Meeting Summary

Health Equity Workgroup Web Meeting 1

The National Quality Forum (NQF) convened a web meeting for the Core Quality Measures Collaborative (CQMC) Health Equity Workgroup on April 7, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants and co-chairs (provider co-chair Dr. Rama Salhi and payer co-chair Dr. Sai Ma) to the Health Equity Workgroup meeting. NQF staff reviewed the antitrust statement, as well as acknowledging that the CQMC is a member-funded effort with additional support from Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

Dana Gelb Safran (NQF President & CEO) provided opening remarks and NQF staff reviewed disclosures of interest (DOIs), facilitated the Workgroup roll call, and reviewed the meeting objectives.

- Review definitions of Health Equity and disparities-sensitive measurement
- Discuss and prioritize measurement domains
- Present preliminary measure scan findings
- Discuss data source and stratification considerations

CQMC Orientation and Health Equity Objectives

NQF staff reviewed the background and aims of the CQMC. The goal of the CQMC is to develop and recommend core sets of performance measures and measurement initiatives that should be prioritized for use across the nation, aimed at improving the quality of healthcare for all.

NQF staff discussed the Health Equity Workgroup's overall objectives for this year's work.

- Review and prioritize health equity measurement domains for the CQMC
- Identify current CQMC measures that are disparities-sensitive
- Prioritize existing health equity measures for use across payers in value-based contracts
- Recommend strategies to implement and adopt CQMC measures that assess existing inequities
- Outline future opportunities for the CQMC to advance health equity measurement

Definitions of Health Equity

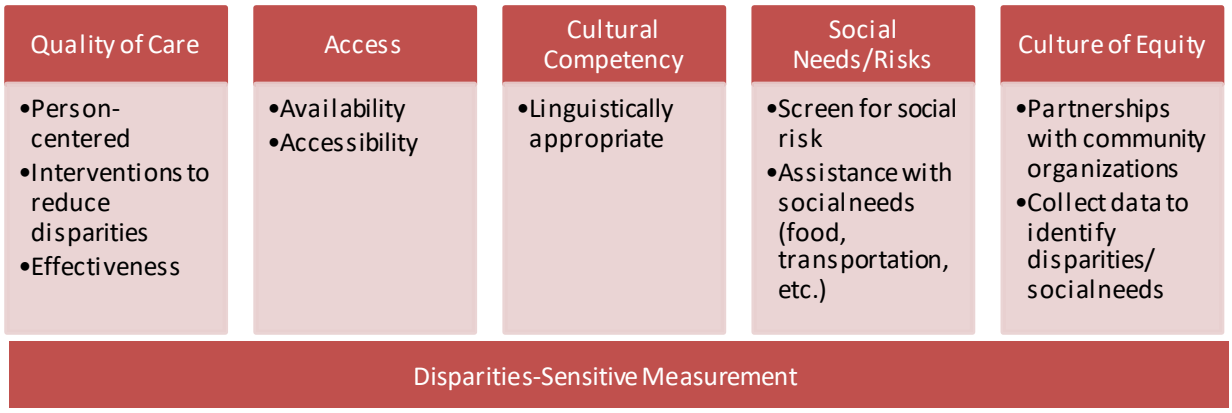
NQF staff shared Health Equity definitions from Healthy People 2030, Robert Wood Johnson Foundation, CMS, World Health Organization, and Healthcare Payment Learning and Action Network Health Equity Advisory Team (HCP-LAN HEAT). The definitions shared the following components: fair and just opportunity to achieve the highest level of health for all individuals regardless of race, sexual

orientation, gender identity, socioeconomic status, geography, preferred language or other factors affecting access and health outcomes; and supporting the societal effort to address avoidable inequalities, historical and contemporary injustice, which include systemic racism, the elimination of health and healthcare disparities which may manifest as negative outcomes impacting life expectancy, disease burden, disability and quality of life. These definitions will help inform how the CQMC identifies, priorities, and aligns health equity measures.

Domains of Health Equity

NQF presented six frameworks from NQF, New England Journal of Medicine (NEJM), Institute of Medicine (IOM), Institute for Healthcare Improvement (IHI), National Committee on Quality Assurance (NCQA), and Robert Wood Johnson Foundation (RWJF) and their respective domains for Workgroup discussion. NQF staff 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, NQF staff presented draft domains (Figure 1) that may be most applicable to the CQMC's scope – clinician/clinician group measurement in the ambulatory setting.

Figure 1: Draft CQMC Health Equity Domains



A co-chair opened discussion by asking the Workgroup which topics were missing from the draft domains. Several Workgroup members commented that there is not a consistent measure evaluation approach between providers and payers. Another member commented on the limitations of using domains in measuring equity for more granular issues including physician level use of measures. For example, access to care may differ by insurance status or type of insurance, which is outside of the clinician's control. The member also shared that a physician's practice size or practice setting could lack the resources to connect patients with social risks to community services including transportation. A member suggested adding the attribute of digital support (e.g., increase broadband access) to the "access" domain to highlight the disparity in internet access.

NQF staff clarified that the primary focus of the CQMC core sets is on clinician or clinician group level

measures that can be aligned across payers in their value-based programs. There are a few exceptions, for example, the ACO/PCMH/PC core set includes measures at the ACO level of analysis. The Health Equity Workgroup should focus their recommendations on clinician level measurement. However, the Workgroup may consider opportunities to stratify measures at the payer level.

A Workgroup member suggested considering the significance of the measure at the patient level regarding disease impact rather than prevalence when measuring health equity. Another Workgroup member asked where patient experience falls within the domains. A co-chair commented that patient experience could overlap between domains since this is a vital component of quality. Another member shared that measures that are appropriate for accountability related to health equity may not be the same measures that drive the most improvement. A Workgroup member suggested multi-level interventions (e.g., patient engagement, community organizations) have been most successful in improving equity and upstream drivers of disparities such as structural racism. The Workgroup also suggested that NQF broaden the definition of the "cultural competency" domain to "cultural humility, agility, or responsiveness".

Workgroup members offered a variety of resources and tools on health equity and screening for discrimination including the following: invisible-inequities, National Academies of Science, Engineering, and Medicine (NASEM) Future of Nursing Report, the Everyday Discrimination Scale, and Discrimination in Medical Settings Scale.

A co-chair commented that the linear representation of the domains may be confusing since there are complexities and overlap between domains. For example, social determinants of health (SDOH) and quality may span multiple domains. Another Workgroup member shared that "linguistically appropriate care" could fit under the "access" and the "quality of care" domains. A member suggested developing a Venn diagram rather than a linear representation of domains to link attributes more closely and emphasized adding discrimination to the framework.

A Workgroup member emphasized that health literacy is foundational for patients and families to understand how to care for themselves or their loved ones. Multiple Workgroup members supported the suggestion to add health literacy to the framework. A co-chair commented that their organization is looking at health literacy for both measurement and intervention because it is such an important topic. NQF staff shared that in addition to helping the Health Equity Workgroup prioritize existing measures, the framework should also serve as a foundation for identifying health equity measure gaps and priorities for development.

NQF staff asked if there were any recommendations on where health literacy would fit best under the domains. The member suggested that SDOH and health literacy could fit under the "Social Needs" domain. A member shared a tool for evaluating literacy using a Single Item Literacy Screener (SILS). Several workgroup members expressed that literacy is an important social risk that often is not identified but has significant impact on healthcare outcomes.

A Workgroup member commented that quality improvement spans multiple domains and shared that measurement approaches should continue to advance to get to the root of SDOH and health equity.

Other Workgroup members added articles defining components of quality: Donabedian Quality Definition and National Health System (NHS) Improvement Brief. A member shared that in Healthy People 2030, SDOH and social needs are framed under five domains. Another Workgroup member suggested creating structure, process, and outcome equity measures depending on the provider's ability to report these metrics. A Workgroup co-chair proposed several issues related to how to collect the data on patient access issues at various levels of care (e.g., from the patient to the population level). A Workgroup member shared the importance of seeking alignment across programs and initiatives and recommended the CQMC review the Gravity Project and Office of the National Coordinator for Health Information Technology (ONC) United States Core Data for Interoperability (USCDI) and USCDI+ for data elements related to health equity. Another member shared an example of payer coverage for social needs in California as part of the California Advancing and Innovating Medi-Cal (CalAIM) Initiative.

A member commented that equity measures linked to financial accountability may negatively impact safety net providers and urged caution about how health equity measures are used for accountability purposes. A member suggested that the Workgroup should avoid reinventing foundational and successful health equity approaches in its recommendations. Another member commented on the lack of common terminology in value-based models which could impede equity reporting.

NQF staff thanked the Workgroup for the feedback and shared that the team will continue to align with other initiatives as it relates to the health equity work and refine the CQMC health equity measurement domains based on the discussion.

Preliminary Measure Scan Findings

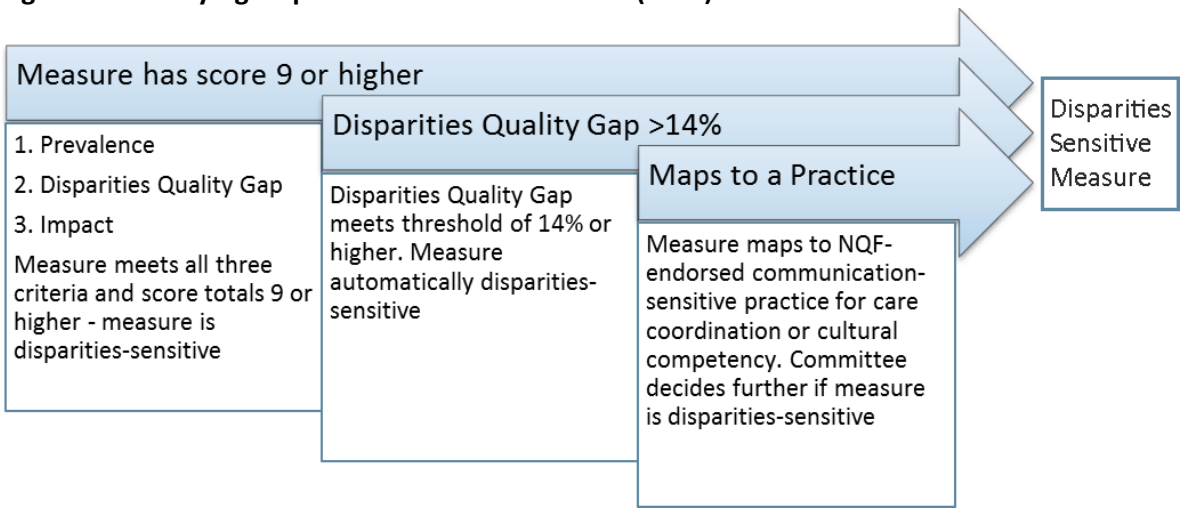
NQF staff shared the preliminary findings of the health equity measure scan. The measure scan synthesized literature related to equity initiatives, identified disparities-sensitive measures, and identified additional health equity measures. NQF staff compared measures identified as disparities-sensitive through various reports to the current CQMC core set measures.

Based on preliminary findings, NQF staff shared that the ACO/PCMH/PC core set had the most disparity-sensitive measures (e.g., controlling high blood pressure, diabetes control, cervical cancer and breast cancer screening, and depression screening and management). 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/Hep C, Gastroenterology, and Neurology core sets did not have disparities-sensitive measures identified. Based on Workgroup feedback on the best approach for determining disparity-sensitivity, NQF will supplement these preliminary findings with an additional analysis of the core set measures that are not NQF endorsed or newly endorsed.

NQF staff reviewed the 2012 NQF Disparities-Sensitive Protocol, which is a tool for assessing which measures are disparities-sensitive. This method is based on three attributes, prevalence, quality gap and impact which are assigned points to determine sensitivity. The methodology also considers a measure "disparities-sensitive" if it has a disparities quality gap of 14% or higher through points assigned if a measure has prevalence among disadvantaged groups, the impact of the condition, and

the quality gap of care. Figure 2 summarizes the NQF 2012 methodology for identifying disparities-sensitive measures.

Figure 2: Identifying Disparities-Sensitive Measures (2012)



A Workgroup member suggested that this tool should be reviewed and potentially revised, noting that it is 10 years old, and the 14 percent benchmark may be arbitrary and central attributes may need updates. A member commented that equity assessment is not a specific component of NQF's Consensus Development Process (CDP) measure endorsement process. A member asked why the specific threshold of 14 percent was established and whether it refers to an absolute or relative difference between groups.

A Workgroup member shared concerns that using "prevalence" in the protocol may inadequately represent high impact and low volume illnesses, including those that may disproportionately impact disadvantaged populations (e.g., sickle cell disease). A co-chair commented that capturing low volume, but impactful diseases could be challenging if stratifying by race, ethnicity, etc. due to small numbers. Workgroup members commented on the difficulty of gathering information from patients on their experience of care, especially around equity, and suggested this could be due in part to lack of trust in the healthcare system. Another workgroup member shared an article on the difficulty patients have sharing personal information. Additionally, Workgroup members pointed to the lack of available measures that would allow patients to report bias and discrimination in their healthcare. A member shared that the VA recently completed the National Veterans Health Equity Report (not yet released), which analyzed quality and patient experience gaps across their populations and adopted the Agency for Healthcare Research and Quality (AHRQ) rubric of a relative disparity gap of 10 percent. This method does not use an absolute threshold but is sensitive to small or large equity gaps within populations and captures low prevalence conditions. A Workgroup member shared a report on the need for gathering information on REAL and SOGI data or race, ethnicity, ancestry, language and sexual orientation and gender identify.

Workgroup members noted that SDOH and social risks are not widely captured in electronic health

records but may be in the future as we move to more sophisticated electronic capture systems. Another Workgroup member commented on the lack of SDOH measures, especially around literacy. Other Workgroup members asked about the role of payers in the use of aligned equity measures and their role in providing interventions for identified social needs. Finally, rather than focusing on individual disparities-sensitive measures, a Workgroup member encouraged the CQMC to consider the role of payers and providers in addressing identified health equity gaps.

The Workgroup suggested NQF revisit the 14 percent criteria and prevalence attributes and consider distribution/variance-based measures to assess smaller disease groups. For instance, in long-term care, several measures (e.g., pain, depression, pressure ulcers) can capture both patient and sub-population level care gaps. Several members commented that the disproportionate impact on quality of life and mortality and morbidity needs to be measured as noted in the AHRQ National Healthcare Quality and Disparities Report. A Workgroup member also shared that it would be helpful to have a standard definition of an equity care gap to allow two-by-two comparisons. Quality gaps are attributed to disadvantaged populations, which may be inaccurate across disease states. NQF staff will use the Workgroup's input to put forth an updated approach for identifying disparities-sensitive measures in the core sets to share with the Workgroup following the meeting.

Public Comment

NQF staff invited members of the public to provide comments. While members of the public did not share verbal comments during the public commenting period, several members of the public did share comments in the chat earlier in the meeting. A participant from the public commented that the CQMC cultural competency domain does not address and specifically name structural racism that has been highlighted as a critical source of healthcare disparities. A member of the public shared that there is a difference between including factors for measurement and holding payers accountable for the outcomes of the measurement. A participant agreed with a Workgroup member that patient experience should be a domain or used across domains (e.g., cross-cutting). A participant suggested sub-categories of patient experience can include engagement and/or activation.

Next Steps

NQF staff shared next steps for the Health Equity Workgroup. NQF will continue analysis of disparities disparities-sensitive measures and health equity measures to discuss during web meeting 2 (tentatively planned for May). During the second web meeting, the Workgroup will continue measure discussion/prioritization, discuss stratification recommendations discussion, put forward considerations for implementing health equity measures, and identify CQMC health equity measure gaps and future priorities. The content from both Workgroup meetings will inform a Health Equity Report. NQF thanked the Workgroup, co-chairs, and the public for their participation in the meeting.