CQMC Core Quality Measures Collaborative

Meeting Summary

Full Collaborative

The National Quality Forum (NQF) convened a Core Quality Measures Collaborative (CQMC) full Collaborative meeting on January 7, 2022, to review the cross-cutting measures and the measure selection principles.

Welcome and Roll Call

NQF staff welcomed participants to the meeting and acknowledged the co-chairs of the Cross-Cutting Workgroup. The payer co-chair provided opening remarks, thanking Collaborative members for their participation and introducing the Workgroup's activities. NQF staff reviewed the antitrust statement and acknowledged that the 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 shared that in the interest of time, attendance would be retrieved from the list generated by the webinar platform. The meeting objectives were highlighted as follows:

- Discussion of the Cross-Cutting Workgroup update and voting results
- Update on the CQMC measure selection principles

Cross-Cutting Workgroup Updates and Measures Discussed

NQF staff shared that the Cross-Cutting Workgroup was formed in 2021 based on the input from CQMC members that the CQMC should explore measures that span specialties but that may be overlooked since the core sets focus on specialty-specific measures. In 2021, the Workgroup met four times to develop a set of cross-cutting measures that would be important to consider and may be applicable across the existing core sets. The Workgroup first agreed on a definition of "cross-cutting measures" for CQMC purposes: measures that address essential aspects of healthcare quality that apply broadly across conditions, disease areas, or specialties; levels of prevention (e.g., primary secondary tertiary); episodes of care; multiple populations (including persons with co-occurring conditions); or different provider types. NQF staff noted that the scope of the CQMC focuses primarily on the clinician group/practice level of analysis and the outpatient setting. These factors were used to identify measures for Workgroup discussion. The Workgroup also established domains (i.e., patient safety, patient and family engagement, care coordination, equity, population health) and subdomains that would ideally be covered by a cross-cutting set. A Workgroup member asked if the cross-cutting definition aligns with CMS' definition of cross-cutting measures. NQF staff shared that there are multiple efforts in the field focused on cross-cutting measurement topics and representation from CMS on the Workgroup as well as input from other participants helped contribute to the definition.

NQF staff introduced that the Cross-Cutting Workgroup recommended 14 measures that could potentially be relevant across specialties. These measures were shared with the Steering Committee in November 2021. Steering Committee members advised that the CQMC provide additional clarity

around the intended use of these measures and degree of applicability to all specialties. NQF staff shared that the core set will not be publicly posted at this time. The CQMC will discuss the measures and their applicability to each of the CQMC specialty sets. Following discussion during the full Collaborative meeting, NQF will solicit additional input on the measures via a voting survey sent to voting members of the CQMC. NQF will also convene additional Cross-Cutting meetings in 2022 to further determine the applicability of the measures across specialties. The initial list of measures and input from the Cross-cutting Workgroup may also serve as guidance for specialty-specific workgroups as they evaluate their core sets during 2022 maintenance. A Collaborative member asked what type of analysis was performed on each individual measure. NQF staff explained that the Workgroup reviewed the measure specifications to discuss and determine if the measures are generally cross-cutting. For some measures, NQF also sought out data about how the measure performed for specific specialties, but this data was often not available. It was recognized during Workgroup discussion that there may be some limitations and reasons why a measure may be less applicable to a certain specialty group. NQF staff also mentioned that they are seeking alternative titles for the "cross-cutting" core set, as there were different perspectives shared about its appropriateness and some concern that it may imply the measures would be applicable in any scenario.

NQF staff shared the process for discussing the cross-cutting measure list. The co-chairs and/or NQF staff presented the recommended cross-cutting measures to the full Collaborative, and members discussed their perspective on the measure. NQF also welcomed input on the applicability of the measures to specific specialties and any comments on how they could be implemented. NQF also shared that additional input on the cross-cutting measures would be collected via an electronic survey sent to voting members following the meeting. Discussion is summarized below for each measure, organized by cross-cutting domain.

Care Coordination

Measures related to care coordination include #0326: Advance Care Plan and #0645: Biopsy Follow-Up. Workgroup members agreed measure #0326 meets the group's definition of cross-cutting, applies to multiple disease states, and is helpful for accessing care for the older populations. There were a few concerns regarding the implementation of the measure; members noted this measure can be calculated through CPT-II codes. A Workgroup member also noted that the measure could potentially pose harm for patients if it establishes an expectation that advance care planning only needs to be discussed once and not updated over time.

The co-chair shared that measure #0645 is no longer NQF-endorsed and has not been updated since 2013, but it is still used in several public reporting programs. The biopsy follow-up measure assesses the percentage of patients undergoing a biopsy whose results have been reviewed by the biopsy physician and communicated to the primary care/referring physician and the patient. The Workgroup liked the idea of including a follow-up measure but were concerned that the measure is no longer being updated. The voting results suggest that this measure should not be included on the cross-cutting measure list. A member asked if there were concerns about the advance care plan measure requiring CPT-II codes. A co-chair explained that this was raised during discussion for several of the measure that include this data source. A full Collaborative member asked if the Workgroup discussed

how to reconcile multiple, different plans of care across different specialties. The co-chair responded that the measure promotes communication across multiple providers caring for a patient and the specifications indicate which provider is accountable and to whom the results should be communicated.

Patient Safety

Patient safety measures discussed include #0419/0419e: Documentation of Current Medications in the Medical Record and #0101 Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls. NQF staff shared that #0419/0419e assesses the percentage of visits for patients 18 years and older for which the eligible professional or eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This measure was recommended to be included on the cross-cutting measure list. Workgroup members noted this topic is essential to represent in a cross-cutting core set. However, some members did have concerns about whether this is a "checkbox" measure.

A co-chair shared that measure #0101 is a clinical process measure that assesses fall prevention in older adults. This measure considers three different rates: the percentage of patients age 65 and older who were screened for fall risk at least once a year, the percentage of patients age 65 and older with a history of falls in the past year, and the 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 in the 2022 proposed rule, CMS is suggesting that this measure be removed from the Merit-based Incentive Payment System (MIPS) due to high performance. Another member shared that while the measure may be high performing in primary care, there may be opportunity for improvement in specialty care. NQF staff was unable to obtain specialty-specific performance data for the measure. The Workgroup members voted to add measure #0101 to the cross-cutting measure list.

Patient and Family Engagement

In the category of patient and family engagement, the Workgroup voted on five measures: #0005: CAHPS for MIPS Clinician/Group Survey; #2962: Shared Decision-Making Process; #0420: Pain Assessment and Follow-Up; #2624: Functional Outcome Assessment; and #3568: Person-Centered Primary Care Measure Patient-Reported Outcome Performance Measure (PCPCM PRO-PM). NQF staff shared that measure #0005 is currently in the ACO/PCMH/PC, Pediatrics, and Neurology core sets. This measure is a standardized survey instrument that asks patients to report on their experiences with primary or specialty care received from providers and their staff in ambulatory care settings over the preceding 6 months. The Workgroup discussed that CAHPS is cross-cutting, patient-centered, and feasible. At least one Workgroup member noted that providers may have concern about certain domains measured by CAHPS (e.g., staff friendliness) and interpretation can be limited based on response rate. The measure is helpful for understanding patient experience at a group level, has established rules around reliable sample sizes, and is already mandated to be reported in several programs. A Workgroup member commented that the clinician group CAHPS is applicable to internal medicine specialties, questions are not appropriate across settings, and different CAHPS measures are required based on setting or level of analysis (e.g., a different survey is necessary to capture the

surgical experience). A Collaborative member suggested that the CQMC consider including CAHPS as a cross-cutting topic but note that different versions of the survey would be needed based on what specifically is being measured for a certain specialty or setting.

A co-chair shared that the Workgroup voted to include measure #2962 on the cross-cutting measure list. This measure assesses the extent to which healthcare providers involve patients in the decision-making process when there is more than one reasonable care option. The measure focuses on seven common and important surgical procedures: total replacement of the knee or hip, lower back surgery for spinal stenosis of herniated disc, radical prostatectomy for prostate cancer, mastectomy for early stage breast cancer or percutaneous coronary intervention (PCI) for stable angina. The shared decision-making process measure has four questions about the patient's interaction with providers about the decision to have the procedure, and the extent to which a provider or provider group is practicing shared decision making.

NQF staff shared that #0420 measures the percentage of visits for patients aged 18 years and older with documentation of a pain assessment using a standardized tool(s) on each visit and documentation of a follow-up plan when pain is present. The Workgroup members agreed that this topic area is important but expressed concerns with potential implementation and administrative burden. It was noted that this measure does not reflect the quality of the discussion on pain, only whether there is a follow-up plan documented. Workgroup members flagged potential concerns related to unintended consequences related to opioid use. The Workgroup voted to include this measure on the cross-cutting list. A full Collaborative Workgroup member asked if the measure looks for standardized pain assessment for all patients. NQF staff clarified that it would depend on how the measure is implemented, but that multiple tools could be used. The specifications include denominator exceptions for severe mental and/or physical incapacity where the person is unable to express himself/herself in a manner understood by others and when a patient is in an urgent or emergent situation where time is of the essence.

A co-chair shared that measure #2624 is in the Neurology core set. This measure assesses the percentage of visits for patients 18 years and older with the documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter and documentation of care plan based on identified functional outcome deficiencies on the date of the identified deficiencies. The Workgroup members voted to include this measure on the cross-cutting list.

NQF staff shared that Workgroup members voted not to include measure #3568 on the cross-cutting list. This measure uses a tool that includes a set of 11 patient-reported items that assess the broad scope of primary care and focus on high-value aspects of primary care. NQF staff stated that the measure was discussed by the ACO Workgroup and will be rediscussed in more detail and considered for potential inclusion during 2022 maintenance. A Workgroup member shared that from their perspective the PCPM PRO-PM measure did not have sufficient real-world testing. Another member disagreed and expressed that the measure is person-centered, and the topic is important to represent in the cross-cutting core set. The Workgroup voted not to include this measure on the cross-cutting, noting concerns that it is not cross-cutting as it focuses on primary care.

Population Health

Seven measures related to population health were discussed and voted on by the Workgroup: #0041/0041e: Preventive Care and Screening: Influenza Immunization; #0028/0028e: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention; NQF #2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling; #N/A: HIV Screening (eCQM); #N/A: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (eCQM); #N/A: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Program (MIPS) Eligible Clinician Groups; and #N/A: Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions. A co-chair shared that the Workgroup voted to include measure #0041/0041e on the cross-cutting list. This measure assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization or who reported previous receipt of an influenza immunization. The Workgroup discussed how information is collected, raising potential concerns around data collection (e.g., pharmacy data not connected to physician data, role of state vaccination registries). NQF staff asked the full Collaborative if this measure is applicable across various specialties or if it has specialty-specific considerations. A member stated that while all specialties could recommend flu shots, the burden of tracking may be challenging.

NQF staff shared that the Workgroup voted to include measure #0028/0028e on the cross-cutting list. This measure assesses the percentage of patients 18 years and older who are screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user. It was noted that this measure is currently used across several of the core sets: ACO, Cardiology, and Behavioral Health. The Workgroup discussed that while MIPS claims data showed high performance, there is still room for improvement.

A co-chair shared that the Workgroup voted to include measure #2152 on the cross-cutting list. Measure #2152 assesses the percentage of patients 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months and who received brief counseling if identified as an unhealthy alcohol user. Workgroup members discussed that these recommendations are standard in the primary care setting and brief interventions in a clinic are effective in reducing unhealthy use of alcohol.

NQF staff shared that the Workgroup voted to include measure *N/A: HIV Screening (eCQM)* on the cross-cutting list. This measure is currently in the HIV/Hepatitis C core set. Workgroup members agreed that HIV screening is critical in ending the HIV epidemic and noted that it is important to identify individuals who are positive so they can begin therapy, improve their quality-of-life, and reduce transmission. It was noted there is no consensus on the screening interval time. However, the United States Preventive Service Task Force (USPSTF) indicates that there is insufficient evidence to determine the appropriate or optimal time intervals for screening. The Workgroup members discussed the importance of this measure for screening for racial minority populations who are disproportionately affected by HIV. A full Collaborative member expressed their support for the HIV screening measure and stated that everyone ages of 15 through 65 should get screened at least once.

The co-chair shared that the Workgroup voted to include measure *N/A: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (eCQM)* on the cross-cutting list. This measure assesses the percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure and a recommended follow-up plan is documented. The Workgroup members emphasized the importance of this preventative measure because it would help ensure comprehensive care.

NQF staff shared that the Workgroup members voted to include *N/A: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for Merit-Based Incentive Payment Programs (MIPS) Eligible Clinician Groups* on the cross-cutting list. This measure is a respecified version of the risk adjusted rate of unplanned readmissions measure but focuses on clinician groups (assessing each group's readmission rates). There were some potential concerns around the potential to game the measure as well as the need for a minimum denominator of 200 to 300 patients. The Workgroup recommended that the minimum sample size note be added to the core set presentation. The co-chair then shared the last measure *N/A: Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions.* Workgroup members voted to include the measure on the cross-cutting list. This measure is the risk standardized hospital admission rate for patients with multiple chronic conditions. While this measure is somewhat simliar to the all-cause unplanned readmission measure the measures are complementary as each serves a different purpose. The readmissions measure is focused on coordinating care between inpatient and outpatient settings, while the admission measure is more focused on chronic care. The co-chair clarified that the admission rate measure defines multiple chronic conditions as people with two or more concurrent chronic conditions that act together to significantly increase the complexity of management. A Workgroup member asked why the Workgroup chose HWR over the National Committee on Quality Assurance (NQCA) all cause readmissions measure. NQF responded that the Workgroup did not discuss NCQA's readmission measures since the scope of the Workgroup was to focus on measures specified at the clinician group/practice level. However, staff noted that NCQA's measure is in the ACO core set, and this may reflect an area for alignment in the future.

Additional Measures Considered by the Workgroup

The co-chair presented other measures that were discussed by the Workgroup, but that did not move to voting based on consensus during the meeting. The measures included:

- N/A: Closing the Referral Loop: Receipt of Specialist Report (eCQM)
- NQF #0421: Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan (eCQM)
- NQF #2483: Gains in Patient Activation (PAM) Scores at 12 Months

Measurement Gaps

NQF staff shared a list of gap areas identified by the Workgroup:

- Interest in broader care coordination/communication measures
- Shared-decision making 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)
- Gaps in measuring the use of patient-reported outcomes (e.g., goal attainment scoring)
- Measures related to care planning and presence or absence of a care plan
- Measurement of appropriate screening for social determinants of health

Measure Selection Principles Update

NQF staff shared that the CQMC Principles for Core Set Measure Selection describe the characteristics individual measures should have to be included in a CQMC core set, as well as the values and concepts that a core sets as a whole should promote. The measure selection principles were last updated in 2018 and are being refined to ensure they remain relevant over time. NQF staff shared that the principles were updated (as included in the presentation slides) based on feedback from CQMC members and the Steering Committee. Feedback received includes:

- Put the measure set principles first as the desirability of a measure is determined by what is valued in a measure set
- Increase the emphasis on outcome measures, and specifically PROMs
- Maintain focus on specialty-specific quality measures but seek to incorporate shared accountability/care coordination/integration across specialties
- More deliberately address emerging areas of healthcare quality:
- Broaden charge to include health equity
- Shift to digital measures
- No cost measures as they are captured in payment programs
- Clarify wording and presentation
- Break apart some principles that had multiple concepts
- Add examples and definitions

NQF requested that any additional comments on the principles be shared with NQF via email. After final Steering Committee approval, the measure selection principles will be finalized and used to inform 2022 core set maintenance.

Next Steps

NQF staff shared that the full Collaborative's discussion will be summarized and shared with Collaborative members via email and posted on the CQMC SharePoint. NQF will share a voting survey with voting members of the Collaborative; the voting survey will be open for four weeks. NQF thanked the co-chairs, partners at CMS and AHIP, and full Collaborative members for participating in the meeting.