NHCR
New Hampshire Colonoscopy Registry
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Merit-based Incentive Payment system (MIPS)
2021 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
GIQIC22	Screening Colonoscopy Adenoma Detection Rate	The percentage of patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy	Outcome / High Priority
GIQIC23	Appropriate follow-up interval based on pathology findings in screening colonoscopy	Percentage of procedures among average-risk patients aged 50 to 75 years receiving a screening colonoscopy with biopsy or polypectomy and pathology findings who had a follow-up interval consistent with US Multi-Society Task Force (USMSTF) recommendations for repeat colonoscopy documented in their 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)
CARE SETTING: Ambulatory Care: Hospital, Outpatient Services
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.

GIQIC22: Screening Colonoscopy Adenoma Detection Rate

DESCRIPTION: The percentage of patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.
TYPE OF MEASURE / PRIORITY STATUS: Outcome / High Priority
CARE SETTING: Outpatient Services
NQS DOMAIN: Effective Clinical Care
NQF#: N/A
MEANINGFUL MEASURE AREA: Preventative Care
MEANINGFUL MEASURE AREA RATIONALE: The removal of adenomatous polyps during a screening colonoscopy is associated with a lower risk of subsequent colorectal cancer incidence and mortality.
DENOMINATOR: (Strata 1) Male patients aged 50 to 75 years undergoing a screening colonoscopy OR (Strata 2) Female patients aged 50 to 75 years undergoing a screening colonoscopy
DENOMINATOR EXCLUSIONS: None
DENOMINATOR EXCEPTIONS: (Strata 1) Documentation that neoplasm detected in a male patient is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma OR (Strata 2) Documentation that neoplasm detected in a female patient is only diagnosed as traditional serrated adenoma, sessile serrated polyp, or sessile serrated adenoma
NUMERATOR: (Strata 1) Number of male patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy OR (Strata 2) Number of female patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy.
NUMERATOR EXCLUSIONS: None
INVERSE MEASURE: No
PROPORTIONAL MEASURE: Yes
CONTINUOUS VARIABLE MEASURE: No

RATIO MEASURE: No
OUTCOME MEASURE: Yes
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 aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy
2) Percentage of male patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy
3) Percentage of female patients aged 50 to 75 years with at least one conventional adenoma or colorectal cancer detected during screening colonoscopy

GIQIC23: Appropriate follow-up interval based on pathology findings in screening colonoscopy
DESCRIPTION: Percentage of procedures among average-risk patients aged 50 to 75 years receiving a screening colonoscopy with biopsy or polypectomy and pathology findings who had a follow-up interval consistent with US Multi-Society Task Force (USMSTF) recommendations for repeat colonoscopy documented in their colonoscopy report.
TYPE OF MEASURE / PRIORITY STATUS: Process / High Priority Care Coordination)
CARE SETTING: Outpatient Services
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 to 75 years with biopsy or polypectomy and pathology findings of
(Strata 1) only hyperplastic polyps
(Strata 2) findings of 1-2 tubular adenoma(s)
(Strata 3) findings of 3-4 tubular adenomas
(Strata 4) findings of 5-10 tubular adenomas
(Strata 5) Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component)
(Strata 6) Sessile serrated polyp ≥ 10 mm OR sessile serrated polyp with dysplasia OR traditional serrated adenoma
DENOMINATOR EXCLUSIONS:
(Strata 1) ≥ 21 hyperplastic polyps or the number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection
(Strata 2) The number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection
(Strata 3) The number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection
(Strata 4) The number of polyps removed does not equal the number of polyps retrieved or Use of endoscopic mucosal resection
(Strata 5) Colonoscopy with findings of > 10 adenomas or findings of adenocarcinoma or Use of endoscopic mucosal resection
(Strata 6) Colonoscopy with findings of > 10 adenomas or findings of adenocarcinoma or Use of endoscopic mucosal resection
DENOMINATOR EXCEPTIONS
(Strata 1) Patients aged 66 to 75 or polyps were removed via piecemeal
(Strata 2) Patients aged 66 to 75 or polyps were removed via piecemeal
(Strata 3) Patients aged 66 to 75 or polyps were removed via piecemeal
(Strata 4) Patients aged 66 to 75 or polyps were removed via piecemeal
(Strata 5) polyps were removed via piecemeal
(Strata 6) polyps were removed via piecemeal
NUMERATOR: Number of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years

(Strata 1) with biopsy or polypectomy and pathology findings of only hyperplastic polyps for which a recommended follow-up interval of 10 years for repeat colonoscopy was given to the patient
(Strata 2) with biopsy or polypectomy and pathology findings of 1-2 tubular adenoma(s) for which a recommended follow-up interval of not less than 7 years and not greater than 10 years was given to the patient
(Strata 3) with biopsy or polypectomy and pathology findings of 3-4 tubular adenomas for which a recommended follow-up interval of not less than 3 years and not greater than 5 years was given to the patient
(Strata 4) with biopsy or polypectomy and pathology findings of 5-10 tubular adenomas for which a recommended follow-up interval of 3 years was given to the patient
(Strata 5) with biopsy or polypectomy and pathology findings of Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) for which a recommended follow-up interval of 3 years for repeat colonoscopy was given to the patient
(Strata 6) with biopsy or polypectomy and pathology findings of 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 was given to the patient
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: 7
DESCRIPTION OF PERFORMANCE RATES: This measure will be calculated with 7 performance rates:
Rate 1: Overall percentage of procedures among average-risk patients aged 50 to 75 years receiving a screening colonoscopy with biopsy or polypectomy and pathology findings who had a follow-up interval consistent with US Multi-Society Task Force (USMSTF) recommendations for repeat colonoscopy documented in their colonoscopy report
Rate 2: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of only hyperplastic polyps for which a recommended follow-up interval of 10 years for repeat colonoscopy was given to the patient
Rate 3: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of 1-2 tubular adenoma(s) for which a recommended follow-up interval of not less than 7 years and not greater than 10 years was given to the patient
Rate 4: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of 3-4 tubular adenomas for which a recommended follow-up interval of not less than 3 years and not greater than 5 years was given to the patient
Rate 5: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of 5-10 tubular adenomas for which a recommended follow-up interval of 3 years was given to the patient
Rate 6: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of Advanced Neoplasm (≥ 10 mm, high grade dysplasia, villous component) for which a recommended follow-up interval of 3 years for repeat colonoscopy was given to the patient
Rate 7: Percentage of complete and adequately prepped screening colonoscopies of average-risk patients aged 50 to 75 years with biopsy or polypectomy and pathology findings of 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 consistent was given to the patient

EVIDENCE OF A PERFORMANCE GAP AND CITATIONS:
After high-quality screening colonoscopy, patients with polyps are risk-stratified based on the histology, number, location, and size of polyps detected. Studies support villous histology as a potential risk factor for advanced neoplasia and there is extended evidence to support high-grade dysplasia as a risk factor for metachronous advanced neoplasia and CRC; therefore, a shorter interval for follow-up colonoscopy is recommended for patients with these findings. Evidence to support best practices for surveillance colonoscopy has strengthened and has helped to support close follow-up for some groups, as well as less intense follow-up for others.(1)

SPECIALTY: Gastroenterology

REFERENCES:
(1) Recommendations for Follow-Up After Colonoscopy and Polypectomy: A Consensus Update by the US Multi-Society Task Force on Colorectal Cancer. Gupta, Samir et al. Gastroenterology, Volume 158, Issue 4, 1131 - 1153.e5