NATIONAL QUALITY FORUM

CALL FOR NOMINATIONS TO STEERING COMMITTEE

Cancer Endorsement Maintenance Project 2011

Cancer refers to a group of more than 100 diseases characterized by uncontrolled cellular growth, proliferation, and spread.[1] This group of diseases has an enormous impact on health in the United States. As the second leading cause of death, cancer was responsible for an estimated 569,490 deaths among adults and children in 2010.[2] The American Cancer Institute estimates that half of all men and one-third of all women in the United States will develop cancer during their lifetimes. Diagnosing and treating cancer also has great economic impact. In 2010, the estimated total annual costs of cancer reached $263.8 billion: $102.8 billion in direct medical costs, $20.9 billion in loss of productivity from illness, and $140.1 billion in lost productivity from premature death.[3] Despite enormous focus on preventing and treating disease, inconsistencies in cancer care exist, with many patients not receiving care that follows clinical practice guidelines.[4] Studies demonstrate persistent socioeconomic disparities in treatment and survival for many different types of cancer, including gastric, breast, prostate, and lung cancers.[5,6,7,8]

Cancer care is complicated for many reasons: treatment regimens are complex, often involving multiple providers, settings of care, and levels of treatment; patients with cancer often require individualized therapies; an evolving evidence base for treatment exists; and care can be hampered by a sometimes limited supply of highly specialized personnel or technologies. Efforts to measure cancer quality can be complicated further by several factors, some of which include:

- ***Treatment-related factors***, including: the inability to identify a standard of care because resources to treat cancer vary regionally; the continuing evolution of the evidence base for cancer care; disagreements over a definition of optimal care; and patient preference for care;
- ***Measure implementation factors***, including: which institution or provider is responsible for quality measurement; and
- ***Measure design factors***, including: given the complexity of care, valid measures might be applicable only to small numbers of patients; and measures functioning across different settings (care coordination measures) are lacking.

This project seeks to identify and endorse performance measures for public reporting and quality improvement that specifically address quality of cancer care.

Additionally, 29 cancer-related consensus standards endorsed by NQF before December 2009 also will be evaluated under the maintenance process.

BACKGROUND

NQF reviewed areas for measurement in 2002, and in 2008 commissioned a white paper discussing the current state of cancer quality measurement and provided opportunities for next steps in measurement.[9] NQF later endorsed 19 performance measures for gauging the quality of

cancer care in the areas of breast cancer, colorectal cancer and symptom management, and end-of-life care.[10]

This project builds on earlier NQF work under the Cancer Quality Measures Project and seeks to identify and endorse additional measures for accountability and quality improvement related to cancer care.

STEERING COMMITTEE

A multi-stakeholder Steering Committee will oversee the development of a draft consensus report that will include recommendations for which measures should be endorsed as consensus standards. The draft consensus report also will include recommendations for measures undergoing maintenance that should continue as endorsed consensus standards. The Steering Committee membership should reflect expertise in quality of cancer care in any type of cancer care including, but not limited to, the areas of breast cancer, colorectal cancer and symptom management, and end-of-life care. Nominees should possess relevant knowledge and/or proficiency in process and outcome quality measurement. We are also seeking nominees with expertise in disparities and care of vulnerable populations.

Steering Committee members should not have a vested interest in the candidate measures. This includes employees or contractors of measure owners/developers, members of workgroups that developed the measures, and members of committees that approve measures or direct or set policy for measure development. Please see the NQF website for additional information about the conflict of interest policy. All potential Steering Committee members must disclose any current and past activities during the nomination process.

The Steering Committee will work with NQF staff to develop specific project plans, provide advice about the subject, ensure input is obtained from relevant stakeholders, review draft products, and recommend specific measures and research priorities to NQF Members for consideration under the Consensus Development Process.

TIME COMMITMENT

The Steering Committee will meet in person for a two-day meeting on March 13-14, 2012, in Washington, DC. Committee members must be available to attend the meeting. Steering Committee members will be assigned to work groups that will meet via conference call during the last two weeks of February 2012. Additionally, Steering Committee members will meet two to three times by conference call for two hours each and be will asked to review materials and provide feedback throughout the process. Additional conference calls may be needed. The introductory orientation call is mandatory for all Steering Committee members and is scheduled for **January 11, 2012, from 2:00-4:00 pm ET**. An optional conference call will be held on **January 30, 2012, from 2:00-4:00 pm ET** to address Committee members' questions about measure evaluation as they review the measures before the in-person meeting. There will be a mandatory post-comment period conference call on **May 22, 2012, from 2:00-4:00 pm ET** to discuss the comments received on the measures and the responses.

CONSIDERATION AND SUBSTITUTION

Priority will be given to nominations from NQF Members. Please note that nominations are to an individual, not an organization, so "substitutions" of other individuals from an organization at conference calls are not permitted.

MATERIAL TO SUBMIT

Self-nominations are welcome. Third-party nominations must indicate that the individual has been contacted and is willing to serve. To be considered for appointment to the Steering Committee, please send the following information:

- a completed nomination form;
- confirmation of availability to participate in the orientation call on January 11, 2012; the March 13-14, 2012, in-person meeting; and the May 22, 2012, post-comment period call;
- a 2-page letter of interest and a short biography (750 characters), highlighting experience/knowledge relevant to the expertise described above and involvement in candidate measure development;
- curriculum vitae or list of relevant experience (e.g., publications) *up to 20 pages*; and
- a completed conflict of interest form.

Materials should be submitted through the project page on the NQF website.

DEADLINE FOR SUBMISSION

All nominations *MUST* be submitted by **6:00 pm ET on Monday, November 14, 2011.**

QUESTIONS

If you have any questions, please contact Angela Franklin, JD; Lindsey Tighe, MS; or Gene Cunningham, MS, at 202-783-1300 or via email at cancerem@qualityforum.org. Thank you for your assistance.

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[1] U.S. Department of Health and Human Services (HHS), National Institutes of Health (NIH), National Cancer Institute (NCI), *Defining Cancer*. Updated 07/12/2010. Bethesda, MD: NCI; 2010. Available at www.cancer.gov/cancertopics/cancerlibrary/what-is-cancer. Last accessed February 2011.

[2] American Cancer Society. *Cancer Facts & Figures 2010*. Atlanta, GA. 2009. Last Medical Review: 05/20/2009. Last Revised: 05/20/2009. Available at http://www.cancer.org/Research/CancerFactsFigures/CancerFactsFigures/cancer-facts-and-figures-2010. Last accessed February 2011.

[3] Ibid.

[4] McGlynn EA, Asch SM, Adams J, et al., The quality of health care delivered to adults in the United States [see comment], *New Engl J Med*, 2003;348(26):2635-2645, and Harlan LC, Greene AL, Clegg LX, et al., Insurance status and the use of guideline therapy in the treatment of selected cancers, [see comment], *J Clin Oncol*, 2005;23(36):9079-9088, as cited in National Quality Forum (NQF), *The Current State of Cancer Quality Measurement 2008: A White Paper*. Washington, DC: NQF; 2008.

[5] Du XL, Lin CC, Johnson NJ et al., Effects of individual-level socioeconomic factors on racial disparities in cancer treatment and survival: findings from the National Longitudinal Mortality Study, 1979-2003, *Cancer*, 2011.

[6] Byers T, Two decades of declining cancer mortality: progress with disparity, *Annu Rev Public Health*, 2010;31:121-132.

[7] Sherr DL, Stessin AM, Demographic disparities in patterns of care and survival outcomes for patients with resected gastric adenocarcinoma, *Cancer Epidemiol Biomarkers Prev*, 2011;20(2):223-233.

[8] Slatore CG, Au DH, Gould MK, American Thoracic Society Disparities in Healthcare Group, An official American Thoracic Society systematic review: insurance status and disparities in lung cancer practices and outcomes, *Am J Respir Crit Care Med*, 2010;182(9):1195-1205.

[9] National Quality Forum (NQF), *The Current State of Cancer Quality Measurement 2008: A White Paper.* Washington, DC: NQF; 2008.

[10] National Quality Forum (NQF), *National Voluntary Consensus Standards for Quality of Cancer Care: A Consensus Report.* Washington, DC: NQF; 2009.