NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Cancer Standing Committee – Fall 2020 Topical Web Meeting

During the fall 2020 cycle, no measures were submitted for the Cancer Standing Committee to evaluate. Therefore, the National Quality Forum (NQF) convened the Cancer Standing Committee for a topical webinar on February 23, 2021.

Welcome, Introductions, and Review of Meeting Objectives

Matt Pickering, NQF senior director, welcomed the Cancer Standing Committee and participants to the web meeting. Dr. Pickering reviewed the meeting objectives and conducted the Standing Committee roll call. The purpose of this topical web meeting was to discuss the role of the Core Quality Measure Collaborative (CQMC), present an overview of the current NQF Cancer measure portfolio, and gain input from the Standing Committee on potential gaps in cancer quality performance measurement.

Topical Webinar Discussion

Nicolette Mehas, NQF senior director, presented a comprehensive overview of the CQMC, with an emphasis on the CQMC Medical Oncology workgroup's environmental scan and core measure set. The CQMC is a broad NQF membership-based and multistakeholder effort to identify core quality measure sets that primarily focus on outpatient and clinician-level measurement. Supported by America's Health Insurance Plans (AHIP) and the Centers for Medicare & Medicaid Services (CMS), CQMC aims to reduce the burden of measurement and align measures across public and private payers to achieve congruence in the measures being used for quality improvement, transparency, and payment purposes. The CQMC also works to prioritize measure gaps and has created an implementation guide to offer guidance on the dissemination and adoption of the newly identified core sets by healthcare providers.

Dr. Mehas further discussed the CQMC's core set for the Medical Oncology workgroup. The workgroup originally identified a number of high priority focus areas that are accompanied by measures within the core set, including breast cancer, colorectal cancer, prostate cancer, and hospice/end of life. These cancer measurement focus areas have recently been updated in 2020 to include admissions/readmissions, patient experience, and financial burden. Dr. Mehas discussed current gaps and measures under development for future core set inclusion. The Medical Oncology workgroup identified core set gaps in patient-reported outcomes and patient experience measures (e.g., symptoms, pain control, care coordination/ navigation, and education). The workgroup discussed ensuring that patients are a part of the accountability structure by eliciting information from them, without creating additional burden to patients. The Medical Oncology workgroup recognized the need for measures that reflect the molecular biology of cancer, interpretation of biomarkers, tumor information, and immunotherapy. It is important to conduct testing and to focus on how this information can be communicated across clinicians to improve treatment, patient outcomes, and quality of life. The Medical Oncology workgroup discussed measures related to telehealth, measures for shared decision making

(i.e., more than just a check box or simple process measure), and utilization (e.g., appropriate use of chemotherapy, emergency department (ED) use, and hospitalizations). The Medical Oncology workgroup also recognized the need for measures that capture cancer staging and cost measures. During the 2020 update, two measures were removed from the original core set, as one measure applied more to pathology and the second measure was no longer maintained (i.e., specifications and the measure overall have not been updated); both were either put on reserve status or not endorsed. Seven measures were added to the updated core set: five new measures and two electronic clinical quality measure (eCQM) versions of currently existing measures (NQF #0384 and NQF #0389). The five new measures filled gaps in patient care outcomes (e.g., patient-reported experience with care), resource utilization (e.g., unplanned hospitalization, ED use), and preventative care (e.g., preventative screening). Dr. Mehas explained the core principles that guide the selection of measures. The core principles state that measures should be person-centered and holistic; relevant, meaningful, and actionable; parsimonious, promoting alignment and efficiency; scientifically sound; balanced between burden and innovation; and unlikely to promote unintended adverse consequences.

During the discussion, a Standing Committee member asked about the impact of creating the core sets on the healthcare system. Dr. Mehas stated that the goal of the core sets is to promote alignment across private and public payers. Originally, the CQMC established a need for greater alignment across payers, specifically for measures used in alignment with clinician groups. Many of the measures are mainly tested at the clinician group-level, but Dr. Mehas stated that the core sets are not solely limited to clinician-level accountability. With respect to the core set and the measure selection principles, the Standing Committee expressed that a gap remains within quality measurement with further respect to identifying and improving disparities in care. Dr. Mehas noted that the CQMC has also recognized this gap. The CQMC looks at each individual measure and the different methods it uses to address patient risks. The CQMC does not change the specifications of the measure, but there is interest in further discussion on identifying what measures could address disparities within minority groups in the future. A Standing Committee member asked whether consumer groups and patient advocates had representation within the CQMC. Dr. Mehas stated that the CQMC has patient consumer groups that are represented by medical oncology and other CQMC workgroups.

Overall, the Standing Committee was very supportive of the CQMC's work, underscoring the importance of being proactive in advocating for the newly identified gap areas for measures to come into existence. It is important to be aware of additional concepts that are currently undeveloped yet meaningful and valuable. The Standing Committee stressed the importance of the relevance of measures used for quality improvement. A Standing Committee member shared that measures should not be created to meet a certain number but to consider the relevancy of the measures to certain groups. For example, instead of trying to achieve eight measures for an oncological surgical gap, in which only four of the measures are relevant, only include the four relevant measures instead of all eight of them. The Standing Committee member added that this is relevant for surgery across the board, not only oncological surgery.

Dr. Mehas noted the areas of opportunity for the future regarding greater alignment of cancer measures and programs. The CQMC workgroup recognized the need for greater coordination across the healthcare system (e.g., individual patient data, the use of different health information technology (IT) systems). There are statistical challenges that exist due to small sample size or specialty-/condition-specific measures that can be challenging to calculate. There are challenges surrounding multispecialty groups not having enough strong incentives to report oncology-specific measures. The Standing Committee further commented on the complexity and cost that go into developing measures. It is one thing to identify gaps, but to get someone to take on the cost, funding, and the search for consultants, and be

successful is very complex.

Measure Gap Discussion

After the CQMC discussion, Dr. Pickering transitioned to an overview of the Cancer measure portfolio. Dr. Pickering shared a review of the number and types of measures within the NQF Cancer portfolio from 2018 to 2020. During the 2018 cycle, the NQF Cancer portfolio contained 27 NQF-endorsed measures of different conditions, such as breast cancer, colon cancer, hematology, lung/thoracic cancer, prostate cancer, and general cancer. By 2020, the number had dropped to 18 NQF-endorsed measures under the conditions of breast cancer, colon cancer, prostate cancer, and general cancer. Dr. Pickering noted the potential reason for this decline: Measures have lost endorsement due to being withdrawn or for failing to meet certain NQF criteria, in addition to new measures not being submitted to the Standing Committee for endorsement consideration. Dr. Pickering stated that the current Cancer portfolio largely consists of process measures that are focused on the clinician/clinician group practice- and facility-levels of accountability.

The Standing Committee discussed the gaps within rehabilitation services, such as orthopedic rehabilitation services and postsurgical services. The Standing Committee agreed that this area needs measurement, as a wide variety of rehabilitation services are available that can lead to improved quality of life, the prevention of resource use (e.g., readmission to the hospital), and associated costs. The Standing Committee also discussed gaps in cancer survivorship/mortality. As more people survive cancer, extending issues arise after surviving, including but not limited to psychological and physical long-term effects (e.g., appropriate screening for long-term cardiac toxicities, chest wall radiation, cancer prevention, and cancer genetic screening). Additionally, such gaps underscore the importance of having patient advocates and representatives within the measure development process. The patient community (i.e., patients, caregivers, and advocates) should be included in determining what measures are important and meaningful to be developed. The Standing Committee suggested that CMS and NQF involve more patients in providing input on the conceptual development of measures. Dr. Pickering noted that NQF seeks patient representatives within measure endorsement, recognizing the importance of the perspectives and lived experiences that are shared. The Standing Committee also mentioned some limits in measure development that occurred for eCQMs due to data accessibility and accuracy and that NQF and CMS can advocate for improved data access and use for measurement.

Public Comment

Dr. Pickering opened the call for public comment. The Alliance of Dedicated Cancer Centers (ADDC) voiced a few comments in relation to the information presented. They expressed their high regards for the CQMC's gap area for future consideration of measure development, which they explained aligns with patient-reported outcomes and molecular biology. Additionally, they suggested examining oncology measures outside of the Cancer portfolio, as some oncology measures apply to other NQF portfolios. For example, the *30-Day With Cancer-Specific Readmission* measure was in the Readmissions folder, but it is also a cancer-specific measure. The ADDC also mentioned that there are palliative care measures in development titled *Heard and Understood* and *Did you Receive the Help you Acquired from Pain*. The ADDC stated that these two measures are current Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)-funded measures under development through a cooperative agreement with CMS. Lastly, the ADDC mentioned the ongoing challenges in disease stratification. These challenges receiving electronic staging, which in turn results with chart abstraction, a process in which important information is collected and transcribed from the patient's medical record. The ADDC mentioned that this becomes a major barrier in the eCQM field.

Next Steps

Karri Albanese, NQF analyst, noted that the “Intent to Submit” deadline for the spring 2021 cycle was January 5, 2021. One eCQM measure was submitted for the spring 2021 cycle. The full measure submission deadline is April 16, 2021. Dr. Pickering thanked the Standing Committee for their time and input and adjourned the call.