Meeting Summary

Core Quality Measures Collaborative (CQMC) Full Collaborative Strategic Meeting Summary: October 15, 2024

The Core Quality Measures Collaborative (CQMC) Full Collaborative convened on Tuesday, October 15, 2024, for their annual strategic meeting.

Welcome and Updates

Kate Buchanan, Battelle CQMC task lead, welcomed attendees to the Full Collaborative Annual Strategic Meeting. Ms. Buchanan reviewed the anti-trust compliance statement and noted that CQMC is a membership-driven and -funded effort, with additional support from Centers for Medicare & Medicaid Services (CMS) and AHIP.

Brenna Rabel, technical director of the Partnership for Quality Measurement (PQM), Battelle, introduced PQM. Battelle, a certified consensus-based entity (CBE), manages PQM. PQM uses a consensus-based process involving a variety of experts—clinicians, patients, measure experts, and health information technology specialists—to ensure informed and thoughtful endorsement reviews of quality measures and pre-rulemaking measure recommendations. Ms. Rabel highlighted the importance of collaboration and engagement in ongoing efforts and invited CQMC members to join the PQM to stay updated.

Ms. Rabel provided an overview of the meeting objectives, which included:

- Presenting CQMC transition and progress to date
- Updating the CQMC charter
- Strategizing future opportunities to drive even greater impact of the CQMC
- Seeking guidance on upcoming work to identify core set implementation challenges and potential mitigation strategies
- Identifying strategies to address current data and interoperability challenges including limited demographic data to support measure stratification
- Determining role of CQMC in encouraging patient safety measures

Danielle Lloyd, the CQMC Steering Committee chair and senior vice president of private market innovations & quality initiatives at AHIP, thanked the CQMC members, the workgroup co-chairs, and Steering Committee for their participation and contributions. She then spoke about the workgroup and white paper activities leading up to and following the contract transition to Battelle. Since the transition, the workgroup's priorities have included of the 10 core sets, identification of barriers and solutions to adoption of the core set measures, discussion around health equity and identifying disparities, and processes enabling digital measurement. Activities on hold include measure model alignment and gaps in measure sets.

The CQMC sunsetted the crosscutting initiative. Ms. Lloyd ended by announcing that dues will not increase in 2025.

Traci Archibald, deputy group director, Quality Measurement and Value-Based Incentives Group (QMVIG), CMS, gave a welcome statement on behalf of CMS noting the progress seen in the last few years on alignment across payers.

Review of Governance Items

Erin O'Rourke, executive director, clinical performance and transformation, AHIP, discussed the proposed CQMC charter update. Currently the charter includes abstentions in the denominator. To align with current CBE practices and to not penalize abstentions, the Steering Committee proposed updating the language to remove abstentions from the denominator. Attendees voted unanimously to approve this change.

Core Set Implementation

Previously, the CQMC developed an Implementation Guide that identifies key elements of success for value-based payment. The CQMC is now moving toward the next phase of its implementation work. Helen Burstin, Steering Committee member and chief executive officer of the Council for Medical Specialty Societies, opnened the conversation and coordinated member input on facilitating CQMC core set implementation.

To facilitate CQMC core set implementation, Real Chemistry will conduct qualitative research to understand what factors are driving or impeding the adoption of the CQMC core measures. Donna Dugan and Palak Patel of Real Chemistry outlined the goals and objectives of this research, which includes member and non-member interviews to identify challenges to measure implementation. Member interviews will begin in November 2024 with interviews of up to 12 CQMC members. In January 2025, Real Chemistry will conduct up to 12 CQMC non-member interviews. In early 2025 they will provide a summary of findings, opportunities, and potential action steps.

During discussion, members spoke about potential challenges that could be addressed, including raising awareness of the CQMC and its core sets, understanding the current usage and assessing their relevance and acceptability for specific needs. Members noted that data availability and collection challenges, along with other logistical issues, are significant hurdles. They also discussed variation and changes to measure specifications as well as permissions and licensing fees for proprietary measures as areas of concern. The Collaborative also recommended that Real Chemistry consider states and state regulations as well as electronic health record vendors in their interviews.

Data Challenges

The discussion aimed to identify strategies that CQMC could take to address health care data challenges. The discussion covered the collection of standardized demographic data and approaches to measure stratification as well as the transition to a digital measurement

ecosystem and data interoperability.

As the health care industry continues to advance efforts to improve interoperability such as by creating standardized data elements in the United States Core Data for Interoperability (USCDI) and by developing new digital ecosystems such as the Trusted Exchange Framework and Common Agreement (TEFCA), the quality measurement enterprise is pushing itself to prepare for the transition. For example, providers and payers could leverage application programming interfaces (APIs) for bidirectional information sharing to support quality measurement. The digital transition also includes identifying what necessary data elements are not currently included in the USCDI, as inclusion supports availability in certified electronic health records (EHRs). To support this effort, the CQMC, under the previous contractor, cross-walked high-priority measures to assess if the necessary data elements were included in USCDI and available as Fast Healthcare Interoperability Resources (FHIR) resources. The CQMC could continue similar work on its own or could collaborate with partners to address these gaps in the USCDI.

Eric Ellsworth, Steering Committee member and director of health data strategy at Checkbook Health, initiated the discussion by summarizing challenges related to data quality, burden reduction, and interoperability. EHR data have significant quality issues with statistics indicating that 50 percent of this data are copy/pasted to fulfill certain documentation requirements, leading to substantial inaccuracies. Before data can be used in any automated measurement system, they require a thorough process of conversion and cleaning. Burden reduction in health care involves improving data accessibility for both patients and providers, which is essential for quality measurement and improvement. Providers frequently face challenges in accessing data related to their own activities used in these measurements. Interoperability introduces a novel approach to measuring and documenting a patient's health care journey through specific episodes or encounters. Provider performance needs to more closely align with consumer's necessities and better reflect the patient's decision-making environment and goals.

Rowan Mahon, senior clinical measure developer analyst, Minnesota Community Measurement (MNCM), presented on clinical quality measures (CQMs) versus digital quality measures (dQMs), the challenges and barriers of converting CQMs to dQMs, and MNCM's work with dQMs. She explained that CQMs and dQMs differ significantly in their data collection methods and sources. CQMs often rely on a mix of manual and semi-automated data collection methods, including manual chart reviews, claims data, and manually extracted EHR data, which may also incorporate unstructured data. In contrast, dQMs leverage completely automated data collection, utilizing structured data captured directly from EHRs or claims, adhering to standardized data formats, and enabling real-time data processing.

The advantages of CQMs include an established and widely recognized framework, the ability to incorporate a comprehensive range of data sources, adaptability to various data types, and increased accuracy at the individual data element level. These measures can also be managed by non-technical staff due to lower technical requirements. On the other hand, dQMs offer efficiency through streamlined data collection and reporting, provide real-time insights with immediate access to quality metrics, utilize standardized data formats, and reduce administrative burdens, potentially increasing accuracy at the population level.

Both approaches have their drawbacks. CQMs are often time-consuming and labor-intensive due to manual data collection, and they can suffer from variability in reporting and limited real-time insights, with potential data gaps in capturing insights from unstructured data. dQMs, while efficient, require significant initial investments in technology and training, depend heavily on reliable digital infrastructure, and may overlook nuances in patient care that are not represented in structured data formats.

Ms. Mahon emphasized the critical importance of data value set creation in health care measurement, noting that it is often underestimated despite its crucial role in defining specific populations for analysis. The CQMC could assist in ensuring that value sets are standardized and usable by others. However, maintaining up-to-date value sets is challenging due to rapid changes such as new drug approvals and discontinuations. Additionally, the variability in package sizes and formulations of medications introduces further inconsistencies in value set definitions. Consequently, continuous monitoring of medication databases is essential to keep value sets current, demanding significant resources and effort from health care organizations.

MNCM has also developed the Process Intelligence Performance Engine (PIPE), which aims to streamline data collection and reduce the reporting burden for providers. This system enhances the efficiency of data usage, maximizes resources, and increases the availability of timely and actionable information for providers and health plans. It also boosts confidence in the reliability and validity of centrally calculated measure results. PIPE data can be utilized for CQMs, data sharing with health plans, new measure testing, and research projects. The transition to dQMs is a significant endeavor for MNCM, but it promises valuable outcomes by enabling access to comprehensive population-level data that can drive meaningful changes.

Alex Baker, deputy director, office of policy, ONC, joined the discussion to present on USCDI+ Quality Domain. Mr. Baker explained the USCDI+ Quality Domain goals and priorities. The USCDI+ Quality Domain goals are part of the broader USCDI+ Initiative, which aims to harmonize quality data elements into a common list that meets the needs of multiple partners and supports CMS' dQM strategy. This involves close collaboration with CMS and the Health Resources and Services Administration (HRSA) to update the Uniform Data System (UDS) system and align quality-reporting policies across Department of Health & Human Services (HHS) agencies. The USCDI+ Quality data priorities incorporate data elements from various sources including CMS electronic clinical quality measures (eCQMs), the CMS Data Element Library (DEL), post-acute care settings, HRSA, Minimal Common Oncology Data Elements (mCODE) for cancer data, and Agency for Healthcare Research and Quality (AHRQ) for patient safety data elements. The process includes continuous expansion and updates to address behavioral health and cancer, among others.

Partner engagement is crucial. Both federal and non-federal entities are involved in developing the data element list. The latest priorities for the USCDI+ Quality include analyzing public comments from 2023, incorporating additional data sources, and ensuring alignment with USCDI domains. The USCDI+ Quality Data Element List is categorized into "Quality Overarching" for elements still under consideration and "Draft USCDI+ Quality V1" for elements ready for implementation and necessary for calculating CMS eCQMs. Public comments are integral to refining the data element list, with a final version expected in early 2025. Mr. Baker highlighted concerns such as patient access to care and administrative factors influencing

provider choice, which indicate the complexity and breadth of data elements considered for quality measurement and reporting.

Next, Kathleen Gallagher and Megan Schoonveld-Diaz, both from the Patient Advocate Foundation (PAF), shared an overview and update on the cognitive testing they conducted of the questions and response options developed as part of the Demographic Data Element Modernization (DEMo) Initiative. AHIP began the DEMo Initiative and Civitas Networks for Health and Health Level Seven (HL7®) now partner with it. The DEMo Initiative invited CQMC members to be participants free of charge in the content development workgroup and they will be able to participate in the next phase: developing FHIR as part of the HL7 standards development process.

The cognitive testing aimed to evaluate the clarity and relevance of revised demographic questions and response options for patients in healthcare settings. The study involved a national survey and focus groups to assess patient comfort and understanding of these questions. The survey, conducted over 3 weeks in August 2024, reached out to patients with complex chronic illnesses; they received 617 completed responses from an 8,000-patient cohort. The focus groups, consisting of a diverse demographic, discussed provider awareness and the importance of explaining why certain demographic information is requested. They also discussed patient fears of bias and concerns about the security of their information. Overall, patients found the language clear and appreciated additional definitions, though there was variability in how well identity choices matched personal views, particularly in domains such as spiritual beliefs, race/ethnicity, and disability status. The project highlighted the need for clear introductory language, the inclusion of open-ended questions to better capture identities, and regular updates to response categories to ensure relevance. Similar work was underway to assess the provider perspective of administering the questions to patients and results will be shared with the CQMC members at a later date.

Report Out from Digital Measurement and Demographic Data/Stratification Breakout

The Full Collaborative broke out into small groups to engage in discussions on the challenges associated with digital measurement and demographic data/stratification, allowing participants to delve deeper into these critical topics.

Those in the digital measurement breakouts highlighted several significant challenges faced by the CQMC, primarily centered around data management and standardization issues. There is considerable variability in data mapping, which the CQMC could potentially standardize to enhance consistency. The presence of multiple similar measures managed by different stewards and deviation from measure specifications lead to confusion among providers, presenting an opportunity for CQMC to further align measures and specifications used by payers. Additional challenges include the high costs of measure development, labor-intensive impacts on clinician workflows, and the difficulties in creating value sets. Participants also discussed licensing issues and the need for more effective use of digital measures, alongside the necessity for CQMC to engage more actively in these areas. The conversation also touched on the need to catalog links in the FHIR resources and to collaborate with partners to address these issues. They noted

payers' challenges with data aggregation are more relevant within accountable care organizations than in general and private contracts because they are aggregating data across disparate entities.

A member provided a summary of the demographic data/stratification breakout session. This discussion centered on the challenges and strategies for measure stratification in health care, particularly focusing on identifying and addressing disparities. The conversation highlighted the complexity of stratification, which varies based on data available. CMS currently stratifies by dual eligibility and imputes race and ethnicity due to incomplete data, using Office of Management and Budget (OMB) standards that allow for multiple variables and combinations; however, this approach faces challenges with small sample sizes. Participants discussed the importance of providers stratifying their own data and the need for a more centralized approach to defining categories and variables to better address disparities. Members emphasized the importance of various demographic factors such as age, sex, race, ethnicity, and geography, but acknowledged the challenges in standardizing these elements. The discussion also touched on the role of CQMC and providers in taking on the work of stratification, with opinions varying on who should lead these efforts. The consensus pointed toward the need for a conceptual model similar to risk adjustment to handle the controversial aspects of stratification and the importance of gathering more information to understand the challenges and opportunities in this area better.

Patient Safety

The Full Collaborative engaged in a discussion on patient safety aimed at developing a framework for patient safety measures within the CQMC. The collaborative covered several topics, included ongoing issues with harm in health care, the launch of safety initiatives by AHRQ, proposals for how the CQMC can enhance patient safety, and an update on current patient safety activities from The Joint Commission.

Michelle Schreiber, Steering Committee member and deputy director, Center for Clinical Standards and Quality (CCSQ), CMS, discussed a few ongoing issues with harm in health care, noting improvements in areas such as health care-acquired infections and the adoption of high reliability practices, but also pointed out vulnerabilities exposed by the pandemic. She noted that CMS' strategy to tackle patient safety involves a cross-federal approach focused on enhancing transparency, advocating for patient safety, and refusing to compensate for preventable harm. Key initiatives include implementing a patient safety structural measure to inform the public about hospital adherence to safety practices, improving the Care Compare tool, and promoting robust event reporting. Efforts to advance safety culture will involve ensuring patient data access and accuracy, fostering learning ecosystems, integrating safety in value-based programs, and providing safety-focused technical assistance. Additionally, CMS plans to incentivize zero harm by rewarding facilities that excel in serving underserved populations and reforming payment policies to avoid funding preventable harm.

Craig Umscheid, director, Center for Quality Improvement and Patient Safety, AHRQ, focused on various safety initiatives spearheaded by AHRQ to enhance patient and workforce safety, particularly in response to the rise in adverse events during the pandemic. Key initiatives include the National Action Alliance for Patient and Workforce Safety (the Alliance), led by AHRQ under HHS, which collaborates with federal and private partners to identify critical safety measures,

provide necessary tools for health care systems, and track safety improvements over time within a learning network. The Alliance encourages health care systems to conduct self-assessments to identify needs and utilize the developed tools and network for addressing these needs. Other significant efforts include the Quality Indicator Program that maintains safety measures, the biennial Surveys on Patient Safety Culture to assess health care worker perspectives, and the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey program that evaluates patient experiences related to safe care. AHRQ also supports common formats for surveillance and event reporting, facilitating the sharing of incident reports among health care providers and safety organizations, and characterizing safety events nationally. Additionally, the Healthcare Cost and Utilization Project (HCUP) collects extensive hospital data nationwide to estimate safety event rates, further supporting these safety initiatives.

Lisa Hines, chief quality and innovation officer, Pharmacy Quality Alliance (PQA), provided an overview of the PQA and how CQMC can advance patient safety. She detailed the process of developing measures and the measure lifecycle, focusing on four medication-use domains: adherence, appropriate use, safety, and medication management services. Measures addressing these domains are implemented across various platforms including Medicare Part C and D Star Ratings, Medicaid Adult Core Set, and other state and regional quality programs. Dr. Hines noted a few challenges in developing certain measures, such as issues with attribution in bleeding events, lack of valid diagnosis codes for overdose measures, and unreliable measure rates for serious hypoglycemic events. She also touched on the retirement of certain measures, the use of existing measures for different levels of analysis, and the limited evidence base and data sources for medication safety measures

Elizabeth Mort, vice president, chief medical officer, The Joint Commission, provided an overview of the National Quality Forum's ongoing project: Harmonizing Accountability Reporting and Monitoring (HARM), which focuses on serious reportable events (SREs). The project aims to update and align the SRE list with the help of an advisory panel and two technical expert panels. The process involves an environmental scan to understand the usage of SRE-type lists, updating inclusion criteria, and soliciting public comments, resulting in a preliminary list submitted to CMS. The updated criteria for SREs require events to be tied to a patient encounter and be both serious (causing death or harm) and largely preventable. The scope of SREs will expand to all health care settings by 2024. Additionally, efforts are being made to align sentinel events (SEs) with the SRE list and encourage more comprehensive reporting to The Joint Commission. The presentation also touched on advancing diagnostic excellence measures, focusing on acute vascular events, infections, and cancers; and highlighted the need for data standards and a call to action to enhance diagnostic measurement.

During the Full Collaborative discussion on patient safety measures, members deliberated on the challenges and strategies for integrating patient safety into quality measurement. The conversation began with a recognition of the uncertainty in the diagnostic process as a significant challenge. One member questioned whether CQMC should develop a core set of patient safety measures or incorporate patient safety measures into each of the core sets. Another member expressed the difficulty in making impactful contributions despite recognizing the importance of patient safety.

The group discussed strategies for advancing patient safety with the CQMC emphasizing the

prioritization of medication safety, focusing on high-risk medications and populations, addressing disparities, enhancing transparency, and promoting incentives for safety improvements. Lastly, a member mentioned that CMS' development of eCQMs and dQMs is a significant step toward improving safety monitoring and reporting.

Additionally, they discussed the need for meaningful measures and the inclusion of patient safety across various domains. They noted that medication safety could be relevant to many core sets, raising concerns about the absence of patient safety measures in some sets. The discussion also covered the adoption of measures and the role of payers in using the information to create incentives or disincentives for patient safety.

Suggestions included convening a safety measures workgroup to identify measure concepts that could lead to the development of crosscutting safety measures. They proposed the idea of a set of safety measures as a "north star" with diagnostic safety measures seen as a potential target for ambulatory safety. Additionally, the group discussed CAHPS measures and patient experience measures related to communication as proxies for safe care in various settings.

Members advocated for starting with simple structure and process measures to incrementally advance safety measures, with a goal set such as for a 50% reduction in harm by 2026. The discussion underscored a collective agreement on the importance of patient safety and the need for a strategic approach to integrating safety measures across health care settings.

Closing Remarks and Next Steps

Ms. Lloyd and Dr. Schreiber provided closing remarks. They expressed gratitude to the speakers, facilitators, and attendees for their contributions. Ms. Lloyd summarized the discussion, which highlighted several key areas of focus: the implementation challenges due to variation in specifications and the tension between alignment and uniformity, difficulties related to data availability, and licensing fees and proprietary aspects of measures. In the data and digital realm, members noted similar issues including data aggregation, accessing and mapping data, and ensuring consistent data definitions. Members emphasized safety concerns, particularly the deterioration during COVID, challenges with small number data, and the necessity for meaningful safety measures in each core set or as crosscutting measures. The group discussed potential solutions, such as the development of implementation guides and engaging more closely with measure developers through interviews to address these challenges effectively.

Ms. Lloyd encouraged attendees to reach out to CQMC@battelle.org with any additional comments or questions. Ms. Lloyd thanked all attendees once more for joining the meeting and adjourned the meeting.