CQMC
Core Quality Measures Collaborative

Meeting Summary

Health Equity Workgroup Web Meeting 2

The National Quality Forum (NQF) convened a web meeting for the Core Quality Measures Collaborative (CQMC) Health Equity Workgroup on May 23, 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).

NQF staff facilitated roll call and reviewed the following meeting objectives:

- Aligning on an updated approach for identifying disparities-sensitive measures within the CQMC core sets
- Refining domains that promote health equity measurement
- Reviewing available measures that promote health equity that align with CQMC's measure selection principles

NQF staff also shared that the Health Equity work will be extended by two meetings to allow additional time for thoughtful discussion and creation of the final Health Equity report. NQF staff will reach out to the Workgroup after the meeting to determine availability for two additional meetings in the summer.

CQMC Overview, Review Health Equity Workgroup Objectives, and Recap Previous Discussions

NQF staff provided an overview of 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. To date, the CQMC has created ten core sets in various clinical areas, ranging in size from five measures (Neurology core set) to 27 measures (Cardiology core set).

NQF staff reviewed the Health Equity Workgroup's overall objectives for this year's work:

- Define domains for the CQMC that promote health equity measurement
- 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

Next, NQF staff shared key themes that emerged from discussions during the first Health Equity Workgroup meeting:

- Key domains for promoting health equity (e.g., quality, access, social determinants of health [SDOH], patient experience of care, cultural responsiveness) should be used to prioritize clinician-level measure alignment.
- Criteria to determine a measure's sensitivity to disparities should be refined and simplified, with clear and transparent guidelines for application.
- Providers may lack resources to provide interventions for identified gaps in social needs.
- It is critical for disparities-sensitive measure data to be actionable by providers and payers to address quality gaps.

The CQMC held a member-only Extended Full Collaborative meeting on April 19, 2022. During this meeting, Collaborative members discussed the role of CQMC in advancing health equity. NQF staff provided an overview of the discussion, noting the overlap between the Full Collaborative discussion and the previous discussion of the Health Equity Workgroup. The Full Collaborative emphasized that equity is a universal issue requiring a collaborative effort from various stakeholders. They also noted there is an absence of standardized, interoperable demographic and social risk data which is a key barrier to action. Alignment on standards for data content and exchange is also needed to improve health equity. The Full Collaborative also agreed that stratification of available measures would be useful and guidance for prioritizing which measures to stratify would be helpful. The Full Collaborative emphasized self-reported data as the "gold standard" for evaluating patient experience, demographics, and social risk factors but also recognized the role for imputed data. The Full Collaborative also discussed the importance of ensuring feasibility and usability of equity measures.

Align on an Updated Approach for Identifying Disparities-Sensitive Measures Within CQMC Core Sets

Updated Approach to Identify Disparities-Sensitive Measures

During the last meeting, the Health Equity Workgroup discussed previous methodologies for identifying disparity-sensitive measures. They discussed that NQF's previously proposed approach, which included prevalence and a performance gap of 14 percent, could potentially be inappropriate because it could exclude measures that address low-volume, high-burden diseases that disproportionately affect underserved communities (e.g., sickle cell disease). Several organizations also shared that they used the NQF Disparities Sensitivity Protocol to assess measure sensitivity but had difficulty applying the protocol. The group recommended that this approach be reviewed and updated.

Based on this feedback, NQF staff modified the approach to identify measures that are disparity sensitive. First, NQF staff established a list of clinical conditions associated with disparities through resources from CMS, Office of Minority Health (OMH), and Agency for Healthcare Research and Quality (AHRQ). NQF also considered measure areas associated with disparities agnostic to diagnosis (e.g., transitions of care), since not all measures address clinical conditions. NQF also gathered measure attributes (e.g., level of analysis, measure type) following recommendations from Robert Wood Johnson Foundation (RWJF) and NQF. Lastly, if available, NQF staff collected testing data from each measure's endorsement submission to assess quality gaps.

NQF staff recognized limitations to this approach and shared that this is a pragmatic approach that might not capture all categories of measures that could be disparities sensitive. This approach may also be limited by the CQMC's scope within the identified clinical conditions as well as measure characteristics. Finally, since performance data was inconsistently available, NQF did not incorporate performance data into this approach.

The updated approach proposes that a CQMC measure be considered disparities-sensitive if (1) it is within one of the identified priority clinical areas OR it addresses an area with disparities, and (2) the measure meets certain predefined characteristics. The process for determining priority clinical areas and areas with disparities, as well as a list of the specific measure characteristics, are described in more detail in the sections below.

Priority Clinical Conditions

NQF staff reviewed the [CMS Framework on Health Equity](), [OMH Focus Areas](), and [AHRQ 2021 National Healthcare Quality and Disparities Report]() to identify priority clinical conditions as follows:

- Substance use disorder (e.g., opioid use)
- Cardiovascular disease (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 (e.g., major depressive diagnosis or episode)
- HIV/AIDS
- COVID-19

Some of these areas (e.g., cardiovascular disease and maternal and infant health) overlap with measures within existing CQMC core sets and some areas (e.g., lupus and sickle cell anemia) do not have measures within the 2021 CQMC core sets.

Measurement Areas Associated with Disparities

To identify measurement areas associated with disparities, NQF referenced the RWJF's 2011 Commissioned Paper: Healthcare Disparities report and NQF's 2012 Disparities-Sensitive Measure Assessment. The specific topic areas included were:

- 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., measures that are linked to social risks)

Measure Characteristics

The modified approach to identify disparities-sensitive measures also includes assessing whether the measure met at least one of the measure characteristics outlined in NQF's 2017 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 disparities-sensitivity evaluation:

- Measures for which the denominator includes many patients affected by a social risk factor or set of risk factors
- Measures for which the denominator is specified for non-inpatient settings (i.e., focus on ambulatory care settings)
- Outcome measures where there is a clear link between the outcome being measured and a set of actions

NQF staff reminded the group that the team reviewed testing data from endorsement applications, but the data available to potentially assess the quality gap between different demographic groups are relatively inconsistent, incomplete, and/or outdated. Because of these limitations, testing data could not be used to draw conclusions on disparities-sensitive measures, and testing data was not included in this updated approach.

NQF staff applied this approach to two CQMC core sets to exemplify the approach in use. For the Human Immunodeficiency Virus (HIV)/Hepatitis C core set, the approach identified all eight measures as disparities sensitive. HIV is a priority clinical area and six measures within the HIV/Hepatitis C cores set are related to HIV. The two measures related to Hepatitis C, which is not a priority clinical area, met the approach as cancer (*MIPS ID #401: Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis*) is a priority clinical area and screening (*NQF #3059e One-Time Screening for Hepatitis C Virus for Patients at Risk)* is a measurement area associated with disparities. Additionally, all eight measures met at least one measure characteristic (patients affected by social risk factors and measure denominators specified for the outpatient setting). For the Neurology core set, four out of five measures were identified as disparities sensitive using this approach. These measures are related to patient surveys/assessments or communication- sensitive services and met at least one measure characteristic. Measure *MIPS ID #187: Stroke and Stroke Rehabilitation: Thrombolytic Therapy* was not identified as disparities sensitive as it did not meet the criteria.

Feedback on the Updated Approach for Identifying Disparities-Sensitive Measures

A co-chair opened the discussion by asking the group for their first impressions and if anyone had questions about the updated approach for identifying disparities-sensitive measures.

Workgroup members asked why specific topics, including tissue plasminogen activator (tPA) for stroke, chronic kidney disease, and end-stage renal disease (ESRD) are not included as part of the disparities-sensitive measures cohort. A member of the public commented that from their experience in Chicago, patients often present later for stroke outside the tPA window, which is associated with high morbidity and mortality. A Workgroup member also shared a research study demonstrating disparities in the use of tPA among stroke patients. Members of the public also asked whether topics including preventive screenings, hospice and palliative care, and lower extremity joint replacement would be included. NQF staff shared that while these topics were not included in the most recent versions of the CMS Framework on Health Equity, OMH Focus Areas, and AHRQ National Healthcare Quality and Disparities Report, NQF is open to updating the list of topics as these resources change over time. NQF also welcomed suggestions from Workgroup members on additional resources that can be referenced to identify priority clinical areas. A member suggested incorporating the National Institute of Minority Health and Health Disparities research framework. This framework includes domains of influence and levels of influence; while it was designed for disparity research, it could be applicable for identifying disparities-sensitive measures. The framework also comments on some of the measures and approaches included in the RWJF Commissioned Paper and the NQF Disparities-Sensitive Measure Assessment, and also addresses potentially relevant factors such as health behaviors, coping strategies, insurance coverage, and health literacy.

A member raised a concern regarding measures that have not been sufficiently tested in vulnerable populations and whether the Workgroup would assume there are gaps when it may be an issue with the survey, health literacy, or other cultural issues. A co-chair commented that this discussion topic would be brought up later in the meeting but for now they are focusing on existing measures for disparities. She added that this group may want to provide guidance for stratifying measures and the which tasks should be done at which level moving forward.

A member commented that the goal of this process is not to focus on specific disparities-sensitive measures, but to agree on a standardized approach for identifying disparities-sensitive measures that is scalable. The member appreciated that prevalence was removed from the updated approach based on discussion of low-prevalence, high-burden conditions during Web Meeting 1. The member also suggested there may be prevalence data that is not being collected for certain populations (e.g., limited collection of data around morbidity and mortality in adults with intellectual and developmental disabilities) and suggested that the group consider conditions even if they do not have well-established data around prevalence.

A member expressed concern that measurement of disparities has frequently been performed with inappropriate analytic methods. The member shared that the data submitted by measure stewards are often incomplete; as a result, the literature based on this data may falsely conclude that there are no disparities in the measure performance.

A member commented that the updated approach identifies a substantial number of disparities-sensitive measures and asked whether it is within the purview of the group to discuss how the measures will be used once they are identified. The member shared that it may be a challenge for end users to understand how to use a lengthy list of disparities-sensitive measures to promote health equity, and that the group should consider usability of the end product. Multiple Workgroup members agreed with this concern. A representative from AHIP shared that, from a governance perspective, part of the Health Equity Workgroup's charge is to provide context around the recommended use of the measures (e.g., stratify measure and use for internal quality improvement purposes among providers, use and stratify within payer programs, make suggestions to measure stewards to update the measures).

A member asked whether this proposed process could flag false positives or false negatives (i.e., measures without disparities are misidentified as being disparities-sensitive, or measures with disparities are not identified as disparities-sensitive). Workgroup members discussed that a measure could theoretically be falsely flagged as disparities-sensitive, but they would expect a small number of "false positives" because disparities exist throughout the healthcare system. NQF staff reiterated a prior Workgroup comment that identification of disparities could vary depending on the methods for collecting and synthesizing the data and reminded the group that the current charge is to create an approach to identify disparities-sensitive measures. NQF staff noted the modified approach tends to identify most measures as being disparities sensitive and requested feedback about if this approach is a workable starting point.

A member asked whether there is a way for the group to incorporate assessments of bias into the process for identifying measures. The member described that within their organization, screenings for sexually transmitted infections (STIs) are higher for people of color due to provider bias, and elevated screening rates may be interpreted as "good performance” despite being worse for patients. A member of the public asked why screening for STIs would be a negative outcome given the potential to prevent sterility, preterm labor, and illnesses such as neurosyphilis. Members shared that over-screening populations due to bias can result in false positive tests, unnecessary follow-up, and negative experiences for people of color who are screened despite no high-risk behaviors. A Workgroup member shared that a similar phenomenon occurs in pediatric populations, where rates of inappropriate antibiotic administration are lower among Black children with ear infections. Workgroup members agreed that assessing bias is important to understand disparities and shared that the group should focus on the outcomes most important to patients.

A co-chair asked the group to provide input on improving the approach to better focus on prioritizing disparities sensitive measures instead of overly identifying measures as being disparities sensitive. She added that all measures could be viewed as disparities-sensitive and asked the group to consider how the approach results can be narrower and more actionable. A member suggested creating guidance for obtaining input from the target population about which measures are most important. Another member suggested considering the impact of the disparity, or how much benefit is missed based on differences in treatment. Lastly, another member shared that the approach could use a graded scale to identify disparities-sensitive measures instead of a yes or no algorithm. Another member suggested looking at screening and outcome measures together because there are health systems that are good at screening patients, but not necessarily good at getting patients treated. The member shared that data from patients in California demonstrate that the breast cancer screening rates for Black women are higher than other groups, but the death rate is also higher. The member suggested bundling these two types of measures or considering alternative measures that may be more informative and actionable (e.g., percentage of patients whose cancer was identified at Stage 4).

A member suggested considering the use of disability-adjusted life years, quality-adjusted life years, or other measurements of burden such as years of life lost or years lived with disability, to prioritize all the core set measures. Another member agreed and suggested that the group consider using health-adjusted life expectancy. A member flagged that using adjusted life years may pose an equity issue because it discounts or diminishes the value of health issues that primarily affect elderly patients. A member of the public also commented that most of the national disability movement oppose use of quality-adjusted life years and shared that the Partnership to Improve Patient Care is leading this effort. The member withdrew their suggestion to use disability-adjusted life years to prioritize the measures based on these comments.

Refine Domains that Promote Health Equity Measurement and Review Measures that Promote Health Equity

Updated Domains that Promote Health Equity Measurement

NQF staff provided an overview of updated domains related to the promotion of health equity measurement. During Web Meeting 1, NQF shared six different frameworks related to health equity.

Based on those frameworks, NQF presented draft domains that may be most applicable to the CQMC's scope of clinician and clinician group measurement in the ambulatory setting. NQF refined the domains based on input from Workgroup members during the previous meeting, noting that the three domains on the right (in a slightly lighter color) are most applicable to the Workgroup's focus:

Enablers of Cultural Responsiveness	Access	Social Needs/Risks	Quality of Care	Equity Ecosystem
•Governance and leadership •Workforce diversity •Learning systems •Collect standardized demographic data (REaL, SOGI)	•Availability •Accessibility •Digital support •Linguistically appropriate	•Screen for SDOH •Assistance with social needs (food, transportation, etc.) •Health literacy	•Interventions to reduce disparities •Effectiveness •Patient engagement •Workforce safety	•Partnership with community organizations •Coordinate care with other healthcare entities
Person-Centered Care, Disparities Sensitivity				

A co-chair commented that having these domains as rough categories is a helpful tool for the group to think through the types of measures needed to improve health equity, and asked whether group members agreed that these domains provided a complete view of measurement related to health equity. A member asked whether the domains are intended to represent the components of an organization that is more likely to prioritize health equity, noting that a mechanism for patient engagement and an accountability mechanism would be necessary within an organization. The co-chairs and NQF staff clarified that the domains are intended to help organize how the group thinks about health equity measurement and are not intended to correspond to components of an organization.

Workgroup members provided the following feedback on the domains (grouped by domain below).

Enablers of Cultural Responsiveness

A member reminded the group of comments related to bias and discrimination shared during the prior discussion on disparities-sensitive measures (e.g., differential rates of screening for STIs), and shared that bias and discrimination should be captured within the domains. A member of the public noted that some of the domain language could be clarified (i.e., whether "learning systems" is the same as "training"). A member of the public commented that the standardized demographic data should include ability to measure populations known to experience access and outcome inequities (e.g., population with intellectual and developmental disabilities).

Access
A member commented that the "linguistically appropriate" item can be separated into three actionable areas: language services, overall literacy, and health literacy. Another Workgroup member added that their organization recently conducted a field survey of over 3,000 Black Californians and found that healthcare literacy is also separate from health literacy. A member of the public added that digital literacy is also a separate topic than health literacy.

A member asked what topics are included in accessibility. NQF staff shared that the accessibility category includes a range of topics related to patients' ability to access medical information and medical care, and the category is intentionally broad to allow room for the group to identify existing or needed measures to address the categories in the domains.

Social Needs/Risks
A member of the public suggested that this category might be better described as "social conditions for health," as SDOH is focused on the social conditions necessary for health. Another member of the public commented that SDOH factors can also have a protective effect, so it may be more accurate to reword the item "screen for SDOH" as "screening for SDHI" (social determinants of health inequalities)."

Quality of Care
A member asked whether general patient experience is included as part of this domain; NQF staff clarified that patient experience would be included in the "patient engagement" item. The member also asked whether engagement of individuals and groups would fall within this category; NQF staff confirmed this would also be included within "patient engagement." The member commented that in value-based systems, the emphasis may be on individuals attributed to the group, not necessarily on patients.

A member suggested that including measures of respect and experience of discrimination would be a helpful addition to the "patient engagement" item. A member also commented that measures of patient experience need to extend beyond the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys; additional measures may be more difficult to capture, but will be a more accurate reflection of the patient experience. Another member agreed that CAHPS on its own is insufficient.

A member commented that the domains should incorporate a feedback loop, where information from patients' care and service experience feeds back into improving the system. A member of the public commented that they collect patient feedback by bringing patients together to talk about their concerns within patient cafes.

A member asked whether the multi-category bar "Person-Centered Care, Disparities Sensitivity" should be expanded to explicitly encompass patient experience and patient engagement. A member of the public suggested that patient-reported information about care should be its own domain or should be included in the cross-cutting bar. This would leave Quality of Care to be defined in narrower clinical terms. A Workgroup member agreed with this comment and noted that if patient-reported information is not moved into a separate domain, patient experience should be called out by name within the Quality of Care domain.

Equity Ecosystem

A member asked whether diversity of community organizations is considered within the Equity Ecosystem domain. The member added that stakeholders may have preconceived notions of the types of organizations and partners that are part of the equity ecosystem, but stakeholders should be inclusive of non-traditional organizations and partners in equity work.

Measure Scan and Initial Findings

NQF staff provided an overview of the approach used to identify measures related to health equity. NQF staff reviewed foundational literature including the NQF Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity and the National Committee for Quality Assurance (NCQA) State of Equity White Paper, as well as reviewing publicly available measure databases such as the Measure Applications Partnership (MAP) Measures Under Consideration (MUC) list, CMS Measure Inventory Tool (CMIT), and NQF Quality Positioning System (QPS). NQF shared that 32 measures and measure concepts were identified related to social determinants of health, cultural competency, accessibility, availability, and evidence-based interventions to reduce disparities.

NQF staff shared that the 32 measures and measure concepts were reviewed against the CQMC's measure selection principles. After eliminating 19 measures and measure concepts which addressed health at the population level or were index measures, a total of 13 measures remained at the clinician, facility, or plan levels of analysis. NQF staff shared that the measures corresponded with the proposed domains as follows, and provided a brief overview of each of the measures identified in the scan:

- Enablers of Cultural Responsiveness
    - NQF #1904 Clinician/Groups Cultural Competence Based on the CAHPS Cultural Competence Item Set (endorsement removed)
    - Hospital Commitment to Health Equity (measure concept)
- 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 Health Care (endorsement removed)
    - Patient-Centered Medical Home Patients' Experiences (related to parents/guardians' ability to get the care their child needs during evenings, weekends, or holidays)
- Social Needs/Risks
    - Screening and Referral for Transportation Insecurity
    - Social Determinants of Health Screening
    - Screen Positive Rate for Social Drivers of Health (measure concept)
    - Screening for Social Drivers of Health (measure concept)

- Quality of Care
    - NQF #0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episode of Care (endorsement removed)
    - NQF #1885 Depression Care: Percentage of Patients 18 Years of Age or Older with Major Depression or Dysthymia Who Demonstrated a Response to Treatment 12 Months (+/- 30 Days) After an Index Visit
    - Adverse Outcome Index
- Equity Ecosystem
    - A Minimum of 3% of Total Enrollment Shall be Served by Community Health Workers or Similar Support Workers

A co-chair opened discussion by asking the group for initial reactions to these measures, as well as any suggestions for measures and measure concepts that were not represented in the initial scan. Workgroup members identified the following topics as initial gap areas:

- Patient experience measures, including not only quality of care but also access to care
- Measures of bias and discrimination in the medical setting
    - The PREM-OB Scale: https://pubmed.ncbi.nlm.nih.gov/35301757/
    - The Everyday Discrimination Scale: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3350778/
- Measures related to accountability for bad behavior (e.g., governance structure that monitors complaints and grievances or adverse events by race/ethnicity)
- Measures related to providers' use of inclusive, non-judgmental language to describe patients (e.g., avoiding labelling patients as "non-compliant")

A member of the public asked how the timeline for the development of the CMS equity measures would affect the CQMC's measures. NQF staff shared that the CQMC performs updates to the core sets on an annual basis, so the CMS measures would be included in the next applicable cycle of core set maintenance after the measures are finalized.

A Workgroup member asked for clarification on whether the group can include measures in the CQMC work if they are no longer endorsed. NQF staff clarified that any scientifically sound measures can be considered for inclusion in the CQMC core sets. While NQF endorsement may be lost due to lack of scientific validity, endorsement can also be lost due to external factors (such as lack of resources to continue submitting documentation for endorsement maintenance). NQF staff shared the reasons for lost endorsement are reviewed with the CQMC workgroups when available, as well as any information on whether the measure steward plans to maintain the measure outside of the endorsement process. The Workgroup member commented that this is helpful; their main concern with including non-endorsed measures was around acceptance by end users, but this concern is alleviated if changes in endorsement are discussed with Workgroup members.

A Workgroup member noted that the first category of measures discussed during the meeting (disparities-sensitive measures) included many measures, while this second category of measures (health equity-related measures) is much smaller. The member asked for clarification on why there are fewer measures in this category (e.g., if this is due to the restrictions on level of analysis). NQF shared that 32 measures related to health equity were identified during the environmental scan and the measures were narrowed down to 13 based on the CQMC's outpatient, clinician-level scope. NQF also shared measures included in the CQMC core sets must be fully developed and ready to implement as specified. A representative from AHIP also clarified the process, noting that measures in the sets must be ready to implement as written, but important measure concepts can be noted in the CQMC's reports related to measurement gaps, and notes on measures ready for testing can also be included. A member of the public also shared that the measures discussed in the initial section are measures that can be used to identify disparities in care, and disparities are present in most areas of care; in comparison, the 13 measures being discussed are designed to measure health equity and enablers of health equity specifically. The Workgroup member shared that this explanation is helpful, and referring to these measures as "enablers of health equity" instead of "concepts related to health equity" would be clearer. A member of the public added that the measures could also address barriers to health equity in addition to enablers.

A member noted that based on the distinction between "disparities-sensitive" measures and "enablers of health equity," the three Quality of Care measures identified above seem more aligned with the "disparities-sensitive" measures in that they address specific conditions. In considering enabling factors for equity related to Quality of Care, factors such as whether a practice reviews their quality reports, whether the practice has capacities to interpret and act on results, and whether the practice has trained staff familiar with disparity reduction interventions and measurement science could be more helpful. A member of the public shared the California Health Care Foundation's Toolkit to Advance Health Equity in Primary Care Improvement, noting that this resource addresses these types of factors and processes. Another member agreed that the Quality of Care measures seem too specific, particularly NQF #1885 *Depression Care: Percentage of Patients 18 Years of Age or Older with Major Depression or Dysthymia Who Demonstrated a Response to Treatment 12 Months (+/- 30 Days) After an Index Visit*. The member noted that the other Quality of Care measures are more global, but #1885 is related to a specific condition instead of being system-focused. NQF staff thanked Workgroup members for sharing this feedback and noted that #1885 was specifically flagged as a health equity measure in a report, but the team will revisit to determine if this measure is appropriate.

A member asked whether the CQMC core sets are informed by the Adult and Child Medicaid Core Set measures. NQF staff clarified that the measures considered for the CQMC core sets are cross-checked for current use in federal programs, including not only the Medicaid core sets but also the Merit-based Incentive Payment System, the Medicare Shared Savings Program, and other programs; this information is presented as part of the Workgroup's discussion. The member asked how many of the measures in the CQMC core sets overlap with the Medicaid core sets; NQF staff shared that an exact count is not available, but there is significant overlap between the sets. A representative from AHIP also shared that from a governance perspective, the CQMC's goal is to align both public and private payers, and there are times where private payer measures are different than those used by CMS, so these do not align perfectly. The member shared that it would be helpful to understand current alignment with the Medicaid set because the child core set and the behavioral health measures will be required as part of mandatory public reporting starting in 2024, and this push to report on certain measures could add momentum to health equity efforts. Identifying equity-related measures that are not already included in the Medicaid sets could be helpful for identifying areas where more support is needed.

A member asked if the measures in this scan will be used for internal quality improvement purposes, or if they will be used to compare entities. A representative from AHIP shared that the intended use of the measures should be discussed as part of the group's activities (e.g., what uses are the measures appropriate for, are there any changes that need to be made to the measures in order for them to be usable, which measures are ready for accountability programs, which measures should be stratified and why). A Workgroup member commented that the group will need to review data from the developers related to aspects such as testing process, testing results, and intended use when reviewing the detailed specifications for these measures and considering appropriate use of the measures.

A member commented that the Workgroup previously discussed that self-reported data from members is the gold standard for stratification. The member shared that the group should address this topic in their recommendations for using the health equity measures, and noted that their organization is currently using imputed data and does not anticipate 100 percent self-reported information will be available until five to ten years from now.

A member of the public commented that when developing measures around health equity, the different preferences and outcomes that communities desire from their healthcare providers may be a helpful starting point for person-centered healthcare planning. Workgroup members agreed, flagging potential measure concepts such as whether practices offer extended hours of care, where care is offered, whether multiple appointments can be scheduled on the same day to save transport and reduce disruptions to work and childcare.

A member asked which stakeholders are the final audience for these quality metrics, sharing a Health Affairs article outlining different types of measures that are more important to various audiences. A representative from AHIP shared that from a governance perspective, the goal of the CQMC is to align across payers, including public payers (state, federal) and private payers. This is within the context of value-based programs, so the measures should be appropriate for use in models such as pay-for-performance, pay-for-reporting, or alternative payment models. The measures should also focus on clinician-level measures and ambulatory care, although certain core sets also contain hospital-level measures (e.g., the Obstetrics/Gynecology and Cardiology core sets include hospital measures because important care happens in the hospital setting, and other sets may include facility-level measures in important topic areas where no clinician-level measures are available). While the stated goal is focused on payers, other stakeholders including consumer groups, employers, regional collaboratives, and other stakeholders are also included in the CQMC and are part of the intended audience for the core sets; the group is seeking broad-based consensus on what measures and outcomes are important to track in the healthcare system.

Public Comment

NQF staff invited members of the public to provide comments. Members of the public reiterated the importance of comments on understanding and measuring bias, as well as the importance of tracking health disparities for patients with disabilities, and provided links to the following equity-related resources:

- Krahn et al.: Persons With Disabilities as an Unrecognized Health Disparity Population (2015)
- Center for Dignity in Healthcare for People with Disabilities: Healthcare Discrimination and Inequities Facing People With Disabilities: A Gap Analysis (2020)
- California Community Living Network: Service Outcomes for California's Developmental Disability Community (2020)
- Kaizen Health, a company providing transportation to appointments including dialysis.

A member of the public also shared comments on three topics discussed during the meeting – alignment, actionability, and scientifically sound measures. The member of the public shared that there are opportunities to take certain categories of measures and bring them together (e.g., aligning the specifications of measures related to medication reconciliation with measures related to patient access to medical lists and health records, or with HIV treatment measures); this does not necessarily mean that composite measures should be developed, but existing measures should be aligned. The member of the public also shared that not all measures are actionable at the clinician level (e.g., a measure related to patient ability to access the electronic health record may be due to lack of broadband internet) and these measures may be impacted by issues external to the measure target. Finally, the member of the public shared that it would be helpful for the group to explicitly cite evidence for the identified disparities/inequities and share the quality of evidence behind each observation or classification, instead of relying on anecdotal evidence to describe the importance of each measure.

Next Steps

NQF staff shared that they will incorporate the feedback from today's discussion on the domains, equity measures, and approach for identifying disparities-sensitive measures. After identifying a list of the disparities-sensitive measures in the core sets, the list will be shared with the Workgroup for further feedback. NQF staff will also reach out to Workgroup members to determine availability for two additional meetings, tentatively scheduled for late June and late August. For members who are unable to join additional meetings, offline options for feedback will also be offered. NQF staff and the co-chairs thanked the Workgroup for their attention and engagement before adjourning the meeting.