NATIONAL QUALITY FORUM

Meeting Summary

MAP Rural Health Workgroup – Webinar #4

The National Quality Forum (NQF) convened the MAP Rural Health Workgroup for a webinar on February 14, 2018 from 1:00 pm - 3:00 pm ET.

Welcome and Review of Web Meeting Objectives

Kate Buchanan, senior project manager, welcomed participants to the web meeting. She reviewed the meeting objectives, which were to solicit feedback on the structure of the first draft report, discuss the core set measure selection criteria and methodology, review the draft core set of measures, and review and prioritize measurement gaps areas. Ms. Buchanan then conducted a roll call of Workgroup members. Workgroup co-chairs, Aaron Garman, MD, and Ira Moscovice, PhD, made opening remarks.

Review Report Structure

Madison Jung, project manager, reviewed the timeline of deliverables for the MAP Rural Health project. NQF staff will submit three deliverables during the course of the project: two draft reports, the first of which is due on February 28, 2018, and a final report that is due on August 31, 2018. Ms. Jung then reviewed the structure of the first draft report. Workgroup members did not have questions or concerns regarding the structure of the draft report.

Review Core Set Measure Selection Criteria and Methodology

Suzanne Theberge, senior project manager, reviewed the core set selection criteria and methodology. Dr. Moscovice facilitated the discussion. A Workgroup member asked what payer type the core set of measures is intended for (e.g., Medicare, Medicaid, or private insurers). Dr. Moscovice clarified that the core set is not meant to apply to an insurer, but should instead focus on the type of patients that rural hospitals and clinicians care for with a reasonable enough volume to achieve reliable and valid measure results. The core set should be useful for both rural providers and rural residents.

Discuss Draft Core Set

Themes

Karen Johnson, senior director, reviewed the Workgroup's feedback on the draft core set that members provided after the January 25 webinar. First, she noted that the proposed size of each core set (10-20 measures) came from the 2015 rural health project, which recommended inclusion of relatively few measures in a core set, as these should be measures applicable to most rural providers and would be used in conjunction with an optional set of measures that focus on an expanded range of topics that may not work for every provider or care setting. Ms. Johnson clarified that this Workgroup has the freedom to select fewer or more than 10-20 measures. She also noted that even though measures are grouped by condition or topic area to facilitate discussion, no rule requires that at least one measure must be chosen from each grouping.

In regards to the 74 measures in the draft core set, the Workgroup raised some concerns. Several members raised one issue concerning several of the measures—particularly outcome measures: Providers being assessed may not have the ability to control outcomes. The Workgroup briefly discussed the changes in healthcare delivery in recent years and the ability of providers to influence outcomes even if they cannot control them. However, other members noted concerns about lack of appropriate risk adjustment (particularly for social risk) for outcome measures and the potential unintended consequences to both rural providers and residents if inadequately adjusted measures are used in public reporting or payment programs. Most members seemed to agree on the need for some outcome measures in the core set. NQF staff noted that developers of outcome measures submitted for endorsement must at least consider adjustment for social risk factors, but acknowledged that these data often are lacking.

Workgroup members agreed that measures that are "topped out" should not be included in the core set. However, one member expressed the hope that the work of the MAP Rural Health Workgroup would continue in the future, providing an ongoing opportunity to evaluate measures and their suitability for inclusion in a core set of rural-relevant measures. Another Workgroup member also noted that since many rural providers do not currently participate in quality reporting programs, measures that seem to be topped out based on providers that do report may not actually be topped out for rural providers. This member also suggested that use of measures that may appear topped out might provide a "transitional" opportunity to gain experience in quality measure reporting among those that have not previously reported on quality measures.

Workgroup members briefly discussed the issue of feasibility of data collection, especially for small rural clinics and hospitals that lack the resources of larger institutions.

Finally, members want to ensure that the measures selected do not have unintended consequences. Overall, Workgroup members strongly agreed the core set should focus on meaningful, actionable items.

The Workgroup then began an in-depth discussion of the 74 measures included in the draft core set. The discussion often included elements of the themes noted above, but many other points were discussed as well. A summary of the Workgroup's discussion of 39 of the 74 measures is included below. NQF staff will reconvene the Workgroup to complete its discussions of the remaining 35 measures.

Transitions

The Workgroup discussed three transitions-of-care measures identified through the core set measure selection process.

The Workgroup noted that 0291 *Emergency Transfer Communication Measure,* which assesses if the emergency department communicates the correct information to the facility to which an emergency patient is transferred, may be covered under the Emergency Medical Treatment and Labor Act (EMTALA)—a federal law. However, the Workgroup noted that information sometimes falls through the cracks and that measure is reasonable to include.

The Workgroup compared 0291 with the 0290 *Median Time to Transfer to Another Facility for Acute Coronary Intervention* to determine if the more important aspect of care to measure is the communication of information or the time it takes to transfer. Members noted that in rural settings there may be issues such as weather that will cause unavoidable delays in transfer time and indicated that the more important part of care is communication. Additionally, unlike 0290, 0291 is not susceptible to the low case-volume problem and will affect more people.

Workgroup members discussed the importance of care coordination that 0228 *3-Item Care Transition Measure (CTM-3)* measures. Although members liked the focus of the measure and the fact that it is a patient-reported outcome measure, they decided not to recommend the measure for the draft core set because it may be included as part of the measure set derived from responses to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and, if so, including the HCAHPS measure in the core set would potentially be duplicative. There was also concern that the response rate may be too low for rural facilities to obtain meaningful results.

Ultimately, the Workgroup agreed to include 0291 in the draft core set.

Mental Health (Depression)

The Workgroup discussed five depression measures. The Workgroup expressed concern about 0418e *Preventive Care and Screening: Screening for Depression and Follow-Up Plan,* an eMeasure, because of potential difficulties due to the data source and data availability in EHRs. The Workgroup noted the similarities between 0710 *Depression Remission at Twelve Months* and 0711 *Depression Remission at Six Months* and recommended only including one. Members did not specifically discuss merits of measure depression response (assessed via 1885 *Depression Response at Twelve Months - Progress Towards Remission*) versus remission.

Ultimately, the Workgroup supported the inclusion of 0711 and 0418 *Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan*. This decision mirrored the quantitative feedback provided by the Workgroup after the previous webinar.

Substance Use—Tobacco

The Workgroup reviewed four measures on tobacco use. The Workgroup recommended against the inclusion of two hospital-level measures, 1651 *TOB-1 Tobacco Use Screening* and 1656 *TOB-3 Tobacco Use Treatment Provided or Offered at Discharge* and the subset measure *TOB-3a Tobacco Use Treatment at Discharge.* Some Workgroup members expressed doubt that the measures of tobacco screening or treatment done during or just after a hospitalization would have a lasting effect. Others noted that 1651 and 1656 are included in The Joint Commission hospital accreditation program, so hospitals likely already report on them. There was concern that both measures may be topped out.

The Workgroup supported the inclusion of 0028 *Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention* in the draft core set because the measure that is used in the ambulatory setting has two important components to care: (1) screening for tobacco use and (2) if the individual screens positive, offering treatment.

The Workgroup was conflicted regarding inclusion of 2803 *Tobacco Use and Help with Quitting Among Adolescents.* Some Workgroup members noted the importance of a measure that focuses on tobacco use among adolescents. Others thought the measure captures too narrow a population—and given the need for a small number of measures in the core set—saw this as a reason for not including it in the core set. The Workgroup also noted that a measure that somehow combines 0028 and 2803 (tobacco screening and cessation geared toward both adolescents and adults) would be a better measure to include in a core set, although such a measure does not yet exist. Members also noted that such measures should be expanded to include other products such as e-cigarettes.

Ultimately, the Workgroup decided to include both 0028 and 2803, although they are open to reconsidering inclusion of 2803.

Substance Use—Alcohol, Other Drugs

The Workgroup considered five measures of substance use that focus on alcohol and other drugs.

Two of the five measures (0004 *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)* and 2940 *Use of Opioids at High Dosage in Persons Without Cancer*) were not endorsed at either the facility or clinician levels of analysis. Although Workgroup members liked the focus of both measures, they ultimately agreed that the level of analysis specified for these two measures makes them inappropriate for inclusion in the core set. (Note that there was some support for including them anyway while waiting for measures to be developed at the needed levels of analysis). Members agreed that there is a gap in measures that focus on opioids and drug abuse treatment more generally at the clinician level of analysis.

The members agreed it is important to include a measure that screens for alcohol use or abuse at the clinician and facility levels of analysis. They therefore agreed to include 2152 *Preventative Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling* (assessed at the clinician level of analysis in the ambulatory setting) and 1661 *SUB-1 Alcohol Use Screening* (assessed at the facility level of analysis in the hospital setting). The Workgroup agreed not include 1664 *SUB-3 Alcohol & Other Drug Use Disorder Treatment Provided or Offered at Discharge and SUB-3a Alcohol & Other Drug Use Disorder Treatment at Discharge,* primarily because of the desire to limit the number of core set measures. Overall, the Workgroup preferred including a screening measure for each care setting rather than two measures for the hospital setting only, even though one of the hospital measures assesses treatment.

Medication: Use, Review, and Reconciliation

The Workgroup considered five measures of medication use, review, and reconciliation.

Measures 0022 *Use of High-Risk Medications in the Elderly (DAE)* and 0553 *Care for Older Adults (COA) – Medication Review* were not endorsed at either the facility or clinician levels of analysis; therefore, Workgroup recommended against the inclusion of these measures in the core set, even though members particularly liked the focus of 0022.

Members supported the inclusion of 0097 *Medication Reconciliation Post-Discharge* and noted that medication errors during transitions of care are a common patient safety problem.

Members did not recommend the inclusion of 0419 *Documentation of Current Medications in the Medical Record* and 2456 *Medication Reconciliation: Number of Unintentional Medication Discrepancies per Patient*.

Screening

The Workgroup considered four screening measures (for body mass index [BMI] and cervical, colorectal, and breast cancer) for inclusion in the core set.

Three of the four measures, 0032 *Cervical Cancer Screening,* 0034 *Colorectal Cancer Screening (COL)*, and 2372 *Breast Cancer Screening*, are not endorsed at either the facility or clinician levels of analysis. However, there was strong support to include at least one cancer screening measure in the core set. Some members supported inclusion of these measures in the core set even though they have not been tested for use at the clinician level of analysis. (The assumption would be that appropriate caveats would be clearly stated and that formal testing of the measures would be encouraged and expected). One member noted use of all three measures at a clinician group (i.e., clinic) level of analysis in the member's state, and members agreed that this could be used as a justification for including the measures. Members agreed that if they made an exception to include measures not specified at either the clinician or facility levels of analysis, they would particularly support including the colorectal cancer screening measure (0034). Ultimately, however, the Workgroup decided against recommending inclusion of these measures in the core set, citing their initial decision to include only NQF-endorsed measures, and the inconsistency in rejecting other measures due to the level of analysis issue. Workgroup members again emphasized the importance of cancer screening measures at the clinician level of analysis and noted this as a gap area. Staff suggested that the final report in some way present a listing of measures that would likely have been included in the core set if not for concerns about the level of analysis.

The Workgroup members supported the inclusion of 0421 *Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow-Up*.

Immunization

The Workgroup considered five measures of immunization for inclusion in the core set. The measure that received unanimous support as part of the post-webinar feedback—0038 *Childhood Immunization Status (CIS*)—is not endorsed at the clinician or facility level of analysis.

Several members indicated that their organizations report on this measure through a state registry or in other ways. However, one member noted that not all states use a state registry. Members also noted that immunizations are administered through sources other than the primary care office, such as pharmacies or district health offices. The members emphasized that the ease of reporting these measures depends on their states' policies and practices. Providers in states without reporting registries may have more difficulties implementing these measures.

The Workgroup did not come to consensus and will discuss 0038 *Childhood Immunization Status (CIS)*, 0041 *Preventive Care and Screening: Influenza Immunization*, *1659 Influenza Immunization,* 1407 *Immunizations for Adolescents*, and 0431 *Influenza Vaccination Coverage Among Healthcare Personnel* at a later time.

Experience with Care

The Workgroup considered three measures of experience with care: 0166 *HCAHPS*, 0005 *CAHPS Clinician & Group Surveys – Adult, Child (CG-CAHPS)*, and 2548 *Child Hospital CAHPS (HCAHPS)*.

Members agreed on the importance of these patient experience measures, but did note the burden of collecting data for the measures. The Workgroup recommended that CMS consider allowing data for the measures to be collected electronically (e.g., via e-mail or apps) as a way to reduce burden and encourage more participation.

While one member noted a concern about comparing 0166 (Hospital CAHPS) results between large and small facilities, another member stated that rural facilities who do report those measures almost always compare favorably.

Workgroup members did not express concerns about the CG-CAHPS measures, except for noting that the instrument itself is quite lengthy. However, in feedback provided after the last webinar, members expressed concern that the Child HCAHPS, in particular, may suffer from the low case-volume issue.

Staff interpreted the conversation of the Workgroup as supporting inclusion of both 0166 and 0005 in the draft core set, but omission of 2548. The Workgroup will revisit this conclusion at a later date.

Cost/Resource Use

The Workgroup considered two measures of cost and resource use for inclusion in the core set: 1604 *Total Cost of Care Population-based PMPM Index* and 1598 *Total Resource Use Population-based PMPM Index,* both of which are specified at the clinician group level of analysis.

Workgroup members generally liked the idea of including a cost measure, but raised concerns with these two measures. They noted that costs may be relatively less under the control of rural providers compared to nonrural providers, particularly for providers who are not part of an integrated system, or who lack access to lower-cost treatment options such as urgent care clinics that might be used by patients instead of emergency rooms. Workgroup members also noted that small facilities may not have access to group purchasing organizations and might therefore have higher supply chain costs. The Workgroup decided against including either of the cost measures in the draft core set.

Diabetes

The Workgroup considered three diabetes measures for inclusion in the core set.

Workgroup members supported the inclusion of 0729 *Optimal Diabetes Care,* an all-or-none composite measure specified for the ambulatory setting, in the core set. Members noted that 0059 *Comprehensive Diabetes Care* has a health plan/integrated delivery system level of analysis, rather than clinician or facility, and therefore agreed not to include the measure. One member suggested that 2326 *Glycemic Control – Hypoglycemia* may have some data collection challenges and also noted that it has not been proposed, to date, for inclusion in the CMS Inpatient Quality Reporting program, and the Workgroup therefore did not recommend the measure for inclusion in the core set.

Review and Prioritize Measurement Gap Areas

The Workgroup did not have an opportunity to discuss and prioritize measurement gap areas on the call. NQF staff will send a follow-up survey to obtain Workgroup feedback.

Public Comment

Ms. Buchanan opened the web meeting to allow for public comment. There were two public comments, both of which referenced measures that the Workgroup discussed and the selection process:

- Two measures that the Workgroup decided not to include in the draft core set, 0710 *Depression Remission at Twelve Months* and 1885 *Depression Response at Twelve Months- Progress Towards Remission*, are included in the Core Quality Measures Collaborative.
- With regards to 0032 *Cervical Cancer Screening (CCS)*, 0034 *Colorectal Cancer Screening (COL),* and 2372 *Breast Cancer Screening*, clinics and individual physicians are not able to get relevant data easily, which may be why those measures have been introduced at the health plan level or integrated system delivery.
- 0005 *CAHPS Clinician & Group Surveys (CG-CAHPS)-Adult, Child* and *0166 HCAHPS* must be implemented by a certified survey vendor, which is the issue in terms of costs associated with the measures.
- The American Academy of Family Physicians (AAFP) has traditionally opposed 0729 *Optimal Diabetes Care* because they believe that physicians need to get credit for the care they provide (that is, AAFP is not a proponent of all-or-none measures). Also, a component of the measure is that the patient is tobacco-free, which may be outside of the control of the physician.
- In general, the Workgroup should consider alignment of the measures with other programs with which members are involved and with CMS meaningful measures.

Next Steps

Decisions agreed upon during this meeting will be included in the first draft report. NQF will post draft report #1 on February 28, 2018 for public viewing.