CQMC
Core Quality Measures Collaborative

Meeting Summary

Cross-Cutting Workgroup Web Meeting 3

The National Quality Forum (NQF) convened the second web meeting for the Cross-Cutting Workgroup on August 30, 2021.

Welcome and Roll Call

NQF staff welcomed participants to the meeting and the co-chairs of the Cross-Cutting Workgroup, Erin Royer and Sandeep Vijan, MD, also 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 reviewed the agenda for the meeting.

Recap of Meeting 2

NQF provided a summary of the Cross-Cutting Workgroup's discussion to date. During Meeting 2, the Workgroup further refined the cross-cutting definition, cross-cutting topics, and measure scan approach. NQF staff shared the updated version of the definition as:

"Cross-cutting measures address essential aspects of healthcare quality that apply broadly across:

- Conditions, disease areas, or specialties
- Levels of prevention (primary, secondary, tertiary)
- Episodes of care
- Multiple populations (including persons with co-occurring conditions)
- Different provider types

Based on the CQMC scope, measures will generally apply at the clinician or clinician group level and focus on the outpatient setting."

NQF staff shared that Workgroup members submitted three additional measures for initial review, for a total of 18 measures under consideration for the Cross-Cutting core set. NQF noted that the overview of measure topics still reflects a gap in the areas of patient safety and equity.

NQF staff shared updates from measure stewards (i.e., National Committee for Quality Assurance [NQCA] and Centers for Medicare & Medicaid [CMS]) on measures for which the Workgroup had requested additional information, as follows:

- *NQF #0326: Advanced Care Plan*

The Workgroup asked whether there was any other action required by clinicians after documenting patients advanced care plan. NQF staff noted that per NCQA's response, the measure does not specify any further action from the physician once the advanced care plan has been documented. However, the goal of asking providers to document an advanced care plan annually is to ensure that there is continuous follow-up on patients' preferences.

In response to a question regarding which clinician is responsible for documenting the advanced care plan, NCQA noted that any MIPS-eligible clinician outside of the emergency room setting can report on the measure. It was highlighted that reconciliation of different information in each advanced care plan (e.g., different surrogate decision makers) is beyond the scope of the measure, as the measure is solely focused on an eligible clinician documenting the wishes (or surrogate decision maker) in an advance care plan. It was noted that the measure does not count the number of advance care plans or attempt to reconcile. Regarding measure use and experiences with information sharing, barriers, burden, and/or unintended consequences, NCQA shared that they did not have data on frequency but shared the most recent performance data for individual and groups. It was noted that there were no unintended consequences identified.

- *NQF #0101: Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls*
  Regarding whether the measure has room for improvement at the specialty practice level, NCQA shared that CMS does not provide details about specialty performance (i.e., performance year 2019 data details only group reporting and clinician reporting).

- *NQF #0419/0419e: Documentation of Current Medications in the Medical Record*
  Regarding, whether the measure has room for improvement at the specialty practice level, CMS shared that primary care doctors are the highest reporters of the measure, but dermatology doctors and orthopedics doctors are in the top five. It was also noted that the Medicare Part B claims version of the measure has the highest performance. CMS indicated that although there are no specific performance results among specialties at this point, there is a likelihood that performance is high.

NQF staff stated that written responses from CMS and NCQA will be shared with the Workgroup to help inform their voting decisions.

Measures for Consideration

Before the review of measures, NQF staff reminded the Workgroup to consider the measure selection principles, cross-cutting definition and domains/topic areas when reviewing each measure. NQF staff also reminded the group that measures should be considered as they are currently specified; if the Workgroup likes the concept of a measure but it is not appropriate to include in the core set as currently specified, the group should not vote to include the measure in the core set but can choose to make recommendations about the measure as part of the CQMC Gaps Analysis report.

Patient and Family Engagement Measures

2624: Functional Outcome Assessment

NQF staff shared an overview of the Functional Outcome Assessment measure, which assesses the percentage of visits for patients aged 18 years and older with documentation of a current functional outcome assessment using a standardized functional outcome assessment tool on the date of the encounter, and documentation of a care plan based on identified functional outcome deficiencies on the date of the identified deficiencies.

A member shared that the intent of the measure was good but expressed concerns that the denominator was too broad (i.e., all patients aged 18 years and older), noting that this type of assessment was not one that was likely to be performed if there was no concern about a patient's health. A co-chair agreed and added that if required to be performed on all healthy patients receiving routine care, the measure has a potential of adding burden to providers. The co-chair highlighted that the measure may be better suited among the Medicare population during an annual wellness screening.

A member speaking from the patient perspective, shared that they support the measure concept but agreed that the denominator is too broad, even if it was only documenting the assessment without a follow-up plan. A member concurred and stated that the denominator exceptions are quite narrow. The member noted that the benchmarking for the measure may be low because not many doctors are performing the assessment if patients are relatively healthy and do not appear to require the screening. A co-chair agreed and added that if the measure were tied to an incentive program, it would be high performing. The co-chair voiced preference for targeted measures versus measures with low benchmarks. NQF staff shared that per the environmental scan performance for the measure is high (i.e., for Medicare Part B claims average performance at 91% and for Merit-based Incentive Payment System Clinical Quality Measurement [MIPS CQMs] average performance at 88%).

A member inquired if the measure was like the depression screening measure. A co-chair responded that depression screening varies depending on whether the patient has a history of depression, but is typically done once a year during a wellness visit. The co-chair shared that workflow may differ, but the requirements are for an annual depression screening and then a follow-up for patients who test positive.

A member inquired if the Workgroup could consider the Patient Activation Measure, to assess engagement and outcomes. In response a member, shared that the measure requires the use of a proprietary instrument and for that reason would not be as supportive of it. The member who recommended the measure agreed that use of proprietary instruments is not ideal. A Workgroup member recommend that NQF staff check to see if the measure still requires use of a proprietary instrument as it did previously.

NQF staff shared that they would keep the Functional Outcome Assessment measure on the list for consideration and will follow-up on the Patient Activation Measure.

2962: Shared Decision-Making Process
NQF staff shared an overview of the Shared Decision-Making Process measure, which assess the extent to which health care providers involve patients in a decision-making process when there is more than one reasonable option.

Workgroup members voiced support for the measure. A member stated that they supported the measure but inquired if it is cross-cutting because it is not as broad. In response, a co-chair stated that the measure may not be applicable in every specialty but is cross-cutting since it involves different specialties (e.g., orthopedics, neurosurgery, urology, oncology, and cardiology). A member voiced support for the measure and added that as a patient advocate, shared decision-making in home health and post-acute care settings is more important than "conditions."

The co-chair asked whether the measure could be broadly applied if the validation is performed against specific outcomes in different conditions. A member voiced support for the concept and noted that the measure is relatively new, and the conditions identified have been validated and tested for use. The member recommended that the Workgroup tracks performance to determine if it should be expanded to other conditions. A member voiced support of the recommended approach, noting that the patient experience in shared decision-making is important in the clinical areas highlighted in the measure because there tends to be over utilization, patient low efficacy, and very expensive surgical interventions. The member, however, noted that the measure is clinically focused (i.e., discussing treatment options) and does not include conversations about other topics that matter to patients that could be suitable across clinical contexts. The member shared their support of the measure due to the absence of a better shared decision-making measure and cautioned against using it as the only standard for shared decision-making across all practice settings. The member noted that there are some measures being developed with other questions (e.g., patients feeling listened to) which can lead to robust conversations about what is important to patients.

A co-chair asked the Workgroup if the measure should be included on the voting list. A member voiced their support for the measure and recommended that if the measure is included in the cross-cutting core set, a note should be included indicating the relevant conditions and other CQMC core sets it applies to NQF staff shared that after the Workgroup recommends cross-cutting measures, there is the need for collaboration between Workgroups to determine a use approach.

A member asked for clarification on who would be held accountable for having the shared decision-making conversation with the patient/family member (i.e., a surgeon or other physicians [e.g., primary care physician]). The member noted that as a primary care doctor, they have conversations with patients about specialty surgeon recommendations and in-turn conduct the shared decision-making discussion by presenting their patients with different treatment alternatives. In response, a member shared that a perioperative clinic may engage in such discussions. An example was shared of how in Boston, Massachusetts, some perioperative clinics have anesthesiologists who can have conversations about risks and alternative care options with patients/family members. A co-chair noted that the measure does not explicitly call out who would be measured but that a logical assumption would be the surgeon or in some places a clinic. The co-chair noted that the primary care physician may be able to give general advice but not to the detailed extent that would meet the

measure. A member concurred and noted that there needs to be clarity on whether the measure specification excludes certain providers and how the measure is applied by the health plan. A member noting that the measure specifications are not as granular as the Workgroup would prefer, recommended that if the measure is included in the cross-cutting core set, it be accompanied by a footnote (e.g., stipulating who the measure is best suited to hold accountable).

NQF staff shared that they would keep the Shared Decision-Making Process measure on the list for consideration and will reach out to the measure steward to request information related to accountability.

Population Health

0028/0028e: Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention

NQF staff shared an overview of the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention measure, which asses the percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months and who received tobacco cessation intervention if identified as a tobacco user. The measure was noted as being included in the Behavioral Health core set and the ACO/PCMH/PC core set. The Cardiology Workgroup recommended it be removed from their core set; the decision is pending full Collaborative discussion and voting.

A member inquired if there is still room for improvement, noting the measure has been in use for a long time. A co-chair noted that per the benchmark reporting, the measure had topped out in MIPS based on Medicare Part B Claims with an average performance rate of 98%, CQM average performance 59%, and eCQM average performance of 60%. The co-chair noted that there could be improvement but questioned if low performance is related to the intervention piece. A member voiced support for the measure if the low performance is tied to an intervention, noting most physicians continue having the tobacco use conversation with their patients until they say they are ready to quit. The member noted that the measure is cross-cutting and should be considered for inclusion, especially if the Cardiology Workgroup is considering its removal. The co-chair concurred with the member, noting that the two-year timeframe is ample time to ask about smoking and discuss interventions. A member agreed and shared that there are many evidence-based interventions that can meet the criteria (e.g., nicotine gum, referral to an intervention line to help quit).

A member inquired if there is a similar measure that targets the pediatric population (e.g., younger teens) and if products such as e-cigarettes and vaping are included in the measure. NQF staff shared that the Pediatric Workgroup discussed a similar measure focused on the pediatric population (NQF #2803). The Workgroup was informed that a decision was made to revisit the measure once it was updated to include vaping and e-cigarettes. The developer is working on updating the measure based on the updated U.S. Preventative Services Taskforce (USPSTF) guidelines.

A co-chair shared that looking at the population health level there are some zip codes, counties, and states that still report high tobacco use in adults (e.g., one in four adults using tobacco products). The

co-chair noted that an update to the measure is good but that the measure as specified is still relevant.

NQF staff shared that they would keep the Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention on the list for consideration.

0041/0041e: Preventive Care and Screening: Influenza Immunization

NQF staff shared an overview of the Preventive Care and Screening: Influenza Immunization measure, which assesses the percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization or who reported previous receipt of an influenza immunization.

A co-chair opened the discussion by posing a question on the two ways of collecting information (i.e., getting a flu shot during a visit in the specified timeframe and patient reporting getting an influenza immunization). The co-chair asked how much of the data comes from patient recollection and/or reporting that the influenza immunization had been administered versus data from the influenza immunization being administered during a visit. The co-chair noted that knowing the number of influenza immunizations administered at a pharmacy may or may not be connected to an individual physician's data. In response, a member questioned if state vaccine registries could come into play. The member questioned if there is a particular CPT code that could be used as opposed to collecting data from the patient, as it may not be possible to collect the data while bypassing a verbal report. The member noted that the information could be pulled via claims, using electronic health records (EHR), or through a patient report.

A co-chair shared that the most vulnerable groups that require influenza immunization are children and older adults. It was noted that depending on the amount of data that comes from self-report, it may not be as reliable. The co-chair voiced support for the measure being cross-cutting and supported its intent (i.e., identifying who has not received an influenza immunization, providing information on where to get it administered). The co-chair, however, voiced concern over the data collection. A member shared that in their state pharmacies do not administer vaccines to children under 12 years of age so for these patients, immunizations must be administered at the pediatrician's office. The member echoed the co-chair, voicing potential concerns around data collection. The member emphasized that including the measure is better than the alternative of not having a measure on this topic.

NQF staff shared that they would keep the Preventive Care and Screening: Influenza Immunization measure, on the list for consideration. NQF staff confirmed that they will reach out to the measure steward to request information on:

- How many patients are reporting to have received the influenza immunization versus those that are receiving the influenza immunization during the visit, and
- Plans for data collection or integrating with registries or different options to collect data besides self-report.

0421/0421e: Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan

NQF staff shared an overview of the Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan measure and noted the measure is no longer endorsed as the developer decided not to pursue NQF re-endorsement. The measure assesses the percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months and with a BMI outside of normal parameters a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter.

A member shared that in the primary care setting, BMI screening is done during every encounter as most EHRs calculate BMI automatically if height is updated every year. The member stated that their concern was with the follow-up plan as its collection is not a discreet data point. The member noted that in their experience it was difficult to attempt to set up the collection and documentation of a follow-up plan. The member inquired about other Workgroup members' experience using the measure. A member shared that from their experience BMI measurement is straightforward since the documentation plan is templated. The member, however, questioned the measure's ability to directly impact patient outcomes. The member highlighted that BMI is challenging to affect. They noted that although physicians should try to help patients improve BMI, there is a question as to whether physicians should be held accountable. A co-chair agreed and stated that unlike the tobacco cessation measure which has clear categories of interventions, this measure's follow-up requirement is broad and less clear. The member shared that the measure appears simple but can get complicated in practice and for that reason did not support including the measure on the voting list. A co-chair voiced their support for the members comments.

A member requested that NQF inquire from the measure stewards why they decided to no longer pursue maintenance endorsement, as their response could help inform the Workgroup's decision. The member noted that health centers are still using the measure and performance data shows that there is room for improvement. Another member requested that NQF staff request information on the follow-up plan (e.g., what is included, how people are connected to resources.

NQF staff shared that they would keep the Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up Plan measure on the list for consideration. NQF staff confirmed that they will reach out to the measure steward to request information on why the measure is no longer maintained and how the follow-up information is collected.

2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling

NQF staff shared an overview of the Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling measure, which assesses the percentage of patients aged 18 years and older who were screened for unhealthy alcohol use using a systematic screening method at least once within the last 24 months and who received brief counseling if identified as an unhealthy alcohol user.

A Workgroup member voiced support for the measure and noted that it is an important screening measure. Another member shared that the measure is a USPSTF recommendation, making it a standard of care in primary care settings. A co-chair voiced their support and added that there is good evidence that brief interventions in clinic are effective in reducing unhealthy use of alcohol. A

member concurred and shared that the measure aligns with Healthy People 2030.

A co-chair inquired if there are any settings or specialties where the measure would not be appropriate. Hearing none, the co-chair requested NQF staff to include the measure on the list for consideration.

NQF staff confirmed that they would keep the Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling on the list for consideration.

N/A: HIV Screening (eCQM)

NQF staff shared an overview of the HIV Screening (eCQM) measure, which assesses the percentage of patients aged 15-65 at the start of the measurement period who were between 15-65 years old when tested for HIV. The measure was noted as being part of the HIV/Hepatitis C core set.

A member shared that HIV screening is very critical in the communities they serve and to the U.S. as it aims to end the HIV epidemic. The member shared that it is important to identify individuals who are HIV positive, so that they can begin therapy, improve their quality-of-life, and reduce the risk of transmission. The member noted that the measure is used by the Center for Disease Control (CDC), National HIV/AIDS Strategy and Health Resources and Services Administration (HRSA)- Bureau of Primary Healthcare. A member also highlighted that the highest prevalence rate was in the 15–24-year-old age group.

A member voiced support for the measure but noted that there is no consensus on the screening interval time. The member shared that the USPTF indicates that there is insufficient evidence to determine appropriate or optimal time intervals for screening. The member was unclear whether based on the specifications every person in the age range regardless of risk needs to be tested unless they opt-out. A co-chair shared that their interpretation of the measure is that it is a once in a lifetime measure. Another member stated that if an individual is low risk, then once in a lifetime is appropriate, but those in the higher risk category (e.g., those that have other STIs) should be screened more often (e.g., once in a measurement year). The member shared they would fully support the measure but need a better understanding on the intent of the measure and the frequency of testing. A member concurred with their fellow member's concerns and shared that their agency and agency-affiliated health centers use the measure. The member indicated that they serve racial minority populations disproportionately affected by HIV, making the measure critical. The member shared that HIV screening at their health centers is low and there is a concerted effort to increase testing. The member voiced support of adding the measure on the voting list for potential inclusion in the cross-cutting core set.

A member shared that there is need to clarify individuals "opting-out". Two members voiced support of the measure.

NQF staff confirmed that the measure will be included on the voting list for consideration. NQF staff also shared that they will follow-up with the measure steward to get a better understanding of the timing and frequency of the measure.

N/A: Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (eCQM)

NQF staff shared an overview of the Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented (eCQM) measure, which assesses the percentage of patient visits for patients aged 18 years and older seen during the measurement period who were screened for high blood pressure AND a recommended follow-up plan is documented, as indicated, if blood pressure is pre-hypertensive or hypertensive. The measure is not currently in any CQMC core sets but is used in MIPS.

A member shared that the measure is very common in the primary care setting. A co-chair inquired if the follow-up piece could be problematic. A member indicated that the follow-up plan for controlling high blood pressure (e.g., recommended patient home monitoring, follow-up visit with a nurse) is more precise than for BMI management.

A co-chair agreed with the response but noted that there is some lack of precision around pre-hypertension follow-up, which may include general counseling, weight loss and lifestyle change recommendations, etc. A member shared that the follow-up plans for pre-hypertension provide clear guidance on other interventions (e.g., prescription medication, and/or lifestyle adaptation), aside from weight loss, diet and exercise which do not always ensure the desired outcome. A co-chair shared that the measure specification provides specific guidance based on the different stages of hypertension what to document as a follow-up plan.

A member voiced support for the measure and indicated that as a preventative measure it would help ensure that care at the population level is comprehensive and allow users to look at different but interconnected factors that influence health.

NQF staff confirmed that the measure will be included on the voting list for consideration.

3568: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM)

NQF staff shared that the measure falls within the patient and caregiver engagement category and was recommended for review by a Workgroup member. The measure is an outcome measure that received conditional support for rulemaking pending NQF endorsement during the 2020/2021 Measurement Applications Partnerships (MAP) cycle. NQF staff noted that the measure received NQF endorsement in June as part of the Primary Care and Chronic Illness fall 2020 review cycle. The measure is also under consideration for addition to the ACO/PCMH/Primary Care core set.

NQF staff provided an overview of the Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure (PCPCM PRO-PM) measure, which uses the PCPCM PROM (a comprehensive and parsimonious set of 11 patient-reported items) to assess the broad scope of primary care. Unlike other primary care measures, the PCPCM PRO-PM measures the high-value aspects of primary care based on a patient's relationship with the provider or practice. Based on

information submitted by the developer during endorsement, patients identify the PCPCM PROM as meaningful and share that it helps communicate the quality of their care to their clinicians and/or care team. The items within the PCPCM PROM are based on extensive stakeholder engagement and comprehensive reviews of the literature.

A member inquired if the measure is cross-cutting since it focuses on primary care. A member shared that their organization's performance measurement committee reviewed the measure but did not support it based on a lack of evidence and a link to improved outcomes. The member indicated that there were some concerns around the face validity of the instrument (e.g., some of the questions and how they may vary based on the patient's tenure with the physician, patient health status). The member also indicated that there was concern regarding the feasibility of the measure and burden to implement in a general internal medicine practice. The member noted that the measure would require some reworking/rebuilding of the instrument for it to become compatible with the practice and/or payer data set.

A member representing the consumer/patient perspective acknowledged the other member's concerns but expressed that the measure is well documented, valid, and already in use with practices (e.g., Board of Family Medicine practices). The member stressed that the measure is very important in messaging and practice in primary care. The workgroup member also noted the measure as being NQF endorsed and supported by MAP. A co-chair stated that in theory the measure is feasible, but shared concerns that the measure is only applicable to the primary care setting and that there is no clear association between the measure and outcomes of interest (e.g., clinical outcomes). A member recommended that the Workgroup hears from the Board of Family Medicine in response to the outlined concerns.

Another member representing the patient perspective shared that they had not been aware of the criticisms surrounding the measure but supported the measure because of its attributes of patient care (e.g., the type of experience a patient is looking for and how components addressed in the measure affect outcomes in some patient populations). A co-chair indicated that the measure concept was good but questioned if it was ready for widespread use.

NQF staff confirmed that the measure will be included on the list for consideration. NQF staff also shared that they will follow-up with the measure steward and inquire if the measure has been tested outside the primary care setting (i.e., specialty groups) and any future plans regarding the measure.

Next Steps

NQF staff shared that the Workgroup's discussion will be summarized and shared with the group via email. NQF staff will work to identify a time and date in September for the Workgroup to review the two remaining measures, follow-up items from this meeting, and recommendations on gap areas and measure concepts. NQF staff and the co-chairs thanked the Workgroup for their participation and adjourned the meeting.