CQMC Core Quality Measures Collaborative

# Meeting Summary

## Core Quality Measures Collaborative (CQMC) Health Equity Workgroup Web Meeting 3

The National Quality Forum (NQF) convened a public web meeting for the CQMC Health Equity Workgroup on June 30, 2022.

### Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting and introduced the co-chairs (provider co-chair Dr. Rama Salhi and payer co-chair Dr. Sai Ma) who also provided welcoming remarks. NQF staff reviewed the antitrust statement as well as 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 and reviewed the following meeting objectives:

- Review results of applying the approach to identify disparities-sensitive measures in the CQMC core sets
- Discuss strategies for addressing disparities observed in the CQMC measures
- Explore future opportunities for the CQMC to advance health equity

### CQMC Overview, Review Health Equity Workgroup Objectives, and Recap Previous Meeting

NQF staff provided an overview of the background and aims of the CQMC. The goal of the CQMC is to develop and recommend core sets of performance measures and measurement initiatives that should be prioritized for use across the nation and aimed to improve the quality of healthcare for all. To date, the CQMC has created ten core sets in various clinical areas, ranging in size from five measures (Neurology core set) to 27 measures (Cardiology core set).

NQF staff reviewed the Health Equity Workgroup's overall objectives for this year's work:

- Identify current measures in the CQMC core set that are disparities-sensitive
- Prioritize existing health equity measures for use across payers in value-based contracts
- Define domains to categorize measures for the CQMC that promote health equity measurement
- Recommend strategies for methods that will enable identifying and prioritizing disparities observed within measures comprising CQMC core sets
- Outline future opportunities for the CQMC to advance health equity measurement

Next, NQF staff shared a brief recap from the previous Health Equity Workgroup meeting where the following objectives were discussed:

- Aligning on an updated approach for identifying disparities-sensitive measures in the CQMC core sets
- Refining domains that categorize measures that promote health equity

- Reviewing available measures that promote health equity that align with CQMC's measure principles

Themes from Workgroup's discussions included concerns about insufficient testing in populations disproportionately affected by social risks, particularly in gap areas, as well as concerns with disparities measurement frequently being performed with inappropriate analytic methods.

## Review CQMC Disparities-Sensitive Measures and Discuss Strategies for Addressing Disparities Observed in CQMC Measures

NQF staff reminded the Workgroup about the updated approach to identify a CQMC measure as disparities sensitive (Figure 1). It was noted that this approach is based on literature reviews and feedback from the Workgroup.

For this approach, a CQMC measure is considered to be disparities-sensitive if (1) it is within one of the identified priority clinical areas OR it addresses a measurement area associated with disparities, and (2) the measure meets certain predefined measure characteristics.

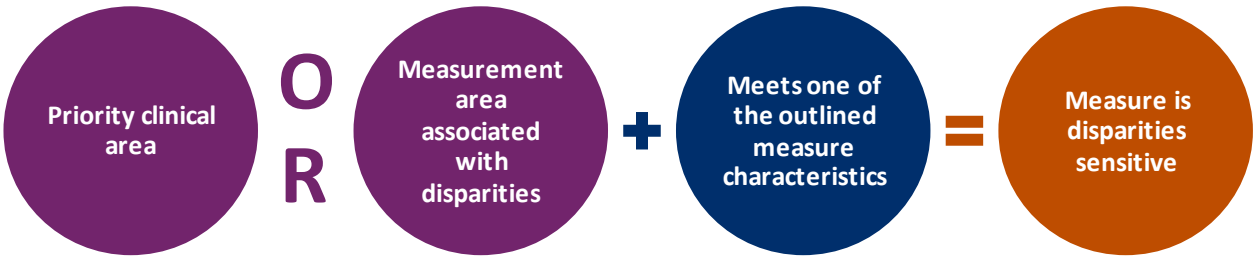


**Figure 1**: Updated Approach for Identifying Disparities-Sensitive Measures in the Core Set

### *Priority Clinical Area*

NQF staff noted the priority clinical areas were identified by reviewing the CMS Framework on Health Equity Report, OMH Focus Areas, and AHRQ 2021 National Healthcare Quality and Disparities Report. The priority clinical conditions are as follows:

- Substance use disorder (e.g., opioid use)
- Cardiovascular disease (e.g., hypertension, congestive heart failure)
- Maternal and infant health
- Sickle cell disease and trait
- Diabetes (e.g., prevention of peripheral artery and kidney disease)
- Lupus
- Cancer (e.g., stomach, liver, and cervical)
- Dementia and Alzheimer's
- Asthma
- Behavioral health (e.g., major depressive diagnosis or episode)
- HIV/AIDS

- COVID-19

NQF staff shared that the list of conditions includes larger topic areas (e.g., cardiovascular disease and behavioral health) that overlap with measures within existing CQMC core sets, and some areas (e.g., lupus and sickle cell anemia) that do not have measures within the 2021 CQMC core sets.

### *Measurement Areas Associated with Disparities*

To identify measurement areas associated with disparities, NQF staff referenced the RWJF's 2011 Commissioned Paper: Healthcare Disparities report and NQF's 2012 Disparities-Sensitive Measure Assessment. The specific topic areas included were:

- Transitions (e.g., discharge, referral)
- Readmissions
- Patient/Consumer Surveys
- Patient Reported Outcomes (e.g., depression assessments)
- Patient Education
- Screening
- Communication-Sensitive Services (e.g., care coordination)
- Care with a High Degree of Discretion (e.g., practices that do not have a standard protocol)
- Social Determinant-Dependent Measures (e.g., measures that are linked to social risks)

### *Measure Characteristics*

NQF shared that the modified approach to identify disparities-sensitive measures also includes assessing whether the measure met at least one of the measure characteristics outlined in NQF's 2017 A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. This report considers the following measure characteristics to further disparities-sensitivity evaluation:

- Measures for which the denominator includes many patients affected by a social risk factor or set of risk factors
- Measures for which the denominator is specified for non-inpatient settings (i.e., focus on ambulatory care settings)
- Outcome measures where there is a clear link between the outcome being measured and a set of actions

## Findings for Disparities-Sensitive Measures in CQMC Core Sets

The table below includes the initial preliminary summary of the findings for applying the approach to the existing CQMC core sets. The approach identified 136 out of 150 CQMC measures as disparities sensitive. NQF noted that the numbers for each category may change based on feedback from the meeting's discussions as well as CMS and AHIP. NQF shared that some core sets (e.g., Behavioral Health, HIV/Hep C, Cardiology) include measures that were all identified as disparities sensitive. NQF staff also highlighted that there were 14 measures that were not identified as disparities-sensitive because they either did not assess a priority clinical condition and/or assess a measurement area not associated with disparities or did not meet one of the measure characteristics. For example, a measure topic area could be related to screening (i.e., measurement area associated with disparities) but if the measure denominator is not specified for patients impacted by social risk, is specified for an inpatient setting, and is a process measure, then the measure is not considered to be disparities sensitive. NQF staff shared that the Workgroup would have an opportunity to review and provide feedback on the measure scan, noting it will include specifics for each individual measure and their designation.

| CQMC Core Set | Meets 3 Measure Characteristics | Meets 2 Measure Characteristics | Meets 1 Measure Characteristic | Not Disparities Sensitive | Total Measures in Core Set |
|---|---|---|---|---|---|
| **ACO/PCMH/ Primary Care** | 3 | 10 | 6 | 3 | 22 |
| **Cardiology** | 4 | 20 | 3 | 0 | 27 |
| **Gastroenterology** | 0 | 3 | 5 | 0 | 8 |
| **HIV/Hepatitis C** | 1 | 6 | 1 | 0 | 8 |
| **Medical Oncology** | 3 | 7 | 6 | 1 | 17 |
| **OB/GYN** | 4 | 11 | 3 | 1 | 19 |
| **Orthopedics** | 0 | 13 | 4 | 3 | 20 |
| **Pediatrics** | 0 | 2 | 4 | 6 | 12 |
| **Neurology** | 0 | 2 | 3 | 0 | 5 |
| **Behavioral Health** | 2 | 6 | 4 | 0 | 12 |
| **Total** | **17** | **80** | **39** | **14** | **150** |

NQF staff then shared a few examples of strategies for addressing disparities-sensitive measures based on previous Workgroup discussions, including

- Prioritize the measure to dedicate resources by:
  - Obtaining input from the target population about which measures are most important
  - Considering the impact of the disparity, or how much benefit is missed based on differences in treatment
  - Evaluating screening and outcome measures together
- Use data stratification to assess disparities for:
  - Internal quality improvement purposes among providers
  - External accountability with payer programs
- Assess stratified results to inform setting benchmarks
- Recommend modifications to measure specifications to enable stratification

## Feedback on the Findings for Disparities-Sensitive Measures in CQMC Core Sets

A co-chair opened the discussion by asking the Workgroup to provide feedback on considerations related to the findings of applying the approach to identify disparities-sensitive measures in CQMC core sets. A Workgroup member raised concerns about the 14 measures that were identified as not disparities sensitive, as the causes of disparities are systemic therefore all measures should be stratified. The member suggested aligning the full measure sets for stratification and review. Another Workgroup member noted there are 150 measures in the CQMC core sets and wondered if it might be helpful to prioritize these measures in some way. However, the member noted most measures have some level of disparity and stratifying all measures would be helpful for making informed decisions. Another Workgroup member agreed the measures are on a continuum and have some level of disparities

sensitivity. The member also noted that from a practical perspective, prioritizing the measures to identify where organizations can start to address disparities would be helpful. A suggestion from a Workgroup member was to rename the 14 measures not identified as disparities sensitive to, "unmeasured disparities," or something similar, to indicate there may be disparities but they have not been measured yet or to indicate more resources are needed in those areas to assess disparities.

Another member commented about their experience at Massachusetts General Hospital, where they stratified core quality metrics by race, ethnicity, and language but found there were no disparities because there had already been a focus on improving those metrics. The member shared that when reviewing the literature, the areas associated most with disparities are not aligned with existing core quality metrics. The Workgroup also shared it is difficult to assess these preliminary findings without reviewing the individual measures in the core sets, noting that reviewing the core set as a whole and evaluating it against the literature may help with prioritizing the measures. NQF staff agreed and shared that the detailed findings from the measure scan will be sent to the Workgroup for their review and feedback after the meeting. A Workgroup member acknowledged the importance of prioritizing the measures and suggested possibly starting with the measures that meet the three measure characteristics and/or select those measures that have the largest performance gaps between different populations. A co-chair raised concerns about some CQMC core sets (e.g., Pediatrics, Neurology, Orthopedics) including measures that did not meet three measure characteristics and asked if, for those CQMC core sets, should measures that meet two measure characteristics instead be prioritized. A Workgroup member agreed, noting specialty care is often not as diverse as primary care, so could be related to having more disparities-sensitive measures in those specialty areas. A Workgroup member suggested prioritizing measures with greater impact and adding ease of measurement (e.g., electronic extraction).

A co-chair then transitioned the discussion to considering the terminology that should be used to categorize the measures. A Workgroup member noted every measure is potentially disparities sensitive so categorizing the measure as very sensitive and at high risk of adverse outcomes might be helpful. For example, maternal morbidity and mortality are at high risk for adverse outcomes related to disparities versus patients getting an appointment within a certain time frame might be lower risk of having an adverse outcome. A member added that there is also a consideration about, for example, immediate adverse outcomes with high-risk obstetrics versus long-term adverse outcomes with processes such as colon cancer screenings. Another member suggested that further evaluating the reasons related to missed appointments may also relate to evaluating the adverse outcome risks. The Workgroup noted that the terminology and categorization of the disparities sensitive CQMC measures might become clearer after reviewing the measures in detail.

The Workgroup then discussed additional strategies to address disparities-sensitive measures within the CQMC core sets. A Workgroup member shared that the strategies presented were a good start, suggesting the strategies should be considered in an iterative approach to successfully be implemented. The member also suggested obtaining input from the target population to identify the groups where the disparities are more prevalent or acute. The member noted the importance of the measures being tested for the groups with highest disparities as well to ensure reliability and validity of the data. Additionally, a member agreed on the iterative process and suggested providing "how to" resources about what organizations should look for when stratifying data and how to use the data since these strategies would be implemented differently based on the population. The member shared the ideal audience for the "how to" guide could include providers, data analytics teams, office managers, or others who are able to stratify and evaluate their data. A co-chair noted that a "how to" resource to tackle disparities and how to improve them may be out of scope for this project but suggested the

Workgroup could explore high-level first steps such as the variables that would be helpful for measure stratification.

Another member suggested evaluating the measures based on how much could be gained rather than evaluating it from a deficit perspective. Additionally, a Workgroup member cautioned assigning accountability for disparities to specialty areas as no single specialty should be accountable, rather the entire care team should be accountable. A member noted how data stratification can be used to addresses social determinants of health (SDOH) to focus more on clinical outcomes rather than a quality improvement process. The Workgroup noted the limitations of existing socioeconomic status data are a challenge to clearly identifying gap areas. A member noted that NQF's Best Practices for Developing and Testing Risk Adjustment Models project has developed Technical Guidance that includes best practices for functional and social risk factor adjustments in measure development and this could be referenced in this Workgroup's work.

A Workgroup member advocated for identifying some orthopedic measures as disparities sensitive. The member highlighted these specialties are often not included but they provide opportunities to improve person-centered outcomes when patients have access to the procedures (e.g., improved pain when walking after a hip replacement surgery).

Another Workgroup member noted the importance of ensuring measures are reliable when the data are stratified, particularly if the measures will be used for accountability. The member also noted reliable data stratification will be important for both internal quality improvement and external accountability. Additionally, a Workgroup member shared that their organization is designing a pay for equity program that stratifies race and ethnicity. One of the main principles in the design is to ensure each racial category improves or maintains their results instead of one category being penalized when improving another category. The member also highlighted that smaller organizations may not have the resources to collect or evaluate their own disparities data. To counteract this, the program design includes provider incentives to collect data at the point of care. The member also shared that their work has shown that using high-quality imputed data aligns to help those organizations illustrate the disparities in their community.

A Workgroup member emphasized the need for a pathway to assist organizations with starting to evaluate and address disparities in their populations. The member noted the importance of including complex patients which multiple dimensions of disparities when testing measures rather than focusing on only one dimension. Another member agreed that it would be helpful to have a guide that includes levels of actions to address disparities based on the number of resources the organization has, noting large health systems will have more resources than a small critical access hospital.

## Explore Future Opportunities for the CQMC to Advance Health Equity

NQF staff provide a recap of the 32 health equity measures and measure concepts that were discussed in the previous Workgroup meetings. The measure selection principles were applied to each measure to ensure alignment with the CQMC focus on the clinician level and outpatient measurement for value-based payments (VBP). The table below includes the 12 measures that were identified at a clinician, facility, or health plan level of analysis.

| Domain | Existing Health Equity Measures and Measure Concepts |
|---|---|
| **Social Needs/Risks** | • Screening and Referral for Transportation Insecurity<br>• Social Determinants of Health Screening<br>• Screen Positive Rate for Social Drivers of Health *(measure concept)*<br>• Screening for Social Drivers of Health *(measure concept)* |
| **Access** | • NQF #1896 Language Services Measure Derived from Language Services Domain of the C-CAT *(endorsement removed)*<br>• NQF #1824 L1A: Screening for Preferred Spoken Language for Health Care *(endorsement removed)*<br>• Patient-Centered Medical Home Patients' Experiences (related to parents/guardians' ability to get the care their child needs during evenings, weekends, or holidays) |
| **Quality of Care** | • NQF #0520 Drug Education on All Medications Provided to Patient/Caregiver During Short Term Episode of Care *(endorsement removed)*<br>• Adverse Outcome Index |
| **Enablers of Cultural Responsiveness** | • NQF #1904 Clinician/Groups Cultural Competence Based on the CAHPS Cultural Competence Item Set *(endorsement removed)*<br>• Hospital Commitment to Health Equity *(measure concept)* |
| **Equity Ecosystem** | • A Minimum of 3% of Total Enrollment Shall be Served by Community Health Workers or Similar Support Workers |

A co-chair asked the Workgroup for feedback regarding the health equity measures that were identified. A member suggested to develop a separate health equity core set which would be helpful to establish the health equity initiatives in relation to the current core sets. Another Workgroup suggested that instead of adding new measures to the core set one approach would be to stratify the existing measures. The co-chair clarified that the existing health equity measures directly assess the drivers of health equity (e.g., social needs assessment, access), as opposed to a different view of current clinical measures (e.g., stratification).

A member shared that screening for transportation insecurity is captured as part of special needs plans (SNP) by CMS rule. The member explained that a challenge to an individual beneficiary is that they can be screened for social needs multiple times within a short period of time, creating individual levels of burden and redundancy. A representative from the public agreed with the member and suggested the potential use of social vulnerability index (SVI) data mapping against hospital service areas and/or Medicare claims data.

A member suggested that the integration of health equity measures and concepts is preferred over creating a separate core set to best illustrate equity within the current clinical core sets as opposed to additional work (e.g., viewed as extra work versus it being integrated into the day-to-day). It was suggested that since not all CQMC core sets are specialty focused, NQF could explore adding all health equity measures to the Accountable Care Organization/Person-Centered Medical Home/Primary Care [ACO/PCMH/PC] core set since it accounts for the whole person. A member shared that the CQMC core set also included primary care and would essentially result in placing the onus on primary care providers. A member agreed and commented that from a traditional viewpoint, the ACO is considered the primary care physician (PCP). The member suggested that the field is moving toward team-based care, resulting in the reduction of burden on primary care providers. A member shared that the CQMC

ACO/PCMH/PC core set was developed as one to create alignment for all three areas and that ACO attribution methodologies are traditionally linked to primary care.

A member asked if the CQMC core measure sets are maintained on an annual basis. NQF shared that the CQMC core sets go through a full maintenance process on an annual basis to ensure that the measures continuously align with the measure selection principles. A member asked how to treat the health equity measures from this list that have different statuses (e.g., endorsement removed, measure concepts). NQF shared that the CQMC measures do not have to be endorsed to be considered, but will need to be scientifically sound and publicly available.

The co-chair asked which gaps should be prioritized to promote health equity in the CQMC. A member shared that the focus is to identify gap areas that encourage measure developers to create measures in the future to address those gaps. A member suggested that the Workgroup should consider incorporating community metrics that inform the work at a patient level. A co-chair responded that the "Equity Ecosystem" domain captures the second level community and could identify additional gaps. Another member commented on a process for including system-level measures for interpreters and translation services to assess communication with patients. NQF staff thanked the co-chairs and the Workgroup members for their discussion.

## Public Comment

NQF staff opened the web meeting to allow for public comment. There were no comments from the public.

## Next Steps

NQF staff shared that the Health Equity Measure Scan will be updated based on the discussion and feedback from the Workgroup, CMS, and AHIP. NQF staff will draft the final Health Equity Report which will be shared with the Workgroup during the public comment period in early August. NQF staff will work to schedule the last meeting of this year for late August. NQF staff and the co-chairs thanked the Workgroup for their attention and engagement before adjourning the meeting.