Meeting Summary

Full Collaborative Meeting 2 (In-Person)

The National Quality Forum (NQF) convened an in-person full collaborative meeting for the Core Quality Measures Collaborative (CQMC) on February 28, 2020.

Welcome, Introductions and Review of Meeting Objectives

Danielle Lloyd (AHIP), Shantanu Agrawal (NQF), and Jean Moody-Williams (CMS) welcomed participants to the meeting, reviewed the agenda for the meeting, and emphasized the importance of the work towards alignment and implementation of the core sets. NQF read the antitrust statement and reminded participants to refrain from discussing or exchanging competitively sensitive information.

Current Scope and Activities to Date

Danielle Lloyd (AHIP) welcomed two new CQMC steering committee members – Amy Helwig (UPMC) and Vikram Shah (Cigna) – and noted that a spot would be opening soon for another patient group to join the steering committee. Ms. Lloyd also provided an update on activities of the CQMC. In 2019, the group held 29 workgroup meetings, developed a website for public presence, developed standardized selection principles, and voted on 7 of 8 core sets. In 2020, the group will increase activities on implementation and scaling of measures, measure gaps analysis and proactive alignment, develop the two new core sets on neurology and behavioral health, and continue with the new Speakers Series.

Vision for the Future

Participants broke out into smaller groups to discuss the path forward after current core sets are finalized. There was much discussion around increasing implementation of these measures by decreasing barriers, most notably the cost barrier. Participants also noted the importance of getting the buy-in from health systems to aid adoption and implementation. To this point, discussion began around what may be the best way to achieve this buy-in. Some groups advocated for the measure sets to be pushed on a national marketing scale soon after the sets have been finalized. Others proposed the possibility of first testing results of measure adoption in smaller markets. Once data is gathered from these trial markets, results can be disseminated to health systems at large outlining the benefits of measure set adoption. An important aspect of numerous measures across all core sets are their involvement with Electronic Health Records (EHR). Thus, many participants highlighted the importance of working with EHR developers to mitigate any burden implementation may have on these systems. Additionally, many groups noted that the CQMC should engage in efforts to highlight the more developmental measures such as PROs and PROMs. In particular, data collection around these types of measures should be outlined clearly as setting unrealistic standards for data collection may create for unnecessary burden on providers and health systems. Many group members emphasized the importance of continually reviewing the core measure sets. Many of the topic areas the CQMC addresses evolve rapidly and thus standard processes for routine measure review is highly

important to the group's mission. Lastly, many groups decided that it is the responsibility of all those involved to continually be on the lookout for new, cross-cutting, credible measures to be added to workgroup discussions.

Federal Quality Roadmap

Joining the CQMC Full Collaborative in-person session was Mr. Eric D. Hargan, Deputy Secretary of Health and Human Services (HHS). Mr. Hargan began his remarks by underlying the importance of communication between the public and private sectors in healthcare as both share the same goal of high-quality care with low costs. The Deputy Secretary noted that new payment models and direct financial incentives are main points of research at the federal level. System innovation is also a large focal point and working towards increased transparency in the healthcare market; consumers should be more aware of the price they are paying for the service they are receiving. Mr. Hargan noted three main themes at the federal level in the quality measurement space. The first being whether the correct metrics are being used. CMS has taken many steps including the Meaningful Measure Initiative to ensure that the proper metrics are being included. It was noted that the U.S. currently lags many international healthcare systems in administrative burden and adopting effective quality measurement practices is a step towards alleviating those issues. The second theme emphasized was the importance of the process of selecting good, credible quality measures. The Deputy Secretary underscored the importance of an ongoing feedback loop to secure buy-in early from those healthcare stakeholders. The third point of emphasis Mr. Hargan noted was the importance of making these metrics useful and available to the public and providers. A shift towards more patient control of their records is a priority in today's healthcare system in addition to more information on prices and quality. It was noted that ideally, one place where all this information is stored is the end goal, but steps must be taken prior to making that possible. The government is looking to rely on the private sector to lead the initiatives on creation of these tools. A question arose from the group as to how the CQMC can aide in furthering the Federal Roadmap once it is released. The Deputy Secretary encouraged the group to continue work that is currently underway with a focus on quality enterprise. Alignment between the public and private sector will also be a major focal point in the administration's efforts in improving healthcare. Data availability is also a major component in the efforts to be outlined in the Federal Roadmap. Lastly, the Deputy Secretary fielded a question regarding Electronic Health Record alignment with measuring quality to which he ensured that spending in IT infrastructure has increased and numerous data initiatives have recently been supported by HHS.

Speaker Panel: Digital Measurement and Electronic Exchange

This panel was moderated by Danielle Lloyd (AHIP) and Michelle Schreiber (CMS) and included Shelby Harrington (Premier), Jana Malinowski (Cerner), Mary Barton and Paul Cotton (NCQA). The panelists were brought together to discuss the market perspective regarding digital measurement. CQMC agrees that this is the direction that we should head in, but there are major hurdles. The discussion addressed how to get to the next level, the roadblocks and how to get past them, recognizing that some partners (non-voting members included) must see how this fit into their business model. CMS is particularly interested in the intersection of quality, electronic records and electronic data systems. CMS is in the process of developing Meaningful Measures 2.0 and what that might look like, both with continued burden and transparency for patients. Two key themes include patient voice and moving quality measures to all digital by 2030. Digital measures are information that comes, shared, transmitted and received digitally, and is seamless to the provider doing the work. ECQMs is digital information that comes specifically from electronic quality records and is a subset of EQMs or DQMs. DQMs can also include census information, patient generated downloadable data from devices, HIE and registry information. Moving to digital measures is key because of the volume of data and rapid cycle feedback in order to act in real time. The data should be applicable at the population level as

well as at the individual provider level. This should be integrated into the workflow as seen in HIEs and registries.

The panelists introduced themselves and talked about the importance of this work. Jana Malinowski from Cerner talked about how her organization sits at the intersection of health and IT. Cerner is heavily invested in measure testing and partner with measure developers and other clients to evaluate and complete data extraction in order to get those incorporated into programs. Mary Barton and Paul Cotton from NCQA talked about where we need to go which is reduced burden, faster turnaround, improved accuracy and being able to use the information for multiple purposes. Shelby Harrington from Premier talked about how her organization runs registries and bringing in the provider perspective. There is a finite capacity for providers to conduct non patient care activities, such as, quality measurement and therefore, taking time, money, and resources away from quality improvement, continuing education, and self-care. The focus will be on measures that are based on reimbursement, which can lead to unintended consequences. The focus will differ by patients based on their respective payer, but the focus should be on all payer data. There is still a need to analyze data by payer because the services vary based on the payer, such as, care coordination which will impact the patient outcome.

The panelists addressed strategies around collection, calculation, submission, and overall organization. Michelle Schreiber talked about standardizing the collection process through standard portals and having seamless communication. There are lots of HIEs across the country currently sharing data. Data aggregators can be used to collect data and conduct the analysis. Michelle Schreiber pointed to ONC and CMS' 43 recommendations for reducing burden using electronic health records. CMS also has Compare websites for transparency purposes at the provider level for consumers to make informed choices. By building standards for data, the data can move accurately across different pathways, such as, registries or HIEs depending on how far along the states are. Data flow can be challenging in terms of different types of data when ambulatory and hospital settings use different EHR vendors. Harmonization of measures are important and should be consistent in what the measures are measuring. HIEs seem to be a natural fit as the central data aggregator, but it can also be a large health system or a health plan that can accomplish this goal in order to improve data accuracy. The providers can send data to this central location, and the central data aggregator can in turn provide value by giving providers better analytics, predictive modeling, and point of care decision support.

Digital measures will allow for personalized measurement based on the individual's risk and preferences and improvement on those rather than on a target that is based on the average patient. Regarding the question of who owns the data, the patient would be willing to releasing their information once they see the value in it. The privacy of patient information is tied up in business agreements at each entity making it complicated, which is something that needs to be resolved. The current structure does not allow for measuring compliance of individualized care plans in accountability programs. The focus should not only be on measurement, but it should also be on the structures and processes in order to get there. A multi-payer collaborative of insurers and states can work together and play a role in consumer facing sharing of data. Measures that matter to patients and can be made available to patients in a consumable way are the ones we should be measuring rather than the measures imposed by the payer. The core sets should be accompanied by consumer language for consumers who are viewing the measures. Proposed certification rules on interoperability are critical for maintenance work and privacy concerns will need to be addressed as part of that in order to get the information in the hands of providers to provide the best care. Real world testing is key to see if we are measuring consistently and accurately across different EHRs.

The CQMC can provide consistent messaging around alignment and standardization. A consistent

data elements library with a consistent format across the different agencies that has measures and different programs will be helpful in order to interpret them accurately.

Speaker Panel: Patient-Reported Outcome Performance Measures

This panel was moderated by Chinwe Nwosu (AHIP) and Reena Duseja (CMS) and included Amy Helwig (UPMC), Rachel Brodie (Pacific Business Group on Health), Julie Sonier (Minnesota Community Measurement) and Theresa Schmidt (Discern Health). CMS indicated that patient centeredness continues to be a top priority as reflected in its 2017 Meaningful Measures Framework, from which 20% of low bar and topped out measures have been identified and eliminated from CMS fee-for-service programs. CMS shared with the Collaborative that it is embarking on launching Meaningful Measurement 2.0, which will usher in digital measurement to reduce clinician burden allowing for CMS timely feedback to influence care burden while incorporating the patient voice. The patient voice is paramount when considering how to get meaningful information to CMS beneficiaries when choosing care. The digital measurement will identify quality problems before patient harm and intervene accordingly. It was noted that the Merit-based Incentive Payment Systems (MIPS) Value Pathways completed in 2019, has incorporated the patient voice by increasing the number of patient reported outcomes with the aim of improving MIPS and making the program more meaningful to patients and clinicians while ensuring that the processes are within the clinicians work flows.

CMS shared that in speaking with its beneficiaries it was discovered that areas of concern include examining health related quality of life, functional status, symptoms and symptom burden, health behaviors, communications, the benefit of support systems, and difficulties in care coordination. CMS is therefore also pushing for publicly displayed information received from its beneficiaries in one place versus the current multiple sites, thus allowing beneficiaries to compare price and quality when making decisions about their care.

Julie Sonier of Minnesota (MN) Community Measurement shared that the organization is a non-profit regional stakeholder multi-collaborative started in 2005 with membership that comprises of healthcare providers, health plans, employer/purchaser groups, consumers and state agencies in Minnesota. The collaborative convenes to discuss common issues and agree on what is important to measure for across its statewide membership. It was noted that the organization also develops measures and has several NQF endorsed measures that are in some CMS programs. Julie Sonier shared that the organization became a measure developer by necessity when the collaborative noted dissatisfaction in the quality and range of measures that were available, especially patient-reported outcome measures. The organization was also engaged in statewide data collection and validation of clinical data on all payors, patients and health plan e.g. claims and HEDIS. Thus, the aggregated data allows for a statistically robust and reliable comparison of providers, which is publicly available.

Julie Sonier shared that to-date MN Community Measurement had developed the following Patient-Reported Outcome Performance Measures (PRO-PMs):

Topic	Measure(s)	Date implemented	NQF endorsed	CMS programs
Depression	Remission; Response	Adults since 2010; adolescents starting 2020	X X	X
Asthma control	Composite: asthma well-controlled & low risk of exacerbation	Adults & children since 2011		X

Total knee replacement	Change in functional status	2013	X	X
Lumbar fusion	Change in functional status; change in back pain; change in leg pain	2013	X	X X X
Lumbar discectomy/laminectomy	Change in functional status; change in back pain; change in leg pain	2013		X X X
Symptom control during chemotherapy	Pain; nausea; Constipation	Implementation (Has undergone testing is will be submitted to NQF for endorsement)		

Julie Sonier shared that for the Asthma control measure there was a choice of tools available for providers, which enhances uptake. It was noted that the Total knee replacement, Lumbar fusion and Lumbar discectomy/laminectomy measures have recently undergone a redesign to become target based versus average change in functional status, based on feedback received from stakeholders on some potential un-intended consequences e.g. not including patients with bad outcomes.

Theresa Schmidt of Discern Health shared that the organization is a strategic advisory services and research firm that focuses on defining and measuring value in healthcare. In Discern's work, a common topic that is encountered is how to make quality measures and performance measures more patient centered and defining value from patient perspectives for value-based payment (VBP).

Theresa Schmidt shared about their work in 2018 Patient Reported Measures in Oncology in partnership with the National Pharmaceutical Council which involved multi-method approach to assess the landscape for available patient reported measures for oncology related measures for patient reported experience, patient reported outcomes, patient reported performance measures of experience and patient reported outcome performance measures. The project also involved researching barriers in measure implementation and gaps in measures specific to VBP. The findings were that over 800 experience and outcome measures (PRO-PMs) of which 515 measures were cross-cutting and thus applicable to oncology and 18 measures specific to oncology with only 8 measures implemented in VBP for oncologists. Interviews and roundtable discussion with stakeholders emphasized the importance of measures for care coordination, access to care, symptoms, and symptom burden. Stakeholders also suggested considering symptom interference with daily activities, emotional and spiritual burden on patients, and whether patient goals and values were considered throughout the treatment process. They also noted that measures could be used to improve clinical care, not just as an accountability measure, and that measures should be selected based on concepts that are important to patients. Ms. Schmidt recommended that patient and family input be incorporated during development of measures and programs, and that any publicly reported measures be presented with enough background/context.

Amy Helwig of UPMC described the organization's role as a health plan and user of patient-reported outcomes, including directly receiving patient-reported data (required for risk assessments) and additional data submitted for value-based payment programs. UPMC's goal is to eventually take this data and integrate it into population stratification programs, which are currently only based on claims

data, to improve the precision of interventions. Ms. Helwig emphasized the importance of having clinicians feel they are getting value out of patient-reported data and that they can champion this data. Ms. Helwig also described areas that need to be addressed, i.e. understanding unseen provider burden for measures (e.g. implementation of iPad survey system requires maintenance, cleaning, etc.) and closing the loop of data with patients (i.e. letting patients see their own reported data over time and describing how care is being adjusted to account for their reported data).

Rachel Brodie of Pacific Business Group on Health (PBGH) described the mission of the organization is to act as a change agent to create value in healthcare, by testing and scaling innovative models for care redesign, value-based payment systems, and policies to promote performance transparency and accountability. For example, PBGH worked with the Michigan Oncology Quality Consortium to test and develop patient-reported outcomes on quality of life, pain, and fatigue for patients undergoing chemotherapy. Ms. Brodie shared that the goal of the consortium is to develop systematic, standardized PRO-PMs that can be used for system comparisons, assessments, and payment models. It was noted that measures that are actionable, meaningful, and immediately useful to providers and patients can lead to increased momentum and interest in providing and collecting this data. PBGH is also working with payers on models for phasing in performance-based payment systems.

The panel addressed questions from the audience on specific outcomes and whether they were used in the panelists' programs; methods for reaching patients and collecting data; and discussion of condition-specific versus general PRO-PMs. Specific outcome measures included use of participant-reported outcomes on disability (required by the state of Pennsylvania), orthopedics measures of improvement in condition, and the PHQ-9 depression questionnaire. Testing options for PHQ-9 (meaningful improvement; absolute outcome; observed vs. expected numerator) are being compared to see which methods are most reliable and most clinically relevant. Panelists also commented that tracking patient-reported outcomes provides an opportunity to understand 'side effects' of healthcare on low-income patients (e.g. transportation burden, cost of care, work disruption) and provide an opportunity to track and reduce these non-medical 'side effects.'

Panelists also discussed the role of face-to-face interviews where possible, supplemented by other options such as phone interviews. Patients should be asked about their condition at baseline and after treatment instead of being asked retrospectively about their condition, especially when trying to risk adjust for conditions such as depression. These assessments could be performed by providers at the point of clinical care.

Panelists discussed the importance of disease-specific measures versus general measures. They commented that more specific measures are helpful to clinicians and patients when trying to understand care for a specific condition but noted the existence of tension between the usefulness of specialized measures and the lower provider burden when collecting general measures. An example was provided of the National Institutes for Health (NIH) PROMIS sets which are being used by organizations despite concern that the questions are sometimes too general to inform specific steps to improve care. It was therefore recommended that additional patient input might be helpful when selecting measures, in response one panelist mentioned the possibility of creating a bank of questions and requiring a core set for all clinicians as well as the option to add additional questions for tracking on an 'as-desired' basis.

Before concluding the session, the moderators asked the panelists what key domains they would recommend the CQMC to focus on in the future. Panelists mentioned specialty care measures; measures useful for making clinical decisions; measures meaningful to help patients understand the value of care; measures of goal-concordant care; quality of life measures; domains of capable, comfort, and calm; and measures of depression because of its co-morbidity with other conditions.

Consideration of Strategic Issues

Chinwe Nwosu (AHIP) gave an update on the state of CQMC membership. Currently, there are 74 members (62 voting, 12 non-voting). Medical associations and payer groups are heavily represented, while other groups such as purchaser and patient-consumer groups are less represented. The imbalance in group representation, in combination with current voting rules on quorum and supermajority, pose a concern for equal weight of voices and for measure parsimony (difficult to add and remove measures). Chinwe then opened discussion on ideal membership balance, ideas for promoting participation from new groups, and thoughts on amending the definition of 'supermajority' for CQMC.

At the beginning of the discussion, group members asked about the composition of the steering committee and the vision for CQMC in the coming 2 to 3 years, in order to inform the best approach. AHIP responded that the steering committee already had a good balance of representation between different groups and that there were no plans to adjust group composition on the steering committee. The future vision is still under discussion, but there is a need to focus on the present-day task of delivering the core measures. Another group member echoed this sentiment, stating that there is still much room to understand the initial sets and challenges to measure adoption (ex. understanding payer commitment to digital measurement), and the group should keep the scope narrow for now.

The group mentioned the need for additional outreach in order to promote participation from all stakeholders and to grow membership. One member commented that committee chairs should explicitly ask people from each perspective or group to give their opinions during calls. Members also commented that the cardiology workgroup could have benefited from additional clinical experience when reviewing the measures, and that smaller physician groups and subspecialty societies should also be included; AHIP asked that members send names of proposed subject matter experts to committee co-chairs for outreach.

Group members also mentioned that perceived transparency was a barrier to participation for consumer and patient-focused groups. Many groups approve of NQF's process (public commenting periods, meeting summaries), but some are wary because of private sector involvement and because specific names, details, etc. cannot be shared. NQF and AHIP responded that in the posted public meeting summaries, there has been an effort to include more detail on the category of person speaking (even if specific names not included) and the process of consensus-building that led to final vote on measure, and welcomed any suggestions for soliciting additional feedback from the public. One member asked if the process for Measure Applications Partnership (MAP) could be used for CQMC and whether this would lead to higher perceived transparency. AHIP responded that the processes are different based on origins of group (MAP legislatively authorized, while CQMC was a private organization driven process), but member suggestions for process changes are welcome.

Regarding the current voting procedure, group members felt that the percentage thresholds for adding or removing measures did not need to be changed. There was one suggestion that the percentage threshold could be stratified by group (e.g. requiring 60% affirmative vote within each group instead of 60% of all voting participants). However, measures could be directed back to workgroups for additional honing if necessary. Members discussed the pros and cons of an in-person procedure for close votes and mentioned that in-person votes allow voters to see where the votes fall, discuss immediately, and re-vote. NQF clarified that in-person votes were previously conducted, but the group shifted away from this because members preferred the option to discuss with their colleagues and constituents before making a final voting decision. AHIP commented that the

discussion and re-voting could still be facilitated through an online vote, if voting information was returned to the group more quickly. One group member also commented that having contacts and meeting information from past discussions could be helpful for the voting process. NQF clarified that this information is captured in meeting summaries but noted that consolidating this information into the excel spreadsheet that houses all measures reviewed by the could be helpful.

Next, Nicolette Mehas (NQF) opened a discussion on short-term goals for prioritizing measure sets and making them more meaningful over the next few years. Ms. Mehas described the current state of the core set measures (mix of process and outcome measures at the clinician level where possible; specialty-specific; increasing number of eCQM reporting options and some PRO-PMs).

Members expressed interest in structural measures (e.g. direct messaging) and self-reported patient outcomes (e.g. self-confidence in managing chronic conditions). Members also discussed measures for social determinants of health and noted that information on impact and outcome of referrals to other nonprofits, as well as data on abuse potential (e.g. narcotics) would be helpful.

The group had conflicting opinions on the inclusion of cost in measure sets. Members mentioned that physicians do not have control over all costs at the physician or group level, costs need to be risk-adjusted, some payers use proprietary cost models, and that prices are heavily distorted by the market and difficult to measure in a way that is transparent and understandable to consumers. Some also expressed concern over cost and quality as competing priorities in measure packages and felt that CQMC should focus strictly on quality measures. However, members also noted that some cost measures have already been developed and adopted (e.g. in Orthopedics) and some standardization around cost could offer benefits for increased transparency and alignment. Other members suggested a proxy approach to measuring cost, pairing outcome measures with measures of appropriateness and overuse.

Scaling the Finalized Core Sets

Chinwe Nwosu (AHIP) presented high-level results from a summer 2019 survey on CQMC measure adoption (report forthcoming). Measure adoption varied by core set (ACO/PCMH/PC, OB/GYN, Pediatrics highest measure-level adoption; Gastroenterology and HIV/HepC lowest measure-level adoption; claims, HEDIS measures at higher adoption than electronic/registry, non-HEDIS measures). Top-ranked challenges to measure set adoption included lack of provider infrastructure to report clinical measures; lack of plan infrastructure; unavailable data; small sample sizes at the provider level; and lack of provider buy-in. Measures are usually not being adopted as full sets, possibly in part due to data availability.

Amy Moyer (NQF) explained that CQMC has convened an Implementation workgroup, which seeks to address these challenges to scaling identified by the survey. Early discussion from the workgroup has focused on barriers to adoption, including lack of interoperability, different reporting mechanisms, timing of core sets vs. timing of contracts, and other methodological challenges (especially for small providers). Workgroup members have expressed a preference for case studies, 'cheat sheets', and smaller digestible guides/information instead of larger reports in order to implement the core sets. AHIP noted that these meetings are open to non-members and the public.

During the discussion, one group member expressed interest in seeing an environmental scan to understand implementation and directives around quality at the state level (e.g. commissions, charters, etc.) NQF noted that there was an environmental scan performed (available on the CQMC website) which found that many states are focused on CMMI state-wide improvement but have not gotten to the implementation stage yet. Another group member echoed the importance of understanding implementation challenges for small providers and expressed that a tool to

automatically pull relevant health data from electronic records and to set up a central data repository across multiple payers could be helpful.

Due to time constraints, the group was unable to discuss a future communication strategy, but Ms. Nwosu and Ms. Lloyd announced that AHIP would likely host a webinar in the future to discuss coordination of communications.

Closing Remarks and Next Steps

AHIP, NQF, and CMS thanked participants for attending and advised that a meeting summary would be circulated later. They noted that remarks from Deputy Secretary Hargan, as well as discussion throughout the day, reinforced the importance of measure alignment for improved quality of care and reduced burden on providers, and reiterated the importance of CQMC's work towards the aligned core sets.