NATIONAL QUALITY FORUM
Driving measurable health improvements together

**Meeting Summary**

# MAP Rural Health Post Public Comment Meeting Summary

The National Quality Forum (NQF) convened a public web meeting for the Measure Applications Partnership (MAP) Rural Health Workgroup on August 26, 2020. The purpose of the meeting was to review and discuss public comments received on the draft recommendations report: *Rural-Relevant Quality Measures for Testing of Statistical Approaches to Address Low Case-Volume.*

## Welcome and Introductions

Nicolette Mehas, NQF director, and Andre Weldy, NQF director, welcomed participants to the web meeting and introduced the NQF project team. Dr. Ira Moscovice and Dr. Aaron Garman, the Workgroup co-chairs, also provided welcoming remarks. NQF staff facilitated roll call and reviewed the following meeting objectives:

- Update on recommendations report
- Review and discuss public comments on recommendations report
- Next steps

## Update on Recommendations Report

NQF staff shared that NQF had updated the draft recommendations report and environmental scan materials following the Workgroup's Rural Health Measure Prioritization meetings, which had occurred on May 27 and May 29. Updates captured the Workgroup's suggestions to provide more information on project background and process, details on what constitutes low case-volume, and other themes from the Workgroup discussions. NQF staff shared that the updated recommendations report and environmental scan had been posted for public comment for 21 days beginning July 14 and ending July 30. The public comment posting asked for feedback on the following:

- Rural relevancy and low case-volume susceptibility of the 15 measures recommended for statistical testing
- Additional reporting challenges
- Additional gaps and future considerations
- Any other general comments

## Review and Discuss Public Comments on Report

NQF staff shared that they had received comments from three organizations/individuals via the public commenting web tool and email. NQF shared that the goal of the discussion with the Workgroup was to consider if the comments warranted revisions to the recommendations report, and if so, what revisions. Additionally, NQF staff instructed the Workgroup to share any other final points to consider in the report.

NQF staff then moved to discuss public comments by theme:

### *Commenters supported the inclusion of transitions of care*

NQF staff shared that transitions are a vulnerable point in care for individuals, and that commenters appreciated that this was addressed in the recommendations report and remained a significant gap area. NQF staff noted that the list of 15 prioritized measures includes NQF #0576 *Follow-Up After Hospitalization for Mental Illness*. A Workgroup member agreed that transitions are an important aspect of care and noted that it is an ongoing challenge to collect information on transitions in care, since data need to be collected from multiple sources. The Workgroup member noted that while there is only one measure on the prioritizations list addressing this, there are few available for consideration. Another Workgroup member emphasized that measures for testing should be feasible for rural facilities to report on. The Workgroup member noted that easily exchangeable data might not be realistic for some rural facilities at this point and that it should be an area for further study.

### *Mixed comments on use of cross-cutting measures*

- Defining cross-cutting measures can be arbitrary
- Focusing on cross-cutting measures could discourage measurement in specialty areas and discourage use of outcome measures
- Alternative: measures with common causal pathway

NQF staff shared that cross-cutting as a measure attribute was considered in selecting which measures to prioritize for the statistical testing and noted that these are measures that reflect broad applicability to patient populations and are not specific to diagnoses or processes. NQF staff noted that they attempted to balance measure characteristics when assembling the list of measures for consideration. NQF shared a public comment that selecting groups of measures with a common causal pathway or an underlying structural connection between them (e.g., related process and outcomes measure for a certain condition) would have been an alternative approach to prioritizing measures for testing borrowing strength. A Workgroup member expressed that the mixed nature of the comments suggests that there is no one answer and supported the process used to select the prioritized measures. Another Workgroup member added their support to this idea and noted that it is a balancing act and that there is a good mix of measure types in the prioritized list.

### *Measures should be assessed for low case-volume (as opposed to limited availability of service) before testing*

NQF staff shared that a commenter suggested that before testing, measures should be assessed for low case-volume rather than limited availability of services. The commenter noted that, for example, a limited number of critical access hospitals (CAHs) have labor and delivery services, but for the few that do provide those services, low case-volume may not be an issue. A Workgroup member pointed out that both limited availability of services and low case-volume are ongoing challenges in rural areas and both issues should be taken into consideration. Another Workgroup member noted that some hospitals in rural areas that offer labor and delivery services still have challenges with low case-volume and reporting. Another Workgroup member noted that rural hospitals in their area do not have OB/GYN specialty care. They have general surgery complete Caesarean sections, for example. The Workgroup member questioned whether it is reasonable to benchmark performance of smaller facilities against larger facilities when similar services are provided by different provider types. Another Workgroup member noted that before testing a measure, it might make sense to double check sample sizes for a subset. NQF staff noted that these are issues that could be explored during testing.

### *Measure-specific updates: NQF#0500 Severe Sepsis and Septic Shock: Management Bundle and NQF#1789 Risk-Standardized, All Condition Readmission*

NQF shared that a commenter noted NQF #0500 is not currently included in the Medicare Beneficiary Quality Improvement Program (MBQIP). Workgroup members noted that it is an important measure and that it is supposed to be implemented in MBQIP in the future. NQF staff said that they will update the recommendations report to reflect this information.

NQF shared that a commenter noted NQF #1789 will be replaced with a hybrid measure in the next several years. The commenter noted that any statistical testing done on this measure should not be on the current claims-only measure but on the new hybrid version (the modified version will use clinical data elements from electronic health records (EHRs) in the risk adjustment model). Workgroup members emphasized that the change should be noted in the report, but that this measure, as it currently stands, is used frequently and that it would be useful to test the statistical methods on a measure as it is currently implemented. Another Workgroup member noted that development, testing, and revisions to measures do not happen quickly and it will likely be at least several years before a hybrid version is actually implemented. The Workgroup member suggested testing the current measure and continuing to evaluate any changes over time.

### *Borrowing strength approach does not require pooling data over time*

NQF shared that a commenter noted that borrowing strength statistical methods do not require combining data over multiple years. They leverage the persistent statistical relationship of a provider's data across years and data across similar providers. This comment was in response to language suggesting that pooling data over time would affect the ability to track changes in quality measurement performance. Workgroup members noted the comment and suggested revising language in the report to reflect that both pooling data and using borrowing strength approaches are useful approaches.

### *Expanding universe of claims data available for calculation of claims-based measures*

NQF shared that a commenter suggested exploring expanding the universe of claims available for calculation of claims-based measures to include Medicare Advantage data and possibly an all-payer claims database. The commenter noted that this would likely increase the utility of existing claims-based measures for rural and low-volume facilities. One Workgroup member expressed a note of caution and stated that bringing in additional data sources could potentially compromise comparability if rural providers were assessed using data from Medicare Advantage, but all other providers were not assessed using this data. The Workgroup member shared that if this approach were applied universally, it would mitigate this potential issue. Another Workgroup member supported that it might be advantageous to use a broader amount of claims but emphasized that whatever method was used for acute care hospitals would need to match what is used for rural hospitals to ensure comparability. NQF noted they would reflect this in the report.

### *Limited number of rural-relevant eCQMs*

NQF shared that a commenter noted that there are few rural-relevant eCQMs included as part of CMS Inpatient Quality Reporting and Promoting Interoperability Programs. Workgroup members noted the comment and shared that, while important, does not necessarily impact the list of prioritized measures for statistical testing. NQF noted that the section of the recommendations report on reporting challenges describes some of the themes related to eCQMs raised by the Workgroup and by the commenter, and that the commenter's concern about eCQMs and rural relevance can be added. A Workgroup member shared that some rural and low-volume providers have been adapting their workflows and documentation processes in order to participate in eCQM reporting, but there is still

opportunity for eCQM measure results to be more actionable for rural providers in order to drive improvement.

### *Infrastructure requirements to implement borrowing strength approaches*

NQF noted that a commenter shared the need to address infrastructure requirements needed to implement the borrowing strength statistical approaches. These infrastructure requirements include the robust statistical expertise and computational power that would be needed to establish benchmarks or thresholds, observe statistical correlations or persistence, and ability to estimate correlated signal variances. Workgroup members noted that this language should be added to the report.

### *Suggested areas for future adaptation/development*

NQF noted that a commenter emphasized there continues to be a significant need for measure adaptation and measure development to help address critical areas of quality and safety for rural health care, such as access and timeliness of care, care transitions, substance use, cost, population health, advance care directives, end-of-life care, and patient outcomes. The commenter strongly encouraged additional support for development of rural-sensitive measures to allow CAHs and other small rural hospitals to demonstrate the quality of care they provide and to continue to participate in improvement and payment programs, which lead to higher quality and lower cost for Americans living in rural places. Workgroup members noted the comment and shared that they agree these continue to be topics of great importance to rural and low-volume providers.

### *Additional support for development of rural-sensitive measures and identification of a core set of cross-cutting measures for all providers and supplemental sets specific to provider categories*

NQF shared that one commenter noted the need for additional support for development of rural-sensitive measures appropriate for rural hospitals and usable in improvement and payment programs. NQF shared another comment suggesting the development of a core set of cross-cutting measures that all providers would report on, as well as supplemental sets specific to provider categories (e.g., a set for CAHs, a set for general acute care facilities, sets for specialty care facilities). Workgroup members noted that these are ongoing issues and that the suggestion for core and supplemental sets of measures is an important consideration, but caution would have to be taken to ensure that it is not interpreted as a multitier system.

## Public and Member Comment

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

## Next Steps

NQF staff notified the Workgroup of upcoming activities, including:

- Posting the summary of this meeting on the MAP Rural Health Workgroup project website
- Incorporating feedback and finalizing the recommendations report by September 15
- Publishing the final report on the NQF website by September 28
- Sharing the final recommendations report via email to the Rural Health Workgroup when it is available online

NQF shared that the next time the MAP Rural Health Workgroup convenes will be for the pre-rulemaking work later this year. Tentative dates for pre-rulemaking meetings were shared.

NQF staff noted that the MAP Rural Health Workgroup would also be reconvened in early 2022 to update the current rural-relevant core set of measures.

NQF staff thanked the MAP Rural Health Workgroup for their commitment and engagement in this work and thanked the co-chairs for their leadership. The co-chairs offered closing remarks.