NATIONAL QUALITY FORUM
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Meeting Summary

MAP Rural Health Workgroup Measure Prioritization Meeting

The National Quality Forum (NQF) convened a public web meeting for the Measure Application Partnership (MAP) Rural Health Workgroup on May 27, 2020 and May 29, 2020.

Welcome and Introductions – Day 1

Shantanu Agrawal, President and Chief Executive Officer of NQF, welcomed participants to the web meeting. Dr. Agrawal gave opening remarks on the importance of rural health and addressing challenges in access to care and thanked participants for their time and energy.

Nicolette Mehas, NQF Project Director, welcomed participants and invited Dr. Ira Moscovice and Dr. Aaron Garman, the Workgroup co-chairs, to give their opening remarks. NQF staff took roll call and reviewed the following meeting objectives:

- Discuss current landscape of rural health measurement and the 2018 Rural Health Core Set
- Review the selection criteria – recommendations from webinar 2 and pre-work
- Begin discussing measures for inclusion on the list for prioritization

Current Landscape of Rural-Relevant Measures

NQF staff reviewed the priority topics and measures included in the rural-relevant core set by the Rural Health Workgroup in 2018, including 9 measures in the hospital setting and 11 measures in the ambulatory care setting. NQF also noted 7 rural-relevant measures endorsed at the health plan or integrated delivery system level for the ambulatory care setting. NQF reminded the group that the current phase of work focuses on measures susceptible to the low case-volume (LCV) challenge and asked for feedback on whether the list should prioritize measures not already covered in the core set.

A Workgroup member asked for clarification on the purpose of the prioritized list and next steps following finalization of measure selection. NQF shared that the list of measures would be given to a group of experts to test the “borrowing strength” statistical approaches. NQF staff noted that it would be ideal if the Rural Health Workgroup could be re-engaged to review and consider the results of the statistical testing. A Workgroup member stated that the group should prioritize measures that would be potentially useful additions to the core set. Another Workgroup member also added that the group should not rule out measures where the topic area was already covered in the core set, but the group should only consider testing measures that had the potential to improve upon existing measures in the core set. The Workgroup agreed to focus on measures that would address areas that were not already well measured in the core set.

NQF also noted that the team added six measures from the core set into the list for testing, as members of the public had commented that these measures still had problems with LCV. The Workgroup agreed that the inclusion of these measures for discussion was reasonable.

Selection Criteria

NQF staff reviewed the selection criteria for narrowing down the list of prioritized measures from the full environmental scan. The NQF team focused on the high-priority issues identified in the 2018 work, then expanded the list of priority issues based on past discussion with the Workgroup and evidence from the literature. The team sent a survey to the Workgroup to vote on the highest-priority topics to consider. The topics most frequently ranked as "most important" were (in order): access to care, vaccinations, cancer screening, stroke, healthcare-associated infections, and emergency department use. End-of-life / advance directives, pneumonia, heart failure, surgical care, heart attack, asthma, and obesity were also identified as important issues, although these had fewer votes.

A Workgroup member asked for clarification on the purpose of the set, and whether it was intended to be used for provider accountability, payment, or another purpose, in order to evaluate the access to care topic. NQF explained that the scan included measures used in federal programs for both federal reporting and pay-for-performance programs. A member noted that the Workgroup had not specified in the past how the core set was going to be used, and that in the future the group should provide guidance and recommendations for how to appropriately use the core set for specific purposes. Another Workgroup member noted that the group should be aware of the level of accountability for each measure as part of this future consideration, but for the Measure Prioritization Meeting the group should focus on providing some basic guidance on measures that might be useful and valuable to test.

Next, NQF staff reviewed measure attributes that the Workgroup felt were important to consider. From the survey, the Workgroup most frequently ranked these attributes as "most important" (in order): NQF endorsement, outcome measures and patient-reported outcome-based performance measures (PRO-PMs), cross-cutting measures, and measures used in multiple programs. The voting results on priority topics and most important measure attributes were used to assign scores for each measure, then several high-scoring measures within each priority topic area were included in the shortlist of measures. The shortlist also included the six measures from the current core set with public comments suggesting ongoing LCV issues.

NQF staff asked for any additional comments on considerations for selecting measures. A Workgroup member suggested that measure #0500 *Severe Sepsis and Septic Shock* be included in discussion as it will be important for critical access hospitals (CAHs) going forward, as well as #0277 *PQI-08 Heart Failure Admission Rate*. NQF staff noted that these two measures would be added to the list of measures for discussion on the second day of the meeting.

Environmental Scan Findings

Andre Weldy, NQF Project Director, reviewed the process for narrowing down the environmental scan. A list of 252 rural-relevant measures used in federal programs and select Center for Medicare & Medicaid Innovation (CMMI) Alternative Payment Models (APMs) was narrowed down to a shortlist of 37 measures for discussion during the Measure Prioritization Meeting using the weighting scheme and selection criteria previously described. Five measures were removed from this list based on Workgroup feedback, including four measures on coronary artery bypass graft (CABG) surgery and readmissions not applicable to small rural hospitals as well as one measure on overuse of bone scan for staging low-risk prostate cancer patients (as there was more concern on underuse than overuse). The final shortlist of 32 measures for discussion included measures on access to care, behavioral health, chronic obstructive pulmonary disease (COPD), diabetes, healthcare-associated infections (HAIs), medication reconciliation, patient experience, pediatrics, perinatal care, readmissions, stroke, substance abuse, transitions of care, and venous thromboembolism (VTE). Approximately two-thirds of the measures were outcome

measures. The majority of measures (56 percent) were analyzed at the facility level, while 25 percent were analyzed at the clinician level and 16 percent at the health plan level. Approximately one third of the measures were cross-cutting. Finally, the majority of measures (53 percent) were in the ambulatory care setting, while 34 percent were in the hospital setting.

Measure Discussion and Voting – Day 1

NQF staff reviewed the process for discussing the list of measures over the two-day meeting. For each measure, a lead discussant would introduce the measure and the workgroup would consider the following questions:

1. Is the measure problematic due to LCV and why?
2. Is the measure pertinent to the rural population and does it have a significant impact on patient care?
3. Does the hospital/clinician have influence over measure performance?
   (Note: Based on Workgroup recommendation, this was reworded from "Does the hospital/clinician have significant control over measure performance?" for greater clarity.)
4. What is the opportunity for performance improvement?
5. Is the measure feasible to report for rural providers?

After discussion on all measures within each topic area, the Workgroup would vote on whether each measure should be added to the priority list of measures. If less than 40 percent of voters chose to include the measure, it would be removed from consideration; if 40-60 percent of voters chose to include the measure, it would be re-discussed if necessary; and if more than 60 percent of voters chose to include the measure, it would be included on the priority list.

Access to Care

2079 HIV Medical Visit Frequency

The group felt that this measure did face challenges due to LCV, was pertinent to a rural population, and had a significant impact on patient care. The measure was noted as important from a health equity standpoint, as patients from the South and African American patients are disproportionately represented among rural HIV cases. The group also noted that this is the only measure on access to care in the shortlist, and the existing core set does not include any care measures on HIV. However, the clinician might have limited influence over this measure as external issues (e.g. lack of transportation) might reduce measure performance.

A Workgroup member requested clarification on the level of analysis; NQF staff clarified that the measure has only been endorsed by NQF for analysis at the facility level, but the measure is still analyzed at the physician level as it is used in the Merit-based Incentive Payment System (MIPS).

The Workgroup could not determine whether the measure included telehealth visits. The group agreed to vote on the measure given the assumption that telehealth options would be included moving forward.

Behavioral Health

0108 Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) [Note: also related to Pediatrics]

The Workgroup felt that the measure would not have LCV problems at the health plan level, as endorsed by NQF; however, the measure would likely have LCV problems at the group practice/clinician level as is used in MIPS reporting. The measure was considered pertinent and impactful, especially given the

implications for mental health and substance use later in life. A Workgroup member felt that clinicians did have some influence over the measure performance by initiating follow-up, although the actual number of visits would also depend on patient-level factors. MIPS data demonstrated an opportunity for performance improvement on this measure. One Workgroup member stated that they were unsure if #0108 should be included in the core set, as there might be more broadly applicable behavioral health measures that should be prioritized in the core set instead of introducing competing measures.

0576 Follow-Up After Hospitalization for Mental Illness

The Workgroup felt that the measure would not have LCV problems at the health plan level, as endorsed by NQF, but might have problems at the individual clinician level. The measure was considered rural-relevant, impactful, and feasible for clinicians to report from existing claims data. It also demonstrated an opportunity for performance improvement. A Workgroup member also noted that the measure covered patients ages six and up, so it included some coverage of children and pediatric health.

A Workgroup member asked for additional clarification on who qualified as a "mental health practitioner" who could provide follow-up as part of the measure. NQF clarified that this could be a MD or DO certified as a psychiatrist or having completed an accredited program in psychiatry, a licensed psychologist, a certified clinical social worker, an RN certified as a psychiatric nurse or mental health specialist, a practicing therapist, or a counselor.

A Workgroup member shared that many providers report that it is difficult to get follow-up behavioral health appointments for their patients because of the low volume of clinicians. They noted that if this is tested and included in the core set in the future, it should be used to identify disparities and help increase access to behavioral health clinicians.

0710 Depression Remission at Twelve Months

The Workgroup noted that this measure is similar to another measure already in the rural core set (#0711 *Depression Remission at Six Months).* While the measure is rural-relevant, impactful, and feasible to report, the Workgroup noted that the 12-month period for #0710 should be less susceptible to LCV than #0711, which was already included in the core set as "resistant to LCV." Another Workgroup member shared that their organization's data on this measure included data from numerous small towns, which might indicate that the measure is resistant to LCV.

1879 Adherence to Antipsychotic Medications for Individuals with Schizophrenia

The Workgroup agreed that this measure was subject to LCV, especially given the rarity of the condition. The group also agreed that the measure addressed an important issue. However, one Workgroup member noted that the measure focuses on patient adherence to medication, rather than clinicians following recommended guidelines on medication, and measure performance might be hard for clinicians to influence. Another Workgroup member noted that as with #2079, telehealth options should be considered. In some complex situations, patients are discharged from the hospital and are monitored or counseled at a long distance via telehealth, but this care has not been integrated with their rural primary care provider.

Patient Experience

0005 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician/Group Survey

The Workgroup felt that this measure was pertinent to the rural population and would impact care, and that the clinician would have influence over measure performance and improvement. NQF noted that

this measure was included in the current rural core set, but members of the public had commented that they faced LCV challenges in reporting on #0005.

The Workgroup felt that feasibility of data collection could be a problem for some facilities (e.g. CAHs) due to cost. The Workgroup also noted that the rules for reporting were difficult for rural providers to meet (e.g. surveys need to be collected via mail or telephone) and this might be the cause of LCV challenges for this measure.

One Workgroup member noted that despite these difficulties, the CAHPS survey is used widely in different programs and it might be helpful to include these for testing purposes to understand how reliable the measure is. A Workgroup member also noted that #0005 *CAHPS* and #0166 *HCAHPS* have a similar data collection process, and the group should prioritize testing for #0166 if there are limited resources for the statistical testing.

0166 Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) [Note: includes 11 performance measures under this NQF number]

The Workgroup noted that this measure was rural-relevant, would impact care, and could be influenced by clinicians. #0166 faces LCV challenges and feasibility challenges similar to those described for CAHPS.

One Workgroup member asked for clarification on how transfers are handled. Another Workgroup member shared that transfers to other hospitals are excluded from analysis. The group also noted that HCAHPS reporting is strongly encouraged under Medicare Beneficiary Quality Improvement Project (MBQIP) and for prospective payment system (PPS) hospitals, but a minimum of 100 surveys are needed to receive a star rating.

COPD

0275 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)

The Workgroup noted that the measure was rural-relevant and impactful, the clinician would have influence over the measure performance (especially in team-based care), there was an opportunity for improvement, and the measure would likely be feasible to report as it is claims-based. However, the group was unsure if the measure was susceptible to LCV. A Workgroup member noted that the measure might face the LCV challenge at the group or practice level, and it might be advisable to test at the group/practice level if the group felt the COPD measure was important for rural populations.

The Workgroup asked for additional clarification on the use of #0275 in federal programs. NQF staff shared that the measure was used in the Medicare Shared Savings Program but was removed in 2017, and the measure had been implemented in Medicaid in 2018. A Workgroup member also asked why COPD and asthma admission rates had been combined in this measure, but NQF staff and other Workgroup members were not aware of any specific rationale provided by the Centers for Medicare & Medicaid Services (CMS).

Diabetes

0055 Diabetes: Eye Exam

The Workgroup noted that there were already two diabetes measures in the current rural health core set (#0059 *Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)* and #0729 *Optimal Diabetes Care).* The group also felt that the measure was not subject to LCV challenges. A Workgroup member also shared that collecting data on whether the eye exam has been performed is difficult, as optometrists often do not use electronic systems to record the data and this information

usually does not come back to the primary care setting without a concerted effort from the primary care provider.

Healthcare-Associated Infections (HAIs)

0138 National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure

NQF noted that this measure is in the current rural core set but was included on this shortlist for consideration based on public comments that #0138 posed reporting challenges due to LCV. The Workgroup agreed that this measure was important, feasible to report, and demonstrated an opportunity for improvement that clinicians had some influence over, as there are clear guidelines for using catheters appropriately.

One Workgroup member asked for clarification on interpreting the standardized infection ratios for this measure. Another member explained that the reported rates compare the actual rate of infections to the expected rate of infections, which is adjusted based on risk factors; if the ratio is greater than 1, a facility is reporting more infections than would be expected based on the condition of the patients. NQF staff also added that one of the adjustments is for whether the hospital is a CAH, which may account partially for rural-urban differences.

One Workgroup member also commented that in the analysis and testing, the final product should provide some guidance on whether differences in infections between individual facilities can be determined given LCV in the rural setting.

0139 National Healthcare Safety Network (NHSN) Central Line Associated Bloodstream Infection (CLABSI) Outcome Measure

The Workgroup commented that this measure is similar to #0138 in that there are clear indications for inserting a central line using sterile technique. The measure faces LCV challenges, is pertinent to the rural population, can be influenced by clinicians by adhering to protocol, and demonstrates an opportunity for improvement. A Workgroup member noted that between #0138 and #0139, #0138 (CAUTI) seemed more valuable for rural practices because catheters are used more frequently.

1717 National Healthcare Safety Network (NHSN) Facility-Wide Inpatient Hospital-Onset Clostridium difficile Infection (CDI) Outcome Measure

The Workgroup was unsure if this measure was susceptible to LCV, given that *C. diff* infections are common (especially in nursing facilities). NQF noted that this measure is in the current rural core set, but was included for consideration based on public comments that #1717 faced LCV challenges when reporting. A Workgroup member also noted that the measure was limited to hospital-onset *C. diff* infections, which would qualify as LCV susceptible. The Workgroup noted that this measure encompassed important topics including environmental hygiene, infection and prevention control policies, and antibiotic stewardship. A Workgroup member also noted that many CAHs report this and feel that it is an important measure to track.

2726 Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections

The Workgroup felt that this measure was probably susceptible to LCV challenges in small rural hospitals. However, they noted that this measure was a self-reported process measure and was likely to be topped out given current performance data in MIPS. A Workgroup member commented that they would prefer to include one of the other HAI measures instead.

Medication Reconciliation

0419 Documentation of Current Medications in the Medical Record

The Workgroup felt that this measure was rural-relevant, had a significant impact on care, and could be influenced by clinicians. However, a Workgroup member commented that CMS has classified this measure as topped out. The Workgroup also did not think this measure was susceptible to LCV: There is already a measure on medication reconciliation in the core set that covers a smaller patient population and would actually be more likely to have problems with LCV. A Workgroup member noted that while compliance with the measure appears to be high, medication reconciliation remains an issue in some settings (e.g. emergency departments). A Workgroup member agreed but noted that #0419 would not cover the emergency department setting.

Public Comment and Next Steps – Day 1

NQF staff opened the web meeting to allow for public comment. No comments were offered.

NQF staff notified the Workgroup that the Measure Prioritization Meeting would continue on Friday, May 29, 2020 at 12:00 PM ET. During this meeting, the group would continue to prioritize measures for testing statistical approaches recommended by the Rural Health Technical Expert Panel, and would incorporate discussion on the two additional measures *(*#0500 and #0277*)* brought forward for consideration by the Workgroup. The group would also discuss challenges and potential solutions for reporting the prioritized measures, as well as discuss gaps and additional considerations for rural health measurement.

Welcome and Introductions – Day 2

NQF staff, Dr. Moscovice, and Dr. Garman welcomed participants to the second day of the Measure Prioritization Meeting. NQF staff took roll call and reviewed the following meeting objectives:

- Continue prioritizing measures for testing the statistical approaches recommended by the Rural Health TEP
- Discuss challenges and potential solutions for low-volume rural providers in reporting the prioritized measures
- Address gaps and additional considerations for the future of rural health measurement

NQF reviewed the activities from the first day of the meeting and shared that of 14 measures considered, eight had met the voting threshold (60 percent) to be added to the prioritized list. These included the CAHPS, HCAHPS, HIV Medical Visit Frequency, ADHD follow-up, follow-up after hospitalization for mental illness, COPD, NHSN CAUTI, and NHSN *C. diff* measures.

Measure Discussion and Voting – Day 2

Pediatrics

0069 Appropriate Treatment for Upper Respiratory Infection

The Workgroup felt that this measure was helpful because it discusses appropriate care and addresses overuse of antibiotics. Members also noted that the measure would not be challenging for clinicians to report on. However, since upper respiratory infections are one of the most common reasons that children are brought in for visits, the Workgroup felt that #0069 did not face challenges due to LCV.

Perinatal

0471 PC-02 Cesarean Birth

The Workgroup noted that this measure was in the current rural core set but was included for consideration due to public comments that the measure was challenging to report. The Workgroup felt that this measure was rural-relevant, demonstrated an opportunity for improvement due to uneven performance, could be influenced by the clinician, and was feasible to report because of the option to pull data from electronic health records (EHRs). The group also noted that the measure was risk-adjusted but did not include adjustment based on the type of provider performing the C-section, and also had a number of exclusions (only for first-time mothers who aren't transferred to another facility for care, medical exclusions also apply).

N/A Maternity Care: Elective Delivery or Early Induction Without Medical Indication at <39 Weeks (Overuse) [Note: This measure is similar to #0469.]

The Workgroup felt that this measure was subject to LCV challenges, especially at the clinician level. The measure could also be influenced by the clinician and was feasible to report. A member also added that this measure could reflect access issues, as the decision to induce early delivery might be connected to distance from facilities equipped to handle deliveries. A Workgroup member noted that over 90 percent of hospitals met the goal of the measure (under 5 percent of patients delivering early with no medical indication) and felt hesitant to prioritize this measure given its relatively high performance.

Readmissions

0173 Emergency Department Use Without Hospitalization During the First 60 Days of Home Health (Claims-Based)

The Workgroup felt that this measure was important for care, could be influenced by the clinician, demonstrated room for improvement, and was feasible for the clinician to report. A Workgroup member asked for clarification on whether the measure was on home health agency resource utilization or the facility; another member clarified that the measure was based on both home health care and provider care of the patient in their home. The Workgroup was unsure if this measure was subject to LCV challenges, noting that the numerator was small but the denominator might be sufficient.

1789 Risk-Standardized, All Condition Readmission

The Workgroup noted that this measure was part of the current rural core set but was included for consideration here due to public comments indicating it has LCV challenges. The group also felt that there was an opportunity for performance improvements, and it was feasible to report because it was a claims-based measure. The measure is endorsed at both the Accountable Care Organization (ACO) and facility levels, and the workgroup felt that LCV could be a problem at the facility level but not the ACO level.

2510 Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)

The Workgroup felt that this would be subject to LCV reporting challenges and that there were opportunities for performance improvement, but were not sure if the clinician had significant influence over the measure. The Workgroup noted that the measure was claims-based and was reported at the nursing facility level, so it should not pose a reporting burden for providers. The Workgroup also noted that if a patient is discharged from the nursing facility to their own home but then returns to the nursing facility again, it is counted as a readmission for the facility. Cancer patients are also excluded from this measure.

[Note: The following three measures addressing procedures at ambulatory surgical centers (#3357, #3366, and #3470) were discussed as a group.]

3357 Facility-Level 7-Day Hospital Visits After General Surgery Procedures Performed at Ambulatory Surgical Centers

3366 Hospital Visits After Urology Ambulatory Surgical Center Procedures

3470 Hospital Visits After Orthopedic Ambulatory Surgical Center Procedures

The Workgroup noted that #3357, #3366, and #3470 assess care at free-standing ambulatory surgical centers, which are not especially prevalent in rural areas, though they are slowly growing. One Workgroup member shared that in their specialty (orthopedics), procedures traditionally done in inpatient settings are increasingly shifting to outpatient settings, indicating that these ambulatory surgical centers may become more common in rural areas in the future. The Workgroup also noted that the ambulatory surgical center market is rapidly conglomerating. The Workgroup discussed who would be held accountable for measure performance and noted that clinicians in ambulatory surgical centers do influence future hospital admissions following procedures.

The Workgroup was not sure if these measures were subject to LCV. A Workgroup member noted that of the three measures presented, general surgery would be least likely to face LCV challenges, urology most likely to face LCV challenges, and orthopedics likely somewhere in between. A Workgroup member felt that if it is economically viable for ambulatory surgical centers to exist and perform these procedures, they are unlikely to face LCV challenges.

A Workgroup member noted that a site-neutral version of these measures would be helpful for patients and would enable them to compare quality and cost across different provider types. Another Workgroup member agreed that this would be useful, although they noted that re-specifying the measures is outside the scope of the current task, and recommended that the final recommendations from the group include a comment on testing these in other settings and the future role of outpatient departments for procedures.

Finally, one Workgroup member noted that CMS has finalized adoption of #3366 and #3470 into their ambulatory surgical center quality program for payment, starting in 2022.

3490 Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy

The Workgroup felt that the measure did face LCV challenges, but noted that rural areas were unlikely to have their own chemotherapy centers and patients often travel many hours out of town to visit chemotherapy centers in urban areas. The treating oncologist would be responsible for measure performance, rather than the home primary care provider, if the patient travels to visit another chemotherapy center.

A Workgroup member noted that many of the measure discussions demonstrate a tension between whether measures are important for quality of care for patients, and whether the rural provider has influence over the performance of the measure. A Workgroup member agreed and noted that while the group is voting on a prioritized list to measure the care that is provided locally in rural settings, patients in rural areas are also affected by the quality of care in urban facilities that they travel to. A Workgroup member also noted that even if high-risk procedures are not being performed at high volume in rural settings, they should still be subject to some kind of quality measurement.

Stroke

1525 Atrial Fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy

The Workgroup felt that this measure was rural-relevant. However, they noted that it is a process measure and does not reflect whether prescriptions had actually been filled or taken by patients. The measure is also not claims-based and would need records or registry information in order to be reported. The Workgroup also noted that there was conflicting information about potential for performance improvement. While the measure developer documented some disparities in performance, the data from the developer is outdated (2012). MIPS performance data suggests that this measure is topped out (average performance at 97 percent), although physician self-reporting in MIPS tends to be very high. The Workgroup felt that this was an important quality measure but might not be the highest priority to test at this time.

Substance Abuse

0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

The Workgroup was unsure if this was subject to LCV challenges, since substance use is not unusual in rural communities. The Workgroup also felt that the clinician did not have much influence over whether their patients engage in additional treatment, and noted that a lack of treatment facilities makes it difficult for primary care providers to refer patients to specialists. While the measure is endorsed by NQF at the health plan level and could be helpful for understanding system performance, the measure is being used in MIPS at the clinician level.

Transitions of Care

0089 Diabetic Retinopathy: Communication with the Physician Managing Ongoing Diabetes Care [Note: Also related to diabetes.]

The Workgroup was not sure if this measure was subject to LCV challenges, as diabetes is common and about half of diabetics have retinopathy problems. They felt that the measure was pertinent to rural populations. The group noted that this is a medical condition where, again, many rural residents travel to urban providers to seek care. The measure may be helpful to a patient for understanding if their primary care provider is well-connected with their specialists, but the primary care provider can only reach out to the specialist for the information and cannot collect the information directly. Since the accountable physician would be the specialist, Workgroup members noted that this measure might be outside the purview of the current task.

0563 Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15% OR Documentation of a Plan of Care

The Workgroup was unsure if this measure was subject to LCV challenges but agreed that it was rural-relevant and impactful, especially given the connection with an aging rural population. However, the measure has a similar problem with feasibility of reporting and clinician influence as was discussed with #0089. The group also noted that this measure has high performance according to MIPS (96-99 percent through registry, almost 100 percent from claims).

1551 Hospital-Level 30-Day All-Cause, Risk-Standardized Readmission Rate (RSRR) Following Elective Primary Total Hip Arthroplasty (THA) and/or Total Knee Arthroplasty (TKA) [Note: Also related to readmissions.]

The Workgroup felt that this measure could be susceptible to LCV challenges, it is pertinent and impactful to an aging rural population, is feasible to report as it is already used for reporting through Hospital Compare, and can be influenced by clinicians. A Workgroup shared that they think this is a

useful benchmark and they have been able to use it in the past without adjustment, but one or two additional readmissions can throw off performance for some facilities. Another Workgroup member noted that CMS publicly reports this information, but it is very hard to use this information to distinguish between facilities as the numerator is so low and most hospitals report a rate of zero for this measure. The Workgroup member noted that it may be helpful to consider measures with low numerators differently than those with low denominators.

2539 Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP32) [Note: Also related to readmissions and emergency department use.]

The Workgroup felt that clinicians had some influence over this measure and it would be feasible to report. A Workgroup member commented that colonoscopies are an important access point for rural patients, and patients express that they do not want to travel to receive their colonoscopies, so this measure is impactful and rural-relevant.

2881 Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction [Note: Also related to readmissions.]

The Workgroup noted that clinicians in rural facilities might be unlikely to admit patients under this measure, and it was more likely that a case would be identified in the emergency department and then transferred to outpatient care after intervention.

Venous Thromboembolism (VTE)

0371 Venous Thromboembolism Prophylaxis

The Workgroup noted that this measure was in the current rural core set but was flagged in public comments as challenging to report on due to LCV. The commenter had also noted limitations in collecting this data via electronic health records in rural areas. A Workgroup member also noted that NQF no longer endorses this measure and the developer has noted this measure as “outdated.” The Workgroup felt that this was not a high-priority measure given these updates.

Sepsis

0500 Severe Sepsis and Septic Shock: Management Bundle

The Workgroup agreed that this measure was subject to LCV issues in the rural context. The Workgroup also agreed that the measure would be a high-value inclusion for improving care for a mix of provider types, and noted that this will be added to MBQIP as a measure for CAHs.

One Workgroup member noted that small rural facilities may transfer patients in septic shock to larger facilities to finish treatment, and asked whether a smaller part of the composite might be appropriate to measure for small rural hospitals. Another Workgroup member noted that some rural hospitals do treat sepsis in full, but a note could be added that the measure could address whether care was managed correctly up to the point of transfer.

Heart Failure

0277 Heart Failure Admission Rate (PQI-08)

The Workgroup noted that this measure is actually not subject to LCV, as it is used at the health plan level (measured per 100,000 beneficiary-months), but highlighted that it is a helpful measure to understand heart failure rates at a community or population level.

Review Final Prioritized List of Measures

The NQF team shared the final list of 15 measures that the group voted to include on the prioritized list of measures for statistical testing:

NQF#	Measure Title
0005	CAHPS Clinician/Group Survey
0166	HCAHPS [Note: includes 11 performance measures under this NQF number]
2079	HIV Medical Visit Frequency
0108	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)
0576	Follow-Up After Hospitalization for Mental Illness
0275	Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)
0138	National Healthcare Safety Network (NHSN) Catheter-Associated Urinary Tract Infection Outcome Measure
1717	National Healthcare Safety Network (NHSN) Facility-wide Inpatient Hospital-onset *Clostridium difficile* Infection (CDI) Outcome Measure
0471	PC-02 Cesarean Birth
0173	Emergency Department Use without Hospitalization During the First 60 days of Home Health (Claims-based)
1789	Risk-Standardized, All Condition Readmission
2510	Skilled Nursing Facility 30-Day All-Cause Readmission Measure (SNFRM)
1551	Hospital-level 30 day, all-cause, risk-standardized readmission rate (RSRR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA)
2539	Facility 7-Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (OP32)
0500	Severe Sepsis and Septic Shock: Management Bundle

NQF staff asked whether the number of measures in the list and mix of measure types felt appropriate to the group, noting that the length of the list might need to strike a balance between meaningfully prioritizing measures and addressing the wide and evolving scope of issues faced by rural Americans.

A question was raised and NQF staff clarified that this was not the final list of measures that would be added to a core set, rather it was a list of measures that the group would recommend to be tested. A member commented that statisticians working on the testing might be able to get additional information on some of the actual case volumes and prioritize the list further based on their needs before starting the testing.

A Workgroup member also recommended that the statisticians conduct testing appropriate for two goals: for understanding and tracking quality improvement and for pay-for-performance purposes (which might require additional analysis). NQF acknowledged this comment and noted that in the next steps, they could make a note about these considerations that the next group should include before performing the testing.

There were also 3 measures that received between 40-60 percent votes to include, but these were not added to the final prioritized list:

NQF#	Measure Title
N/A (similar to #0469)	Maternity Care: Elective Delivery or Early Induction Without Medical Indication at <39 Weeks (Overuse)
3490	Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
2881	Excess Days in Acute Care after Hospitalization for Acute Myocardial Infarction

A Workgroup member expressed interest in looking at the group of measures as a whole, and whether the group of measures accurately reflects care across rural facilities and whether there are any gaps that are represented in the measurement list. A Workgroup member agreed and emphasized the importance of thinking of patients' needs and whether they are covered by measurement in a holistic way.

Challenges and Potential Solutions in Reporting the Prioritized Measures

NQF staff summarized some of the reporting challenges that had been described so far during the meeting, including:

- Some measures do not qualify as having LCV based on the denominator, but primary care providers face difficulties obtaining the data (e.g. information flow from specialists, or from additional providers in urban areas).
- The CAHPS measures do not include an electronic reporting option.
- For surgical care measures, ambulatory surgical centers and outpatient facilities do not always use the same measures to address the quality of surgical procedures.
- Availability of certain data sources (e.g. using electronic health records) in rural care settings.

One Workgroup member commented that CAHs are required to submit electronic clinical quality measures (eCQMs) as part of interoperability programming for CMS, but it is uncertain how many CAHs are reporting/using eCQMs. CMS has also proposed shifting to public reporting of the data and changing reporting timeframes. At least one Workgroup member supported the expansion of eCQMs but noted that these need to be adapted to be rural-relevant. Another Workgroup member commented that rural providers are less likely to be using one of the major EHR companies and are usually using smaller, less expensive, and less advanced EHR systems; rural providers are less likely to have in-house expertise to perform data extraction and analysis; and rural providers are more likely to be independent and not part of a larger system, which reduces their performance on some of the measures relying on inter-provider communication of data.

One Workgroup member asked whether the process should be more patient-centric in the future and if patients would be interested in including different measures. Another member noted that the current list includes measures that are important for rural patients, but it may be helpful to supplement the core set in the future with population-based measures in order to assess characteristics that are difficult to assess on the individual provider level.

In terms of unintended consequences, a Workgroup member mentioned that pooling data over several years for one provider would affect the ability to track improvement over time due to lag, which might pose a challenge for pay-for-performance programs. Another Workgroup member emphasized the role of attribution, noting that physician assistants and nurse practitioners may be the actual provider of care in many cases but the service is submitted under the supervising physician. Another Workgroup member noted that implementing the measures could lead to the unintended consequence of reducing access to care (disincentivizing providers to offer certain types of care in rural or underserved areas based on risk

of reduced payment, or encouraging providers to avoid procedures like C-sections even when it would be beneficial for the patient).

A Workgroup member commented that in the future, the group will also need to balance quantitative measures with more qualitative methodologies that represent patient voices and patient experience.

Finally, a Workgroup member commented that there are ongoing changes in the structure of the healthcare delivery system, especially given the current COVID-19 crisis. As these structures shift and as health systems consolidate/regionalize, the group should consider how measurement will be affected by these changes.

Addressing Gaps: Recommendations to Advance Rural Health Measurement

NQF staff noted that the group had identified access to care, transitions in care, cost, substance use measures, and outcome measures as gaps during the work in 2018. During the current phase of work, the group also noted that infection prevention, health system preparedness, patient resilience, and health system resilience were additional measure gaps.

Workgroup members suggested the following considerations:

- Community and population health
    - Community-based measures
    - Systems of care across a community
    - Keeping populations healthy
    - Correlating access to care with population health outcomes
- Chronic illness
- Telehealth
    - Telehealth options for measures
    - Understanding differences in care delivered virtually versus in-person
- Measuring information flow between providers and community-based human service agencies
- Dementia-related measures (Note: The Workgroup was not sure if this was rural-specific so much as a general measure gap across all settings.)

NQF welcomed any additional comments from the Workgroup via email.

Public Comment and Next Steps – Day 2

NQF staff opened the web meeting to allow for public comment. A representative from CMS thanked the Workgroup members for their time and thoughtful input during the Measure Prioritization Meeting.

NQF staff updated the Workgroup on the next steps for the project. The NQF team will draft and post a meeting summary on the public website, and will use the discussion from this meeting to inform the content of the upcoming recommendations report. After drafting the recommendations report, the report will be posted for public comment in July. The NQF team is preparing to schedule the post-comment call in the last week of August, and the final date and time will be posted publicly once confirmed. The final report will be posted in September.