

American Academy of Dermatology/Physician Consortium for Performance Improvement®

FOR CONSORTIUM VOTE

**Melanoma
Physician Performance Measurement Set**

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Melanoma Work Group

Dirk Elston, MD (Co-Chair)
Raj Behal, MD, MPH (Co-Chair)

Gregory W. Cotter, MD
Evan Ragland Farmer, MD
Steven R. Feldman, MD, PhD
Ronald Gabel, MD
Joel M. Gelfand, MD
Reed Pyeritz, MD, PhD, FACP, FACMG

Jack S. Resneck, Jr., MD
John Schneider, MD, PhD
Arthur Joel Sober, MD
Steve W. Strode, MD, MEd, MPH
David Witte, MD, PhD
James Zalla, MD

American Academy of Dermatology

Sandra Peters, MHA
Carol Sieck, RN, MSN

Health Plan Representative

Andrea Gelzer, MD, MS FACP

American Medical Association

Karen S. Kmetik, PhD
Erin O. Kaleba, MPH
Beth Tapper, MA
Samantha Tierney, MPH

National Committee for Quality Assurance

Donna Pillitere, MS

Mathematica Policy Research

Tom Croghan, MD

Centers for Medicare & Medicaid Services

Latousha Leslie, RN, MS
Susan Nedza, MD, MBA, FACEP
Sylvia Publ, MBA, RHIA

Facilitators

Timothy F. Kresowik, MD
Rebecca A. Kresowik

Joint Commission on Accreditation of Healthcare Organizations

Lisa Buczkowski, RN, MS

American Society of Clinical Oncology

Kristin McNiff, MPH

American Society for Therapeutic Radiology and Oncology

Emily Wilson

Intended Audience and Patient Population:

Any physician caring for patients with a current diagnosis of melanoma or a history of cutaneous melanoma

Patients of all ages

These clinical performance measures are designed for individual quality improvement. Some of the measures may also be appropriate for accountability if appropriate sample sizes and implementation rules are achieved.

Accountability Measures:

Measure #1: Patient History

Measure #2: Complete Physical Skin Examination

Measure #3: Counseling on Self-Examination

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Measure #1: Patient Medical History

This measure may be used as an Accountability measure.

Data Elements	Clinical Performance Measure	Feedback
<p>Per Patient, Per Year</p> <p>Yes/No – Patient medical history taken that includes being asked if presence of any new or changing moles</p> <p>Yes/No – Documentation of medical reason(s) for not asking about presence of any new or changing moles</p> <p>Yes/No – Documentation of patient reason(s) for not asking about presence of any new or changing moles</p> <p>Yes/No – Documentation of system reason(s) for not asking about presence of any new or changing moles</p> <p>Sources</p> <p>Electronic medical record</p> <p>Paper medical record</p> <p>Flowsheet</p> <p>Administrative claims data*</p> <p><i>*adequate data source only if new codes are developed specific to the intent of this measure</i></p>	<p>Numerator: Patients who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months</p> <p>Denominator: All patients with a current diagnosis of melanoma or a history of cutaneous melanoma</p> <p>Denominator Exclusions:</p> <p>Documentation of medical reason(s) for not asking about presence of any new or changing moles</p> <p>Documentation of patient reason(s) for not asking about presence of any new or changing moles</p> <p>Documentation of system reason(s) for not asking about presence of any new or changing moles</p> <p>Measure: Percentage of patients with either a current diagnosis of melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles at least once within 12 months</p>	<p>Per Patient</p> <p>Whether or not the patient with either a current diagnosis of melanoma or a history of cutaneous melanoma had a medical history taken that included being asked if they have any new or changing moles at one or more office visits within 12 months</p> <p>Per Patient Population</p> <p>Percentage of patients with either a current diagnosis of melanoma or a history of cutaneous melanoma who had a medical history taken that included being asked if they have any new or changing moles at one or more office visits within 12 months</p>
<p>The following clinical recommendation statements are quoted <u>verbatim</u> from the referenced clinical guidelines and represent the evidence base for the measure:</p> <p>The results of routine interval history and physical examination should direct the need for laboratory tests and imaging studies. (AAD) (Evidence level 3)¹</p> <p>For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated. For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated. (NCCN) (Level of Evidence - Category 2A)³</p>		

Rationale for the measure:

While there are not widely available data documenting a gap in care for whether a history was taken, consensus exists among practicing dermatologists that there is room for improvement regarding physicians asking patients about new or changing moles. Early detection of additional primary melanomas is the goal of follow-up care. The majority of recurrences are discovered by the patient or family member. Data elements required for the measure can be captured and the measure is actionable by the physician.

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Measure #2: Complete Physical Skin Examination

This measure may be used as an Accountability measure.

Data Elements	Clinical Performance Measure	Feedback
<p>Per Patient, Per Year Yes/No – Patient had a complete physical skin exam performed <i>(Complete exam -inspection of the skin of the whole body; genital area may be excluded per patient preference. Exam may be documented by bullets or by the words complete or full skin examination.)</i></p> <p>Yes/No – Documentation of medical reason(s) for not performing a complete skin exam</p> <p>Yes/No – Documentation of patient reason(s) for not performing a complete skin exam</p> <p>Yes/No – Documentation of system reason(s) for not performing a complete skin exam</p> <p>Sources Electronic medical record</p> <p>Paper medical record</p> <p>Flowsheet</p> <p>Administrative claims data*</p> <p><i>*adequate data source only if new codes are developed specific to the intent of this measure</i></p>	<p>Numerator: Patients who had a complete physical skin exam performed at least once within 12 months</p> <p>Denominator: All patients with a current diagnosis of melanoma or a history of cutaneous melanoma</p> <p>Denominator Exclusions: Documentation of medical reason(s) for not performing a complete skin exam</p> <p>Documentation of patient reason(s) for not performing a complete skin exam</p> <p>Documentation of system reason(s) for not performing a complete skin exam</p> <p>Measure: Percentage of patients with either a current diagnosis of melanoma or a history of cutaneous melanoma who had a complete physical skin exam performed at least once within 12 months</p>	<p>Per Patient Whether or not the patient with either a current diagnosis of melanoma or a history of cutaneous melanoma had a complete physical skin exam performed at one or more office visits within 12 months</p> <p>Per Patient Population Percentage of patients with either a current diagnosis of melanoma or a history of cutaneous melanoma who had a complete physical skin exam performed at one or more office visits within 12 months</p>
<p>The following clinical recommendation statements are quoted <u>verbatim</u> from the referenced clinical guidelines and represent the evidence base for the measure:</p> <p>Routine interval follow-up physical examinations are recommended at least annually. (AAD) (Evidence level 1 and 2)¹</p> <p>For patients with stage IA melanoma, a comprehensive H&P (with specific emphasis on the regional nodes and skin) should be performed every 3 to 12 months as clinically indicated. For patients with stage IB-III melanomas, a comprehensive H&P (with emphasis on the regional nodes and skin) should be performed every 3 to 6 months for 3 years; then every 4 to 12 months for 2 years; and annually (at least) thereafter, as clinically indicated. (NCCN) (Level of Evidence - Category 2A)³</p>		

Rationale for the measure:

A complete skin examination should be performed to identify recurrences of melanoma; the genital area may be excluded per patient preference. Published literature suggests that a complete skin exam performed by a physician may result in identification of a second melanoma at an earlier stage, which positively impacts life expectancy and cost effectiveness, when compared with other screening strategies.^{4,5} Data elements required for the measure can be captured and the measure is actionable by the physician.

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Measure #3: Counseling on Self-Examination

This measure may be used as an Accountability measure.

Data Elements	Clinical Performance Measure	Feedback
<p>Per Patient, Per Year</p> <p>Yes/No – Patient was counseled to perform a self-examination for new or changing moles</p> <p>Yes/No – Documentation of medical reason(s) for not counseling the patient to perform a self-examination for new or changing moles</p> <p>Yes/No – Documentation of patient reason(s) for not counseling the patient to perform a self-examination for new or changing moles</p> <p>Yes/No – Documentation of system reason(s) for not counseling the patient to perform a self-examination for new or changing moles</p> <p>Sources</p> <p>Electronic medical record</p> <p>Paper medical record</p> <p>Flowsheet</p> <p>Administrative claims data*</p> <p><i>*adequate data source only if new codes are developed specific to the intent of this measure</i></p>	<p>Numerator: Patients who were counseled, at least once within 12 months, to perform a self-examination for new or changing moles</p> <p>Denominator: All patients with a current diagnosis of melanoma or a history of cutaneous melanoma</p> <p>Denominator Exclusions:</p> <p>Documentation of medical reason(s) for not counseling the patient to perform a self-examination</p> <p>Documentation of patient reason(s) for not counseling the patient to perform a self-examination</p> <p>Documentation of system reason(s) for not counseling the patient to perform a self-examination</p> <p>Measure: Percentage of patients with either a current diagnosis of melanoma or a history of cutaneous melanoma who were counseled, at least once within 12 months, to perform a self-examination for new or changing moles</p>	<p>Per Patient</p> <p>Whether or not the patient with either a current diagnosis of melanoma or a history of cutaneous melanoma was counseled, at least once within 12 months, to perform a self-examination for new or changing moles</p> <p>Per Patient Population</p> <p>Percentage of patients with either a current diagnosis of melanoma or a history of cutaneous melanoma who were counseled, at least once within 12 months, to perform a self-examination for new or changing moles</p>
<p>The following clinical recommendation statements are quoted <u>verbatim</u> from the referenced clinical guidelines and represent the evidence base for the measure:</p> <p>Patient education on self-examination of the skin and lymph nodes is recommended. (AAD) (Evidence level 3)¹</p> <p>All patients should be taught self-examination because many recurrences are found by patients themselves at home rather than by clinicians in the clinic. (BAD) (Not ranked)²</p>		

Rationale for the measure:

Significant opportunity exists to increase rates of patient self-examination. Educating patients to perform self-examinations will lead to earlier detection of secondary sites of melanoma. Data elements required for the measure can be captured and the measure is actionable by the physician.

EVIDENCE CLASSIFICATION/RATING SCHEME

American Academy of Dermatology (AAD) recommendation rating scale¹

Recommendations are based on:

- Unanimous task force opinion supported by strong to moderate levels of evidence
- Majority task force opinion supported by strong to moderate levels of evidence
- Unanimous task force opinion supported by limited or weak scientific evidence
- Majority task force opinion supported by limited or weak scientific evidence
- Unanimous task force opinion only
- Majority task force opinion only

Level of Evidence Rating

Strong: Based on high quality scientific evidence
Moderate: Based on good quality scientific evidence
Expert opinion: Based on limited scientific evidence and task force opinion
Clinical Option: Intervention that the task force failed to find compelling evidence for or against and that a reasonable provider might or might not wish to implement

Level of Evidence Criteria

- Attributes of Study on Diagnosis
 1. good diagnostic test
 2. good diagnostic criteria
 3. test and criteria reproducible
 4. proper patient selection
 5. at least 50 cases and 50 controls

Level 1 = all attributes 1-5; Level 2 = 4 of the 5 attributes; Level 3 = 3 of the 5 attributes; Level 4 = 2 of 5 attributes; Level 5 = 1 of 5 attributes

High quality evidence = Levels 1&2; Good quality evidence = Level 3; Limited evidence = Levels 4&5

- Attributes of Study on Prognosis ⁴³
 1. cohort
 2. good inclusion/exclusion criteria
 3. follow-up of a least 80%
 4. adjustment for confounders
 5. reproducible outcome measures

Level 1 = all attributes 1-5; Level 2 = attribute 1 + any 3 of attributes 2-5; Level 3 = attribute 1+ any 2 of attributes 2-5; Level 4 = attribute 1 + any 1 of attributes 2-5; Level 5 = attribute 1 and no other attributes; Level 6 = none of the attributes.

High quality evidence = Levels 1 & 2; Good quality evidence = Levels 3 & 4; Limited evidence = Level 5

- Levels of Evidence of Studies on Treatment and Prevention ⁴⁴
 1. Several randomized controlled trials (RCT) that demonstrate a significant difference
 2. An RCT that demonstrates a significant difference
 3. RCT showing some difference
 4. A nonrandomized controlled trial or subgroup analysis of an RCT

- 5. A comparison study with some kind of control/comparison
- 6. Case series without control
- 7. Case report with < 10 patients

High quality evidence = Levels 1, 2, or 3, Good quality evidence = Levels 4 or 5; Limited evidence = Levels 6 or 7

British Association of Dermatologists (BAD) recommendation rating scale²

Levels of Evidence

- Ia: Evidence obtained from meta-analysis of randomized controlled trials
- Ib: Evidence obtained from at least one randomized controlled trial
- IIa: Evidence obtained from at least one well-designed controlled study without randomization
- IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study
- III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies
- IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grades of Recommendations

- A. There is good evidence to support the use of the procedure.
- B. There is fair evidence to support the use of the procedure.
- C. There is poor evidence to support the use of the procedure.
- D. There is fair evidence to support the rejection of the use of the procedure.
- E. There is good evidence to support the rejection of the use of the procedure.

National Comprehensive Cancer Network (NCCN) Recommendation Rating Scale³

Category of Consensus	Quality of Evidence	Level of Consensus
1	High	Uniform
2A	Lower	Uniform
2B	Lower	Non-uniform
3	Any	Major disagreement

References

1. American Academy of Dermatology (AAD) Practice Management. Guidelines of care for primary cutaneous melanoma. Task Force: Sober AJ, Chuang T-Y, Duvic M, et al. Available at: www.aad.org/professionals/guidelines.
2. Roberts DL, Anstey AV, Barlow RJ, Cox NH, Newton Bishop JA, Corrie PG, Evans J, Gore ME, Hall PN, Kirkham N. U.K. guidelines for the management of cutaneous melanoma. *Br J Dermatol* 2002 Jan;146(1):7-17
3. National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Melanoma. 2006. Available at: www.nccn.org/professionals/physician_gls/default.asp.
4. DiFronzo et al. Earlier diagnosis of second primary melanoma confirms the benefits of patient education and routine post-operative follow-up. *Cancer* 2001 Apr 15; 91(8):1520-4.
5. Freedberg et al. Screening for malignant melanoma: a cost-effective analysis. *J Am Acad Dermatology* 1999 Nov; 41(5 Pt 1):738-45.