CQMC Core Quality Measures Collaborative

Meeting Summary

Core Quality Measures Collaborative (CQMC) Health Equity Workgroup Web Meeting 4

The National Quality Forum (NQF) convened a public web meeting for the Health Equity Workgroup on August 29, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

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

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

- Review public comments received on the draft report and proposed responses, and
- Discuss approaches to refine disparities-sensitive measure identification in CQMC core sets

Overview of Final Report

NQF staff provided a review of the CQMC Health Equity Final Report content, noting the content builds on the measure scan previously shared with the Workgroup and incorporates the approach used for identifying disparities-sensitive measures in the CQMC core sets and the existing measures and measure concepts that promote health equity. NQF staff also provided an overview of new content in the report.

The report identifies three strategies to further enable the identification and prioritization of disparities-sensitive measures: 1) determining measures for prioritization and resource allocation, 2) supporting and advancing the development of electronic data elements and data sharing standards, and 3) stratifying data to assess disparities and inform benchmark setting. NQF staff emphasized that, per discussion by the Workgroup, the first strategy is not intended to identify any conditions or topics as being more important for health equity, but rather to identify starting points for action.

The report additionally includes the following future opportunities for the CQMC to address health equity measurement:

- 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

Review and Discuss Public Comments

NQF staff shared that the public commenting period for the Draft CQMC Health Equity Final Report was open from August 11th through August 24th with a total of eight comments received from three organizations and individuals. The public comments received are organized by their respective commenting prompts soliciting feedback on:

- the identified disparities-sensitive measures within the CQMC core sets;
- strategies for enabling further identification and prioritization of disparities observed in the core set;
- existing measures and measure concepts that promote health equity and align with CQMC's measure selection principles;
- future opportunities for the CQMC to advance health equity measurement; and
- other general feedback on the report.

The first question prompt requested comments on the disparities-sensitive measures identified in the CQMC core sets. Public commenters supported the approach to use priority conditions to identify disparities-sensitive measures, but noted that some conditions (e.g., gastric cancer screening, sickle cell anemia) that are known to have very strong disparities are currently not included in the CQMC core sets. NQF's proposed response to the comment is to acknowledge the limitation of only examining measures in the current CQMC core sets and to note that the suggestion to use priority conditions to create future measure sets could be raised with the CQMC members. Another comment stated that disparities-sensitive measures should be based on consensus or evidence-based definition of "disparities" and should include patient engagement or patient-reported measure sets. In response, NQF staff noted that the definition adopted in the 2022 CQMC Health Equity Report for "disparities" is from Healthy People 2020 and defines a disparity as "a particular type of health that is closely linked with social, economic and/or environmental disadvantages." The response also highlights the use of published literature and prior work by a technical expert panel to identify the priority conditions and measure characteristics used to determine if measures were disparities-sensitive.

A co-chair opened the discussion by asking the Workgroup to provide feedback on the proposed responses to public comments on the disparities-sensitive measures within the CQMC core sets. Workgroup members participating in other initiatives, including the CQMC Pediatric Workgroup and one that focuses on measures used in Medicaid, noted that some measures for the priority conditions highlighted in the comments, such as sickle cell anemia, are under consideration but face substantial challenges from low denominator numbers. Another Workgroup member expressed that only sharing the official definition used in the report for "disparity" limits the inclusion of the patient voice and is not responsive to the commenter's concerns. The Workgroup member suggested including patient engagement throughout the report to cement the importance of this stakeholder group. NQF staff agreed to include additional language about patient engagement in the report.

NQF then shared the second question prompt that requested comments on the strategies for identifying and prioritizing disparities. One public comment was received, which supported the three strategies recommended by the Workgroup, highlighting the importance of using an iterative approach that will allow the strategies to evolve. There were no additional comments from the Workgroup on this public comment and proposed response.

NQF staff shared the third question prompt that requested comments on the existing measures and measure concepts for health equity that align with the CQMC measure selection principles. A public commenter suggested the use of an existing framework or developing a new framework to address care gaps and transitions of care as patients shift between care settings toward end-of-life care. Additionally, the commenter described this as a "macro-framework" that would encompass multiple framework approaches (e.g., quality, equity ecosystem, social needs). The proposed response notes that the 2022 CQMC Health Equity Final Report is informed by several existing frameworks for health equity published by NQF, the New England Journal of Medicine, the Institute of Medicine (IOM), National Committee for Quality Assurance (NCQA), the Robert Wood Johnson Foundation, and the Institute for Healthcare Improvement (IHI). The proposed response supports the holistic examination of health equity throughout a patient's journey.

A co-chair opened the discussion by asking the Workgroup to provide feedback on the public comment and proposed response on the existing measures and measure concepts for health equity. A Workgroup member commented that the proposed response does not capture the essence of the comment, which focuses on creating a framework that includes how patients move in a life cycle through different stages of illness and the correlation with health equity. The member proposed that the response should capture how inequalities make these transitions more difficult, so that measurement is performed more effectively. Another Workgroup member responding as Steering Committee chair informed the Workgroup that developing a new framework is out of the CQMC scope and asked if the CQMC Analysis of Measurement and Gap Areas and Measure Alignment report would be a better fit to include this consideration, or in other CQMC gaps discussions. Additional comments from Workgroup members agreed that the comment's call for such a framework may be out of scope due to the limitations of the CQMC's focus on measures in ambulatory care settings that does not allow for full-cycle examination of patient trajectories. However, Workgroup members agreed that the response to the public comment should not include a list of frameworks utilized in the development of the CQMC Health Equity Final Report, since that does not address the true nature of the comment. NQF staff agreed that it is not in the current CQMC Health Equity Workgroup scope to develop a new framework, but the response could acknowledge the importance of additional work needed for developing frameworks in the future as well as the importance of recognizing each patient's individual experiences with health equity throughout their care trajectory.

NQF staff then transitioned to the fourth question prompt that requested comments on the future opportunities to advance health equity measurement. The first comment supported calls to diversify the workforce and promote cultural responsiveness, linguistically appropriate care, and increasing health literacy. The second comment supported the opportunities described in the report and suggested providing additional communications and resources for smaller providers or providers who may influence measures but are not primarily responsible for them. The proposed response highlights the opportunity in the CQMC Health Equity Final Report's to create "how to" resources to guide organizations in their efforts to stratify data to assess and address disparities, which would include strategies tailored to organizations varying in size, resources, and populations served.

NQF and the co-chair asked the Workgroup to share thoughts on other approaches the CQMC could take, in addition to the creation of these "how to" resources, to facilitate cross-organizational sharing of best practices. Workgroup members discussed using terminology such as "recommended processes" if the evidence base does not yet support claims for "best practices" and considered opportunities through learning collaboratives. Several Workgroup members noted that "how to" resources and learning collaboratives may be outside the charter of the CQMC, and discussed opportunities to partner with other organizations already leading similar efforts, such as IHI.

Lastly, NQF shared general comments on the report submitted during the public comment period. One comment was submitted, which noted the lack of hospice and palliative care core sets in the CQMC. The comment did acknowledge opportunities to improve health equity in these care settings through better access to primary care and curative care services but called for health equity to be addressed and ensured throughout the healthcare ecosystem for all patients, including those with life-limiting illnesses. NQF shared a proposed response that agreed with the call to promote health equity throughout the care continuum and acknowledged that the CQMC does not currently have core sets for hospice and palliative care. However, several measures related to hospice and end-of-life care are included in the Medical Oncology Core Set that was included in the review of measures for the report. During the discussion, Workgroup members discussed ever-blurring lines between ambulatory care and other care settings and opportunities for the continuum of care within the CQMC's purview to better address the needs of complex patients, such as those in hospice and palliative care.

Refining Disparities-Sensitive Measure Identification in CQMC Core Sets: AHIP Case Example and Discussion

NQF staff transitioned the discussion to refining disparities-sensitive measure identification in CQMC core sets. NQF staff shared the updated approach to identifying disparities-sensitive measures (Figure 1) in the current CQMC core set from the previous Workgroup meeting.

For this approach, a CQMC measure is considered to be disparities-sensitive if (1) it is within one of the identified priority clinical areas OR the measure assesses a measurement area associated with disparities, and (2) it meets certain predefined measure characteristics as described in the previous Workgroup meeting.

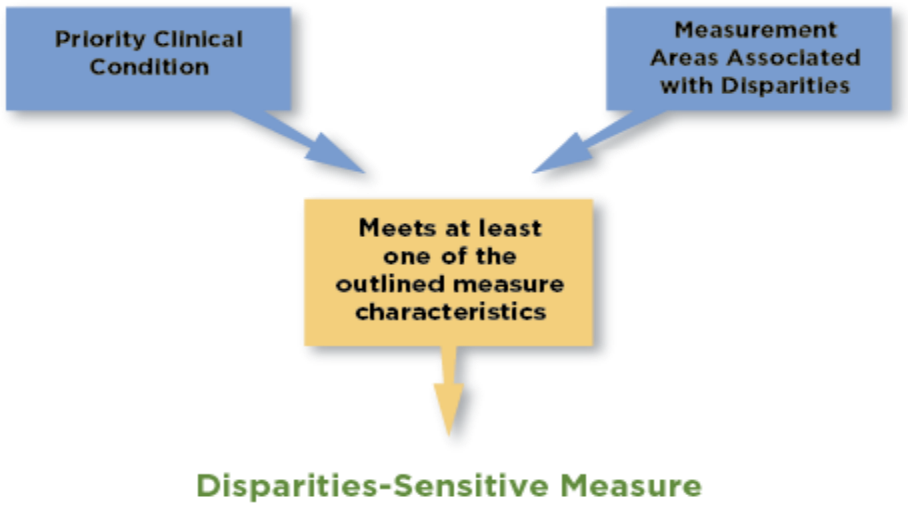

Figure 1: Approach to Identify Disparities-Sensitive Measures Within the CQMC Core Set

Findings for Disparities-Sensitive Measures in CQMC Core Sets

The table below (Table 1) includes the preliminary summary of the findings for applying the approach to the existing CQMC core sets. The approach was applied to the 150 measures within the 10 condition-specific core sets and identified 137 measures to be disparities-sensitive. NQF staff shared that 19

measures met all three of the measure characteristics, 90 measures met two of the measure characteristics, and 28 met one of the measure characteristics. It was noted from previous discussions that all measures likely have some level of disparities, including the 13 measures that weren't identified as being disparities-sensitive with the approach. NQF staff shared that as the next steps, the Workgroup will explore potential approaches to further prioritize the measures identified as disparities-sensitive in the CQMC core sets to help organizations focus their resources to identify and address disparities.

Table 1: Summary of Findings from Disparities-Sensitive Measure Identification

CQMC Core Set	Meets 3 Measure Characteristics	Meets 2 Measure Characteristics	Meets 1 Measure Characteristic	Unmeasured Disparities	Total
ACO/PCMH/PC	3	13	4	2	**22**
Behavioral Health	2	7	3	0	**12**
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**	**28**	**13**	**150**

AHIP Presentation: Health Equity Measures for Value-Based Care

NQF staff introduced AHIP guest speakers Erin O'Rourke, Executive Director of Clinical Performance and Transformation, and Michelle Jester, Executive Director of Social Determinants of Health. Since 2020, AHIP has developed a set of health equity measures that could potentially be used to support value-based care. AHIP noted that COVID-19 has shown the urgency of reducing healthcare disparities and advancing health equity. To address this need, AHIP convened a group of members that began identifying potential measures available to underpin value-based care models as well as the key gaps for future measure development. AHIP shared that the group defines health equity as "everyone having a fair and just opportunity to be as healthy as possible."

Similar to the CQMC Health Equity Workgroup, AHIP reviewed NQF's 2017 *Health Equity Roadmap: Four I's for Health Equity*, which includes recommendations to (1) identify and prioritize reducing health disparities; (2) implement evidence-based interventions to reduce disparities; (3) invest in the development and use of health equity measures; and (4) incentivize the reduction of disparities and the achievement of health equity. The roadmap includes two approaches of stratifying the existing

measures that are currently used to identify disparities and implementing measures that directly assess health equity and interventions to achieve it. Additionally, AHIP defined health equity measures as performance measures that can drive the reduction in disparities. AHIP's Value-Based Workgroup also developed a set of recommended health equity measures for value-based care. Their process included developing a framework and vetting measure selection criteria, identifying priority conditions and care settings, a Workgroup review of potential measures, developing a set of prioritized health equity measures, vetting those measures with other stakeholders (e.g., consumers, providers, credentialing organizations, etc.), and partnering with measure developers and policy makers to support the implementation of the priority measures identified. AHIP developed two sets of measure selection criteria for measures intended for use in quality improvement and for value-based payment.

AHIP's framework for equity measurement includes the following domains: prioritize culture of equity, quality, data, accountability, access, community partnerships, and member experience. These seven domains focus on identifying existing measures that are implemented or proposed measure concepts based on the existing gap areas to develop, test, and vet new measures. Additionally, the domains include a range of structural measures to direct the organization's structure or culture of equity in efforts of diversifying the skill sets of their staff (e.g., community health workers, doulas, patient navigators) for the overall continuum of care. To develop the domains, AHIP reviewed published literature and other existing equity proposals or frameworks to categorize the major themes. Within each category, AHIP identified the measures that should be (1) prioritized for quality improvement, (2) prioritized for value-based payment, or (3) not prioritized.

AHIP identified measures in their quality domain by reviewing sources and databases for alignment of the measures used to assess health and the provider's quality of care. Then, AHIP examined the potential sources in care settings and the level of analysis for health plans, hospitals, and clinician measures. The prioritized measures address conditions/aspects of care with known disparities in maternal health, respiratory diseases, behavioral health, cancer, cardiovascular disease, diabetes, chronic kidney disease (CKD), and pediatrics. AHIP noted that no measures were selected that specifically addressed CKD.

A co-chair asked the presenters if there was overlap between the findings of their work and the CQMC Health Equity Workgroup's final report. AHIP responded that the work relied heavily on the CQMC core sets, but expanded the list to include additional measures that would potentially drive the most change. This list focused on the conditions with the largest disparities, screening measures, and measures that addressed outcomes or processes applying to a broader population. NQF added that all of the included measures from AHIP's work are available in the meeting slides, including measures that were identified as disparities-sensitive that are not currently included in the CQMC core sets. Workgroup members also inquired about AHIP's timeline to identify health equity measures for other domains and if composite measures would be considered in future work. AHIP noted that the remaining "accountability" domain would be covered in September, but that the list would be further refined before finalization, and highlighted the importance of first focusing on structural needs of organizations to address health equity and disparities-sensitive measures. Workgroup members also commented on the need for all parties engaging to this work to align to prevent duplication and provide each organization the opportunity to lead in its areas of strength to ultimately fill gaps in health equity measurement.

Possible Approaches to Refine the Identification of Disparities-Sensitive Measures in CQMC Core Sets

NQF staff transitioned to the next section on the possible approaches to refine the identification of disparities-sensitive measures in the CQMC core sets. NQF staff shared two potential strategies to

prioritize measures for initial action and resource allocation. The first approach considers prioritizing the measures that met all three of measure characteristics used to identify measures as disparities-sensitive. NQF reminded the group that those characteristics are measures with a denominator that includes patients disproportionately affected by social risks compared to the general population, measures specified for ambulatory settings, and measures classified as outcome measures. 19 out of the 150 measures met all three of the characteristics across seven of the core sets. The CQMC core set measures that met all three of the characteristics are listed below and could also be found on the Draft CQMC Health Equity Final Report that was shared during the public commenting period.

- **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 second approach for consideration is to examine measures that are broadly applicable. This approach would build off the process to identify disparities-sensitive measures in the CQMC core sets to include additional categorization by measures that are used in multiple core sets and measures that were identified as broadly applicable (i.e., cross-cutting) in previous CQMC efforts. NQF staff shared that those previous efforts considered measures to be cross-cutting based on factors such as if the denominator was the general population or a reasonable subpopulation (e.g., adults 15-65 years old) or

if the measure fell in certain domains, such as patient safety, patient engagement, care coordination, equity, and population health. Overall, out of the 129 unique measures within the CQMC core sets, 23 met at least one criterion of being broadly applicable (see Table 2). Additionally, two of the 23 measures also met all three measure characteristics of being a disparities-sensitive measure.

Table 2: Results of Identifying Broadly Applicable Measures

NQF Number (links to specs)	Measure Title	Disparities-Sensitive Measure Characteristics Met	Alignment across CQMC core sets	Number of core sets measure is included	Identified as Cross-Cutting in Previous CQMC Efforts
0018	Controlling High Blood Pressure	3	ACO/PCMH, Cardiology	2	Yes
1885	Depression Response at Twelve Months-Progress Towards Remission	3	ACO/PCMH, Behavioral Health	2	-
0418/0418e (no longer endorsed)	Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan	2	MedOnc, OB/GYN, ACO/PCMH/PC, Behavioral Health, Pediatrics	5	Yes
0005	CAHPS Clinician & Group Surveys (CG-CAHPS) Version 3.0 -Adult, Child	2	Pediatrics, Neurology, ACO/PCMH	3	Yes
0028/0028e	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	2	Cardiology, Behavioral Health, ACO/PCMH/PC	3	Yes
3059e / MIPS ID 400	One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	2	HIV/Hep C, Gastro, ACO/PCMH	3	-
2372	Breast Cancer Screening	2	ACO/PCMH/PC, OB/GYN	2	Yes
0032	Cervical Cancer Screening	2	ACO/PCMH, OB/GYN	2	Yes
MIPS ID 475	HIV Screening	2	OB/GYN, HIV/Hep C	2	Yes
MIPS ID 443	Non-recommended Cervical Cancer Screening in Adolescent Females	2	ACO/PCMH, OB/GYN	2	Yes

NQF Number (links to specs)	Measure Title	Disparities-Sensitive Measure Characteristics Met	Alignment across CQMC core sets	Number of core sets measure is included	Identified as Cross-Cutting in Previous CQMC Efforts
2152	Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling	2	Behavioral Health, ACO/PCMH/PC	2	Yes
1800	Asthma Medication Ratio	2	ACO/PCMH/PC, Pediatrics	2	-
0033	Chlamydia Screening in Women	2	Pediatrics, OB/GYN	2	-
MIPS ID 401	Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis	2	Gastro, HIV/Hep C	2	-
0034	Colorectal Cancer Screening	2	ACO/PCMH Only	1	Yes
2624	Functional Outcome Assessment	2	Neurology Only	1	Yes
1741	Patient Experience with Surgical Care Based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surgical Care Survey	2	Orthopedics only	1	Yes
2962	Shared Decision-Making Process	2	Orthopedics only	1	Yes
0097	Medication Reconciliation	1	ACO/PCMH/PC, Neurology	2	Yes
2651	CAHPS® Hospice Survey (experience with care)	1	Med Onc only	1	Yes

NQF Number (links to specs)	Measure Title	Disparities-Sensitive Measure Characteristics Met	Alignment across CQMC core sets	Number of core sets measure is included	Identified as Cross-Cutting in Previous CQMC Efforts
0419e	Documentation of Current Medications in the Medical Record	1	Neurology Only	1	Yes
0421/0421e	Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up	1	ACO/PCMH/PC Only	1	Yes
1768	Plan All-Cause Readmissions (PCR)	1	ACO/PCMH/PC Only	1	Yes

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NQF solicited feedback from Workgroup members on both proposed approaches. One member commented that in the second approach, it is difficult to determine when the same measure is used in multiple value-based payment programs because measures are often altered slightly for each program and may not truly be identical. Workgroup members also suggested including the measure sampling or retesting and providing real-world data for even a small number of the measures to confirm where disparities exist that should be prioritized. Members noted that this lack of data makes it challenging to understand if measures have been sufficiently tested in a wide variety of the beneficiary population (e.g., advanced illness stages) with enough sample size to allow subgroup analysis, since complex cases are often excluded from the sample. Other Workgroup members responded that this lack of data requires different approaches, such as those proposed by NQF, that might call for initial prioritization using criteria such as cross-cutting measures or those that fit three measure characteristics. NQF staff shared that the data resources available for identifying disparities would help influence the CQMC health equity approach as it is evolved. Finally, a Workgroup member reminded the group that as this prioritization occurs, it will be important to center community voices and input on these metrics.

Public Comment

NQF staff opened the web meeting to allow for public comment. There were no comments from the public.

Next Steps

NQF staff shared that the CQMC Health Equity Final Report will be updated based on the public comments, and Workgroup feedback from the day's discussion. NQF staff will follow up with additional next steps for the Workgroup. NQF staff and the co-chairs thanked the Workgroup for their attention and engagement before adjourning the meeting.