Meeting Summary

Cross-Cutting Workgroup Web Meeting 4

The National Quality Forum (NQF) convened the fourth web meeting for the Cross-Cutting Workgroup on September 22, 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 3

NQF provided a summary of the Cross-Cutting Workgroup's discussion to date. During Meeting 3, the Workgroup further refined the cross-cutting definition, cross-cutting topics, and measure scan approach. NQF staff shared the updated version of the definition as:

"Cross-cutting measures address essential aspects of healthcare quality that apply broadly across:

- Conditions, disease areas, or specialties
- Levels of prevention (primary, secondary, tertiary)
- Episodes of care
- Multiple populations (including persons with co-occurring conditions)
- Different provider types

Based on the CQMC scope, measures will generally apply at the clinician or clinician group level and focus on the outpatient setting."

NQF staff shared updates from measure stewards (i.e., Massachusetts General Hospital, National Committee for Quality Assurance [NCQA], Centers for Medicare & Medicaid [CMS], Mathematica, and American Board of Family Medicine) on measures for which the Workgroup had requested additional information, as follows:

- *NQF #2962: Shared Decision-Making Process*
  The Workgroup asked for additional clarification on who at the clinician or group/practice level is held accountable for the measure, as well as whether there are plans to expand the measure to address a broader range of conditions. In terms of accountability, the steward shared that the measure is intended to measure the overall patient experience but there is no one best way to work with patients when making decisions (e.g., in some centers the

surgeon is the main patient contact, while other centers use a team-based model with nurses or health coaches); because of this variation, the questions are purposely worded so that they do not assume that a single person on the care team is solely responsible for interactions with a patient; instead, the overall practice needs to make sure that the patient is informed and involved. The steward also shared that when #2962 was being submitted for endorsement, most available data was related to surgical decisions; since this time, they have collected additional reliability data for a wider range of decisions (e.g., taking long-term medications for depression, menopause, high cholesterol, high blood pressure; cancer screening) and have submitted a manuscript summarizing data from eight non-surgical studies.

- *NQF #0041/0041e: Preventive Care and Screening: Influenza Immunization*
  The Workgroup asked for additional information on the number of patients who self-report receiving the influenza immunization vs. the number of patients who receive immunizations directly during their appointment, as well as whether the developers are planning to expand data collection (e.g., integration with registries, data collection options outside of self-reporting). The steward did not have information available on self-report vs. directly receiving the immunization during appointments, and also shared that there are currently no plans to expand data collection options. The steward also highlighted that electronic clinical quality measures (eCQMs) implemented in the Quality Payment Program are limited to data from the electronic health record (EHR) and certified modules attached to the EHR, so this limitation applies to #0041e.

- *NQF #0421/0421e: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan*
  The Workgroup asked for additional information on why this measure lost endorsement. The steward shared that this measure is topped out in performance and was not submitted for re-endorsement.

- *HIV Screening (eCQM)*
  The Workgroup asked for additional information on the timing and frequency of the measure, as well as for clarification on how patients who 'opt out' of screening should be considered as part of the measure. The steward shared that this measure reflects the percentage of patients seen for outpatient visits who have documentation of an HIV test ever conducted between ages 15 and 65, but no other frequency or timing is specified in the measure; instead, timing is typically set by the programs in which the measure is used (e.g., annual reporting in the Merit-Based Incentive Payment System [MIPS]). The steward also clarified that unless a patient has opted out of testing, all patients seen during the measurement period should be tested for HIV if they have not previously been tested between ages 15 and 65. This is consistent with clinical recommendations from the Centers for Disease Control and Prevention (CDC) for routine opt-out HIV screening.

- *NQF #3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPM PRO-PM)*

The Workgroup asked for additional information on the settings where this measure has been tested, as well as plans for future use of this measure. The steward shared that outside of the primary care setting, this measure has been tested in family medicine, internal medicine, and pediatrics. The steward also shared that this measure is currently used for quality improvement efforts and as part of maintaining clinician certification, and is being considered for use in MIPS and other public and private payment programs. In the 2022 Physician Fee Schedule proposed rule, CMS specifically noted that the PCPCM PRO-PM was being considered over the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey in order to capture patient experience with one quality measure.

NQF staff stated that these written responses will also be shared with the Workgroup to help inform their voting decisions, along with summaries of previous meeting discussions.

The Workgroup continued to discuss #2962: Shared Decision-Making Process. A member shared concerns that while the measure wording is appropriate for decisions where a single yes/no option is presented, the measure does not capture more ambiguous decisions (e.g., broader process of discussing why a procedure is being considered and what the alternatives are); the measure is akin to an informed consent measure rather than a true shared decision-making measure. Another member noted that the developer shared this measure has been tested with some chronic conditions, although the actual testing data is not yet available. Another member shared that the current version of #2962 focuses on orthopedic procedures and may not qualify as cross-cutting as specified. The member also shared it is unclear how this measure would be used for chronic diseases, since the specific decision counted in the denominator would be unclear.

Another Workgroup member agreed that the measure has limitations, but emphasized the importance of including a good shared decision-making measure in the set now instead of waiting indefinitely for a perfect shared decision-making measure in the future. A Workgroup member agreed that waiting for perfect measures is not realistic, but noted that they still have concerns that 'good-enough' measures may not always be well balanced or reliable but still ultimately affect payment and reimbursement.

NQF staff summarized that while some Workgroup members have concerns about the narrow scope of the measure, other Workgroup members expressed the importance of including a shared decision-making measure in order to consider measures meaningful to patients. This measure will be moved forward to Workgroup-level voting, and if the Workgroup votes to include this measure, NQF can include notes on the application and implementation of this measure as part of the core set presentation.

The Workgroup also continued discussion of #0421: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan. A member flagged that if this measure is high-performing and the steward noted that it is topped out in performance, they would advocate for this measure to be removed from consideration. At least four Workgroup members agreed that this measure should be removed from consideration. NQF staff confirmed that #0421 would be removed from the voting list.

The Workgroup continued discussion of #3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPM PRO-PM). A Workgroup member flagged that during previous discussion, a provider organization had expressed concerns with the measure, and the member would not feel comfortable voting on #3568 without input from the provider organization on whether the developer's follow-up answers resolve their concerns. A representative from the provider organization shared that they continue to have reservations about this measure and the developer's responses did not adequately address concerns around evidence, testing, and case mix adjustment. Another provider group agreed with this comment.

A Workgroup member noted that case mix adjustment is a challenge for many measures. The member stated that it is inconsistent for the group to reject the PCPM PRO-PM based on this concern while continuing to consider other measures with case mix challenges. The member also shared that the developer has provided extensive information on testing, the measure has been NQF-endorsed, and it is being considered for use in federal programs by CMS. The member noted that if the Cross-Cutting core set does not include any patient-reported measures, this poses a messaging and credibility problem for the CQMC. The member shared that while other Workgroup members may not support this measure, they would like this measure to go to a vote.

A Workgroup member shared that they believe core set measures should fulfill higher standards beyond endorsement; while the measure is endorsed, they believe that the measure does not have enough real-world use to date, the pilot testing has included a sample size of less than 10,000, and the questionnaire is not relevant for all encounters in the practice. The member also reiterated that they are uncomfortable moving forward with this measure given provider group concerns. Another payer agreed with these concerns.

A provider group representative acknowledged that leaving this measure out of the core set could be perceived poorly by the patient community, but noted they cannot support a measure that does not adequately differentiate good and poor quality care. The representative also shared that while risk adjustment and case mix challenges apply to many measures, the PCPM PRO-PM measure is particularly sensitive to case mix adjustment because measure performance is so dependent on tenure with physician as well as patient health status.

NQF staff summarized that Workgroup members have concerns about the evidence, lack of risk adjustment, and need for real-world testing of the PCPM PRO-PM measure; however, others expressed that the measure is person-centered and the topic is important to represent in the core set. NQF shared that since at least one person was interested in moving this measure to a vote, #3568 will proceed to Workgroup-level voting. NQF shared that for context, the ACO/PCMH/Primary Care Workgroup also voted on this measure but several Workgroup members asked for additional time to discuss the measure next year; ACO will likely continue discussing the measure next year and voting results will be used to understand perspectives and inform discussion. NQF also reminded the group that the Workgroup-level voting results will still need to be reviewed by the Steering Committee and the full Collaborative before the core set is finalized.

A Workgroup member asked for clarification on whether all CQMC measures are used in payment

programs. NQF staff clarified that the intent of the core sets is to create measure sets that can be used across both public and private payers, and the measures should be appropriate for accountability and value-based programs.

Measures for Consideration

Before the review of measures, NQF staff reminded the Workgroup to consider the measure selection principles, cross-cutting definition and domains/topic areas when reviewing each measure. 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.

Population Health Measures

N/A: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups

NQF staff shared a brief overview of the measure specifications and highlighted that this CMS-stewarded measure is a re-specified, clinician-level version of #1789: Hospital-Wide All-Cause Unplanned Readmission Measure (HWR). NQF also clarified that this is not the same readmissions measure that is currently included in the ACO/PCMH/Primary Care core set. The measure included in the ACO/PCMH/Primary Care core set is the HEDIS measure #1768: Plan All-Cause Readmissions, and this measure was intended for measurement at the ACO level only, not in PCMH or primary care settings.

A Workgroup member asked for additional clarification on the level of analysis for this new measure and #1768. NQF staff clarified that the new measure is specified at the clinician/clinician group level, while #1768 is specified at the plan level. However, the ACO Workgroup recommended that #1768 be used at the ACO level, although it has technically not been tested at this level yet. The Workgroup member thanked NQF for this clarification and commented that based on this information, they are not concerned about redundancy between the Cross-Cutting and ACO core sets in this area.

A Workgroup member commented that this measure seems appropriate to include, since it spans multiple conditions. Another Workgroup member agreed with this comment.

A Workgroup member shared that their organization reviewed the specifications for this measure and were unsure if the measure would be applicable to different size clinician groups. The member shared that the measure is less reliable with sample sizes below 200, so the measure may not be applicable to individual clinicians but may be appropriate for hospitals, clinician groups, etc. The member also shared that people may also 'game' performance on this measure by placing patients in short-stay admissions, observation stays, and other lower-intensity care to avoid penalties for excessive readmissions.

Another Workgroup member agreed that a denominator size of 200 to 300 is necessary for this

measure and shared that their organization uses this measure at the plan level. The member shared that they would be in favor of addition of this measure if a note on minimum sample size is included. A co-chair asked NQF staff for clarification on whether a note could be included in the core set; NQF staff confirmed that a sample size note has been included in core set presentations for the CAHPS measures, and a similar note could be included alongside this measure if the Workgroup recommends. A Workgroup member shared that they would feel more comfortable including this measure if the sample size note is added to the presentation.

NQF staff summarized that the Workgroup considered this measure cross-cutting because it spans multiple conditions, and there are concerns around the potential to 'game' the measure as well as the need for a minimum denominator around 200-300. If this measure is included, Workgroup members would like a note on minimum sample size to be added to the core set presentation. This measure will be moved forward to Workgroup-level voting.

N/A: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions

NQF staff shared an overview of the measure specifications, highlighting that this measure was flagged by a Workgroup member as a new measure proposed in the Physician Fee Schedule for 2022. NQF stated that patients with multiple chronic conditions are defined as people with two or more concurrent chronic conditions that act together to significantly increase the complexity of management, and affect functional roles and health outcomes, compromise life expectancy, or hinder self-management.

A Workgroup member asked whether this measure and the previous Hospital-Wide 30-Day All-Cause Unplanned Readmission measures are duplicative. Another member shared that the populations covered by these measures are slightly different; the hospital readmissions measure is focused on coordinating care between inpatient and outpatient settings, while this measure is more focused on chronic care. Another member asked if one measure is more actionable than another; the Workgroup discussed again that the measure specifications are slightly different and the hospital readmissions measure is focused on a narrower time window, while the current measure addresses risk of being admitted over the course of a year. A Workgroup member shared that they support the intent of this measure, and that the list of conditions covered by this measure include chronic conditions where good management can prevent significant health impacts.

A co-chair asked for clarification on the measure use status ("inactive for MIPS") and whether the measure had ever been used in MIPS. NQF staff shared that they will follow up with the developer for clarification. The developer confirmed via email that this measure is a new measure proposed for CY 2022 and has not been implemented in any programs to date.

NQF summarized group discussion that the 30-day hospital admission and hospital admission rates for multiple chronic conditions measures have some overlap, but have different focus areas and intents. NQF confirmed that this measure will be included on the Workgroup-level voting list.

Patient and Family Engagement Measures

NQF #2483: Gains in Patient Activation (PAM) Scores at 12 Months

NQF staff shared that this measure was suggested for consideration by a Workgroup member during earlier discussion on measures related to Patient and Family Engagement. In previous discussion, Workgroup members had questions around whether the measure and questionnaire tool were proprietary. The developer and steward confirmed that a license is required to use the PAM measure; this is in order to ensure that the statements are used as designated and the scoring algorithm is protected. The developer and steward also noted that the license includes access to all versions of PAM including solutions for digital reporting, benchmarking, as well as additional training and support, and master licenses are available through the Center for Medicare & Medicaid Innovation (CMMI) and National Health Service in England. The cost of implementation aligns to scale of use, and this measure has been integrated at the point of care.

A Workgroup member shared that the topic area is important, but they would prefer not to use a proprietary measure. A Workgroup member shared that they agree with concerns about using a proprietary measure, but added for context that the Medicaid Home and Community-Based Services program uses proprietary measures. However, the member did not feel strongly that this specific measure should move to Workgroup voting.

A Workgroup member asked for additional information on the fee for using and scaling the measure. NQF staff shared that the fee for the measure typically ranges between .40c and .90c per patient/year for population-based programs. The Workgroup discussed that it would be difficult to collect PAM scores twice a year for every patient. A Workgroup member also noted that the fee could foster inequity, since this measure would be less likely to be used in lower-income populations.

A Workgroup member shared that their organization has found it extremely difficult to convince groups to adopt proprietary tools, and there are enough barriers in implementing patient-reported outcome-based tools into clinical workflow that even small costs pose large barriers to encouraging measure use.

NQF staff confirmed that due to Workgroup concerns about the proprietary nature of the measure, the group would no longer consider this measure for addition. NQF staff reminded the Workgroup that a voting survey will be shared via email following the meeting.

Gap Areas and Workgroup Recommendations

Previously Identified Gap Areas

NQF staff shared that during this initial year of discussion, the Cross-Cutting Workgroup discussed 19 measures potentially within the Workgroup's agreed-upon scope and domains. NQF staff acknowledged that several of the cross-cutting domains identified by the Workgroup had few or no existing measures to discuss. During discussion, Workgroup members also expressed several times that they would prefer to use modified versions of existing measures, or measures with broader specifications. NQF asked that Workgroup members share any recommendations they have in terms

of measure gaps, important measure concepts for development, and any other guidance on priorities for future work.

NQF shared a list of gaps that have been discussed by the Workgroup to date:

- Interest in broader care coordination/communication measures
- Measures related to follow-up care or closing the loop (e.g., referrals, communication between primary care and other specialty settings, communicating follow-up clearly to patients)
- Measures related to pain, falls, and other topics with major societal impact (e.g., multimodal treatment plan for pain)
- Measures that capture patient experience and person-centered care
- Measures related to equity and patient safety (e.g., process measures related to social determinants of health, screenings and interventions)

NQF opened discussion by asking Workgroup members to share whether there are additional gaps that are not captured in the list presented, or any specific recommendations related to these gaps.

Workgroup Discussion

A Workgroup member shared that CMS has announced the core measure sets for Medicaid and the Children's Health Insurance Program on a yearly basis for the past three to four years; while there are currently a set of optional core measures, CMS' goal is to make these measures mandatory in 2024. The Workgroup member shared that CMS works with Mathematica to gather stakeholder input and analysis related to the core measures, and that Mathematica identified five cross-cutting gap areas in their 2021 report to CMS (reference "Exhibit 7," on pages 35 and 36). The member suggested that these gap areas be referenced in future work.

Another Workgroup member shared that a gap still persists around shared decision-making measures. The member shared that there are several measures being developed around patients feeling listened to and heard in palliative care, as well as measures related to trust. A Workgroup member shared that the American Academy of Hospice and Palliative Medicine has just developed two patient-reported experience measures in this area, Feeling Heard and Understood and Desired Help for Pain. These two measures will be evaluated by NQF's Geriatrics and Palliative Care Standing Committee during the Fall 2021 cycle.

A Workgroup member also noted gaps in measuring the use of various patient-reported outcomes, such as goal attainment scoring. The member noted that NCQA is doing some work in this area that can be referenced in future.

A Workgroup member suggested that the group could review work related to care planning and measurement related to presence or absence of a care plan as a stand-alone measure.

A co-chair asked the group whether any members were aware of new measures related to patient safety, since patient safety was identified as an important domain for the Cross-Cutting Workgroup

but no relevant measures were identified. The group was not aware of any specific measures that should be reviewed, but a Workgroup member reaffirmed that patient safety including medication safety and medication reconciliation (both at points of transition and regular review) remains an important cross-cutting topic. NQF staff shared that they can search for additional medication reconciliation measures and measures on high-risk medication use in the future. A Workgroup member noted that in terms of medication safety, they are aware of an existing measure on concurrent use of benzodiazepenes and opioids; however, they are unsure if this measure qualifies as cross-cutting due to the focus on specific medications. Another member noted that psychiatric medications and counter-indicators for specific treatments (e.g., schizophrenia drugs that may cause weight gain and tremors) are a topic of concern to psychiatry and the Substance Abuse and Mental Health Services Administration, and it may be helpful to seek input from the Behavioral Health Workgroup on this area.

A Workgroup member shared that a major gap is measurement of appropriate screening for social determinants of health (SDOH). Another Workgroup member shared that there are non-proprietary survey tools that are used for SDOH screening; while they are not aware of any measures that directly connect to these tools, these tools could potentially be used in the future.

A Workgroup member commented that in the absence of measures, it may be appropriate to start with an existing, condition-specific measure and put out a vision for expanding the scope of the measure over the following years. The member commented that the Workgroup could consider the area of overlapping topics between physical and mental health, and could talk through topics and measures that need to be developed in that overlapping area.

NQF thanked the group for their additional input and shared that these gap areas will be included as part of the draft Cross-Cutting core set presentation. NQF will share a draft of the core set back with the group for feedback before finalizing the set and posting any materials online.

Next Steps

NQF staff shared that the Workgroup's discussion will be summarized and shared with the group via email. Along with the summary, NQF will share an electronic voting link with voting members of the Workgroup in order to vote on measures that should be included in the Cross-Cutting core set; the voting survey will be open for four weeks before being tallied and shared with the Steering Committee and Full Collaborative. NQF asked that members share voting rationale if possible in order to help understand reasons for the vote.

NQF thanked the co-chairs, partners at CMS and AHIP, and Workgroup members for participating in the Cross-Cutting Workgroup's first year of work. The co-chairs also provided closing remarks and thanked the Workgroup for their participation.