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Meeting Summary

Cross-Cutting Workgroup Web Meeting 2

The National Quality Forum (NQF) convened the second web meeting for the Cross-Cutting Workgroup on August 24, 2021.

Welcome and Roll Call

NQF staff welcomed participants to the meeting and the co-chairs of the Cross-Cutting Workgroup, Erin Royer and Sandeep Vijan, MD, also provided welcoming remarks. NQF staff reviewed the antitrust statement and acknowledged that CQMC is a member-funded effort with additional support from the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP). NQF staff facilitated roll call by organization and reviewed the agenda for the meeting.

Recap of Meeting 1

NQF provided a summary of the Cross-Cutting Workgroup's discussion to date. During Meeting 1, the Workgroup discussed the overall goals of the CQMC to identify high-value core sets of measures to encourage alignment across public and private payers and reduce measurement burden, and the goal of the Cross-Cutting Workgroup to identify measures that are more broadly applicable across specialties and settings. The Workgroup reviewed a draft cross-cutting definition, as well as a proposed list of topics in scope for the core set; members generally agreed the scope was appropriate but noted that level of analysis, clinician burden, data availability, etc. could pose challenges for individual measures. Workgroup members also discussed the importance of cost for patients and the need to understand social determinants of health (SDOH).

NQF shared that based on feedback from the Workgroup, the cross-cutting definition wording was updated to specify that cross-cutting measures apply broadly across conditions/disease areas/specialties, levels of prevention, episodes of care, and populations. The definition was also updated to specify that cross-cutting measures should apply to complex populations. In addition, the suggested scope of potential cross-cutting topics was expanded to include patient activation, shared decision-making, follow-up after hospitalization, utilization, and process measures related to SDOH. NQF staff asked whether the Workgroup had any additional feedback on the definition and scope.

A Workgroup member asked whether it would be possible to add the specific level of analysis to the definition and clarify that the Cross-Cutting Workgroup will align with CQMC and focus on measures that are at the clinician or clinician group/practice level of analysis. A co-chair agreed that this would be a helpful clarification.

A Workgroup member asked for clarification on the categorization of social determinants of health and shared decision-making in the proposed scope. The member noted that social determinants of

health are listed under "Equity" and shared decision-making is listed under "Patient and Family Engagement," but these topics also underpin other topics including medication safety and diagnostic accuracy. A co-chair clarified that during Meeting 1, the group had discussed that some of the proposed topics may overlap (e.g., the equity topics are applicable to all other topics); the list of topics is meant to help illustrate the spread of categories, but the topics are not mutually exclusive. The member thanked the co-chairs for this clarification and recommended that the group recognize that some measures may cross over multiple topics.

Workgroup members also discussed the "Patient Safety" category, which includes the subtopics "diagnostic accuracy" and "medication safety." A Workgroup member noted that it is limiting to focus on medication safety instead of broader patient safety; another member shared that focusing on medication safety excludes non-physician providers or providers who do not have the legal authority to prescribe or monitor medication use. The group discussed that "medication management" might be more broadly applicable across provider types. Group members also asked for clarification on whether the final core set is intended to apply to physicians only, or if it should also apply to other providers including physician assistants, pharmacists, nurse practitioners, etc. NQF staff shared that the final core set should be inclusive of multiple provider types if possible, but the specific providers covered by the core set may depend on how existing measures are specified and the context of the program in which they are used.

NQF staff summarized the Workgroup's feedback as follows:

- Provide additional scope within the definition that the Cross-Cutting Workgroup will focus on clinician-level measures for CQMC purposes.
- Acknowledge that the topics considered by the Workgroup are overlapping.
- Consider patient safety as a broader topic instead of focusing in on medication safety.
- Consider measures that are broadly applicable to multiple types of providers where possible.

Measure Scan and Methodology

NQF staff provided an overview of the methodology for the updated measure scan. NQF staff scanned for measures potentially relevant to the Cross-Cutting Workgroup from the CMS Measures Inventory Tool (CMIT), and identified 60 measures that fulfilled the following criteria:

- Active in at least one CMS program that is not specialty-specific or care setting specific (e.g., home health, cancer, renal, post-acute care/long-term care, skilled nursing, rehabilitation)
- Tagged with one of the following Meaningful Measures areas: Care is Personalized and Aligned with Patient's Goals, Functional Outcomes, Equity of Care, Medication Management, Patient's Experience of Care, Patient-focused Episode of Care, Preventable Healthcare Harm, Preventive Care, Transfer of Health Information and Interoperability
- Tagged with one of the following levels of analysis: Clinician: Individual, Clinician/Group, Clinicians: Group/Practice, Not Specified

After reviewing the 60 measures from CMIT, NQF staff identified 14 measures likely to be relevant to the Cross-Cutting Workgroup, after removing measures with limited populations (e.g., pediatric measures) or relatively condition-specific measures (e.g., Barrett's Esophagus, Diabetic Foot and

Ankle Care measures).

In addition to scanning CMIT for measures, NQF staff also searched the NQF Quality Positioning System (QPS) system for relevant measures. NQF staff identified 28 measures that were NQF-endorsed and tagged as "non-condition-specific" within QPS. After reviewing these 28 measures, NQF staff identified 6 measures likely to be relevant to the Cross-Cutting Workgroup after removing measures that are used in the inpatient setting only.

After combining the 14 measures from CMIT and 6 measures from NQF QPS most likely to be relevant to the Workgroup and removing duplicate measures, NQF staff created a final list of 15 measures for the Cross-Cutting Workgroup to consider for the initial core set.

NQF staff asked the Workgroup for any feedback or questions on the measure scan approach. The Workgroup did not offer any additional comments on the measure scan approach.

Measures for Consideration

NQF staff shared that the initial list of measures identified during the measure scan included 4 measures related to patient and family engagement, 4 care coordination measures, 6 population health measures, and one other measure. NQF staff noted that the scan did not identify any measures related to patient safety or equity and welcomed any suggestions from the Workgroup. NQF staff also noted that Workgroup members had proposed additional measures around vaccination, controlling high blood pressure, use of high-risk medications in older patients, population health measures including a person-centered primary care measure, and admissions/readmissions measures. These measures will not be reflected in the discussion for Meeting 2, but will be reviewed by NQF and added to the list of measures for discussion during Meeting 3 as appropriate.

NQF staff shared that they will provide an overview of each measure's specifications and use before the co-chairs facilitate discussion on the measure. NQF staff asked that Workgroup members consider whether each measure is cross-cutting based on the Workgroup's definitions and domains and whether it adheres to the CQMC's measure selection principles. If Workgroup members agree that a measure is appropriate to consider for inclusion in the Cross-Cutting core set, the measure can be included in later voting. NQF staff also reminded the group that measures should be considered as they are currently specified; if the Workgroup likes the concept of a measure but it is not appropriate to include in the core set as currently specified, the group should not vote to include the measure in the core set but can choose to make recommendations about the measure as part of the CQMC Gaps Analysis report.

Care Coordination Measures

0326: Advance Care Plan

NQF staff shared an overview of the Advance Care Plan measure, which assesses the percentage of patients 65 years or older who have an advance care plan or surrogate decision-maker documented in the medical record, or documentation that the advance care plan was discussed.

A Workgroup member shared that they believe this measure meets the group's definition for a cross-cutting measure. Another Workgroup member agreed, noting that the measure applies to multiple disease states and is especially helpful for assessing care for the older population. The member noted that the measure description targets discussion of the advance care plan, and it would be more helpful to have a measure that distinguishes between different stages towards developing an advance care plan (patient does not want to discuss; patient is considering/putting together a plan; patient has an established plan), but the measure is still helpful.

A Workgroup member expressed concern about the implementation of this measure. The member shared that advance care planning is an important part of care, but it is unclear what meets the criteria for "documentation of a discussion about the advance care plan" (e.g., is specific paperwork required to be on file? does the measure require a chart audit?). Another member agreed that the concept is important but this measure may be burdensome to implement. Members discussed that if the data source for the measure is claims, the measure would be calculated based on attestation through CPT-II codes.

A Workgroup member also shared that it is unclear how the measure would be calculated across multiple providers and if multiple surrogates are designated to support one patient. Another Workgroup member noted that advance care plans are a common and advocated approach in the areas of disability, mental illness, and aging, and the measure should not be rejected on this basis alone; the member suggested that the group follow up with the steward (National Committee for Quality Assurance/NCQA) for additional information on this area.

A Workgroup member also noted that the measure could potentially pose harm for patients, if the measure establishes an expectation that advance care planning only needs to be discussed once and does not need to be updated. Another member agreed that as specified, the measure only assesses whether the patient and provider have discussed the advance care plan once; it does not assess whether the plan is discussed and updated routinely. The Workgroup discussed that in the rationale provided in the technical specifications for the measure, the original workgroup that developed the measure "determined that the measure should remain as specified with no required timeframe… people do change their preferences often with regard to advanced care planning, but it primarily occurs after a major medical event or other health status change. In the stable patient, it would be very difficult to define the correct interval" (reference). A Workgroup member noted that there may be some additional information on potential harm in intensive care unit (ICU) literature.

Workgroup members asked for additional information on the implementation of this measure in MIPS. Another Workgroup member noted that this measure may also be used in Bundled Payments for Care Improvement (BPCI). NQF staff shared that they will follow up with additional information on the application of this measure and its use in MIPS, as well as any additional information NCQA can provide on the actionability and usefulness of this measure. NQF will leave this measure on the list for consideration and the Workgroup will continue to discuss during the next meeting.

0419/0419e: Documentation of Current Medications in the Medical Record (eCQM)
NQF staff shared an overview of measure 0419, which assesses the percentage of visits for patients 18 or older where the clinician attests to documenting a list of current medications for the patient. NQF staff noted that this measure is no longer NQF-endorsed due to high performance, but it is still used in several public reporting programs; the measure is also included in the current CQMC Neurology core set.

A Workgroup member noted that this is a "checkbox" measure in electronic health record systems; the member also noted that if the measure is high performing and is no longer endorsed, it may not be an appropriate addition to the CQMC sets to encourage innovation. Another Workgroup member agreed that this does not seem like a high-bar measure. A member noted that the measure might be more relevant and could have more room for improvement in certain specialties (e.g., behavioral health), but agreed that the measure is likely to top out in the next few years for at least some specialties. Another member agreed that this measure is unlikely to be helpful in the primary care setting but could still be helpful for specialty providers. A member noted that as specified, this measure does not necessarily "cross" different medical groups and help encourage care coordination; another member added that specialists typically confirm medications only within their specialty, and primary care physicians are more likely to review all the medications a patient is taking.

Workgroup members asked whether data is available on performance rates between primary care physicians and specialty physicians, or data separated by sites of care (e.g., community clinics vs. clinics part of a larger health system or academic medical system). NQF shared that they will look for additional performance data for this measure, but noted that they are limited to information that is publicly available. The Workgroup agreed to keep this measure on the list for further consideration; while members were also open to other measures, a member noted that this topic is essential to represent in the final Cross-Cutting set.

0645: Biopsy Follow-Up and N/A: Closing the Referral Loop: Receipt of Specialist Report (eCQM)
NQF staff shared an overview of the Biopsy Follow-Up measure, which assesses the percentage of patients undergoing a biopsy whose results have been reviewed by the physician and communicated to both the primary care/referring physician and patient. NQF noted that this measure is no longer NQF-endorsed and has not been updated since 2013, but it is still used in several public reporting programs.

A Workgroup member noted that the measure is stewarded by the American Academy of Dermatology and asked for clarification on whether the measure is limited to skin biopsies. The group discussed that the measure denominator does not specify biopsy type; a provider member confirmed that when their organization implemented this measure in their registry, they did not limit it to dermatological biopsies. A payer member confirmed that the denominator includes procedures other than dermatology and is calculated using outpatient CPT codes; the member also noted that this is claims-based, so tracking may be challenging and may require an in-depth chart review, which can lead to consistency issues when reporting.

A Workgroup member shared that they like the idea of including a measure on follow-up, but since this measure is no longer being updated, it may be difficult to implement. Another member commented that it would be helpful to include a measure on follow-up from any specialist referrals, not just biopsies. The Workgroup discussed whether N/A: Closing the Referral Loop: Receipt of Specialist Report might capture this concept; a member noted that Biopsy Follow-Up includes closing the loop with not only the referring physician, but also the patient. The group agreed to discuss Closing the Referral Loop in additional detail before returning to Biopsy Follow-Up.

NQF staff provided an overview of Closing the Referral Loop, which assesses the percentage of patients with referrals for which the referring provider receives a report from the provider to whom the patient was referred. A Workgroup member asked whether the measure specifies a timeframe for receiving the report, or a mechanism for how the referrals and reports are tracked. Workgroup members discussed that the measure is likely tracked through HCPCS codes, and the measure does not clearly specify a timeframe for follow-up, so in practice the measure would likely be tracking that a referral report was received within the calendar year.

Workgroup members expressed concerns with implementation of Closing the Referral Loop. The group agreed that the concept is important, but in practice the measure could hold primary care providers accountable for specialists who fail to report back results; the measure would also pose administrative burden for primary care providers. Other Workgroup members added that the measure does not capture whether the report is acted on, and the connection to improved patient outcomes is weak (likely due to the wide variety of referral and report types). A Workgroup member shared that this measure is a PCMH reporting requirement, but the data collected is not meaningful other than distinguishing between patients who were seen vs. not seen after referrals. The group decided to remove Closing the Referral Loop from consideration.

A Workgroup member shared that they prefer the Biopsy Follow-Up measure to the Closing the Referral Loop measure if one measure needs to be included, but they would prefer to consider measures with a wider scope than biopsies if other measures are available. NQF shared that they can review for additional measures but welcome any suggestions from Workgroup members. A co-chair also reminded the group that they are not required to include either of the measures if they are not right for the core set – the group can acknowledge the importance of the concept but note that there are not measures ready to include in the set as they are currently specified. NQF staff shared that they will keep the Biopsy Follow-Up measure on the list for consideration.

Other Measures

0101: Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

NQF staff provided an overview of this measure, which includes three rates: (1) the percentage of patients 65 and older who were screened for future fall risk at least once in the past year; (2) percentage of patients 65 and older with a history of falls who had a risk assessment for falls in the past year; and (3) percentage of patients 65 and older with a history of falls who had a plan of care for falls documented within the past year. A Workgroup member noted that it might make sense to

categorize this measure as a patient safety measure.

A Workgroup member asked whether specialists typically screen for falls, or if this is typically performed by primary care providers. The member also asked whether measures in the cross-cutting set would need to apply to all specialists (e.g., urogynecologists, gastroenterologists), or if measures would just need to be applicable to multiple groups. NQF staff shared that the Workgroup's definition included the wording "broadly applicable," but this would ultimately be up to the Workgroup's discretion, likely with input from the specialty-specific CQMC Workgroups.

Workgroup members noted that falls screening has been implemented as a "universal ask" for primary care, but it is also asked by specialists. It is performed by occupational therapists and geriatricians; other specialists might screen based on the circumstances (e.g., neurology visit post-stroke; cardiology visit where patient reports dizziness; OB/GYN visit identifying or treating osteoporosis). A Workgroup member shared that this measure is similar to another measure the CQMC discussed on screening for cognitive decline; the member shared that while the first intervention that people typically have is with their primary care provider, all providers should be able to recognize major causes of disability and illness and direct patients to appropriate care. A Workgroup member agreed that it is important that the fall question be asked to a patient at least once a year, but noted that it does not make sense for every provider to ask the question.

A Workgroup member noted that in the 2022 proposed rule, CMS is suggesting that this measure be removed from MIPS due to high performance. Another member shared that it may be topped out in primary care, but not necessarily in specialty care. A member asked whether this is another measure where NQF staff could look for any data on uptake among non-physician providers and specialty providers. NQF staff confirmed they will follow up for additional information on this measure. The Workgroup will keep this measure on the list for consideration and further discussion.

Patient and Family Engagement Measures

0005: CAHPS for MIPS Clinician/Group Survey

NQF staff provided an overview of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician & Group Survey. CAHPS asks patients to provide feedback on their experience with care received from providers and staff in ambulatory care over the past six months, including timeliness, communication, respectfulness, and coordination.

A Workgroup member asked for clarification on whether this measure could be applied outside of the hospital setting. A co-chair clarified that there are different CAHPS surveys for different settings, so the hospital and outpatient surveys are separate and the Workgroup is considering the outpatient version.

The Workgroup discussed that CAHPS is cross-cutting, patient-centered, and feasible. The group also discussed that clinicians sometimes object to some of the domains measured by CAHPS (e.g., staff friendliness) and interpretation can sometimes be limited based on response rate, but the measure is helpful for understanding patient experience at a group level, has established rules around reliable

sample sizes (e.g., 15-30 responses minimum per provider), and is already mandated to be reported for many programs. A member also noted that since CAHPS is reported on a yearly basis, providers are limited in how proactive they can be about improving patient experience, but over time this is an excellent measure of patient input.

NQF staff confirmed that since the Workgroup generally supported this measure, it will be included on the list for voting. NQF staff also noted that some of the other CQMC Workgroups that have included this measure in their core sets have elected to add a caveat/note about minimum sample size, and the Cross-Cutting group could choose to do the same to help inform users if this measure is selected for the core set.

0420: Pain Assessment and Follow-Up

NQF staff provided an overview of the Pain Assessment and Follow-Up Measure, which assesses the percentage of visits for patients 18 or older with documentation of a pain assessment using a standardized tool and documentation of a follow-up plan for any pain identified.

A Workgroup member noted that this measure addresses an important topic, but it poses an administrative burden and the specifications for what qualifies as documentation of a follow-up plan. Another Workgroup member agreed that assessing medical records for the follow-up plan would be burdensome, but noted that the measure could probably be calculated using CPT-II codes. However, information from CPT-II codes would not be helpful in assessing the quality of the discussion and follow-up plan – it would only reflect whether the discussion was held. A Workgroup member suggested that a more nuanced pain measure would be helpful – e.g., a measure assessing whether patients with pain have a multimodal treatment plan.

A co-chair asked whether Workgroup members had any comments on the measure related to opioid use and pain management. A Workgroup member shared that treating pain as the fifth vital sign has likely impacted the opioid crisis, and another member added that including this measure on its own could have potential unintended consequences. However, another Workgroup member flagged that given the gap in performance by race/ethnicity, pain management measures are also important to consider in terms of health equity.

A Workgroup member shared that there are a number of side effects and quality of life items to measure other than pain, and a broader assessment of need would be more helpful. Another member asked what other measures would be as broadly applicable across demographics besides pain; a member suggested that the Patient Activation Measure could be considered.

Finally, a Workgroup member emphasized the need for the Cross-Cutting core set to acknowledge topics such as pain, falls, etc. with major societal impact. The member noted that while there are legitimate concerns with existing measures that address these topics, the final core set needs to send the message that these topics are important in responding to patient needs and addressing serious health challenges. A co-chair agreed and suggested that the initial core set document may need to include more detailed description of an ideal “future state” core set, acknowledging specific topics that Workgroup members wanted to address but were not able to incorporate in the core set due to

the current state of measure availability. This measure will remain on the voting list.

Next Steps

NQF staff shared that the Workgroup's discussion will be summarized and shared with the group via email. The Workgroup will continue discussion of potential measures for the Cross-Cutting core set during Web Meeting 3 on August 30 from 2:00 – 4:00 pm ET; NQF staff encouraged Workgroup members to send any additional candidate measures that the group should consider via email. NQF staff and the co-chairs thanked the Workgroup for their participation and adjourned the meeting.