NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Rural Core Set Update Web Meeting 3

The National Quality Forum (NQF) convened a public web meeting for the Rural Health Advisory Group on April 29, 2022.

Welcome, Introductions, and Review of Web Meeting Objectives

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 Dr. Kimberly Rask and Dr. Keith Mueller, who provided opening remarks.

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:

- Review public and NQF member comments received on the environmental scan;
- Continue discussion of the current measures in the core set and their continued relevance for rural healthcare; and
- Continue discussion of the new topic areas/measures for inclusion and remaining gap areas in the core set.

Ms. Guo also reviewed the True North statement, which serves as a reminder of the final goals of the project and measure set:

- 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.

Environmental Scan Public Comments

Ms. Guo provided an overview of the public comments received on the environmental scan. The environmental scan was available for comment during a 21-day period between March 21 and April 11, 2022; a total of 15 comments on the scan were received from seven different organizations and individuals. Ms. Guo noted that the comments have been grouped into four categories for ease of review (Current Core Set Measures; Newly Endorsed Rural-Relevant Measures; Emerging Areas for Rural Measures; and Additional Comments); she also noted that the majority of comments were specific considerations for individual measures included as part of the environmental scan, and the details of these measures will be shared as part of the measure-by-measure discussion during the second portion of the meeting.

Current Core Set Measures

Overall, comments were received in favor of six current core set measures. These measures were previously discussed by the Advisory Group, and the group was in consensus that these measures remain important and will remain in the updated rural core set.

- #0028 Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention
- #0138 National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure
- #0471 PC-02 Cesarean Birth
- #1717 National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital Onset *Clostridium difficile* Infection (CDI) Outcome Measure
- #1789 Hospital-Wide All-Cause Unplanned Readmission Measure (HWR)
- #0729 Optimal Diabetes Care

In addition, comments encouraged the removal of #0202 *Falls with Injury,* #0371 *Venous Thromboembolism Prophylaxis,* and #0291 *Emergency Transfer Communication Measure.* Ms. Guo noted that the Advisory Group agreed to discuss #0202 and #0371 in more detail during Web Meeting 2, but #0291 had received support to remain in the core set from approximately two-thirds of the group. However, based on a public comment expressing concerns with loss of endorsement and stating that the exchange of medical information between hospitals is less of a concern for rural areas than it was during the original formation of the core set, this measure was added to the list to allow room for further discussion.

Newly Endorsed Rural-Relevant Measures

Next, Ms. Guo shared comments on newly endorsed rural-relevant measures in the environmental scan. Overall, comments agreed that behavioral health, substance use, access to care, and patient-reported outcome performance measures (PRO-PMs) remained important areas to consider in the updated core set, especially as some of these areas have been affected by the COVID-19 pandemic. Two comments also emphasized the importance of nutrition and malnutrition screening as an equity consideration, and flagged that #3592e *Global Malnutrition Composite Score* could be a helpful addition in this area. Ms. Guo noted that this measure has been added to the list of measures for discussion.

In addition, comments were received on five individual measures in this portion of the environmental scan. Commenters were against the addition of two measures in the shortlist, #3590 *Continuity of Care after Inpatient or Residential Treatment for Substance Use Disorder (SUD) Treatment* and #3490 *Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy.* Commenters also suggested further consideration of the following measures, which have been added to the list for discussion:

- #3316e Safe Use of Opioids – Concurrent Prescribing
- #3357 Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers
- #3510 Screening/Surveillance Colonoscopy

Emerging Areas for Rural Measures

Ms. Guo noted that the comments received on emerging areas for rural measures were similar to those received for newly endorsed rural-relevant measures. Commenters affirmed the importance of the measures in this portion of the scan that address behavioral health, substance use, access to care, and telehealth use. Commenters emphasized again that health equity needs to be represented in the final

core set as a signal to clinicians, hospitals, and health systems that social determinants of health must be addressed to reduce disparities, and that nutritional status should be considered as part of discussion on equity measures.

Additional Public Comments

Ms. Guo shared that the final category of additional public comments included two themes. First, a commenter emphasized the severe burden of sepsis and noted that rural patients with sepsis are more likely to die than suburban or urban patients; Ms. Guo encouraged the group to consider this comment when discussing the related measure #0500 *Severe Sepsis and Septic Shock: Management Bundle*. Second, a commenter noted that the current core set relies heavily on manual abstraction, and suggested that promoting electronic clinical quality measures (eCQMs) in the rural core set could help reduce burden for small and rural providers.

Dr. Rask opened discussion on these comments. A federal liaison commented that while it may be difficult to obtain some of the data for measures in the rural measure set, their organization does not have any comments on feasibility specifically related to eCQM status. An Advisory Group member shared that small and rural communities are struggling with staffing, and they would be open to the use of eCQMs to streamline reporting as opposed to needing to hire more staff to perform manual abstraction for measures. Another Advisory Group member shared that workflow is heavy in the rural areas where they work, and they have hired medical assistants to help with documentation for measures. They agreed that burden could be reduced after a successful shift to eCQMs, but highlighted that the shift from manual abstraction to eCQM collection is a monumental task for a physician, and that many rural family physicians could struggle with the transition. Another Advisory Group member acknowledged that this shift will be difficult for many providers, but emphasized again that digital quality measures including eCQMs will be built on value sets of information already present in the medical record and will significantly reduce the burden of data collection going forward.

Additional Advisory Group and Federal Liaison Comments

In addition to the public comments, Ms. Guo noted that Advisory Group members and Federal Liaisons also provided general comments on the environmental scan and measures after reviewing the shortlist of measures for discussion. One comment noted that about half of the potential additions could be used within nursing homes as well as hospitals, and it could be helpful to add notes to the following measures encouraging data collection within nursing homes: #0202 *Falls with Injuries*, #0138 *National Healthcare Safety Network (NHSN) Catheter-associated Urinary Tract Infection (CAUTI) Outcome Measure*, and #1717 *National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital onset Clostridium difficile Infection (CDI) Outcome Measure.* Another comment noted that Tribal leaders may be sensitive to use of the word “core,” given the homophone “corps” and historical connotations with conflict and displacement in indigenous lands. The stakeholder suggested that another synonym like “essential” should be used to refer to this work going forward.

Dr. Rask asked Advisory Group members for reactions and proposed next steps based on these comments. An Advisory Group member asked for additional clarification on how nursing homes are being covered within NQF’s work. Dr. Rask clarified that NQF’s Measure Applications Partnership (MAP) work includes a Workgroup addressing quality measurement in long-term care, including nursing homes, but within the current measure set work, the group is charged with reviewing measures in a variety of rural care settings, including nursing homes. Dr. Mehas also reminded the group that the current measure set work is separate from the pre-rulemaking process, and during the meeting the group is not making any recommendations for use of measures in any specific CMS programs. Instead, the resulting measure set is intended to broadly cover healthcare in rural settings.

An Indian Health Service federal liaison shared that the comment on "core" terminology was received from one of their stakeholders who recommended consultation with Tribal leaders and organizations. The liaison noted that the word "core" has been used in quality measurement efforts for years now (e.g., references to the Core Quality Measure Collaborative on the CMS website since 2015), but synonyms such as "key," "essential," or "main" could be viable alternatives. An Advisory Group member commented that the word "key" effectively conveys that the group is identifying measures important to rural areas, without implying that the measure set comprehensively covers all of the most important areas (as "essential" would do). The measure set does not include certain areas because measures are not available or endorsed in those areas. Other Advisory Group members concurred that "key" would be a good replacement for "core" in referring to the measure set.

Dr. Rask and Ms. Guo thanked Advisory Group members and federal liaisons for their input on the environmental scan public comments. Ms. Guo shared that this feedback would be integrated into the environmental scan, as well as in the recommendations report going forward.

Discussion of Existing Core Set

Rebecca Payne, NQF Manager, introduced the group of five measures selected for review and consideration for removal from the core measure set. Ms. Payne reminded Advisory Group members that four of these measures were selected through voting during Web Meeting 2 (PDF), when measures that did not receive at least 60% support for maintenance in the core measure set were identified for potential removal. A fifth measure, NQF #0291 *Emergency Transfer Communication Measure*, obtained 67% support during Web Meeting 2, but received persuasive public comments suggesting its removal from the core measure set and was brought forth for Advisory Group consideration.

Ms. Payne reviewed the process for removal discussions, noting that after a brief introduction of each measure, co-chairs would lead discussion among the Advisory Group considering criteria of importance, reliability and validity, and implementation for each measure. Following all discussion, Advisory Group members would vote whether or not to remove the measures, using a 60% threshold for removals.

Current Core Set Measures

For each measure, Ms. Payne provided a brief overview of the measure's characteristics and relevant public comments, and Dr. Mueller facilitated discussion with the Advisory Group.

#0202 Falls with Injury

Ms. Payne reviewed the measure, which addresses falls within adult acute care inpatients and adult rehabilitation patients, and noted that this outcome measure's endorsement status was removed due to concerns with measure validity. During Web Meeting 2, Advisory Group members commented on the survey that the measure was an important concept that should be analyzed differently for low case-volume outcomes, but its reliability and significance was in question. One public comment shared on the Environmental Scan was in favor of removal given the loss of endorsement due to validity concerns, and noted that there were other data that could identify injury during hospital stays.

A federal liaison commented that falls are important to consider from a prevention perspective. An Advisory Group member asked why this measure is only being used in the hospital inpatient setting only, noting that falls are a major problem in nursing homes because they have far fewer staff per patient than in hospitals. NQF staff clarified that while the description on relevant care setting is based on the specifications provided by the developer (i.e., in the endorsement submission), the Advisory Group may choose to add a note to this measure or include language in the final report describing if the measure is relevant to other care settings in the future.

#0371 Venous Thromboembolism Prophylaxis

Ms. Payne noted that this process measure was withdrawn by the developer and subsequently lost endorsement in 2018. Advisory Group members commented on the survey that the measure had volume challenges and was not used in CMS programs. However, a public comment was in support of keeping the measure, noting that endorsement was removed when the measure was withdrawn from consideration and expressing that it had continued relevance for small, rural facilities.

A federal liaison noted that this measure has been used in their quality reporting since 2018 and is also recognized as CMS 108.

#1661 SUB-1 Alcohol Use Screening

Ms. Payne noted that #1661 focuses on hospitalized adults who are screened upon admission for unhealthy alcohol use. Endorsement was removed for NQF #1661 *SUB-1 Alcohol Use Screening* when the measure was withdrawn in 2018, and the measure is not currently used in any federal programs. Despite low polling results on the Web Meeting 2 Survey (46%), some Advisory Group members commented on the survey that the measure was an important concept that would be redesigned as an electronic clinical quality measure (eCQM) and supported its continuation in the core measure set. No public comments were submitted for the measure.

A federal liaison noted that they do not use #1661; instead, their organization reports on a different measure, *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* (CMS 137), when assessing alcohol use.

An Advisory Group member noted that alcohol use is an important topic to address in rural areas. Another member agreed that this is an important topic where performance has not topped out. The member asked for clarification on how loss of endorsement should be considered when updating the measure set, noting that the three measures discussed so far are all important but are no longer endorsed (e.g.,, falls measure is an important concept, but failed on validity; venous thromboembolism prophylaxis is important and is now a standard of care). NQF staff clarified that the Advisory Group previously discussed that NQF endorsement is preferred, but is not a strict requirement for measures to be included in the set. If a measure is removed from the set, the Advisory Group also has the option to add language to the report explaining why the measure was removed and emphasizing any gap areas that should be addressed in future updates of the set. An Advisory Group member noted that #1661 lost endorsement because the developer is planning to adapt it into an eCQM, not because the idea is no longer valuable. The member shared that they view this as a “temporary withdrawal” to redevelop the measure into a new form, and they would be in favor of keeping this measure in the set and waiting for the redevelopment of the measure to be completed.

#0421 Preventive Care and Screening: Body Mass Index (BMI) Screening and Follow-Up

Ms. Payne reviewed the specifications for #0421, which documents body mass index screening and follow-up for patients 18 and older; an eCQM version of this measure is also available. Ms. Payne reminded the Advisory Group that the measure developer did not pursue continued endorsement but intended to maintain the measure independently. Advisory Group members commented on the Web Meeting 2 survey that the measure’s topic was important, but could be pursued through alternative measures that maintained endorsement. No public comments were submitted for the measure.

A federal liaison shared that they use this measure in their reporting programs; another federal liaison shared that they also use this measure for eligible clinicians as of 2018, and noted that this measure is also referred to as CMS 069v8.

An Advisory Group member asked if there are other measures that cover this topic, and asked whether the measure should be removed from the set because it is already being addressed in federal reporting. A federal liaison clarified that CMS 069v8 is the same measure as #0421. NQF staff also clarified that in the current measure set, there are several other measures addressing chronic disease care and outcomes, but there are no other measures that specifically address BMI screening. NQF staff also reminded the group that the rural measure set is intended to summarize the best measures available for use in rural areas, but is not intended for use in a specific program – if the group concurs that the measure is important and usable among rural areas, it should not be removed from the core set because it is already being used in other programs. A federal liaison commented that if the intention is to build a balanced portfolio of rural-relevant measures, this measure is valuable because it addresses not only screening but also follow-up.

#0291 Emergency Transfer Communication Measure

NQF #0291 *Emergency Transfer Communication Measure* focuses on documentation of information sharing for patients transferred from one emergency department to another. Ms. Payne reminded the group that #0291 received 67% support for continuation in the core measure set during the Web Meeting 2 survey, but was brought forth for further discussion due to public comments focusing on the measure's endorsement removal due to reliability concerns and the changing circumstances that facilitate the exchange of medical information between hospitals. The public comment emphasized that the measure is no longer necessary and that many small rural hospitals have joined larger systems in which the medical record can be viewed.

Advisory Group members had no comments on the measure. A member of the public shared additional background from the endorsement process for this measure. The member of the public shared that 90% of critical access hospitals report this measure through the Medicare Beneficiary Quality Improvement Project (MBQIP); the primary challenge during endorsement was that this data is reported at an aggregate level, and there is limited availability of patient-level data to run the statistical testing required to pass endorsement on scientific acceptability. The member of the public also shared that this measure was redesigned in 2018-2019 to reduce data burden and it is still chart-abstracted.

Discussion of Measures for Potential Addition

Next, Dr. Mehas introduced the process for discussing measures for potential addition to the rural measure set. Dr. Mehas shared that the group will review a shortlist of 37 measures, grouped by topic area to streamline discussion. The shortlist was determined using a weighted scoring approach based on four desirable measure characteristics (NQF endorsement status, cross-cutting measure type, outcome or PRO-PM measure type, active status in federal programs), in combination with Advisory Group rankings on the most important clinical and cross-cutting topics to add to the rural measure set and additional feedback shared via email and public commenting.

Dr. Mehas reminded the group of the process for discussion. After an initial overview of the measures being considered in each group, including a summary of any public or Advisory Group comments, co-chairs would invite lead discussants to provide opening thoughts on the measures. After lead discussants shared any thoughts, co-chairs would facilitate further discussion with the full group. Voting would be conducted after each group of measures, again using a 60% voting threshold to add any new measures.

Kidney Health Measures

The first group of measures discussed by the Advisory Group were related to kidney health. This group of measures included the following:

- #3565 Standardized Emergency Department Encounter Ratio (SEDR) for Dialysis Facilities
- #2594 Optimal End Stage Renal Disease (ESRD) Start

Dr. Mehas shared that #3565 measures the ratio of observed number of emergency department encounters that occur for adult Medicare ESRD dialysis patients at a particular facility to the expected number of encounters given patient characteristics. #2594 measures the percentage of new dialysis patients who experience a planned start of renal replacement therapy through a preemptive kidney transplant or initiation of home or outpatient in-center hemodialysis. Dr. Mehas also noted that a federal liaison confirmed prior to the meeting that they are able to calculate the numerator for both of these measures.

Dr. Rask invited lead discussants to share input on the measure. The lead discussant shared that their only concern is related to low case-volume for measures addressing dialysis facilities.

An Advisory Group member asked if these measures are specific to standalone dialysis facilities, as opposed to general hospitals that provide dialysis services. Dr. Rask clarified that the measure may apply to an outpatient dialysis facility in a hospital, but it should not apply to emergency dialysis in emergency rooms or hospitals.

An Advisory Group member asked whether any of the measures in this category have similar measures currently being used. Dr. Rask and NQF staff clarified that the measures in this grouping were selected based on kidney health being identified as an area of emerging importance to the rural group, that was not addressed in the original measure set; there are no kidney health measures currently included in the measure set.

An Advisory Group member asked for clarification whether #2594 specifies an optimal timeframe for each modality for renal replacement therapy. Dr. Rask clarified that the trigger event for the measure is not the timeframe for dialysis, but how they start dialysis (i.e., planned start dialysis vs. emergency dialysis in a hospital after rapid decline).

Emergency Care Measures

Next, the Advisory Group discussed the following measures related to emergency care:

- #3490 Admission and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
- #2605 Follow-Up After Emergency Department Visit for Mental Illness or Alcohol and Other Drug Abuse or Dependence

Dr. Mehas shared that #3490 estimates hospital-level, risk-adjusted rates of inpatient admissions or ED visits for adult cancer patients due to anemia, dehydration, diarrhea, emesis, fever, nausea, neutropenia, pain, pneumonia, or sepsis within 30 days of hospital-based outpatient chemotherapy treatment. #2505 assesses the percentage of discharges where the patient had an ED visit related to mental health or alcohol or other drug dependence during the measurement year, and had a follow-up visit with any provider related to these topics within 7 and 30 days of discharge. After providing an overview of the measure specifications, Dr. Mehas also noted that a public commenter stated that #3490 was potentially not applicable to clinicians in their smaller rural settings.

An Advisory Group member commented that the group has previously discussed that patients in rural areas often travel outside the community for chemotherapy and are not able to return to the tertiary care facility where they are receiving treatment; #3490 may penalize small rural hospitals providing care to people in their communities who are receiving chemotherapy elsewhere. The member also

commented that behavioral health measures are a priority for the Advisory Group, but rural providers may perform poorly on #2605 due to lack of availability for follow-up services. Another member agreed that these are important topics, but they also have concerns that lack of access could unfairly penalize rural providers.

Population Health Measures

Next, the Advisory Group discussed the following population health measures:

- #1382 Percentage of low birthweight births
- #3449 Hospitalization for Ambulatory Care Sensitive Conditions for Dual Eligible Beneficiaries
- #0716 Unexpected Newborn Complications in Term Infants

#1382 measures the percentage of births with birthweight less than 2500 grams. #3449 assesses rates of state-level admissions for ambulatory care sensitive conditions, with both observed and risk-adjusted reporting on three rates (chronic condition composite, acute condition composite, total composite) stratified for three populations (community-dwelling home and community-based services, or HCBS, users; community-dwelling non-HCBS users; and non-community-dwelling population). Finally, #0716 reports the percentage of full-term newborns with no preexisting conditions and unexpected newborn complications at the hospital level. After reviewing these measure specifications, Dr. Mehas shared initial comments on each of the measures. Dr. Mehas shared that a member expressed concern over potential data burden for #1382 if it uses a survey, and clarified that this measure uses public-use birth certificate data from the National Center for Health Statistics. A federal liaison also shared ahead of time that their organization is able to calculate the numerators for both #1382 and #3449.

A lead discussant expressed concern about the potential for low case-volume challenges for NQF #1382 and #0716, noting that not all rural facilities offer delivery services and that complicated pregnancies may be referred out to other counties or facilities. Dr. Mehas acknowledged these concerns, but noted that the measures were at the population, rather than facility level, which may mitigate some concerns about low volumes. An Advisory Group member noted that low birthweight births were a known disparity that would be important to measure for rural populations.

Dr. Rask clarified that NQF #3449 seeks to identify when patients with chronic conditions could have avoided hospitalization with appropriate access to high quality primary care, and does include risk adjustment. One lead discussant noted that these comparisons still may not be mitigated by risk adjustment due to foundational differences in rural populations, social drivers of health, and the acuity of each patient's condition.

Patient Experience Measures

Dr. Mehas reviewed the specifications for the following measures for patient experience:

- #3622 National Core Indicators for Intellectual and Developmental Disabilities (ID/DD) Home- and Community-Based Services (HCBS) Measures
- #3420 CoreQ: AL Resident Satisfaction Measure
- #3422 CoreQ: AL Family Satisfaction Measure

#3622 refers to a group of 14 measures aimed at assessing person-reported outcomes and understanding state developmental disabilities service system performance. The measures address domains including person-centered planning and coordination, community inclusion, choice and control, and human and legal rights. #3420 assesses satisfaction among assisted living residents who have lived in the facility for two or more weeks; similarly, #3422 assesses satisfaction among the family or

designated responsible party for assisted living residents. Dr. Mehas noted that there were no comments received from Advisory Group members, federal liaisons, or members of the public on these measures.

Dr. Rask reminded participants that the Advisory Group had previously prioritized patient reported measures. A lead discussant noted that all three measures were already collected or looked at through other programs or mechanisms and felt that it might be burdensome to set additional requirements or recommendations for their collection. In contrast, an Advisory Group member shared that through personal experience, these measures could be seen as directing future goals for patients. The Advisory Group member suggested that members consider the value of these measures for assessing the quality of care for patients with disabilities over time.

Dementia Measures

Dr. Mehas shared that one dementia measure was being considered for discussion:

- #2872e Dementia: Cognitive Assessment

#2872e assesses the percentage of dementia patients who had a cognition assessment performed and the results reviewed at least once within a 12-month period. Dr. Mehas noted that two Advisory Group members shared comments on this measure prior to the meeting. One member expressed concern about the data burden for documenting this measure annually, while another member shared that their organization is able to calculate the numerator for this measure.

An Advisory Group member shared that this is a process measure currently being used as part of Merit-Based Incentive Payment System (MIPS) voluntary reporting. This measure is an eCQM, which means that the burden of chart abstraction will not apply for this measure. The member also highlighted that this measure addresses an emerging topic area that the group previously agreed was important to rural areas. Another Advisory Group member commented that they support this measure, as it allows their providers to better manage care and prevent complications. Another member agreed that a dementia measure is important for rural areas.

Patient Hand-Offs and Transitions Measures

Dr. Mehas provided an overview of three measures related to patient hand-offs and transitions:

- N/A Closing the Referral Loop: Receipt of Specialist Report
- #3312 Continuity of Care After Medically Managed Withdrawal from Alcohol and/or Drugs
- #3590 Continuity of Care After Receiving Hospital or Residential Substance Use Disorder (SUD) Treatment

Dr. Mehas shared that the *Closing the Referral Loop* measure calculates the percentage of patients with referrals for which the referring provider receives a report from the provider to whom the patient was referred. #3312 measures the percentage of discharges from a medically managed withdrawal episode for adult Medicaid beneficiaries that were followed by treatment for substance use disorder within 7 or 14 days after discharge. #3590 measures the percentage of discharges from inpatient or residential substance use disorder treatment among adult Medicaid beneficiaries that received follow-up treatment within 7 or 30 days of discharge.

Dr. Mehas also shared initial comments on the measures. An Advisory Group member shared prior to the meeting that the *Closing the Referral Loop* measure addresses an important priority area, but the current specifications are not detailed enough to be able to understand the feasibility or impact on rural providers; the member suggested that this measure could be included in a category of ‘developmental

metrics in important priority areas.' Another member shared that their organization is able to calculate the numerator for #3312. Finally, during the public commenting period, a commenter shared that #3590 may be a good measure to include in future iterations of the measure set, but the timing does not seem right to include the measure in this next update given staffing issues and high demand for behavioral health professional services.

An Advisory Group member shared that they do not support the addition of *Closing the Referral Loop;* their rural providers previously tried to report on this measure, but found it burdensome and difficult to manage. Another Advisory Group member agreed that finding data sources for this measure is difficult, and inconsistency in data sources between providers may make it difficult to meaningfully detect differences in provider performance.

A member commented that #3312 and #3590 also address behavioral health and substance use issues, which are a high priority for the Advisory Group; another member agreed that continuity of care measures for substance use are important. A member also noted the measures can also be calculated from billing and claims data, so they pose less provider burden. Another member commented that #3590 uses Medicaid billing data, but many of those services are now done through contracts with Medicaid managed care organizations. The member added that unless the state requires these organizations to report that data, they are unsure how to access the data for those measures.

Behavioral Health and Substance Use Measures

Next, the Advisory Group reviewed behavioral health and substance use measures:

- #3175 Continuity of Pharmacotherapy for Opioid Use Disorder
- #3316e Safe Use of Opioids –Concurrent Prescribing
- #3589 Prescription or administration of pharmacotherapy to treat opioid use disorder (OUD)
- #3539e Use of Antipsychotics in Older Adults in the Inpatient Hospital Setting

Dr. Mehas shared that #3175 addresses the percentage of adults with pharmacotherapy for opioid use disorder who have at least 180 days of continuous treatment. #3316e measures the percentage of adult patients concurrently prescribed two or more opioids or an opioid and benzodiazepine at discharge from a hospital-based encounter. #3589 reports the percentage of a provider's adult Medicaid beneficiaries who filled a prescription or were administered or ordered a medication to treat opioid use disorder within 30 days of the first OUD-related encounter with that provider. Finally, #3539e measures the proportion of inpatient hospitalizations for patients 65 and older who receive an order for antipsychotic medication therapy. After sharing measure specifications, Dr. Mehas also noted the following comments received before the meeting. A federal liaison shared that the numerator for #3175 may be calculable, but would be difficult and would require electronic health record (EHR) development or access to third party data, which would not be guaranteed accurate and could require additional fees. A public commenter shared that 3316e may have low volume for small rural hospitals, but it is currently a measure required for eCQM reporting so its addition would align with existing reporting. Finally, a federal liaison shared that the numerators for both #3589 and #3539 are calculable by their organization.

A lead discussant noted that all of these measures are feasible to collect and pose low burden to clinicians, since they are claims-based; #3316e is also an eCQM, which reduces data collection burden. The lead discussant also noted that #3175, #3316e, and #3589 address opioid use disorder, which a public commenter emphasized disproportionately affects people in rural areas.

Dr. Rask noted that behavioral health and substance use is a high priority area for the group, and asked if Advisory Group members have one or two preferred measures within this group for a more parsimonious measure set. A member commented that #3589 and #3316e are their preferred measures; #3175 is an important goal, but 180 days of continuous treatment could be less feasible and more burdensome for rural providers. Another member commented that #3539e is a priority for them, as antipsychotic use is important for nursing homes and long-term care.

Coronavirus Disease 2019 (COVID-19) Measures

Dr. Mehas shared the specifications for four measures focused on COVID-19:

- #3677 Population COVID-19 Immunization Status (COV)
- #3636 Quarterly Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel
- N/A SARS-CoV-2 Vaccination Coverage among Healthcare Personnel
- #3664 Biannual Reporting of COVID-19 Vaccination Coverage among Healthcare Personnel

#3677 assesses the annual percentage of attributed individuals five years and older who have completed the recommended initial series of vaccines for COVID-19. #3636 measures the percentage of healthcare personnel who were completely vaccinated for COVID-19 since December 2020. *SARS-CoV-2 Vaccination Coverage among Healthcare Personnel* addresses COVID-19 vaccination coverage among healthcare personnel working in inpatient prospective payment system hospitals, inpatient rehabilitation, long-term care, inpatient psychiatric, ESRD, ambulatory surgical centers, hospital outpatient, skilled nursing, and prospective payment system exempt cancer hospitals. Finally, #3664 identifies the percentage of healthcare personnel who were completely vaccinated for COVID-19 among personnel who work in the facility at least one day a week. Dr. Mehas also noted the following feedback on these measures from a federal liaison – the numerator for #3677 is calculable by their organization, #3636 and #3664 may be calculable with a high level of effort, and *SARS-CoV-2 Vaccination Coverage among Healthcare Personnel* may be calculable but would require EHR development or access to third party data.

A lead discussant shared that they fully support the measure concept for COVID-19 vaccination, and that out of these four measures, #3677 (population-level COVID-19 immunization status) is likely the most feasible. The lead discussant noted that the guidelines for COVID-19 vaccination are still developing (e.g., guidelines around booster timing). The components of the measure could be difficult to capture in the span of a single measurement year, as opposed to other immunization measures that have a set schedule (e.g., childhood immunizations by age 2, adolescent immunizations by age 13, annual flu vaccines in the fall, one-time pneumococcal vaccine). The lead discussant commented that #3636, *SARS-CoV-2 Vaccination Coverage among Healthcare Personnel,* and #3664 require employers to track and report this data, and these measures may need more testing to understand feasibility.

An Advisory Group member asked whether these measures would account for patients who independently received the vaccine from a pharmacy or other site, instead of going through their provider. A member added that many patients received their vaccines through these avenues, and they may be accounted for in claims data, but reliability may be affected because vaccines were available for free during the pandemic and claims may not have been processed. Another member agreed that it would be difficult to collate data since the vaccine can be obtained for free from so many locations. A member noted that their organization tracks COVID-19 data from the Centers from Disease Control and Johns Hopkins, but they have trouble reliably obtaining statistics at the county level, which would be necessary for rural reporting. A member commented that in some states, COVID-19 immunization records are recorded as part of a centralized registry, where all vaccination states are required to submit records to the state.

Another member noted that quarterly reporting of COVID-19 vaccine status for healthcare personnel has been very burdensome for their providers in the current state given changing guidance around boosters and the detail required in reporting; they shared that simpler and less frequent reporting (as with seasonal influenza reporting) would be more manageable.

An Advisory Group member asked if the group could signal the importance of the measure concepts in the report, even if the measures are not ready for endorsement or inclusion within the final measure set. NQF staff shared that the report provides an opportunity for the group to share these types of comments and recommendations, and asked whether the broader Advisory Group had additional feedback on the perceived importance of this topic area and any rationale behind adding or not adding the measures. A member shared that the topic area is important, and they would encourage consideration of the measures after more time for testing and understanding feasibility, especially around data sources for employer-reported measures and data capture that accounts for the multiple ways vaccines were distributed during the pandemic (e.g., multiple vaccination sites, claims, free vaccines).

An Advisory Group member also noted that it is important to understand how the data on COVID-19 vaccinations will be used, and whether the group envisions it would be similar to existing immunization measures. An Advisory Group member noted that the main differentiating factor between COVID-19 vaccination measures and other vaccination measures is that guidance around the right number and timing of booster shots to be considered "fully vaccinated" remains unclear. Another member agreed and added that they envision a COVID-19 measure that functions similarly to other immunization measures currently used in reporting programs, once the guidance around boosters has been settled. A federal liaison commented that COVID vaccine adherence may not align with flu vaccine adherence based on political and other differences that impact COVID-19 vaccine rates.

Dr. Mueller summarized that the group was in favor of measuring vaccine adherence for an important infectious condition, but the current measures available may require additional testing and refinement given data availability and differences in vaccination and booster requirements.

Infectious Disease Measures (Excluding COVID-19 Measures)

The Advisory Group also reviewed four additional infectious disease measures that were not focused on COVID-19:

- #0753 American College of Surgeons –Centers for Disease Control and Prevention (ACS-CDC) Harmonized Procedure Specific Surgical Site Infection (SSI) Outcome Measure
- #2082 HIV Viral Load Suppression
- #0684 Percent of Residents with a Urinary Tract Infection (Long-Stay)
- #0500 Severe Sepsis and Septic Shock: Management Bundle

Dr. Mehas shared the specifications for these measures. #0753 provides a standardized infection ratio and adjusted ranking metric for deep incisional and organ/space surgical site infections at the primary incision site among adult patients. #2082 calculates the percentage of HIV patients with a viral load of less than 200 copies/mL at their last HIV viral load test during the measurement year. #0684 measures the percentage of long-stay residents in a nursing home who have had a urinary tract infection in the 30 days prior to assessment #0500 assesses adults with a diagnosis of severe sepsis or septic shock, including measurements of lactate, obtaining blood cultures, administering broad spectrum antibiotics, fluid resuscitation, vasopressor administration, reassessment of volume status and tissue perfusion, and repeat lactate measurement. Dr. Mehas noted that a federal liaison shared prior to the meeting that #2082 may be calculable by their organization, but it would require EHR development or access to third

party data. Dr. Mehas also reminded the group of the public comment in favor of including a sepsis measure within the updated measure set.

A lead discussant expressed support for the importance NQF #0753, noting that two of the procedures included in the measure are among the most common in rural areas and can account for approximately 20% of hospital-acquired infections. However, the lead discussant stated that there may be a primary concern about case-volume challenges in hospitals and some implementation challenges among any electronic medical record (EMR)-based measures.

The lead discussant also noted that sepsis is a critical area of concern with a high burden in both urban and rural areas, with potentially even higher mortality in rural regions. The lead discussant did not have concerns about the measure specifications, but pointed out that the EMR measure may be difficult to implement due to its complexity and documentation requirements for timely interventions.

Finally, the lead discussant expressed concern that NQF #2082 was not risk-adjusted or stratified, noting that HIV-positive populations are often uninsured.

No concerns were raised for NQF #0684, and an Advisory Group member noted that all of the measures were relevant to rural settings and actionable outcomes measures.

Health Equity Measures

Next, the Advisory Group reviewed measures related to health equity:

- #3592e Global Malnutrition Composite Score
- N/A Hospital Commitment to Health Equity
- N/A Screening for Social Drivers of Health
- N/A Screen Positive Rate for Social Drivers of Health

#3592e is a composite measure which focuses on adults 65 and older who were screened for malnutrition risk, completed a nutrition assessment (if applicable), had malnutrition documented in their medical record (if applicable), and had a nutrition care plan developed (if applicable). *Hospital Commitment to Health Equity* is a structural measure including five attestation-based questions representing domains of strategic priorities, data collection, data analysis, quality improvement, and leadership engagement. The *Screening for Social Drivers of Health* and *Screen Positive Rate for Social Drivers of Health* measures address the number of adult beneficiaries who were screened and screened positive for food insecurity, housing instability, transportation needs, utility assistance, and interpersonal violence.

Dr. Mehas reminded the group of public comments received on this group of measures. A commenter encouraged Advisory Group members to consider #3592e, emphasizing the importance of robust nutrition measures for health equity and noting that up to half of hospitalized patients and 35-85% of older long-term care residents are undernourished, which is associated with both acute and chronic diseases and injury. An Advisory Group member also shared prior to the meeting that the *Hospital Commitment to Health Equity* and *Social Drivers of Health* measures address priority areas, but are so early in the specification process that there is not sufficient detail to understand the feasibility or impact on rural providers, suggesting listing these in the measure set gaps.

An Advisory Group member shared that they are supportive of the screening and screen positive measures. The member also suggested that it would be beneficial for CMS to promote the importance of providing information to support the *Hospital Commitment to Health Equity* measure (similar to

promotional activities around the U.S. Census); these activities may be helpful in gaining trust and increasing responses among rural areas. Another member agreed with this comment.

An Advisory Group member commented that it may be interesting to consider area-level measures of social drivers of health (e.g., area deprivation index or social vulnerability index) in the future.

Other Measures – Mortality

The Advisory Group discussed two mortality measures:

- #3502 Hybrid Hospital-Wide (All-Condition, All-Procedure) Risk-Standardized Mortality Measure
- #3504 Claims-Only Hospital-Wide (All-Condition, All-Procedure) Risk-Standardized Mortality Measure

Dr. Mehas reviewed the specifications for these measures, both of which estimate a hospital-level 30-day risk-standardized mortality rate from any cause among adult Medicare fee-for-service patients. The claims-only measure uses administrative claims data only for risk adjustment, and the hybrid measure currently adds ten clinical risk variables extracted from the EHR. Dr. Mehas noted that the claims and hybrid measures will ultimately be harmonized and will use the same cohort specifications, with the exception of additional risk adjustment from core clinical data elements in the hybrid measure. Dr. Mehas also shared that an Advisory Group member had commented that they would favor #3504 (claims-based) over #3502 (hybrid) for purposes of burden reduction.

An Advisory Group member commented that the hybrid measures are important, but they support the claims-only measure due to cost and reporting burden. Two Advisory Group members agreed with this comment.

Other Measures – Admissions and Hospital Visits

The Advisory Group reviewed the following measures related to admissions and hospital visits:

- #3597 Clinician-Group Risk-Standardized Acute Hospital Admission Rate for Patients with Multiple Chronic Conditions under the Merit-based Incentive Payment System
- #3357 Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers

Dr. Mehas shared that #3597 calculates a risk-standardized rate of acute, unplanned hospital admissions among Medicare fee-for-service patients 65 and older with multiple chronic conditions, while #3357 calculates a facility-level risk-standardized ratio of acute unplanned hospital visits within 7 days of a procedure at an ambulatory surgical center for Medicare fee-for-service patients 65 and older. Dr. Mehas noted a federal liaison comment that their organization is able to calculate the numerator for #3597, as well as a public comment that #3357 would be a good measure to add, as it can be a reflection of discharge education and inadequate follow-up and would not cause undue hardship to small rural hospitals.

An Advisory Group member commented that the number of ambulatory surgical centers may be increasing in rural areas, and if so #3357 is a helpful quality measure to include in the measure set.

Other Measures – Cost

Next, the Advisory Group discussed cost measures:

- #3575 Total Per Capita Cost (TPCC)
- #3510 Screening/ Surveillance Colonoscopy

Dr. Mehas shared that #3575 assesses the overall cost of care delivered to a beneficiary, with a focus on primary care; the score is a clinician's average risk-adjusted and specialty-adjusted cost across all beneficiary months attributed to the clinician during a one-year performance period. #3510 assesses clinicians' average risk-adjusted cost to Medicare for screening and surveillance colonoscopy episodes of care attributed to the clinician. After reviewing the measure specifications, Dr. Mehas also shared a public comment in favor of #3510. The commenter supported this measure given its potential benefit in timely diagnosis and treatment of colon cancer.

A lead discussant expressed concern that NQF #3575 would not distinguish between primary care providers in rural areas obligated to provide services that might elsewhere be covered by specialists and urban areas where those options would be available. Other Advisory Group members raised concerns that the measure would only come from claims data and therefore would not cover costs such as patient transportation to care. Advisory Group members noted that the measure is actively used in Center for Medicare & Medicaid Innovation (CMMI) programs.

Other Measures – Controlling High Blood Pressure

Finally, the Advisory Group discussed one measure focused on controlling high blood pressure:

- #0018 Controlling High Blood Pressure

Dr. Mehas shared that this measure calculates the percentage of adult patients who had a diagnosis of hypertension and whose blood pressure was adequately controlled (less than 140/90 mmHg) during the measurement year. Dr. Mehas noted that the measure was considered for the original measure set in 2017-2018 and a measure on the topic was strongly recommended, but NQF #0018 was not selected as it was not specified at the clinician level of analysis and was not cross-cutting or related to transitions of care. However, prior to the web meeting, an Advisory Group member suggested that the measure be reconsidered given the significant burden of cardiovascular disease on morbidity and mortality rates in the US. Measures addressing this topic could be meaningful and assist to avoid exacerbations of preventable conditions.

Advisory Group members shared comments supporting the importance of the measure, noting that high blood pressure would be essential to capture in the measure set if not already captured elsewhere. Dr. Mehas provided a clarification for participants on the measure's level of analysis, noting that in the original rural-relevant measure set, Advisory Group members had restricted the measure set to include only measures specified at clinician or facility levels. However, in previous web meetings for the current initiative, the Advisory Group had supported a move to include some population health level measures. Advisory Group members commented that the measure is currently used at the provider level.

Additional Gap Areas

Dr. Mehas and Dr. Mueller closed the conversation on measures for potential addition by seeking input from the Advisory Group on any gaps that may have been identified throughout the day's discussions. Advisory Group members were asked to consider any priority areas that were not represented and what measure concepts could address those gaps or future rural-relevant measurement needs.

An Advisory Group member commented that the topic areas discussed during the meeting covered the gap areas previously identified by the group. The member shared that the challenge is not identifying gap areas – instead, the most immediate issue is that the group has not identified measures that address these gap areas and that area good fit for rural settings and providers.

Dr. Mueller encouraged Advisory Group members to share additional comments via email. Dr. Mehas also noted that NQF staff will synthesize prior input from the Advisory Group on gap areas, as well as noting gap areas that remain after the voting has been finalized.

Public Comment

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

Next Steps

Ms. Payne noted that the input from the day's discussions would be incorporated into the Environmental Scan and final Recommendations Report as appropriate, and encouraged participants to share any additional thoughts with the team by contacting RuralCoreSet@qualityforum.org. The measure voting survey will remain open through the weekend, and the NQF team will share results with Advisory Group members via email. Voting results will be used to inform updates to the key measures that will be reflected in the final report. Ms. Payne also reminded participants that the draft Recommendations Report will be available on the project website for public comment from June 8 - June 27, 2022. Finally, Ms. Payne shared that the final meeting of the Advisory Group would take place on July 14, 2022, from 12:00-2:00pm ET, at which time the Advisory Group will discuss public comments on the draft Recommendations Report and any outstanding items for review in the report. Dr. Mehas thanked all participants for their attendance and adjourned the meeting.