Core Quality Measures Collaborative

Meeting Summary

Gastroenterology Workgroup Meeting 4

The National Quality Forum (NQF) convened a closed session web meeting for the Gastroenterology Workgroup on August 12, 2020.

Welcome and Review of Meeting Objectives

NQF staff and Workgroup co-chairs welcomed participants to the meeting. NQF staff read the antitrust statement and reminded the Workgroup of the voluntary nature of the CQMC and the obligation of all participants to comply with all applicable laws. NQF staff notified Workgroup members that the meeting is being recorded for the purpose of accurately capturing the discussion for meeting minutes and to allow CQMC members to listen to the meeting for a limited time only. The recording will be destroyed as soon as reasonably practical. NQF shared that CQMC is a membership-driven and funded effort, with additional funding provided by Centers for Medicare and Medicaid Services (CMS) and America's Health Insurance Plans (AHIP).

NQF staff reviewed the following meeting objectives:

- Provide overview of CQMC decision-making process
- Review full Collaborative voting results
- Discuss core set presentation and messaging
- Prioritize gaps and future considerations

Review of Decision-Making Process and Voting Results

NQF staff briefly reviewed the decision-making process for core set approval, reminding the group that the full Collaborative reviews the Workgroup's recommendations and casts a final vote on the measures that should be added or removed from the core set. For a vote to be valid at the full Collaborative level, it must achieve quorum (at least 20% of voting members reporting from each voting category: health plans, providers, or other voting participants). In order for a vote to pass, it must achieve a supermajority (at least 60% of voting participants voting affirmatively and at least one representative from each voting category casting an affirmative vote).

NQF staff shared the full Collaborative voting results with the Workgroup:

Measure	Voting Totals	Results
0658: Appropriate Follow-Up Interval for Normal Colonoscopy in Average Risk Patients	Keep: 26 Remove: 0	Keep
0659: Colonoscopy Interval for Patients with a History of Adenomatous Polyps-Avoidance of Inappropriate Use	Keep: 23 Remove: 3	Keep
MIPS #343 Screening Colonoscopy Adenoma Detection Rate	Keep: 22 Remove: 3	Keep

MIPS #439 Age Appropriate Screening Colonoscopy	Keep: 24 Remove: 1	Keep
MIPS #271 IBD: Preventive Care: Corticosteroid Related Iatrogenic Injury-Bone Loss Assessment	Keep: 23 Remove: 2	Keep
MIPS #275 IBD: Assessment of Hepatitis B Virus (HBV) Status before initiation Anti-TNF (Tumor Necrosis Factor) Therapy	Keep: 25 Remove: 1	Keep
MIPS #401: Screening for Hepatocellular Carcinoma (HCC) in Patients with Hepatitis C Cirrhosis	Keep: 23 Remove: 3	Keep
MIPS #400: Hepatitis C: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	Keep: 24 Remove: 1	Keep
3059e: One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk	Add: 23 Do not add: 1	Add
3060e: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users	Add: 4 Do not add: 19	Do not add
3061e: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection	Add: 2 Do not add: 21	Do not add
MIPS #425 Photodocumentation of Cecal Intubation	Add: 2 Do not add: 23	Do not add

NQF staff shared that the full Collaborative voted in alignment with the recommendations from the Workgroup, and the Collaborative will be adding one eCQM reporting option to the Gastroenterology core set. NQF staff also noted that the final core set recommendations are aligned with those of the HIV/Hepatitis C Workgroup (both groups elected to include #3059e *One-Time Screening for Hepatitis C Virus (HCV) for Patients at Risk* but did not recommend to add #3060e or #3061e at this time).

Core Set Presentation and Messaging

NQF staff shared that the CQMC team is seeking feedback on the proposed presentation of the final Gastroenterology core set. NQF staff shared the previous core set presentation (table containing NQF measure number, measure name, measure steward, level of analysis, and notes on consensus). The proposed new presentation of the core set has been simplified based on feedback from other Workgroups and includes the following changes:

- An introductory paragraph (consistent across all core sets) has been added at the beginning of the document.
- The NQF number now links to a more detailed list of measure specifications online.
- The level of analysis (LOA) column has been removed. The LOA is noted in the introductory paragraph ("primarily… outpatient measures at the clinician reporting level"), and any exceptions will be noted in the Notes & Comments column.
- Additional notes from the Workgroup discussion are included in the Notes & Comments column.
- Information about core set updates is included at the end of the document.

A co-chair asked the Workgroup whether any additional information would be helpful to include in order to make the core sets more user-friendly. A Workgroup member shared that they would like to include benchmarking information or targets. Another member agreed and shared that a histogram showing targets or performance of other similar groups would be helpful in identifying areas for improvement. NQF staff agreed that benchmarking information could be useful in promoting use of the core set across payers and programs, but noted that accurately capturing this data across payers and programs could be difficult. A Workgroup member agreed that obtaining the data could be

challenging, especially for measures that are not frequently used, and suggested that the original testing results for NQF-endorsed measures or benchmarking data from MIPS could be used to demonstrate the range of performance for some measures. NQF staff shared that MIPS data is often pulled for the detailed measure scan (Excel sheet) but there often performance differences based on reporting method and noted that since providers select measures for which to report data, performance may not be representative of all providers across the nation. A Workgroup member asked if any data was publicly available from CMS and could be used for this purpose. NQF staff shared that they will follow up with CMS on the availability of benchmarking data and its appropriateness for use for CQMC core set purposes. A Workgroup member commented that obtaining data for benchmarking might become easier as interoperability progresses, and this should be considered for future iterations of work.

A Workgroup member shared that the core set should include a note on the updated US Multi-Society Task Force on Colorectal Cancer guidance released in March 2020, for #0659 *Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use (MIPS ID #185).* The core set should include a line noting that this updated guidance for colonoscopies is available and the measure still aligns with the guidance.

A Workgroup member commented that the note in the final core set should clarify why the adenoma detection rate measure (MIPS ID #343) was removed from MIPS. The member commented that the note should reflect that the measure was removed because of technical reasons (higher detection rate does not necessarily reflect better provision of care), not a judgment on the meaningfulness of the measure area.

Next, the Workgroup discussed potential communication platforms for disseminating the core sets. A Workgroup member commented that the best way to reach the appropriate audience would likely be through the major professional societies (American Gastroenterological Association (AGA), American Society for Gastrointestinal Endoscopy (ASGE), and American College of Gastroenterology (ACG)), possibly through email or through presentations at major meetings. The Digestive Health Physicians Association could also be targeted for messaging. Another Workgroup member agreed with this comment and shared that AGA, ASGE, and ACG often coordinate to send joint emails to their membership, and this could be used to distribute information about the core sets. Another Workgroup member agreed that a joint communication would be effective and would carry more impact than communication from an individual society.

A Workgroup member shared that if large organizations such as CMS, NQF, and NCQA could promote the core sets through social media avenues such as LinkedIn, this could be a good way to promote the core sets. Another Workgroup member noted that the three professional societies (AGA, ASGE, ACG) could also be approached about social media promotion as well.

A Workgroup member asked if NQF staff could share any additional ideas from other workgroups that should be considered for the Gastroenterology core set. NQF staff shared that the team is planning to send out communications about the core sets using the AHIP, NQF, and CMS listservs as well as releasing a joint press release when the core sets are released. The core sets are planned to release in in batches starting in September, and the Gastroenterology set is planned to release in the first batch (along with the HIV/Hepatitis C, Pediatrics, and OB/GYN core sets). NQF staff also shared that other groups had discussed promotion of the core sets through a journal article (e.g., a Health Affairs piece) and promotion through social media channels.

Gaps and Future Considerations

NQF staff shared a list of gap areas identified in previous discussions with the Workgroup:

- Need for measurement to reflect the diversity of conditions that affect the liver and gastrointestinal tract
- The workgroup is interested in reviewing ten AGA measure currently under development once tested or endorsed, specifically prioritizing measures related to Hepatitis C SVR, Barrett's esophagus, and IBD.
- Non-alcoholic fatty liver disease
- Quality of colonoscopy, including measures for post-colonoscopy complications
- Adverse events related to colonoscopy screening (e.g., ER or hospital visit after a procedure, perforation, hemorrhage)
- Patient safety, including complications after procedures
- Pancreatitis
- Medication management and adherence, especially for patients with IBD and patients on immunosuppressive medications
- Measures that consider the patient continuum of care and vulnerable points of information exchange
- PRO-PMs
- GERD and cirrhosis measures
- Resource utilization during acute episodes of care
- Measures not selected for inclusion that may be revisited: 2539: Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy, 3510: Screening/Surveillance Colonoscopy, 3060e: Annual Hepatitis C Virus (HCV) Screening for Patients who are Active Injection Drug Users, 3061e: Appropriate Screening Follow-up for Patients Identified with Hepatitis C Virus (HCV) Infection, and Photodocumentation of Cecal Intubation (MIPS ID 425)

NQF staff shared that the team is documenting gap areas for each of the core sets for purposes of updating stakeholders and assessing which areas should encourage measure development. A co-chair suggested that the group consider the CQMC measure alignment principles before discussing any changes to the list, and reminded the group that individual measures should advance health/healthcare improvement; be high-impact; be unlikely to promote unintended adverse consequences; be scientifically sound; and represent a meaningful balance between burden and innovation. Core sets should provide a holistic, patient-centered view of quality; provide meaningful and usable information to stakeholders; and contain a mix of measure types. The Workgroup did not have any suggestions for additions or removals from the gaps list.

A co-chair asked the Workgroup how the CQMC can promote development of measures in these gap areas, such as CQMC providing resources or guidance to societies or developers on testing infrastructure. A Workgroup member shared that the limiting factor for AGA has been measure testing, and it has been difficult to recruit enough practices to participate in a testing collaborative. A Workgroup member commented that establishing additional payer-provider partnerships to test and share newly developed measures (with NQF acting as the neutral partner) would be helpful.

A Workgroup member also shared that there is an opportunity to develop measures that capture disparities in disease states. NQF staff shared that the need for measures that address social determinants of health (SDOH) has been brought up in other Workgroups as well, along with stratification of measures to identify differences in outcomes between different groups. NQF staff asked whether the group knew of any specific measures that target SDOH or disparities that should be considered in future rounds of work. The group suggested that colorectal cancer screening could be a useful area to monitor, as certain groups are less likely to be screened and to get follow-up. A

Workgroup member suggested that CQMC could endorse stratification while reporting certain measures (e.g., encourage reporting performance rates by socioeconomic status, gender, race). Another Workgroup member suggested that performance could also be stratified by zip code or area (e.g., number of colon cancer cases by zip code).

Next Steps

NQF staff thanked the Workgroup for their input and encouraged the Workgroup to share any additional comments via email. NQF staff advised that, as discussed earlier, the Gastroenterology core set is planned to release in September. The Workgroup will meet again on September 1 to discuss any outstanding items and discuss next year's work, proposed timing for core set updates, and process improvements.