NATIONAL QUALITY FORUM
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Meeting Summary

Rural Core Set Update Web Meeting 2

The National Quality Forum (NQF) convened a public web meeting for the Rural Health Advisory Group on March 1, 2022.

Introduction and Overview

Nicolette Mehas, NQF Senior Director, began by welcoming participants to the web meeting. Dr. Mehas reviewed agenda items for the meeting and introduced Advisory Group co-chairs Kimberly Rask and Keith Mueller, who welcomed the group and expressed enthusiasm for the day's conversations.

Amy Guo, NQF Manager, facilitated roll call for the Advisory Group and acknowledged partners at the Centers for Medicare & Medicaid Services (CMS) and the Health Resources and Services Administration (HRSA). Ms. Guo also reviewed the following objectives for Web Meeting 2:

- Provide results of the Environmental Scan;
- Begin discussion of the current measures in the core set and their continued relevance for rural healthcare; and
- Identify criteria to narrow down the measures being considered for addition.

Ms. Guo also reviewed the True North statement with the Advisory Group. The True North statement reflects the overall end goal of the project and reads as follows:

- The purpose of this project is to update the core set of rural-relevant core measures originally created by the Rural Health Advisory Group in 2017-2018, so that the included measures remain relevant to the most important issues that rural areas face today.
- The updated core set will inform key stakeholders about the best measures available for use in a range of rural healthcare settings; promote alignment in the measures used to assess rural healthcare quality; and encourage development of new measures in priority gap areas. The updated core set is not designed to make specific recommendations for measure use in current or future CMS programs.

Finally, Ms. Guo reminded Advisory Group members of the purpose of the environmental scan. The environmental scan identifies changes to the current measures in the core set, as well as newly available measures in topic areas previously identified as rural-relevant as well as measures in emerging areas of concern for rural health. The measures identified in the environmental scan will be narrowed down and prioritized to inform updates to the rural core set and the final recommendations report.

Review and Discussion of Existing Core Measure Set

Dr. Mehas provided an update on major changes to measures in the current rural core set. Overall, ten measures (50% of the core set) are actively used in federal programs, and 14 measures (70% of the core set) have maintained NQF endorsement. Two measures in the core set underwent notable changes in measure specifications, including NQF #1717 *National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital Onset Clostridium difficile Infection (CDI) Outcome Measure* (specification updates

submitted through the 2021 Measure Applications Partnership cycle) and #0059 *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* (adjusted to support telehealth use).

Dr. Mehas also noted six measures in the rural core set that have been discussed since 2017 by the Rural Health Advisory Group and identified as potentially having low case-volume challenges:

- NQF #0138 *NHSN Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure*
- NQF #0166 *Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) [Note: includes 11 performance measures under this NQF number]*
- NQF #0371 *Venous Thromboembolism Prophylaxis*
- NQF #0471 *PC-02 Cesarean Birth*
- NQF #1789 *Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)*
- NQF #1717 *NHSN Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI) Outcome Measure*

Dr. Mehas remarked that NQF staff sought data on the ability of critical access hospitals (CAHs) to report on these measures through a random sampling of 25 CAH facilities using the Hospital Compare tool of CMS' Care Compare website. Two of the measures, NQF #0138 (CAUTI outcome) and #1717 (*C. difficile* outcome), were reported on by 2 and 11 facilities in the sample, respectively. Dr. Mehas noted that reporting in Hospital Compare is voluntary, and therefore non-reporting may not be due to inability to report a measure. Non-reporting may be the result of low case-volume, a lack of claims data, or the facility may choose not to report on a given measure, among other reasons.

Advisory Group members discussed how certain aspects of a measure's specifications may make it more prone to case volume challenges in rural areas. One member noted that although some measures, such as NQF #0166 (HCAHPS), may be important to providers in rural settings, they are hampered by exclusions that greatly reduce the number of eligible cases or by low response rates due to the timing of survey administration. The HCAHPS measure can lose reliability without a sufficient sample size. Advisory Group members agreed that patient-reported outcome measures are critical, but difficult to capture in rural settings. Therefore, maintaining NQF #0166 in the existing core measure set and exploring modifications of its specifications for rural settings may be desirable. NQF staff noted that as part of the updates to the core measure set, the Advisory Group may choose to make recommendations on how to improve the reportability of some measures in rural settings, such as relaxing exclusion criteria for rural settings to achieve sufficient response levels.

Dr. Mehas shared a list of ten measures identified for further discussion based on inactivity in federal programs and loss of endorsement, or potential low case-volume challenges. Dr. Mehas explained that based on these criteria, which the Advisory Group identified as important in Web Meeting 1, Advisory Group members may consider removing some of these measures from the core measure set. Dr. Mehas emphasized that today's discussion would not eliminate any measures, only identify those that will be discussed for removal in Web Meeting 3. An Advisory Group member commented that NQF #1661 (alcohol use screening) addresses an important topic area and the measure developer is working on redesigning this measure as an electronic clinical quality measure (eCQM), and encouraged the group to discuss the potential value of this measure. Another member noted that recent C-section statistics show elevated rates, and shared that NQF #0471 (cesarean birth) would be helpful to identify states with excessive C-sections. Finally, a group member asked if there is still a performance gap for #0138 (CAUTI outcome); another member shared that recent Centers for Disease Control and Prevention data demonstrated a rise in NHSN rates during the pandemic, so room for improvement remains for both #0138 and #1717 (*C. difficile* outcome). One member also shared that NQF #0421, *Preventive Care and*

Screening: Body Mass Index (BMI) Screening and Follow-Up, is currently being used by the Health Resources & Services Administration (HRSA).

The Advisory Group completed an in-meeting survey to gauge initial views on whether each of these 10 measures should be considered for potential removal. If less than 60% of the group agreed that a measure should stay in the core set, the measure would be discussed in further detail during Web Meeting 3. Measures that surfaced for further discussion for removal (27%-45% vote to keep in core measure set) during Web Meeting 3 include:

- NQF #0202 *Falls with injury*
- NQF #0371 *Venous Thromboembolism Prophylaxis*
- NQF #1661 *SUB-1 Alcohol Use Screening*
- NQF #0421 *Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up*

The Advisory Group was in strong agreement that the current measures related to catheter-associated urinary tract infections, *C. difficile* infection, cesarean birth, HCAHPS, and hospital-wide all-cause unplanned readmissions (NQF #0138, #1717, #0471, 0166, and #1789, respectively) should stay in the rural core set (64% to 91% voting to keep in core set, excluding abstentions). The group was in moderate agreement that measure #0291 *Emergency Transfer Communication Measure* should stay in the rural core set (60% vote to keep in core set).

Dr. Mehas caveated that these results may shift slightly, as the survey would remain open until the end of the day to allow for additional responses from Advisory Group members who were unable to attend the meeting. The final results will be shared with the Advisory Group via email in the days following the meeting. Dr. Mehas asked if there were any additional questions on the results; there were no additional questions.

Discussion of New Rural-Relevant Measures and Prioritizing Emerging Areas for Measurement

Dr. Mehas provided an overview of the newly endorsed measures identified in rural-relevant areas. As part of the scan, NQF staff identified 71 measures newly endorsed in 2018 or later and reviewed these measures to determine whether they addressed rural-relevant topic areas previously identified by the group. NQF excluded measures that did not address any rural-relevant topic areas, as well as measures outside the clinician, facility, or population level of analysis. NQF also excluded several measures that were likely to face low case-volume challenges based on a review of the description (i.e., measures addressing very specific conditions or procedures). After these exclusions, a total of 37 measures remained for further consideration. Of these measures, 54% were cross-cutting. The most commonly addressed topic areas included patient hand-offs and transitions and patient experiences of care, and the most commonly addressed services were outpatient and inpatient services.

Dr. Mehas also shared an overview of the measures identified in emerging areas for measurement. NQF staff reviewed public health statistics and reports on rural health to identify topic areas of increasing importance in rural areas, as well as soliciting input from Advisory Group members during Web Meeting 1 in January. The identified topic areas included measures that can be used to understand telehealth use, equity (including social determinants of health and access to social services), infectious diseases (including COVID-19), population or community-level health measures, kidney health, and dementia. A total of 137 measures were initially identified in these areas; after excluding measures previously discussed for the core set, measures already represented in the “New Rural-Relevant Measures” portion of the scan, measures outside the target level of analysis, measures with likely low case-volume

challenges based on NQF review, and measures where specifications are no longer publicly available, a total of 81 measures remained for further consideration. The most commonly addressed topic areas were infectious disease and population health measures, while the most common care settings were outpatient and inpatient services.

An Advisory Group member remarked that there are few measures that have been specifically developed for low-volume environments, and asked how the Advisory Group can encourage measure development to avoid intensive review of measures in the future to identify rural-relevant measures. Another Advisory Group member agreed with this comment, noting that low case-volume is an inherent part of quality measurement in rural areas and measures that address rural-relevant topic areas but are not resistant to low case-volume are a missed opportunity. An Advisory Group member commented that the challenge may be in part due to transitions in care, where patients receiving care at multiple facilities are not receiving surveys or filling them out for multiple locations. A member suggested that adjusting existing measures (e.g., HCAHPS) to use more rural-friendly methodologies could be another avenue for development; the member commented that most measures are developed for high-volume hospital environments, and without specific statistical adjustments, these measures are not usable in rural areas. Another member provided an example, suggesting that for rural populations (especially for elderly patients and patients with limited access to computers), it may be easier to get responses to surveys through phone interviews than other methods. NQF thanked the Advisory Group for this input and noted that they will hold some time in the remaining Web Meetings to discuss gap areas and suggestions for promoting development of rural-relevant measures resistant to low case-volume.

Dr. Mehas shared that between the newly endorsed rural-relevant measures and the measures related to newly identified emerging areas, a total of 118 new measures currently remain for further consideration. Dr. Mehas shared that the team is proposing a scoring approach similar to the tiered weighting approach used in 2017-2018 to help prioritize measures within the most important topic areas and develop a shortlist of measures to discuss during Web Meeting 3. The shortlist will be developed using a two-part approach. First, NQF will solicit the Advisory Group's feedback on the relative importance of measure characteristics (endorsement status, whether the measure is cross-cutting, outcome or patient-reported outcome-based performance measure [PRO-PM] measure type, and active status in federal programs). NQF will use this information to generate a weighted score in which measures with a greater number of these characteristics will have a higher overall score. NQF will also seek input from the Advisory Group on the highest priority conditions and topic areas for addition to the core set. In preparation for Web Meeting 3, NQF will group measures into high-priority, rural-relevant topic areas and select high-scoring measures within each group for further consideration. The Advisory Group would also have an opportunity to review the measures and propose additional measures for discussion during the meeting.

Dr. Rask opened discussion to the Advisory Group on the characteristics that would be most helpful to consider for narrowing the measures. An Advisory Group member affirmed that cross-cutting measures remain important, as many measures are developed for high-volume hospital settings and are not relevant to small rural hospitals, and cross-cutting measures avoid this concern. Another member agreed that cross-cutting measures are important to avoid low case-volume issues. Another member noted that care in settings outside hospitals (e.g., outpatient care) is also important, and reiterated the importance of NQF endorsement and outcome measures. Another member agreed that NQF endorsement remains very important as a desired characteristic.

A member asked for clarification on the difference between NQF and federal endorsement; a co-chair clarified that NQF endorses measures and the government selects measures to use in federal payment

programs, but these are two separate processes. NQF staff clarified that for the purposes of the environmental scan, the team noted whether each measure came through the NQF endorsement process, meaning that a committee reviewed the evidence and testing supporting the appropriateness of the measure. The team also separately noted whether the measures are being used in federal programs as a proxy for promoting alignment and understanding which measures are already being widely reported. Another Advisory Group member commented that the criteria for submitting a measure to CMS' Measures Under Consideration list (for measures to be considered for use in federal programs) are similar to those required for the NQF endorsement process.

Dr. Rask also facilitated discussion on conditions and topic areas that are highest priority for addition to the core set. Dr. Mehas noted that measures were identified in the following clinical and cross-cutting topic areas as part of the environmental scan:

Table 1. List of Topic Areas Addressed by New Measures in Environmental Scan

Clinical Care	Cross-Cutting
• Alzheimer's disease/dementia • Asthma • Behavioral/Mental Health • Cancer Screenings • Chronic Obstructive Pulmonary Disease • Diabetes • Emergency Services • Heart Failure • Hypertension • Infectious diseases (including COVID-19) • Kidney Care • Pediatrics • Pneumonia • Substance Use • Surgical Care	• Access to Care • Equity/social determinants of health (SDOH) • Medication Management • Patient Experiences of Care • Patient Hand-Offs and Transitions • Population or community-level health • Readmissions • Telehealth-relevant

An Advisory Group member emphasized that access to care should be part of any effort to assess quality of care, and that it remains a critical part of understanding care in rural communities. A member noted that the current core set was not developed with a telehealth lens, so considering additional telehealth-relevant measures would be a valuable addition; another member agreed with this comment. A member also reiterated the importance of measures related to emergency services. A member noted that measures related to diabetes and kidney care could be considered together as one category. A member noted that in previous conversations, group members placed high priority on cancer screenings due to limited access to care and lower rates of cancer screenings in rural communities; a general cancer screening measure could be resistant to low case-volume issues. Another member agreed that cancer screening is important, noting that follow-up for cancer care is lower in rural areas and death rates may be higher in rural areas (e.g., cancers related to environmental toxins).

The Advisory Group completed an in-meeting survey to provide input on the relative importance of measure characteristics, as well as the most important clinical care and cross-cutting topic areas to add to the rural core set. NQF staff clarified that the intent of the survey was not to limit additions to five

topics overall, but to understand the topics where the Advisory Group is in strong agreement. The overall number of topics considered would depend on the distribution of votes and is not limited to five. Dr. Mehas noted that the results would be shared back with the group via email following the meeting to allow the Advisory Group time to complete their responses and the project team time to analyze the results.

Dr. Mehas thanked the group for providing their input and noted that NQF will share back a shortlist of measures in each condition/topic area prior to Web Meeting 3. As previously noted, the Advisory Group will have an opportunity to suggest any additional measures that should be reconsidered for discussion. During Web Meeting 3, the group will discuss measures grouped by topic area using the following questions as guidance:

- Is the measure susceptible to low case-volume?
- Does the measure have opportunity for improvement?
- Is the measure risk adjusted appropriately for rural providers?
- Does data collection burden for the measure outweigh the benefit for rural residents and providers?
- Will this measure meaningfully affect patient outcomes?
- Does this measure have potential unintended consequences?
- Does this measure assess care for the appropriate entities?
- What is the intended use of the measure (e.g., pay-for-performance, pay-for-reporting, quality improvement)?

Public Comment

Dr. Mehas opened the web meeting to allow for public comment. There were no comments offered.

Next Steps

Rebecca Payne, NQF Manager, shared that the feedback from the meeting would be used to inform additional updates to the environmental scan. Ms. Payne noted that after these changes are integrated into the scan, it will be posted for public comment from March 23 through April 20, 2022. After the public commenting period, the Advisory Group will meet on April 29 to discuss comments received on the scan, as well as discussing individual measures for potential addition and removal from the core set. NQF staff will share the meeting summary and voting results with the Advisory Group via email next week. Dr. Mehas and the co-chairs thanked the Advisory Group for their participation before adjourning the meeting.