NATIONAL QUALITY FORUM
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Meeting Summary

Cancer Standing Committee—Measure Evaluation In-Person Meeting

The National Quality Forum (NQF) convened the Cancer Standing Committee for an in-person meeting on February 26, 2020 at the NQF offices in Washington, DC to evaluate nine measures.

Welcome, Introductions, and Review of Meeting Objectives

NQF welcomed the Standing Committee and participants to the in-person meeting. NQF staff reviewed the meeting objectives. Committee members each introduced themselves and disclosed any conflicts of interest; none were disclosed. Quorum was met and maintained throughout the in-person meeting. Three members left early, and the vote totals reflect the members present and eligible for each vote.

Topic Area Introduction and Overview of Evaluation Process

NQF staff provided an overview of the topic area and reviewed the Consensus Development Process (CDP) and the measure evaluation criteria. To maximize discussion time for the measure under review, these agenda items were intentionally brief.

Measure Evaluation

During the meeting, the Cancer Standing Committee evaluated nine measure for endorsement consideration. A summary of the Committee deliberations will be compiled and provided in the draft technical report. NQF will post the draft technical report on March 30, 2020 for public comment on the NQF website. The draft technical report will be posted for 30 calendar days.

Rating Scale: H – High; M – Medium; L – Low; I – Insufficient; NA – Not Applicable

1858 Trastuzumab administered to patients with AJCC stage I (T1c) – III human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy (American Society of Clinical Oncology)

Measure Steward/Developer Representatives at the Meeting

David Ryan, August Knape, Caitlin Drumheller (American Society of Clinical Oncology)

Standing Committee Votes

- Evidence: H-12; M-5; L-0; I-0
- Performance Gap: H-0; M-12; L-5; I-0
- Reliability: H-1; M-13; L-3; I-0
- Validity: H-14; M-3; L-0; I-0
- Feasibility: H-10; M-7; L-0; I-0
- Use: Pass-17; No Pass-1
- Usability: H-2; M-15; L-0; I-1

Standing Committee Recommendation for Endorsement: Yes-18; No-0

The Standing Committee recommended the measure for continued endorsement. The measure captures the percentage of female patients aged 18 and over with HER2/neu positive invasive breast cancer who were administered trastuzumab.

The Committee noted that this measure represents a standard of cancer care measure that remains relevant for measurement. There was mention of the measure being topped out for performance gap as the 2017 QPP (quality payment program) data on this measure indicates the performance rate is 97.5%. However, the Committee expressed strong views on the importance of this measure and cited that gaps persist in the medical literature. The developer offered that this measure focuses on the importance of making sure records connect in order to get the necessary information to the physician in a timely manner and if this is lacking, it could be an indication of a larger systems issue rather than a physician's lack of adherence to guidelines.

The Committee discussed the age range for the measure, noting that the measure should consider an upper bound in which treatment would stop. The developer noted that another measure is in development that will specify an age cut off for treatment. The Committee discussed the lack of data on minority populations, noting concerns that the performance rates may mask underlying disparities.

When discussing the reliability of the measure, the Committee revisited the concern of data granularity and the level of testing for the measure specifications was mentioned. The developer computed signal-to-noise scores to address precision of measurement (measure score) and used a beta-binomial model. There was concern raised by one committee member about a statement in the denominator exclusions which state - *Reason for not administering trastuzumab documented (e.g. patient declined, patient died, patient transferred, contraindication or other clinical exclusion, neoadjuvant chemotherapy or radiation therapy not complete).* Specifically, the concern was that this statement gave the impression that physicians can give any reason at all for not administering Trastuzumab and be excluded from the denominator. The Committee urged the developer to think about this exclusion as they are developing a new measure.

The Committee reviewed and discussed the remaining evaluation criterion – validity, feasibility, use, and usability and did not express any concerns.

1859 RAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy (American Society of Clinical Oncology)

Measure Steward/Developer Representatives at the Meeting

David Ryan, August Knape, Caitlin Drumheller (American Society of Clinical Oncology)

Standing Committee Votes

- Evidence: H-4; M-13; L-1; I-0
- Performance Gap: H-7; M-10; L-1; I-0
- Reliability: H-2; M-14; L-2; I-0
- Validity: H-2; M-13; L-3; I-0
- Feasibility: H-1; M-17; L-0; I-0
- Use: Pass-18; No Pass-0

- Usability: H-4; M-12; L-1; I-1

Standing Committee Recommendation for Endorsement: Yes-16; No-2

The Standing Committee recommended the measure for continued endorsement. The measure captures the percentage of adult patients (aged 18 and over) with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy for whom RAS (KRAS and NRAS) gene mutation testing was performed.

The Committee reviewed the updated evidence, specifically the guidelines used to support it – an American Society of Clinical Oncology recommendation and National Comprehensive Cancer Network guideline on colon cancer. One Committee member mentioned that the evidence provided by the developer seems to be indirect support of this measure since it is focused on whether a test was performed. The developer responded citing that there is a need for this testing and the current evidence supports those with a KRAS gene mutation receiving anti-epidermal growth factor receptor monoclonal antibody therapy, and patients without a KRAS gene mutation are actually harmed by this treatment. This led to the development of a second measure (#1860) to address this difference. There was overall consensus among the Committee that data showed a persistent performance gap.

During the discussion on reliability, the developer clarified that the scientific acceptability numbers in the preliminary analysis were accidently transposed from measure #1860, but that this issue is being fixed. Committee comments indicated they were comfortable with the reliability and testing.

During the discussion of validity, the Committee expressed a concern with the numerator of the measure of whether RAS gene mutation testing was performed. The measure is capturing a process that may not be sufficiently granular enough to ensure that the molecular test identifies the important mutations for the treatment of colon cancer. While the Committee agreed that the issue of the granularity of the measurement is a challenge, the measure still does address an important quality goal in the treatment of cancer.

The Committee agreed that since this measure is reported, the measure is feasible. The Committee also agreed that use and usability are not issues for this measure.

1860 Patients with metastatic colorectal cancer and RAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies (American Society of Clinical Oncology)

Measure Steward/Developer Representatives at the Meeting

David Ryan, August Knape, Caitlin Drumheller (American Society of Clinical Oncology)

Standing Committee Votes

- Evidence: H-11; M-6; L-0; I-0
- Performance Gap: H-15; M-3; L-0; I-0
- Reliability: H-10; M-8; L-0; I-0
- Validity: H-12; M-6; L-0; I-0
- Feasibility: H-1; M-17; L-0; I-0
- Use: Pass-17; No Pass-1

- Usability: H-2; M-15; L-1; I-0

Standing Committee Recommendation for Endorsement: Yes-17; No-1

The Standing Committee recommended the measure for continued endorsement. This measure captures the percentage of patients with metastatic colorectal cancer and RAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies. The Committee generally agreed that sufficient evidence was provided for this measure and the discussion of measure 1859 on evidence would apply to this measure as well. It was acknowledged that this measure was a companion measure to 1859, the difference being that treatment is not administered for patient who is positive for the KRASG mutation. There was not much discussion on performance gap as it appears to be 91% and the Committee noted room for improvement.

During the discussion on reliability, one Committee member asked about patient re-test and whether a former test for NGS tumor would be applicable for this measure. The Committee discussed the probability of Medicaid covering the cost for more than one test for each NGS tumor and the potential risk of financial burden for a patient. The Committee did not express any significant concerns or comments on validity.

When discussing feasibility, the Committee noted that the data to support this measure is not structured in the Electronic Health Record (EHR) and requires abstraction, and questioned why this measure was not an eCQM, which may improve feasibility. The developer informed the Committee that not all EHRs are able to accommodate this but as the technology becomes more widely available, they intend for the measure to move in that direction. It was noted by the Committee that this measure is currently used in various accountability programs and the benefits outweigh the harms.

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0383 Oncology: Medical and Radiation – Plan of Care for Pain (American Society of Clinical Oncology)

Measure Steward/Developer Representatives at the Meeting

David Ryan, August Knape, Caitlin Drumheller (American Society of Clinical Oncology)

Standing Committee Votes

- Evidence: M-3; L-4; I-11
- Performance Gap: H-1; M-13; L-3; I-0
- Reliability: H-1; M-13; L-3; I-0
- Validity: H-1; M-14; L-2; I-0
- Feasibility: H-0; M-13; L-5; I-0
- Use: Pass-18; No Pass-0
- Usability: H-1; M-13; L-3; I-1

Standing Committee Recommendation for Endorsement: Yes-15; No-2

The Standing Committee recommended the measure for continued endorsement. This measure captures the percentage of visits for patients, regardless of age, with a diagnosis of cancer currently

receiving chemotherapy or radiation therapy who report having pain with a documented plan of care to address pain.

The Committee agreed that there was clear evidence for the importance of addressing pain and having a plan of care, but that the evidence provided does not directly relate to the measure as stated. To meet NQF's standard measure criteria, a process measure must include a systematic assessment and grading of the quality, quality and consistency of the body of evidence that the measured process leads to a desired health outcome. According to NQF measure criteria, if a measure does not include a systematic review of the evidence, the Committee may choose to consider it as having an exception to evidence requirement. The Committee acknowledged that commonly, Level 1 guidelines are related to randomized control trials (RCT), but it would be unethical to have an RCT for patients who are experiencing pain, so the highest level of guideline rating is 2A (weak recommendation; benefits closely balanced with risks and burdens). The Committee agreed that the information presented to support evidence did not show that the measured process leads to a desired health outcome and therefore the measure was rated insufficient on evidence. The Committee then voted to pass the measure on evidence with exception to evidence. The Committee determined there is consensus of expert opinion that the benefits of what is being measured (documented plan of care to address pain) outweighs any potential harm.

For performance gap, the Committee noted that the developer provided data from the literature clearly demonstrating that patients with cancer receive disparate treatment across groupings.

The Committee also had no concerns about the reliability or validity of the measure. During the discussion on feasibility, the Committee noted the difficulty with extracting the information from an EHR, since there is no designated field. Traditionally the extraction is completed through audits. Another member noted that this has been a challenging measure to measure consistently. The Committee noted that it could be extremely difficult to get accurate number of visits, however, one unforeseen benefit is that practices are improving their electronic infrastructure to accurately capture this documentation. However, the committee overall agreed that the measure was feasible to report and passed it on feasibility.

This measure is currently being publicly reported in the Merit-based Incentive Payment System (MIPS) and in the Prospective Payment System-exempt Cancer Hospital Quality Reporting Program, and the Committee expressed no concerns about the use of the measure. When discussing usability, the Committee noted the dangers of opioid prescribing patterns associated with this measure and suggested a future version of the measure might consider the distinction between pain in patients with an incurable cancer versus a curable cancer. Patient representatives on the Committee also noted the importance of providing better patient education about medications prescribed to them.

The Committee also discussed whether there was a way to create a unified measure between 0383 and 0384, as a composite measure. The developer clarified that this is an area of interest but might be procedurally challenging as these measures return for maintenance and are related but no longer paired, and there is no current data for testing on such a composite.

0384 Oncology: Medical and Radiation – Pain Intensity Quantified (PCPI)

Measure Steward/Developer Representatives at the Meeting

Elvia Chavarria, Paul Wallner, Heather Tinsley, Jamie Lehner (PCPI)

Standing Committee Votes

- Evidence: M-11; L-6; I-1
- Performance Gap: H-0; M-15; L-3; I-0
- Reliability: H-0; M-16; L-2; I-0
- Validity: H-0; M-16; L-2; I-0
- Feasibility: H-0; M-17; L-1; I-0
- Use: Pass-18; No Pass-0
- Usability: H-0; M-14; L-3; I-1

Standing Committee Recommendation for Endorsement: Vote Postponed – Overall Suitability for Endorsement

This measure captures the percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

Since the evidence is the same for 0384 and 0384e, the discussion on evidence and vote from 0384e can be applied to 0384. During Standing Committee's discussion on 0384e, they mentioned when measuring whether the plan of care is completed focuses on the provider, whereas measuring whether the pain is assessed and documented is focused on the performance of the health system. These are inter-related, but also acknowledged different processes.

It was noted that measure 0384e, similar to 0384, is a quantified measure that allows for the quantification of pain, which then can lead to an action plan for addressing that pain. One Committee member mentioned how pain can often be subjective and many times hard to measure. Patients may experience unrelated pain but still report this patient if asked. In addition, the intensity of pain may vary particularly since there is no validated pain score. Ultimately, the Committee agreed it was vital to quantify pain and passed 0384e on evidence.

The Standing Committee noted that this measure, similar to all measures discussed up to that point, is lacking in disparities data. While the Developer reiterated that disparities data is not available from the data source they used, the Committee still wished to note that the literature demonstrates there is a disparity gap, and the lack of disparities data is a larger problem that must be addressed in the future.

During the discussion on validity, the Standing Committee expressed concern that the measure exclusions remove a significant number of people from the denominator. The evidence base for this measure is specific to all patients with cancer, but this measure excludes patients who are not actively receiving chemotherapy and radiation treatment. The Committee was concerned that this presented a threat to validity.

The Standing Committee vote for overall suitability for endorsement was postponed due to a process error during the discussion of the evidence criterion. The Committee will vote on the measure on the post-comment web meeting on May 12, 2020.

0384e Oncology: Medical and Radiation – Pain Intensity Quantified (PCPI)

Measure Steward/Developer Representatives at the Meeting

Elvia Chavarria, Paul Wallner, Heather Tinsley, Jamie Lehner (PCPI)

Standing Committee Votes

- Evidence: M-11; L-6; I-1
- Performance Gap: H-2; M-14; L-2; I-0
- Reliability: H-0; M-16; L-2; I-0
- Validity: H-0; M-8; L-7; I-3
- Feasibility: H-0; M-8; L-8; I-1
- Use: Pass-13; No Pass-5
- Usability: H-0; M-10; L-7; I-1

Standing Committee Recommendation for Endorsement: Consensus Not Reached

This measure captures the percentage of patient visits, regardless of patient age, with a diagnosis of cancer currently receiving chemotherapy or radiation therapy in which pain intensity is quantified

At the start of discussion, NQF clarified that there were updates to the measure performance gap and testing that were not included in the measure form due to technical errors. The updated data on performance gap and reliability and validity testing was shared with the Committee the day before the meeting and the Developer provided a recap of the updated data. In addition, NQF provided clarification on the staff ratings that were present on the preliminary analysis. These ratings were based on inaccurate information and therefore should not be considered during the Committee discussion.

The Standing Committee began their discussion by acknowledging the relationship between 0383 and 0384 (and thus 0348e). Specifically, they mentioned that when measuring whether the plan of care is completed focuses on the provider, whereas measuring whether the pain is assessed and documented is focused on the performance of the health system. These are inter-related, but also acknowledged different processes.

It was noted that measure 0384e is a quantified measure that allows for the quantification of pain, which then can lead to an action plan for addressing that pain. One Committee member mentioned how pain can often be subjective and many times hard to measure. Patients may experience unrelated pain but still report if asked. In addition, the intensity of pain may vary particularly since there is no validated pain score. Ultimately, the Committee agreed it was vital to quantify pain and passed this measure on evidence.

During the discussion on reliability, the PQRS EHR data set was mentioned and how it may differ from actual data from an active EHR system. The developer noted that the PQRS data set provides a mix of data across multiple EHR vendors. It was noted by the Committee that a signal-to-noise analysis was completed for the reliability of this measure, and for providers that had at least one eligible patient, the reliability came to be 0.96.

During the discussion of validity, the Committee discussed the correlation analysis between the eCQM and another process measure and the exclusions for this measure. Specifically, they questioned whether a hormonal therapy measure was the best choice for testing validity of a pain quantification measure. The developer mentioned that measure selection for a comparative analysis of an eCQM is often limited and they choose a measure that would be reported in a similar manner – e.g., similar diagnosis and face-to-face encounter. Additionally, the Committee questioned whether patients who opt out of chemotherapy and experience pain would be captured by the measure. Clarification was provided by the developer that the patient population was divided into two groups – those receiving chemotherapy or radiation therapy and had a face to face encounter with the provider 30 days before OR 30 days after that visit. This measure also accounts for different types of chemotherapy administration.

The feasibility of the data elements also came up as a point of clarification and the measure developer mentioned that the test sites were radiation oncology clinics and could capture the elements related to radiation and not chemotherapy. The Committee also expressed concerns regarding the use of billing codes as they believe there to be insufficient difference in codes between types of chemotherapy. Overall, the Committee agreed that this topic was important to measure but was concerned that issues remained with the mode of measurement.

During the discussion on use and usability, it was noted that the measure is currently included in the Merit-based Incentive Payment System (MIPS). The Committee agreed the measure use was appropriate and expressed no concerns with usability.

The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on validity—a must-pass criterion. The Committee will re-vote on the measure on the post-comment web meeting on May 12, 2020.

0219 Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer (Commission on Cancer)

Measure Steward/Developer Representatives at the Meeting

Bryan Palis and Ryan McCabe (Commission on Cancer)

Standing Committee Votes

- Evidence: M-15; L-0; I-0
- Performance Gap: H-2; M-12; L-1; I-0
- Reliability: H-3; M-12; L-0; I-0
- Validity: M-14; L-1; I-0
- Feasibility: H-9; M-6; L-0; I-0
- Use: Pass-15; No Pass-0
- Usability: H-12; M-3; L-0; I-0

Standing Committee Recommendation for Endorsement: Yes-15; No-0

The Standing Committee recommended the measure for continued endorsement. The measure captures the percentage of female patients, age = 18 and <70 at diagnosis, who have their first diagnosis of cancer (epithelial malignancy), whose primary tumor is of the breast, had breast conserving surgery and was administered radiation therapy within 1 year of diagnosis.

The Committee had no concerns about evidence since it had not changed since the last review and chose not to discuss it further. With regards to performance gap, the Committee noted that it's clear significant progress in performance has been made since the last review. Disparities related to race/ethnicity and insurance status persist, so there is still a viable performance gap. The Committee had no concerns with reliability.

For validity, measure score testing was not performed by the developer so the highest rating available to the Committee was 'moderate.' The Committee did not have any concerns with the measure's validity. Concerning feasibility, the Committee noted that this data is regularly generated by any facility with a cancer registry. The concern would be a smaller hospital that might not have a registry. The Committee inquired on whether this measure was limited to National Cancer Database hospitals. The Developer clarified that a benefit of being part of the Commission on Cancer (COC) is they report back to COC programs, but that the measure specifications can be applied to any registry data, regardless of whether it is from a reporting hospital. The Committee had no further questions on feasibility.

The Committee also had no issues with the use of this measure as it is currently publicly reported and used in a number of accountability programs. They likewise had no concerns about the usability of this measure and noted being able to see improvement as the measure is having an effect.

0220 Adjuvant hormonal therapy is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0 or Stage IB – Stage III hormone receptor positive breast cancer (Commission on Cancer)

Measure Steward/Developer Representatives at the Meeting

Bryan Palis and Ryan McCabe (Commission on Cancer)

Standing Committee Votes

- Evidence: M-18; L-0; I-0
- Performance Gap: H-3; M-14; L-1; I-0
- Reliability: H-2; M-16; L-0; I-0
- Validity: H-5; M-12; L-0; I-0
- Feasibility: H-9; M-7; L-0; I-0
- Use: Pass-16; No Pass-0
- Usability: H-10; M-6; L-0; I-0

Standing Committee Recommendation for Endorsement: Yes-16; No-0

The Standing Committee recommended the measure for continued endorsement. The measure captures the percentage of female patients, age = 18 at diagnosis, who have their first diagnosis of cancer (epithelial malignancy), at AJCC T1cN0M0 or stage IB to IIIC, whose primary tumor is of the breast, and is progesterone or estrogen receptor positive with adjuvant hormonal therapy within 1 year of diagnosis

The Committee agreed that there has been no change in evidence since the last evaluation. Although the performance data from the National Cancer Database is from 2015, the Committee accepted the developer's justification that a lag exists in data collection because it takes longer to document receipt of adjuvant therapy. Committee members noted although the performance gap is fairly narrow, the data from 2008 and 2015 demonstrate improvement over time and disparities exist based on race and

ethnicity, age, insurance status, income, educational level, facility type, and region of the country. The Committee agreed there is continuing gap in performance that justifies ongoing performance measurement and reporting. The Committee was pleased that the National Cancer Database used by the developer contained disparities data, including race/ethnicity data and insurance data, and encouraged other developers to take note.

The Committee did not have any concerns with the reliability or validity of this measure and did not have substantial discussion regarding these subcriteria. The Committee agreed that the measure remains feasible for Commission on Cancer (CoC) accredited hospitals, though it may not be as feasible for non-CoC accredited centers. The Committee had no concerns with the use or usability of this measure as it is currently used in accountability programs.

0223 Adjuvant chemotherapy is recommended, or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer (Commission on Cancer)

Measure Steward/Developer Representatives at the Meeting

Bryan Palis and Ryan McCabe (Commission on Cancer)

Standing Committee Votes

- Evidence: M-15; L-0; I-0
- Performance Gap: H-5; M-10; L-0; I-0
- Reliability: H-1; M-13; L-1; I-0
- Validity: M-9; L-4; I-2
- Feasibility: H-3; M-12; L-0; I-0
- Use: Pass-15; No Pass-0
- Usability: H-2; M-13; L-0; I-0

Standing Committee Recommendation for Endorsement: Consensus Not Reached

The measure captures the percentage of patients, age equal to 18 and less than 80 at diagnosis, who have their first diagnosis of cancer that is lymph node positive and at AJCC stage III, whose primary tumor is of the colon and chemotherapy was recommended or administered within 4 months of diagnosis.The Committee thought the evidence base for this measure was strong and had no concerns. Similar to the other CoC measures, the Committee noted an improvement in performance in this measure since last review. However, the Committee noted that there continues to be room for improvement and improvement in disparities across racial and ethnic groups. There were no concerns on performance gap.

The Committee noted that reliability was lower in hospitals with fewer than five cases per year. The Developer agreed that case volume was primarily driving the testing model results, that hospitals with more cases had greater reliability, and that performance variability across hospitals was factored into their results.

For validity, the NQF measure evaluation criteria states that testing must be completed on critical data elements and therefore the measure was rated as insufficient. The developer confirmed this but explained that CoC does not do any re-abstraction to assess validity in this instance. While the Committee comments indicated that they were, in general, comfortable with the validity of this

measure, they had reservations passing this measure on validity when no testing information was supplied to support them doing so, resulting in a consensus not reached vote.

The Committee noted that this measure has been in use for many years, and data elements are routinely collected during care delivery and are available on the EHR. They had no concerns with the feasibility of this measure. The Committee also had no concerns with the use or usability of this measure.

The Standing Committee did not vote on the recommendation for endorsement at the meeting because the Committee did not reach consensus on scientific acceptability (validity)—a must-pass criterion. The Committee will re-vote on the measure on the post-comment web meeting on May 12, 2020.

Public Comment

No public or NQF member comments were provided during the measure evaluation meeting.

Next Steps

NQF will post the draft technical report on March 30, 2020 for public comment for 30 calendar days. The continuous public comment with member support will close on April 28, 2020. NQF will re-convene the Standing Committee for the post-comment web meeting on May 12, 2020.