CQMC Core Quality Measures Collaborative

Meeting Summary

Core Quality Measures Collaborative (CQMC) Implementation Workgroup Web Meeting 2

The National Quality Forum (NQF) convened a public web meeting for the Implementation Workgroup on June 16, 2022.

Welcome, Roll Call, and Review of Web Meeting Objectives

NQF staff welcomed participants to the meeting, as well as introducing the co-chairs Dr. Robert Rauner and 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 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 by the organization and then reviewed the meeting objectives:

- Review the 2022 Workgroup goals and objectives
- Discuss updates to the Implementation Guide recommendations

2022 Implementation Workgroup Goals and Objectives

NQF staff outlined the 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 direction on technical aspects of core set implementation for payment and quality reporting purposes; strategies to encourage buy in among clinicians, providers, facilities, and consumers; and approaches to increase core set adoption by raising awareness and increasing stakeholder knowledge.

The Workgroup met in March to refine the barriers, solutions, and strategies included in the Guide. This web meeting served as an opportunity to build upon previous recommendations and address content gaps in the Guide.

Updates to the Implementation Guide Recommendations

NQF staff shared an overview of the Elements of Success to encourage greater adoption of the CQMC core sets in value-based payment programs. This edition of the Implementation Guide identifies four key Elements of Success:

1. Leadership and Planning
2. Stakeholder Engagement and Partnership
3. Measure Alignment
4. Data and Quality Improvement Support

During the previous Workgroup meeting, NQF proposed an additional Element of Success – Using Data to Identify and Address Disparities – which would address opportunities for more standardized collection of race, ethnicity, sexual orientation, and gender identity data. Based on the feedback from

the previous full Collaborative meeting, members suggested that the opportunities for *Using Data to Identify and Address Disparities* should not be presented as a separate Element of Success. Additionally, a new section, *CQMC Drivers of Change,* which focuses more broadly on advancement of the CQMC's work including other high-priority workgroups and efforts (e.g., Measure Model Alignment, Digital Measurement, Health Equity) was added to the Guide.

Element of Success 1: Leadership and Planning

NQF staff shared the first Element of Success which outlines the following leadership and planning strategies:

- Establish a cross-functional team for entire implementation process
- Set clear goals for measurement tied to patient care
- Create a culture that welcomes innovation and change
- Determine current incentives and measurement structures and consider alignment in planning phases

NQF staff shared additional strategies including assessments of organizational readiness for priority care areas as well as establishing the initial design of the program. Element of Success 1 aims to identify potential barriers that can occur in the leadership and planning phase within an organization. A co-chair emphasized the importance of a leadership structure that creates a culture supportive of measurement initiatives within an organization and share the importance of engaging clinical leadership and staff. A Workgroup member shared a challenge related to healthcare worker and leadership turnover, emphasizing the need for long-term commitment to measurement goals and a planning period (e.g., three years). A co-chair agreed and shared that Medicare Shared Savings Program (MSSP) has transitioned to a five-year contract that would potentially incentivize a sustained commitment. The MSSP is voluntary but encourages providers to collaborate as accountable care organizations (ACOs) to provide high-quality care to Medicare beneficiaries. A Workgroup member suggested including a sub-bullet stating "ensure the institutional commitment is still present" in the short-term planning period. Another member shared that choosing the right leader of the cross-functional team is critical to implementation success. A Workgroup member also suggested that organizations should develop ongoing implementation and/or quality improvement capabilities that allow for continued progress even if there is staffing or leadership turnover.

A co-chair asked if initiative leaders and/or champions should have a clinical background. A member shared that a "champion" role is often suited for an individual with a clinical background while a "leadership" role is often for an individual with non-clinical experience (e.g., administrative). Another member shared it depends on how "clinical" is defined. The Workgroup shared that balancing both clinical and support perspectives are important to the success of measure implementation initiatives.

A Workgroup member shared that the culture of a successful measurement implementation welcomes innovation, change, and leverage. The Workgroup suggested prioritizing this strategy to first in this section due to its importance at the initiation of measure implementation. Another Workgroup member emphasized the significance of culture and commented that when commitment occurs on all levels (e.g., frontline staff, clinicians, executives, managers), alignment is built within the team. The Workgroup discussed that aligned efforts create a culture that strives to meet organizational improvement goals. Members agreed that a culture of improvement that welcomes innovation and change is a key requirement for successful alignment initiatives. Another Workgroup member agreed, sharing that in order for quality improvement to be successful, organizational culture must allow for risk and failures and provide the opportunity to learn from mistakes and improve.

Leadership and Planning – Current Barriers

NQF staff transitioned the discussion to leadership and planning barriers currently identified in the Guide. A co-chair shared that the lack of defined benefits of selecting or adopting particular measures is a barrier, specifically a failure to identify the "why" as well as the inability to define the benefit of improving a measure. A Workgroup member suggested rewording the first barrier to "failure to clearly define the benefit for measure selection and adoption," since there may be a benefit but likely challenges with defining it for a specific organization. Another Workgroup member shared that overly complex projects are difficult to execute and suggested breaking complex projects into smaller segments to make goals more attainable. The member explained that in their experience, most unsuccessful projects lack clearly defined goals and are too large or too complicated to successfully implement. A co-chair asked if it is possible for groups to overly define a process for an organization. A member responded that groups should seek to strike a balance between standardization and over-standardization.

NQF staff highlighted there may be antitrust concerns with sharing certain information (e.g., performance data), limiting collaboration between stakeholders. A co-chair shared that in addition to the antitrust concerns, there are also competitive practices that may deter collaboration. Members should focus on collaborating on measures and practices that are less competitive (e.g., screenings, immunizations) and avoid discussion of competitive information such as pricing. Community health needs assessments (CHNAs) were suggested as a potential way to identify and align with needs of the community. A member shared that the Minnesota Community Measurement (MNCM) was formed from regional stakeholders collaborating on Healthcare Effectiveness Data and Information Set (HEDIS) measures. Another Workgroup member commented that all items related to measures should be discussed collectively (e.g., definitions, measure specifications, technical considerations), but that price negotiation should remain protected to separate any perceived antitrust concerns.

NQF staff thanked the Workgroup for discussion and shared they will identify common themes from the discussion to update the Guide.

Element of Success 2: Stakeholder Engagement and Partnership

NQF staff shared the following implementation strategies related to Stakeholder Engagement and Partnerships:

- Partner and build relationships with external and internal stakeholders
- Utilize a neutral facilitator to help achieve alignment
- Collaborate with other entities and work toward cross-organizational alignment on measurement
- Build on existing stakeholder strengths

A co-chair shared that engagement from external stakeholders is challenging due to the lack of measure alignment between payers. Another member shared that it is challenging for plans and providers to standardize implementation at a national level due to a lack of agreement on what to measure and how to measure. NQF shared that an overarching goal of the CQMC is to bring public and private payers together to align on measures through the development and maintenance of the CQMC core sets. The member commented that it may be easier to engage stakeholders if there are transactional needs to incentivize participation (e.g., financial reward, public reporting, recognition, participation in a network) but stakeholders may also have more challenges agreeing on these topics. Members emphasized that private payers may have competing priorities to differentiate themselves from one another, which may impact engagement and alignment.

NQF staff asked the Workgroup about the roles of registries or health information exchanges (HIEs) in measure alignment. A co-chair shared that the PRIME Registry compiles data from various primary care practices for free or at a low cost to the provider. The co-chair explained that the data from the registry allows you to compare results at a national level. One of the barriers to funding an HIE is determining who would cover the cost to share data. A member suggested that a potential solution to the HIE funding barrier for providers is to include participation at no cost or other incentives to encourage involvement.

Stakeholder Engagement and Partnership – Current Barriers

NQF staff transitioned to the barriers to stakeholder engagement and partnership identified in the Guide. A member asked if the Guide defines the key internal and external stakeholders. NQF staff shared that the main audience is payers who implement and/or select measures from the CQMC core sets. Additionally, a co-chair shared external payers can further be distinguished by the patients they serve (e.g., commercial, Medicare, Medicaid).

A Workgroup member stated that the relationship between brokers, payers, and purchasers is a barrier because brokers may not be fully aware of an organization's measurement and value-based priorities. Another member suggested defining relevant stakeholders who help with engagement. The member also explained that brokers are different than employers and patients differ from patient advocacy organizations. Another member commented that the state's Medicaid agency could be a stakeholder depending on the program. The member explained that in their value-based program for outpatient providers the state's Medicaid agency informed measurement decisions.

A Workgroup member asked which entity is responsible for regulating antitrust. A co-chair responded that the state Department of Health is generally the organizational body that enforces antitrust from the policy or regulatory level. As a potential solution to antitrust concerns, a member suggested developing a communication charter that allows participants to discuss rules prior to the meeting. A communication charter would also align expectations and create trust among members.

NQF summarized the discussion, noting that key stakeholders involved in implementation success may include, but are not limited to providers and clinicians, health systems, health plans, employers, purchaser groups, insurance brokers, patients, state Medicaid agencies, departments of health and healthcare services, colleges of public health, Quality Improvement Organizations (QIOs), and accreditation bodies such as National Committee for Quality Assurance (NCQA).

Element of Success 3: Measure Alignment

NQF staff introduced the third Element of Success which includes the following implementation strategies:

- Prioritize core measures for implementation in new or existing programs
- CQMC core set measures, which are updated on an annual basis, should serve as a starting point for implementation and alignment
- Compare core sets with measures you already use and use measures as specified by the steward

A Workgroup member shared that an additional strategy for measure alignment is to include different methods (e.g., digitization) to standardize the measurement process. The member gave an example of creating a standardized process for collecting patient feedback that led to more consistent data. Ae co-chair suggested tailoring alignment strategies to meet community needs.

Measure Alignment – Current Barriers

The Workgroup transitioned to discussing barriers to measure alignment. A key barrier to alignment is a lack of resources to update existing measures or adopt new ones. A Workgroup member shared that measure specifications updates often lag clinical guideline updates, which may lead to confusion for stakeholders held accountable. The member also shared that another barrier is lack of electronic health records (EHRs) interoperability. NQF staff acknowledged the comment and shared that EHR-related challenges are described under *Element of Success 4: Data and Quality Improvement Support*.

A Workgroup member shared that there are challenges with aligning organizational and individual practitioner incentives (e.g., cascading goals). A Workgroup member shared those physicians involved in quality measurement and improvement work should not be compensated less because they had less time to bill for providing direct patient care services. A workgroup member suggested to align incentives with measures, but to use caution in focusing only on payment penalties – as some individuals or organizations may be motivated differently.

Element of Success 4: Data and Quality Improvement Support

NQF staff introduced the fourth Element of Success which includes the following strategies:

- Collaborate to identify data needs, technical assistance gaps, and reimbursement requirements supporting infrastructure modifications
- Align with data and interoperability standards
- Utilize EHR capabilities and align with measures to encourage wider EHR uptake
- Technical considerations for implementation
    - Benchmarking/performance targets
    - Patient attribution
    - Addressing small numbers

Data and Quality Improvement Support – Current Barriers

A co-chair shared that patient attribution is a challenge for providers who are part of small group practices; these physicians may be disadvantaged due to the low case volume, and it may be difficult to identify top performers. A co-chair shared that the patients with Medicaid insurance may change providers more often, leading to difficulties accurately assigning patients to providers. Providers who see less patients that have certain conditions or care needs (e.g., providers practicing in rural areas) are often limited in what measures they can report due to sample size and reporting requirements. Another Workgroup expressed the potential benefit of statistical approaches to overcome case volume challenges for rural providers (e.g., Battelle's work with CMS on Rural Health Quality). Another strategy suggested by the Workgroup was using a frequent event calculator with measurement data. This approach is similar to how patient safety metrics can be tracked by a health system (e.g., using control charts to observe trends of frequent events).

A Workgroup member stated that there are opportunities to leverage EHRs, for example by using software that supports more accurate data collection and aligning on data and interoperability standards. A member agreed and suggested that the Office for the National Coordinator for Health Information Technology (ONC) 2015 EHR Certification should be updated to reflect current interoperability standards. Another Workgroup member shared that EHRs play an important role in interoperability and standardized data capture, while registries are involved in calculating measures A Workgroup member suggested that CMS should continue to encourage greater standardization and play a role in requiring certain data to be shared.

CQMC Drivers of Change

NQF staff shared that the *CQMC Drivers of Change* section focuses on high-priority topic areas in which the CQMC seeks to influence measurement advancement and alignment across stakeholders. A Workgroup member shared that there have been challenges with alternative payment models (APMs) and benchmarking, and the Workgroup suggested that innovation and additional participation in APMs is needed. The member asked if the CQMC collects data on core set adoption. NQF staff shared that current adoption data is from 2019, but that there is currently a survey out to payers to analyze more recent progress on core set adoption. The CQMC intends for the data to help inform future activities related to implementaion. A Workgroup member suggested the CQMC develop a crosswalk outlining core set use. NQF shared the Analysis of Measurement Gap Areas and Measure Alignment report includes a crosswalk of the use of the CQMC core set measures in certain public programs and in HEDIS. NQF noted that the crosswalk is based on publicly available information and acknowledged that it could be expanded if private payers were willing to share measures used in their programs. Another member expressed that it would be beneficial to demonstrate use cases of successful core set implementation and how shared savings were achieved. NQF shared the previous version of the Implementation Guide included some use cases and asked the Workgroup to share any additional use case ideas. NQF staff thanked the Workgroup for the discussion and encouraged members to direct any additional comments to the CQMC team via email following the meeting.

Public Comment

NQF staff provided the opportunity for members of the public to share comments. No comments were provided.

Next Steps

NQF staff shared that the Workgroup's discussion points would be incorporated into the Guide. After NQF incorporates Workgroup feedback into the Guide, it will be posted to the CQMC website for public commenting. NQF thanked the Workgroup, co-chairs, and the public for their participation in the meeting.