NATIONAL QUALITY FORUM

Meeting Summary

MAP Rural Health Workgroup—Webinar #4.5

The National Quality Forum (NQF) convened the MAP Rural Health Workgroup for a webinar on March 14, 2018 from 3:00 pm to 5:00 pm ET.

Welcome and Review of Web Meeting Objectives

Suzanne Theberge, NQF senior project manager, welcomed participants to the web meeting. Ms. Theberge made opening remarks and reviewed the following meeting objective: finalize Workgroup input on measures being considered for the draft core set. Ms. Theberge conducted a Workgroup roll call and then turned the call over to Karen Johnson, NQF senior director, and Ira Moscovice, Workgroup co-chair, to facilitate the discussion.

Continue Discussion of Draft Core Set

The Workgroup completed its in-depth discussion of the 35 remaining measures included in the draft core set. Further, the Workgroup revisited some measures identified as needing further discussion during its February 14 web meeting.

Readmission

The Workgroup discussed two readmissions measures identified through the core set measure selection process. Workgroup members agreed that both of these measures suffer from potential low case-volume issues. NQF staff noted feedback from another MAP Workgroup that urged caution when selecting readmission measures for rural hospitals because these measures are constructed a way that makes it difficult to distinguish between providers when sample sizes are small. The Workgroup was particularly concerned about 2393 *Pediatric All-Condition Readmission Measure*, because pediatric hospitalizations are rare and readmissions even rarer, and members felt that many rural hospitals do not have the volume to report on this measure. In addition, rural hospitals may be more likely to transfer pediatric patients out to larger hospitals due to limited staffing (for example, only one full time pediatric provider for an entire hospital); lack of resources to treat certain illnesses; or the aim of ensuring access to a pediatric intensive care unit, if needed. Given these concerns, the Workgroup agreed that 2393 was not an appropriate measure to include in the core set. Workgroup members noted that the 1789 *Hospital-Wide All-Cause Unplanned Readmission Measure* is being used for acute care hospitals, and that including this measure in the core set would allow rural hospitals to compare themselves to hospitals nationwide. Workgroup members liked the idea of having a measure they could use to compare rural and urban hospitals, but after discussion, remained concerned about the volume issues and the risk adjustment methodology used in the measure. Ultimately, the Workgroup did not come to consensus about inclusion of this measure in the core set. Members will revisit this measure after obtaining feedback during the public commenting period.

Perinatal

The Workgroup next discussed four measures of perinatal care. Group members favored including 2903 *Contraceptive Care—Most & Moderately Effective Methods*, a facility, health plan, and population level measure. Workgroup members again had low case-volume concerns with the other three perinatal measures, 0469 *PC-01 Elective Delivery*, 0471 *PC-02 Cesarean Birth*, and 0476 *PC-03 Antenatal Steroids*. Workgroup members noted that limited resources in terms of providers who can provide obstetrical care are a concern for rural areas (e.g., some hospitals may only be able to do deliveries a few days a week). Workgroup members also noted that in very rural areas, family practice providers are doing deliveries, and general surgeons are providing cesarean sections, and members wondered if their care can be fairly compared to care provided by obstetricians. However, other members noted that these measures focus on what are considered best practices in obstetric care (reduction in cesarean section deliveries, elimination of premature deliveries that are not medically necessary, and provision of steroids in cases of premature labor). These Workgroup members further expressed that care provided should meet these standards. Workgroup members noted that many rural hospitals do not provide any obstetric care at all, and while it varies, they thought close to 40 percent of rural hospitals do not do deliveries. Ultimately, the Workgroup decided to include 0471, but not to include 0469 and 0476 due to low case-volume issues.

Pediatrics

The Workgroup discussed four potential pediatrics measures for inclusion in the core set. Three of the measures are specified at the health plan level, and Workgroup members discussed creating an additional list of rural-appropriate measures that would be specified at the plan level (as opposed to facility or ambulatory care level). Workgroup members agreed not to include 1516 *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*, due to concerns about data collection over such a long period. Workgroup members also decided not to include 0047 *Asthma: Pharmacologic Therapy for Persistent Asthma* and 1392 *Well-Child Visits in the First 15 Months of Life*. The Workgroup recommended measure 0024 *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* on the health-plan level list because the topic plays a major role in pediatric health.

Palliative

The Workgroup considered three measures of palliative care. Workgroup members agreed that all three are strong measures that cover an important topic for rural communities, but that given the small size of the core set, they should only select one measure. The Workgroup selected measure 0326 *Advance Care Plan* as the most cross-cutting measure, and because it addresses transitions of care, as well as being the one most resistant to low volume issues. The Workgroup did not select measures 0420 *Pain Assessment and Follow-Up* and 1641 *Hospice and Palliative Care—Treatment Preferences*.

Patient Safety—Falls

The Workgroup considered three measures of Patient Safety—Falls (distinct from the larger topic of patient safety). The Workgroup noted that 0141 *Patient Fall Rate* and 0202 *Falls with Injury* were redundant. They strongly preferred measure 0202 *Falls with Injury,* noting that 30 percent of inpatient falls result in injury, leading to increased morbidity and mortality; further,

this is an outcome measure, and the Workgroup agreed that it was a valuable addition to the core set. The Workgroup elected not to include 0141 *Patient Fall Rate* or 0101 *Falls: Screening, Risk-Assessment, and Plan of Care to Prevent Future Falls.* They felt that 0101 was a simple clinician-level process measure with very limited room for improvement in performance (i.e., it is "topped out").

Patient Safety

The Workgroup considered five measures that assess patient safety: 0371 *Venous Thromboembolism Prophylaxis*, 1550 *Hospital-level risk-standardized complication rate (RSCR) following elective primary total hip) and/or knee arthroplasty*, 2720 *National Healthcare Safety Network (NHSN) Antimicrobial Use Measure*, 0531 *Patient Safety for Selected Indicators (modified version of PSI90)*, and 0709 *Proportion of patients with a chronic condition that have a potentially avoidable complication during a calendar year*. The Workgroup noted that three of the measures (1550, 2720, and 0531) are susceptible to low case-volume concerns. One member said that the concept of 0709, assessing a population for a variety of conditions, would be useful, but thought that because it is measured at the clinician level, there might be a heavy reporting burden. Although the Workgroup expressed initial concern that 0371 would be susceptible to low case-volume issues, upon reflection, members noted that the measure applies to patients who have received prophylaxis or who had documentation as to why no prophylaxis was given; it also applies to both medical and surgical inpatients (though there are some exclusions). The Workgroup agreed to include 0371 and not the other four measures due to low case-volume concerns for 1150, 2720, and 0531, and concerns about reporting burden for 0709.

Healthcare Associated Infections (HAI)

The Workgroup discussed four measures of healthcare associated infections. They agreed that low case-volume might be a concern for all four measures, but that acute care hospitals and nursing homes are already reporting on this topic area, and many structures are in place for this process. Workgroup members with expertise in the area noted that 0139 *National Healthcare Safety Network (NHSN) Central line-associated Bloodstream Infection (CLABSI) Outcome Measure* and 1716 *National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia Outcome Measure* represent a sicker patient set and would be especially sensitive to the low case-volume concerns for rural hospitals, whereas 0138 *National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure* targets the most common hospital infection and would have the highest volume among the four measures. Workgroup members also favored 1717 *National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset Clostridium difficile Infection (CDI) Outcome Measure*. Ultimately, they agreed to include 0138 (CAUTI) and 1717 (CDI) in the core set, and agreed not to include 1716 and 0139 due to the low case-volume concerns.

Emergency Department Timing

The Workgroup discussed three measures of emergency department timing, 0495 *Median Time from ED Arrival to ED Departure for Admitted ED Patients*, 0496 *Median Time from ED Arrival to ED Departure for Discharged ED Patients*, and 0497 *Admit Decision Time to ED Departure Time*

for Admitted Patients. Workgroup members felt that these measures are more relevant for overcrowded urban emergency rooms than for rural facilities, where overcrowding is not as much of an issue. Members also noted concerns with potential unintended consequences of the measures for rural providers, although they did not elaborate on what these might be. Ultimately, the Workgroup decided none of the three measures were appropriate for inclusion in the core set.

Post-procedure outcomes

The Workgroup considered three measures assessing outcomes after procedures, 2539 *Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy*, 2877 *Hybrid hospital 30-day, all-cause, risk-standardized mortality rate (RSMR) following acute ischemic stroke hospitalization with risk adjustment for stroke severity*, and 0533 *Postoperative Respiratory Failure Rate (PSI 11)*. Workgroup members voiced concerns about low case-volume for all three measures. They also did not think that these measures met any of the criteria used for selecting measures into the core set. Ultimately, the Workgroup agreed not to include any of the three measures in the core set.

Other

The Workgroup considered four additional measures that did not fit into the other topic areas: 0018 *Controlling High Blood Pressure*; 0439 *STK-06: Discharged on Statin Medication*; 2455 *Heart Failure: Post-Discharge Appointment for Heart Failure Patients*; and 0661 *Head CT or MRI Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke Patients who Received Head CT or MRI Scan Interpretation within 45 minutes of ED Arrival*. Workgroup members liked the blood pressure control measure (0018), and discussed the importance of tracking this chronic condition, but noted that the level of analysis is health plan, not facility or clinician. Members had extensive discussion on the exact specifications of 0661 (door-to-interpretation time, limited to patients with confirmed stroke diagnosis). Workgroup members with the appropriate expertise explained how CT scans often are read (by radiologists or neurologists, not family physicians) and noted that the availability of teleradiology services may affect performance on this measure. The Workgroup agreed that timely imaging and interpretation of results are extremely important, clinically, but ultimately agreed not to include this measure in the core set. Workgroup members decided not to include 2455 because of the initial concern that the measure is not cross-cutting and 0429 since it only applied to individuals who suffered from a stroke and is susceptible to low case-volume concerns. The Workgroup decided to recommend 0018, while noting that the level of analysis is problematic, and stating that staff need to consider how to handle 0018 and other health plan level measures in the core set listing.

Measures Requiring Further Discussion after Webinar 4 on February 14

Measures in the following categories required further discussion following Webinar 4.

Diabetes

Following Webinar 4, NQF staff learned that 0059 *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* is also endorsed at the clinician level of analysis. During the Webinar 4 discussion, 0059 was not considered for the core set because the measure appeared to be endorsed only at the health plan and integrated delivery system levels of analysis. At the

time, the Workgroup only recommended the inclusion of 0729 *Optimal Diabetes Care*. As a result of this clarification, the Workgroup had the opportunity to reconsider inclusion of 0059 in the core set.

The Workgroup discussed whether to include both 0729 and 0059. NQF staff noted that 0729 is an all-or-none composite measure that includes a component of hemoglobin A1c control. The Workgroup discussed whether or not including both measures in the core set would be duplicative. Members agreed that 0729 would provide a view of overall clinical management, while 0059 would provide insight specifically into a patient's degree of control of diabetes. Workgroup members supported including both 0059 and 0729 in the core set.

Transitions

During the previous webinar, the Workgroup did not recommend 0228 *3-Item Care Transition Measure (CTM-3)* because the Workgroup raised concerns that 0228 had elements that would be captured when measuring 0166 *HCAHPS,* and it therefore could be duplicative.

During the March 14 webinar, staff clarified that 0166 is sampled from individuals who are hospitalized, while 0228 includes everyone in a hospital, not just a sample; consequently, 0228 will only be duplicative for the subset of people who received 0166.

The Workgroup members did not change their previous recommendation to exclude 0228 based on this new information.

Substance Use—Tobacco

During the previous webinar, the Workgroup did not come to consensus on whether to include 2803 *Tobacco Use and Help with Quitting Among Adolescents* in the core set. Workgroup members expressed a preference for including a measure in the core set that evaluates a larger population over a narrower one. Members noted that this does not diminish the importance of measuring tobacco use among adolescents, but agreed to recommend only the previously selected measure, 0028 *Preventative Care & Screening Tobacco Use: Screening & Cessation Intervention,* which focuses on adults.

Immunization

During the previous webinar, the Workgroup did not come to consensus on 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*. During Webinar 4, the Workgroup supported measure 0038 but ultimately did not recommend it for inclusion in the core set due to its levels of analysis (i.e., health plan and integrated delivery system rather than clinician). However, during the current webinar, Workgroup members strongly recommended inclusion of some measures (including this one) that could be used at the clinician level even though they have not be specified, tested, or endorsed at that level of analysis.

During the current webinar, Workgroup members reconsidered whether to include one or more measures assessing immunization for influenza. The Workgroup noted that immunizations are administered through sources other than the primary care office, such as pharmacies or district

health offices. While members had previously discussed that the ease of reporting for some of these measures depends on their states' participation in reporting registries, they also agreed that this does not relieve the provider of the responsibility of asking about immunization.

Ultimately, the Workgroup chose to focus on the immunization of patients and did not recommended 0431, which focuses on immunization of medical staff.

The Workgroup also expressed a preference for a measure with a clinician level of analysis over one in which a hospital is the accountable entity, seeing clinician-level accountability as supporting preventive care and a population-based approach to health. Thus, the Workgroup did not recommend 1659 for inclusion in the core set, as it is measured at the hospital level of analysis, but did recommend 0041.

Experience with Care

During the previous webinar, 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)*.

The Workgroup had previously raised concerns regarding low case-volume for 2548; it reiterated this concern and thus did not recommend this measure for inclusion in the core set. However, the Workgroup supported the inclusion of patient experience measures for both the inpatient setting and outpatient setting, and therefore recommended the inclusion of both 0166 and 0005.

Mental Health (Depression)

A Workgroup member expressed the preference for a depression measure that is currently included in federal quality payment programs for the purpose of alignment. The staff clarified that both 0710 *Depression Remission at Twelve Months* and 0711 *Depression Remission at Six Months* are included in the Merit-Based Incentive Payment System (MIPS). Workgroup members did not change their previous recommendation for inclusion of 0711.

Public Comment

Kate Buchanan, senior project manager, opened the web meeting to allow for public comment. There was one public comment from the National Accreta Foundation. The commenter felt that 0471 *PC-02 Cesarean Section* meets the majority of the Workgroup's criteria for rural-relevant measures and that the Workgroup's only issue with the measure was the low case-volume challenge. The commenter requested that the Workgroup consider looking at the actual birth volume data of rural hospitals prior to making its final decision on 0471.

Ms. Buchanan thanked the commenter and noted that the Workgroup will consider this input during future deliberations.

Next Steps

Following the webinar, staff will provide the Workgroup with a summary of its decisions on measures for inclusion in the core set. The Workgroup will have the opportunity to review the core set prior to Webinar 7 on July 19. The next two webinars, Webinar 5, on March 28, and

Webinar 6, on April 25, will be dedicated to discussing recommendations for the measurement topic of access to care. A second draft report will summarize the recommendations and the most recent version of the core set. The second draft report will be posted for a 30-day public comment period on May 31.