CQMC Core Quality Measures Collaborative

# Meeting Summary

## Implementation Workgroup Web Meeting 1

The National Quality Forum (NQF) convened the Core Measures Quality Collaborative (CQMC) Implementation Workgroup for a web meeting on February 19, 2020.

### Welcome, Review of Web Meeting Objectives and Disclosures of Interest

Co-chairs Rajesh Davda and Sarah Dinwiddie introduced themselves and provided welcoming remarks to the workgroup members and general public.

Nicolette Mehas, NQF Director, welcomed the workgroup and reviewed the meeting objectives:

- An overview of the CQMC project scope and workgroup charge
- Review of past work and current measure sets
- Identification of sources for report

Maha Taylor, NQF Managing Director, reviewed the DOI's with the workgroup members.

### Overview of the CQMC and Workgroup Charge

Ms. Mehas reviewed the background and aims of the CQMC, current measure sets, project approach, and timeline. NQF, in collaboration with Centers for Medicare and Medicaid Services (CMS) and America's Health Insurance Plans (AHIP), will convene the core set workgroups over a series of web meetings to maintain the core sets, identify priority areas for new core sets, prioritize measure gaps and provide guidance on dissemination and adoption of the core sets.

The Implementation workgroup will convene for four web meetings to develop an implementation guide that addresses:

- Guidance on technical aspects of core set implementation for payment and quality reporting purposes
- Strategies to encourage buy in among clinicians, provider facilities, and consumers
- Strategies to increase core set adoption to raise awareness and increase stakeholder knowledge

## Review of past CQMC work

Ms. Mehas shared the Principles for measures included in the CQMC core measure sets as follows:

- Advance health and healthcare improvement goals and align with stakeholder priorities.
    - *Address a high-impact aspect of healthcare where a variation in clinical care and opportunity for improvement exist.*
- Are unlikely to promote unintended adverse consequences.
- Are scientifically sound (e.g., NQF-endorsed or otherwise proven to be evidence-based, reliable, and valid in diverse populations).
    - *The source of the evidence used to form the basis of the measure is clearly defined.*
    - *There is high quality, quantity, and consistency of evidence.*
    - *Measure specifications are clearly defined.*
- Represent a meaningful balance between measurement burden and innovation.
    - *Minimize data collection and reporting burden, while maintaining clinical credibility (i.e., measures that fit into existing workflows, are feasible, and do not duplicate efforts).*
    - *Are ambitious, yet providers being measured can meaningfully influence the outcome and are implemented at the intended level of attribution.*
    - *Are appropriately risk adjusted and account for factors beyond control of providers, as necessary.*

Ms. Mehas shared the Principles for the CQMC core measure sets as follows:

- Provide a person-centered and holistic view of quality, including consideration of Social Determinants of Health (SDOH) and experience of care.
- Provide meaningful and usable information to all stakeholders.
- Promote parsimony, alignment, and efficiency of measurement (i.e., minimum number of measures and the least burdensome measures).
- Include an appropriate mix of measure types while emphasizing outcome measures and measures that address cross-cutting domains of quality.
- Promote the use of innovative measures (e.g., eMeasures, measures intended to address disparities in care, or patient-reported outcome measures).
- Include measures relevant to the medical condition of focus (i.e., “specialty-specific measures”).

Ms. Mehas provided an overview of the Core Set Progress to Date as follows:

- NQF convened the CQMC to update the existing eight core sets
- CQMC workgroups, made up of subsets of CQMC members with expertise in the respective topic areas, reviewed new measures that could be added to the core sets to address high-priority areas
- Workgroups removed measures that no longer show an opportunity for improvement, do not align with clinical guidelines, or have implementation challenges
- HIV/Hepatitis C and Gastroenterology workgroups finalized their maintenance discussion and voted on measures to be added or removed from their respective existing core sets. Voting results for the two workgroups were presented to the Steering Committee and are waiting to be presented the Full Collaborative for final approval in early 2020.
- Voting for the Cardiology, Orthopedics, and Pediatrics core sets was finalized and is awaiting presentation to the Steering Committee and Full Collaborative in early 2020.
- The Medical Oncology, Accountable Care Organization (ACO), and Obstetrics and Gynecology workgroups are yet to finalize their maintenance discussion. Finalization of the maintenance

discussion for the three workgroups is expected to take place in early 2020 with all voting to be completed by spring 2020.

## Discussion on Potential Sources for Implementation Guide

Ms. Mehas shared with the workgroup that during the initial environmental scan staff identified the following potential sources for the implementation guide: existing input from CQMC workgroups, scan of publicly available information, input from the Implementation Workgroup, other sources identified through the work of the Workgroup.

The workgroup started with some questions to frame the discussion. They wondered if there was information currently available about usage of the core sets and measures within those sets. AHIP responded that they conducted a survey of health plans and usage varies by set with usage generally highest for ACO and pediatrics and lower for gastroenterology and pediatrics. The survey results contain data at the measure level, but AHIP has concerns about the ability to identify individual survey responses if data are shared for low-use measures. AHIP further clarified that the survey results are not finalized yet and that additional information would be shared in the future.

The discussion then turned to potential sources for the guide. A workgroup member shared that the Catalyst for Payment Reform has created a set of implementation resources for self-funded employer groups to use. Another workgroup member recommended reaching out to the Accountable Care Learning Collaborative, which is planning to publish some implementation information. A member mentioned that there have been several learning collaboratives over the years that have looked at implementation issues and that collecting the result and the information published would be useful to assembling the guide.

Several workgroup members urged CQMC to carefully consider how it frames and publishes materials around implementation. These members all had experience creating or using information around implementation and stated “bite-sized” information, such as infographics, blogs, cheat sheets, and one-pagers, was more useful than consolidated comprehensive documentation. They advocated for simple and straightforward communications. In addition to formal guide or white-paper information, the workgroup recommended providing step-by-step information and technical assistance during implementation. Workgroup members expressed a desire for examples and case studies of implementation, providing information both on what went well and on pitfalls to avoid. They would like to learn about how other organizations overcame barriers and unintended consequences during implementation, issues around burden, how to interpret results, and how use of the measures has helped practices and patients.

Workgroups members also offered advice on messaging around the core sets and what types of information might help increase usage. They stressed that providers must find measures and sets useful to their work and that providers will compete to improve performance on meaningful measures, even in the absence of financial incentives. Several members mentioned that greater transparency into the methods and methodology of the CQMC core set development would be useful. They stated that improved visibility into the methods would increase the credibility of the work. Members described the processes their organizations use to arrive at decisions regarding which measures to use and stated knowing the development methodology that the core sets had followed would be useful during these discussions. There was broad support across the group for measure alignment with individuals from state Medicaid, CMS, commercial payers, and provider organizations all indicating measure alignment is important to their organizations.

To preface a discussion around barriers to implementation, Ms. Mehas provided an overview of themes around barriers to implementation as provided by the core set workgroups:

- Lack of interoperability/clinical data availability (most mentioned)
- Methodological challenges when measures reported at individual or group level
- Challenges related to confidence intervals and reliability
- Challenges of different reporting mechanisms and benchmarks (eMeasure vs web vs registry)
- Some core measures have little room for improvement
- Variation in measure specifications and use of measures
- Timing of core sets vs timing or contracts, need to repeatedly promote core sets
- Core sets need to cover a meaningful proportion of care provided to be useful

The workgroup first discussed interoperability and clinical data availability. A representative from CMS shared that they hear from state Medicaid agencies that it is very difficult to implement measures with electronic clinical quality measure (eCQM) specifications or clinical data requirements, especially at the provider level. It's challenging for these organizations to "roll up" results from these measures as well. A workgroup member added that it's a multi-issue problem. They stated some smaller electronic health records (EHRs) don't have the measures embedded in their products and may not have the ability to capture necessary fields for measure calculation. Some provider organizations don't have the ability to mine their data and may not have access to technical resources. Even though consultants and vendors may be available to help with data capture and mining, it can be expensive to hire these resources. The member also stated that certified EHRs may only have the most popular measures embedded, such as health effectiveness and data information systems (HEDIS) measures but have a gap when it comes to smaller and more specialized measures. A large commercial payer shared that even where interoperability standards exist, such as in lab values, collecting data using Health Level Seven (HL7) standards has been difficult. The workgroup noted that increased alignment around core sets should send a more unified signal to the marketplace and help increase inclusion of core set measures in embedded measure sets.

The workgroup agreed that reporting and benchmarking with different submission methods can be challenging. There's a desire to allow groups to use the easiest reporting mechanism to reduce burden; however, this increases the difficulty of interpreting results. A workgroup member shared that some provider organizations have reported difficulty reporting on registry-based measures because the reporting mechanism is outside of their core platform, requiring data exports for entry, and yielding results that are difficult to integrate back into their systems.

The workgroup touched on the timing of changing or adding measures to contract-based programs. Representatives from CMS reminded workgroup members that CMS has a formal rulemaking-based process for adding measures to its programs. Measures must be proposed for the Measures Under Consideration (MUC) list and then these measures can proceed through the rulemaking process. This process takes place annually. CMS also shared that the Medicaid Core Sets are updated annually as well and workgroup members who participate in the Medicaid Core Set process stated that the group tries to be very mindful of the impact of changes made to the program. A workgroup member shared that for their state's Medicaid waiver program, a six-month lead time for incorporating measures into contracts has appeared to be sufficient; however, once the contracts are finalized, the contracts are in place for a two-year period. A workgroup member noted that NQF-endorsed measures have a three-year review cycle and that this is a predictable update schedule.

The workgroup briefly discussed the challenge of covering a significant proportion of care with core sets. Workgroup members noted that CMS is working on addressing this challenge through the Merit-based Incentive System (MIPS) Value Pathways (MVPs). The number of measures varies greatly by set and the workgroup felt it would be challenging to set a target number of measures to adequately

capture care quality. A workgroup member stated physicians value meaningful measures more than percent of care covered by measures. Another workgroup member pointed out that the more specialized the practice area is, the more difficult it may be to cover the care area with existing measures.

## SharePoint Tutorial/Next Steps

NQF staff briefly introduced the CQMC SharePoint site and shared that all CQMC-related correspondence should be sent to CQMC@qualityforum.org . The workgroup was notified that the next meeting would be held on March 12, where the workgroup would continue discussion implementation issues, including prioritizing the issues. The workgroup will also review and provide insight on encouraging buy-in and promoting core set adoption.