Meeting Summary

Cross-Cutting Workgroup Web Meeting 1

The National Quality Forum (NQF) convened the inaugural web meeting for the Cross-Cutting Workgroup on August 11, 2021.

Welcome, Roll Call, and Orientation to Core Quality Measures Collaborative (CQMC)

NQF staff welcomed participants to the meeting and introduced the co-chairs of the Cross-Cutting Workgroup, Erin Royer and Sandeep Vijan, MD, 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 by organization and provided a background to the CQMC. The CQMC was founded in 2015 and is a public-private partnership with a membership of more than 75 stakeholders (e.g., consumer groups, medical associations, health insurance providers, and purchasers). The CQMC develops and recommends core sets of performance measures that should be prioritized for use by public and private payers across the nation. NQF reviewed the aims of the initiative which include identifying high-value, high impact, and evidence-based measures; aligning measures across public and private health insurance providers to achieve congruency; and reducing the burden of measurement by eliminating low-value metrics, redundancies, and inconsistencies in measure specifications.

NQF staff provided a brief overview of the CQMC's achievements in 2019-2020:

- Updated eight original core sets, including ACO/PCMH/Primary Care, Cardiology, Gastroenterology, HIV/Hepatitis C, Medical Oncology, Obstetrics & Gynecology, Orthopedics, and Pediatrics
- Created two new core sets: Behavioral Health and Neurology
- Released documents including Approaches to Future Core Set Prioritization, Analysis of Measurement Gap Areas and Measure Alignment report, and the Implementation Guide

NQF staff also shared goals to build on this work in the 2020-2021 year by developing new guides on Measure Model Alignment and Digital Measurement; developing a new cross-cutting core set; updating the Implementation Guide; and performing ad hoc maintenance on the existing core sets. The Workgroup was also notified that the CQMC will continue exploring opportunities to integrate equity considerations into the core sets and measurement initiatives.

NQF staff shared that the CQMC approach is to collaboratively drive measure alignment, identify

measurement gaps, and support the adoption of aligned core sets.

Cross-Cutting Workgroup Overview and Discussion

NQF staff shared an overview of the background leading to the formation of the Workgroup. Staff noted that previous measure reviews reflected a need for a broader view of the quality measurement ecosystem. NQF staff shared that the goal for the Workgroup is to develop a core set of cross-cutting measures. The Workgroup will also identify and discuss specific gaps, barriers, and solutions to implementation. Some of the potential topics based on previously identified and overarching gaps include patient safety (e.g., diagnostic accuracy, medication safety), patient and family engagement (e.g., patient-reported outcomes), care coordination (e.g., transitions of care, care planning), equity (e.g., access, social determinants of health (SDOH), as well as population health measures (e.g., immunizations, screening). NQF considered cross-cutting topics that can be relevant across multiple clinical conditions, settings, or procedure/services (e.g., patient experience), as opposed to condition-specific measures which are specific to a specific clinical condition or diagnosis (e.g., hemoglobin A1c control measures for diabetes treatment).

NQF staff noted that the preliminary approach to identifying measures included scanning NQF's Quality Positioning System (QPS), CMS' Measure Inventory Tool (CMIT), as well as previous and current NQF framework projects (e.g., 2017 Roadmap for Promoting Health Equity and Eliminating Disparities; 2020 Improving Diagnostic Quality and Safety report; ongoing work on PRO-PMs).

NQF staff highlighted that the Cross-Cutting work was discussed during the April 13 full Collaborative meeting and provided a summary of feedback received during that meeting. During that meeting, NQF staff presented the Workgroup's tasks: establish a common definition and scope, determine an approach for identifying priority areas for measurement, connect the Workgroup's findings with the other CQMC core sets. The full Collaborative discussed that as the Workgroup works to establish a common definition, it would also have to consider defining the relevant populations and any overarching topics or themes that need to be addressed. Also highlighted was the need for the Workgroup to consider measures based on user outcomes (e.g., consumer trust, helpfulness in decision-making) and patient-centered measures in the context of clinical pathways.

The full Collaborative recognized that there may be some challenges developing a set ready for implementation (e.g., due to a lack of measures that fit the identified topic areas) and recommended that the Workgroup consider how to best signify the importance of the areas where measures are not available. The full Collaborative recommended that the Workgroup agree on the highest priority subdomains/topics and possible data sources before reviewing available measures. For areas where measures or data are limited (e.g., SDOH), Collaborative members recommended that the Workgroup consider prioritizing measure concepts, recommending measures for testing, and compiling/reviewing existing tools used by health systems/plans.

NQF staff shared that the full Collaborative recommended that the Cross-Cutting Workgroup create a measure set that would be shared with the clinical workgroups for inclusion in their respective core

sets and works closely with the Digital Measurement Workgroup to consider digital measures when possible.

Definition and Scope Discussion

Cross-Cutting Draft Definition
NQF staff reviewed the source documents used to develop a working definition for cross-cutting domains (i.e., Centers for Medicare & Medicaid Services (CMS), National Committee on Quality Assurance (NCQA), Health People 2020, and the Centers for Disease Control and Prevention (CDC). NQF staff developed a draft definition of "cross-cutting measures" for CQMC purposes based on these sources. Cross-cutting measures are measures that address essential aspects of healthcare quality that apply across:
- Conditions/disease areas/specialties;
- Levels of prevention (primary, secondary, tertiary);
- Episodes of care; and
- Multiple populations.

Examples of cross-cutting topics from the CQMC perspective (i.e., focusing on clinician measurement in the outpatient setting) include patient safety, patient and family engagement, care coordination, equity, and population health.

NQF staff asked the Workgroup if there were any additional definitions for cross-cutting that should be considered and if there were additional aspects that should be included in the definition. NQF requested that Workgroup members use the 'raise hand' feature on the meeting platform and shared that NQF would first recognize voting members then non-voting members. Members were asked to state their name and organization before speaking. NQF asked the co-chair to facilitate Workgroup discussion.

A co-chair opened the discussion by acknowledging that "cross-cutting" is a broad and challenging topic, especially when considering that the Workgroup should consider context of the other clinical core sets. The co-chair recommended that the Workgroup think broadly and consider measures that focus on outcomes that patients and health systems care about (e.g., better quality of life and better experiences with care). The co-chair encouraged members to state their organization to help other members understand their perspective.

A member representing persons with disabilities and individuals with co-occurring disorders/disabilities and conditions, shared that the current measurement environment is highly siloed, as there is usually focus on single health needs rather than complex ones. The member highlighted a challenge faced by the Behavioral Health Workgroup: whether to focus on behavioral health measures in a general setting or a specialty setting. A co-chair concurred with the member and encouraged the Workgroup to consider condition/specialties that are traditionally siloed when determining the cross-cutting core set scope. The co-chair further suggested defining "multiple populations" or calling out specialty populations that are typically siloed as part of the definition.

A member shared their perspective as a measure developer, noting that as part of the measure development process developers typically consider a particular disease/condition, the care setting, and the type of specialist providing care. The member provided an example of their suite of depression measures, which are assessed in both the primary care and behavioral health setting. The member shared that their idea of cross-cutting measures as measures that cross settings and/or can cross settings. The member, however, shared that it may be challenging to explain these measures to individuals being measured (e.g., exactly what the results mean and specific opportunities for them to improve care). For this reason, the member indicated that using condition/disease-specific measures alongside cross-cutting measures may provide a more comprehensive picture of quality for those being measured.

A co-chair summarized that the member would like the Workgroup to ensure that cross-cutting measures cross specialties but have an action item or indication of what to do next to ensure improved quality. The member agreed with the co-chair's interpretation of their comment. The member provided an example of a general quality of life measure that is being implemented and noted the importance of stratifying the measure by different conditions to understand the outcomes. Another co-chair voiced support for this recommendation and noted that actionability is a component that the Workgroup had not considered. The co-chair noted that actionability is key because if a measure is not actionable (because it lacks the necessary specificity or is not tied to an affective intervention) there is not much use in measuring it. The co-chair shared that the idea of stratifying cross-cutting metrics is interesting and worth exploring.

A member shared that the cross-cutting core set should comprise a concise set of measures that work across settings and populations and complement condition-specific measures (e.g., quality of life measures, PROMIS, person experience measures, person-centered measures, care coordination measures). The member indicated that the Workgroup should consider how to bring together cross-cutting measures with clinical measures and cost measures to support improved population health outcomes. A co-chair asked the Workgroup if they should consider looking at the condition-specific measures for awareness of what exists and suggested that the Workgroup recognizes that the scope of this topic area will continue to evolve. NQF staff advised measures are available on [CQMC website](#).

A co-chair shared that some of the cross-cutting measure concepts their organization was considering aligned with the Workgroup discussion. They acknowledged that there are some significant technical and statistical challenges in trying to move from condition/disease-specific measures to cross-cutting measures. The co-chair indicated that some of the previously discussed measures (e.g., quality of life measures, PROMIS) tend not to be particularly sensitive to improvements in narrowly-focused conditions. The co-chair recommended that the Workgroup considers global care standards (e.g., care coordination, patient experience). The co-chair indicated that patient safety is an important topic to consider, despite there being less robust measures for safety in the ambulatory setting versus the inpatient setting. The co-chair voiced support for patient engagement and patient activation, as both highly correlate with most healthcare outcomes and should be encouraged across all types of diseases and conditions. The co-chair indicated that in some areas the Workgroup may be able to move forward building from existing measures. On equity, the co-chair indicated that it is an important cross-cutting area to measure. The co-chair added that a lack of equitable health outcomes

is a moral failing of the healthcare system. In response, another member agreed that equity is important and asked the Workgroup if measures focusing on access and/or utilization would be in scope. The co-chair also inquired if total cost of care measures that examine burden of payment or patient experience related to cost with payers could be considered if they are within scope.

A member who is also a member of the Steering Committee shared that on cost and utilization, the CQMC has generally not included total cost of care measures. The CQMC's perspective is that its core sets of quality measures are already intended for use in measurement systems that include financial benchmarking (e.g., penalties or bonuses). The member, however, noted that there have been some innovative "wallet share" measures examining the up or down of the patient share on cost (e.g., a measure on financial toxicity), which may be more appropriate for consideration. The co-chair agreed that such a concept is what they had in mind.

A member speaking from a government agency perspective recommended that the Workgroup considers data sources when selecting measures (e.g., how easily data for all required aspects can easily be retrieved during normal workflows). Both co-chairs voiced support, noting that the point raised is an essential part of the Workgroup discussion. A member who is also part of the Steering Committee shared that when gaps are identified, they are included in the core set presentation or gaps report. The member noted that gaps analysis information is shared with developers to support their measure development activities. The member encouraged the Workgroup to make recommendations to help inform future CQMC work but also to suggest measures that can be implemented now based on available data.

Cross-Cutting Topics
NQF staff shared examples of cross-cutting topics (Figure 1) to help inform the Workgroup's discussion on which domains and/or subdomains should be included in the core set scope.

Patient Safety	Patient and Family Engagement	Care Coordination	Equity	Population Health
Diagnostic Accuracy	Patient Reported outcomes(e.g., functional status, pain management, quality of life)	Transitions	Access	Immunizations
Medication Safety	Patient Experience	Plan of care and follow up	Social determinates of health	Screening

Figure 1. Cross-Cutting Topics

A co-chair opened the discussion by voicing support for patient and family engagement, care coordination, and equity, noting that they are important domains and are cross-cutting. The co-chair

reiterated that patient safety is critical but that from their professional experience is challenging to measure. The co-chair also noted that the population health domain may also be challenging as immunizations and screenings are typically delivered in narrow settings versus broader settings, making it difficult to cross domains. The co-chair requested input from the Workgroup on how to address the challenges.

The other co-chair added that the Workgroup should also consider the extent to which the categories are simultaneously their own separate domains and overlapping (e.g., equity is a domain but can also be a form of stratification when examining immunizations, screening, or diagnostic accuracy by various social determinants of health [SDOH]). A member shared that from a patient perspective, equity is essential and needs to be included. The member highlighted concern that the current state of risk adjustment and stratification for social risk has not advanced fast enough.

A member shared that as a pathologist, measuring diagnostic accuracy is very challenging, especially if the focus is on measures that can be attributed at the individual clinician/ clinician group level versus the hospital/system level. The member stated that quantifying diagnostic accuracy at an individual provider level is very challenging, from both ordering physician and diagnostic clinicians' perspectives (i.e., coming up with measures that address both perspectives). The member agreed that diagnostic accuracy is an important aspect of patient safety and does not want it removed from consideration but wanted the Workgroup to be aware of the existing challenges.

A member shared that potential outpatient patient safety issues may include follow-up after hospitalizations, coordination of care, access to complete patient information, over-treatment (e.g., overuse of antibiotics, excess imaging, duplicative testing), and off-label drug usage.

A member representing a payer organization voiced their support for patient and family engagement, and equity. The member requested clarification on whether there was an exclusive focus on outcome measures or process measures can also be considered (e.g., access as a proxy for equity, shared decision making under the patient and family engagement domain). NQF advised that outcome measures are prioritized but that process measures are also included within the core sets. On the recommendation of access as a prerequisite to equity, a co-chair inquired whether the Workgroup would want to further define the access sub-domain. The co-chair noted that access could mean different things (e.g., access to a physician, access to a hospital, access to personal medical records). Another member voiced support for the shared decision-making concept but highlighted difficulty measuring shared decision making in the current environment. A member shared that it can be done through patient surveys measurement work but cautioned it may result in measurement burden. The co-chair then shared their experience with a patient who was adamant about not getting any cancer screenings. The co-chair noted that based on traditional measures they would be penalized for the patient making their own informed decision despite physician intervention. The co-chair shared that in this scenario a shared decision-making measure would be useful.

A member inquired if it is a requirement that measures in the cross-cutting core set be NQF endorsed or in national reporting program. NQF staff stated that NQF endorsed measures are preferred because they meet rigorous standards for scientifically acceptability, evidence, feasibility, etc.

However measures that are not NQF endorsed but are tested with specifications available can be brought forth for discussion and potential inclusion in core sets.

Responding to comments regarding shared decision-making, a member shared that there are several instrument questions around patient experiences. The member noted that some physicians may not be in favor of such measures because the results are based on patient' perception. However, the aggregated results can inform person-centered care. A co-chair noted that patient surveys are an integral part of the patient experience sub-domain.

A member solicited feedback from the Workgroup on including advanced care planning as a care coordination. The member considered it applicable to different disease states and suggested it signifies good care. A co-chair supported the idea and stated that advance care planning is a critical part of quality care. The co-chair shared a personal experience where some specialties within their health system were not in favor of advanced care measures because they did not think they were applicable to their specialty. The co-chair indicated the importance of context and framing of measures, so they make sense across specialties. The co-chair requested that the Workgroup considers if measures in the core set pertain to all specialties, most specialties, or some specialties.

NQF staff asked for feedback on the Population Health domain (i.e., whether immunizations and screening were appropriate sub-topics and if other sub-topics should be included). A co-chair shared that they were personally in favor of including a mortality measure but recognized that such measures could be limited depending on specialty and level of care. The co-chair suggested that mortality may be considered a component of population health.

A member shared that they would not be in favor of mortality measures because the numbers are often small, and they would not be appropriate at the clinician level. The member stated that mortality measures are better suited for the hospital level. A co-chair agreed with the member, stating that the Workgroup should consider the level of care delivery and applicability when reviewing all measures (e.g., a neurologist being held accountable for immunization/screening versus a health plan and/or health clinic). The co-chair indicated that there needs to be careful structuring to ensure proper implementation of the measures. NQF staff asked if the Population Health domain should be reframed to Preventative Care. In response, the co-chair stated that the issue of accountability would still apply. A member agreed stating that the sub-domains are cross-cutting but may not align with the Workgroup's definition of cross-cutting.

Workgroup members discussed whether anticipatory guidance should be included as a sub-domain under Population Health/Preventive Care. A member indicated that patients with various conditions can be provided with guidance on what to expect related to their care. A co-chair indicated that the information piece could be a cross-cutting population health concept (e.g., patients having easy access to their health records and information, ease in accessing a provider). NQF staff shared that family engagement could also be applicable in the equity domain as it may relate to access. A co-chair agreed, stating that the Workgroup may have to consider the extent to which the domains overlap.

A member suggested the Workgroup consider prioritizing high-burden, high-cost areas for

measurement. NQF staff recommended the Workgroup focus on quality measures rather than cost measures but noted that innovative measures or measure concepts can be posed to the group. A member shared that they were in support of having measures on high-cost, high-burden areas (e.g., utilization, appropriate use of resources). The member also inquired about the applicability of medication adherence, noting that it may be driven by the patient and that a clinician may have less control over it. A member representing patients with disabilities shared that for mental illness and substance abuse disorder, the term adherence is viewed as contentious. The member indicated that the term is often thought to imply medical authority over how patients should live their lives. The member agreed that it is an important area. A co-chair stated recommended that in place of adherence the Workgroup considers self-advocacy and self-management skills.

A member asked the Workgroup if it is an important consideration that measures can be captured using electronic data sources or digitally. The member noted that some of the suggested concepts may entail deviating from the use of technology to build measures. NQF staff shared that the CQMC prioritizes electronic measures but recognizes that there are barriers to their widespread use.

Related to SDOH measurement, a co-chair stated that they had used the CDC Social Vulnerability Index as a tool to help improve the equity of their outcomes and patients' health. The co-chair noted that the index has four major themes (i.e., socioeconomic status, household status, race/ethnicity/language, and housing/transportation) and asked the Workgroup if that type of categorization in the SDOH sub-domain would be helpful as it is already in use and publicly available. The co-chair noted that getting data around SDOH on all levels can be a challenge. A member agreed that gathering data can be a challenge and noted that there are several scales available when surveying patients. A co-chair noted that their concern is not if it is important to measure or what the right measure is, but if it is really a measure of quality. The co-chair shared that SDOH underpins the ability to deliver high quality (i.e., addressing SDOH can help improve health outcomes) but it may not be a true quality metric. A member supported the current model of equity as a domain and noted that it is more encompassing. The member then stated that the notion of quality could be measured by providing an example of patients who are receiving more diagnostic service than others can be an indication of a quality problem. NQF staff stated the Workgroup's recommendations would be used to inform the measure scan, which will be reviewed at the next meeting.

Measure Scan Approach

NQF staff shared an overview of the initial cross-cutting measure scan. Overall, NQF staff considered measures from three different sources during the scan: the CMS Measures Inventory Tool (CMIT), NQF Quality Positioning System (QPS), and additional measures from related NQF projects. In the initial scan, staff considered measures in CMIT that were tagged as active in federal programs and with at least one of the following Meaningful Measures areas: Care is Personalized and Aligned with Patient's Goals; Functional Outcomes; Equity of Care; Medication Management; Patient's Experience of Care; Patient-Focused Episode of Care; Preventable Healthcare Harm; Preventive Care; and Transfer of Health Information and Interoperability. Staff also considered measures in QPS that were tagged as non-condition-specific, NQF-endorsed, outpatient setting, and clinician level of analysis.

NQF staff shared that this scan was performed in April 2021 and resulted in 42 potentially-relevant measures related to access to care, screening, care coordination, patient safety, immunizations, and patient-reported outcomes.

NQF staff asked the Workgroup for feedback on whether the described approach seemed appropriate, and whether any additional search terms or domains should be considered for the scan. Workgroup members discussed that CMIT and QPS already reflect most of the measures in use. A Workgroup member suggested that NQF should also scan measures that have been submitted for the NQF Fall 2021 review cycle, as new patient-reported outcome performance measures (PRO-PMs) have recently been developed. Another Workgroup member suggested that the NQF Roadmap for Health Equity could also be reviewed for measures related to equity.

A Workgroup member asked for additional clarification on the level of analysis for measures that will be included in the Cross-Cutting set. NQF staff clarified that ideally, measures would be specified at the clinician level in order to align with the existing goals and structure of the CQMC. However, as with other Workgroups, clinician level measures may not be available in the topic areas that the Workgroup feels are most important; if it makes sense to include measures at a different level of analysis in order to represent these topics, the group could also include them. Another Workgroup member reminded the group that if the group elects to include measures that are not specified at the clinician level, this can be annotated clearly in the Notes portion of the final core set presentation (e.g., "This measure is only appropriate for use at the plan level.")

A Workgroup member shared feedback that the overall approach is reasonable, but the presentation of the approach and search terms is difficult to follow. The member suggested referring to the graphic used by CMS to communicate the priorities for the Meaningful Measures 2.0 framework, including patient-centered care, equity, safety, affordability and efficiency, chronic conditions, wellness and prevention, seamless care coordination, and behavioral health.

NQF staff shared that since the group did not have objections to the overall structure and scan strategy, NQF will conduct an updated version of the scan and will bring a list of potentially relevant measures back to the group for consideration during Web Meetings 2 and 3.

NQF staff also asked for additional feedback from the Workgroup as to whether it should be used as a standalone core set or a complement to the existing specialty-specific core sets. A Workgroup member commented that they would prefer a standalone Cross-Cutting set with parameters on how measures can be selected and integrated into other sets. Another member agreed and noted that they think of the set as being a standalone that can overlay across all the other sets. Another member also expressed strong support for a standalone core set, noting that first-time users of the core sets may opt to start by measuring items from a standalone Cross-Cutting set and then supplementing with the specialty-specific core set measures as appropriate. One member expressed concerns that if the Cross-Cutting measure set is a standalone set with many new measures, it may be difficult to convince new users to use the Cross-Cutting set in its entirety.

A Workgroup member agreed that they like the idea of developing the Cross-Cutting set as a

standalone that can overlay the specialty sets, but cautioned that the decision may depend in part on what measures are selected for the core set. The member noted that some of the measures that are applicable to multiple core sets may already be included in existing core sets and shared that it may be helpful to see a list of the measures that are already used across multiple core sets. At least two Workgroup members agreed that this would be helpful. NQF staff noted that they can share this information in future meetings.

Next Steps

NQF staff shared that the Workgroup's discussion will be summarized and shared with the Workgroup. NQF staff also noted that they will use the discussion from Web Meeting 1 to inform the initial measure scan of potential cross-cutting measures. NQF shared that Web Meeting 2 will be held on August 24 from 12:30 – 2:30 pm ET, and Web Meeting 3 will be held on August 30 from 2:00 – 4:00 pm ET.NQF staff and the co-chairs thanked the Workgroup for their discussion and adjourned the meeting.