical risk model method and variables (Name the statistical method - e.g., logistic regression and list all the risk factor variables. Note - risk model development and testing should be addressed with measure testing under Scientific Acceptability)

Not applicable

S.15. Detailed risk model specifications (must be in attached data dictionary/code list Excel or csv file. Also indicate if available at measure-specific URL identified in S.1.)

Note: Risk model details (including coefficients, equations, codes with descriptors, definitions), should be provided on a separate worksheet in the suggested format in the Excel or csv file with data dictionary/code lists at S.2b.

S.15a. Detailed risk model specifications (if not provided in excel or csv file at S.2b)

Not applicable

S.16. Type of score:

Rate/proportion

If other:

S.17. Interpretation of Score (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)

Better quality = Higher score

S.18. Calculation Algorithm/Measure Logic (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; aggregating data; risk adjustment; etc.)

Performance is calculated as:

1. Identify those patients that meet the denominator criteria defined in the measure.
2. Subtract those patients with a denominator exclusion from the denominator if applicable.
3. From the patients who qualify for the denominator (after any exclusions are removed), identify those who meet the numerator criteria.
4. Calculation: Numerator/Denominator-Denominator Exclusions

S.19. Calculation Algorithm/Measure Logic Diagram URL or Attachment (You also may provide a diagram of the Calculation Algorithm/Measure Logic described above at measure-specific Web page URL identified in S.1 OR in attached appendix at A.1)

No diagram provided

S.20. Sampling (If measure is based on a sample, provide instructions for obtaining the sample and guidance on minimum sample size.)

IF a PRO-PM, identify whether (and how) proxy responses are allowed.

QOPI registry abstraction is offered twice a year to participating Medical Oncology and Hematology Oncology Practices. The minimum sample size for each data abstraction period is based on the number of med-onc and hem-onc FTEs at the practice and/or site level. For breast cancer, patients must be female, 18 years and older with a diagnosis of [C50.01-, C50.11-, C50.21-, C50.31-, C50.41-, C50.51-, C50.61-, C50.81-, C50.91-] within the one year diagnosis window applicable to the round. The practices follow a chart selection methodology which identify patients who had a diagnosis date within one year of the abstraction period start date AND had two office visits with a practitioner in the office within three months of the abstraction data period start date.

S.21. Survey/Patient-reported data (If measure is based on a survey, provide instructions for conducting the survey and guidance on minimum response rate.)

IF a PRO-PM, specify calculation of response rates to be reported with performance measure results.

Not applicable

S.22. Missing data (specify how missing data are handled, e.g., imputation, delete case.)

Required for Composites and PRO-PMs.

This measure is specified with specific criteria and data elements. If a patient record does not include one or more of these components for the initial patient population or denominator, then patients are not considered eligible for the measure and not included.

If data to determine whether a patient should be considered for the numerator or exclusions is missing, then the numerator or exclusions not considered to be met and the practice will not get credit for meeting performance for that patient.

S.23. Data Source (Check ONLY the sources for which the measure is SPECIFIED AND TESTED).

If other, please describe in S.24.

Registry Data

S.24. Data Source or Collection Instrument (Identify the specific data source/data collection instrument e.g. name of database, clinical registry, collection instrument, etc.)

IF a PRO-PM, identify the specific PROM(s); and standard methods, modes, and languages of administration.

[ASCO Quality Oncology Practice Initiative \(QOPI®\)](#)

S.25. 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.26. Level of Analysis (Check ONLY the levels of analysis for which the measure is SPECIFIED AND TESTED)

[Clinician : Group/Practice](#)

S.27. Care Setting (Check ONLY the settings for which the measure is SPECIFIED AND TESTED)

[Outpatient Services](#)

If other:

S.28. 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](#)

2a. Reliability – See attached Measure Testing Submission Form

2b. Validity – See attached Measure Testing Submission Form

[1857_MeasureTesting_Data_1857_Update-637262737540421415.doc](#)

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 or collected by and used by healthcare personnel during the provision of care \(e.g., blood pressure, lab value, diagnosis, depression score\)](#)

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)

[ALL data elements are in defined fields in electronic clinical data \(e.g., clinical registry, nursing home MDS, home health OASIS\)](#)

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.

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.

[No feasibility assessment](#) 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. Describe what you have learned/modified 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 a PRO-PM, consider implications for both individuals providing PROM data (patients, service recipients, respondents) and those whose performance is being measured.

The measure and its specifications have been in place for several years and ASCO continues to monitor and ensure that the measure and its specifications are up to date for widespread use.

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).

Not applicable

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.

Planned	Current Use (for current use provide URL)
Payment Program	

4a.1. For each CURRENT use, checked above, provide:

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

Quality Oncology Practice Initiative:

In 2002, the American Society of Clinical Oncology established the Quality Oncology Practice Initiative (QOPI®). QOPI® is a practice-based quality assessment and improvement program designed to foster a culture of self-examination and improvement in oncology. Collection rounds are offered twice per year, in spring and fall, for an eight week period. QOPI® continues to be a successful program in the United States and 12 other countries, with 441, 313, 361 and 256 unique practices participating in Fall 2013, Spring 2014, Spring 2015 and Fall 2015 respectively.

4a.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?)

We are continuously seeking opportunities to advocate for expanded use of this measure in government or other programs, including those intended for accountability or public reporting. For example, this measure was recently selected for inclusion in a Medical Oncology Core Measure Set supported by America's Health Insurance Plans and CMS. See section 4a.3. below for additional details.

4a.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.*)

This measure has also been included in America's Health Insurance Plans Medical Oncology Core Measure Set. The purpose of this program is to reduce variability in measure selection, specifications and implementation. The measures will be implemented nationally by private health plans using a phased-in approach. Contracts between physicians and private payers are individually negotiated and therefore come up for renewal at different points in time depending on the duration of the contract. It is anticipated that private payers will implement these core sets of measures as and when contracts come up for renewal or if existing contracts allow modification of the performance measure set. CMS is also working to align measures across public programs. They intend to include, for broad input, the agreed upon draft measure sets in the Physician Fee Schedule and other proposed rules. For measures that are not currently in CMS programs, CMS would go through the annual pre-rulemaking and rulemaking processes to solicit stakeholder and public input. Depending on public response, these measures will be included in a timeframe determined by the Agency.

4b. 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.

4b.1. Progress on Improvement. (Not required for initial endorsement unless available.)

Performance results on this measure (current and over time) should be provided in 1b.2 and 1b.4. Discuss:

- Progress (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

While performance continues to be generally high, some variation still remains as evidenced by the performance ranges by year and from the time of the last NQF endorsement review. The data available are based on QOPI® self selecting practices that voluntarily report data and may not be reflective of care provided outside of the QOPI® program.

Additional information on overall performance rates across the U.S. will hopefully become available with the AHIP Core Measures Collaborative.

4b.2. 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 performance continues to be generally high, some variation still remains as evidenced by the performance ranges by year and from the time of the last NQF endorsement review. The data available are based on QOPI® self selecting practices that voluntarily report data and may not be reflective of care provided outside of the QOPI® program.

Additional information on overall performance rates across the U.S. will hopefully become available with the AHIP Core Measures Collaborative.

4c. 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).

4c.1. Were any unintended negative consequences to individuals or populations identified during testing; OR has evidence of unintended negative consequences to individuals or populations been reported since implementation? If so, identify the negative unintended consequences and describe how benefits outweigh them or actions taken to mitigate them.

There have been no reports of unintended consequences with 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.
No

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.

5a. Harmonization

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 completely harmonized?

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

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.)

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: QOPI_Adoption_of_ICD10_020916-635933001750874650-637262737541046196.docx](#)

Contact Information

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

Co.2 Point of Contact: [Tayyaba, Shehzadi, Tayyaba.Shehzadi@asco.org, 571-483-1673-](#)

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

Co.4 Point of Contact: [Tayyaba, Shehzadi, Tayyaba.Shehzadi@asco.org, 571-483-1673-](#)

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.

ASCO Breast Cancer Measures Development Panel

The panel is responsible for reviewing evidence and maintaining measures

Gary Lyman, MD, MPH, FASCO, FRCP

Co-Chair

Fred Hutchinson Cancer Research Center

Gabrielle Rocque, MD

Co-Chair

University of Alabama

Banu Arun, MD

University of Texas

MD Anderson Cancer Center

Gary Cohen, MD, FASCO

Cancer Center at GBMC

Shelley Fuld Nasso, MPP

National Coalition for Cancer Survivorship

Jennifer Griggs, MD, MPH

University of Michigan

Michael Hassett, MD, MPH

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Michael Neuss, MD, FASCO

Vanderbilt Ingram Cancer Center

Ann Partridge, MD, FASCO

Dana-Farber Cancer Institute

Michael Soble, MD

North Shore Oncology/Hematology Associates

Ann Von Gehr, MD

Permanente Medical Group Inc.

Antonio Wolff, MD, FACP, FASCO

Johns Hopkins Kimmel Cancer Center

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: 02, 2016

Ad.4 What is your frequency for review/update of this measure? q3years

Ad.5 When is the next scheduled review/update for this measure? 02, 2017

Ad.6 Copyright statement: The Measures are not clinical guidelines, do not establish a standard of medical care, and have not been tested for all potential applications.

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ASCO encourages use of the Measures by other health care professionals, where appropriate.

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Ad.7 Disclaimers:

Ad.8 Additional Information/Comments: