Core Quality Measures Collaborative

Meeting Summary

ACO and PCMH/Primary Care Workgroup Meeting 8

The National Quality Forum (NQF) convened a closed session web meeting for the ACO and PCMH/Primary Care Workgroup on June 18, 2020.

Welcome and Review of Web Meeting Objectives

NQF staff and 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 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. The recording will be deleted as soon as reasonably practical.

NQF staff reviewed the following meeting objectives:

- Review survey 2 voting results
- Discuss opioid use, readmissions, and medication reconciliation measures
- Continue discussion on core set measure gaps

Update on ACO and PCMH/Primary Care Voting Survey Two Results

NQF staff shared that since Meeting 7, the second ACO and PCMH/Primary Care voting survey had closed. NQF shared the results of the survey (see below):

Category	Measure	Voting Totals	Result
Behavioral Health / Substance Use	0710: Depression Remission at 12 Months	Keep: 7 Remove: 15	Remove from core set
	1885: Depression Response at Twelve Months-Progress Towards Remission	Keep: 17 Remove: 5	Keep in core set
	0418/0418e: Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Add: 19 Do not add: 3	Add to core set
	1879: Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Add: 8 Do not add: 11 Other: 2 Abstain: 1	Do not add to core set
	2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Add: 16 Do not add: 6	Add to core set
	N/A: Use of Opioids at High Dosage (HDO) (HEDIS)	Add: 15 Do not add: 6 Abstain: 1	Add to core set

	3389: Concurrent Use of Opioids and Benzodiazepines (PQA)	Add: 12 Do not add: 10	Do not add to core set *(54% voted to add)*
Care Coordination / Patient Safety	0097: Medication Reconciliation	Keep: 9 Remove: 13	Keep in core set *(59% voted to remove)*
Readmissions	1768: Plan All-Cause Readmissions (PCR) 1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)	Add 1768: 9 Add 1789: 7 *(1 with caveat)* Add neither: 5 *(1 with caveat)* Abstain: 1	Do not add 1768 or 1789 to core set *(both <60%)*

A Workgroup member asked NQF staff to review the supermajority voting rules before the Workgroup discussed any measures. NQF staff reminded the group that in order to add or remove a measure at the Workgroup level, at least 60% of votes must be in favor of adding or removing the measure, and at least one affirmative vote must come from each voting category.

Discussion of Opioid Use, Readmissions, and Medication Reconciliation Measures

NQF staff shared that the ACO and PCMH/Primary Care voting results had been presented to the Steering Committee. The Steering Committee appreciated the discussion and votes of the Workgroup and suggested further discussion on three topics (opioid use, readmissions, and medication reconciliation) where votes were close or concerns about the measure were expressed during voting. NQF advised that they will send out a survey to re-vote on the measures discussed during the meeting: while no one is required to change their vote, the team wanted to offer the opportunity to re-vote after discussion to confirm the recommendations of the Workgroup.

The Workgroup began with discussion of *N/A: Use of Opioids at High Dosage (HDO) (HEDIS).* NQF staff shared that the Workgroup voted to add this measure, but a medical association expressed concern in the voting survey that the measure does not align with CDC/HHS guidance on opioid prescriptions, and there is concern about potential unintended consequences including abrupt discontinuation of opioids. However, other members commented that the measure was aligned across the AMP Commercial ACO program and supported by their stakeholders, and another member felt that the measure was not fully tested. NQF staff also clarified that this measure is similar to the PQA measure on opioid use (NQF #2940) used in Medicaid, but the two are separate measures.

A Workgroup member commented that their organization concurs with the implementation concerns expressed by the medical association, and the measure may encourage clinicians to adjust or discontinue therapy inappropriately and encourage illicit drug-seeking behavior among patients. The Workgroup member also commented that if the HEDIS measure contains buprenorphine in the list of prescriptions (as the PQA measure does), this is counterproductive as it is used to treat opioid addiction. Upon review of the specifications following the meeting, NQF staff noted that buprenorphine is not included in the HEDIS HDO measure.

One Workgroup member expressed concern that if the HDO measure is not added to the core set, there will be no measure in the core set addressing opioid use. However, behavioral health and substance use was identified as a high-priority topic for the ACO and PCMH/Primary Care core set. The member asked whether the group would be open to including another measure as an alternative and noted that their organization uses *N/A: Use of Opioids at High Dosage (HDO)* for payment, as well as *3389: Concurrent Use of Opioids and Benzodiazepines* for additional accountability.

A Workgroup member strongly opposed the premise that at least one opioid measure should be included in the core set. The member felt that the Workgroup should be focusing on pain control and patient function, and that in terms of substance use the Workgroup should focus attention on illicit drug use as an increasing number of people are overdosing on substances such as heroin. The member felt that if there was no good alternative measure to address substance use, the Workgroup should not include any measure on this topic for the time being. Another Workgroup member endorsed this position.

A Workgroup member shared that the HDO measure would be acceptable to them if it included exclusions for those with serious illness, but acknowledged that capturing this population in measure specifications is difficult. The member felt that this measure could result in people with serious illnesses or at end-of-life being denied necessary treatment. They agreed that if an appropriate measure to address opioid use does not exist, the Workgroup should leave it out for the time being and consider some new measures next year (e.g., patient-reported outcomes). Another Workgroup member reinforced this comment and shared that spinal cord injury patients have expressed concerns that their pain needs are not being fully addressed based on concerns over opioid misuse. While the Workgroup member is open to a placeholder measure, they noted that the HDO measure is not flexible to populations with special needs.

NQF staff noted that during the voting survey, 12 were in favor of adding a possible alternative *3389: Concurrent Use of Opioids and Benzodiazepines* and 10 were against adding it. NQF staff asked whether the same concerns apply to measure 3389. Two Workgroup members shared that they still have similar concerns with measure 3389 and therefore it was not seen as a better option for addition than the HDO measure.

NQF staff asked whether the group would be open to including the HDO measure with a caveat or note specifying some of the cautions or concerns raised by Workgroup members. A Workgroup member stated that a caveat would not be sufficient and their organization has a policy against supporting any measures that advocate for hard thresholds. Another Workgroup member felt that the idea of a caveat could be helpful at a stage prior to implementation (e.g., providing comments to measure developers), but they would not support inclusion with a caveat for a measure that is already included in programs.

Workgroup members discussed alignment with other core sets, as the HDO measure is still under discussion by the Behavioral Health Workgroup. A Workgroup member noted that the ACO and PCMH/Primary Care Workgroup rejected some measures but felt that they would be appropriate for a more specific core set. Another Workgroup member felt that if the Behavioral Health Workgroup includes this measure but the ACO and PCMH/Primary Care Workgroup rejects this measure, this would pose a communications challenge, as users could be unclear about when to use which measures and which core sets. The Workgroup member who originally raised the concern shared that they would not vote for the measure for Behavioral Health and would not endorse the core sets for either ACO and PCMH/Primary Care or Behavioral Health if this measure was included. A Workgroup member commented that there might be use for the HDO measure for internal improvement and that inclusion of the measure did not mean that the Workgroup was endorsing a goal of no high-dosage opioid prescriptions. Two Workgroup members acknowledged this comment but felt that this would not be put in practice by most organizations. NQF thanked the Workgroup for their comments and noted that the team would send out *N/A: Use of Opioids at High Dosage (HDO)* out for a re-vote, but would not include measure 3389 on the re-vote survey.

The Workgroup discussed the readmissions measures *1768*: *Plan All-Cause Readmissions (PCR)* and 1789: *Hospital-Wide All-Cause Unplanned Readmission Measure (HWR).* NQF staff summarized past discussion on these measures, where the Workgroup wanted to include a readmissions measure in the core set but could not come to consensus on whether measure 1768 or measure 1789 should be included. NQF staff provided the following overview of some of the differences between the two measures, noting that 1768 is no longer NQF endorsed.

	1768: Plan All-Cause Readmissions (PCR)	**1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)**
Steward	NCQA	CMS
Endorsement	No longer NQF endorsed (as of June 11, 2020). Withdrawn by steward, but still being maintained.	NQF-endorsed
Level of analysis	Health plan	Facility, ACO
Age groups	18 years and older for Medicare 18-64 years for Medicaid and commercial	65 years and older
Exclusions	Death, pregnancy, perinatal condition, or planned admission within 30 days	Patients in PPS-exempt cancer hospitals; Patients without 30 days post-discharge enrollment in Medicare FFS; Discharge against medical advice; Admission for primary psychiatric diagnoses, rehabilitation, or cancer treatment
Programs	HEDIS, Medicaid, Marketplace Quality Rating System (QRS), Medicare Part C Star Rating	Inpatient Quality Reporting (IQR), Medicare Shared Savings Program (MSSP), MIPS
Risk adjustment methodology	Risk model accounting for observation stays status at discharge, surgeries, discharge condition, comorbidity, age and gender	Hierarchical logistic regression models with 33 risk factors accounting for age, clinical covariates, and hospital-level effects and case mix

A Workgroup member inquired why NCQA withdrew measure 1768 from endorsement. NQF staff shared that NCQA did not provide a rationale, but they are still using the measure and maintaining it. The member noted that if NCQA is still maintaining the measure, the measure is still valid and usable.

A Workgroup member asked if a representative from CMS could provide a more detailed response on why both measure 1768 and measure 1789 are being used in programs, other than the age group difference. NQF noted that they had responded that they are also in their respective programs based on aligning the level of analysis of the measures with the context of the programs.

A Workgroup member shared that the group could include the measures with caveats (e.g., if the group supported inclusion of #1768, add a note such as, "Recognizing that CMS uses #1789, consideration should be given as to whether measure 1768 or measure 1789 should be used to provide a consistent signal to clinicians"). The member also felt that if there was agreement that measure 1768 was better, CQMC should include it in the core set as a message that it is more useful, even though CMS still widely uses the other measure.

A Workgroup member felt that features of 1768 were desirable, but they have concerns because there is no information on reliability and validity at the ACO and PCMH levels. Another member shared that their organization has been doing some testing at the ACO level and the measure appears to be valid, but they can share testing results with the group if it would be helpful. The member also shared that they like that measure 1768 is stratified into different age groups.

The Workgroup agreed to re-vote on measure 1768 and measure 1789 separately. These measures will also be voted on separately at the ACO level and the PCMH level.

Finally, the Workgroup reviewed *0097: Medication Reconciliation.* The Workgroup voted to keep this measure in the core set, but the vote was close (59% vote to remove). A co-chair noted that this was potentially the only care coordination/patient safety measure in the ACO and PCMH/Primary Care set. There were few comments on this measure from the Workgroup, but Workgroup members suggested that the measure be included on the re-vote survey as well.

Discussion of Core Set Measure Gaps

NQF staff thanked the Workgroup for their feedback on the core set measure gaps and shared back the results of the survey on prioritizing measure gaps.

Workgroup members ranked these gaps as highest-priority (in order): patient reported outcomes (PROs), measure stratification to address health disparities, cost of care, unnecessary services and waste/overuse, comprehensive primary care, and misdiagnosis/delayed diagnoses. Workgroup members also suggested that continuity of care, integration across settings/specialties (e.g., integration of behavioral health services with primary care), and integration across populations (e.g., persons with co-occurring mental illness and substance use disorders) be considered as additional gap areas.

Workgroup members also provided suggestions on how CQMC could address these gaps in the future. These included adding existing measures (especially PRO-PMs and cost measures); working with measure developers to understand upcoming measures in priority areas, providing input on desirable measure characteristics, and identifying funders for measure development; and supplementing the core set with population-based outcome measures to address social determinants of health and disparities.

NQF welcomed any additional survey responses or feedback on these gap areas via email.

Next Steps

The workgroup was notified of the next steps that would be undertaken by NQF staff:

1. NQF will disseminate a short survey to re-vote on the opioid use, readmissions, and medication reconciliation measures discussed during the meeting.
2. After the re-vote, the core set will be reviewed by the full Collaborative and will proceed to full Collaborative voting (anticipate meeting in mid-July).
3. NQF will continue to use the feedback from the survey and discussion to inform their report on gap areas and future CQMC activities.