Meeting Summary

Core Quality Measures Collaborative

Medical Oncology Workgroup: Measure Selection Approach and Evaluation Meeting

The National Quality Forum (NQF) convened a closed session web meeting for the Medical Oncology Workgroup on April 12, 2019.

Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff read the antitrust statement and reminded the Workgroup of the voluntary nature of the CQMC and the obligation of all participants to comply with all applicable laws. NQF staff reviewed the following meeting objectives:

- Discuss core set implementation challenges
- Review the CQMC decision making process
- Discuss current measures in the core set
- Evaluate new measures for addition to the core set

Decision making process

Voting and Quorum

NQF staff gave an overview of quorum and voting process. The Workgroup was informed that voting and non-voting participants could take part in discussion, but only voting participants would participate in the voting process. Quorum is defined as representation from at least one health insurance provider representative, at least one medical association representative, and at least one representative from the remaining voting participant categories (i.e., consumers, purchasers, regional collaboratives).

NQF staff advised that the Workgroup will thoroughly discuss each item and all views will be heard. Items for which the co-chairs determine that a consensus and quorum has been reached may be approved or disapproved by a voice vote. Items for which voting participants express dissenting opinions or when a quorum has not been reached, the Workgroup co-chairs will subject the applicable item(s) to an electronic vote. In the event that reaching consensus is not possible, the measure will be presented to the Collaborative for additional discussion. The Collaborative will be responsible for the final decision to approve a core measure set.

Principles for measures included in the CQMC core measure sets

1. Advance health and healthcare improvement goals and align with stakeholder priorities.
    a. Address a high-impact aspect of healthcare where a variation in clinical care and opportunity for improvement exist.

2. Are unlikely to promote unintended adverse consequences.
3. Are scientifically sound (e.g., NQF-endorsed or otherwise proven to be evidence-based, reliable, and valid in diverse populations).
    a. The source of the evidence used to form the basis of the measure is clearly defined.
    b. There is high quality, quantity, and consistency of evidence.
    c. Measure specifications are clearly defined.
4. Represent a meaningful balance between measurement burden and innovation.
    a. Minimize data collection and reporting burden, while maintaining clinical credibility (i.e., measures that fit into existing workflows, are feasible, and do not duplicate efforts).
    b. Are ambitious, yet providers being measured can meaningfully influence the outcome and are implemented at the intended level of attribution.
    c. Are appropriately risk adjusted and account for factors beyond control of providers, as necessary.

Principles for the CQMC core measure sets

1. Provide a person-centered and holistic view of quality, including consideration of Social Determinants of Health (SDOH) and experience of care.
2. Provide meaningful and usable information to all stakeholders.
3. Promote parsimony, alignment, and efficiency of measurement (i.e., minimum number of measures and the least burdensome measures).
4. Include an appropriate mix of measure types while emphasizing outcome measures and measures that address cross-cutting domains of quality.
5. Promote the use of innovative measures (e.g., eMeasures, measures intended to address disparities in care, or patient-reported outcome performance measures, or PRO-PMs).
6. Include measures relevant to the medical condition of focus (i.e., "specialty-specific measures").

Discussion on Implementation Considerations and Measurement Gaps

Workgroup co-chairs facilitated the discussion on goals and challenges related to using the medical oncology core measure set. A Workgroup member reported concerns over "measure bloat" and emphasized the importance of value-based, cross-cutting measures geared toward improving quality of care. It was discussed that it is important for measures to be collectable, have the ability to be benchmarked, and influence provider care at the frontline. It was reiterated that core measures should be selected and aligned for use by the public and private payers; decreasing reporting burden is a main goal.

A Workgroup member identified the need for selected measured to be tailored towards accountability, safety/monitoring, and formal reporting for programs. The Workgroup discussed that a recurring concerns include the inability for measures to be adaptable across settings and difficulty measuring patients' care as they move across providers. A Workgroup member proposed selecting core measures that are actionable and for which the data is already collected and available (e.g., using claims data). It was shared that private payers do not having access to certain clinical data (e.g., cancer stage, lab results) needed to calculate some of the existing core set measures. A Workgroup member highlighted potential challenges related to regional variability, which affects how data is collected and disseminated between patients and providers.

The need for measures that consider the patient's perspective was voiced by the Workgroup. A Workgroup member shared that a limitation of current measure sets is their inability to appropriately capture the patient experience in its entirety and share meaningful information back to patients. An

ideal core set was therefore presented as one that captures patient outcomes creatively using various available data sources. It was noted the ideal "core set" may be core measure concepts that could be applied across settings and levels of analysis. It was discussed that addressing feasibility and data access challenges is vital to developing useable core sets.

A Workgroup member noted the need to focus on high-value measures, such as patient-reported outcome performance measures, and allow patients to be part of the accountability structure without exerting undue burden. A Workgroup member shared that the ideal core set should directly impact on the quality of care that patients receive and include patients' reported experience (e.g., experience with care planning, decision-making, side effects).

A co-chair requested more information about core set uptake. AHIP shared that a measure adoption survey was conducted in 2017, and the results would be circulated to the Workgroup members.

A co-chair raised the idea of creating a framework for the composition of the ideal medical oncology measure set as the foundation for measure selection. There was general agreement with this approach from Workgroup members, who stressed the importance of further identifying and prioritizing areas of importance for medical oncology. It was expressed by AHIP and NQF, that one of the goals of the gap identification and future work on gap analysis is to identify missing concepts and important areas not currently reflected by the core set. NQF expressed support for the model, but noted that even after constructing the conceptual model, there may still be the same measures available to select for inclusion in the core set. It was agreed that the Workgroup would work in parallel to develop a conceptual blueprint for the ideal state of measures for medical oncology and to update the current core set.

Discussion on Current Measures in Core Set

A Workgroup member inquired if there was a limit on the number of measures that could be included in a core set. NQF stated that there is not a minimum or maximum number of measures. The previous Workgroup selected 8 of 25 measures that were discussed.

Current measures in Medical Oncology Core Set

NQF#	Measure	Steward	Level of Analysis	Endorsement Status	Performance Data	Use
0559	Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer	American College of Surgeons	Facility	Endorsed	Mean performance increased from 85.1% (95% CI: 84.5-85.6) n= 16,263 in 2008 to 89.4% (88.9-89.9) n=14,331 in 2013. Data from Commission on Cancer (CoC)-accredited facilities.	Hospital Compare; Pennsylvania Health Care Quality Alliance; CoC, National Cancer Data Base, Quality Oncology Practice Initiative (QOPI®); QOPI® Certification Program

1857	Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab	ASCO	Clinician	Endorsed	Mean performance 2013: 99.25, 2014: 99.26, 2015: 99.54. Data from approximately 230-265 practices that report using QOPI registry.	Quality Oncology Practice Initiative; MIPS
1858	Trastuzumab administered to patients with AJCC stage I (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy	ASCO	Clinician	Endorsed	Mean performance 2011: 97% (range 60%-100%), N=786 patient records, 96 practices. Data from QOPI	PPS-Exempt Cancer Hospital Quality Reporting (PCHQR) Program, Pennsylvania Health Care Quality Alliance; Quality Oncology Practice Initiative (QOPI®), CoC National Cancer Data Base; MIPS
0223	Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	Commission on Cancer, American College of Surgeon	Facility	Endorsed	Mean performance has increased from 82% (Std. =0.23; n=1455 facilities) in 2008 to 86.5% (std. 0.21; n=1386 facilities). Data CoC-accredited facilities.	Pennsylvania Health Care Quality Alliance; Quality Oncology Practice Initiative (QOPI®), Commission on Cancer, National Cancer Data Base; Hospital Compare
1859	KRAS gene mutation testing performed for patients with metastatic colorectal cancer who receive anti-epidermal growth factor receptor monoclonal antibody therapy	ASCO	Clinician	Endorsed	Mean performance 2011: 73% (range 33%-100%), N=151 patient records, 18 practices. Data from QOPI	MIPS

1860	Patients with metastatic colorectal cancer and KRAS gene mutation spared treatment with anti-epidermal growth factor receptor monoclonal antibodies	ASCO	Clinician	Endorsed	Mean performance 2011: 85% (range 0%-100%), N=444 patient records, 136 practices. Data from QOPI.	MIPS
0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	AMA-PCPI	Clinician	Endorsed	Based on MIPS benchmarking (registry): Decile 3: 98.92-100, decile 10: 100. Topped out. From NQF submission 2014: EHR performance mean 90.76, registry performance 90.24. Developer notes in 2013 8.3% of eligible professional reported, therefore rates may not be nationally representative.	MIPS
1853	Radical Prostatectomy Pathology Reporting	College of American Pathologists	Clinician	Endorsed	Based on MIPS benchmarking (registry): Decile 3: 97.28-100, decile 10: 100. Topped out. From NQF submission: CAP Q probes data (2006) indicates that 11.6% of prostate pathology reports had missing elements	MIPS
0210	Proportion of patients who died from cancer receiving chemotherapy in the last 14 days of life	ASCO	Clinician	Endorsed	Mean performance 2013: 11.47, 2014: 12.92, 2015: 13.16. Data from approximately 172-222 practices that report using QOPI registry.	Quality Oncology Practice Initiative; MIPS, Hospital Compare, Prospective Payment System-Exempt Cancer Hospital Quality Reporting
0211	Proportion of patients who died from cancer with more than one emergency room visit in the last 30 days of life	ASCO	Clinician	No longer endorsed	Integrated delivery system 1: 2013 performance: 43.90%. Integrated delivery system 2: 2013-2015 mean: 5.38%	MIPS; QI for integrated delivery systems

0213	Proportion of patients who died from cancer admitted to the ICU in the last 30 days of life	ASCO	Clinician	Endorsed	Integrated delivery system 1: 2013 performance – 37%. Integrated delivery system 2: 2013-2015 performance – 9.02%	MIPS; Hospital Compare and Prospective Payment System-Exempt Cancer Hospital Quality Reporting; QI: Integrated delivery systems
0215	Proportion of patients who died from cancer not admitted to hospice	ASCO	Clinician	Endorsed	Mean performance 2013: 41.44, 2014: 42.6, 2015: 42.53. Data from approximately 172-222 practices that report using QOPI registry.	MIPS; Quality Oncology Practice Initiative
0216	Proportion of patients who died from cancer admitted to hospice for less than 3 days	ASCO	Clinician	Endorsed	Mean performance 2013: 16.63, 2014: 18.22, 2015: 17.86. Data from approximately 170-222 practices that report using QOPI registry.	MIPS; Quality Oncology Practice Initiative; Hospital Compare; Prospective Payment System-Exempt Cancer Hospital Quality Reporting
0384	Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology	AMA-PCPI	Clinician	Endorsed	Based on MIPS benchmarking (registry): Decile 3: 82.03 - 90.77, decile 5: 95.4 - 97.57, decile 7: 99.1 – 100, decile 10: 100. Topped out. Based on MIPS benchmarking (EHR): Decile 3: 82.07 - 91.91, decile 5: 96.55 - 99.08:, decile 7: 99.87 - 100, decile 10: 100. Topped out. Based on NQF submission, 2016 PQRS mean performance: 0.88 (n=251 physicians). Developer notes MIPS is voluntary and therefore rates may not be nationally representative.	MIPS; Physician Compare (late 2019)

Measures Previously Considered but Not Included

NQF#	Measure	Previous Notes
0208	Family Evaluation of Hospice Care	• Data collection for this measure will be problematic
0219	Post breast conservation surgery irradiation	• Workgroup members discussed if this measure is more appropriate for a surgeon or an oncologist
0220	Adjuvant hormonal therapy is recommended or administered	• For future reporting when data can be captured more easily

	within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor-positive breast cancer	
0386	Oncology: Cancer Stage Documented	• Low bar measure proposed for removal from PQRS. Important to clinical care but better outcomes measures preferred. Measures is reported at a low rate, but documentation of cancer stage is important.
0457*	Recording of Performance Status prior to Lung or Esophageal Cancer Resection	• Documentation measure. Low bar. Proposed to be removed from PQRS. • Would suggest updating the measure to be more contemporary and reassess in the future.
1878	Human epidermal growth factor receptor 2 (HER2) testing in breast cancer	• Need clarity on the measurement period. • Low bar measure – 98.6% performance
2100	Oncology Paired Measure (0383: Plan of Care for Pain and 0384: Pain Intensity Quantified)	• Oncology Paired Measure (0383: Plan of Care for Pain and 0384: Pain Intensity Quantified)
0221*	Needle biopsy to establish diagnosis of cancer precedes surgical excision/resection	• N/A
0225	At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer	• N/A
0381*	Treatment Summary Communication – Radiation Oncology	• N/A
0382*	Radiation Dose Limits to Normal Tissues	• N/A
0387*	Radiation Dose Limits to Normal Tissues	• N/A
0391*	Breast Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	• N/A
0392*	Colorectal Cancer Resection Pathology Reporting- pT category (primary tumor) and pN category (regional lymph nodes) with histologic grade	• N/A
0455*	Recording of Clinical Stage Prior to Surgery for Lung Cancer or Esophageal Cancer Resection	• N/A
0456	Participation in a Systematic National Database for General Thoracic Surgery	• N/A
0458*	Pulmonary Function Tests Before Major Anatomic Lung Resection (Pneumonectomy, Lobectomy, or Formal Segmentectomy)	• N/A

0459*	Risk-Adjusted Morbidity: Length of Stay >14 Days After Elective	• N/A
0508	Diagnostic Imaging: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms	• N/A
0509	Reminder System for Mammograms	• N/A
0740	Participation in a Systematic National Dose Index Registry	• N/A
1617	Patients Treated with an Opioid who are Given a Bowel Regimen	• N/A
1790	Risk-Adjusted Morbidity and Mortality for Lung Resection for Lung Cancer	• N/A
1855*	Quantitative HER2 evaluation by IHC uses the system recommended by the ASCO/CAP guidelines*	• N/A

*no longer NQF endorsed

Previously Identified Medical Oncology Measure Gaps

- Pain control
- Functional status or quality of life
- Shared decision-making
- Appropriate use of chemotherapy
- Under or overtreatment (will need to develop a baseline or a threshold based on data)
- ER utilization
- Inpatient hospital admission rate
- Reporting of cancer stage
- Disease free survival for X number of years.
- Patient experience / PRO for level of pain experienced by patient
- Cost measures
- Lung Cancer
- Five-year cure rate
- 0390: Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients - Not included in the core set at present but would like to reevaluate once better data/systems become available to collect necessary information and measure denominator issues are resolved.
- Social determinants of health
- Financial burden
- Anxiety/stress management and screening
- Care coordination, transitions of care, care navigation
- Patient education
- ASCO/ABIM Choosing Wisely list: Metrics included are of value and should be pushed to measure development
    - Concept #2 is addressed in the core set in measure #0389
    - Concept #10 is a valuable metric
    - Concept #7 is of lower priority (than other measures)

A Workgroup member expressed challenges faced by private payers in tracking hospice enrollment. Another Workgroup member shared that it can be difficult for plans to measure some of the

outcomes (referencing the end of life measures in the current set) unless the patient dies in the hospital. It was discussed that a measure about shared-decision making or end of life conversations with providers may be more feasible, as there are billing codes available for these aspects of care.

Evaluation of new measures

NQF staff shared findings from the environmental scan of medical oncology measures. NQF-endorsed measures and measures in MIPS and other federal programs were included.

Review of Potential Medical Oncology Measures
Highlighted in the scan were measures that were previously discussed and recommended for future consideration, new measures endorsed by NQF since 2016, and eMeasure versions of current core set measures.

- 0220: Adjuvant hormonal therapy is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor-positive breast cancer
- 0383: Oncology: Plan of Care for Pain – Medical Oncology and Radiation Oncology
- 0385/0385e: Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients
- 0390: Prostate Cancer: Adjuvant Hormonal Therapy for High Risk Prostate Cancer Patients
- 0384e: Oncology: Medical and Radiation – Pain Intensity Quantified
- 0389e: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
- 2930: Febrile Neutropenia Risk Assessment Prior to Chemotherapy
- 3188: 30-Day Unplanned Readmissions for Cancer Patients
- 3490: Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy (submitted for NQF endorsement)
- N/A: Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy
- 2651 CAHPS® Hospice Survey (experience with care)
- 3235 Hospice and Palliative Care Composite Process Measure—Comprehensive Assessment at Admission

Additional measures to potentially discuss include:

- OCM-2 Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode
- OCM-3 Proportion of patients that died who were admitted to hospice for 3 days or more (similar to measure #0216 in core set)
- 0418/OCM-5 Screening for Depression and Follow Up Plan
- OCM-6 Patient-Reported Experience of Care
- QOPI 5 Chemotherapy administered to patients with metastatic solid tumor with performance status of 3, 4, or undocumented
- QOPI 23 Concurrent Chemoradiation for Patients with a Diagnosis of Stage IIIB NSCLC
- AQUA29 Prostate Cancer: Patient Report of Urinary function after treatment
- AQUA30 Prostate Cancer: Patient Report of Sexual function after treatment
- 0032: Cervical Cancer Screening
- 0034: Colorectal Cancer Screening
- 0377: Hematology: Myelodysplastic Syndrome (MDS) and Acute Leukemias: Baseline Cytogenetic Testing Performed on Bone Marrow
- 2372: Breast Cancer screening

- 3365e: Treatment of osteopenia or osteoporosis in men with non-metastatic prostate cancer on androgen deprivation therapy (submitted for NQF-endorsement)

The Workgroup started discussing four measures for potential addition.

0220: Adjuvant hormonal therapy is recommended or administered within 1 year (365 days) of diagnosis for women with AJCC T1cN0M0, or stage IB - III hormone receptor-positive breast cancer
The Workgroup discussed that feasibility may be an issue, based on previous conversations around access to staging data. A co-chair inquired of the appropriateness of the measure for inclusion if focus is on the clinician level of analysis. The was additional discussion that facility level may not be appropriate level for accountability. It was noted that there are multiple parties involved: physician who writes the script, a dispensing pharmacy, and patient/caregiver who picks up the medication. A co-chair expressed the importance of further discussing the measure's intended setting. NQF shared that this measure was not included in the core set by the previous Workgroup, but they noted that it should be assessed in the future when data can be more easily captured. Workgroup members stated that the measure should be kept for consideration but expressed concern with the level of analysis.

0383: Plan of Care for Pain—Medical Oncology and Radiation Oncology
The Workgroup requested clarity around the scope of the measure set (e.g., oncology treatment, immunotherapy, surgical oncology, medical oncology, radiation oncology). A Workgroup member was concerned that #0383, a portion of which addresses radiation oncology, may not necessarily fit the needs of the medical oncology core set. The Workgroup stated that the varying branches of oncology are fundamentally different. AHIP advised they would further discuss the scope with the Steering Committee and that the Workgroup should continue to discuss the measures brought forward realted to Medical Oncology.

0385e: Colon Cancer: Chemotherapy for AJCC Stage III Colon Cancer Patients and 0384e: Oncology: Medical and Radiation - Pain Intensity Quantified
NQF shared that these measures are eMeasure versions of measures in the current core set. The Workgroup was asked to consider if these eMeasures should be included in the core set as potential options in addition to the original measures. A Workgroup member expressed concern over the feasibility of implementing eMeasures, as not all entities have the same reporting capabilities. Some Workgroup members agreed that including eMeasures will, over time, allow payers to further develop their systems to allow for the electronic capture of metrics and lead to burden reduction. It was noted that most public payers have the ability to receive eMeasure data. A Workgroup member stressed the need to have a core set that can be easily adopted by most primary and secondary users. A co-chair requested that NQF staff provide the Workgroup with additional information on eMeasures.

Next Steps

NQF staff shared that the focus of the next Workgroup meeting would be to continue discussing measures for potential addition, provide input on a blueprint of important concepts for medical oncology measurement, and identify potential measures for removal from the core set. NQF staff will share information about eMeasure considerations and work with AHIP to further define the scope of medical oncology workgroup. NQF staff requested members who have not submitted DOI forms to send the completed DOIs to the CQMC email CQMC@qualityforum.org.