NHCR
New Hampshire Colonoscopy Registry
46 Centerra Parkway • EverGreen Building, Ste 105 • Lebanon NH 03766
603.650.3414 (phone) • 603.650.3415 (fax)

Merit-based Incentive Payment system (MIPS)
2020 Qualified Clinical Data Registry (QCDR) Measure Specifications

Summary Listing of QCDR measures supported by the NHCR

Measure #	Title	Description	Type / Priority
NHCR4	Repeat screening/surveillance colonoscopy recommended within 1 yr due to inadequate / poor bowel preparation	Percentage of patients recommended for repeat screening or surveillance colonoscopy within one year or less due to inadequate/poor bowel preparation quality	Process / High Priority
GIQIC12	Appropriate Indication for Colonoscopy	Percentage of colonoscopy procedures performed for an indication that is included in a published standard list of appropriate indications and the indication is documented	Process
GIQIC15	Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients	Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component), Sessile serrated polyp (SSP) ≥ 10 mm OR SSP with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy	Process / High Priority
GIQIC17	Appropriate follow-up interval of 5 years for colonoscopies with findings of sessile serrated polyps < 10 mm without dysplasia	Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of sessile serrated polyp(s) < 10 mm without dysplasia with a recommended follow-up interval of 5 yrs for repeat colonoscopy documented in colonoscopy report	Process / High Priority
GIQIC21	Appropriate follow-up interval of not less than 5 yrs for colonoscopies with findings of 1-2 tubular adenomas < 10 mm OR of 10 yrs for colonoscopies with only hyperplastic polyp findings in rectum or sigmoid	Percentage of average-risk patients aged 50-75 yrs receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 1-2 tubular adenomas<10 mm with a recommended follow-up interval of not less than 5 yrs OR pathology findings of only hyperplastic polyps in rectum or sigmoid with a recommended follow-up interval of 10 yrs for repeat colonoscopy documented in colonoscopy report	Process / High Priority

NHCR4: Repeat screening or surveillance colonoscopy recommended within one year due to inadequate / poor bowel preparation

DESCRIPTION: Percentage of patients recommended for repeat screening or surveillance colonoscopy within one year or less due to inadequate/poor bowel preparation quality
TYPE OF MEASURE / PRIORITY STATUS: Process / High Priority (Care Coordination)
NQS DOMAIN: Communication and Care Coordination
NQF#: N/A
MEANINGFUL MEASURE AREA: Appropriate use of Health Care
MEANINGFUL MEASURE AREA RATIONALE: Colonoscopies with poor bowel preparation are considered incomplete due to inadequate mucosal visualization, and shorter follow-up intervals are recommended to ensure effective care.[1-5] National guidelines issued in 2012 by the US Multi Society Task Force on Colorectal Cancer recommend repeat colonoscopies within a year following most colonoscopies with poor bowel prep.[6]
DENOMINATOR: # of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor
DENOMINATOR EXCLUSIONS OR EXCEPTIONS: None
NUMERATOR: # of screening and surveillance colonoscopies with bowel preparation documented as inadequate/poor and whose recommended follow-up was ≤ 1 year
NUMERATOR EXCLUSIONS: None
INVERSE MEASURE: No
PROPORTIONAL MEASURE: Yes
CONTINUOUS VARIABLE MEASURE: No
RATIO MEASURE: No
OUTCOME MEASURE: No
RISK ADJUSTED: No
DATA SOURCE: NHCR Procedure form, (Q. 2 Indication for Procedure, Q. 4 Bowel preparation quality, Q. 9, Follow-up recommendation)
NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 1
EVIDENCE OF A PERFORMANCE GAP AND CITATIONS: Evidence suggests that adherence to this guideline is surprisingly inconsistent, with intervals following poor bowel prep often highly variable. [7-9] "If bowel cleansing is inadequate to identify polyps >5 mm in size, and the procedure is being performed for CRC screening or colon polyp surveillance, then the procedure should be repeated in 1 year or less. Adequate preparation carries the implication that the recommended interval before the next colonoscopy will be consistent with guidelines." from Rex DK, Schoenfeld PS, Cohen J, Pike IM, et al. . Quality indicators for colonoscopy. Gastrointest Endosc. 2015;81(1):31-53. Epub 2014/12/07. doi: 10.1016/j.gie.2014.07.058. PubMed PMID: 25480100.

REFERENCES

1. Rex DK, Johnson DA, Anderson JC, et al. American College of Gastroenterology guidelines for colorectal cancer screening 2009 [corrected]. Am J Gastroenterol 2009;104:739-50.
2. Rex DK, Bond JH, Winawer S, et al. Quality in the technical performance of colonoscopy and the continuous quality improvement process for colonoscopy: recommendations of the U.S. Multi-Society Task Force on Colorectal Cancer. Am J Gastroenterol 2002;97:1296-308.
3. Bond JH. Should the quality of preparation impact postcolonoscopy follow-up recommendations? Am J Gastroenterol 2007;102:2686-7.
4. Levin TR. Dealing with uncertainty: surveillance colonoscopy after polypectomy. Am J Gastroenterol 2007;102:1745-7.
5. Rex DK, Bond JH, Feld AD. Medical-legal risks of incident cancers after clearing colonoscopy. Am J Gastroenterol 2001;96:952-7.
6. Lieberman DA, Rex DK, Winawer SJ, et al. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology 2012;143:844-57.
7. Ben-Horin S, Bar-Meir S, Avidan B. The impact of colon cleanliness assessment on endoscopists' recommendations for follow-up colonoscopy. Am J Gastroenterol 2007;102:2680-5.
8. Larsen M, Hills N, Terdiman J. The impact of the quality of colon preparation on follow-up colonoscopy recommendations. Am J Gastroenterol 2011;106:2058-62.

9. Menees SB, Elliott E, Govani S, et al. The impact of bowel cleansing on follow-up recommendations in average-risk patients with a normal colonoscopy. Am J Gastroenterol 2014;109:148-54.

GIQIC12: Appropriate Indication for Colonoscopy

DESCRIPTION: Percentage of colonoscopy procedures performed for an indication that is included in a published standard list of appropriate indications and the indication is documented.
TYPE OF MEASURE / PRIORITY STATUS: Process / N/A
NQS DOMAIN: Effective Clinical Care
NQF#: N/A
MEANINGFUL MEASURE AREA: Appropriate use of Health Care
MEANINGFUL MEASURE AREA RATIONALE: When colonoscopy is done for an appropriate indication, significantly more clinically relevant diagnoses are made.
DENOMINATOR: all colonoscopies
DENOMINATOR EXCLUSIONS OR EXCEPTIONS: None
NUMERATOR: Number of colonoscopies performed for an indication included in published standard lists of appropriate indications
NUMERATOR EXCLUSIONS: None
INVERSE MEASURE: No
PROPORTIONAL MEASURE: Yes
CONTINUOUS VARIABLE MEASURE: No
RATIO MEASURE: No
OUTCOME MEASURE: No
RISK ADJUSTED: No
DATA SOURCE: NHCR Procedure form (Q.2, Indication for Procedure).
NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 1
EVIDENCE OF A PERFORMANCE GAP AND CITATIONS: In 2012, ASGE updated its indications for endoscopic procedures, Appropriate Use of Gastrointestinal Endoscopy.(1) This list was determined by a review of published literature and expert consensus. Studies have shown that when colonoscopy is done for appropriate reasons, significantly more clinically relevant diagnoses are made.(2,3,4)

Based on the evidence GIQuIC's supporting societies agree the performance target for an appropriate indication measure should be > 80%.

SPECIALTY: Gastroenterology
REFERENCES:
(1) ASGE Standards of Practice Committee, Early DS, Ben-Menachem T et al. Appropriate use of GI endoscopy. Gastrointest Endosc 2012;75:1127-31.
(2) Balaguer F, Llach J, Castells A, et al. The European panel on the appropriateness of gastrointestinal endoscopy guidelines colonoscopy in an open-access endoscopy unit: a prospective study. Aliment Pharmacol Ther 2005;21:609-13.
(3) Vader JP, Pache I, Froehlich F, et al. Overuse and underuse of colonoscopy in a European primary care setting. Gastrointest Endosc 2000;52:593-99.
(4) de Bosset V, Froehlich F, Rey JP, et al. Do explicit appropriateness criteria enhance the diagnostic yield of colonoscopy? Endoscopy 2002;34:360-8.

GIQIC15: Appropriate follow-up interval of 3 years recommended based on pathology findings from screening colonoscopy in average-risk patients

DESCRIPTION: Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component), Sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy.
TYPE OF MEASURE / PRIORITY STATUS: Process / High Priority (Care Coordination)
NQS DOMAIN: Communication and Care Coordination
NQF#: N/A
MEANINGFUL MEASURE AREA: Appropriate use of Health Care
MEANINGFUL MEASURE AREA RATIONALE: Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective.
DENOMINATOR: All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 years and older with biopsy or polypectomy and pathology findings of 3-10 adenomas, OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma
DENOMINATOR EXCLUSIONS OR EXCEPTIONS: None
NUMERATOR: Number of average-risk patients aged 50 years and older receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas OR Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) OR Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma who had a recommended follow-up interval of 3 years for repeat colonoscopy
NUMERATOR EXCLUSIONS: None
INVERSE MEASURE: No
PROPORTIONAL MEASURE: Yes
CONTINUOUS VARIABLE MEASURE: No
RATIO MEASURE: No
OUTCOME MEASURE: No
RISK ADJUSTED: No
DATA SOURCE: NHCR Data Collection Forms, Web-Based data collection, Paper Medical Record, EMR
NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 1
EVIDENCE OF A PERFORMANCE GAP AND CITATIONS:
The Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer(1) presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 3-10 adenomas, advanced neoplasm (≥ 10 mm, high grade dysplasia, villous component), sessile serrated polyp ≥ 10 mm OR sessile serrate polyp with dysplasia or traditional serrated adenoma should receive a recommended follow-up interval of 3 years for repeat colonoscopy.

Evidence from surveys indicates that post-polypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines, that knowledge of guideline recommendations is high, and lack of guideline awareness is unlikely to account for overuse of colonoscopy. These surveys underscore the importance of measuring intervals between examinations in continuous quality improvement programs.(2)

SPECIALTY: Gastroenterology

REFERENCES:
(1) Lieberman DA, Rex DK, Winawer SJ, et al. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology 2012;143:844-57.
(2) Rex, DK, et al. Quality indicators for colonoscopy. Gastrointest Endosc 2015;81:31-53 / DOI: http://dx.doi.org/10.1016/j.gie.2014.07.058

GIQIC17: Appropriate follow-up interval of 5 years for colonoscopies with findings of sessile serrated polyps < 10 mm without dysplasia

DESCRIPTION: Percentage of average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of sessile serrated polyp(s) < 10 mm without dysplasia with a recommended follow-up interval of 5 years for repeat colonoscopy documented in their colonoscopy report.
TYPE OF MEASURE / PRIORITY STATUS: Process / High Priority (Appropriate Use)
NQS DOMAIN: Efficiency and Cost Reduction
NQF#: N/A
MEANINGFUL MEASURE AREA: Appropriate use of Health Care
MEANINGFUL MEASURE AREA RATIONALE: Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective.
DENOMINATOR:
All complete and adequately prepped screening colonoscopies of average-risk patients aged 50 years and older with biopsy or polypectomy and pathology findings of sessile serrated polyp(s) < 10 mm without dysplasia
DENOMINATOR EXCLUSIONS OR EXCEPTIONS: None
NUMERATOR: Number of average-risk patients aged 50 years and older receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and pathology findings of sessile serrated polyp(s) < 10 mm without dysplasia who had a recommended follow-up interval of 5 years for repeat colonoscopy
NUMERATOR EXCLUSIONS: None
INVERSE MEASURE: No
PROPORTIONAL MEASURE: Yes
CONTINUOUS VARIABLE MEASURE: No
RATIO MEASURE: No
OUTCOME MEASURE: No
RISK ADJUSTED: No
DATA SOURCE: NHCR Data Collection Forms, Web-Based data collection, Paper Medical Record, EMR
NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 1
EVIDENCE OF A PERFORMANCE GAP AND CITATIONS:
The Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer(1) presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of sessile serrated polyp(s) < 10 mm with no dysplasia should receive a recommended follow-up interval of 5 years for repeat colonoscopy.

Evidence from surveys indicates that post-polypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines, that knowledge of guideline recommendations is high, and lack of guideline awareness is unlikely to account for overuse of colonoscopy... These surveys underscore the importance of measuring intervals between examinations in continuous quality improvement programs.(2)

SPECIALTY: Gastroenterology

REFERENCES:
(1) Lieberman DA, Rex DK, Winawer SJ, et al. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology 2012;143:844-57.
(2) Rex, DK, et al. Quality indicators for colonoscopy. Gastrointest Endosc 2015;81:31-53 / DOI: http://dx.doi.org/10.1016/j.gie.2014.07.058

GIQIC21: Appropriate follow-up interval of not less than 5 years for colonoscopies with findings of 1-2 tubular adenomas < 10 mm OR of 10 years for colonoscopies with only hyperplastic polyp findings in rectum or sigmoid

DESCRIPTION: Percentage of average-risk patients aged 50 years to 75 years receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 1 or 2 tubular adenomas < 10 mm with a recommended follow-up interval of not less than 5 years OR pathology findings of only hyperplastic polyp findings in rectum or sigmoid with a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report
TYPE OF MEASURE / PRIORITY STATUS: Process / High Priority (Appropriate Use)
NQS DOMAIN: Efficiency and Cost Reduction
NQF#: N/A
MEANINGFUL MEASURE AREA: Appropriate use of Health Care
MEANINGFUL MEASURE AREA RATIONALE: Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective.
DENOMINATOR: All complete and adequately prepped screening colonoscopies of average risk patients aged 50 years to 75 years with biopsy or polypectomy and pathology findings of: (Strata 1) 1 to 2 tubular adenomas < 10 mm OR (Strata 2) only hyperplastic polyp(s) in rectum or sigmoid
DENOMINATOR EXCLUSIONS: None
DENOMINATOR EXCEPTIONS: Patients aged 66 to 75
NUMERATOR: Number of average-risk patients aged 50 years to 75 years receiving a complete and adequately prepped screening colonoscopy with biopsy or polypectomy and: (Strata 1) pathology findings of 1 to 2 tubular adenomas < 10 mm who had a recommended follow-up interval of ≥ 5 years for repeat colonoscopy OR (Strata 2) pathology findings of only hyperplastic polyp(s) in rectum or sigmoid who had a recommended follow-up interval of 10 years for repeat colonoscopy documented in their colonoscopy report
NUMERATOR EXCLUSIONS: None
INVERSE MEASURE: No
PROPORTIONAL MEASURE: Yes
CONTINUOUS VARIABLE MEASURE: No
RATIO MEASURE: No
OUTCOME MEASURE: No
RISK ADJUSTED: No
DATA SOURCE: NHCR Data Collection Forms, Web-Based data collection, Paper Medical Record, EMR
NUMBER OF PERFORMANCE RATES TO BE SUBMITTED: 3
This measure will be calculated with 3 performance rates:
1) Overall percentage of patients given an appropriate follow-up interval of greater than 5 years or of 10 years for their next colonoscopies based on specific findings of their screening colonoscopy associated with longer follow-up intervals
2) Percentage of patients with screening colonoscopy findings of 1-2 tubular adenomas < 10 mm given an appropriate follow-up interval of not less than 5 years for their next colonoscopies
3) Percentage of patients with screening colonoscopy findings of only hyperplastic polyp findings in rectum or sigmoid given an appropriate follow-up interval of 10 years for their next colonoscopies

EVIDENCE OF A PERFORMANCE GAP AND CITATIONS:
The Guidelines for Colonoscopy Surveillance After Screening and Polypectomy: Consensus Update by the US Multi-society Task Force on Colorectal Cancer(1) presents recommendations for surveillance intervals in individuals with baseline average risk. Colonoscopies should follow recommended post-polypectomy surveillance intervals to be clinically effective and to minimize risk and further to be cost-effective. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of 1–2 small (< 10 mm) tubular adenomas should receive a recommended follow-up interval of 5 to 10 years for repeat colonoscopy. Average-risk patients aged 50 years and older receiving a screening colonoscopy with biopsy or polypectomy and pathology findings of distal small lesions (<10 mm) hyperplastic polyps should receive a recommended follow-up interval of 10 years for repeat colonoscopy.

Evidence from surveys indicates that post-polypectomy surveillance colonoscopy in the United States is frequently performed at intervals that are shorter than those recommended in guidelines, that knowledge of guideline recommendations is high, and lack of guideline awareness is unlikely to account for overuse of colonoscopy. These

surveys underscore the importance of measuring intervals between examinations in continuous quality improvement programs.(2)

REFERENCES:

(1) Lieberman DA, Rex DK, Winawer SJ, et al. Guidelines for colonoscopy surveillance after screening and polypectomy: a consensus update by the US Multi-Society Task Force on Colorectal Cancer. Gastroenterology 2012;143:844-57.
(2) Rex, DK, et al. Quality indicators for colonoscopy. Gastrointest Endosc 2015;81:31-53 / DOI: http://dx.doi.org/10.1016/j.gie.2014.07.058