Draft CQMC Health Equity Final Report

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Contents

Core Quality Measures Collaborative

The Core Quality Measures Collaborative (CQMC) is a public-private partnership working to address the proliferation of measures by facilitating cross-payer measure alignment. The CQMC was convened in 2015 by America's Health Insurance Plans (AHIP). CQMC membership includes the Centers for Medicare & Medicaid Services (CMS), health insurance providers, medical associations, consumer groups, purchasers (including employer group representatives), and other quality collaboratives working together to recommend core sets of measures by clinical area to assess the quality of healthcare in the United States (U.S.). The CQMC is a voluntary effort in which members choose to participate and subsequently promote the adoption of the core measures.

Executive Summary

Health equity is the fair and just opportunity to achieve the highest level of health for all individuals regardless of race, sexual orientation, gender identity, disability, socioeconomic status, geography, preferred language, or other factors that can affect access to healthcare and health outcomes.[1–5] There are numerous definitions of health equity with overarching themes, such as the support of societal efforts to address avoidable inequities (i.e., "systemic differences in the health status of different population groups")[6] and historical and contemporary injustices, including systemic racism, and the elimination of health and healthcare disparities (i.e., "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantages"),[7] which may manifest as negative outcomes impacting life expectancy, disease burden, disability, and quality of life.[1–5] A focus on health equity is essential in helping to identify unwarranted variation in care, improving the quality and outcome of the healthcare provided, and identifying and eliminating health disparities.

The CQMC is a public-private partnership between AHIP and CMS convened by National Quality Forum (NQF). The CQMC is composed of over 70 member organizations, including health insurance providers, primary care and specialty societies, consumer and employer groups, and other quality collaboratives, working to facilitate cross-payer measure alignment. The CQMC has developed core measure sets that demonstrate an industry commitment to advancing healthcare quality and creating actionable information for consumers while simultaneously reducing stakeholder burden.

The Coronavirus disease 2019 (COVID-19) pandemic illuminated stark disparities in our healthcare systems and highlighted the need to improve health equity. Recognizing the important role of performance measurement and value-based care in advancing health equity, the CQMC has taken several steps to begin addressing disparities. First, the CQMC revised its Principles for Core Measure Selection to more clearly emphasize the importance of selecting measures that advance health equity. Additionally, recent CQMC work identified measurement gaps and priorities and highlighted the broad need for measures that incorporate our understanding of social determinants of health (SDOH) and can be used to identify and therefore address disparities. In 2022, the CQMC established the Health Equity Workgroup to ensure perspectives on health inequities and disparities are considered and elevated through the CQMC core sets. This report highlights the Workgroup's efforts by describing the following:

- Approach for identifying disparities-sensitive measures within the CQMC core sets
- Results of applying the disparities-sensitive identification approach to measures within the CQMC core sets
- Strategies for methods that will enable identifying and prioritizing disparities observed within the measures that compose the CQMC core sets
- Classifications of domains to categorize measures for the CQMC that promote health equity measurement
- Methodology for identifying existing measures and measure concepts that promote health equity
- List of existing measures and measure concepts that promote health equity and align with the CQMC's measure selection criteria
- Opportunities for the CQMC to advance health equity measurement in the future

The approach for identifying disparities-sensitive measures in the CQMC core sets is as follows: If the measure topic area assesses one of the identified priority clinical areas (i.e., clinical areas or conditions determined to disproportionately impact underserved communities), OR it addresses an area with disparities, AND it meets at least one predefined characteristic, then the measure is disparities-sensitive. Based on the 2017 NQF report titled A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity, the measure characteristics being evaluated for this approach are as follows: (1) The measure's denominator includes patients disproportionally affected by social risks compared to the general population, (2) The measure is specified for ambulatory settings, and (3) The measure is classified as an outcome measure (see Figure 1). After applying this approach to 150 measures across 10 CQMC core sets, 136 disparities-sensitive measures were identified. Of the measures:

- 19 met the priority clinical area or measurement area with disparities criterion and met all three measure characteristics;
- 90 met the priority clinical area or measurement area with disparities criterion and met two measure characteristics; and
- 27 met the priority clinical area or measurement area with disparities criterion and met one measure characteristic.

A significant finding of this work is that almost all measures in the CQMC core sets are disparities-sensitive, suggesting that implementation of the core measures is an important strategy in advancing equity. Although 14 measures did not meet the criteria for disparities sensitivity using this approach, the Health Equity Workgroup recognized that all measures likely have some level of disparity, but the disparities may not have been measured yet, or more resources are needed in those areas to assess the disparities. The Workgroup also recognized the need to prioritize which measures to implement and stratify to make measurement and improvement feasible, particularly as there are often limited resources to support such work. The Workgroup identified three strategies to enable further identification and prioritization of disparities observed within measures that compose current CQMC core sets: (1) Determine which measures to dedicate resources to; (2) Improve the ability to stratify measures by modifying measure specification and testing requirements; and (3) Stratify data to assess disparities and inform setting benchmarks.

NQF reviewed foundational literature, measure databases, and measures included in value-based programs to identify existing measures and measure concepts that are not currently in the CQMC core sets that promote health equity and are publicly available. A total of 31 additional existing measures and measure concepts were identified, and the CQMC's measure selection principles were applied. After eliminating 20 measures and measure concepts that addressed health at the population level or were index measures (i.e., assesses a topic using more than one data item)[8], a total of 11 measures and measure concepts remained at the clinician, facility, or plan level of analysis. These 11 measures and measure concepts were then categorized into domains for the CQMC that promote health equity. The domains are Enablers of Cultural Responsiveness, Access, Social Needs/Risks, Quality of Care, and an Equity Ecosystem.

The Workgroup also explored future opportunities for the CQMC to advance health equity measurement. These opportunities include the following:

- Encouraging stratification of all existing measures in the core sets to help assess and address disparities
- Incorporating measures that directly assess the drivers of health equity (e.g., social needs assessment, access to care) into each core set
- Supporting and aligning with initiatives related to standardizing health equity-related electronic data elements
- Creating "how to" resources to guide organizations in their efforts to stratify data to assess disparities and to leverage the data to address the disparities identified
- Closing identified measurement gaps to promote health equity in the CQMC

This report is foundational to identifying and addressing disparities identified in CQMC measures and advancing health equity within the CQMC. The CQMC remains dedicated to these goals and will continue to engage the Health Equity and clinical core set Workgroups to build upon and refine the activities described in the report during future work.

About the CQMC

The CQMC is a unique and collective effort designed to align measures and promote measurement initiatives between public and private payers across the country. The CQMC accomplishes these goals by maintaining clinical core measure sets, or parsimonious groups of scientifically sound measures, that efficiently promote a patient-centered assessment of quality and should be prioritized for adoption in value-based payment (VBP) programs and alternative payment models (APMs). The CQMC prioritizes clinician-level measurement in the outpatient setting and is developed using a multistakeholder process.

These core sets are available on the CQMC core sets page and cover the following topic areas:

1. Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMH), and Primary Care (PC)
2. Cardiology
3. Gastroenterology
4. Human Immunodeficiency Virus (HIV) and Hepatitis C
5. Medical Oncology
6. Obstetrics and Gynecology (OB/GYN)
7. Orthopedics
8. Pediatrics
9. Neurology
10. Behavioral Health

The CQMC also focuses on high-priority measurement initiatives, including digital measurement, measure model alignment, implementation of the CQMC core measure sets, and health equity. These ongoing initiatives utilize the expertise and varied perspectives across members to gather current efforts and advance measurement by sharing best and promising practices. More about the CQMC can be found on the CQMC website.

About the CQMC Health Equity Workgroup

The CQMC Health Equity Workgroup is composed of 35 experts (Appendix C) with varied expert perspectives, representing payers, providers, consumers, health equity researchers, measurement experts, regulatory agencies, and healthcare collaboratives, to provide and share ongoing expertise in this field. This Workgroup was convened through a public call for nominations process and aims to advance health equity by ensuring perspectives on health inequities and disparities are elevated and integrated throughout the future of the CQMC core sets. The Workgroup met in April, May, and June 2022 to meet the following objectives:

- Identify current CQMC measures that are disparities-sensitive
- Identify existing health equity measures and measure concepts for potential use across payers in value-based contracts
- Classify domains to categorize existing measures and measure concepts for the CQMC that promote health equity measurement
- Recommend strategies for methods that will enable identifying and prioritizing disparities observed within measures that compose current core sets
- Outline future opportunities for the CQMC to advance health equity measurement

The Workgroup's discussions were incorporated into this Final Report, which will be posted for a 14-day review and commenting period in August 2022. The Workgroup will meet again in August 2022 to review public comments received and finalize this report.

Unless a fact or comment is explicitly attributed to a specific source, the information in this report was based on the Workgroup's deliberations and synthesized by NQF.

Disparities-Sensitive CQMC Measures

The identification of disparities-sensitive measures within the CQMC core sets is intended to help direct efforts on gathering actionable performance data to those stakeholders able to affect change within their practices. A disparities-sensitive measure detects not only differences in quality across institutions or in relation to certain benchmarks, but also differences in quality among populations or social groups (race, ethnicity, language, etc.).[9] The process to identify disparities-sensitive measures within the CQMC core sets has evolved based on discussions with the Workgroup. The identification of disparities-sensitive measures within the CQMC core sets is separate from the identification of existing measures and measure concepts that promote health equity in the Health Equity Measure Scan below.

Background for the Approach

The initial high-level environmental scan to inform the identification of measures as disparities-sensitive reviewed NQF's earlier work and the work of other key stakeholders that focused on disparities-sensitive measurement. The following literature were selected for this review:

- NQF's National Voluntary Consensus Standards for Ambulatory Care – Measuring Healthcare Disparities (2008)
- The Robert Wood Johnson Foundation's (RWJF) Commissioned Paper: Healthcare Disparities Measurement (2011)

- NQF's Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment (2012)
- NQF's Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity (2017)
- National Committee for Quality Assurance's (NCQA) State of Equity White Paper (2021)

Additionally, the 2012 NQF Disparities-Sensitive Protocol from the Healthcare Disparities and Cultural Competency Consensus Standards: Disparities-Sensitive Measure Assessment is a tool for assessing which measures are disparities-sensitive. This method evaluates and assigns a separate point value to three attributes:

- prevalence (i.e., considers how prevalent the condition or topic is among underserved populations, with more prevalent conditions receiving a higher point value);
- disparities quality gap (i.e., consider the percent difference in quality of care between an underserved population and the population with the highest quality for that measure with larger percentage gaps receiving a higher point value); and
- Impact (i.e., considers the effect of the condition or topic financially, publicly, and on the population with higher impact measures receiving a higher point value).

If the point values for the three attributes total nine or higher, the measure is considered disparities-sensitive. The methodology also considers a measure to be disparities-sensitive if it has a disparities quality gap of 14 percent or higher, regardless of the point value total for all three attributes.

The high-level environmental scan of the literature listed above identified a range of measures within the CQMC core sets as disparities-sensitive. The ACO/PCMH/PC core set had the most measures identified as disparities-sensitive by the literature (e.g., controlling high blood pressure, diabetes control, cervical cancer and breast cancer screening, and depression screening and management), which was likely due to the measure denominators including large populations generally associated with screenings and other prevention measures. The Pediatrics, OB/GYN, Cardiology, Orthopedics, Medical Oncology, and Behavioral Health core sets each had one or two measures identified as disparities-sensitive, while the HIV/Hepatitis C, Gastroenterology, and Neurology core sets did not have disparities-sensitive measures identified by the literature, including the 2012 NQF disparities-sensitive protocol.

The Workgroup found the results of the environmental scan to be insufficient. It also noted that the NQF Disparities-Sensitive Protocol is 10 years old and may need to be revised, citing that the 14 percent benchmark was noted to be arbitrary, and using "prevalence" in the protocol may inadequately represent high-impact and low-volume illnesses, including those that may disproportionately impact underserved communities (e.g., sickle cell disease). Therefore, a modified approach to identifying disparities-sensitive measures within the CQMC core sets was developed in conjunction with the Workgroup to address the limitations in the existing protocols.

Approach

The Health Equity Workgroup developed a modified approach to determine whether measures within the CQMC core sets are disparities-sensitive (see Figure 1). This approach first considers whether the measure addresses a priority clinical area or a measurement area associated with disparities. These areas were identified based on existing literature; additional details can be found below.

Next, the process assesses whether the measure meets at least one measure characteristic. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity lays out four actions stakeholders can employ to reduce disparities: identify and prioritize reducing health disparities, implement evidence-based interventions to reduce disparities, invest in the development and use of health equity performance measures, and incentivize the reduction of health disparities and achievement of health equity. Based on that report, the measure characteristics being evaluated for this approach are as follows: (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 about disparities for the relevant measure topic, such as cardiovascular disease [CVD]); (2) the measure is specified for ambulatory settings; and (3) the measure is classified as an outcome measure. Additional details can be found below.

Measures that met those criteria (either addressing a priority condition or a measurement area associated with disparities and meeting at least one of the predefined measure characteristics) were determined to be disparities-sensitive.

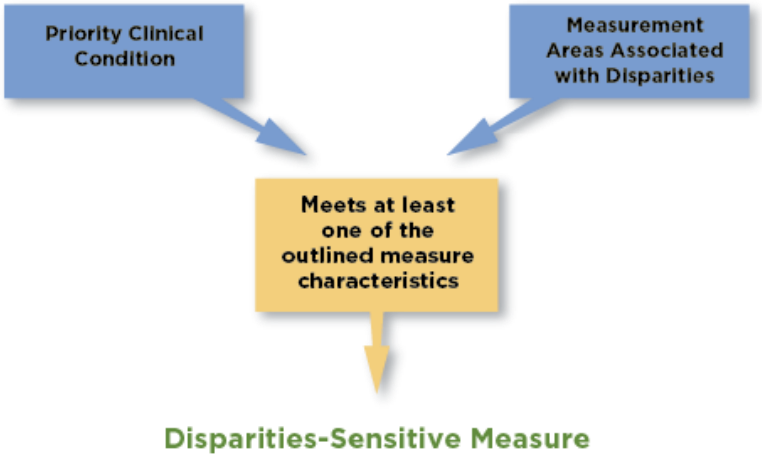


Figure 1: Approach to Identify Disparities-Sensitive Measures Within CQMC Core Sets

Priority Clinical Conditions

A list of initial priority clinical conditions were identified based on the CMS Framework on Health Equity, OMH Focus Areas, and the Agency for Healthcare Research and Quality (AHRQ) 2021 National Healthcare Quality and Disparities Report and include the following conditions:

- Substance use disorder (e.g., opioid use)
- CVD (e.g., hypertension, congestive heart failure)
- Maternal and infant health
- Sickle cell disease and trait
- Diabetes (e.g., prevention of peripheral artery and kidney disease)
- Lupus

- Cancer (e.g., stomach, liver, and cervical)
- Dementia and Alzheimer's
- Asthma
- Behavioral health
- HIV/Acquired immunodeficiency syndrome (AIDS)
- COVID-19

Some areas (e.g., CVD and maternal and infant health) overlap with measures in existing CQMC core sets, and some areas (e.g., lupus and sickle cell anemia) do not have measures represented in the 2021 CQMC core sets. This initial list of priority clinical conditions should evolve over time with the inclusion of additional literature.

Measurement Areas Associated With Disparities

The initial measurement areas associated with disparities were identified based on the RWJF's 2011 Commissioned Paper: Healthcare Disparities Report and NQF's 2012 Disparities-Sensitive Measure Assessment. Of note, measures are often multifactorial and may be classified in multiple measurement areas (e.g., readmissions are linked with transitions and communication-sensitive services). The specific topic areas included are as follows:

- Transitions (e.g., discharge, referral)
- Readmissions
- Patient/Consumer Surveys
- Patient-Reported Outcomes (e.g., depression assessments)
- Patient Education
- Screening
- Communication-Sensitive Services (e.g., care coordination)
- Care With a High Degree of Discretion (e.g., practices that do not have a standard protocol)
- Social Determinant-Dependent Measures (e.g., measure performance is linked to social risks)

Measure Characteristics

The approach to identifying disparities-sensitive measures also includes assessing whether the measure meets at least one of the measure characteristics outlined in A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. This report considers the following measure characteristics to further the evaluation of disparities sensitivity:

- Measure Characteristic 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 about disparities for the relevant measure topic, such as CVD; denominators that include the entire population do not fit this criterion).
- Measure Characteristic 2: The measure's denominator is specified for ambulatory settings.
- Measure Characteristic 3: The measure is classified as an outcome measure.

The NQF Disparities Standing Committee developed these criteria as a strategy to identify outcome measures that could address disparities but did not meet the NQF disparities-sensitive criteria in use at the time of the 2017 report. However, these criteria could help the CQMC to identify measures that meet its charge of aligning clinician-level measures that address ambulatory care. Additionally, these criteria attempt to ensure measures are actionable and within a clinician's locus of control.

Limitations

The approach to identifying disparities-sensitive measures within the CQMC core sets is pragmatic. It serves as the first step to identify disparities-sensitive measures and may not capture all categories of measures that could be disparities-sensitive. For example, the list of priority clinical areas and measurement areas associated with disparities may evolve over time. The results produced by this approach will not be reflective of all disparities across the health ecosystem because it is focused on identifying disparities-sensitive measures within the CQMC core sets. This approach also does not incorporate performance data for the measures because these data were inconsistently available, incomplete, and/or outdated. The measure characteristic that assesses whether the measure's denominator includes patients disproportionally affected by social risks compared to the general population may be subjective because there are limited data available to fully assess social risks. Therefore, this classification was designated to be consistent with the current state of the literature related to disparities for the relevant measure topic, such as CVD; denominators that include the entire population did not fit this measure characteristic. Additionally, some measure specifications were not fully publicly available, resulting in those measure characteristics being approximated based on information that was publicly available.

While not identified as a limitation by the Workgroup, this approach identifies most CQMC measures as disparities-sensitive and additional prioritization may be needed.

Findings

As of 2021, there are 150 measures within the CQMC core sets. The approach to identifying disparities-sensitive measures within the CQMC core sets identified 136 disparities-sensitive measures. Of these measures:

- 19 met the priority clinical area or measurement area associated with disparities criterion and met all three measure characteristics;
- 90 met the priority clinical area or measurement area associated with disparities criterion and met two measure characteristics; and
- 27 met the priority clinical area or measurement area associated with disparities criterion and met one measure characteristic.

Measures not identified as disparities-sensitive by this approach either did not assess an identified priority clinical condition or a measurement area associated with disparities, or separately, did not meet any of the measure characteristics. Of note: If the measures are not identified as disparities-sensitive by this approach, it does not necessarily mean they are not disparities-sensitive. Rather, their status is unclear based on current information and can be reevaluated in the future. A summary table is included in Appendix A; additional information about each core set is below.

Table 1: Summary of Disparities-Sensitive Measures by CQMC Core Set

CQMC Core Set	Meets 3 Measure Characteristics	Meets 2 Measure Characteristics	Meets 1 Measure Characteristic	Unmeasured Disparities	Total
ACO/PCMH/PC	3	13	3	3	**22**
Behavioral Health	2	7	3	0	**12**

CQMC Core Set	Meets 3 Measure Characteristics	Meets 2 Measure Characteristics	Meets 1 Measure Characteristic	Unmeasured Disparities	Total
Cardiology	5	20	2	0	**27**
Gastroenterology	1	3	4	0	**8**
HIV/Hepatitis C	1	7	0	0	**8**
Medical Oncology	4	6	6	1	**17**
Neurology	0	3	2	0	**5**
Obstetrics and Gynecology	3	12	3	1	**19**
Orthopedics	0	15	2	3	**20**
Pediatrics	0	4	2	6	**12**
Total	**19**	**90**	**27**	**14**	**150**

The 19 measures that met the priority clinical area or measurement area associated with disparities criterion and met all three measure characteristics are as follows:

- ACO/PCMH/Primary Care:
  - NQF #0059 Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)
  - NQF #0018 Controlling High Blood Pressure
  - NQF #1885 Depression Response at 12 Months – Progress Towards Remission
- Cardiology:
  - NQF #0018 Controlling High Blood Pressure
  - NQF #2474 Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation
  - MIPS ID 377 Functional Status Assessments for Congestive Heart Failure
  - NQF #0694 Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator
  - MIPS ID 441 Ischemic Vascular Disease (IVD) All or None Outcome Measure (Optimal Control)
- HIV/Hepatitis C:
  - NQF #2082/NQF #3210e HIV Viral Load Suppression
- Gastroenterology:
  - MIPS ID 343 Screening Colonoscopy Adenoma Detection Rate Measure
- Medical Oncology:
  - NQF #3490 Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
  - NQF #0384/NQF #0384e Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology
  - OCM-6 Patient-Reported Experience of Care
  - NQF #0211 Proportion of Patients Who Died From Cancer With More Than One Emergency Room Visit in the Last 30 Days of Life
- Obstetrics and Gynecology:

    - NQF #2902 Contraceptive Care – Postpartum
    - NQF #3543 Person-Centered Contraceptive Counseling (PCCC) Measure
    - HEDIS Postpartum Depression Screening and Follow-Up (PDS)
- Behavioral Health:
    - NQF #1884 Depression Response at Six Months – Progress Towards Remission
    - NQF #1885 Depression Response at 12 Months – Progress Towards Remission

The Cardiology, Gastroenterology, HIV/Hepatitis C, Neurology, and Behavioral Health core sets are fully composed of measures that are categorized as disparities-sensitive; additional details can be found in Appendix A.

Summary of Measures Not Identified as Disparities Sensitive

The 14 measures not categorized as disparities-sensitive are in the ACO/PCMH/PC, Medical Oncology, Obstetrics and Gynecology, Orthopedics, and Pediatrics core sets. A description of how each measure did not meet the disparities-sensitive criteria is below.

ACO/PCMH/PC Core Set

Three measures were not identified as being disparities-sensitive. Two measures did not focus on a priority clinical condition or measurement area associated with disparities:

- NQF #0052 Use of Imaging Studies for Low Back Pain
- NQF #0058 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

Additionally, one measure, NQF #1768 *Plan All-Cause Readmissions (PCR)*, did focus on a measurement area associated with disparities (readmissions) but did not meet any of the measure characteristic criteria.

Medical Oncology

One measure, NQF #0223 *Adjuvant Chemotherapy Is Considered or Administered Within Four Months (120 Days) of Diagnosis to Patients Under the Age of 80 With AJCC III (Lymph Node Positive) Colon Cancer*, was not identified as being disparities-sensitive. While the measure does focus on a priority clinical area (cancer), it does not meet any of the measure characteristic criteria.

Obstetrics and Gynecology

One measure, NQF #0223 *Adjuvant Chemotherapy Is Considered or Administered Within Four Months (120 Days) of Diagnosis to Patients Under the Age of 80 With AJCC III (Lymph Node Positive) Colon Cancer*, was not identified as being disparities-sensitive. While the measure does focus on a priority clinical area (cancer), it does not meet any of the measure characteristic criteria.

Orthopedics

Three measures were not identified as being disparities-sensitive because they were not focused on a priority clinical condition or measurement area associated with disparities:

- NQF #3493 Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-Based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups

- NQF #1150 Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
- NQF #1551 Hospital-Level 30-Day, All-Cause Risk Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)

Pediatrics

Six measures were not identified as being disparities-sensitive. Five measures did not focus on a priority clinical condition or measurement area associated with disparities:

- NQF #0038 Childhood Immunization Status (CIS)
- NQF #1407 Immunizations for Adolescents (IMA)
- NQF #0002 Appropriate Testing for Children With Pharyngitis (CWP) (no longer endorsed)
- NQF #0069 Appropriate Treatment for Children With Upper Respiratory Infection (URI)
- NQF #2811e Acute Otitis Media – Appropriate First-Line Antibiotics

Additionally, one measure, NQF #1448 *Developmental Screening in the First Three Years of Life* (no longer endorsed), did focus on a measurement area associated with disparities (screening) but did not meet any of the measure characteristic criteria.

Support for Implementing CQMC Core Set Measures

Overall, this approach highlights that the CQMC core set measures are highly sensitive to identifying healthcare disparities, underscoring the importance of these measures and their implementation. The CQMC Principles for Core Measure Selection emphasize selecting measures that will drive improvements in quality and equity. Given the high concordance between the core set measures and disparities-sensitivity, implementation of the CQMC core sets is an important strategy to advance health equity. The CQMC core set measures could be prioritized for use to advance health equity through value-based care arrangements. However, implementing and stratifying measures to advance equity will require an incremental approach given limitations in data and resources. Additional work is needed to prioritize measures within the core sets to begin to work towards the goal of advancing equity.

Strategies to Enable Identifying and Prioritizing Disparities Observed Within Measures That Compose Current CQMC Core Sets

The Health Equity Workgroup used a pragmatic approach to determine which measures in the CQMC core sets are disparities-sensitive and to help identify which measures providers, payers, and other stakeholders may want to prioritize to begin to address observed disparities. A significant challenge to identifying healthcare disparities is the limited data available on patient demographics as well as on social risks and needs. Although 14 measures did not meet the criteria for disparities sensitivity using this approach, the Workgroup recognized that all measures likely have some level of disparity; however, the disparities may not have been measured yet, or more resources are needed in those areas to assess the disparities. The Workgroup acknowledged that, from a practical perspective, it would be helpful to prioritize the identified disparities-sensitive measures so organizations can focus potentially limited resources and understand how best to begin addressing disparities. The Workgroup identified three strategies to enable further identification and prioritization of the disparities observed within measures that compose current CQMC core sets.

The first strategy is to determine which measures to prioritize and dedicate resources to by:

- obtaining input from the target population to identify the groups in which the disparities are more prevalent or acute;
- considering the impact of the disparity, either by evaluating 1) benefits missed based on the differences in treatment, or 2) potential benefits gained by reducing disparities, and focusing on the measures with the biggest impact;
- evaluating screening and outcome measures together to tie the impact of processes to healthcare outcomes;
- assessing the ease of data collection for the measures (e.g., prioritizing measures that use electronically extracted data);
- appraising the core set in its entirety against the literature to identify the measures with the most disparities sensitivity;
- starting with the disparities-sensitive measures that meet all three measure characteristics; and
- focusing on the measures that are cross-cutting and applicable to multiple populations.

The second strategy is to support and advance the development of electronic data elements and data sharing standards for robust, accurate, interoperable demographic and social risks data. These data will improve the ability to stratify measures by modifying measure specifications and testing requirements. For example, the CQMC can coordinate with measures stewards to encourage that measures are tested for the groups with the highest disparities to ensure the reliability and validity of the data when measures are stratified. The Health Equity Workgroup noted that the limitations of existing socioeconomic status data are a challenge to clearly identifying the gap areas that should be tested. NQF's Developing and Testing Risk Adjustment Models for Social and Functional Status-Related Risk Within Healthcare Performance Measurement Technical Guidance includes best practices for functional and social risk factor adjustments in measure development and can be used as a reference for improving the ability to stratify measures.

The third strategy is to stratify data to assess disparities and inform setting benchmarks. The results of assessing stratified data can be used for both internal quality improvement purposes among providers and external accountability with payer programs. However, the Workgroup cautioned that the measures must be reliable when the data are stratified, particularly if used for accountability. Additionally, care must be taken to ensure each disparities category that is stratified should improve or maintain its results instead of one category being penalized when improving another category. The Workgroup also acknowledged that data collection and stratification can be burdensome, particularly for smaller organizations that may not have the resources to collect or evaluate their own disparities data. In those circumstances, the Workgroup noted high quality imputed data from the community level has been shown to align with disparities seen at the organizational level. However, the Workgroup noted these data should be used for performance improvement and not for accountability.

The Workgroup recommends that these strategies be considered in an iterative approach for them to be successfully implemented and that the entire care team should be accountable to addressing disparities, not solely individual clinicians or single specialty areas.

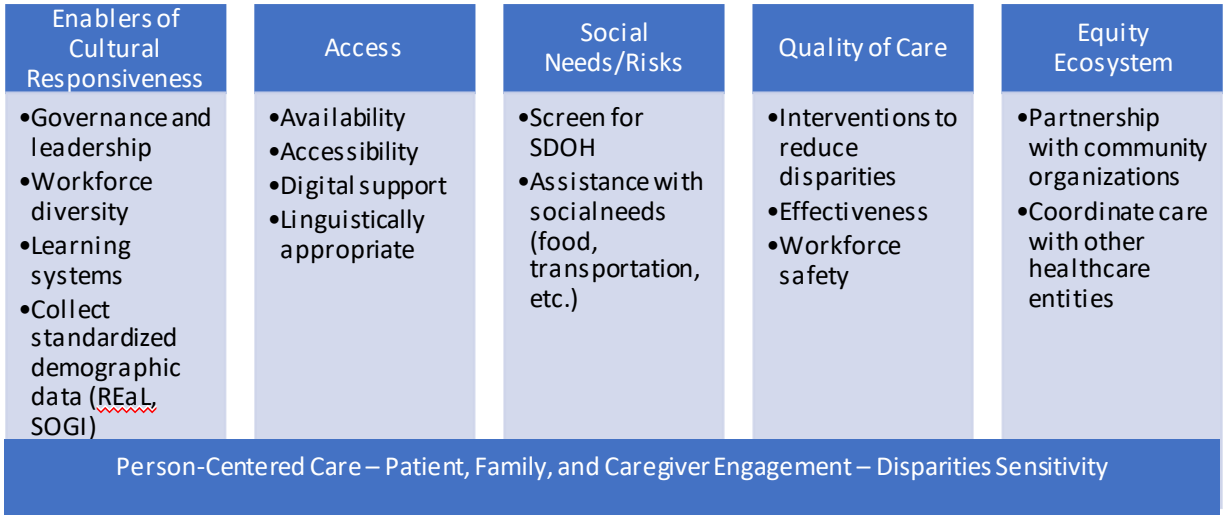
Domains to Categorize Measures and Measure Concepts That Promote Health Equity

To further advance health equity measurement within CQMC, the Health Equity Workgroup classified domains to categorize the identified existing measures and measure concepts that promote health equity. The intent was not to create a formal measurement framework; rather, these domains are a starting point to provide a complete view of health equity measurement as it relates to the CQMC's scope. They also serve as a foundation for the CQMC to build upon over time as health equity measurement advances.

The Workgroup considered the domains from six existing frameworks:

- NQF's Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity (2017)
- *New England Journal of Medicine's* (NEJM) Health Care Equity: From Fragmentation to Transformation (2020)
- Institute of Medicine's (IOM, now National Academy of Medicine) Six Domains of Health Care Quality (2001)
- Institute for Healthcare Improvement's (IHI) Advancing Health Equity: A Guide for Health Care Organizations (2016)
- NCQA's Multicultural Health Care: Demonstrating a Commitment to Equity (2020)
- RWJF's Taking Action (2022)

During the first web meeting, NQF shared the comparisons of frameworks and domains, which demonstrated differences in population focus and application to healthcare settings. For example, the IOM framework focuses on quality of care (with equity as a component of quality), while others focus on equity and include quality as a component. Several frameworks emphasize community partnerships and socioeconomic and environmental impacts. Using these frameworks as a starting point, the Workgroup identified and refined domains that may be most applicable to the CQMC's scope—clinician/clinician group measurement in the ambulatory setting (with the three domains on the right in light orange, Social Needs/Risks, Quality of Care, and Equity Ecosystem, being most applicable). A visual representation of the domains and example topic areas is below, followed by additional detail about each domain.



Foundational Aspects

The Workgroup considered the importance of person-centered care; patient, family, and caregiver engagement; and disparities sensitivity as foundational to all domains.

Enablers of Cultural Responsiveness

The Enablers of Cultural Responsiveness domain includes topic areas such as governance and leadership, workforce diversity, learning systems, and collecting standardized demographic data. The standardized collection of demographic data should include the ability to measure populations known to experience access and outcome inequities (e.g., population with intellectual and developmental disabilities).

Access

The Access domain includes topic areas such as availability, accessibility, digital support, and linguistically appropriate care. Availability assesses the extent to which the healthcare system has the resources to meet the needs of the patient.[8] Accessibility includes a range of topics related to patients' ability to access medical information and medical care, including geographic distance.[10] Linguistically appropriate care can include language services, overall literacy, health literacy, and digital literacy.[11]

Social Needs/Risks

The Social Needs/Risks domain captures SDOH screening, which focuses on the social conditions necessary for health. Included in this domain are identification and assistance with social needs, including food and transportation. While typically framed as social risks or social needs, SDOH can have both protective and adverse effects on a population.

Quality of Care

The Quality of Care domain emphasizes topics such as interventions to reduce disparities, effectiveness of care, and workforce safety. This domain is derived from the IOM's six domains of quality, which include safe, timely, effective, efficient, equitable, and patient-centered care.[12] These components reflect the importance of high quality clinical care within the healthcare delivery system.

Equity Ecosystem

The Equity Ecosystem domain includes the importance of partnering with community organizations and the coordination of care with other healthcare entities. Within this domain, an emphasis is placed on the inclusion of nontraditional organizations within care delivery and beyond to ensure patient needs are met outside of a traditional healthcare setting.

Health Equity Measure Scan

Approach

To further advance health equity measurement within the CQMC, the Health Equity Workgroup considered existing, publicly available measures and measure concepts that promote health equity and align with the CQMC's scope. Measures are tools to quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems that are associated with the ability to provide high quality healthcare.[13] Measure concepts are ideas for measures that are not fully specified or tested.[14] A health equity measure is linked to interventions that are known to reduce disparities in populations with social risk factors and/or aligned with the priority domains of measurement.[15] A health equity measure illustrates or summarizes the extent to which the quality of healthcare provided by an organization contributes to reducing disparities in health and healthcare at the population level for those patients with greater social risk factor burden by increasing access to care, improving the care received, and improving the health of those patients.[16]

To identify existing measures and measure concepts that promote health equity, NQF reviewed foundational literature:

- NQF's Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity
- NCQA's State of Equity White Paper

Additionally, NQF reviewed publicly available measure databases: CMS Measure Inventory Tool (CMIT), Measure Applications Partnership (MAP) Measures Under Consideration (MUC) list, and NQF's Quality Positioning System (QPS). The following search terms were used:

- Access
- Equity
- Timeliness
- Social Determinants of Health
- Social Drivers
- Social Need
- Culture
- Cultural Competency
- Transitions
- Disparity
- Disparities-Sensitive

Findings

The scan identified 31 measures and measure concepts related to SDOH, cultural competency, accessibility, availability, and evidence-based interventions to reduce disparities. The existing measures and measure concepts that promote health equity were reviewed against the CQMC's measure selection principles. After eliminating 20 measures and measure concepts that addressed health at the population level or were index measures (i.e., assesses a topic using more than one data item),[8] a total of 11 measures and measure concepts remained at the clinician, facility, or plan level of analysis. Please note: Some measures identified are proprietary or may not have publicly available information at the time of distribution.

A description of each of these measures and measure concepts is categorized by domain below. Additional information about the 11 measures and measure concepts can be found in Appendix B.

- Enablers of Cultural Responsiveness
  - NQF #1904 Clinician/Groups Cultural Competence Based on the CAHPS Cultural Competence Item Set (endorsement removed)
  - MUC2021-106 Hospital Commitment to Health Equity (measure concept under development)
- Access
  - NQF #1896 Language Services Measure Derived From Language Services Domain of the C-CAT (endorsement removed)
  - NQF #1824 L1A: Screening for Preferred Spoken Language for Healthcare (endorsement removed)
  - Patient-Centered Medical Home Patients' Experiences
- Social Needs/Risks
  - Social Determinants of Health Screening
  - MUC2021-134 Screen Positive Rate for Social Drivers of Health (measure concept under development)
  - MUC2021-136 Screening for Social Drivers of Health (measure concept under development)
  - Screening and Referral for Transportation Insecurity (measure under development from CyncHealth)
- Quality of Care
  - NQF #0520 Drug Education on All Medications Provided to Patient/Caregiver During Short-Term Episode of Care (endorsement removed)
- Equity Ecosystem
  - A Minimum of 3% of Total Enrollment Shall be Served by Community Health Workers or Similar Support Workers (page 354)

Future Opportunities for the CQMC to Advance Health Equity Measurement

To build on the foundational work of this report, the Health Equity Workgroup identified future opportunities for the CQMC to advance health equity measurement. First, this work illustrates that the CQMC core sets have the potential to advance high equity and that implementing the core set measures would result in the use of a high number of measures that are sensitive to identifying healthcare

disparities. Achieving health equity will require the use of both measures that identify disparities as well as the use of measures that directly promote health equity.[15]

Next, the Workgroup recommends encouraging the stratification of all existing measures in the core sets to help assess and address disparities, recognizing, however, that this will take time and will require action on the part of the measure stewards. The Workgroup also noted that since healthcare is moving towards team-based care and the entire team should be accountable for improving equity and addressing disparities, health equity measures should be incorporated into more than just the ACO/PCMH/PC core set as specialists and other care providers can play an impactful role. Rather, the Workgroup recommends that the CQMC incorporate measures that directly assess the drivers of health equity (e.g., social needs assessment, access to care) into each core set, as this will best illustrate that equity is integral to primary care, specialty areas, and ACOs. The Workgroup noted that the development of a separate core set of only health equity measures could be considered, but the preference would be to incorporate health equity measures into all core sets.

A significant impediment to stratifying measures for disparities and directly measuring efforts to advance health equity is the lack of available data on patient social risks and needs. Improved interoperability is key to improving stratification and reporting. Due to the importance of collecting standardized data elements to support interoperability, the Workgroup recommends supporting and aligning with initiatives related to standardizing health equity-related electronic data elements. For example, the Gravity Project is a Health Level Seven International (HL7) Fast Healthcare Interoperability Resources (FHIR) Accelerator project with a multistakeholder public collaborative to develop, test, and validate standardized SDOH data within EHRs using identified coded data elements. Additionally, the Office of the National Coordinator for Health Information Technology (ONC) United States Core Data for Interoperability (USCDI) is facilitating the standardization of EHR data elements, including data elements related to race, ethnicity, preferred language, sexual orientation, and gender identity as well as SDOH-related data elements.[17] There is also a new initiative, USCDI+, to define and advance interoperable data sets for specific use cases, such as the unique programmatic requirements for quality measurement for CMS or surveillance programs for the Centers for Disease Control and Prevention (CDC).[18]

The Workgroup also identified an opportunity for the CQMC to create "how to" resources to guide organizations in their efforts to stratify data to assess disparities and to leverage the data to address disparities identified. These "how to" resources would need to include strategies that could be implemented differently based on the organization's size, resources, and populations served. The audience for the guides would include clinicians, data analytics teams, office managers, or others who are able to stratify and evaluate their data.

The Workgroup began to highlight measurement gaps that should be prioritized to promote health equity in the CQMC. The Workgroup noted the insufficient number of existing health equity measures and measure concepts across all domains, particularly in the three domains most applicable to the CQMC: Social Needs/Risks, Quality of Care, and Equity Ecosystem. The Workgroup noted that focusing on the Equity Ecosystem domain for additional measure development would assist in capturing community- or population-level metrics that can inform the care provided at the patient level. Additionally, system-level measures to assess the availability of interpreters and translation services are needed since communication with patients is vital to improving care.

Conclusion

Focusing on health equity is essential to identifying unwarranted variations in care, improving the quality and outcomes of healthcare provided, and identifying and eliminating health disparities. The CQMC Health Equity Workgroup was established to ensure perspectives on health inequities and disparities are considered and elevated through the CQMC core sets. This report describes the approach used to identify disparities-sensitive measures within the CQMC core sets. The approach identified 136 out of 150 disparities-sensitive measures, with 19 measures meeting the priority clinical area or measurement area with disparities criterion and all three measure characteristics. Although 14 measures did not meet the criteria for disparities sensitivity using this approach, the Workgroup recognized that all measures likely have some level of disparity. Additional prioritization of the disparities-sensitive measures will be needed in future work. However, this report demonstrates the implementation of the CQMC core set measures is an important way to leverage value-based care to advance health equity.

The Workgroup also recognized the efforts to advance equity must be focused to be successful. Therefore, the Workgroup identified three strategies to enable further identification and prioritization of disparities observed within measures that compose current CQMC core sets: (1) Determine which measures to prioritize and dedicate resources to; (2) Improve the ability to stratify measures by modifying measure specification and testing requirements; and (3) Stratify data to assess disparities and inform setting benchmarks.

This report also describes the 11 existing measures and measure concepts that promote health equity and align with the CQMC's measure selection principles. NQF categorized these measures and measure concepts into five domains for the CQMC that promote health equity measurement as identified by the Workgroup. While the CQMC considers measures for inclusion in the core sets based on its current specifications, an opportunity exists for clinical Workgroups or the Health Equity Workgroup to recommend updates to the specifications to ensure they provide actionable information about disparities to payers and providers.

Understanding this report is foundational to identifying and addressing disparities identified in the CQMC measures and advancing health equity within the CQMC, the Workgroup also identified future opportunities for the CQMC to advance health equity measurement. These opportunities are:

- encouraging stratification of all existing measures in the core sets to help assess and address disparities;
- incorporating measures that directly assess the drivers of health equity (e.g., social needs assessment, access to care) into each core set;
- supporting and aligning with initiatives related to standardizing health equity-related electronic data elements;
- creating "how to" resources to guide organizations in their efforts to stratify data to assess disparities and to leverage the data to address disparities identified; and
- closing identified measurement gaps to promote health equity in the CQMC.

The CQMC remains dedicated to advancing health equity and will continue to engage the Health Equity and clinical core set Workgroups to build upon and refine the activities described in the report during future work.

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Appendix A: Disparities-Sensitive Measures Within Core Quality Measures Collaborative Core Sets

Below are the results of applying the approach for identifying disparities-sensitive measures in the CQMC core sets. The approach for identifying disparities-sensitive measures in the CQMC core sets is as follows: If the measure topic area assesses one of the identified priority clinical areas, OR it addresses an area with disparities, AND it meets at least one predefined characteristic, then the measure is disparities-sensitive. Based on A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity, the measure characteristics being evaluated for this approach are the following: (1) The measure's denominator includes patients disproportionally affected by social risks compared to the general population; (2) The measure is specified for ambulatory settings; and (3) The measure is classified as an outcome measure.

Accountable Care Organizations, Patient-Centered Medical Homes, and Primary Care Core Set

The ACO/PCMH/PC core set includes 22 measures, and 19 were identified as being disparities-sensitive. Of the disparities-sensitive measures:

- three met one measure characteristic;
- 13 met two measure characteristics; and
- three met three measure characteristics.

Three measures were not identified as being disparities-sensitive. Two measures did not focus on a priority clinical condition or measurement area associated with disparities:

- NQF #0052 Use of Imaging Studies for Low Back Pain
- NQF #0058 Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)

Additionally, one measure, NQF #1768 *Plan All-Cause Readmissions (PCR)*, did focus on a measurement area associated with disparities (readmissions) but did not meet any of the measure characteristic criteria.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0059	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Diabetes	-	Yes	Yes	Yes	3
0018	Controlling High Blood Pressure	CVD	-	Yes	Yes	Yes	3
1885	Depression Response at 12 Months – Progress Towards Remission	Mental Health	Screening	Yes	Yes	Yes	3
1800	Asthma Medication Ratio	Asthma	-	Yes	Yes	No	2
0034	Colorectal Cancer Screening	Cancer	Screening	Yes	Yes	No	2
0055	Comprehensive Diabetes Care: Eye Exam	Diabetes	-	Yes	Yes	No	2
2372	Breast Cancer Screening	Cancer	Screening	Yes	Yes	No	2
N/A	Kidney Health Evaluation for Patients With Diabetes	Diabetes	-	Yes	Yes	No	2
0005	CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 – Adult, Child	-	Patient Reported Outcome	No	Yes	Yes	2
N/A	Statin Therapy for Patients With Cardiovascular Disease (SPC)	CVD	-	Yes	Yes	No	2
N/A	Statin Therapy for Patients With Diabetes (SPD)	Diabetes	-	Yes	Yes	No	2
0032	Cervical Cancer Screening	Cancer	Screening	Yes	Yes	No	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
MIPS ID 443	Non-Recommended Cervical Cancer Screening in Adolescent Females	Cancer	Screening	Yes	Yes	No	2
3059e / MIPS ID 400	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	-	Screening	Yes	Yes	No	2
0028/0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CVD	Screening	Yes	Yes	No	2
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Substance Use	Screening	Yes	Yes	No	2
0421/0421e	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	-	Screening	No	Yes	No	1
0097	Medication Reconciliation	-	Communication-Sensitive Services	No	Yes	No	1
0418/0418e (no longer endorsed)	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Mental Health	Screening	No	Yes	No	1
0058	Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis (AAB)	-	-	No	Yes	No	-
1768	Plan All-Cause Readmissions (PCR)	-	Readmission	No	No	No	-
0052	Use of Imaging Studies for Low Back Pain	-	-	No	Yes	No	-

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Cardiology Core Set

The Cardiology core set includes 27 measures. All measures in this core set were identified as disparities-sensitive, given the impact of CVD on underserved communities.[19] Of these measures:

- two met one measure characteristic;
- 20 met two measure characteristics; and
- five met three measure characteristics.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0018	Controlling High Blood Pressure	CVD	-	Yes	Yes	Yes	3
2474	Cardiac Tamponade and/or Pericardiocentesis Following Atrial Fibrillation Ablation	CVD	-	Yes	Yes	Yes	3
MIPS ID 377	Functional Status Assessments for Congestive Heart Failure (MIPS ID 377)	CVD	Patient-Reported Outcome	Yes	Yes	Yes	3
0694	Hospital Risk-Standardized Complication Rate Following Implantation of Implantable Cardioverter-Defibrillator	CVD	-	Yes	Yes	Yes	3
MIPS ID 441	Ischemic Vascular Disease (IVD) All-or-None Outcome Measure (Optimal Control) (MIPS ID 441)	CVD	-	Yes	Yes	Yes	3
0535	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients Without ST Segment Elevation Myocardial Infarction (STEMI) and Without Cardiogenic Shock	CVD	Care Coordination	Yes	No	Yes	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0536	30-Day All-Cause Risk-Standardized Mortality Rate Following Percutaneous Coronary Intervention (PCI) for Patients With ST Segment Elevation Myocardial Infarction (STEMI) or Cardiogenic Shock	CVD	Care Coordination	Yes	No	Yes	2
1525	Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	CVD	-	Yes	Yes	No	2
0066	Chronic Stable Coronary Artery Disease: ACE Inhibitor or ARB Therapy – Diabetes or Left Ventricular Systolic Dysfunction (LVEF)	CVD	-	Yes	Yes	No	2
0067	Chronic Stable Coronary Artery Disease: Antiplatelet Therapy	CVD	-	Yes	Yes	No	2
0070/0070e	Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy – Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF	CVD	-	Yes	Yes	No	2
0081 / 0081e	Heart Failure (HF): Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)	CVD	-	Yes	Yes	No	2
0083 / 0083e	Heart Failure (HF): Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)	CVD	-	Yes	Yes	No	2
0505	Hospital 30-Day All-Cause Risk-Standardized Readmission Rate (RSRR) Following Acute Myocardial Infarction (AMI) Hospitalization	CVD	Readmission	Yes	No	Yes	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0230	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Acute Myocardial Infarction (AMI) Hospitalization for Patients 18 and Older	CVD	Care Coordination	Yes	No	Yes	2
0229	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Heart Failure (HF) Hospitalization for Patients 18 and Older	CVD	Care Coordination	Yes	No	Yes	2
0330	Hospital 30-Day, All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Heart Failure Hospitalization	CVD	Readmission	Yes	No	Yes	2
2558	Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate (RSMR) Following Coronary Artery Bypass Graft (CABG) Surgery	CVD	Care Coordination	Yes	No	Yes	2
2515	Hospital 30-Day, All-Cause, Unplanned, Risk-Standardized Readmission Rate (RSRR) Following Coronary Artery Bypass Graft (CABG) Surgery	CVD	Readmission	Yes	No	Yes	2
2459	In-Hospital Risk-Adjusted Rate of Bleeding Events for Patients Undergoing PCI	CVD	-	Yes	No	Yes	2
0733	Operative Mortality Stratified by the Five STS-EACTS Mortality Categories	CVD	Care Coordination	Yes	No	Yes	2
2514	Risk-Adjusted Coronary Artery Bypass Graft (CABG) Readmission Rate (30 Days)	CVD	Readmission	Yes	No	Yes	2
0119	Risk-Adjusted Operative Mortality for CABG	CVD	Care Coordination	Yes	No	Yes	2
MIPS ID 438	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease	CVD	-	Yes	Yes	No	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0028/0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CVD	Screening	Yes	Yes	No	2
2377	Overall Defect-Free Care for AMI (Composite Measure)	CVD	-	Yes	No	No	1
0964	Therapy With Aspirin, P2Y12 inhibitor, and Statin at Discharge Following PCI in Eligible Patients	CVD	Transition	Yes	No	No	1

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Gastroenterology Core Set

The Gastroenterology core set includes eight measures. All measures in this core set were identified as disparities-sensitive due to the impact of colon cancer on underserved populations[19] and the importance of screening for related conditions. Of these measures:

- four met one measure characteristic;
- three met two measure characteristics; and
- one met three measure characteristics.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
MIPS ID 343	Screening Colonoscopy Adenoma Detection Rate Measure	Cancer	Screening	Yes	Yes	Yes	3
MIPS ID 439	Age-Appropriate Screening Colonoscopy	Cancer	Screening	Yes	Yes	No	2
3059e / MIPS ID 400	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	-	Screening	Yes	Yes	No	2
MIPS ID 401	Screening for Hepatocellular Carcinoma (HCC) in Patients With Hepatitis C Cirrhosis	Cancer	Screening	Yes	Yes	No	2
0658	Endoscopy/Polyp Surveillance: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Cancer	Care Coordination	No	Yes	No	1
0659 (No longer NQF endorsed)	Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients With a History of Adenomatous Polyps – Avoidance of Inappropriate Use	Cancer	Care Coordination	No	Yes	No	1
MIPS ID 275	Inflammatory Bowel Disease (IBD): Assessment of Hepatitis B Virus (HBV) Status Before Initiating Anti-TNF (Tumor Necrosis Factor) Therapy	-	Screening	No	Yes	No	1

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
MIPS ID 271	Inflammatory Bowel Disease (IBD): Preventative Care: Corticosteroid Related Iatrogenic Injury– Bone Loss Assessment	-	Screening	No	Yes	No	1

Cells marked by a dash (-) are intentionally left blank.

HIV/Hepatitis C Core Set

The HIV and Hepatitis C core set includes eight measures. All eight measures were identified as disparities-sensitive, primarily because HIV is a priority clinical area.[19,20] Of these measures:

- zero met one measure characteristic;
- seven met two measure characteristics; and
- one met three measure characteristics.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
2082 / 3210e	HIV Viral Load Suppression	HIV	-	Yes	Yes	Yes	3
MIPS ID 475	HIV Screening	HIV	Screening	Yes	Yes	No	2
2080	Gap in HIV Medical Visits	HIV	Care Coordination	Yes	Yes	No	2
2079 / 3209e	HIV Medical Visit Frequency	HIV	-	Yes	Yes	No	2
0405	HIV/AIDS: Pneumocystis jiroveci Pneumonia (PCP) Prophylaxis	HIV	-	Yes	Yes	No	2
0409	HIV/AIDS: Sexually Transmitted Diseases – Screening for Chlamydia, Gonorrhea, and Syphilis	HIV	Screening	Yes	Yes	No	2
3059e / MIPS ID 400	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	-	Screening	Yes	Yes	No	2
MIPS ID 401	Screening for Hepatocellular Carcinoma (HCC) in Patients With Hepatitis C Cirrhosis	Cancer	Screening	Yes	Yes	No	2

Cells marked by a dash (-) are intentionally left blank.

Medical Oncology Core Set

The Medical Oncology core set includes 17 measures, and 16 were identified as being disparities-sensitive, given the impact of cancer on underserved populations.[8, 9] Of the disparities-sensitive measures:

- six met one measure characteristic;
- six met two measure characteristics; and
- four met three measure characteristics.

One measure, NQF #0223 *Adjuvant Chemotherapy Is Considered or Administered Within 4 Months (120 Days) of Diagnosis to Patients Under the Age of 80 With AJCC III (Lymph Node Positive) Colon Cancer*, was not identified as being disparities-sensitive. While the measure does focus on a priority clinical area (i.e., cancer), it does not meet any of the measure characteristic criteria.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
3490	Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy	Cancer	Care Coordination	Yes	Yes	Yes	3
0384 / 0384e	Oncology: Pain Intensity Quantified – Medical Oncology and Radiation Oncology	Cancer	Patient-Reported Outcome	Yes	Yes	Yes	3
OCM-6	Patient-Reported Experience of Care	Cancer	Patient-Reported Outcome	Yes	Yes	Yes	3
0211	Proportion of Patients Who Died From Cancer With More Than One Emergency Room Visit in the Last 30 Days of Life	Cancer	Care Coordination	Yes	Yes	Yes	3
1860	Patients With Metastatic Colorectal Cancer and KRAS Gene Mutation-Spared Treatment With Anti-Epidermal Growth Factor Receptor Monoclonal Antibodies	Cancer	-	Yes	Yes	No	2
0216	Proportion of Patients Who Died From Cancer Admitted to Hospice for Less Than Three Days	Cancer	Care Coordination	Yes	Yes	No	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0213	Proportion of Patients Who Died From Cancer Admitted to the ICU in the Last 30 Days of Life	Cancer	Care Coordination	Yes	Yes	No	2
0215	Proportion of Patients Who Died From Cancer Not Admitted to Hospice	Cancer	Care Coordination	Yes	Yes	No	2
0210	Proportion of Patients Who Died From Cancer Receiving Chemotherapy in the Last 14 Days of Life	Cancer	Care Coordination	Yes	Yes	No	2
1858	Trastuzumab Administered to Patients With AJCC Stage I (T1c) – III and Human Epidermal Growth Factor Receptor 2 (HER2) Positive Breast Cancer Who Receive Adjuvant Chemotherapy	Cancer	-	Yes	Yes	No	2
3188	30-Day Unplanned Readmissions for Cancer Patients	Cancer	Readmission	No	No	Yes	1
2651	CAHPS® Hospice Survey (Experience With Care)	Cancer	Patient Reported Outcome	No	No	Yes	1
0559	Combination Chemotherapy Is Considered or Administered Within Four Months (120 days) of Diagnosis for Women Under 70 With AJCC T1c, or Stage II or III Hormone Receptor Negative Breast Cancer	Cancer	-	Yes	No	No	1
1859	KRAS Gene Mutation Testing Performed for Patients With Metastatic Colorectal Cancer Who Receive Anti-Epidermal Growth Factor Receptor Monoclonal Antibody Therapy	Cancer	-	No	Yes	No	1
0389 / 0389e	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low-Risk Prostate Cancer Patients	Cancer	-	No	Yes	No	1

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0418/0418e (no longer endorsed)	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Mental Health	Screening	No	Yes	No	1
0223	Adjuvant Chemotherapy Is Considered or Administered Within Four Months (120 days) of Diagnosis to Patients Under the Age of 80 With AJCC III (Lymph Node Positive) Colon Cancer	Cancer	-	No	No	No	-

Cells marked by a dash (-) are intentionally left blank.

Obstetrics and Gynecology Core Set

The Obstetrics and Gynecology core set includes 19 measures, and 18 measures were identified as being disparities-sensitive. Of the disparities-sensitive measures:

- three met one measure characteristic;
- 12 met two measure characteristics; and
- three met three measure characteristics.

One measure, NQF #3475e *Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture*, does not focus on a priority clinical condition or measurement area associated with disparities.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
2902	Contraceptive Care – Postpartum	-	Care with a High Degree of Discretion	Yes	Yes	Yes	3
3543	Person-Centered Contraceptive Counseling (PCCC) Measure	-	Care with a High Degree of Discretion	Yes	Yes	Yes	3
N/A	Postpartum Depression Screening and Follow-Up (PDS)	Mental Health	Screening	Yes	Yes	Yes	3
2372	Breast Cancer Screening	Cancer	Screening	Yes	Yes	No	2
0032	Cervical Cancer Screening	Cancer	Screening	Yes	Yes	No	2
0033	Chlamydia Screening in Women	-	Screening	Yes	Yes	No	2
MIPS ID 475	HIV Screening	HIV	Screening	Yes	Yes	No	2
MIPS ID 443	Non-recommended Cervical Cancer Screening in Adolescent Females	Cancer	Screening	Yes	Yes	No	2
0418/0418e (no longer endorsed)	Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Mental Health	Screening	Yes	Yes	No	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
2904	Contraceptive Care – Access to LARC	-	Care with a High Degree of Discretion	Yes	Yes	No	2
MIPS ID 336	Maternity Care: Postpartum Follow-Up and Care Coordination	Maternal Health	Care Coordination	Yes	Yes	No	2
0471	PC-02 Cesarean Section	Maternal Health	-	Yes	No	Yes	2
3484	Prenatal Immunization Status†	Maternal Health	-	Yes	Yes	No	2
MIPS ID 433	Proportion of Patients Sustaining a Bowel Injury at the Time of Any Pelvic Organ Prolapse Repair	Maternal Health	-	Yes	No	Yes	2
0716	Unexpected Complications in Term Newborns	Infant Health	-	Yes	No	Yes	2
0470	Incidence of Episiotomy	Maternal Health	-	Yes	No	No	1
0469/0469e	PC-01 Elective Delivery (Patients With Elective Vaginal Deliveries or Elective Cesarean)	Maternal Health	-	Yes	No	No	1
0480/0480e	PC-05 Exclusive Breast Milk Feeding and the Subset Measure	Maternal Health	-	Yes	No	No	1
3475e	Appropriate Use of DXA Scans in Women Under 65 Years Who Do Not Meet the Risk Factor Profile for Osteoporotic Fracture	-	-	Yes	Yes	No	-

Cells marked by a dash (-) are intentionally left blank.

Orthopedics Core Set

The Orthopedics core set includes 20 measures, and 17 measures were identified as being disparities-sensitive. Of the disparities-sensitive measures:

- two met one measure characteristic;
- 15 met two measure characteristics; and
- zero met three measure characteristics.

Three measures were not identified as being disparities-sensitive because they were not focused on a priority clinical condition or measurement area associated with disparities:

- NQF #3493 Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-Based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups
- NQF #1150 Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)
- NQF #1551 Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA).

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
MIPS ID 459	Back Pain After Lumbar Discectomy/Laminectomy	-	Patient Reported Outcome	No	Yes	Yes	2
MIPS ID 460	Back Pain After Lumbar Fusion	-	Patient Reported Outcome	No	Yes	Yes	2
MIPS ID 471	Functional Status After Lumbar Discectomy/Laminectomy	-	Patient Reported Outcome	No	Yes	Yes	2
2643	Functional Status After Lumbar Fusion	-	Patient Reported Outcome	No	Yes	Yes	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
2653	Functional Status After Primary Total Knee Replacement	-	Patient Reported Outcome	No	Yes	Yes	2
MIPS ID 376	Functional Status Assessment for Total Hip Replacement (eCQM)	-	Patient Reported Outcome	No	Yes	Yes	2
MIPS ID 375	Functional Status Assessment for Total Knee Replacement (eCQM)	-	Patient Reported Outcome	No	Yes	Yes	2
0425	Functional Status Change for Patients With Low Back Impairments	-	Patient Reported Outcome	No	Yes	Yes	2
3461	Functional Status Change for Patients With Neck Impairments	-	Patient Reported Outcome	No	Yes	Yes	2
3470	Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures	-	Transition	No	Yes	Yes	2
2958	Informed, Patient-Centered (IPC) Hip and Knee Replacement Surgery	-	Patient Reported Outcome	No	Yes	Yes	2
MIPS ID 461	Leg Pain After Lumbar Discectomy/Laminotomy	-	Patient Reported Outcome	No	Yes	Yes	2
MIPS ID 473	Leg Pain After Lumbar Fusion	-	Patient Reported Outcome	No	Yes	Yes	2
1741	Patient Experience With Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey	-	Patient Reported Outcome	No	Yes	Yes	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
2962	Shared Decision-Making Process	-	Communication-Sensitive Services	No	Yes	Yes	2
3559	Hospital-Level, Risk-Standardized Improvement Rate in Patient-Reported Outcomes Following Elective Primary Total Hip and/or Total Knee Arthroplasty (THA/TKA)	-	Patient Reported Outcome	No	No	Yes	1
MIPS ID 355	Unplanned Reoperation Within the 30-Day Postoperative Period	-	Care Coordination	No	No	Yes	1
1551	Hospital-Level 30-Day, All-Cause Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	-	-	No	No	Yes	-
1550	Hospital-Level Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA)	-	-	No	No	Yes	-
3493	Risk-Standardized Complication Rate (RSCR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) for Merit-Based Incentive Payment System (MIPS) Eligible Clinicians and Eligible Clinician Groups	-	-	No	No	Yes	-

Cells marked by a dash (-) are intentionally left blank.

Pediatrics Core Set

The Pediatrics core set includes 12 measures, and six measures were identified as being disparities-sensitive. Of the disparities-sensitive measures:

- two met one measure characteristic;
- four met two measure characteristics; and
- zero met three measure characteristics.

Six measures were not identified as being disparities-sensitive. Five measures did not focus on a priority clinical condition or measurement area associated with disparities:

- NQF #0038 Childhood Immunization Status (CIS)
- NQF #1407 Immunizations for Adolescents (IMA)
- NQF #0002 Appropriate Testing for Children With Pharyngitis (CWP) (no longer endorsed)
- NQF #0069 Appropriate Treatment for Children With Upper Respiratory Infection (URI)
- NQF #2811e Acute Otitis Media – Appropriate First-Line Antibiotics

Additionally, one measure, NQF #1448 *Developmental Screening in the First Three Years of Life* (no longer endorsed), did focus on a measurement area associated with disparities (screening) but did not meet any of the measure characteristic criteria.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
1800	Asthma Medication Ratio	Asthma	-	Yes	Yes	No	2
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child	-	Patient Reported Outcome	No	Yes	Yes	2
0033	Chlamydia Screening for Women	-	Screening	Yes	Yes	No	2
0418/0418e (no longer endorsed)	Preventative Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Mental Health	Screening	Yes	Yes	No	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	-	Communication-Sensitive Services	No	Yes	No	1
1516	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)	-	Social Determinant Dependent	No	Yes	No	1
2811e	Acute Otitis Media – Appropriate First-Line Antibiotics	-	-	No	Yes	No	-
0002 (no longer endorsed)	Appropriate Testing for Children With Pharyngitis (CWP)	-	-	No	Yes	No	-
0069	Appropriate Treatment for Children With Upper Respiratory Infection (URI)	-	-	No	Yes	No	-
0038	Childhood Immunization Status (CIS)	-	-	No	Yes	No	-
1448 (no longer endorsed)	Developmental Screening in the First Three Years of Life	-	Screening	No	No	No	-
1407	Immunizations for Adolescents (IMA)	-	-	No	Yes	No	-

Cells marked by a dash (-) are intentionally left blank.

Neurology Core Set

The Neurology core set includes five measures, and all measures within this core set were identified as being disparities-sensitive. Of the disparities-sensitive measures:

- two met one measure characteristic;
- three met two measure characteristics; and
- zero met three measure characteristics.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
0005	CAHPS Clinician & Group Surveys (CG-CAHPS)	-	Patient Reported Outcome	No	Yes	Yes	2
2624	Functional Outcome Assessment	-	Patient Reported Outcome	No	Yes	Yes	2
MIPS ID 187	Stroke and Stroke Rehabilitation: Thrombolytic Therapy (MIPS ID 187)	CVD	-	Yes	Yes	No	2
0097	Medication Reconciliation	-	Communication-Sensitive services	No	Yes	No	1
0419e	Documentation of Current Medications in the Medical Record	-	Communication-Sensitive services	No	Yes	No	1

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Behavioral Health Core Set

The Behavioral Health core set includes 12 measures, and all measures within this core set were identified as being disparities-sensitive, given the impact of behavioral and mental health within underserved communities. Of these measures:

- three met one measure characteristic;
- seven met two measure characteristics; and
- two met three measure characteristics.

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
1884	Depression Response at Six Months – Progress Towards Remission	Mental Health	Screening	Yes	Yes	Yes	3
1885	Depression Response at 12 Months – Progress Towards Remission	Mental Health	Screening	Yes	Yes	Yes	3
1879	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Mental Health	Communication-Sensitive Services	Yes	Yes	No	2
3489	Follow-Up After Emergency Department Visit for Mental Illness	Mental Health	Care Coordination	Yes	Yes	No	2
0576	Follow-Up After Hospitalization for Mental Illness (FUH)	Mental Health	Care Coordination	Yes	Yes	No	2
2800	Metabolic Monitoring for Children and Adolescents on Antipsychotics	Mental Health	-	Yes	Yes	No	2
N/A	Pharmacotherapy for Opioid Use Disorder (POD)	Substance Use	-	Yes	Yes	No	2
0028/0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	CVD	Screening	Yes	Yes	No	2
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	Substance Use	Screening	Yes	Yes	No	2

NQF Number (links to specs)	Measure Title	Priority Clinical Condition	Measurement Area Associated With Disparities	Measure Characteristic 1: Social Risk Factors	Measure Characteristic 2: Ambulatory Settings	Measure Characteristic 3: Outcome Measure	Measure Characteristics Met
1932	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Mental Health	Screening	Yes	No	No	1
0108	Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Mental Health	Care Coordination	No	Yes	No	1
0418/0418e (no longer endorsed)	Preventive Care and Screening: Screening for Depression and Follow-Up Plan	Mental Health	Screening	No	Yes	No	1

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Appendix B: Measures and Measure Concepts That Promote Health Equity

The identification number, measure title, National Quality Forum (NQF) endorsement status, measure description, level of analysis, and domain are provided for 11 existing measures and measure concepts that promote health equity at the clinician, facility, or plan level of analysis. Please note: Some measures and measure concepts identified are proprietary or may not have publicly available information at the time of publication.

Identification Number	Measure Title	NQF Endorsement Status	Measure Description	Level of Analysis	Domain
NQF #1904	Clinician/Group's Cultural Competence Based on the CAHPS® Cultural Competence Item Set	Endorsement Removed	These measures are based on the CAHPS Cultural Competence Item Set, a set of supplemental items for the CAHPS Clinician/Group Survey.	Clinician: Group/Practice, Clinician: Individual	Enablers of Cultural Responsiveness
MUC2021-106	Hospital Commitment to Health Equity	Not Endorsed*	Among Medicare beneficiaries, racial and ethnic minority individuals, individuals with limited English proficiency or disabilities often receive lower quality of care and higher rates of readmission and complications than beneficiaries without these characteristics. Strong and consistent hospital leadership can be instrumental in setting specific, measurable, and attainable goals to advance equity priorities and improve care for all beneficiaries. This includes promoting an organizational culture of equity through equity-focused leadership, commitment to robust demographic data collection, and active review of disparities in key quality outcomes, which are assessed in this measure.	Facility	Enablers of Cultural Responsiveness
NQF #1896	Language Services Measure Derived From Language Services Domain of the C-CAT	Endorsement Removed	0-100 measure of language services related to patient- centered communication, derived from items on the staff and patient surveys of the Communication Climate Assessment Toolkit (C-CAT)	Facility	Access

Identification Number	Measure Title	NQF Endorsement Status	Measure Description	Level of Analysis	Domain
NQF #1824	L1A: Screening for Preferred Spoken Language for Healthcare	Endorsement Removed	This measure is used to assess the percent of patient visits and admissions where preferred spoken language for healthcare is screened and recorded. Access to and availability of patient language preference is critical for providers in planning care. This measure provides information on the extent to which patients are asked about the language they prefer to receive care in and the extent to which this information is being recorded.	Clinician: Group/Practice, Facility	Access
Not applicable (Page 28)	Patient-Centered Medical Home Patients' Experiences	Not Endorsed*	Percentage of parents or guardians who reported how often they were able to get the care their child needed from their child's provider's office during evenings, weekends, or holidays	Clinical Practice or Public Health Sites	Access
Not applicable	Social Determinants of Health Screening	Not Endorsed*	One Social Determinants of Health screening during the episode duration with G9919 or G9920 Procedure Code claims, including ICD-10 Z-codes when relevant to those determinant areas as defined by Social Determinants Health	Plan Level	Social Needs/Risks
MUC2021-134	Screen Positive Rate for Social Drivers of Health	Not Endorsed*	Percent of beneficiaries 18 years and older who screen positive for food insecurity, housing instability, transportation problems, utility help needs, or interpersonal safety.	Clinician; Group; Facility; Other: Beneficiary, Population	Social Needs/Risks
MUC2021-136	Screening for Social Drivers of Health	Not Endorsed*	Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation problems, utility help needs, and interpersonal safety.	Clinician; Group; Facility; Other: Beneficiary, Population	Social Needs/Risk

Identification Number	Measure Title	NQF Endorsement Status	Measure Description	Level of Analysis	Domain
Not applicable – Measure under development by CyncHealth	Screening and Referral for Transportation Insecurity	Not Endorsed*	Percentage of patients aged 18 years and older who were screened for transportation insecurity within the measurement period AND/OR received a referral or intervention to address transportation insecurity. Three rates reported: a. Percentage of patients aged 18 years and older who were screened for transportation insecurity within the measurement period. b. Percentage of patients aged 18 years and older who received a referral or intervention for transportation insecurity. c. Patients who were screened for transportation insecurity AND who received a referral or intervention to address transportation insecurity during the measurement period.	Individual Practitioner	Social Needs/Risks
NQF #0520	Drug Education on All Medications Provided to Patient/Caregiver During Short-Term Episodes of Care	Endorsement Removed	Percentage of short-term home health episodes of care during which patient/caregiver was instructed on how to monitor the effectiveness of drug therapy, how to recognize potential adverse effects, and how and when to report problems	Facility	Quality of Care
Not applicable (Page 354)	A Minimum of Three Percent of Total Enrollment Shall Be Served by Community Health Workers or Similar Support Workers	Not Endorsed*	A minimum of three percent (3%) of total enrollment shall be served by Community Health Workers (CHWs), Community Health Representatives (CHRs) and Certified Peer Support Workers (CPSWs) for activities such as Care Coordination activities, home visiting, health education, health literacy, translation and/or community supports linkages. … [There will be annual increases to the percentage targets to be determined by the Human Services Department.]	Plan Level	Equity Ecosystem

*Not Endorsed: The measure may have been submitted to NQF for endorsement evaluation and did not pass, or the measure was never submitted to NQF for endorsement evaluation.

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