Meeting Summary

Core Quality Measures Collaborative Full Collaborative Meeting 4

The National Quality Forum (NQF) convened a Core Quality Measures Collaborative (CQMC) Full Collaborative meeting on Wednesday, January 18, 2023, to review and discuss updates from the Health Equity, Digital Measurement, Measure Model Alignment (MMA), and Cross-Cutting Workgroups.

Welcome, Opening Remarks, and 2022 CQMC Recap

Meredith Gerland, NQF Senior Director, welcomed participants to the meeting. Ms. Gerland reviewed the antitrust statement, as well as 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). Ms. Gerland provided an overview of the agenda and reviewed the meeting objective, which was to review updates from four of the CQMC high-priority topic area Workgroups.

Ms. Gerland introduced Steering Committee chair, Danielle Lloyd, Senior Vice President of Private Market Innovations and Quality Relations at AHIP. Ms. Lloyd reviewed the work completed in 2022, including a series of reports from the Health Equity, Digital Measurement, and MMA Workgroups and an update of the core measure sets that will be completed by early 2023. Ms. Lloyd reminded the Collaborative that the upcoming 2023 core set reviews will be limited to measures that may have lost endorsement, are no longer stewarded, or are no longer valid due to changes in clinical guidelines. Ms. Lloyd also shared that invoices for membership dues have been distributed and thanked the members that have already renewed their membership.

Ms. Gerland thanked Ms. Lloyd for the overview on the work conducted in 2022 and introduced Dana Gelb Safran, NQF President and CEO, for opening remarks. Dr. Safran highlighted that in a previous Extended Full Collaborative meeting, members shared that health equity, implementation, and digital measurement were some of the CQMC's highest impact workstreams and were most meaningful to member organizations. Dr. Safran thanked the NQF team, the workgroup co-chairs, CMS, and AHIP for their participation in the meeting and ongoing engagement with the CQMC. Dr. Safran expressed her enthusiasm for the work to come and the importance of the work being done that will be highlighted in the workgroup final reports, set to be released in early 2023.

Overview of High-Priority Workgroups

Ms. Gerland provided an overview of the CQMC's five high-priority topic area workgroups, sharing that this meeting will provide an overview of several final reports from these groups that will be released in early 2023. The Implementation Workgroup last met in June 2022 and updated the CQMC Implementation Guide; the updated Guide will be released alongside the updated core sets. The

Health Equity Workgroup endeavors to align on equity measures and measurement methods. The Digital Measurement Workgroup is focused on measure driven prioritization of data standards and is in the process of piloting an approach with the Accountable Care Organizations/Patient Centered Medical Homes/Primary Care (ACO/PCMH/Primary Care) core set of measures. The Measure Model Alignment Workgroup explored models for centralizing various components of measurements, such as data collection and dashboards. Finally, the Cross-Cutting Workgroup strived to identify measures that are relevant to multiple settings and span their relevance across the core set portfolio.

Health Equity Core Set Workgroup Recommendations

Chelsea Lynch, NQF Director, introduced the co-chairs, Dr. Sai Ma and Dr. Rama Salhi. Ms. Lynch shared that the Workgroup convened for the first time in early 2022. The Workgroup's goal is to advance health equity by ensuring perspectives on health inequities and disparities are elevated and integrated throughout the future of the CQMC. Ms. Lynch added that in the first year of work, the Workgroup focused on identifying disparities-sensitive measures currently in the CQMC core sets. The Workgroup also identified existing health equity measures and measure concepts for potential use in the core sets, and classified domains to categorize those existing measures and measure concepts. The Workgroup recommended strategies for methods to enable further identification and prioritization of disparities observed within the CQMC measures and outlined future opportunities for the CQMC to advance health equity measurement. The result of this work is captured in the CQMC Health Equity Final Report which will be published and available in early 2023.

Ms. Lynch added that the report identifies disparities-sensitive measures using an approach that considers if measures address a priority clinical area or a measurement area associated with known disparities. Measures meeting at least one of those two criteria are then reviewed against the following three measure characteristics: (1) The measure's denominator includes patients disproportionally affected by social risks compared to the general population (e.g., consistent with the current state of the literature); (2) The measure is specified for ambulatory settings; and (3) The measure is classified as an outcome measure. A total of 137 out of 150 measures were identified to be disparities-sensitive. The Health Equity Workgroup will continue to refine this list of measures by trialing additional prioritization approaches, which will first be applied to the Pediatric and Cardiology core sets. Members from the Health Equity, Pediatrics, and Cardiology Workgroups will convene in February to discuss the results of applying the additional prioritization approaches.

Ms. Lynch introduced the co-chairs to facilitate the discussion. Dr. Ma asked participants for any feedback or comments regarding the work presented or for any high-level feedback (e.g., key challenges, barriers, best practices) the members may have in relation to health equity measurement. Dr. Salhi noted that this work has highlighted the challenges of utilization, such as patient identification and the complexities of stratifying data.

A member noted that, in 2021, CMS began reviewing measures related to screening patients for social risk factors for inclusion into federal programs. The member highlighted that screening for social risk factors focuses less on what should be measured and more on the information needed to understand what actions must be taken to improve equity, and asked if this would be in scope for the

future work of the Health Equity Workgroup. Ms. Lloyd clarified this query by noting that there may be other determinants, outside of the set of social determinants of health, that would be beneficial to collect to be able to address barriers that are factoring into outcomes. Dr. Ma shared that NQF has recently published its report, *Developing and Testing Risk Adjustment Models for Social and Functional Status-Related Risk Within Healthcare Performance Measurement*, which includes a list of available social risks data sources and variables that should be considered in a risk adjustment model. Dr. Ma noted that identifying what social risks are involved for each relevant measure could potentially be in scope for this work. Ms. Lloyd reminded members that the Health Equity work examined two workstreams, one to examine disparities in clinical quality measures in CQMC core sets, which do include screening measures, and one to identify health equity measures. Therefore, the screening measures referenced in the initial question would be within scope for the CQMC to consider. Dr. Safran shared that CQMC could potentially serve as a resource and platform to determine how to stratify CQMC measures to identify disparities by determining what variables to include and how to get the data for those measures. Ms. Lloyd reminded members that the CQMC's scope includes consideration of existing measures rather than measure development. She also noted that there is not yet consensus on whether the CQMC should make recommendations to stratify measures that do not include stratification in their specifications or if those measures should be returned to the measure developer for further testing to determine when and how a measure could be stratified. Dr. Ma added that the Health Equity Workgroup previously discussed the importance and high demand for providing technical assistance to measure developers regarding stratification.

A member called attention to challenges caused by the incorporation of value-based payment into private and public health plans on different timelines. The member noted that quality improvement and care standards may be designed for one set of criteria that subsequently do not align with new quality measures and requirements needed from others. The number of different requirements and core sets across plans leads to a heavy administrative burden. Dr. Salhi acknowledged comments in the chat agreeing that it is critical to recognize the administrative burden of increased numbers of measures at the implementation level.

Dr. Ma thanked the members and opened the discussion for further feedback, comments, or suggestions for future work. Dr. Salhi invited participants to share other comments throughout the course of the meeting. Ms. Lynch thanked the co-chairs for facilitating the discussion and reminded CQMC members to contact NQF if they have any ideas or feedback for the future.

Digital Measurement Core Set Workgroup Recommendations

Ms. Lynch introduced Dr. Elizabeth Drye, NQF Chief Scientific Officer. Dr. Drye acknowledged the Digital Measurement Workgroup co-chairs, Dr. Helen Burstin and Mr. Patrick Sturgeon. Dr. Drye reviewed the 2022 work and shared that the final report will be released soon. The Workgroup convened four times in 2021 to identify the current landscape, barriers, and path forward for digital quality measure implementation, as well as to discuss the business case for the CQMC to use digital data to advance alignment.

Dr. Drye shared that there are approximately 30 electronic clinical quality measures (eCQMs) in the CQMC core sets, but these measures have low uptake due to barriers such as implementation costs

and reporting requirements for multiple programs. Low burden measures, such as those from clinical electronic health records (EHRs) may be more meaningful to patients and clinicians, and have better uptake. Dr. Drye also shared collaborative efforts to map out data flows, including how data flows from sources and is aggregated in physical and virtual spaces and how scores are evaluated and shared. These efforts allowed the members to determine which areas to focus on for action and policy change. The Workgroup opted to focus current work on forward-looking opportunities, such as advancing data interoperability to promote low burden, exchangeable, interoperable data that is defined consistently across EHRs. Therefore, the group is focusing on data that will be defined and exchanged in Fast Healthcare Interoperability Resources (FHIR). Dr. Drye stated that the Workgroup will identify the highest priority measures that use clinical EHR registry data, and then NQF staff will support a process to identify the data elements required by those measures for specification in FHIR. This approach will be piloted in the ACO/PCMH/Primary Care core set. Dr. Drye added that the Office of National Coordinator for Health Information Technology (ONC) is engaged in this approach to translate data elements in FHIR, and once the prioritized measures are specified, ONC can then move them forward in its process to advance interoperable data.

Dr. Burstin led the discussion and emphasized that a significant number of existing ACO/PCMH/Primary Care core set measures are National Committee for Quality Assurance (NCQA) measures, and NCQA is already striving to make them digital. Dr. Burstin added that it will be important to reflect on key challenges that would help transition to digital quality measurement. Mr. Sturgeon emphasized the need to evaluate challenges that may come up for the varying organizations when transitioning to digital quality measurement. Dr. Safran solicited input from participants on what digital measures they would like to be able to use sooner rather than later, and what other core sets should be evaluated in addition to the pilot test of the ACO/PCMH/Primary Care core set.

Dr. Burstin invited the members to share questions and comments for discussion. A member agreed that the ACO/PCMH/Primary Care core set is an appropriate starting point, as it has overlapping measures for various topics and across different populations. The member emphasized that the next step would be determining a prioritization process, as it is difficult to have large core sets to evaluate for digital prioritization.

A member asked for clarification on how core sets are created, and how measures are determined for different core set topic areas. Amy Guo, NQF Manager, provided a brief overview of the NQF Measure Selection Principles, which help determine what measures are included in a core set. Some characteristics include scientific acceptability, opportunity for improvement, and unlikely to have unintended consequences, among others. Ms. Guo added that interested parties can reach out to CQMC, CMS, and AHIP to discuss opportunities to develop additional core sets and shared a link to potential topic areas for future CQMC core sets.

A member emphasized that much of primary care still faces challenges with capturing eCQMs, especially in smaller clinic settings, given that older EHRs may not be able to accurately produce them. The member continued that without updates to ONC certification requirements, it may be difficult to make progress as a field. Dr. Drye acknowledged these challenges and shared that ONC is moving toward certifying data elements in the future, so EHRs will need to generate data elements,

but not calculate measure scores, which will reduce this burden. A member asked for clarification on whether there will be a universal add-on tool in the future to determine data elements. Dr. Burstin shared the purpose of the mapping exercise done with collaboration from the Council of Medical Specialty Societies (CMSS), NCQA, CMS, and NQF was to know what the building blocks are to determine interoperability based on ONC and CMS requirements. Dr. Drye added that ONC has a particular process and would like to hear from the CQMC workgroups on what the most important data elements are to advance interoperability standards.

A member shared a concern about data quality and if the current process has aligned incentives for coding across payers. Dr. Burstin shared that the interoperability rules going into effect will require a data mapping process that will be payer-agnostic. Dr. Drye shared that data validation would be critical in the process. An NQF consultant shared that the best practice framework has been compiled and provided to the Workgroup that determines the most useful codes for quality improvement. The consultant provided a comparison between using the framework to determine data elements and leveraging existing work, such as implementation guides used in FHIR, which bridge the gaps and educate provider networks and frontline workers who can then further improve data collection.

A member suggested that there should be a standard approach to aggregate data from both claims and electronic sources, noting that the US Core may provide a default option, to reduce the burden of measure computation. An NQF consultant shared that the US Core is used as the foundation for Healthcare Effectiveness Data and Information Set (HEDIS) specifications and agreed there should be multiple sources to aggregate data. The consultant added that EHRs should not be expected to conduct the measure calculations. A member agreed that having an eventual means of standardized reporting process would lead to less variation in the implementation of computed measures.

Dr. Drye thanked members for the comments and Dr. Burstin agreed that the discussions provided excellent feedback. Dr. Burstin added that the Digital Measurement Workgroup looks forward to future feedback from the broader CQMC community about additional core sets to be reviewed beyond the ACO/PCMH/ Primary Care core set.

Measure Model Alignment Core Set Workgroup Recommendations

Ms. Gerland provided an overview on MMA and acknolwedged the co-chairs, Dr. Jamie Reedy and Dr. Ranyan Lu. Ms. Gerland shared the goal of the MMA Workgroup was to develop best practices and policy recommendations that address governance, structural, and operational models for payer and purchaser alignment around the collection, transmission, standardization, aggregation, and dissemination of data to support scaled core set adoption and implementation while reducing provider burden. Ms. Gerland shared that the workgroup met five times through 2021 and 2022, and meeting discussions focused on reviewing characteristics of publicly available collaborative models, discussing barriers and solutions towards greater standardization of measurement, and outlining options for creating an aligned measurement model across payers to reduce burden and provide clear information on quality of care.

Ms. Gerland added that the MMA report will be released in early 2023. She shared a high-level outline of the report, which serves as a starting point for the development of collaborative models of

quality measurement across the nation. The report includes descriptions of existing measure models, a business case highlighting the need to align measure models, and three potential structural options for regional and national alignment. Ms. Gerland highlighted key pieces of information and critical operational elements which were adapted according to elements of a measurement system from NQF. The MMA workgroup concluded that specific operational elements are important considerations for stakeholders. The workgroup emphasized the alignment of elements such as measure selection and adoption, data collection and transmission, stratification and risk adjustment, attribution, and scoring and reporting. Ms. Gerland provided an overview of the measurement process described in the MMA report that includes end-to-end processes starting with the collection of data and ending with the dissemination of data. Ms. Gerland also shared three potential structures that could be used to promote model alignment on a national scale: one utilizing existing regional models, one network of regional models through a common system, and one where a third-party aggregator compiles data from multiple providers and organizations. Ms. Gerland invited the co-chair, Dr. Lu, to facilitate additional discussion on potential benefits of alignment and future opportunities for the CQMC to promote model alignment.

Dr. Lu highlighted the CQMC's efforts to create standard measure sets in specialty areas and shared that the MMA work is a natural next step to understand governance structures and frameworks that can help support broader alignment of measurement process across the nation. Dr. Lu reiterated that the MMA report will be released soon, and invited attendees to share their perspectives on how members can benefit from the framework and what opportunities may exist to promote alignment on a national and regional level. Dr. Safran also prompted members to share any factors that help facilitate alignment in their respective organizations, or any gaps that exist that could be filled through MMA.

A member shared that MMA can help address a small portion of provider burden, but the majority of burden is related to administrative waste related to payment, which is beyond the scope of the MMA work. The member shared that their providers expressed a desire for quality measurement and quality of care to be consistent with payment mechanisms (e.g., providers who consistently provide high-quality care should require fewer pre-authorizations to order services; services that are considered a standard of care should not require pre-authorization). The member emphasized that reducing this administrative burden is extremely important to primary care providers.

Another member asked whether the group will be discussing measure implementation during the meeting. Ms. Gerland shared that the Implementation Workgroup would not be discussed during the meeting, and updates to the Implementation Guide would be shared in a future meeting. The member commented that promoting implementation of the core sets across payers is the top priority for their organization and encouraged the group to consider opportunities to improve implementation of the core sets in the future.

A member reiterated previous comments on the burden associated with prior authorization, especially for smaller providers, and the importance of understanding ways to promote implementation of the core sets. Dr. Lu thanked the members for raising the issue of reducing provider burden and added that the goal of MMA is to reduce burden from misalignment for multiple

stakeholder groups, including providers and health plans. Dr. Lu asked the Collaborative for additional feedback on how data aggregation can be improved to remove barriers to data flow; members did not provide any further comments. Ms. Gerland thanked the group for their feedback and encouraged members to share any additional thoughts or feedback in the chat.

Cross-Cutting Core Set Workgroup Recommendations

Ms. Guo provided an overview of the Cross-Cutting Workgroup's goals and work to date, and acknowledged the co-chairs, Erin Royer and Dr. Sandeep Vijan. Ms. Guo shared that the Cross-Cutting Workgroup was formed based on prior Collaborative feedback that there are overarching gap areas across quality measurement, and that a broader approach to quality measurement could help address these areas. The Cross-Cutting Workgroup convened four times in 2021 and worked to develop a definition of cross-cutting measures, a framework of important cross-cutting topics, and a list of cross-cutting measures the Workgroup agreed can be applied across specialties.

Ms. Guo reviewed a table of the framework with topics of cross-cutting measures including patient safety, patient and family engagement, care coordination, equity, and population health. Ms. Guo also reviewed the measure scan approach that was used to identify cross-cutting measures from the CMS Measure Inventory Tool (CMIT) and NQF Quality Positioning System (QPS) databases, and noted that the Workgroup created a final list of 14 cross-cutting measures addressing topics such as advance care planning, medication documentation, falls prevention, patient experience, shared decision-making, pain assessment, functional outcome assessment, preventive care and screening measures, and readmissions.

The list of cross-cutting measures was reviewed by the Steering Committee, which expressed concerns related to the implementation of the cross-cutting measures. The Committee noted that while the cross-cutting measures are relevant to multiple specialties, they are not relevant to all specialties. The Committee noted that if the cross-cutting measures were published as a standalone core set, it could imply that all providers should report on the full list of cross-cutting measures, which would increase reporting burden for clinicians – counter to the original goals of CQMC. Based on this feedback, the CQMC adopted a different approach for the cross-cutting measures going forward.

The Full Collaborative reviewed the 14 measures at a 2022 meeting, were surveyed once to confirm that the list of 14 measures was cross-cutting, and then surveyed again to determine which measures Workgroup members agreed were most applicable to their own core sets. Based on these voting results, several Workgroups affirmed the importance of NQF #0028/0028e and #2152, measures related to preventive care and screening for tobacco use and unhealthy alcohol use that were already included in their respective core sets. The Medical Oncology and Orthopedics Workgroups also indicated that NQF #0420 *Pain Assessment and Follow-Up* was a cross-cutting measure relevant to their specialties.

Ms. Guo added that the cross-cutting measures will not be published as a standalone set; instead, the measures that each Workgroup indicated were relevant to their specialties will be included as a separate section in their individual core set presentations. The updated core set presentations will include language emphasizing that these cross-cutting measures can provide helpful supplemental

information and are potentially relevant across multiple topic areas. Ms. Guo acknowledged that there are additional opportunities for the group to integrate cross-cutting topics into Workgroup-specific discussions, and to continue adjusting the approach to updating and formatting the core sets to make them more useful for end users. Ms. Guo invited the co-chair, Dr. Vijan, to highlight any additional points of discussion from the Cross-Cutting Workgroup and facilitate additional discussion on these opportunities.

Dr. Vijan emphasized that during discussion and review of available measures, the group had challenges identifying measures that apply to all specialties and eventually agreed that it was reasonable to include measures that applied to multiple specialties. This challenge still remains going forward, and the CQMC will need to continue identifying measures that capture aspects of care important to all patients across specialties and settings and capture shared responsibilities across the healthcare system. Dr. Vijan welcomed additional comments from the Collaborative.

A member emphasized the potential value of a population health-based approach, noting that for maximum impact, the core sets should address areas that broadly affect the population (e.g., high blood pressure control, diabetes, infant mortality, access to primary care, vaccinations, medication reconciliation). The member acknowledged that the CQMC core sets largely focus on specialties, but specialty measures are likely to cover a much smaller population and have a more limited impact than primary care measures. Dr. Vijan asserted that this comment aligns with the Cross-Cutting Workgroup's aim to identify measures that affect a broad population, but the group struggled to balance issues around responsibility, accountability, and population health (e.g., whether an orthopedic surgeon, primary care provider, or cardiologist should be assigned accountability for blood pressure control). The member shared a Health Affairs blog post, "The Case for Aligning Quality Improvement," for additional perspective on streamlining measurement and focusing on topics with a significant impact on population health.

Another member added that the majority of topics in the list of cross-cutting measures seem relevant to primary care and asked for a brief overview on the core sets (e.g., typical size, types of measures, and method of dispersion). Dr. Vijan shared that his own primary care organization tracks approximately 80 measures, three to four times the typical number of measures tracked in other specialties. Ms. Guo shared that there is a supplemental section for cross-cutting measures in the respective specialty core sets, which the CQMC anticipates will be released in the coming months. Ms. Guo also shared a link to the CQMC's Analysis of Measurement Gap Areas and Measure Alignment report, which summarizes statistics on the size and characteristics of measures in the CQMC core sets ("Core Set Measure Characteristics," page 8). Dr. Vijan shared that while the cross-cutting measures included some patient-reported measures (e.g., shared decision-making and functional outcomes assessment), there may be future opportunities to promote more patient-oriented measures.

A member asked for more context on how the Cross-Cutting Workgroup defined cross-cutting measures, and how the final definition will affect how the cross-cutting measures are used and presented in the future. Dr. Vijan shared that the Workgroup had difficulty identifying measures that apply to all aspects of healthcare, and to address the Workgroup's goal of identifying highly relevant

measures, the group agreed it would still be helpful to identify measures that are relevant to multiple specialties (if not all) – e.g., smoking cessation or pain assessment. Ms. Guo agreed with the co-chair and reiterated that the decision to adapt the CQMC's overall approach for cross-cutting measures was related to the Workgroup's desire to include broadly relevant measures, while recognizing differences in accountability for some outcomes based on provider type.

A member shared that it would be relevant to include discussion in any future reports related to cross-cutting measures about how all providers share a responsibility regarding patient health. Patients' health problems are interrelated, and certain populations are at risk for worse health outcomes because of silos in healthcare and unwillingness to address all aspects of a patient's care (e.g., patients in psychiatric hospitals die earlier than the general population due to limited treatment for chronic illnesses such as diabetes and high blood pressure). Dr. Vijan noted that this broad issue may be beyond the scope of the CQMC and is connected to the overall structure of the healthcare system and how different providers' core competencies and scope are defined, and thanked the member for their insight.

Next Steps

Ms. Gerland reviewed the upcoming activities. NQF will hold the Health Equity meeting on February 16 and the Digital Measurement meeting on March 1. The Health Equity, Digital Measurement, and Measure Model Alignment reports are scheduled for release in early February. Ms. Gerland shared that the next Full Collaborative meeting will likely be scheduled for March 2023 to vote on the remaining ACO/PCMH/Primary Care and Orthopedics core set updates. Ms. Gerland thanked attendees for joining the meeting, shared the CQMC's contact information, and adjourned the meeting.