CQMC
Core Quality Measures Collaborative

Meeting Summary

Implementation Workgroup Web Meeting 1

The National Quality Forum (NQF) convened a web meeting for the Core Quality Measures Collaborative (CQMC) Implementation Workgroup on March 15, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants and co-chairs (provider co-chair Dr. Robert Rauner and payer co-chair Dr. Rajesh Davda) to the Implementation Workgroup meeting. The co-chairs provided welcoming remarks. NQF staff reviewed the antitrust statement, as well as acknowledging that the CQMC is a member-funded effort with additional support from Centers for Medicare & Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

NQF staff facilitated roll call by the organization and then reviewed the meeting objectives:

- Provide a brief orientation of CQMC and overview of the previous Implementation Guide work
- Review the 2022 Workgroup goals and objectives
- Discuss the focus areas for the Implementation Guide update

CQMC Overview and Recap of Previous Work

NQF staff reviewed the background and aims of the CQMC, recent accomplishments, current work, and future opportunities. NQF staff shared that the CQMC will convene the new Health Equity Workgroup for their first meeting in early April.

NQF staff discussed the recap of the Implementation work, which started in 2020. As part of this work, the Workgroup convened four times to develop the content for the Implementation Guide. While the primary audience of the Implementation Guide is health plans seeking to implement and/or evolve value-based payment programs, it is also relevant to a broad audience.

The first version of the Implementation Guide identifies four key elements of success for value-based payment programs:

- Leadership and Planning
- Stakeholder Engagement
- Measure Alignment
- Data and Quality Improvement

In 2021, the Implementation Workgroup met twice to refine the Guide, adding content from both Workgroup discussion and key informant interviews. Key insights and promising practices shared by regional quality collaboratives, purchasers, and health plans, as well as approaches to identify and

address disparities were added to the Guide.

NQF staff shared strategies identified during last year's work that could be addressed by the Implementation Workgroup in 2022 or future years.

- Stratification to identify opportunities for improvement, resource allocation, and disparities identification
- Exploring population health through the collection and analysis of social determinants of health (SDOH) data
- Align with meaningful measures (CMS and others) work through identification of promising practices
- Identify strategies to further align with a core set of measures and measure specification for greater adoption
- Align with a core set of measures and measure specifications
- Create a decision tree template that organizations can use to objectively guide measure selection
- Create a plan for improved uptake of criteria for specialty measure selection
- Develop recommendations for incorporating both quality and cost for reporting
- Create recommendations or best practices for using new data sources to support meaningful measurement which promotes scalability
- Identify policy levers
- Select a smaller set of meaningful measures – core measures with early adopter/development measures categorization
- Adopt an Implementation pathway for meaningful measures – recommendations on how to operationalize more complex measures

2022 Implementation Workgroup Goals and Objectives

NQF staff outlined project goals for this year's work. To achieve widespread adoption of parsimonious CQMC measure sets, diverse constituencies must collaborate to find opportunities for alignment, identify critical gaps, and support the adoption of aligned measure sets. The Implementation guide includes guidance on technical aspects of core set r implementation for payment and quality reporting purposes; strategies to encourage buy in among clinicians, provider facilities, and consumers; and approaches to increase core set adoption to raise awareness and increase stakeholder knowledge.

The Workgroup will meet twice (March and early May) to update the barriers, solutions, and strategies included in the Guide. NQF staff asked the Workgroup if there were any questions regarding this year's work. There were no questions raised by the Workgroup members.

Focus Areas for Implementation Guide Update

NQF staff shared that the discussion would be centered around the Elements of Success outlined in version one of the Implementation Guide with the goal of expanding upon barriers, lessons learned, and promising practices from the past two years. NQF staff shared an additional Element of Success, *Using Data to Identify and Address Disparities,* for the Workgroup to consider in the update.

NQF staff shared that one of the potential barriers to adoption and alignment may be that the core sets are too large; a potential solution may be to reduce the size of the core sets in the future. Another barrier previously identified by CQMC members is inconsistent electronic health record (EHR) standards, use, and capabilities. It was suggested that it may be helpful to engage EHR vendors in CQMC work and consider input from the Digital Measurement Workgroup. The next barrier presented was resource limitations in updating and/or adding new measures. A potential solution may be to make a clearer distinction between ad hoc maintenance versus full maintenance of the core sets to understand the resource needs. Additional barriers included a need to define the value proposition for core set usage and the lack of awareness and education regarding the CQMC. The potential solutions include highlighting benefits (e.g., lower burden on providers, better information for payers/purchasers/consumers), increasing the dissemination of CQMC work, aligning with state efforts, and engaging employers.

A co-chair shared that it is difficult to completely align measures and opened discussion on implementation barriers and solutions. A Workgroup member shared that instead of reducing the size of the core sets, the measures withing them could be prioritized using tiering or ranking. This approach would focus on aligning a smaller number of core measures, while also providing some flexibility. The member suggested using criteria such as measurement burden, implementation ability, feasibility, current endorsement status, for example. A Workgroup member asked if the CQMC has reviewed which measures are being used consistently and have been successfully implemented. A co-chair shared different priorities across public and private payers and providers impact adoption rates. Another Workgroup member shared that her organization's value-based payment measure sets include three different tiers of measures. The member explained that category one includes approved quality measures deemed to be clinically relevant, valid, reliable, and feasible; category two includes measures endorsed by major stakeholders but that could have feasibility issues; category three includes insufficient measures that are not feasible to implement at this time.

NQF staff shared the details of the three elements of success which are leadership and planning, stakeholder engagement, and measure alignment. A Workgroup co-chair provided an overview of Nebraska's measure alignment strategies. The co-chair shared their state's project is called ALIGN and includes insurance plan chief medical officers, health systems, Accountable Care Organizations (ACOs), and federally qualified health centers.

CQMC Core Quality Measures Collaborative

Category	ALIGN Measure	NQF	HEDIS
Adult	Diabetes: Hemoglobin A1c (HbA1c) Poor control (>9%)	0059	HBD
-	Hypertension Control <140/90	0018	CBP
-	Colorectal Cancer Screening	0034	COL
-	Breast Cancer Screening	2372	BCS
Pediatric	Immunization 0-2 years, Combo 10 (DtaP, IPV, MMR HiB, HepB, VZV, PCV, HepA, RV, Flu)	0038	CIS
-	Immunization Adolescents, Combo 2 (HPV, Tdap, Meningitis)	1407	IMA
-	Well Child Checks (0-30 months)	1392	W30
Maternal	Prenatal and Postpartum Care	1517	PPC
-	Perinatal Depression Screening	1401	-
Behavioral Health	Unhealthy Alcohol Use: Screening and Brief Counseling	2152	ASF-E
-	Depression Screening (ages 12+)	0418	DSF

(-) dashes represent blank cells on the table

Figure 1: Nebraska's ALIGN Measure Set

Figure 1 is Nebraska's ALIGN measure set developed by their Measure Subcommittee. The co-chair shared that they asked their Measure Subcommittee to prioritize measures, ranking them using a one to five scale. Ten of the 11 measures identified in Figure 1 received top votes from the Measure Subcommittee. Additionally, the same survey was sent to lead physicians in 20 primary care clinics, and the same 10 measures were selected. Measure #2152 Unhealthy Alcohol Use: Screening and Brief Counseling was suggested as an addition because of Nebraska's prevalence of alcohol use.

The co-chair shared that one of the key reasons that quality measure alignment efforts fail is because of a lack of buy-in from clinicians (e.g., physicians, nurses, and/or nurse practitioners). He also shared that health disparities are not only based on race, ethnicity, and income, but can also include disparities between urban and rural geographic locations. For example, the Medicare Quality Improvement Organization (QIO) focused on colon cancer screening and identified disparities based on geographic region. The colorectal cancer screening project in Nebraska included 24 clinics, two hospital systems, and participation from an independent physician network.

A Workgroup member asked why the over 65 population was not included in the evaluation. The co-chair clarified for the purposes of time, the over 65 age group was not included in the presentation, but the project does include patients of all age groups. The member asked about managing exclusions for people with serious illness and if it was evaluated from a performance or cost perspective. The co-chair shared that patients with diabetes and patients with high blood pressure tend to cover the majority of chronic patients in an outpatient setting. This year, the ALIGN project is adding advanced care planning since Nebraska is becoming a Physician Orders for Life Sustaining Treatment (POLST) state and the annual wellness visit rate measure will capture those individuals. Another member inquired about the Use of Imaging Studies for Low Back Pain measure and the reason why it was not

included in the measure set. The co-chair indicated that low back pain is a high-cost diagnosis and is hard to measure from a quality perspective. Similar to the depression readmission measure, it is a useful measure but hard to monitor due to difficulty gathering usable data from multiple electronic health record (EHR) systems.

The co-chair asked the Workgroup members if there were any additional approaches on prioritizing measures to get to a more parsimonious set. A Workgroup member shared the need for building a measure specific evidence base that could be used to prioritize measures that bring the most value (cost and quality) to the population. A Workgroup member shared that they developed a standardized quantitative and objective selection process for advanced primary care measures that identifies measures for inclusion in the final recommended set. NQF staff shared that the CQMC follows the measure selection criteria and measures are selected through a voting process requiring a quorum from major participant perspectives. The co-chair shared that healthcare needs vary from population to population and depend on the medical infrastructure in that region, and that the focus of the CQMC is to clearly prioritize measures to include in sets and to identify the barriers to alignment.

NQF staff shared the *Elements of Success 4: Data and Quality Improvement Support* which identifies the data needs, technical assistance gaps, and reimbursement requirements supporting infrastructure modifications. NQF staff shared the current CQMC core set measure characteristics, including overall increasing trends in priority areas of outcome measures, Patient-Reported Outcome Performance-Measures (PRO-PMs), cross-cutting measures, and measures endorsed at the clinician level from the first CQMC core sets (2015 – 2017) to the 2021 updated sets. Data sources of CQMC include 42 percent of claims-based, 34 percent are registry data, 29 percent are from EHRs or Electronic Health Data, with other sources (e.g., instrument-based data, enrollment data, administrative data) sharing a smaller proportion of CQMC data sources. It was noted that measures can have more than one data source. A co-chair shared that the National Committee for Quality Assurance (NCQA) is working to shift to all digital quality measures (dQM) by 2025 which aligns closely with CMS' goals. The co-chair asked about the difficulty to implement a program that is predominantly registry-based and the challenges of other sources. A co-chair shared the challenges that include lack of interoperability, the lack of trust of EHRs, and the way to conceptualize electronic clinical quality measures (eCQMs). A Workgroup member commented that it is difficult to validate eCQMs due to the measures capturing the entire patient population. It was also shared that manual chart abstraction results are hard to replicate. A participant asked if any members of the Workgroup use natural language processing (NLP) as part of their measurement process. The co-chair responded that NLP may not be used in quality, but it is used as a prior authorization tool.

A Workgroup co-chair asked if any health information exchanges (HIEs) can run quality measures. A member shared that there are some national HIEs able to capture quality measures but there are limited provider groups are submitting adequate data to HIEs for purposes of quality measurement. Another Workgroup member shared that their organization has a data aggregator pilot for HIEs using dQMs in their state.

NQF staff shared that the last *Elements of Success 5: Using Data to Identify and Address Disparities*

was not explicitly identified as an *Element of Success* in the previous version of the Implementation Guide but noted that it may be categorized as such in future versions. This section emphasized the importance of capturing race, ethnicity, and language and utilizing these data fields to address and reduce disparities. Some potential barriers included lack of interoperability and data flow among stakeholders, patient reluctance to provide information, organization reluctance to share data, and lack of consistent collection and specifications to allow for data stratification. The co-chair inquired about the social determinants of health (SDOH) their role in reducing disparities. A Workgroup member suggested that instead of looking at the rate of dual eligibility to identify a useful strategy for targeted action. The member also shared that language is relatively easy to collect from individuals and is useful with targeting efforts because it gives a sense of ethnicity. NQF staff asked a member about population measures (e.g., social vulnerability index (SVI), healthy places index (HPI)) and the challenges with collecting that data. The member commented there are challenges with collecting at the patient level and noticed a growing category for race/ethnicity that people select is "other" or decline to respond. California's HPI is a census tract level that has eight domains and 25 different measures that map into a provider organization (e.g., clinic, hospital).

Public Comment

During the public comment section of the meeting, NQF staff opened the floor to members of the public. A member of the public, who is also a participant in NQF's Patient Experience and Function Committee, commented on the great work that CQMC is doing thus far and suggested taking advantage of identifying groups in clinical areas (e.g., Million Hearts, National Hypertension Control Initiative) to receive more enthusiasm for improvement. The co-chair commented that the blood pressure measurement is complicated and agreed with the participant on the self-monitoring, especially with telehealth. A participant representing the Family Voices in New Jersey recommended disability to demographic data in the current *Elements of Success 5: Using Data to Identify and Address Disparities.* A participant that has a background in SDOH agreed with the perspectives of a top-down approach to data collection but also consider a bottom-up approach, emphasizing the importance of the technical pieces of the process to improve patient outcomes The participant shared that the use of imputed data sources helps at some level but may not help with the specific sources of variation that prevent an organization from meeting a measure. NQF staff share for awareness that the CQMC Health Equity Workgroup has their first meeting scheduled on April 7th at 3:00 – 5:00 PM ET and welcomed members from the public to attend.

NQF staff opened the floor to the public to share additional feedback. No additional feedback was provided from the public at this time.

Next Steps

NQF staff shared that the next steps for the Implementation Workgroup discussion will be incorporated into the guide and shared with the members in April for their feedback. After Workgroup feedback is incorporated the guide will be posted on the CQMC website for the public commenting period. The next meeting will be scheduled for early May. NQF thanked the Workgroup, co-chairs, and the public for their participation in the meeting.