CQMC Core Quality Measures Collaborative

Meeting Summary

Core Quality Measures Collaborative Health Equity Workgroup November Web Meeting

The National Quality Forum (NQF) convened a public web meeting for the Health Equity Workgroup on November 17, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

Chelsea Lynch, Director, NQF, welcomed the participants to the meeting and introduced the co-chairs of the Health Equity Workgroup, who provided welcoming remarks. Ms. Lynch reviewed the antitrust statement and acknowledged that the Core Quality Measures Collaborative (CQMC) is a member-funded effort with additional support from the Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

Ms. Lynch summarized the results of the Health Equity Workgroup's prior work. The Health Equity Workgroup identified disparities-sensitive measures within CQMC core sets and also identified existing health equity measures and measure concepts that might be relevant to the core sets. The workgroup identified 137 out of 150 core set measures as disparities-sensitive and began to explore possible considerations for further prioritizing these measures to help organizations focus resources to identify and address disparities.

During the next two meetings, the workgroup will identify these approaches for further prioritization of the disparities-sensitive measures. The workgroup will also identify health equity measures that should be considered for inclusion in the core sets. Between the web meetings, NQF staff will apply these approaches to the Pediatrics and Cardiology core sets to exemplify how the approaches impact the core sets. Results will be reviewed and discussed during the February web meeting. These efforts will lay the foundations for future work which may include applying these prioritization approaches and health equity measure recommendations to the other core sets.

Ms. Lynch reviewed the following meeting objectives:

- Provide feedback on approaches to further prioritize disparities-sensitive measures in the CQMC core sets
- Provide feedback on approaches to identify health equity measures for individual CQMC core sets

Discussion on Approaches to Further Prioritize Disparities-Sensitive Measures in CQMC Core Sets

Ms. Lynch reviewed the approach that was used to identify disparities-sensitive measures in CQMC core sets (see Figure 1). A CQMC measure is considered disparities-sensitive if the topic area of the measure is within one of the identified priority clinical areas OR the measure assesses a measurement area associated with disparities. Additionally, the measure must also meet one of three outlined measure

characteristics. The measure characteristics are based on whether the measure's denominator includes (1) patients disproportionally affected by social risks compared to the general population, (2) The measure is specified for ambulatory settings, and (3) The measure is classified as an outcome measure.

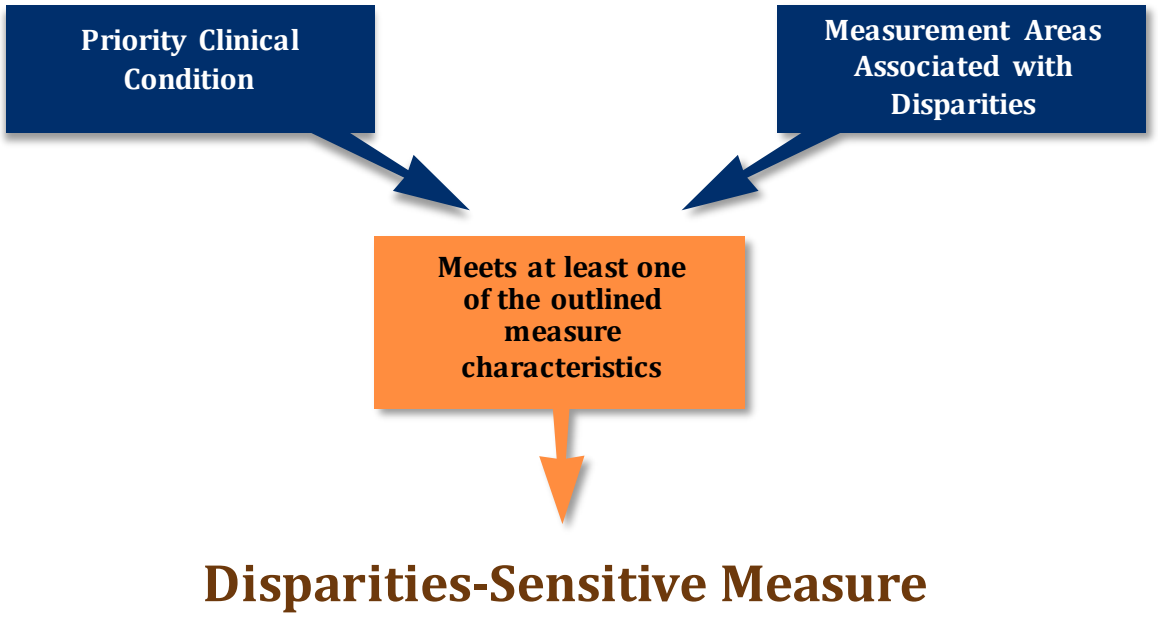

Figure 1. Approach to Identify Disparities-Sensitive Measures Within the CQMC Core Sets

Ms. Lynch reminded workgroup members that this approach identified 137 of 150 CQMC measures as disparities-sensitive, noting that the remaining 13 measures may also be disparities-sensitive but were not captured by the criteria used in this approach.

The Health Equity Workgroup previously identified several potential criteria to further prioritize the disparities-sensitive measures for action. Ms. Lynch reviewed the following criteria, categorized into impact-based and feasibility-based groupings:

- **Impact-based criteria**
  - broadly applicable measures (measures used in multiple core sets or identified as cross-cutting in previous CQMC work)
  - measures used in multiple value-based programs (VBPs)
  - outcome measures
  - evidence of disparities
- **Feasibility-based criteria**
  - measures that meet three measure characteristics from the initial approach
  - electronically extracted data

While evidence of disparities was included as a critical impact-based criterion, Ms. Lynch clarified that this may be considered for future initiatives based on data availability.

Ms. Lynch reiterated that the criteria preferred by the Health Equity Workgroup in discussions will be applied to the CQMC Cardiology and Pediatrics core sets in advance of the February web meeting. These core sets were selected based on the results of applying the initial disparities-sensitive approach to the core sets. For the Cardiology core set, all measures were identified as being disparities-sensitive with a balance of measures meeting the three measure characteristics from the approach. For the Pediatrics core set, only half of the measures were identified as being disparities-sensitive, yet Health Equity

Workgroup members noted that some of the measures are associated with known disparities. Members of the Cardiology and Pediatrics Workgroups are invited to participate in these web meeting activities. During the February meeting, Health Equity Workgroup members and members of the Cardiology and Pediatrics Workgroups will provide feedback on the results and make additional recommendations for approaches to prioritize disparities-sensitive measures within each core set.

Dr. Rama Salhi, Health Equity Workgroup Co-chair, opened the discussion to workgroup members by soliciting feedback on the list of potential criteria.

Workgroup members discussed the criterion of use in multiple VBPs. Workgroup members expressed concern that measures must be demonstrated as valid at the clinician level of analysis if intended to be used at that level. Members also questioned if this criterion could result in emphasizing payment and accountability instead of improvement, which could preclude the sharing of best practices. Dr. Sai Ma, Health Equity Workgroup Co-chair, clarified that this criterion does not indicate that the workgroup will decide which level of analysis a measure applies to, but rather, if an identified disparities-sensitive CQMC measure is already in use in multiple VBPs, the measure will be prioritized over those only applicable to one VBP. Other workgroup members noted that this criterion would likely be focused on ambulatory care due to the measures included in CQMC core sets, but would allow for greater alignment in the future if these measures are also used in different settings across multiple VBPs. This may be particularly beneficial for patients who cross multiple specialty areas or present at multiple care settings. One member commented that, while they are comfortable including the VBP criterion, without data, it would be difficult to know if there are any variances in disparities or patient experiences between value-based and non-value-based contracts. Workgroup members discussed whether this criterion should be a "must-have" requirement or considered as an "extra point" for prioritization. One member offered that prioritization could be built on a point system of these criteria.

Dr. Salhi solicited any additional prioritization criteria that should be considered. One member suggested that prioritization criteria should include patient-centeredness or impact on patient engagement.

Workgroup members commented that while outcome measures are critical for capturing impact, process measures play an important role in improving outcomes. Many measures that are disparities-sensitive, such as access to services or eligibility, are process measures. Several workgroup members commented that this criterion should be removed, however, one member expressed that examining outcome measures was still valuable even when disparities may be attributable to processes. Workgroup members noted that for best assessments of impact, process measures and outcome measures should be coupled, or additional links should be built between process, outcome, and structural measures for a balanced evaluation of impact.

Several workgroup members noted the continued importance of data-based evidence, but acknowledged the feasibility challenges of extracting these data, even with the use of some electronically available data. One member promoted the use of feasibility-based criteria, noting that these allow for faster changes that can positively impact patients.

Discussion on Approaches to Identify Possible Health Equity Measures for CQMC Core Sets

Ms. Lynch noted that all CQMC measures are based on CQMC measure selection principles (PDF), and each core set is intended to align quality measures that are used by public and private payers in value-based programs, with a focus on what measures can be used for accountability that outpatient clinicians

can influence. Core sets typically focus on ambulatory care measures that have been tested and specified at the clinician level of analysis.

The Health Equity Workgroup previously identified 11 health equity measures and measure concepts that could be considered for addition to the CQMC core sets, falling into five domains of equity measurement:

- enablers of cultural responsiveness
- access
- social needs/risks
- quality of care
- equity ecosystem

Person-centered care; patient, family, and caregiver engagement; and disparities sensitivity are integral to these domains.

Ms. Lynch also reviewed the draft principles for prioritizing health equity measures for value-based care shared by AHIP in the prior web meeting. The principles focus on prioritizing health equity measures for value-based care, and include:

- Measures meaningfully advance health equity or reduce healthcare disparities with strong level of evidence necessary to include in value-based pay arrangements;
- Measures are unlikely to promote unintended adverse consequences;
- Measures are fully developed, accepted, and implemented measures (e.g., NQF-endorsed, in use by health plans and/or CMS/states, used by NCQA or other similar entities);
- Measures should represent a balanced mix of process, outcome, and structural measures;
- Measures should be implementable in value-based purchasing or alternative payment models;
- Measures should be within the locus of control of the measured entity;
- Measures should incentivize the reduction of disparities while protecting the safety-net; and
- Measures should balance between innovation and feasibility while minimizing burden.

Dr. Ma opened discussion about health equity measures for possible inclusion into the CQMC core sets, asking workgroup members to consider if these measures should be standard for all core sets or condition-specific, and to share any additional considerations for the selection of health equity measures for the core sets.

Workgroup members reflected on the challenges facing providers when implementing screening measures such as those included in the list of 11 health equity measures and measure concepts. Providers who screen without sufficient resources to address patient needs risk furthering harm and increasing distrust in the healthcare system. Additionally, workgroup members noted that any screening tools must be psychometrically valid. One member noted that stratifying these measures to view performance can allow for evaluation of how providers are performing in their unique environments, whether or not resources are available. Another member cautioned that when stratifying these measures, thresholds should not be set in a way that targets majority performers and ultimately increases gaps that leave lower performers further behind. Workgroup members discussed the importance of including screening tools both in terms of specific needs (language/interpreter needs, barriers such as transportation to care, etc.) and in terms of broader health equity summary score

screening tools, such as the CMS Health Equity Summary Score (HESS) that could summarize the extent to which individual measures or patient experiences from a given provider can vary across populations.

A Health Equity Workgroup member raised questions about how the information acquired from these measures will be used in the context of CQMC work. Ms. Lynch clarified that the prioritization process for disparities-sensitive measures will be a starting point to identify where organizations can dedicate initial resources for stratification and improvement. A workgroup member also noted that most measures are not stratified, and conversations could be initiated with measure developers based on this prioritization to align on stratification approaches and begin assessing differential outcomes in future work.

Public Comment

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

Next Steps

Ms. Lynch reminded participants that the next web meeting of the CQMC Health Equity Workgroup will take place on **February 16, 2023 from 1:30-3:30pm ET**. Participants should register for the web meeting in advance of the event. Workgroup members can share any additional health equity measures or other comments with the team before that time by emailing CQMC@qualityforum.org. The co-chairs and Ms. Lynch thanked participants for their time and adjourned the meeting.