CQMC
Core Quality Measures Collaborative

Meeting Summary

Core Quality Measures Collaborative

Cardiology Workgroup: Orientation Web Meeting

The National Quality Forum (NQF) convened a closed session web meeting for the Cardiology Workgroup on December 6, 2018.

Welcome and Review of Web Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff reviewed the following meeting objectives:

- Provide an overview of the CQMC and workgroup charge,
- Discuss the CQMC measure selection principles,
- Review past work and current measure set, and
- Identify potential sources for additional measures.

Overview of the CQMC and Workgroup Charge

NQF staff reviewed the background and aims of the CQMC, current measure sets, project approach, and timeline. NQF, in collaboration with CMS and AHIP, will convene the workgroups over a series of web meetings to provide input on measure selection criteria, evaluate current measure sets to provide recommendations for removal and identify potential gaps, identify potential sources for additional measures, evaluate measures for addition to the core sets, prioritize measure gaps, and provide guidance on dissemination and adoption of the core sets.

Measure Selection Principles Discussion

Current Principles for Measure Selection:

- Measure sets must be aimed at achieving the three-part aim of the National Quality Strategy: better care, healthier people and communities, and more affordable care.
- NQF-endorsed measures are preferred. In the absence of NQF endorsement, measures must be tested for validity and reliability in a manner consistent with the NQF process, and may have been published in a specialty-appropriate, peer-reviewed journal and have a focus that is evidence-based.
- Data collection and reporting burden must be minimized.
- Measure sets for clinicians should be as parsimonious as possible and should focus on those measures delivering the most value.
- Measures should be meaningful to and usable by consumers, physicians, other clinicians, purchasers and payers, and also applicable to different patient populations.

- Measures that are currently in use by physicians, including those reported through qualified clinical data registries, measure patient outcomes, and have the ability to drive improvement are preferred. Measure sets will be continually iterated upon to add new measures and retire existing measures.
- Measure sets should provide a comprehensive picture of quality, patient-centered care, chosen from the existing measurement landscape to address outcomes of care, overuse, and underuse.
- Overuse and underuse measures should both be included as well as total cost of care measures, where appropriate, that are tested and feasible for implementation.
- Priority should be given to measures that reflect cross-cutting domains of quality (e.g., patient experience with care, patient safety, functional status, managing transitions of care, medication reconciliation).
- Patient outcomes measures should be evidence-based and should focus on those areas where the potential to improve health outcomes and increase the effectiveness and efficiency of care is greatest.
- As with all measures, those which assess performance in payment and delivery reform models should be evidence-based, apply at the appropriate level of analysis, and strive to measure on achievement of the Triple Aim of improving clinical quality, patient experience, and lower cost.

NQF staff provided an update on the refinement of the core measure set selection principles and shared a comparison of the CQMC principles with those used by other state and federal initiatives. NQF staff stated that a memo will be sent out in December 2018 to obtain the full Collaborative's feedback on the updated principles before finalizing them. A co-chair inquired if the measure selection criteria used by private payers align with the CQMC principles. A health plan member shared that their criteria mostly align with the CQMC selection principles. Occasionally, they need to consider "business" measures to drive priorities and/or provide infrastructural support. The health plan member noted that if a core set measure is not used, it is usually due to a data issue.

A co-chair suggested that some principles are must-have criteria (e.g., scientific acceptability) for all measures, while others are desirable (e.g., cross-cutting, address disparities). NQF staff noted that each measure may not be able to meet all principles as currently defined, but that the measure set as a whole should encompass the values set forth in the principles.

A co-chair highlighted that requiring NQF-endorsement may not allow for inclusion of the most current measures, as the endorsement process takes time. A co-chair suggested that the Workgroup consider measures that are scientifically acceptable, but may not have yet went through the endorsement process. NQF staff clarified that although NQF-endorsed measures may be preferred, it is not mandatory and encouraged the Workgroup to consider and share innovative measures.

A health improvement collaborative member suggested to change a selection principle from "triple aim" to "quadruple aim" and suggested prioritizing measures that address the notion of vertical integration of the healthcare supply chain (e.g., clinicians, pharmacy, and payers are measured separately, but have the same goal of improving care for individuals with a particular medical condition). The co-chairs noted these ideas align with the goals of parsimony, impact, and burden reduction. A payer representative highlighted the need for consistent guidance regarding the inclusion of measures that use electronic data sources. A payer representative noted this was a rate-limiting step in selecting measures since some payers are unable to access and use electronic data. A medical society member agreed and noted the need for clarity around data access, especially since variability in the ability to use certain measures impacts broad core set adoption.

Review of Current Core Set

Current measures in the Cardiology Core Set:

- NQF# 0330: Hospital 30-day, all-cause, risk-standardized readmission rate (RSRR) following heart failure hospitalization
- NQF# 0229: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following heart failure (HF) hospitalization for patients 18 and older
- NQF# 0081: Heart Failure (HF): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- NQF# 0883: Heart Failure (HF): Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- NQF# 0018: Controlling High Blood Pressure
- N/A: Controlling High Blood Pressure (HEDIS 2016)
- NQF# 0066: Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy--Diabetes or Left Ventricular Systolic Dysfunction (LVEF <40%)
- NQF# 0067: Chronic Stable Coronary Artery Disease: Antiplatelet Therapy
- NQF# 0070: Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy--Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
- NQF# 2558: Facility: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery
- NQF# 0119: Risk-Adjusted Operative Mortality for CABG
- NQF# 2515: Hospital 30-day, all-cause, unplanned, risk-standardized readmission rate (RSRR) following coronary artery bypass graft (CABG) surgery
- NQF# 2514: Facility: Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate (30-days)
- NQF# 1525: Chronic Anticoagulation Therapy
- NQF# 0028: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- NQF# 0505: Hospital 30-day all-cause risk-standardized readmission rate (RSRR) following acute myocardial infarction (AMI) hospitalization
- NQF# 0163: Primary PCI received within 90 minutes of hospital arrival
- NQF# 0070: Clinician: Coronary Artery Disease (CAD): Beta-Blocker Therapy—Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF <40%)
- NQF# 0230: Hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute myocardial infarction (AMI) hospitalization for patients 18 and older
- NQF# 0536: 30-day all-cause risk-standardized mortality rate following Percutaneous Coronary Intervention (PCI) for patients with ST segment elevation myocardial infarction (STEMI) or cardiogenic shock
- NQF# 0535: 30-day all-cause risk-standardized mortality rate following percutaneous coronary intervention (PCI) for patients without ST segment elevation myocardial infarction (STEMI) and without cardiogenic shock
- NQF# 0964: Therapy with aspirin, P2Y12 inhibitor, and statin at discharge following PCI in eligible patients
- NQF# 0694: Hospital Risk-Standardized Complication Rate following Implantation of Implantable Cardioverter-Defibrillator (ICD)
- NQF# 0715: Standardized adverse event ratio for children < 18 years of age undergoing cardiac catheterization
- NQF# 0733: Operative Mortality Stratified by the Five STS-EACTS Mortality Categories

A co-chair noted the importance of understanding uptake of the current core set. AHIP staff stated that a survey was conducted in 2017 to look at adoption within provider contracts and implementation challenges. AHIP staff offered to share findings with the Workgroup and solicited input on when the next survey should be conducted. The Workgroup agreed that conducting the survey now, rather than waiting until the core sets are updated, would provide valuable information. A payer representative suggested newer data would help the Collaborative better understand implementation challenges related to the timing of contracting.

A health improvement collaborative member noted that long-term care is a gap area in the current cardiology core set. A payer representative shared that during previous CQMC work, the decision was made to focus on the ambulatory setting. However, the current core set includes hospital-level measures. A payer representative noted the need to better define the measure setting of focus for all workgroups. A health plan member noted it would be useful to either have separate sets based on measurement setting (e.g., ambulatory and hospital, both under the cardiology umbrella) or to clearly define the setting of each measure in the set. A payer representative noted that physicians are increasingly being held responsible for hospital-level metrics. AHIP staff stated that the issue of “setting” will be discussed by the Steering Committee.

Identification of Future Measures

NQF staff advised that NQF would scan its portfolio and major public programs for potential measures and encouraged the Workgroup to share gap areas and measures to be considered. A payer representative recommended that measures under development as well as those in the ACC registry and QCDRs be included in the environmental scan.

SharePoint Tutorial/Next Steps

NQF staff briefly introduced the CQMC SharePoint site and shared that all CQMC-related correspondence should be sent to CQMC@qualityforum.org. NQF’s next steps include finalizing the selection principles by December/January 2018 and performing an environmental scan of measures to discuss during the next workgroup meetings in February/March 2019.