NATIONAL QUALITY FORUM

Meeting Summary

Cancer Standing Committee Measure Evaluation Web Meeting

The National Quality Forum (NQF) convened the Cancer Standing Committee for a web meeting on July 13, 2018 to evaluate one cancer measure.

Welcome, Introductions, and Review of Meeting Objectives

NQF welcomed the Standing Committee and participants to the web meeting. NQF staff reviewed the meeting objectives. Committee members each introduced themselves and disclosed any conflicts of interest.

Topic Area Introduction and Overview of Evaluation Process

NQF staff provided an overview of the topic area and the current NQF portfolio of endorsed measures. Additionally, NQF reviewed the Consensus Development Process (CDP) and the measure evaluation criteria.

Measure Evaluation

During the meeting, the Cancer Standing Committee evaluated one new measure for endorsement consideration. A summary of the Committee deliberations will be compiled and provided in the draft technical report, which will be posted to the NQF website in August. As of June 19, 2018, no comments were submitted on the measure under review.

Measure Evaluation Criteria Rating Key: H – High; M – Medium; L – Low; I – Insufficient

3365e Treatment of Osteopenia or Osteoporosis in Men with Non-Metastatic Prostate Cancer on Androgen Deprivation Therapy (Large Urology Group Practice Association [LUGPA])

This is an electronic clinical quality measure (eCQM)

Measure Steward/Developer Representatives at the Meeting

- Colleen Parker (Oregon Urology)
- Rachel Buchanan (Oregon Urology)

Standing Committee Votes

- Evidence: H-0; M-13; L-0; I-1
    - The Committee noted that there was ample evidence that androgen deprivation therapy (ADT) contributes to loss of bone density, which in turn increases the risk of bone fracture. They also noted that the evidence underlying the National Comprehensive Care Network (NCCN) guideline and citations submitted with the measure appear sufficient to support the measure and link it to preferred patient outcomes, i.e., a relationship between initiation of osteoporosis/osteopenia treatment and the bone health of patients with prostate cancer undergoing ADT. The evidence applies to the treatment of osteopenia or osteoporosis in men with non-metastatic prostate cancer receiving ADT.

  - The Committee noted that if a patient has already received a DEXA scan and a diagnosis of osteoporosis/osteopenia they would already be aware that they are at high risk for bone loss and bone fracture.
  - The Committee noted that urologists typically treat early stage prostate cancer patients. These physicians may be less used to giving chronic therapies to their early stage patients than physicians who have more experience providing long-term care treating patients who present at a general oncology office
- Performance Gap: H-6; M-7; L-1; I-0
  - The Committee noted that ordering DEXA scans is not a normal practice within urology practices. They are treating early stage prostate cancer and are given ADT, but they do not typically provide care to treat osteoporosis/osteopenia. The Committee noted the importance of this measure, especially when paired with a screening measure.
  - The Committee noted that unless there is a mandated consult to medical oncology—as there might be in large teaching hospital—it is unlikely that most patients will receive appropriate care (i.e., treatment with bisphosphonates or denosumab) when treated in the community or in local urology practices. This indicates a large gap in performance.
  - The Committee discussed information presented by the developer, which stated that men on ADT have between a 9 to 53 percent risk of osteoporosis and that testing and/or treatment of osteoporosis/osteopenia ranges from 9 to 59 percent. On average, less than 25 percent of the patients received appropriate care.
  - The Committee noted that the provided figures suggest a high incidence of patients not receiving recommended care and a high incidence of poor performance. The developers presented an analysis of two large databases (one urology group, LUGPA, and the other a radiation oncology group). The analysis involved chart abstraction of the electronic data. Group 1 demonstrated an average performance rate of 47.91 percent with a range from 0 to 87 percent among 11 clinicians. Group 2 had only one clinician reviewed with 0 percent compliance.
  - The Committee asked if there was stronger evidence that untreated osteoporosis/osteopenia prostate cancer patients on ADT is a widespread issue across urology practices in the United States. They noted concerns that the specifications used in the measure were general recommendations and that all NCCN recommendations were considered to be of 2A grade unless otherwise noted. The Committee also noted concerns that the two studies were representative of a larger set of urology practices, given that Committee experience indicated that urologists are routinely ordering DEXA scans.
- Reliability: *[No vote was to be taken on reliability, as empirical validity of testing data was conducted. Per NQF guidance, the Committee used the rating from patient-level data element validity testing and applied the vote for both reliability and validity.]*
  - The Committee noted concerns regarding the multiple components needed for patients to be considered in the numerator: all male patients with a diagnosis of non-metastatic prostate cancer, on ADT, and diagnosed with osteoporosis or osteopenia though a DEXA scan. To further qualify for the numerator, patients

must have an order for or be taking bisphosphonates or denosumab, have a vitamin D and calcium level completed prior to the start of treatments, and currently be taking calcium and vitamin D.

- The Committee noted that the measure is set up as an eCQM, and that all of the components are retrievable through the electronic health record. The three exceptions (patients on comfort measures, dental issues, or patient refusal) may not be captured but may represent a minority of patients.
- The Committee noted concerns that patients that are contraindicated should be excluded from both the numerator and the denominator—since they would never be eligible for the numerator. The Committee also noted that these exclusions are relatively rare.
- Radiation of the jaw is included as an exclusion, as it can lead to osteonecrosis of the jaw. For this reason patients must receive a dental clearance before receiving ADT.
- The Committee members believed that there was substantial ambiguity in the measure specifications that may lead to differing interpretations between practices and difficulty making comparisons.
- The Committee noted that some of the electronic elements are data that are derived electronically from an online form and some are derived from billing codes. In order to participate in the measure, a practice would need to develop the infrastructure in order to pull all of the required data.
- Committee members questioned the clarity of the specifications, because additional explanation and qualification from the developer was needed in order to understand the measure. As a result, Committee members noted that the measure is insufficient as currently presented and may lead to differences in implementation. The developer noted that ADT needed to be used for 12 months, but this was not clearly stated in the specifications.
- The NQF staff clarified that the Committee would be voting on the measure as currently specified, but that the Committee could provide recommendations to the developer to include in the measure to help clarify the the specifications.
- The Committee made a motion to decide whether to continue discussion and voting on the measure. Committee members noted their support of the measure's concept and intent, but were concerned that the specifications were not clear as currently written. The Committee voted to stop voting.
    - **Continue Voting-5; Stop Voting-8**
- The Committee recommended that the developer simplify the measure description and restate the numerator and denominator in plain language.
- The developer suggested that it clarify vitamin D levels (Moderate, Low, and High).
- Additional data are not needed, but wording clarification is needed. The Committee noted support of the measure, but noted that there was a high level of misunderstanding of the measure specification that made it difficult for the Committee to understand what they are voting on.
- The Committee noted concern that several of the data elements may be challenging to abstract and expressed confusion over how the feasibility scorecard scores are obtained.

Standing Committee Recommendation for Endorsement

Because the Standing Committee agreed to stop voting on the measure's validity—a must-pass criterion—the Committee did not vote on the measure's overall endorsement. During the meeting, the measure developer withdrew the measure from this cycle and stated its intention to resubmit the measure for consideration by the Cancer Standing Committee during the fall 2018 measure evaluation cycle.

Public Comment

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

Next Steps

NQF will post the technical report in August 2018.