Meeting Summary

Core Quality Measures Collaborative Health Equity Workgroup February Web Meeting

The National Quality Forum (NQF) convened a public web meeting for the Health Equity Workgroup on February 16, 2023.

Welcome, Roll Call, and Review of Web Meeting Objectives

Meredith Gerland, Managing Director, NQF, welcomed the participants to the meeting and thanked all for their time and prioritization of the Core Quality Measures Collaborative (CQMC) health equity work. Ms. Gerland shared with participants that NQF's contract with the Centers for Medicare & Medicaid Services (CMS) will be concluding on March 26, 2023. NQF will be collaborating with CMS, America's Health Insurance Plans (AHIP), and the successor contractor in the weeks ahead to ensure a smooth transition of the federal CQMC initiatives. Ms. Gerland shared that AHIP will be working closely with the Steering Committee to determine the next steps for the AHIP components of CQMC, and -participants will be contacted with further information when available.

Chelsea Lynch, Director, NQF, introduced the co-chairs of the Health Equity Workgroup, who provided welcoming remarks. Ms. Lynch reviewed the antitrust statement and acknowledged that the CQMC is a member-funded effort with additional support from CMS and AHIP. Ms. Lynch noted that attendance would be collected offline for the web meeting and reviewed the following meeting objectives:

- Discuss strategies to identify and recommend measures promoting health equity for possible addition in to the CQMC core sets
- Review the results of applied prioritization criteria within the CQMC Cardiology and Pediatrics core sets
- Discuss the implemented prioritization scoring criteria and identify potential modifications

Benefits and Opportunities of CQMC Health Equity Work

Becky Payne, Manager, NQF, reminded attendees of the opportunities of conducting health equity work across the CQMC. Ms. Payne noted that applying a health equity lens across the CQMC allows healthcare stakeholders to move towards meaningful actions to reduce disparities and improve health equity, and that the efforts of this workgroup serve as a critical first step to integrate health equity into CQMC core sets. Ms. Payne reminded attendees of the two separate workstreams pursued by the Health Equity Workgroup towards these goals:

1. Identifying measures that promote health equity for future consideration in CQMC core sets, and
2. Identifying and prioritizing disparities-sensitive measures already within CQMC core sets.

Health Equity Measure Selection

Ms. Lynch transitioned to a discussion of the first workstream in the CQMC Health Equity initiative: identifying measures that promote health equity for future consideration in CQMC core sets. Ms. Lynch reviewed a list of 11 previously identified measures in the CQMC Health Equity Final Report (PDF) across domains (i.e., enablers of cultural responsiveness, access, social needs/risks, quality of care, and the equity ecosystem) that could be considered for future addition into core sets. Ms. Lynch also reviewed new examples of health equity measures from the measures under consideration (MUC) list from the 2022-2023 cycle of the Measure Applications Partnership (MAP), including:

- MUC2022-098: Connection to Community Service Provider
- MUC2022-111: Resolution of At Least 1 Health-Related Social Need

Dr. Sai Ma, Health Equity Workgroup Co-Chair, prompted Health Equity Workgroup members to consider how health equity measures should be reviewed and implemented in CQMC core sets, and whether any of the listed measures should be raised for consideration in CQMC core sets.

Workgroup members commented that structural health equity measures should be considered in healthcare systems in addition to process and outcomes measures, and noted that feasibility of measure implementation should be considered before adopting any measures. Workgroup members cautioned that while many of these measures are conceptually important, it is critical not to move prematurely into financial accountability before it is clear that measures can be implemented, data collected, and resources provided for action without substantial additional burden to providers. The feasibility of data collection must be considered, but so should the actionability of outcomes from that data in order to ensure true impact. Workgroup members noted the potential harm of implementing measures before these elements are prepared.

A Workgroup member pointed out that while in theory it would be beneficial for all CQMC core sets to incorporate the same health equity measures, it would be impractical for many specialties that do not have the opportunity to report or address social health needs. Dr. Ma suggested creating a framework approach to define what applicable health equity measures might be for each specialty, using criteria that would incorporate feasibility, proximity to healthcare organizations or payers, and the actionability or impact of these measures, and considering outcome, process, and structural measures.

Prioritization Process and Scoring Criteria

Ms. Lynch introduced the next meeting discussion focused on the second workstream in the CQMC Health Equity initiative: identifying and prioritizing disparities-sensitive measures that already exist in the CQMC core sets. Ms. Lynch reminded attendees that in the CQMC Health Equity Final Report, a CQMC measure was considered disparities-sensitive if 1) the topic area of the measure was within one of the previously identified priority clinical areas OR the measure assesses a measurement area associated with known disparities in the literature, and 2) the measure also met at least one of three measure characteristics (the measure's denominator includes patients disproportionately affected by social risks as compared to the general population, the measure is specified for ambulatory settings, or the measure is classified as an outcome measure). Through this approach, 137 of 150 CQMC measures were identified as disparities sensitive, including all 27 measures in the Cardiology core set and 6 measures in the Pediatrics core set.

Ms. Lynch noted that in order to be actionable, the list of disparities-sensitive measures requires further refinement. While the Health Equity Workgroup previously concluded that data analysis and stratification of measure results would provide the most accurate picture of disparities, data availability

and organizational resources may limit this option when looking at such a large set of measures. Ms. Lynch reviewed a process that could potentially be employed by CQMC members to secure empirically informed prioritization of the disparities-sensitive measures. The current health equity work addresses the first few steps in the process, including applying scoring criteria to create a narrowed group of disparities-sensitive measures, and engaging clinical experts (CQMC Workgroup members) to review these measures in order to produce a final shortlist of measures. Following the conclusion of this work, the shortlist of measures could then have their data analyzed to confirm or dismiss the presence of disparities. Those measures that are confirmed to have disparities would be ideal candidates for organizations to address with resources and quality improvement efforts.

Ms. Lynch transitioned to reviewing the pilot scoring criteria used for this process. Measures were first classified as outcome measures or non-outcome measures based on Workgroup member feedback from the November 2022 web meeting that all types of measures were important to review when addressing disparities. Measures then received one point for each of the following criteria related to assessing disparities:

- Priority clinical condition (e.g., cardiovascular disease, behavioral health, sickle cell anemia)
- Measurement area associated with disparities (e.g., transitions, patient-reported assessments)
- Denominator includes patients disproportionately affected by social risks compared to the general population
- Measure specified for ambulatory settings

Finally, additional scores were calculated for impact and feasibility within CQMC core sets, awarding a half point each for use in multiple core sets and measures using electronically extracted data. The highest possible score for any measure in this process was 5, with a threshold of 3.5 (meeting 70% of criteria) for a measure to be prioritized for discussion.

Prior to the web meeting, NQF staff applied this pilot criteria to the Cardiology and Pediatrics core sets in order to create tentative shortlists of measures for future action and to solicit feedback on the effectiveness of the scoring criteria. Within the Cardiology core set, two outcome and six non-outcome measures met the score threshold of 3.5 or above. Within the Pediatrics core set four non-outcomes measures met the criteria.

Cardiology Core Set Prioritization Results

Becky Payne, Manager, NQF, provided an overview of the scoring results for the Cardiology core set. Of the Cardiology outcomes measures, two met the prioritization threshold of a score of 3.5 or above: NQF #0018 Controlling High Blood Pressure and NQF #0694 Hospital Risk-Standardized Complication Rate following Implantation of Implantable Cardioverter-Defibrillator. Both measures met all of the same criteria, with the exception of use in multiple core sets in the additional impact and feasibility criteria column. Of the non-outcome measures, six met the threshold score:

- NQF #0028/0028e Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention
- MIPS ID 377 Functional Status Assessments for Congestive Heart Failure
- NQF #0070/0070e Chronic Stable Coronary Artery Disease: Beta-Blocker Therapy- Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF)
- NQF #0081/0081e Heart Failure (HF): Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD)
- NQF #0083/0083e Heart Failure (HF): Beta Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)

- MIPS ID 438 Statin Therapy for the Prevention and Treatment of Cardiovascular Disease

Dr. Rama Salhi, Health Equity Workgroup Co-Chair, prompted Cardiology and Health Equity Workgroup members to share feedback on the prioritized measures and modifications to the scoring criteria that may better identify measures for prioritization in the future. Several Workgroup members shared feedback on modifications that could be made for the scoring criteria, such as including reference to epidemiology or impact factors associated with the measures to ensure that meaningful measures are selected. Alternatively, these modifications could be included as supplemental information to scoring criteria. Other members questioned if there were any gaps in the existing criteria that would allow for measures with minimal impact to meet the threshold. Workgroup members were strongly in favor of criteria that identify measures with denominators that include patients disproportionately affected by social risks. Ms. Lynch reminded Workgroup members that the lists of topic areas or measurement areas in the criteria could be found in the final report, and should be periodically revisited for updates. Finally, Workgroup members noted that stratification itself does not necessarily improve equity, but is a critical next step in an iterative process.

Pediatrics Core Set Prioritization Results

Ms. Payne transitioned to an overview of the Pediatrics core set scoring results. The Pediatrics core set contains one outcome measure, which did not meet the threshold score for prioritization. Four non-outcome measures did reach a score of 3.5 or above, including:

- NQF #0418/0418e Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan
- NQF #2797 Transcranial Doppler Ultrasonography Screening Among Children with Sickle Cell Anemia
- NQF #0033 Chlamydia Screening for Women
- NQF #1800 Asthma Medication Ratio

Ms. Payne noted that overall, measures in the Pediatrics core set trended towards lower scores than those in the Cardiology core set, although NQF #0418/0418e achieved a perfect score.

Ms. Payne and Dr. Salhi opened the floor for discussion on the results of the scoring exercise. A Workgroup member pointed out that the criterion of use in multiple CQMC core sets may work against the Pediatrics core set as a whole, as many of those measures are unlikely to be included in other core sets which are focused on adult populations. Another Workgroup member noted that the current rubric prioritizes screening and de-emphasizes treatment. While screening is of paramount importance for reducing disparities, the member expressed that screening and treatment should be equally weighted to better support certain subpopulations. As an example, NQF #3595 Hydroxyurea Use Among Children with Sickle Cell Anemia, did not reach prioritization and is a treatment-focused measure rather than a screening measure, but this treatment is lifesaving for patients.

A Workgroup member noted that two National Committee for Quality Assurance (NCQA) child and adolescent well-care visits measures, Well-Child Visits in the First 30 Months of Life and Child and Adolescent Well-Care Visits, have received measure specification updates and have shown equity gaps when stratified. The member suggested that the Workgroup review and consider these measures in its next maintenance cycle. Workgroup members additionally raised concerns about the completeness of data for race, ethnicity, and language, pointing out that this scoring system allows for the prioritization of measures already known to have disparities, while new measures that would benefit from review would be overlooked due to missing data.

Discussion on Prioritization Criteria

Dr. Ma invited Workgroup members to provide thoughts on the expansion of use for this scoring criteria across all CQMC core sets and to share any final thoughts on modifications to criteria. Workgroup members reiterated that it would be positive to have a standardized set of criteria, but there may be too much risk of bias against particular core sets with the criteria provided. Some Workgroup members suggested weighting the criteria uniquely for each core set to combat this risk. One Workgroup member reiterated discomfort with the scoring criterion of use in multiple core sets, and Ms. Lynch acknowledged that this criterion was not incorporated as a marker to assess disparities but rather as a way to identify greater potential impact if looking to work across CQMC core sets.

Workgroup members also saw value in conducting further data analysis, as long as data analysis continued to be accompanied by other sources of information to avoid biases such as those found in electronic health records (EHRs) or provider interactions that can impact how codes are entered for data collection. A Workgroup member also noted that specific to the day's conversations, the Pediatrics core set may need to be considered as unique, given that parents or guardians often provide the information used in data collection on behalf of pediatric patients. Pediatric patients with chronic or complex conditions also face challenges with small denominators not seen in adult populations for data analysis.

Public Comment

Ms. Lynch opened the web meeting to allow for public comment. No public comments were offered.

Next Steps

Simone Bernateau, Analyst, NQF, shared that a meeting summary would be posted following the meeting and encouraged attendees to continue disseminating the CQMC Health Equity Workgroup Final Report. Ms. Bernateau encouraged participants to reach out to the team with any additional questions or comments at CQMC@qualityforum.org. Ms. Lynch thanked all attendees for coming and for their support of the first year of the CQMC Health Equity Workgroup before concluding the meeting.