NATIONAL QUALITY FORUM

Meeting Summary

MAP Rural Health Workgroup – Webinar #3

The National Quality Forum (NQF) convened the MAP Rural Health Workgroup for a webinar on January 25, 2018 from 1:00-3:00 pm ET.

Welcome and Review of Meeting Objectives

NQF welcomed the MAP Rural Health Workgroup and participants to the webinar. NQF staff reviewed the meeting agenda and conducted a roll-call of Workgroup members.

Review of Measure Selection Criteria and Draft Core Set

Karen Johnson, senior director, reviewed the process used to identify a "strawman" draft core set of measures that are appropriate for hospital inpatient and ambulatory care settings in rural areas. The goal is to identify no more than 10 to 20 measures for each setting.

Using selection criteria identified by the Workgroup in previous webinars, NQF staff developed a tiered weighting system to apply to NQF-endorsed measures that apply to hospital and ambulatory settings (see table below). NQF staff used this system to assign a score to each measure, then used the scores to help identify the "strawman" draft core set for Workgroup discussion.

Tiered Selection Criteria and Weights Used to Identify Draft Core Sets

Tiered selection criteria	Weight
Tier 1: Cross-cutting	25%
Tier 1: Resistant to the low case-volume challenge	25%
Tier 1: Transitions of care	20%
Tier 2 • Mental health • Substance abuse • Medication reconciliation	15%
Tier 3 • Diabetes • Hypertension • Chronic obstructive pulmonary disease (COPD)	10%
Tier 4 • Readmissions • Perinatal • Pediatrics	5%

Tier 1 includes the selection criteria most preferred by the Workgroup to identify core set measures. Tiers 2-4 include additional conditions or topics that the Workgroup identified as important to consider for potential inclusion in the core sets. The descending tiers and their weights reflect the relative strength of preference by the Workgroup.

To obtain a score for each measure, staff first tagged the measure with a "one" or "zero" (1/0) to indicate whether the measure is cross-cutting; resistant to low case-volume; assesses transitions of care, and reflects topics included in tiers 2-4. Then, staff calculated the score using the percentage weights noted above.

Of the 444 NQF-endorsed measures considered, 284 had a nonzero score. Staff used the 75th percentile of the nonzero scores (≥0.50) as a cut-point to further narrow the list of measures; this step resulted in 119 measures. After review, staff identified a strawman core set of 44 measures, based on earlier Workgroup discussions as well as information from NQF's 2015 Rural Health Project.

Ms. Johnson also oriented the Workgroup to the excel spreadsheet of measures provided for their review. This spreadsheet contains basic information about each measure, as well as the tagging and scoring information and information regarding inclusion in the strawman draft core set.

Workgroup Discussion

Following Ms. Johnson's presentation, Dr. Ira Moscovice, Workgroup co-chair, facilitated discussion of the strawman draft core set. The Workgroup identified the following as additional considerations for identifying a core set of rural-relevant measures:

- **Ease and cost of data collection**. Workgroup members noted that different care entities that serve rural areas may have differing abilities to collect and report measure data and core set measures must be feasible for the majority of rural providers.
- **Balancing measure types**. Members inquired as to the balance of the measure types included in the strawman core set and suggested that outcome measures receive a higher rating than others, given CMS's preferences for using outcome measures.
- **Consider measures related to venous thromboembolism (VTE)**. This condition was not initially included in the list of conditions/topic areas for consideration, but one member suggested that it should be considered. Another member noted that VTE is different from the conditions in tier 3, which are chronic conditions that have high cost, high utilization, and high prevalence in rural areas.
- **Use in federal or other programs**. The Workgroup suggested considering use of measures in federal or other programs as a way to align measures across various programs. The spreadsheet provided to the Workgroup flagged those measures used in many CMS programs. Staff suggested that Workgroup members add to this information as part of their post-webinar work.
- **Consideration of the set and its ability to describe the overall quality of the measured entity**. Workgroup members noted that as they become closer to finalizing the core sets, they should consider whether the set, in its entirety, adequately addresses the quality of a hospital, clinic, clinician, etc.

- **Consideration of potential unintended consequences.** Although this topic was addressed primarily in the discussion of measurement gaps, the Workgroup agreed that potential unintended consequences should be assessed as part of identifying the core set of measures.

Discussion of Measurement Gap Areas

The Workgroup also discussed and identified measurement gap areas. Ms. Johnson reviewed the measurement gaps identified in the 2015 rural health report and strawman draft core set. Dr. Aaron Garman, Workgroup co-chair, facilitated the discussion for additional gaps. Key points of the discussion included the following.

Access

- The Workgroup noted the absence of telehealth, describing it as a way to address lack of access to care. While members felt that measures should include telehealth as an option for care delivery, the focus should be on measuring access to care more generally.
- The Workgroup agreed that access to care is a measurement gap, but that measuring access should be done with careful consideration for potential unintended consequences. Members discussed measures of timeliness of care as an example, recognizing their usefulness as indicators of access, but also the potential unintended effect of penalizing a provider that transfers a patient to another facility because of the patient's increased wait time for receiving a procedure.

Disparities in Care

- The Workgroup discussed the lack of measures that can be used to assess disparities in care. NQF staff noted that measures submitted to NQF for endorsement sometimes have information regarding disparities, but these data are not easily extractable.

Differing Values of Patients and Providers

- Members noted that the patients and providers often value different things. They pointed to recent research by the University of Utah indicating that while access and cost are most important to patients, providers often are more interested in their patients' health outcomes and their own adherence to standards of care. Members suggested that the core set include measures that address these different values.

Outcome Measures, Particularly Patient-Reported Outcomes

- Some Workgroup members thought that the strawman draft core set does not include enough outcome measures in general, and particularly not enough measures from the "patient's voice."
- Workgroup members emphasized that it should strive to include outcome measures in the core set that are not overly specialized. For example, a measure that assesses cancer versus breast cancer only will be more applicable to rural providers and more resistant to the challenges of low case-volume.

Discuss Rural-Relevant Measurement Topic

In addition to identifying a core set of measures and measurement gap areas, the Workgroup is charged with addressing a rural-relevant measurement topic. The Workgroup has discussed potential topic ideas during previous calls, but only in a very limited way. During this call, the project team summarized two topics that seemed to be of most interest to the Workgroup. Suzanne Theberge, senior project manager, introduced and reviewed two topics: access to care and swing bed quality. NQF staff welcomed the Workgroup to propose additional measurement topics.

In describing the access-to-care topic, Ms. Theberge suggested that the Workgroup could focus how access could be best assessed for rural areas and how the discussion might be scoped; she flagged previous access issues that the Workgroup had mentioned, including timeliness of care, distance to care, cost/affordability, and specific topic areas, including trauma care and obstetrics. One of the potential areas of focus could be that the Workgroup take the NQF definition of access to care and discuss how it would apply to rural residents and providers.

Dr. Moscovice briefly summarized work on swing bed quality that is underway at the University of Minnesota, and how the Workgroup could potentially contribute. Dr. Moscovice explained that his team is developing and testing quality measures for swing bed patients in critical access hospitals. He suggested that the Workgroup could offer some helpful input on this topic, including identifying how currently existing measures could be modified to include swing bed patients.

Staff clarified that the measurement topic and the measure core set are two distinct deliverables of the Workgroup and that they can, but do not have to, overlap.

Workgroup members supported the selection of access to care as the measurement topic, while also agreeing that the time constraints of the project would require a very narrow focus.

Public Comment

Dr. Moscovice opened the web meeting to allow for public comment. One public comment was received. The public comment was from the Centers for Medicare & Medicaid Services (CMS). The commented noted that CMS encourages the development of more outcome measures and notes that decisions related to the inclusion and removal of process measures from federal programs will be done on a case-by-case basis.

Next Steps

Following the webinar, staff will ask the Workgroup to suggest additional measures to be considered for the core set. Following this, staff will ask the Workgroup to provide specific feedback as indicated from today's discussion, on the 44 strawman measures and any additional measures identified by the Workgroup.

This feedback will be included in draft report #1. NQF will re-convene the Workgroup for webinar #4 on February 14, 2018 to review this draft report. NQF will post draft report #1 on February 28, 2018 for public viewing.