Core Quality Measures Collaborative

Meeting Summary

Medical Oncology Workgroup Meeting 7

The National Quality Forum (NQF) convened a closed session web meeting for the Medical Oncology Workgroup on May 12, 2020.

Welcome and Review of Web Meeting Objectives

NQF staff and the Workgroup co-chairs welcomed participants to the meeting and took roll call. 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 notified Workgroup members that the meeting is being recorded for the purpose of accurately capturing the discussion for meeting minutes. The recording will be available to CQMC members for a limited time only and will be deleted as soon as reasonably practical.

NQF staff reviewed the following meeting objectives:

- Review voting results for the measure (0389/0389e) flagged by the Steering Committee
- Discuss core set presentation and communication
- Discuss approach for addressing measure gaps

Review of Voting Results for 0389/0389e

NQF staff reminded the Workgroup that in the first round of voting, the Workgroup reached consensus during discussion that the registry-based measure *0389: Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients* should remain in the core set. *0389e,* the eCQM version of *0389,* was included in the list of measures for voting, but the Workgroup did not vote to add *0389e;* while over 60% of votes were affirmative, there was no affirmative vote from the consumer/purchaser/regional collaborative category. The Steering Committee felt that including *0389* but not *0389e* did not align with decisions from other Workgroups to promote electronic versions of measures and recommended a re-vote.

A total of eight organizations voted during the second round of voting. The group voted to keep *0389* and add *0389e,* with a 62.5% affirmative vote and at least one affirmative vote from each category. In the survey, members commented that they supported inclusion of additional voting options, that eCQMs should be supported whenever possible, that the performance of *0389* and *0389e* was similar despite different data sources, and that *0389e* was being used by CMS in its programs. One member also suggested in the survey that the measure developer include imaging, MRI use, etc. in future iterations of the measure.

NQF reviewed the final recommendations from the Workgroup for the core set, noting that there were a total of 17 measures in the updated recommendations and that the Workgroup had recommended the removal of two measures (*1857: Patients with breast cancer and negative or undocumented human epidermal growth factor receptor 2 (HER2) status who are spared treatment with trastuzumab* and *1853: Radical Prostatectomy Pathology Reporting*).

Discussion of Core Set Presentation and Communication

NQF staff shared that the CQMC Workgroups are being asked for their suggestions and comments on updating the current core set presentation. NQF will collect feedback from the Workgroups and use it to update the current template for core set presentation across all core sets. NQF shared the current core set template, a table which includes NQF measure number, measure name, measure steward, level of analysis, and notes on discussion and consensus. For Medical Oncology, the current core set presentation is also organized by type of cancer and hospice/end of life care.

A Workgroup member commented that the current core sets do not include descriptions of rationale for why measures are included (e.g., addressing high cost, overuse, safety). Another Workgroup member commented that mentioning costs and indicating the highest-cost areas would be helpful. A member noted that programs such as Hospital Compare describe measures in plain language, allowing the public to understand the importance of individual measures and why they are included. Another member agreed this was a good idea but noted that individual measure stewards would need to provide or approve language on rationale to ensure their intentions were being captured accurately. A Workgroup member suggested that NQF-endorsed measures could be linked to forms on the NQF website for in-depth information on the most recent version of the measure and noted that rationale for endorsed measures might be available in the original submission forms to NQF.

Another Workgroup member commented that the current format of the core set does not allow for technical questions and feedback on the measures (e.g., why a measure using KRAS gene mutation was selected or rationale for a certain time period of measurement). The member noted that if the CQMC was able to establish a feedback mechanism, there would be an opportunity to gauge reactions from external commenters and understand if stakeholders think the core set is measuring the most important topics.

A member noted that collecting information on how the measures are used would be helpful. A co-chair concurred and noted that some measures might have limited usefulness on their own in practice because of statistical limitations and that understanding current use of measures could help the group decide whether they should be promoting measures appropriate for comparing performance of clinicians or measures for clinicians to track and improve their own performance. One member noted that in their experience, *0210: Proportion receiving chemotherapy in the last 14 days of life, 0211: Proportion with more than one emergency room visit in the last 30 days of life,* and *0213: Proportion admitted to the ICU in the last 30 days of life* have been assessed together to inform advance care planning discussions and goals of care conversations.

NQF staff thanked the group for their suggestions and noted that these would be combined with suggestions from other Workgroups. NQF staff also asked for feedback on the best ways to communicate future core set updates. A co-chair asked for clarification on the CQMC's current process for disseminating the core sets. NQF staff shared that the plan includes development of press release messaging, with a focus on messaging for payer organizations in order to promote use of the core sets. However, the complete strategy is still being developed. The other co-chair commented that dissemination through appropriate journals, including specialty areas and quality measurement venues, might be helpful. There were no additional comments from the Workgroup, and NQF staff asked that Workgroup members share any additional comments via email.

Discussion of Approach to Addressing Measure Gaps

NQF staff shared the list of gaps from prior discussions and asked whether the group was comfortable with the gaps list, which three to five topics the group considered highest priority, and whether there were any suggestions for what action the CQMC should take to address these gaps.

A co-chair raised the issue of statistical validity and reliability of measures being used and whether measures were appropriate for distinguishing performance between practices. The co-chair noted that the group could prioritize measures for the goal of differentiating between practices, or for improving performance within a practice. A Workgroup member commented that measure developers often talk about sample size as one of the first considerations when deciding which measures to develop. The member commented that there is no strict sample size cutoff, although CMS often uses measures that need a minimum of 20 patients per practice. The appropriate sample size will depend on the nature of the measure. More condition-specific measures have less statistical power than cross-cutting measures because they apply to fewer people. If a large number of measures are recommended, fewer people may choose to use each measure, reducing the data available for benchmarking.

A Workgroup member commented that the gap on ER utilization, unplanned hospitalization, and inpatient hospital admissions could be tied with the gap on patient education. Another member commented that care coordination and transitions of care could also be linked to these measures. One Workgroup member commented that measures on patient education and care coordination are difficult to measure in a meaningful way and usually become checkbox measures, and they are likely inappropriate for measuring performance at the individual clinician level. A co-chair highlighted challenges with collecting the data for these measures, where practices often report that they do not hear back about patient deaths or ER visits. Another member commented that avoidance of ER and hospital stays would be of interest to consumers. A member noted that unplanned use of services can serve as a proxy for care coordination and transitions of care, as it can indicate that a patient is not being adequately managed.

A member commented that shared decision-making is an area of high interest that does not have robust measures available, and there is a potential opportunity for the CQMC to provide thought leadership and support for identifying and driving measure development in this area. A white paper could be a potential avenue for promoting this topic.

NQF staff noted that the CQMC is currently considering the role of social determinants of health (SDOH) in the core set work and welcomed any feedback on an approach for data collection and measurement around SDOH. A co-chair commented that there has been an effort to develop a common set of codes for oncology so that data from electronic health records can be retrieved without manual abstraction, and SDOH should be represented within the demographic codes to the extent possible. Another member agreed with this and noted that considering the most useful types of measures to collect and delineating the key opportunities (e.g., creating diagnosis codes, CPT codes that map to SDOH) would be helpful as stakeholders start to establish measures and interventions in this space.

Members also commented that other gap areas that should be addressed are telemedicine and immunotherapy.

Next Steps

NQF staff shared that the Workgroup's recommendations for measure addition and removal will be discussed at the full Collaborative level (currently anticipated to be in June). After discussion, the measures will be voted on by the full Collaborative. The discussion on measure gaps will be used to inform an analysis of gap areas report. Finally, NQF will continue to gather feedback on the core set presentation from the other CQMC Workgroups and will share a template with the Collaborative for review.