Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment

TECHNICAL REPORT

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NATIONAL QUALITY FORUM

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Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment

TECHNICAL REPORT

Introduction

In 2011, the National Quality Forum (NQF) sought to establish a broader platform for addressing healthcare disparities and cultural competency in measurement. The Healthcare Disparities and Cultural Competency Consensus Standards project[1] was focused on identifying valid and reliable performance measures in these areas, as well as a set of disparities-sensitive measures among the existing NQF portfolio of endorsed measures. This project sought to enhance NQF's 2006 work addressing disparities and cultural competency, which included establishing criteria to evaluate measures for disparities sensitivity and endorsing 35 disparity-sensitive measures for the ambulatory care setting under the project National Voluntary Consensus Standards for Ambulatory Care—Measuring Healthcare Disparities. Also, in 2009, NQF completed an extensive project endorsing a definition, framework, and set of 45 preferred practices for measuring and reporting cultural competency under the project A Comprehensive Framework and Preferred Practices for Measuring and Reporting Cultural Competency.

The 2011 project had two phases: (1) development of a commissioned paper focused on measurement implications for healthcare disparities, and (2) identifying performance measures for healthcare disparities and cultural competency. The project has been focused on healthcare disparities and cultural competency for racial and ethnic minority populations. In this final phase of work, the disparities-sensitive criteria were finalized and an initial set of disparities-sensitive measures was identified. These disparities-sensitive measures should be routinely stratified and reported by race/ethnicity and language. As part of this effort, NQF has developed a prospective approach for the assessment of disparities-sensitivity for all new and maintenance measures submitted to NQF.

Measuring Healthcare Disparities

The commissioned paper on Healthcare Disparities Measurement, developed by The Disparities Solution Center at Massachusetts General Hospital, provided background context and recommendations to NQF regarding the selection and evaluation of disparity-sensitive quality measures, outlined the methodological issues with disparities measurement, and identified cross-cutting measurement gaps in disparities. The paper served as a foundational document to assist the Healthcare Disparities and Cultural Competency Steering Committee with its recommendations on methodological concepts for disparities measurement and a protocol for identifying measures as disparities-sensitive.

The commissioned paper recommended a three-step process for identifying disparities-sensitive measures: First, assessing the NQF portfolio of performance measures with special emphasis on quality gap and prevalence and comparing these measures with the literature on known areas of disparities; the

[1] NQF defines healthcare disparities as differences in health care quality, access, and outcomes adversely affecting members of racial and ethnic minority groups and socially disadvantaged populations.

second and third steps recommend new principles for identifying disparities-sensitivity. For performance measures that are not stratified by race/ethnicity or when known disparities do not exist, emphasis should be placed on measures that meet standard protocols or clinical guidelines, measures that address communication-sensitive services, social-determinant dependent measures, and outcomes.

Identifying Disparities Measures and Indicators

Using the guidance and algorithm provided in the commissioned paper as a starting point, the Steering Committee established a draft protocol for identifying measures as disparities-sensitive. NQF had previously established criteria for evaluating disparities-sensitive measures as part of *National Voluntary Consensus Standards for Ambulatory Care – Measuring Healthcare Disparities;* these criteria (prevalence, impact of condition, impact of the quality process, quality gap, and ease and feasibility of improving the quality process) also served as a foundation for further discussion and refinement of the current protocol.

The Committee noted that certain selection criteria have demonstrated to be more subjective than others, such as impact. Of note, an alternate approach to selecting disparities-sensitive measures was initially discussed. Specifically, an approach of "opt in" versus "opt out" (i.e., assuming all measures as disparities-sensitive and then use the selection criteria to remove measures as appropriate) was considered.

In addition to using the systematic protocol to evaluate and "tag" disparities-sensitive measures in NQF's existing portfolio, the Committee recommended that NQF consider process and outcome measures separately to ensure both types are represented at this time. The Committee also recommended that measures that map to the NQF-endorsed preferred practices for care coordination and cultural competency should be tagged as disparities-sensitive, even in the absence of quantitative gap data. It also recommended that the disparities-sensitive subset be examined to ensure representation of system-based vs. provider-based measures; additionally, cross-cutting measures should be identified. Finally, the Committee noted that all disparities-sensitive measures should be stratified by race/ ethnicity and language, and institutions should consider prioritizing disparities-sensitive measures for implementation and uptake.

Disparities-Sensitive Measure Assessment Protocol and Process

Although the commissioned paper served as the starting point, the Steering Committee refined the protocol to include a hierarchical approach and scoring system. This scoring system was developed to provide a more quantitative, systematic approach to selecting disparities, rather than an ad hoc, expert opinion based approach. This protocol was then applied to the existing portfolio of NQF-endorsed performance measures.

Disparities-Sensitive Screening Protocol

The Committee developed a protocol to systematically screen and tag NQF-endorsed measures as disparities sensitive. The Committee identified first-tier criteria (prevalence, quality impact, and disparities quality gap) and second-tier criteria (care with a high degree of discretion, communication-sensitive services, and social-determinant dependent measures). Table 1 provides an illustrative example of how the protocol was applied to each measure. The following sections summarize in greater detail the protocol's criteria.

First-tier Criteria of the Disparities-sensitive Measure Identification Protocol

The Committee placed emphasis on prevalence, quality gap, and impact to identify disparities-sensitive measures.

- Prevalence - How prevalent is the condition among the minority population? Based on the clinical conditions identified by the Office of Minority Health as large contributors of health disparities, the NQF portfolio was first reviewed for performance measures related to the following conditions: Cancer, Diabetes, Heart Disease (including Hypertension), HIV/AIDS, Immunizations, Infant Mortality, and Stroke, Tobacco use, Oral care. These measures were given 3 points. Measures that fell in cross-cutting areas (e.g., patient safety, care coordination, functional status, palliative care, pain management or *any* child health/pediatrics) also were scored 3 points. Measures that fell into the prioritized list of top 20 conditions for Medicare (amended to include substance abuse, obesity, and End Stage Renal Disease) were scored 2 points. All other measures scored 1 point.

- Disparities Quality Gap – How large is the gap in *quality of care* between the disadvantaged population and the group with the highest quality for that measure? The disparities quality gap indicated on the measure submission/evaluation form was reviewed and recorded. In some cases, information was not available and literature searches were performed by NQF staff to supplement where possible.

- Impact – The influence a condition or topic has financially, publically, and on the community at large was evaluated. Performance measures addressing the National Quality Strategy priority areas or goals were given a score of 1 point each and/or a demonstrated high impact aspect of healthcare (e.g., affects large numbers, leading cause of morbidity/mortality, high resource use (current and/or future), severity of illness, and patient/societal consequences of poor quality) as demonstrated on the measure submission/evaluation form also were given 1 point.

Second Tier Criteria of the Disparities-sensitive Measure Identification Protocol

Following the initial review, an additional filter was applied to those measures where performance data stratified by race/ethnicity were not provided or when a known disparity could not be identified through the literature at this time. These second tier criteria were utilized during the full assessment of the NQF portfolio of measures. While all second tier criteria are described below, the Committee decided to move forward only with the criteria related to communication-sensitive services. The measures were reviewed using the following criteria:

- Communication-Sensitive Services - Disparities are more likely to occur when there are challenges to communication across language and cultures.2 As an indicator of communication-sensitive services, performance measures were tagged when they matched one of the following NQF-endorsed framework domains and/or preferred practices; scoring those that do as having 2 points and those that do not as 0.

    a. Cultural Competency Framework Domain: Patient-Provider Communication and the corresponding sub-domains and/or preferred practices.
    b. Care Coordination Framework Domain: Communication and the corresponding sub-domains and/or preferred practices

- Care with a High Degree of Discretion - Many disparities arise because of a certain degree of discretion on the part of the clinician—i.e., the less there is a standard protocol that should be followed, the easier it is to offer a procedure differently based on the patient's socio-demographic characteristics.[2] The measure submission/evaluation forms were reviewed to identify those measures that do not cite a clinical guideline, receiving two points and those that specifically cite a clinical guideline as part of the evidence receive 0 points.

- Social Determinant-Dependent Measures - Disparities often are seen in areas that relate to behavioral aspects of health, including patient self-management (e.g., diet, exercise, and medication adherence for diabetes or congestive heart failure management)[2.] As an indicator of social determinant-dependent measures, performance measures were matched to social or behavioral aspects of health. Measures in the NQF portfolio that are within the direct "control sphere" of either healthcare delivery or public health as demonstrated by the specifications of the measure were given a score of 3 points; measures that address behavioral aspects of health were given a score of 2 points; and measures that address environmental aspects were given 1 point and measures that meet other social determinant indicators were given a score of 0.

As noted above, the Committee members decided to include only the indicator of communication-sensitive services in the final protocol. It was deemed significant if a measure could be mapped to a NQF-endorsed preferred practice for care coordination or cultural competency because both are emerging areas for performance measures and emphasize the importance of quality of care for minority populations.

Ultimately, the Committee focused the identification of disparities-sensitive measures on prevalence, quality gap, impact, and whether a measure mapped to a communication-sensitive practice.

Categorization of Measures

The following six categories, recommended by the commissioned paper, were used as a categorization system to better assess the care settings or other factors represented by the final set of disparities-sensitive measures. For example, under the protocol, it was theoretically possible that the disparities-sensitive set would be comprised of only hospital-level measures (and hence require additional criteria, different emphasis of existing criteria, or other considerations). All measures were tagged as belonging to a specific category:

- Practitioner performance
- Consumer surveys that measure patient experience
- Hospital, ambulatory care, or home health nursing home
- Ambulatory care sensitive conditions and management
- Cultural competency
- Patient-centered

All measures were further identified as system-based or provider-based, then cross-cutting or the potential to influence multiple measures. In addition, the measure type (structure, process, and outcome) was indicated.

[2] National Quality Forum. Commissioned Paper: Healthcare Disparities Measurement. 2011

Table 1. Illustrative Example of Protocol

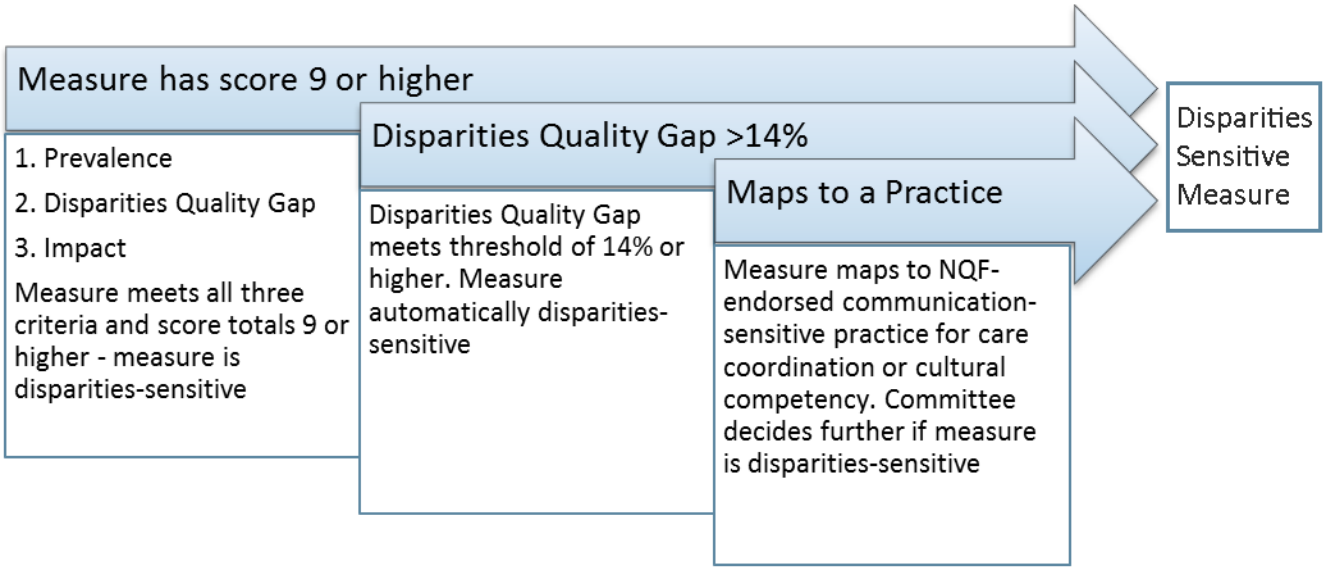
NQF #18: Controlling High Blood Pressure. The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. (Steward: National Committee for Quality Assurance)

Protocol Indicator	Measure Rationales	Scoring
Prevalence	Measure meets one of the conditions under prevalence – Heart Disease	3 points
Quality Gap	a quality gap of 13.0 percent was provided in measure form	3 points
Impact	Measure can be mapped to at least one of the NPP priorities or goals	1 point
High Degree of Discretion	Measure meets a clinical guideline and citation for guideline is provided in measure form	0 points
Communication-sensitive services	Measure do not map to the NQF-endorsed preferred practices addressing communication services	0 points
Social-determinants	Measure determined to be in the direct "control sphere" of the healthcare delivery or public health; based on measure description and specifications.	3 points
Category	Measure category determined – Practitioner performance and provider-based	Not applicable as pertains to point assignments; for categorization purposes (N/A)
Measure Type	Process Measure	N/A
Cross-Cutting	Measure is not cross-cutting	N/A
Linked to the NQF Ambulatory care project	Measure originally endorsed under the NQF Ambulatory Care Disparities Sensitive Measure Set	N/A

Identifying a Set of Disparities-Sensitive Measures

More than 500 endorsed measures were reviewed using the disparities-sensitive screening protocol[3]. For purposes of selecting a set of NQF endorsed measures as disparities-sensitive, emphasis was placed on prevalence, the threshold of the quality gap, impact and whether a measure could be mapped to a NQF-endorsed preferred practice addressing care coordination or cultural competency; figure 1 illustrates the process. Each measure was given a point value for the indicators in accordance with the specificity provided by measure developers on the measure forms. In many cases, literature searches were performed to fill in information for the quality gap when such data were omitted or lacking from the measure form.

Figure 1. Guidance Table for Selecting Disparities-Sensitive Measures



The completed quality gap percentages for each measure allowed for the information to then be separated into quartiles, providing a score range as follows:

Quartile of Quality Gap	Quality Gap (Percent)	Assigned Points
Lowest quartile	0-2 percent	1 point
2nd quartile	2.1 percent to 5.9 percent	2 points
3rd quartile	6 percent to 14 percent	3 points
Highest quartile	14 percent	4 points

The measures that fit within the highest quality gap quartile also had the highest first-tier score; this defined the initial set of disparities-sensitive measures, a set of 62 measures. Additional analysis of the entire portfolio as to whether a measure mapped to an NQF-endorsed practice(s) for care coordination and/or cultural competency was performed; this analysis and Committee discussion brought 14 additional measures to the disparities-sensitive set. The final set of 76 disparities-sensitive measures

[3] Performance Measures currently undergoing maintenance were not assessed using the disparities-sensitive protocol.

(Appendix B), represent those measures that meet one or more of the following characteristics, quality gap greater than14 percent, first-tier score of 9 or higher, or can be mapped to an NQF-endorsed practice for care coordination or cultural competency. A threshold of 14 percent for the quality gap was selected as an initial cut-off based on the data collected from the retrospective review of the NQF-endorsed measures. Specifically, once the quality gap percentages were identified, the set was divided into quartiles. Those measures with a gap equal to or greater than 14 percent were assigned 4 points, as just indicated in the table; the measures that reflected a quality gap of 14 percent or higher also had higher scores under the protocol. The Committee emphasized the importance of having a concise, parsimonious set of disparities-sensitive measures, rather than including all NQF-endorsed measures or choosing more measures on an ad hoc basis or expert opinion. Accordingly, they recommended against moving down into the lower three quartiles.

Identifying the set of disparities-sensitive measures was challenging, and the Steering Committee had reservations about the accuracy of some quality gap information and/or lack of available good quality gap data—despite a general sense that for some measures, significant disparities existed. Nevertheless, the Committee recognized the importance of advancing a disparities-sensitive set and notes this initial set is part of an iterative process going forward.

The Committee emphasized that exclusion of a measure from this set was not intended to indicate that a disparities quality gap does not exist in a given area or measure. Indeed, given the quartile approach adopted by the Committee, nearly three-quarters of measures did not have a demonstrable quality gap or lacked information on a quality gap, specifically out of the 500+ measures reviewed; approx. 58 percent had quality gap data versus 42 percent which did not. The Committee noted that additional areas may emerge as disparities-sensitive as research and measurement efforts demonstrate that a quality gap exists. Tagging a measure as disparities-sensitive is intended to convey that reporting of the measure should include stratification by race/ethnicity and language.

NQF's Prospective Approach for Assessing Disparities-Sensitivity

Globally, the Committee emphasized the importance of considering whether a measure should be viewed as important for assessing disparities during the usual NQF evaluation and/or maintenance processes. The Committee recommended changes to the measure submission form, as follows: (1) advising measure developers more specifically about including disparities data within the submission form; and (2) aggregating the currently dispersed disparities sections within each evaluation criterion to a new, separate section toward the beginning of the form.

More specifically, the recommended process going forward as it relates to the established protocol, will consist of the following parameters for determining disparities-sensitivity.

Disparities Quality Gap

Given the quartile boundaries may shift as more data accumulates, but recognizing the need to provide some degree of consistency, NQF-endorsed measures with data that reveal a gap of greater than14 percent or greater shall be tagged as disparities-sensitive regardless of any other scoring or other considerations. NQF shall annually review this cut-point of greater than 14 percent and adjust as necessary based on the quality gap data reported for measures at the time of the re-evaluation—i.e., in the future the top quartile in the portfolio may indicate a cut-point of 12 percent instead of 14 percent.

First-tier Score

All future Steering Committees will identify measures as disparities-sensitive based on the first-tier indicators (prevalence, quality gap score, and impact). If the first-tier score is 9 points or greater regardless of the numeric value of the disparities quality gap percentage, that measure will automatically be included in the disparities-sensitive set. In addition, measures that can be mapped to a preferred practice for care coordination or cultural competency, regardless of the disparities quality gap percentage, will be reviewed by Committees in order to determine if the measure should be considered disparities-sensitive. For submitted measures that do not include information on a quality gap, members of NQF's Endorsement Maintenance Committees will be offered an opportunity to provide evidence and/or data on disparities.

In addition, Committees will have the opportunity to identify measures as "potentially" disparities-sensitive where expert opinion suggests areas at risk for disparities and evidence and data should be closely tracked.

Disparities-Sensitive Measures: Implications for Implementation

Equity is a central tenet of healthcare quality. Since 2001, assessment of disparities has been a core component of NQF's work. In this project, NQF attempted to systematically identify a subset of NQF-endorsed measures—already demonstrated to be important, scientifically acceptable, feasible, and usable—for which there is a significant disparities quality gap by race and ethnicity. This initial set of disparities-sensitive measures will be tagged as "disparities-sensitive" in the NQF measures data base – the Quality Positioning System. Stratified reporting of these measures, subject to adequate sample size and availability to demographic data, could be useful for both accountability and quality improvement. While the use of disparities-sensitive measures for accountability remains unslear, the identification of disparities-sensitive measures is an important step toward more routine assessment of disparities.

Concerns have been raised regarding potential unintended consequences related to deployment of stratified reporting of disparities measures for accountability, including potential adverse financial impact on safety net providers or "cherry picking" those patients most likely to improve their quality scores. While acknowledging these concerns, the Committee agreed that identification of measures with disparities should be highlighted to make rapid and significant progress toward reducing the many disparities that exist in healthcare quality today. This initial set of disparities-sensitive measures, the prospective approach for all measures undergoing endorsement maintenance, and the use of disparities-sensitive measures for accountability will continue to evolve as quality and disparities measurement evolve.

Appendix A: Project Steering Committee and NQF Staff

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Appendix B: Recommended Set of 76 Disparities-Sensitive measures

Table B1: Disparities-sensitive measures based on the quality gap percentage of greater than 14 percent and/or a high score for the first-tier of the protocol.

The following set of 60 measures were selected as disparities-sensitive based on the quality gap percentage of greater than 14 percent and/or a high score for the first-tier of the protocol. The measures are ranked according to the first-tier score (highest to lowest).

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
543	Coronary Artery Disease and Medication Possession Ratio for Statin Therapy	Medication adherence to statin therapy for Part D beneficiaries with Coronary Artery Disease (CAD). The measure reports both an average medication possession ratio (MPR) and the percentage of Part D beneficiaries who have an MPR ≥ 0.80 for statin therapy.	14.2%	9	
719	Children Who Receive Effective Care Coordination of Healthcare Services When Needed	This is a composite measure used to assess the need and receipt of care coordination services for children who required care from at least two types of health care services which may require communication between health care providers, or with others involved in child's care (e.g. school).	14.5%	9	Yes

[4] Quality Gap: Highest gap reported. How large the gap in quality of care between the disparity population and the group with the highest quality for that measure. Measure submission/evaluation forms will be reviewed and the gap information for that measure will be recorded.

[5] As an indicator of communication-sensitive services, performance measures were tagged when they matched one of the following NQF-endorsed preferred practices for cultural competency or care coordination.

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
460	Risk-adjusted morbidity and mortality for esophagectomy for cancer	Percentage of patients aged 18 years and older undergoing elective esophagectomy for esophageal cancer who developed any of the following postoperative conditions: bleeding requiring reoperation, anastomosis leak requiring medical or surgical treatment, reintubation, ventilation 48 hours, pneumonia, or discharge mortality	17.6%	9	
1558	Relative Resource Use for People with Cardiovascular Conditions	The risk-adjusted relative resource use by health plan members with specific cardiovascular conditions during the measurement year.	18%	9	
0039	Flu Shots for Adults Ages 50 and Over	This measure represents the percentage of adults aged 50 and over who received an influenza vaccine within the measurement period within the respective age-stratified CAHPS surveys. This measure is only reported by age group stratification. The terms FSA and FSO, defined below, will be used to identify any differences between the two age stratifications.	18.7%	9	
164	Fibrinolytic Therapy received within 30 minutes of hospital arrival	Percentage of acute myocardial infarction (AMI) patients with ST-segment elevation or LBBB on the ECG closest to arrival time receiving fibrinolytic therapy during the hospital stay and having a time from hospital arrival to fibrinolysis of 30 minutes or less.	22.4%	9	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
1333	Children Who Receive Family-Centered Care	A composite measure designed to assess the family-centeredness of care delivery along several dimensions: whether doctor 1) partners with family in care, 2) listens to patient/parent carefully, 3) spends enough time with child, 4)is sensitive to family values/customs, 5) provides needed information, 6)whether family is able to access interpreter help, if needed.	35.10%	9	Yes
390	Prostate Cancer: Adjuvant Hormonal Therapy for High-Risk Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at high risk of recurrence, receiving external beam radiotherapy to the prostate who were prescribed adjuvant hormonal therapy (GnRH agonist or antagonist)	60.00%	9	
1557	Relative Resource Use for People with Diabetes (RDI)	The risk-adjusted relative resource use by health plan members 18-75 years of age who were identified as having diabetes (type 1 and type 2) during the measurement year.	2.2 relative risk	9	
389	Prostate Cancer: Avoidance of Overuse Measure – Bone Scan for Staging Low-Risk Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer, at low risk of recurrence, receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	60.00%	9	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
386	Oncology: Cancer Stage Documented	Percentage of patients, regardless of age, with a diagnosis of breast, colon, or rectal cancer who are seen in the ambulatory setting who have a baseline AJCC cancer stage or documentation that the cancer is metastatic in the medical record at least once during the 12 month reporting period	60.00%	9	
289	Median Time to ECG	Median time from emergency department arrival to ECG (performed in the ED prior to transfer) for acute myocardial infarction (AMI) or Chest Pain patients (with probable cardiac chest pain).	17.00%	9	
723	Children Who Have Inadequate Insurance Coverage For Optimal Health	The measure is designed to ascertain whether or not current insurance program coverage is adequate for the child's health needs--whether the out of pocket expenses are reasonable; whether the child is limited or not in choice of doctors; and whether the benefits meet child's healthcare needs.	7.00%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
417	Diabetic Foot & Ankle Care, Peripheral Neuropathy – Neurological Evaluation	Evaluating neurological status of patient with diabetes to assign risk category and therefore have appropriate foot and ankle care to prevent ulcerations and infections ultimately reducing the number and severity of amputations that occur. Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities during one or more office visits within 12 months.	8.00%	8	
519	Diabetic Foot Care and Patient Education Implemented	Percent of diabetic patients for whom physician-ordered monitoring for the presence of skin lesions on the lower extremities and patient education on proper foot care were implemented during their episode of care.	8.00%	8	
545	Diabetes Mellitus and Medication Possession Ratio (MPR) for Chronic Medications	Medication adherence to three classes of chronic medications for Part D beneficiaries with diabetes. The measure reports both a continuous medication possession ratio (MPR) and the percentage of diabetic Part D beneficiaries who have an MPR ≥ 0.80 for three classes of medications: oral hypoglycemic agents, statins, and angiotensin converting enzyme inhibitors (ACEIs)/angiotensin receptor blockers (ARBs).	12.00%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
81	Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge	12.40%	8	
1659	Influenza Immunization	Inpatients age 6 months and older discharged during October, November, December, January, February or March who are screened for influenza vaccine status and vaccinated prior to discharge if indicated.	14.10%	8	
1560	Relative Resource Use for People with Asthma	The risk-adjusted relative resource use by health plan members with asthma during the measurement year. This measure addresses the resource use of members identified as having asthma. Both encounter and pharmacy data are used to identify members for inclusion in the eligible population, and the results are adjusted to account for age, gender, and HCC-RRU risk classifications that predict cost variability.	14.20%	8	
1653	Pneumococcal Immunization (PPV 23)	Inpatients age 65 years and older and 6-64 years of age who have a high risk condition who are screened for 23-valent Pneumococcal Polysaccharide Vaccine (PPV23)status and vaccinated prior to discharge if indicated.	14.80%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
1634	Hospice and Palliative Care -- Pain Screening	Percentage of hospice or palliative care patients who were screened for pain during the hospice admission evaluation / palliative care initial encounter.	15.00%	8	Yes
1637	Hospice and Palliative Care -- Pain Assessment	This quality measure is defined as: Percentage of hospice or palliative care patients who screened positive for pain and who received a clinical assessment of pain within 24 hours of screening.	15.00%	8	Yes
480	PC-05 Exclusive Breast Milk Feeding	This measure assesses the number of newborns exclusively fed breast milk feeding during the newborn´s entire hospitalization. This measure is a part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-02: Cesarean Section, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns).	15.50%	8	
41	Influenza Immunization	Percentage of patients aged 6 months and older seen for a visit between October 1 and the end of February who received an influenza immunization OR patient reported previous receipt of an influenza immunization.	15.60%	8	
0525	Pneumococcal Polysaccharide Vaccine (PPV) Ever Received (Home Health)	Percentage of home health episodes of care during which patients were determined to have ever received Pneumococcal Polysaccharide Vaccine (PPV).	16.00%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
673	Physical Therapy or Nursing Rehabilitation/Restorative Care for Long-stay Patients with New Balance Problem	Percentage of long-stay nursing home patients 65 years old or older who have a new balance problem who receive physical therapy or nursing rehabilitation/restorative care	16.20%	8	
721	Children Who Attend Schools Perceived as Safe	This measure ascertains the perceived safety of child's school.	16.50%	8	
230	Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older	The measure estimates a hospital-level risk-standardized mortality rate (RSMR), defined as death from any cause within 30 days after the index admission date, for patients 18 and older discharged from the hospital with a principal diagnosis of AMI.	16.80%	8	
605	Patient(s) that had a serum creatinine in last 12 reported months.	This measure identifies patients with hypertension (HTN) that had a serum creatinine in last 12 reported months.	17.00%	8	
1337	Children With Inconsistent Health Insurance Coverage in the Past 12 Months	Measures whether children are uninsured at the time of the survey or if currently insured children experienced periods of no insurance during past 12 months	17.90%	8	
0432	Influenza Vaccination of Nursing Home/ Skilled Nursing Facility Residents	Percent of nursing home/ skilled nursing facility residents given the influenza vaccination during the flu season.	18.00%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
57	Hemoglobin A1c testing	The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had HbA1c testing.	18.00%	8	
1561	Relative Resource Use for People with COPD	The risk-adjusted relative resource use by health plan members with COPD during the measurement year. This measure addresses the resource use of members identified with COPD. Clinical diagnosis of COPD during the measurement year is used to identify members for inclusion in the eligible population and the results are adjusted to account for age, gender, and HCC-RRU risk classifications that predict cost variability.	20.00%	8	
603	Adult(s) taking insulin with evidence of self-monitoring blood glucose testing.	This measure identifies patients with diabetes mellitus taking insulin that had evidence of self-monitoring blood glucose testing in last 12 reported months.	20.00%	8	
0617	High Risk for Pneumococcal Disease - Pneumococcal Vaccination	The percentage of patients age 5-64 with a high risk condition, or age 65 years and older who: 1. Received a pneumococcal vaccine (reported separately) 2. Had a contraindication to pneumococcal vaccine(reported separately)	20.10%	8	
720	Children Who Live in Communities Perceived as Safe	This measure ascertains the parents' perceived safety of child's community or neighborhood.	21.70%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
0433	Pneumococcal Vaccination of Nursing Home/ Skilled Nursing Facility Residents	Percent of nursing home/skilled nursing facility residents whose pneumococcal polysaccharide vaccine (PPV) status is up to date during the 12-month reporting period.	22.00%	8	
1334	Children Who Received Preventive Dental Care	Assesses how many preventive dental visits during the previous 12 months	23.90%	8	
471	PC-02 Cesarean Section	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section. This measure is part of a set of five nationally implemented measures that address perinatal care (PC-01: Elective Delivery, PC-03: Antenatal Steroids, PC-04: Health Care-Associated Bloodstream Infections in Newborns, PC-05: Exclusive Breast Milk Feeding).	24.00%	8	
0421	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented	27.80%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
1340	Children with Special Health Care Needs (CSHCN) who Receive Services Needed for Transition to Adult Health Care	Whether children with special health care needs (CSHCN) ages 12-17 have doctors who usually/always encourage increasing responsibility for self-care AND (when needed) have discussed transitioning to adult health care, changing health care needs, and how to maintain insurance coverage	30.90%	8	
1641	Hospice and Palliative Care – Treatment Preferences	Percentage of patients with chart documentation of preferences for life sustaining treatments.	31.90%	8	Yes
1454	Proportion of patients with hypercalcemia	Proportion of patients with 3-month rolling average of total uncorrected serum calcium greater than 10.2 mg/dL	39.00%	8	
1394	Depression Screening By 13 years of age	Percentage of adolescents 13 years of age who had a screening for depression using a standardized tool	50 – 60%	8	
1515	Depression Screening By 18 years of age	Percentage of adolescents 18 years of age who had a screening for depression using a standardized tool	50 – 60%	8	
0032	Cervical Cancer Screening	Percentage of women 21–64 years of age received one or more Pap tests to screen for cervical cancer.	8 – 16%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
681	Percent of Residents Assessed and Appropriately Given the Seasonal Influenza Vaccine (Long-Stay)	This measure is based on data from the MDS 3.0 assessment of long-stay nursing facility residents and reports the percentage of all long-stay residents who were assessed and appropriately given the seasonal influenza vaccine during the influenza season. The measure reports on the percentage of residents who were assessed and appropriately given the seasonal influenza vaccine (MDS items O0250A and O250C) on the target MDS assessment (which may be an admission, annual, quarterly, significant change or correction assessment).	6 – 16%	8	
59	Diabetes: Hemoglobin A1c Poor Control (>9.0%)	Percentage of adult patients with diabetes aged 18-75 years with most recent A1c level greater than 9.0% (poor control)	18.00%	8	
569	Adherance to Statins	To ensure that members who are taking statins to treat hyperlipidemia filled sufficient medication to have at least 80% coverage during the measurement year.	14.20%	8	
624	Atrial Fibrillation - Warfarin Therapy	The percentage of adult patients, with atrial fibrillation and major stroke risk factors, on warfarin	19.00%	8	
0043	Pneumonia vaccination status for older adults	Percentage of patients 65 years of age and older who ever received a pneumococcal vaccination	21.00%	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
1381	Asthma Emergency Department Visits	Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the measurement period.	21.00%	8	
1399	Developmental Screening by 2 Years of Age	The percentage of children who turned 2 years old during the measurement year who had a developmental screening performed between 12 and 24 months of age.	23.00%	8	
0736	Survival Predictor for Abdominal Aortic Aneurysm (AAA)©	A reliability adjusted measure of AAA repair performance that optimally combines two important domains: AAA hospital volume and AAA operative mortality, to provide predictions on hospital AAA survival rates in patients age 18 and over.	25.00%	8	
380	Multiple Myeloma – Treatment with Bisphosphonates	Percentage of patients aged 18 years and older with a diagnosis of multiple myeloma, not in remission, who were prescribed or received intravenous bisphosphonates within the 12 month reporting period	>50%	8	
575	Comprehensive Diabetes Care: HbA1c control (<8.0%)	The percentage of members 18 - 75 years of age with diabetes (type 1 and type 2) who had HbA1c control (<8.0%).	0.76 odds ratio	8	
630	Diabetes and Elevated HbA1C – Use of Diabetes Medications	The percentage of adult patients 18- 75 years of age with diabetes and an elevated HbA1c who are receiving diabetic medications	0.76 odds ratio	8	

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[4]	First-tier Score	Maps to a communication-Sensitive Practice[5]
215	Proportion not admitted to hospice	Percentage of patients who died from cancer not admitted to hospice	1.17 odds ratio	8	Yes
581	Deep Vein Thrombosis Anticoagulation >= 3 Months	This measure identifies patients with deep vein thrombosis (DVT) on anticoagulation for at least 3 months after the diagnosis	1.87 odds ratio	8	
18	Controlling High Blood Pressure	The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year.	13.00%	8	

Table B2: Disparities-sensitive measures based on the indicator of mapping to a NQF-endorsed communication-sensitive practice.

The following set of 17 measures was selected as disparities-sensitive based on the indicator of mapping to a NQF-endorsed communication-sensitive practice. The measures are ranked according to the first-tier score (highest to lowest).

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[6]	First-tier Score	Maps to a communication-Sensitive Practice[7]
1902	Clinicians/Groups' Health Literacy Practices Based on the CAHPS Item Set for Addressing Health Literacy	These measures are based on the CAHPS Item Set for Addressing Health Literacy, a set of supplemental items for the CAHPS Clinician & Group Survey. The item set includes the following domains: Communication with Provider (Doctor), Disease Self-Management, Communication about Medicines, Communication about Test Results, and Communication about Forms.	10.00%	9	Yes
272	Diabetes Short-Term Complications Admission Rate (PQI 1)	The number of discharges for diabetes short-term complications per 100,000 Age 18 Years and Older population in a Metro Area or county in a one year period.	6.00%	8	Yes
274	Diabetes Long-Term Complications Admission Rate (PQI 3)	The number of discharges for long-term diabetes complications per 100,000 populations Age 18 Years and Older in a Metro Area or county in a one year time period.	6.00%	8	Yes

[6] Quality Gap: Highest gap reported. How large the gap in quality of care between the disparity population and the group with the highest quality for that measure. Measure submission/evaluation forms will be reviewed and the gap information for that measure will be recorded.

[7] As an indicator of communication-sensitive services, performance measures were tagged when they matched one of the following NQF-endorsed preferred practices for cultural competency or care coordination.

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[6]	First-tier Score	Maps to a communication-Sensitive Practice[7]
285	Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)	The number of discharges for lower-extremity amputation among patients with diabetes per 100,000 population Age 18 Years and Older in a Metro Area or county in a one year time period.	12.10%	8	Yes
285	Rate of Lower-Extremity Amputation Among Patients With Diabetes (PQI 16)	The number of discharges for lower-extremity amputation among patients with diabetes per 100,000 populations Age 18 Years and Older in a Metro Area or county in a one year time period.	12.10%	8	Yes
1904	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey that includes the following domains: Patient-provider communication; Complementary and alternative medicine; Experiences of discrimination due to race/ethnicity, insurance, or language; Experiences leading to trust or distrust, including level of trust, caring and confidence in the truthfulness of their provide; and Linguistic competency (Access to language services).	10.00%	7	Yes

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[6]	First-tier Score	Maps to a communication-Sensitive Practice[7]
326	Advance Care Plan	Percentage of patients aged 65 years and older who have an advance care plan or surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision maker or provide an advance care plan	0.34 relative risk	7	Yes
1821	L2: Patients receiving language services supported by qualified language services providers	This measure is used to assess the percentage of limited English-proficient (LEP) patients receiving both initial assessment and discharge instructions supported by assessed and trained interpreters or from bilingual providers and bilingual workers/employees assessed for language proficiency.	NA	6	Yes
1824	L1A: Screening for preferred spoken language for health care	This measure is used to assess the percent of patient visits and admissions where preferred spoken language for health care is screened and recorded.	NA	6	Yes
0646	Reconciled Medication List Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a reconciled medication list at the time of discharge including, at a minimum, medications in the specified categories	NA	5	Yes

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[6]	First-tier Score	Maps to a communication-Sensitive Practice[7]
0647	Transition Record with Specified Elements Received by Discharged Patients (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care, or their caregiver(s), who received a transition record (and with whom a review of all included information was documented) at the time of discharge including, at a minimum, all of the specified elements	NA	5	Yes
638	Uncontrolled Diabetes Admission Rate (PQI 14)	The number of discharges for uncontrolled diabetes per 100,000 populations Age 18 Years and Older in a Metro Area or county in a one year time period.	NA	5	Yes
0649	Transition Record with Specified Elements Received by Discharged Patients (Emergency Department Discharges to Ambulatory Care [Home/Self Care] or Home Health Care)	Percentage of patients, regardless of age, discharged from an emergency department (ED) to ambulatory care or home health care, or their caregiver(s), who received a transition record at the time of ED discharge including, at a minimum, all of the specified elements	NA	5	Yes

NQF #	Measure Title	Measure Description	Disparities Sensitive Indicator		
			Quality Gap Percentage[6]	First-tier Score	Maps to a communication-Sensitive Practice[7]
648	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Percentage of patients, regardless of age, discharged from an inpatient facility (eg, hospital inpatient or observation, skilled nursing facility, or rehabilitation facility) to home or any other site of care for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge	NA	5	Yes
213	Proportion admitted to the ICU in the last 30 days of life	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life	NA	5	Yes
8	Experience of Care and Health Outcomes (ECHO) Survey (behavioral health, managed care versions)	52- questions including patient demographic information. The survey measures patient experiences with behavioral health care (mental health and substance abuse treatment) and the organization that provides or manages the treatment and health outcomes.	NA	4	Yes
1647	Percentage of hospice patients with documentation in the clinical record of a discussion of spiritual/religious concerns or documentation that the patient/caregiver did not want to discuss.	This measure reflects the percentage of hospice patients with documentation of a discussion of spiritual/religious concerns or documentation that the patient/caregiver/family did not want to discuss.	NA	4	Yes

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