NATIONAL QUALITY FORUM

Meeting Summary

MAP Rural Health Workgroup—Webinar #5

The National Quality Forum (NQF) convened the MAP Rural Health Workgroup for a webinar on March 28, 2018 from 1:00 pm to 3:00 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 meeting objective to discuss measuring access to care. Ms. Theberge conducted a Workgroup roll call and then turned the call over to Karen Johnson, NQF senior director, to begin the discussion of measuring access to care from a rural perspective.

Review and Discuss Measuring Access to Care

Ms. Johnson reviewed previous NQF work on access to care by the Disparities and Telehealth committees. Ms. Johnson then introduced additional concepts of access to care for the Workgroup's consideration. This laid the foundation for the Workgroup's discussion of measuring access to care through a rural lens.

Review NQF's Definition and Frameworks

Ms. Johnson reviewed NQF's definition of access-to-care measures: "measures that assess the ability to obtain needed healthcare services in a timely manner, including the perceptions and experiences of people regarding their ease of reaching health services or health facilities in terms of proximity, location, time, and ease of approach." Ms. Johnson then presented two NQF measurement frameworks that feature domains and subdomains relevant to access to care. NQF's Health Equity Framework includes a domain of assessing equitable access to care, with subdomains that further describe the concepts of availability, accessibility, affordability, and convenience. NQF's Measurement Framework for Telehealth includes a domain of assessing access to care via telehealth, with subdomains that further describe concepts of access for the patient, family, and caregiver, access for the care team, and access to information. These subdomains are further explained by referencing the affordability, availability, accessibility, accommodation, and acceptability of telehealth.

Discuss Additional Concepts for Consideration

Ms. Johnson then reviewed several additional concepts for consideration around measuring access to care from the rural perspective, including:

- accommodation (e.g., language, literacy, culture, transportation, cognitive barriers such as dementia, etc.);
- accessibility (in terms of frequency of available care, such as for mental health treatment, or types of care, such as prenatal, pediatric, dental, etc. and access to health information such as patient portals and medical records);
- affordability (including underinsurance); and
- geography (e.g., barriers of distance, travel time, or availability of transportation).

Discuss Measurement of Access to Care from the Rural Perspective

Ms. Johnson briefly reviewed several questions and then asked Dr. Moscovice to facilitate the Workgroup's discussion of the questions during the remainder of the meeting.

How is access related to quality?

The Workgroup discussed how access is related to quality; whether or not they are the same thing; and if not, how they are different. Dr. Moscovice launched the discussion by noting that while many are thinking about it, it is not yet clear how access and quality are related in the rural environment and how that relationship might differ in an urban environment. Workgroup members agreed that access and quality are difficult to de-link. Some members equated access to quality, suggesting that without access to care, one cannot have quality care. However, they also acknowledged that access does not ensure quality, and noted the importance of avoiding a two-tiered system wherein rural residents have reasonable access yet receive less-than-optimal care. Given these two somewhat contradictory statements, Dr. Moscovice suggested that access isn't equivalent to quality but is a strong determinant of quality, at least in some environments. He suggested that the Workgroup discuss the various components of access and how they relate to quality.

Workgroup members noted that quality measurement that does not take into account the lack of access can have unintended consequences. One member commented that it is difficult to account for the outcomes that are not measured (the "null set"). Using the example of a baby delivered outside a hospital because the hospital stopped providing obstetric care, this member noted that it then becomes difficult to measure the infant mortality rate and associate it with the lack of access. Thus, an unintended consequence is a potentially faulty view of care quality when the scope of services is limited, for whatever reason. In addition to obstetric care, Workgroup members highlighted emergency care and colonoscopy screening services as two areas that are particularly rural sensitive. Because timeliness is key for trauma care, members noted that decisions regarding trauma management (e.g., whether to send car crash victims to a local facility for triage or directly to a tertiary center) may differ in rural versus urban areas. For colonoscopy care, the issue for rural residents is distance and/or travel time. Specifically, when travel is required in order to obtain this screening, rural residents may find it difficult to adequately prepare for the procedure, unless, for example, they have the means to afford a hotel room. A Workgroup member from Alaska noted additional access issues include seasonal timing, for example, planning on not sending specialists out to remote areas during fishing season. She also noted challenges with patient communication for some rural areas due to lack of reliable internet or telephone services. Another member also noted the difficulties for many rural residents in accessing chemotherapy and care for children with chronic conditions.

One member also noted that from a system of care perspective, the failure to provide some services (such as access to behavioral health services) can complicate the need for and delivery of other services (e.g., those with unaddressed depression or anxiety may have higher levels of pain).

Lack of insurance and underinsurance can also affect access to care. For example, rural residents may be less likely to have generous post-retirement coverage, making it less affordable to obtain Medicare-covered services.

Workgroup members noted problems with payment based on measurement; a rural hospital providing good but not great care may not be adequately reimbursed (or may even be penalized financially) and may therefore struggle to provide needed care. NQF staff cautioned that it is important not to conflate the construction of a measure with the construction of a payment program using measures. In turn, Workgroup members noted the importance of accounting for the particular challenges rural providers face and recommended consideration of any data that illuminate the payment implications for rural providers when contemplating use of particular measures.

Who should be held accountable?

Ms. Johnson raised some preliminary questions on accountability for access to care. As an example, she noted that while it does not make sense to hold an individual clinician accountable for the availability of specialists, it may be reasonable to hold them accountable for improving access by having flexible appointment times. She also noted that the discussion doesn't have to be limited to individual clinicians, as other entities such as hospitals, health plans, communities, and states could reasonably influence access to care.

One Workgroup member noted the challenges of holding individual clinicians accountable for things that can also be influenced by regional realities or personal decisions by patients, yet acknowledged the role of individual clinicians in influencing outcomes that he or she may not be able to control completely. As an example of ways to influence access to care, one member informed the Workgroup that her organization is working with Lyft and the Blue Cross Blue Shield Institute to meet transportation needs of patients, noting that such collaborations can be key to improving access. Other Workgroup members highlighted the importance of higher levels of accountability, including the integrated health plan and integrated health delivery system levels, and even the program level (e.g., Medicare or Medicaid programs). Another member flagged the importance of considering who is actually providing care: a physician's assistant or nurse practitioner may be the one providing the service, yet the EHR or billing system may attribute that care to the supervising physician.

Workgroup members agreed on the need for discussion about what barriers are particular to rural areas, and who has a role to play (either directly or indirectly) in resolving those barriers. Workgroup members agreed that health system accountability is extremely relevant, and perhaps more so than individual clinician accountability for certain facets of access to care. Again, Workgroup members noted the potential for unintended consequences, citing the example of a large system closing outlier facilities because they are not as efficient, and in the process, creating barriers to access for residents in smaller communities who had been served by these facilities.

Can we prioritize certain domains/subdomains for rural populations?

The Workgroup opened the discussion with examples of the subdomains of access to care that are particularly sensitive to the needs of rural residents and providers.

- availability – timeliness of appointments with specialists (particularly when travel distance is great)
- accessibility – language, both in terms of the language spoken and health literacy

- affordability – insurance has become more expensive and coverage is less broad
- convenience – many individuals travel great distances to receive specialist care

The Workgroup also noted an additional facet of access to care not previously discussed: that of reconnecting residents to local care after they have "left the community" in order to obtain specialized care (i.e., a particular rural-relevant aspect of follow-up care and care coordination).

Members also noted that prioritization of the domains and subdomains depends heavily on the perspective used. For instance, from a patient's perspective, affordability and convenience may be the most important domains. On the other hand, a system of care may prioritize the availability of essential services such as primary care or behavioral health, while a third-party payer or an Accountable Care Organization (ACO) might focus on time and distance of services.

Finally, one member suggested that the group consider whether to prioritize digital access and health information access as key measurement opportunities from the rural perspective, as these subdomains may be especially important in fostering patient involvement in their own care.

Can we make valid comparisons between providers (rural and nonrural) for the domains/subdomains?

The Workgroup agreed that the ability to compare rural providers with each other or with nonrural providers exists in some areas of care and quality. For instance, do providers offer appointments outside of usual hours; do patients have access to an electronic portal; or do providers offer televisits? However, members noted that some comparisons may be more appropriate at a systems level instead of an at the individual clinician level.

Another member reminded the Workgroup that additional provider types beyond individual clinicians and hospitals (e.g., home health agencies) must be considered when measuring access to care. This member noted again the importance of measuring access at the system and program levels to ensure that they are designed to facilitate access to care (for example, availability of home and community-based services). This member also cautioned about comparing rural and nonrural providers on things like timeliness or numbers of visits, because variations in provider density, distance, or travel time might invalidate those comparisons.

How can measures be constructed to ensure validity of comparisons across providers?

The Workgroup agreed that risk adjusting quality measures for social determinants of health as well as for other aspects of rural environments and populations (e.g., transportation) could increase the validity of quality measures and the ability to compare performance among various rural and nonrural providers. Members also cautioned against constructing measures that are not flexible enough to allow various modes of care delivery, such as telehealth, and suggested that measuring patient experience or satisfaction or other types of outcomes might allow less focus on the mechanics of care delivery that often might depend on the local environment.

Public Comment

Ms. Buchanan opened the web meeting to allow for public comment. There were no public comments.

Next Steps

During the next webinar, Webinar 6, on April 25, the Workgroup will continue discussing its recommendations for measuring access to care. A second draft report will summarize those recommendations, as well as present the Workgroup's most recent version of the core set of measures. NQF will post the second draft report for a 30-day public comment period on May 31, 2018.