NATIONAL QUALITY FORUM
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Memo

August 18, 2020

To: Measure Applications Partnership (MAP) Rural Health Workgroup

From: NQF staff

Re: Post-comment web meeting to discuss public comments received on report

Purpose of the Call

The MAP Rural Health Workgroup will meet via web meeting on August 26, 2020 from 1:00 pm to 3:00 pm ET. The purpose of this call is to:

- Review and discuss comments received during the public commenting period; and
- Provide feedback in response to the public comments.

Workgroup Actions

1. Review this briefing memo and consider the full text of all comments received.
2. Be prepared to provide feedback and input to respond to the comments.

Webinar Information

- MAP Rural Health Workgroup members, public participants, and NQF staff dial **800-768-2983** to access the audio platform.
- Access code: **5148141**
- Weblink: https://core.callinfo.com/callme/?ap=8007682983&ac=5148141&role=p&mode=ad

Background

Low case-volume poses a measurement challenge for many healthcare providers in rural areas and reduces reliability and validity of measure scores. In 2018-2019, the National Quality Forum (NQF) convened a Technical Expert Panel (TEP) to discuss statistical approaches for addressing low case-volume in healthcare measurement. In 2019-2020, NQF convened the Measures Application Partnership (MAP) Rural Health Workgroup to develop a list of rural-relevant measures that face low case-volume challenges and should be prioritized in future testing of the statistical approaches (e.g., "borrowing strength") recommended by the TEP. NQF released a draft report summarizing the recommendations of the Workgroup, which identified 15 high-priority rural-relevant measures that are susceptible to low case-volume challenges. This draft report also included a summary of Workgroup discussion on reporting challenges and gaps in rural healthcare quality measurement.

Comments Received

The draft recommendations report, *Rural-Relevant Quality Measures for Testing of Statistical Approaches to Address Low Case-Volume,* was posted on the project webpage for public and NQF member comment on July 10, 2020 for 21 calendar days. During this commenting period, NQF received nine total comments from three organizations through the public commenting tool and via email. Below

is a summary of the comments by theme. Full text comments are included in the Appendix alongside the commenter's name/organization and comment theme.

Themes

Measure Recommendations

Three organizations submitted comments related to this topic. These included comments on the measure characteristics used while prioritizing the list of measures, as well as notes on specific measures and additional criteria to consider before any testing is performed.

One commenter expressed that they were highly supportive of the measure selection criteria for measures relevant to low-volume service environments, measures addressing transitions in care, and cross-cutting measures. Another commenter shared that prioritizing cross-cutting measures might be contrary to the 2019 TEP recommendation. The TEP had previously discussed the use of cross-cutting measures but noted that defining cross-cutting measures could be arbitrary, and limiting selection to cross-cutting measures such as screening or immunizations could impact quality improvement efforts for other activities such as specialty care or surgery and discourage use of outcome measures. The commenter suggested that a more relevant criterion might be groups of measures with a common causal pathway.

One commenter shared additional information on the use of specific measures included in the 15-measure priority list. They shared that the sepsis measure (#0500 *Severe Sepsis and Septic Shock: Management Bundle*) has not yet been included in MBQIP by the Federal Office of Rural Health Policy. They also shared that #1789 *Risk-Standardized, All Condition Readmission* does not face challenges due to low case-volume in their experience, and if statistical testing is done on this measure it should be performed on the new hybrid version of this measure (as the claims-only measure will no longer be used by CMS starting in 2023).

Finally, one commenter encouraged that availability of services be considered before applying testing to any of these measures. They noted that a limited number of facilities may be performing a service, but the facilities performing these services may not face low case-volume. The commenter noted that this should be considered for #0471 *PC-02 Cesarean Birth*, #1551 *Hospital-level 30 day, all-cause, risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)*, and #2539 *Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP32).*

Reporting Challenges

Two organizations submitted comments related to this topic. One commenter noted that applying the "borrowing strength" approach would not require combining data over multiple years or providers but would instead utilize the statistical relationship over years. Another commenter shared that expanding the sources available for calculating claims-based measures (e.g., calculating readmissions measures with Medicare Advantage data in addition to FFS Medicare claims) could help address volume challenges for claims-based measures. Finally, a commenter shared that an additional challenge with eCQM use is the limited inclusion of rural-relevant eCQMs (such as N/A: *Median Admit Decision Time to ED Departure Time for Admitted Patients (ED-2)* and N/A: *Venous Thromboembolism Prophylaxis (VTE-1)*) as part of CMS Inpatient Quality Reporting and Promoting Interoperability programs.

Gaps and Future Considerations

Two organizations submitted comments related to this topic. One commenter noted that the report does not address the infrastructure requirements needed for further testing of the "borrowing strength"

approach, including the ability to establish benchmarks, observe statistical correlations or persistence, and estimate correlated signal variances for each of the recommended measures. Another commenter encouraged continued measure adaptation and development to address critical areas including access and timeliness of care, care transitions, substance use, cost, population health, advance care directives, end-of life care, and patient outcomes.

Other General Comments

Two organizations submitted comments related to this topic. One commenter strongly encouraged additional support for development of rural sensitive measures appropriate for Critical Access Hospitals and other small rural hospitals as part of improvement and payment programs.

Another commenter shared a concern that the measures listed in the report are difficult to apply in low-volume rural hospitals and cost and reporting rules could make it difficult to collect data for some of the measures. The commenter recommended that NQF identify a core set of cross-cutting measures that all providers report on, as well as separate supplemental sets specific to provider categories (e.g., Critical Access Hospitals, general acute care facilities, different specialty care facilities). The commenter also shared that they believe process measures are more appropriate for low-volume facilities and recommended development of a Critical Access Hospital specific set of quality measures based on MBQIP.

Appendix A: Public Comments

Battelle Memorial Institute (commenter: Jeffrey Geppert)

Measure Recommendations: Do you agree that the 15 measures recommended for statistical testing are relevant for rural populations and are susceptible to low case-volume reporting challenges? If not, please provide feedback.

Among the measure attributes used for prioritization item #3 (Cross-cutting measures reflect broad applicability to patient populations by not limiting measurement to a specific diagnosis or process) may be somewhat contrary to the TEPs recommendation. The use of cross-cutting measure was one of the measurement recommendations the TEP considered.. Specially (p. 9)

The TEP also noted some potential drawbacks of this approach. In particular, limiting the selection of measures to those that are applicable for most rural providers places artificial constraints on the available measures. This could result in the neglect of other measures that are important for rural populations. For example, a focus on screening or immunizations might jeopardize quality improvement efforts in rural areas for other important conditions or healthcare activities such as specialty care or surgical services. TEP members also suggested that such a focus might, in some cases, tilt selection away from use of outcome measures. Finally, there may not be an objective way to determine which measures meet the criterion of "broadly applicable" (or a way to otherwise reach consensus on what it means to be broadly applicable).

Rather than using a cross-cutting measures criterion, a more relevant criterion to the "borrowing strength" approach would have been groups of measures that have a common causal pathway. What makes borrowing strength "work" is the existence of underlying structural similarities in that causal pathway across time, peer providers, or related process and outcome measures. Those structural similarities are also what makes the borrowing strength approach either actionable (if those elements of structure are loosely under the provider's or system's control) or illuminating of an unintended consequence (if not).

Reporting Challenges: Are there additional reporting challenges that should be considered in future rural health measurement work? If so, please describe.

The comment "pooling data over several years for one provider would affect the ability to track improvement over time due to lag, which might pose a challenge for pay-for-performance programs intended to serve this purpose" (p. 11) again seems to miss the utility of the "borrowing strength" approach, which does not in fact require combining data over multiple years (or across peer providers) but rather leverages the persistent statistical relationship across years.

Gaps and Future Considerations: Are there additional gaps that should be considered in future rural health measurement work? If so, please describe.

The report does not really address the infrastruture requirements for implementing the "borrowing strength" approach which may have informed the selection of measures for testing. For example, the ability to establish benchmarks or thresholds, observed statistical correlations or persistence, and the ability to estimate correlated signal variances.

Stratis Health (commenter: Karla Weng)

What general comments do you have on the recommendations report?

Stratis Health is a non-profit organization whose mission is to lead collaboration and innovation in health care quality and safety. We have a long history of working closely with Critical Access Hospitals

(CAHs) and other rural health care organizations and clinicians, with a focus on supporting quality reporting and improvement.

We applaud the ongoing work by NQF to address rural-relevant and low-case volume measurement, but strongly encourage additional support for development of rural sensitive measures to allow CAHs and other small rural hospitals to demonstrate the quality of care they provide, and to continue to participate in improvement and payment programs which lead to higher quality and lower cost care for Americans living in rural places.

Thank you for the opportunity to submit comments, and in particular, to help assure that patients living in rural places continue to receive the highest quality care possible in our nation's rural hospitals.

Measure Recommendations: Do you agree that the 15 measures recommended for statistical testing are relevant for rural populations and are susceptible to low case-volume reporting challenges? If not, please provide feedback.

We encourage consideration of availability of services in rural hospitals before applying testing of statistical methods for low-volume. For example, a limited number of CAH have labor and delivery services available. For those that do offer that service, is low case volume still an issue for the PC-02 measure, or is there just a limited number of rural hospitals providing that service? The same question would apply for the THA/TKA readmission measure and OP-32.

The potential inclusion of the Sepsis measure in the MBQIP program is exploratory at this time, and no decision has been made by the Federal Office of Rural Health Policy to include it as a core measure for that program.

Per the Risk Standardized, All Condition Readmission measure. The majority of CAHs currently meet the minimum threshold for calculation of Hospital-Wide Readmission measure, and we encourage review of that information prior to inclusion of the measure as a priority for statistical testing. CMS has indicated that they will be shifting to utilization of a hybrid measure for calculation of Hospital-Wide Readmissions, and will no longer be utilizing the claims-only measure starting in 2023. If testing is pursued on this measure, we'd encourage it be done on the hybrid version (voluntary reporting for the hybrid version begins in 2021).

We found the legends for the charts on page 10 hard to read and interpret, we'd encourage you to use larger color boxes in the legend or use a different format for that information.

Gaps and Future Considerations: Are there additional gaps that should be considered in future rural health measurement work? If so, please describe.

There continues to be a significant need for measure adaptation and measure development to help address critical areas of quality and safety for rural health care such as priorities identified in previous NQF Rural reports including: access and timeliness of care, care transitions, substance use, cost, population health, advance care directives, end-of life care, and patient outcomes.

Reporting Challenges: Are there additional reporting challenges that should be considered in future rural health measurement work? If so, please describe.

We encourage exploration of the potential to expand the universe of claims available for calculation of the claims-based measures. A limitation of the current CMS measure reporting system is that measures such as hospital readmissions are only calculated using FFS Medicare claims. Expansion to inclusion of Medicare Advantage data, or ideally to an all-payer claims database (where available) would likely increase the utility of existing claims-based measures for rural and low-volume facilities.

We agree with the potential challenges identified regarding greater use of eCQMs, but would also highlight that an additional issue is that there is limited rural relevancy to the currently available eCQMs

for hospital reporting through part of the CMS Inpatient Quality Reporting (IQR) and Promoting Interoperability Programs. Only 2 of the 8 eCQMs measures currently available (ED-2 and VTE-1) are relevant to most CAHs and hospitals are required to report on 4 measures (https://www.qualityreportingcenter.com/globalassets/iqr_resources/ecqm-resources-for-iqr/cy-2020/ecqm_cy-2020-available-ecqms-table_vfinal508.pdf). There are good opportunities for reduction of measurement burden through expanded use of eCQMs, but the challenges in availability of quality data for small rural hospitals will remain the same unless the eCQMs selected for inclusion in those programs are rural-relevant.

National Organization of State Offices of Rural Health (NOSORH) (commenter: Teryl Eisinger)

The National Quality Forum (NQF) recently released the latest draft of a report on ***Rural-Relevant Quality Measures for Testing of Statistical Approaches to Address Low Case-Volume***. In this communication National Organization of State Offices of Rural Health (NOSORH) is providing comments on that report. NOSORH had submitted comments on a previous iteration of NQF's rural-relevant quality measures – a copy of those comments is attached.

NOSORH was established in 1995 to assist State Offices of Rural Health (SORH)s in their efforts to improve access to, and the quality of, health care for nearly 57 million rural Americans. All 50 states have a SORH, and each SORH helps their state's rural communities to build effective health care delivery systems. SORHs work with the rural health care system nationwide, with a particular emphasis on rural hospitals, including smaller rural hospitals and Critical Access Hospitals (CAHs). NOSORH and its member SORHs have a long history of working with quality monitoring and quality improvement in these facilities, and are integrally involved in the operations of the Medicare Beneficiary Quality Improvement Project (MBQIP). MBQIP is the primary resource for quality monitoring for the more than 1,300 CAHs nationwide.

NOSORH is strongly supportive of several of the measure selection criteria used by NQF in the development of its report.

- **Cross-cutting measures**: applicable to the broadest range of patients and services
- **Measures relevant to low volume service environments**: applicable for measuring quality with relatively small numbers of reportable incidents.
- **Measures that address transitions in care**: assessing the broader context of care continuity across multiple environments, including a patient's home.

NOSORH believes that a quality measurement scheme developed with these selection criteria will be a major step forward in understanding quality trends in rural health services.

NOSORH believes that the final set of recommendations in the NQF would improve rural health system monitoring, but that additional changes would be beneficial. NOSORH has identified multiple measures in the final set included in the report that would be ***difficult to apply in CAH and other low-volume rural hospitals***. The NQF report itself includes comments from the NQF Workgroup and the public that indicate that ***measures might not be feasible in these hospitals due to low case-volumes in rural areas***. The NQF report further notes Workgroup comments questioning the ***feasibility of data collection in CAHs*** for several measures, due to cost and reporting rules that are difficult for rural providers to meet.

Given these challenges, NOSORH recommends that additional changes be made to the report. NOSORH believes that ***no single measurement set should be created for all providers***. A 'one size fits all' approach has been taken by some CMS provider evaluation schemes - in particular the Hospital Star Rating system. Under this scheme hospitals are assessed on 57 separate reported measures grouped in 7 Domains. Few hospitals can acceptably report on all 57 measures. This has led to different hospitals being assessed on

completely different numbers of measures and different mixes of measures. This severely limits the usefulness of the ultimate comparisons.

NOSORH has conducted a study of the Hospital Star Rating system and identified major problems with its treatment of rural providers. NOSORH analysis has indicated that, in the most recent iteration of the data reporting, ***fewer than half of all CAHs were able to report on enough measures to be rated***. In addition, among rated hospitals, fewer than 10% of all CAHs were rated on the important Patient Safety domain, compared to more than 90% of all acute care hospitals. This is very problematic. NOSORH believes that the current measurement recommendations included in the NQF report could lead to a quality measurement scheme that repeats these problems – excluding many CAHS from monitoring.

To address these problems, NOSORH recommends that NQF identify a core set of cross-cutting measures for all providers and also identify ***separate supplemental sets of measures that are specific to different provider categories***. Separate inpatient measure sets can be established for CAHs, general acute care facilities and for specialty care facilities. Separate outpatient category measure sets can be established for primary care providers and key categories of specialists/subspecialists.

NOSORH believes that ***process*** measures are more appropriate for lower volume facilities, such as CAHs. NOSORH feels that the MBQIP measure set, which includes several process measures, has shown its worth as quality index for low-volume hospitals. NOSORH recommends the development of a CAH-specific set of quality measures based upon MBQIP.

NOSORH recognizes the challenge faced by NQF in the development of quality measures relevant for low-volume rural providers. NOSORH commends NQF for its efforts and hopes that these comments can help support some additional improvements.