NATIONAL QUALITY FORUM

Moderator: Rural Health
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Operator: This is Conference #: 88441471.

Operator: Welcome, everyone. The webcast is about to begin, please note today's call is being recorded. Please standby.

Karen Johnson: Good afternoon, everybody, this is Karen Johnson with NQF. Thank you for joining us this afternoon. We're going to delve right into out third webinar with our MAP Rural Health Workgroup.

So I'm going to start out by asking Ira and Aaron to say hello to everybody, and then we'll turn it over to Suzanne to walk us through our roll call. And then, we'll get into the meet of the discussion today.

Ira Moscovice: So this is Ira and I'll just start off by saying, we're glad everybody is on the call. And today's calls are really important one. Staff have really been working hard in terms of moving the process forward and we're going to get a chance now to have everybody to be able to provide input on the selection criteria that were used for measures. And that we're going to start looking at the draft core sets of measures and get a chance for people to provide input in terms of things that aren't on it that they like to see on it. Things that are on it that they would prefer not be on it and any other questions you might have about that draft core set of measures.

And then, we'll move forward in terms of looking at measurement gap areas and also discuss rural-relevant measurement topics. So we have a lot to do today and welcome everybody. And we hope to have a really great call with

lot of input from participants.

Aaron Garman: Thanks, Ira. This is Aaron. I do want to thank everybody for attending the call today. It's very ambitious agenda. And so, I will turn it over to our staff to lead us through it.

Suzanne Theberge: Great, thank you. This is Suzanne Theberge. I'm the Senior Project Manager on the team and I'm just going to review some quick housekeeping items on the agenda before we do the roll call.

So just a reminder as usual, please mute your line if you're not speaking to reduce feedback. Workgroup members, please do dial-in to the phone as well as the webinar. And of course, please say your name before you speak as we're all still learning each other's voices.

So today, as we have just heard, we're going to be looking at the measure selecting criteria and the draft core set. Then, we're going to spend a little time discussion measurement gap areas. And then, finally, we're going to, again, briefly discuss the rural-relevant measurement topic that we are hoping to address in this project.

So next slide, just a quick reminder of your project team which is Karen, myself, Kate and Madison. And then, I would like to do the workgroup roll call. I'm going to start with the organization and if there is someone from that organization on the line, please just introduce yourself.

So our co-chairs, Aaron and Ira have already introduced themselves. So someone on from Alliant Health Solutions?

Kimberly Rask: Yes, this is Kimberly Rask.

Suzanne Theberge: Thank you. American Academy of Family Physicians?

David Schmitz: Yes, this is David Schmitz.

Suzanne Theberge: Thank you. American Academy of PAs? American College of Emergency Physicians?

Steve Jameson: Yes, this is Steve Jameson.

Suzanne Theberge: Thank you. American Hospital Association? Geisinger Health?

Karen Murphy: Yes, this is Karen Murphy.

Suzanne Theberge: Health Care Service Corporation?

Shelley Carter: Hi, this is Shelley Carter.

Suzanne Theberge: Thank you. Intermountain Healthcare?

Mark Greenwood: Yes, this is Mark Greenwood.

Suzanne Theberge: Thank you. Michigan Center for Rural Health?

Crystal Barter: Good afternoon, this is Crystal Barter.

Suzanne Theberge: Thank you. Minnesota Community Measurement?

Julie Sonier: Hello, this is Julie Sonier.

Suzanne Theberge: Thank you. National Association of Rural Health Clinics?

Bill Finerfrock: Yes, this is Bill Finerfrock.

Suzanne Theberge: Thank you. National Center for Frontier Communities? National Council for Behavioral Health?

Sharon Raggio: Sharon Raggio.

Suzanne Theberge: Thank you. National Rural Health Association?

Brock Slabach: This is Brock Slabach here.

Suzanne Theberge: Thank you. National Rural Letter Carriers' Association?

Cameron Deml: Yes, good afternoon. This is Cameron Deml here.

Suzanne Theberge: Thank you. RUPRI Center for Rural Health Policy Analysis?

Marcia Ward: Hi, this is Marcia Ward representing the center today.

Suzanne Theberge: Thank you. Rural Wisconsin Health Cooperative?

Tim Size: Hello, it's Tim Size.

Suzanne Theberge: Thank you. And Truven Health Analytics?

Cheryl Powell: Yes, hello. It's Cheryl Powell.

Suzanne Theberge: Thank you. And were there any organizational representative who were perhaps on mute or just dialing in that didn't already say their name?

Karen Johnson: I believe Dr. Tahta, Stephen Tahta from AHA is dialing in. He sent us a message to the web platform.

Suzanne Theberge: OK. Great, all right.

Now, let's just do a quick roll call for our subject matter experts. John Gale?

John Gale: I'm here.

Suzanne Theberge: Thank you, Curtis Lowery? Melinda Murphy?

Melinda Murphy: Yes.

Suzanne Theberge: Thank you. Ana Verzone? And Holly Wolff? OK.

And our federal liaison. Susan Anthony?

Karen Johnson: Susan is on the platform as well and will dial-in later.

Suzanne Theberge: Great. Craig Caplan?

Craig Caplan: Hi, this is Craig.

Suzanne Theberge: Thank you. And Juliana Sadovich?

All right, anyone else who hasn't yet introduced themselves?

Steven Tahta: Yes. This is Steven Tahta from the American Hospital Association.

Suzanne Theberge: Great, thank you. All right.

Next slide, just a quick reminder of where we are in our timeline. We are at webinar number 3. And our next webinar will be in about three weeks on February 14th. And we will be talking about the draft report at the next webinar.

So I will now turn it over to Karen and Ira to talk about the draft core sets and the measure selection criteria.

Karen Johnson: Thank you, Suzanne. So, based on some of our conversation from our last call, we wanted to make sure that everybody felt comfortable about what we're working towards in this part of our project. So basically, what we're looking to identify is a core set of measures that are appropriate for the hospital inpatient settings and ambulatory care settings in rural areas.

So to think of it as one core set that covers both of those kind of settings or, you know, you could think of these two core sets, however you want to think about it. But really, we're looking to identify no more than about 10 or 20 measures for each setting, hospital in patient and ambulatory. So, again, the idea here is identifying a core set of measures.

We may at some point, the CMS decides to fund us for continued work. We may delve into identifying measures that would work for optional sets, but we're not there yet. So, for measures that would work for hospitals, we want to identify measures that are applicable to most critical access hospitals as well as other small rural hospitals.

So we know that, you know, that the three bed hospitals that are out there, you know, some measures even on the core set, you know, may or may not have enough patients to be able to respond, you know, reliable and valid way to some measures. But I think what we are trying for is for that to be the exception, not the rule for these core sets.

For ambulatory care measures, we would expect them to be applicable to rural health clinics and FQHCs, as well as other, you know, offices, clinics in rural areas, you know, and the clinicians who work in those clinics.

So, hopefully, that's a little more clear. I think, you know, we're not going to try to delve into, you know, this measure will work for an FQHC and not an RHC. We're going to leave that aside for now and I think we're going to be able to identify measures that should work across those types of settings. If there are, you know, concerns that something that we identify, maybe wouldn't work in one of those, we can talk about that a little bit later in the project.

So with that, the draft selection criteria, so there's a lot on the slides and I apologize for the tiny script. But I wanted to make sure that we let you know how we took your input in the last couple of calls and came up with our, what we're calling our draft selection criteria and then our scoring methodology.

So first of all, apologies, tier 1 is a little bit misnamed, our real tier 1 or our base tier was, we were going to confine ourselves to looking at measures that are endorsed by NQF. So that's the baseline. So we're only looking at NQF-endorsed measures.

And then, within that, what we heard from you is, the stuff that we thought that everybody was kind of unanimously, very strongly in favor of, is what we are calling our tier 1 criteria. Basically that covers measures that are cross-cutting, measures that are, I'm calling it resistant to the low case volume challenge.

We might come up with better wording as we go along with that. That's the idea that, you know, most providers would be able to report on those. And also, this idea of transitions of care, we want to be able to make sure that we have some measures that look at transitions.

So those were tier 1, and we can come back a little bit later. And as a matter of fact, we will need your health in may be refining our definitions a little bit in terms of cross-cutting and resistant to low volume. But what I have on the

screen is kind of our working definition that we applied to the measure set that we were looking at.

So the next three tiers were pretty much based on discussion from our last webinars as well as your input. You may remember back a couple of months ago, we ask you to fill out a SurveyMonkey and we were able to quantify some of your strongly agrees, agrees, with several different types of measures.

So our second tier is the one that folks felt pretty strongly about, with having some measures around mental health and with the special note about depression. And, you know, let we back up a little bit and apologies. What you have on the screen here in front of you, under tier 1 and these other ones. I had just a few examples of what I mean by the various things.

So up to this and there is just the kind of make it a little more concrete for you. So going back to tier 1 and cross-cutting, a tobacco use screening measure, we would consider to be cross-cutting. All-cause readmission, again, cross-cutting. Contraceptive care most and moderately effective methods also cross-cutting.

And again, basically, agnostic to condition or kind of procedure or is perhaps a screening measure. So the idea there is, you know, it's not just one condition, it's not just one kind of patient that would be eligible to be included in the measure.

Resistant to low volume, the adequate sample size was really looking more at the denominator, not necessarily the numerator, although a little bit later on, we might be more concerns about making sure that there's going to be adequate numerators, not a really, really rare event. But just examples of that would be well-child visits, total cost of care, osteoporosis testing in older women.

Again, these are just some examples of ones that what we went through and tag measures these, you know, these three measures are examples of ones that we tag as being resistant to low case volume. And then, transitions of care, you see our definition there.

And so that's tier 2. In tier 2, we have measures related to mental health. An example is, screening for depression. And that one actually was mentioned specifically on one of the calls. So we want to make sure that we had that one in there. Measures related to substance abuse and medication reconciliation measures. So, again, tier 2, so still strongly supported from what we heard from you, that maybe not quite as strong as what is in tier 1.

Next slide takes us to what we're calling tier 3. These also were pretty strongly supported but not quite as much as the other ones. And we rank those because they are condition specific. There was at least some feeling that, well, cross-cutting was really, really important. In some cases, some disease conditions are so prevalent. And maybe particularly so in many rural areas that we would want to at least consider measures around those in core set. So, those conditions include diabetes, hypertension and COPD.

And then finally, our fourth tier, this one came about – and I think there was more – just more – not so much discussion on this, in general, on the cost. But they did receive quite a bit of support in our SurveyMonkey exercise that you guys did. But, again, not quite so much of a support that we saw for tiers one, two, and three, and those include readmissions, measures around perinatal activities, and then measures that – are specific to the pediatric population.

And the (teen's) group is pretty interesting, you know, so much primary care which is a lot of what being done in the rural health clinic as primary care, of course, a big user of the services are kids. So that's, I think, probably why that made the list.

So, let me keep going a little bit and then I'll stop and ask questions and then we'll get into the need of our discussion. So our next slide, we do our scoring method.

So basically what we did is we took all the measures that were NQF-endorsed, there were 444 of them and just – if you're keeping track and wondering, you know, we probably told you that we had, excuse me, more measures than that, that were NQF-endorsed.

We did limit that group of NQF-endorsed measures to measures where the level of analysis is at least clinician or an inpatient hospital. So in other words, we didn't include measures that are assessing care provided, for example, by nursing homes or by home health agencies, or dialysis facilities, those kinds of things.

We also took out measures that were assessing care and measuring performance of health plans. You know, that is kind of an interesting question because sometimes those are used in ACOs. But again, we're kind of – thinking about limiting our thinking to in-patient hospital and clinicians.

And we are defining that right now as actually measuring the performance and potentially holding clinician vendor hospital accountable. So, again, that's how our bigger number of NQF-endorsed measure got down to the 444.

So then, we rated yes or no, or if you like math, one, zero binary for six different components. So, was it cross-cutting, yes or no? Was it low case volume? Was it a measure around a transition? And then, was it a measure that fell into tier 2, tier 3 or tier 4? So, again, we just went through and call those one or zeros for those six group.

Now, the caveat of course, is, you know, anybody including myself can look back at the work that we did at staff and maybe disagree with ourselves. So, you guys might certainly look at our list of measure and say, "Well, I wouldn't call that cross-cutting or I wouldn't call that low case volume. And we can certainly, you know, take any of that kind of input if you have it. Although, I think, maybe at this point that might be a little premature or maybe a little bit too much playing around the margins, is that make sense?

And, you know, even as I said, I did a final cut at one point and then another one later. I did one before our last webinar and then one before this one. And I even disagreed with myself. So, you know, you kind of, you know, those are a little bit fluid, but again, the idea there was – to help us put a little bit of order around this list of 400 and some measures.

So we rated them, and then we assigned a percentage weight to each of those components. And you see the weight that we had there. And the weight

basically reflects what we think we heard from you, which is your desire to really have those characteristics.

And the weighting was completely arbitrary. We believe and we'll be very embarrassed if it's not the case, but those weights should add up to 100 percent. So that was the idea. And, again, as you can see cross-cutting, low case-volume, transitions, have the higher weights and et cetera down the tiers.

So we assign the weight and basically gave all 444 measures a score. So – then we sorted by score and applied a cut-point. Now, the cut-point was the 75th percentile, again, arbitrary. But I chose that way mainly because I wanted to have enough measures for us to talk about in a draft core set but not too many, so the 75th percentile seem like a good cut-point.

And then from there, that basically took us down to – of the 444 measures that were NQF-endorsed, once we applied the weightings for those tiers or the really the yes/nos, one/zeroes and did a score, 284 of those had a score greater than zero, OK. So our selection criteria as we've interpreted your desires has worked us down to about half of the measures that we had, so little over half the 284.

After applying that cut-point, the 75th percentile, that took us down to 119 measures. So still quite a few measures to try to get our arms around.

So instead of presenting you with 119 measures today, I actually went through and did – and I take full responsibility for this, I selected a subgroup of those. And this was basically my feeling of what I kind of thought you guys might like to see. So somewhat based on your conversations or conversations that we had a couple of years back, I also kind of unofficially looked at some of the other – the measures that are being used in different programs that sort of thing and basically did a staff cut.

So I worked our way down to 44 measures. And of those 44, 37 of those had a score that was at least greater than or equal to that cut-point, that 75th percentile. And actually a few more of those that I picked didn't make our cut-point but they same likely should at least consider them. So I put them on our list as well.

So again, that gets us to 34 – or sorry, 44. And just so you know, the seven that I added in a couple of them had to do with alcohol or drug and treatments, which was something mentioned a couple of years ago as being important for rural areas.

One had to do with giving stat and medication for – patients and hospital discharge, one with a high blood pressure measure. So again, that was one of these measures that was in tier 3. It just didn't make the high enough score when I used the cut-point. A couple more were diabetes measures and then one was an asthma measure, again, thinking about the idea of pediatrics and things that might be of interest to rural residents.

So, with that, the next couple of slides, just kind of shows what we're calling the Strawman Draft Core Set. So I'm going to do a couple of things and then hand it over to Ira.

So we're calling it a Strawman because it very much is. This is something that we want to get your reactions to. And is it morphs from what we have today to something completely different, that's absolutely fine. We don't necessarily – we wouldn't completely be surprised by some changes. So it's Strawman again to give you something to react to.

And I think the next thing that I want to do because we can't really work off of this slide. I think our best way to go is to actually pull up the Excel file that we sent to you. And, Madison, can you bring that up on our screen?

And we really encourage you to have this open on your PC or Mac or whatever it is you're using so that you can kind of work around. And I don't know if you can make that any bigger or not. I may have to walk a closer to the screen if not. But before we go any further, I want to orient you to the spreadsheet. Hopefully most of you are used to working in spreadsheet but not everybody is.

So those of you who might be less familiar, one of the best things about Excel spreadsheet is the ability to filter. So you'll see that there's little arrows at the

top rows, top cells there. So for cross-cutting, Madison, if you'll just click that arrow, you can see that you can filter.

So right now, everything is in there but if I want to see just the measures that are cross-cutting, so they have a one, you'll notice – and this is not telling me that sometimes it's the bottom. It will tell you that that brought up X out of 444. Looks like a product, 131 out of 444 were cross-cutting according to our tagging efforts.

So just by looking across there with that little arrow filter, you can tell that something is filtered and then you can just put it back when you're done filtering. So let's put that back. OK.

So this spreadsheet gives you quite a bit of information. You've got the measure title and measure number. You've got our six kind of components of our selection criteria. Again, telling you there's one/zeroes, yes/nos. The light yellow column, that's column I is – especially the title is not probably – well, that's a fine title. It's really the score.

So basically again after applying the weighting methodology that we showed you before, these are the scores that the various measures we see. There's another column just for fun that tells you whether or not it – a measure score was greater than or equal to our cut-points, which was 0.5. And then following the bright yellow column is the yes or no, it's in our Strawman core set.

And then there are some other columns over there. Use of federal programs that's a basic yes or no, that one is updated, right? OK, so that one is updated. We have more information if we need to kind of get more granular to tell you that it's in the IQR or the OQR or the MIPS program for example. But we just don't have that in here at this point.

A really important column is the measure descriptions. You know, you really have to look at the measure descriptions. The title won't always do it for you. And then a little bit of information about numerator/denominator exclusions whether it's risk adjusted, the type of measure that will be process, structure, outcome, PROPM stands for patient-reported outcome performance measure

that's usually in this case, it's going to be usually experience of care kinds of measures.

Level of analysis is the – what NQF calls basically the entity that is being measured. So for that first measure there, it's a facility level of analysis in the care setting of hospitals. So what that saying is this measure assesses the performance of a hospital. And then there's a few other things there as well.

The blue stuff, you can take or leave, that's a little bit more about the tiers. If you want to know something with the diabetes measure that's in there, that's column Y.

And then finally, the last column, again, this was something that we used really early on just to kind of give an overall condition or topic. It's just kind of good to help you kind of short quickly by using that filtering functions, probably this when more than anything people could fuss about, did I, you know, call it the right topic area or not. Many measures would actually fit under several. But again it's just meant to help you kind of navigate within the spreadsheet.

So with that, it's almost time to hand it to Ira to facilitate this conversation. Some of the questions that I would like you to give your input on, is the criteria that we used, those six things, the four tiers that we described. Is there anything additional that you think we need to add? It works fairly well. As I said, it got to stand to 284 out of 444 measures. So it did fairly well. But if we had more strengthened criteria, that could take us down more.

What about the weighting (scheme)? Again it was arbitrary. I will tell you that the way we set it up with the ones and zeros and the tiers and that sort of thing, is a little bit impervious to what our waiting numbers actually were. But we're certainly open to changing the waiting scheme. And then, of course, what should be on here but isn't, and then the flip of that, what is on here that you actually don't want to see.

Now, we're not going to be able to get definitive answers on our call today so I would tell you what we're thinking after our conversation today. We are going to ask you to go back and look at that list of 444 or maybe even – if you

are really happy with the selection criteria that we've articulated thus far that list of 119. Look at those, and if they're things that didn't make our Strawman list, I want you to e-mail us and let us know what you would like to add, and we're going to ask you to do that. And that we're going to send you an e-mail after the call to remind you.

We would ask you to look at that list and tell us if there's anything on the list that didn't make it that you definitely would like to see. E-mail us and let us know by noon on Monday, OK? And the reason we have such a tight turn around is we actually have to get a draft report ready before our next call, which is on the 14th of February.

The other thing that we are planning on what we get kind of a bigger list from you guys is send another SurveyMonkey out for you to give your thoughts, yes/no/maybe, on that shorter list. So, basically, we'll start with the 44 that we've identified anything that you tell us you really want to add or consider adding and then get your feedback through that SurveyMonkey.

So, with that, Ira, I hope all was clear, if not, please clear it up for folks and then let's just kind of talk about what we have in front of us.

Ira Moscovice: OK. Thanks, Karen.

So, we have about 25 minutes or so to talk about the draft selection criteria, the scoring method, Strawman draft core set. So why don't we start off by offering comments about the draft selection criteria. The floor is open if anybody who's one the committee wants to offer some thoughts about the draft selection criteria which relates to the four tiers. Now is the time to offer comments.

Tim Size: Ira, this is Tim Size. I just – is it reasonable for us to be thinking in terms of the ease of the date collection or cost of data collection, because this is not something (inaudible)?

Ira Mascovice: That's a good question. And I – well, for my comments, but I'd be interested in what Karen and NQF staff have to say.

When we have done this kind of exercise in the past, we have looked at the, I would call it feasibility of data collection, which includes honestly both the cost and also just the availability of information when we've used the expert groups. And so, I think it's a fair comment.

NQF staff, do you want to have any thought on that?

Karen Johnson: So, this is Karen. I have a couple of thoughts. Number one, by limiting to NQF-endorsed measures, feasibility is one of our endorsement criteria. So, standing committees in the past at NQF have felt that these measures are at least feasible to some extent, maybe not, you know, with the lens of the rural, but we do have feasibility in there a little bit by dent of being NQF-endorsed.

We have another column that we hadn't included in this spreadsheet, but we can easily include. And apologies, I don't know why I deleted it. It is a data source. And sometimes data source can give you a flavor of feasibility. For example, claims data are very feasible, right, because people are putting in claims. However, with – and we have this discussion very early on, you know, that might not work.

My understanding is it's getting better now, but since many rural health clinics, FQHCs are paid differently. The question would be our claims-based measures, would they be complete enough to reflect accurate measure results if it's based on claims. But we, you know, that feel – could tell you claims are not based on EHR or not, you know, and few other things that might give you a flavor.

If we're going down that path of cost or ease of data collect, I think it would have to be, you know, it really these other ones are a little bit more objective I think even though, you know, we have some wiggle room. But I think the staff would really have to have your help in telling us whether these measures really are fairly easy or cost-effective to implement in rural areas. So that would be an additional thing that you guys would really have to help us do.

Ira Mascovice: Yes. And that's what I was going to suggest to Tim, which is as each of us goes through the draft core set, if we feel that there is specific measures that appear to be relevant but really are difficult to collect for a small rural hospital

or an FQHC that's – that'd be the time by Monday noon to sort of point that out. And if enough of us feel that way, I think that will need to be taken to account for particular measures. Other comments?

Marcia Ward: This is Marcia Ward from RUPRI. And I'm looking at column L1 of the spreadsheet, which is use in federal programs. And I think this is a consideration and particularly for our effort in rural that we should be sensitive to that. And I'm wondering if column L might help us if there are measures that are already being used required of these entities to report and for some other federal program, would that help?

Ira Mascovice: I'll offer a comment and maybe staff wants also or others. Certainly, the notion of not, you know, the complaints we often hear are, you know, if there were a core set of measures and everybody use them, it'd be great. And so, if we can avoid duplications, I think that would be great and I think you make a good point there, Marcia, in terms of us thinking carefully about by these measures already being used elsewhere.

Staff, how do you fee about that?

Karen Johnson: I think we can certainly do it. I did a real quick check of the 44 that's in our Strawman right now. Thirty-four of them are being used in federal programs at some point. I think what's not included in that and, Marcia, tell me if I'm wrong, I don't think we've added in the Medicaid child and adult set so that may increase that a little bit. We could that put that in there.

I don't know – I don't think we'll be able to get that in there by tomorrow when send it out. But we could certainly maybe in the exercise that we ask you to do with SurveyMonkey we could potentially add these kind of other dimensions. And let you guys use the information that you have in some way to do that. So, we have a couple of options here. We could go back and rescore potentially based on some of these or let you guys use these columns in a systematic way with us.

Bill Finerfrock: This is Bill Finerfrock with Rural Health Clinics. So, I'm a little concern without additional information of – if it just simply is in use in a federal program that maybe the case, but it may not be in use in a federal program, for

example, for Rural Health Clinics. And so, something that's in used that's collecting data on a 1500 would not – the claim form would not be (inaudible) Rural Health Clinic and it may not be appropriate for UB-04 claim form.

So, I think it needs to be a bit more granular that simply if in use by federal program. But if in use by a federal program, that is applicable to a critical access hospital in FQHC or in RHC.

Ira Moscovice: I guess so. I will push back a little bit in terms of saying I think when we're looking at not duplicating, it really is across a wide range of entities and not specifically just being already use just as small rural hospitals. I think if they are for clinics small rural hospital, that's even better. But I think there is some utility just, you know, they being used elsewhere.

Bill Finerfrock: I don't disagree with that. But if we're going – I think the earlier point that was made is, you know, can we – just because it's a use, it may not feasible to do that for rural health clinic or in FQHC because of the way that they are reporting data.

Ira Moscovice: OK.

Bill Finerfrock: And I think it might be helpful if there is – if that information is available so that in looking at something that say, OK, yes, that does make sense but we've got a reporting problem here because of that. That's all. I just think it gives us some more insight.

Ira Moscovice: Yes, I know that's fair enough. Other comments on the draft selection criteria?

Julie Sonier: This is Julie Sonier at Minnesota Community Measurement, and I was wondering if you considered including in the criteria placing higher weights on measures that are outcome versus process?

Karen Johnson: This is Karen. That didn't come up before in our discussion. So we have not done that today. Are you suggesting that we should or – what do you think in that?

Julie Sonier: Well, I think that would be consistent with other priorities that CMS has. So and so – but for example in the quality payment program, I know there's a strong push toward getting towards more outcomes and especially patient reported outcome. So I'm just curious whether it played into the discussion and whether there's a point later on in the process where we can look at the measures we have.

I don't think we would want a core set that is entirely process. So maybe there's a point later on where you can check to see if it's balanced between process and outcome.

Ira Moscovice: And I think that, Julie, it's a good comment. As we – once again, go over the measures that have been sent out to us in terms of this draft core set, that kind of thought also should entered to the process. If we feel we don't, you know, there are some measures there that really need to be replaced more by outcome measures. Are there patient – I haven't look at the list recently, are there patient reported satisfaction measure et cetera in this list?

Karen Johnson: This is Karen. Yes, there are – we included the child hospital CAHPS, and the adult hospital CAHPS and the clinician CAHPS, so basically hitting those through the CAHPS measures.

I'll also get that kind of an oddity of our numbering system in NQF. We have one number for example for hospital CAHPS. We may need to clean that up a little bit, hospital CAHPS has 11 separate performance measures in it, that had been endorse. But you can't see what those 11 are and there are one number.

So it could be that your, you really like the idea of hospital CAHPS that maybe only one through would be interested and three of those 11, for example.

Right now, I think it's probably better to – to keep at, you know, thinking about hospital CAHPS and we can refine a little bit later if we need to. But yes there are.

And then back to Julie's question for outcomes. Of the 44 that we have suggested in the Strawman, 15 of them are marked as outcome measures of

some sort, either patient experience or intermediate clinical outcome or outcome.

So as it stands now, we do have mostly process measures, but definitely some outcomes. What we don't have is I don't think I included any structure measures and I know there are a few structural measures that are available for example, nursing staff ratios, those kind of things.

And I hesitated including those mainly because I wasn't sure with workforce challenges being what they are et cetera, if that would be a reasonable role relevant measure.

Ira Moscovice: OK. We have time maybe for one more comment on the draft selection criteria before we move on to the – the scoring …

Brock Slabach: Ira, this is Brock here.

Ira Moscovice: Yes.

Brock Slabach: I think this is a brilliant job of testing through hundred of measures into rationale set to start with. At what point and I guess we're at it now, we're getting close to it, do we look at this in the corpus in terms of the entire set? And does this describe the quality of an institution adequately in looking at it all the measures collected into a total?

Ira Moscovice: Hello?

Brock Slabach: Given the public or whoever is looking at this from an external point of view, is this going to assure them that for the services largely that the facility is using, that it's going to be recognizing the quality that's inherent within that facility or clinic?

Ira Moscovice: I think it's a good point. And, you know, as has been pointed out in the literature, you know, if you're going into the hospital or a particular type of surgery or heart related problems. You know, as much interest and personally is the pediatrics care that's provided there.

So, you know, my initial reaction is, you know, the latter tiers 2, 3 and 4 relate to specific areas. But the highest ways to go into the tier 1 which were the cross-cutting measures that aren't specific to a condition and that's what the groups said initially, the cross-cutting and the low volume issue within things that the majority of the group really were focused on, so they got higher weights. I think it's a good question then.

Karen, what are your thoughts?

Karen Johnson: Well, I think it's a brilliant question actually. And I think we were probably thinking exactly like Brock was thinking in terms of, you really kind of have to have your, you know, a good starting point before you can think of the set as a whole and evaluate it.

So in terms of timing, should we be doing it now, should we doing a little bit later? That might need to push a little bit more maybe to our next call, realizing that we still have some time to get public comment and that sort of thing.

A couple other ideas that we could do and we have information in terms of, you know, whether a particular measure hits one of the six aims of the National Quality Strategy for example. And so – and we don't have that on the spreadsheet, but we do have that or at least an initial tagging of that. And that might inform to some extent, you know, are we hitting the six priorities. And if we're not, why do we missing?

That might be one way to do it. And we had talked about earlier the Triple Aim which is, you know, overall health and healthcare and affordability kind of next level up. So I think it's doable and I think we probably need to start thinking about it now, but making the decision a little bit later.

Ira Moscovice: OK. So I think we've got some good comments on drafts selection criteria. And when we get e-mail from staff tomorrow, I think the issue that we just raise the things we should be thinking about as we say yes, you know, these measures are good or, you know, or be really great to add additional measures. So I think these are really good comments.

Why don't we move on to the scoring method, which basically is getting at – assigning the waiting scheme and then using a 75th percentile cost point. And just the notion of looking at each of the components that were laid out in the four tiers, so (that's) on the scoring method, comments?

Craig Caplan: This is Craig Caplan. Can a – the same measure count under multiple tiers?

Karen Johnson: This is Karen. Great question. Yes, although I'll give you the first caveat. By definition if I called it cross-cutting, I didn't call it any of these conditions specific. So, there won't be an overlap between, for example the diabetes measures and the cross-cutting measures. So, given that – but there's a lot overlap especially between the cross-cutting and the low case volume, and that's expected.

So, I didn't write down the numbers, I consider (that) really quickly if you want it. But for example, cross-cutting measure that I thought was not addressing low case volume is actually a measure for pediatric, where they're actually assessing their preparation for transition to adult care.

So this is a patient reported outcome measure, 16- to 17-year-olds with a chronic health condition. So they're going to be kind of moving their way out of the peds into adult. But, I actually wasn't sure, you know, how common, you know, in some rural areas, the chronic health condition 16- to 17-year-old kid, he would get that survey.

So, I thought it probably wasn't resistance to the low case volume, even though it is a cross – I would consider a cross-cutting measure. And then kind of, have already mentioned, the condition specific measures I did not call cross-cutting.

Ira Moscovice: Other comments on scoring method?

Melinda Murphy: This is Melinda …

Ira Moscovice: OK.

Melinda Murphy: … I have a question. In looking at the scoring method and looking back at some of the measures, I guess I have a question with respect to carefree and conditions that listed whether or not being thromboembolism should be included with that, because when I look at the measures – because it's not included – they are going to lose a point in considerations. And thinking about incidents of VTE and issues with – actually using prophylaxis, I wonder if that should be included.

Karen Johnson: Ira, I'll let you keep going. Let me see if I can – I don't know if I have it tagged as VTE or not to tell us even how many of those measures we have. I don't think I – yes, I do actually. We have – I have one measure of VTE and it is actually included at this point in our core set. It is – yes, Madison has found it.

(Inaudible)

Karen Johnson: (0371). Do we have that one?

Ira Moscovice: Yes, it's on the third page there, printed out.

Karen Johnson: So you can see that my physician coding didn't hit all the VTE. So that's kind of an obvious example of how my condition coding didn't work, you know, completely, but at least one of them.

So I guess, the question for the group would be, should we go back and rescore including the VTE or should we just kind of stick with what we have now. And, Melinda, you would bring, you know, this weekend when you're looking at the list and telling us what you want to had. Do you want to go ahead and add to VTE, would be another option.

Melinda Murphy: Right, and whenever I look at the scoring, the tier 3, if it's a VTE measure, it does not get score as being included in tier 3 in the current scheme.

Karen Johnson: Right. And the current scheme we only did diabetes, hypertension, and COPD.

Melinda Murphy: Right. So that was my question. Should it be included?

Marcia Ward: This is Marcia Ward from RUPRI. And when I looked at tier three and was trying to remember back to our discussion. I think diabetes and hypertension COPD were suggested by committee members as chronic conditions that have high cost, high utilization and are common in rural areas.

And so, really for the benefit of – I know there will be a report and how this is described maybe a more general label to tier three will help people understand why we picked out those three. And that might get around some of the problems in which case VTE, but probably does not fit in tier 3.

Ira Moscovice: I think that's a goof timing, Marcia, and it would be good for each of the tiers in the report to have a short paragraph so to describing the thinking behind how the tier came together before we get into what's in the tiers. Because I think that's a good description of tier 3.

But let's think about the VTE issue as we go through this by Monday at noon. I think we have a little bit of time left, five plus minutes, to talk about to talk about the draft core set. And obviously there's a lot of information there but people have some initial comments and we'll get a chance, but Aaron suggested to look at this in more depth after this discussion.

Any initial comments on the draft core set? Anything that really should be in there, that people thinking about that aren't right now or questions about why something is in there?

John Gale: That's the – over the Strawman draft core set.

Ira Moscovice: I didn't catch that.

John Gale: No, I answered my own question, sorry.

Ira Moscovice: OK.

John Gale: But nice (set).

Julie Sonier: Ira, this is Julie Sonier. I just have a clarifying question that we ultimately are trying to have two core sets, right? One is for hospital and one is for ambulatory?

Ira Moscovice: That was what was stated upfront, yes. That we would – our 10 to 20 measures for each of the – for the inpatient and for to the ambulatory side.

And I think that's important but, you know, so much focus and start doing on the inpatient side and, you know, NQF is balancing it now. And I think that's really important.

Julie Sonier: So one thing that I think would be helpful would be to have – I don't know if it make sense, but separate at this point or to see like – of the measures we have on the list right now, which are – which would be appropriate in which settings.

Ira Moscovice: I think that's a good suggestion. Is that easily doable, Karen?

Karen Johnson: Yes and no. It's kind of mixed with columns (S and T), level of analysis and care setting. And on occasion, developers who submit measures to us may actually be giving us measures that work for both or at least it seems it works for both based on what they reported in terms of care setting. So, I could do my best there.

I think I would really need some guidance and, you know, I said ambulatory. There's a lot of measures that come through as outpatient. Does that count with that being an ambulatory or is that really more – is that kind of a bit more with hospitals, maybe a little bit of insight from you guys as to how you would do that.

But again, it is doable. It may – it won't be necessarily as clean as you would think. There's probably going to be some overlap between the two.

Ira Moscovice: Any reactions to what Karen just asked?

Male: I think it's worth just making that distinction. I mean it may – it may not be completely perfect, maybe overlap but I think it – it helps. I mean I've been –

that's what I was trying to do. As I'm looking through here just trying to pick out those that, you know, would be the outpatient or ambulatory, if you could pre, you know, do that and say, here's at least, you know, we've filtered out those that you don't really be need to be looking at as rural (health) (inaudible) it would be helpful.

Ira Moscovice: And Karen, I think the way this is setup, I think people are going to be looking for inpatient and for ambulatory/outpatient measures. And there maybe some that are relevant from both as you said. But I think in the report right up at the end, it probably would be helpful one way or another to identify which measures fits which kind of setting.

Karen Johnson: OK.

David Schmitz: This is David Schmitz from the American Academy of Family Physicians. I would just make some balancing comment to that. I think the more (inaudible) intergraded to achieve quality, which is often in much closer proximity geographically at least in a rural area, I think our report should reflect that.

So, for example, if we look at a certain parameters that is measured and reported out of what environment inpatient versus outpatient, but the decision hinges upon, for example, a family physician's activities in the other environment. Frankly, it's a seamless set of decision and quality indicators resulting in patient care across both settings, it's just measured and reported by one or the others.

So, I think we should be cautious about creating the perception that we've agreed to silo these quality activities whether it's the outpatient FQHC setting and how that affects something that might be reported by the hospital for example. I think many us, physicians, live that each day and realize that we – actually we need to be making sure we're accountable to each other in those various healthcare settings.

Ira Moscovice: And that's good comment, Dave. And I think as the reports written up, we certainly can focus in that, into that. And the question in my mind is, can we avoid the silos but yet, make sure that people like Bill and others feel that

there is an adequate set of measures, as Brock said early, that reflect the quality of that institution, recognizing that, sometimes that's dependent on who's walking in the door and also the availability of other resources in the community or outside of the community.

So, I think that's something we need to grapple with but it's a good comment. Other comments about the draft core sets?

John Gale: I can have one quick comment, Ira. It's John Gale. Looking to and pretty comfortable in most of the measures, and I know this and I appreciate the scoring process. But it strikes me that we have a couple of screening measures tobacco, alcohol and (now) the alcohol use. And then when go down to the – towards the latter part of the list that we talk about treatment alcohol and other drug use, treatment disorders provided or often at discharge.

I'm a little concerned that, that we're not – the drug screening should be measure that's included, maybe something a bit more comprehensive in just alcohol.

Ira Moscovice: OK.

David Schmitz: This is David Schmitz from the American Academy of Family Physicians. Just to note that it makes me a little nervous in a relatively narrow number of measures around obstetrics that elective delivery (at least) to find would be the measure we choose. I'll explain briefly and then comment over the weekend.

It may be safer to deliver within a certain gestational age window depending on resource availability in a rural remote area. It may actually the better decision. And whether that's decided and coded as an elective delivery or medical necessity, I think sometimes of course should be done as accurate as possible. But it would be possible unless you dorm the patient as they do in Anchorage, Alaska, for example, it maybe possible make the right decision to do an elective delivery under certain circumstances like a history of shoulder dystocia in prior deliveries.

On the other hand, something like antenatal therapy administration might be much reasonable of quality, measure of quality at prenatal care. So I'll

comment over the weekend but I'm little nervous about there being just that for (OB).

Ira Moscovice: Thanks for that comment. Time for one last comment. Anybody else that would comment on the draft core set?

OK, I'll push this back to Karen.

Karen Johnson: Thank you, Ira. This has been incredibly helpful. I think we definitely have some better ideas about what we're going to construct the SurveyMonkey that we're going to ask you to respond to, so we can take into account the things that you're – that you brought up.

And going back to the inpatient versus ambulatory, I will do a little bit of looking after the call and I'll let you know if you can use the level of analysis and/or care setting columns to be your own kind of filtering so that you can kind of look as a group or if we need to give you something in addition that would be best for you.

I'm hoping that what we have there will be doable so that you don't have to wait on us to add something in this. We'll get back to you on that very soon.

So going into our discussion in measure gap areas, this is something that we were asked to do. We kind of have a couple of ways to go on this. In our 2015 work, we did talk about gaps in the measurement for rural areas. And we kind of did it under the – it actually came if you go to the report when you look for gaps, that's not a header that use. But we actually talked about it when we talked about the need for development of new measures.

So, just a reminder in case you haven't read that report recently at the time, folks talked about needing additional measures that hand off in transition. And specifically things like appropriateness of transfers and maybe timeliness of transfers, so not just didn't happened but, you know, getting a little bit more into the details of transfer.

As I mentioned, alcohol and drug treatment was noted as a gap in measurement at the time, access to care and timeliness of care, those also were

discussed at length by the committee at that time. Cost measures and again with – a lot of caveat there because different rural providers are paid differently, so, you know, a bit of a discussion about, you know, how that would or wouldn't work.

We talked about population heath at the geographic level. So instead of focusing, as I said, you know, measuring an individual clinician or maybe an individual what about thinking about measures at a regional or even a community level what would that look like, what is the process under that. And then find the advance directive and/or end of life kinds of measures. There is not a whole lot of those available to choose from.

So those really gaps that we identified back then. This discussion can go either way and it may end up kind of morphing into both ways. We could talk about, you know, are these still gap and measurement, you know, for two years ago and are there things just kind of broadly that would be considered gap and measurements for rural areas.

But more specifically, I think, it would be helpful to talk about gaps in our core set. And by that, and it will be a little harder to talk about gaps and core set because we haven't actually come to consensus about what's going to be in that core set. So if there may be very obvious things that you feel should be there that aren't there and then when you go back and look more closely, excuse me, the 444 measures that we have available to you that what you're thinking have might not be there at all. And it could because that measure doesn't exist, or perhaps, it hasn't been brought to NQF for endorsement.

So kind of two different ways to think about gaps. I think both would be useful. So let me stop there and, Aaron, I'm going to turn it over to you to facilitate this portion of the call and also knowing if this is a little bit fluid, a little bit difficult to talk about, so.

Aaron Garman: Sure. Well, thank you, Karen. So, you know, I guess discussion can revolve like Karen said about are there – is there a list of gaps that we can identify from the previous report or looking at the Straw set – the Strawman gap core set or core set in front of us, are there gaps in that set that we can see that are

glaring? And I think in the discussion that we've had so far, several people have brought forth ideas and thoughts on things that may need to be included that maybe we're just missing the mark on when it comes to rural health care. So, I would just – with that, I would open it up for comments. Any thoughts?

One of the things that comes to my mind I guess in this is from previous discussions, we've talked about telehealth and I don't see anything in there regarding telehealth. Correct me if I'm wrong but I did not.

Karen Johnson: So, Aaron, this is Karen. You are correct. There's nothing in there that it's a specific telehealth measure. Telehealth is one of those kind of iffy measures. Two years ago when we talked about this telehealth actually and I neglected to see it on that list in the previous slide, we actually talked quite a bit about, you know, structural measures of telehealth, you know, do you offer telehealth options, that sort of thing.

And at least a couple of years ago, the sentiment seem to be that those really wouldn't quite work from a structural measures standpoint. To some extent, because of, you know, state laws and that sort of thing. And also realizing that somebody may very will be willing to do telehealth but, you know, you have to have somebody on the other end willing to provide it, so kind of some difficulties with structural measures.

But there was also the discussion about telehealth and just it might be that some measures just need to be modified so that provisions of care via telehealth method are included in the measure. And I think – so from that perspective, you know, we don't have an easy way to go through and check to see, you know, this is measure, this is measure, this is measure, include telehealth as a care setting, if you will.

Stephen Tahta: Sure.

Karen Johnson: Let me stop there.

Stephen Tahta: Aaron, could I make a comment. You know, I do think access – this is Stephen Tahta from the American Hospital Association. I think access to care is a very important gap and it's very relevant here in what we're trying to do.

I don't know that going forward we should focus on the different techniques of the access or the different ways to access. You know, that, you know, if we have a hospital that is very weak in telehealth but strong in access, you know, is that a huge negative problem for that hospital. I think access is important thing to focus on, not necessarily how to access.

And in the coming years, we're going to see different ways that access will be offered and it may not be telemedicine.

Aaron Garman: Do you feel that that is adequately represented in the Strawman draft core set or?

Stephen Tahta: No, I think we have some work there if we all feel that access is very important. I think we have some work to figure out how to address that properly. I don't think we're there yet.

Bill Finerfrock: Yes, I would agree. This is Bill Finerfrock. Access isn't there. The other I would ask, is there any way to look at measures and distinguished or looked at in a context of the race or ethnicity of the patients and ability to get at health disparities? I did – if it was there I didn't see anything. But is that something that would be possible?

Aaron Garman: Karen, what do you think?

Karen Johnson: I think from the NQF standpoint, we wouldn't be able to give you that information in a timely manner. I think it was probably be something that you guys would have to help with. I'm not as familiar. We actually are dealing quite a bit of work on, you know, disparities and that sort of thing.

But, you know, one of the questions that coming up, you know, in my mind anytime we talked about disparity sensitive measures is, you know, there's many conditions that are disparity sensitive. You know, one particular group maybe has a higher prevalence of a condition or something like that.

Bill Finerfrock: There be some prevention of the ECB, whatever, right?

Karen Johnson: Absolutely. The question would be, you know, does the measure itself and, you know, in my mind, the question would be does the measure itself has some room to improve in terms of disparity. So, for example, care for heart attacks in women might be one. And it's much harder to get that information.

So, we know, about prevalence of the condition. We don't always have the bright down of difference sub – populations sub-rate for the actual performance measures that we have. And when we do have it, unfortunately, they're buried in, you know, very long submission materials that were given. We don't – we wouldn't be able to go pull that for you.

Bill Finerfrock: Thanks.

Aaron Garman: Great. Thank you. Are there other areas that you can see that we're light on or missing in this core set that perhaps most focus we need to begin? And, Brock, you had mad the point earlier that it may not adequate reflect what's going on in the institution itself. Well, are there areas that are important from a hospital standpoint for instance that do reflect that? Are they – and not included in this core set?

Brock Slabach: You know, Aaron, that's a good question. I guess I was thinking more systematically or more in terms of harmonizing all of the measures that has set in making sure that the – if you were to develop a composite of all of the measures, would it give someone an adequate representation of the quality in that particular a facility.

And then now, you're asking kind of a structural question, are they meeting the mission, do they have represent the – (firstly) in the – being able to serve the unique populations that they have in their communities. Those are some really good questions. I don't that we have measures in our toolbox to be able to assist some of those. But I – gosh, that would be awesome if could come up with something there.

David Schmitz: This is David Schmitz with American Academy of Family Physicians. I would just comment on the last few areas. In the discussion about the access disparity with the note that's represented by timeliness of care and also how difficult some of those things to be to measure.

One of the things I tried to do is I look the Strawman proposal because I think about, you know, if we use this measure, will it have the unintended consequence of actually worsening access to care. And I think those are often around time sensitive procedures, such as obstetrical delivery, time sensitive procedures where it's not better to send somebody through a good communication and transfer somewhere else.

So another would be, for example, trauma care or some things that have to be done, let's say, it can be done by telemedicine. And people doing a good job is better than not having the job done as long as they're doing a good job. Those are the most rural-relevant in my mind way to try at this point, balance access is by avoiding those unintended consequences.

Cheryl Powell: This is Cheryl Powell. I'm going to highlight that I agree that access to care critically important and a gap. And I also feel like outcomes. I know we don't have a ton of great outcome measures generally, but I feel strongly that it's important and I feel like the outcomes are missing. I feel the patient's voice is missing. I know we have some CAHPS measures, but I don't feel like it's well-rounded.

Aaron Garman: Thank you for that. One of the concerns back in 2015 that was raised regarding outcome measures, and correct if I'm wrong, but the concern was the volume. Some of those outcome issues, the volume is so low that we can't get statistically significant data. So, that's my only concern with that and I think having outcome measures which allow from higher volume will help with that.

But anybody else have any comments on outcome measures that we're missing?

Stephen Tahta: Yes, Aaron, this is Stephen Tahta again. I would voice the same thing. I have concerns about inadequacy of outcome measures. I think that, you know, one of the important things we have to keep in mind is, if we add outcome measures to the core set for rural health, they have to be more generalized. So your comments about picking specific diseases may create challenge in terms

of adequate volumes, but I think we just have to keep in mind that outcomes measures need to be there. They just need to be more generalized.

And that reflects in my mind how rural health might be different, you know, as opposed to an oncologist in L.A. who takes care of only breast cancer patients and an oncologist in Missoula, Montana, you know, has to see who – whoever comes in through the door depend, you know, doesn't matter which kind of cancer. So, we have like just keep in mind that the outcomes have to be more generalized.

Aaron Garman: Thank you for that.

Bill Finerfrock: I want to reinforce that. The patient component to this, imagine many if not all of you saw the University of Utah analysis that came out not too long ago. You know, what is it that patients value versus what is it the providers value. And for patients the top three were, you know, my out-of-pocket cost is affordable, I'm able to schedule a timely appointment the way time at the office is reasonable. So, things that are getting at, you know, access and cost.

For the physician the responses were, I know and care about the patient, I ordered the appropriate exam lab in imaging and the patient health improves or stabilizes, again, important things but very different from what the patient value. So I think it just reinforces that we can't lose sight of – as we're doing this what is it that the patient values and in trying to create a system about what we looking at it predominantly from a provider perspective perhaps determine as a value we overlooked or ignore what is a patient value component as well.

Aaron Garman: Very excellent point.

Shelley Carter: You know, this is Shelley Carter from Health Service Corporation. With regard to health plans and they conduct CAHPS surveys which is member-oriented. That's a sample size and it's a small sample size and it doesn't designate whether it is rural or urban in its output.

So, that's a very limited perspective. So – and I know that we have used national quality information for CAHPS. But I'm not sure that that's the exact

measures that we need to pull on because it's so – it's such a small sample and it's such a mismatch of people.

Aaron Garman: So I appreciate that.

Ira Moscovice: Karen, this is Ira. I'm just wondering given the comments we've gotten back about the measurement gaps, I guess two questions. The first is were you anticipating that the draft core set would reflect some of these measurement gap areas that were identified in the previous report that we're going to include now.

And I guess the second point is, would staff be able go back after this call and look at some of the areas that have been mentioned on this call and if those – and if measures in these areas aren't already included. I don't know if you look at the access measures and they're included in the list or if there's other measures we might consider that – based on the call – the comments we've just have.

Karen Johnson: Yes, so great question. I did think about the gaps that were identified last time. I will tell you that, I don't think we have a huge number of new measures that were available that weren't there two years ago. But gap areas that we do have it, I did, included at least in the Strawman where the drug and alcohol treatment measures, and I think there was a tobacco treatment measure in there as well.

I don't and apologies, I've already forgotten whether or not I put the cost measure in the Strawman. But we do have kind of a overall PMPM cost measure. And I probably did not because of the difference in the way cost is done.

You know, in terms of what was I expecting you guys to point out, I don't think much of what you said so far has surprised me. I will kind of go back to Brock's point. You know, there are things – especially that hospitals do surgery for example, O.B. I think was another one, that they do a lot of those but maybe not all of them do them in rural areas so we get into, you know, that, you know, hospital provide these services.

So you'll notice that I don't think I have any surgery measures or if I do it's only one kind of very overarching surgery measure if you will in the draft core set.

So from that perspective, there's certainly things that are missing from the – with the idea that, you know, not all hospitals provide all the services. You know, nothing specific to ICU for example because I guess not all hospitals in rural areas have ICUs. I'm not sure I quite answered your question.

Going to back to access to care, I don't think we have actually coded or tagged anything as access to care. We're going to get into that just a little bit in our next section of this call. But I think what that might be is probably some more help from you guys because some of these timeliness measures that we do have available could be considered access measures and it kind of depends on, you know, your perspective.

So, I think that was still a little bit up for interpretation.

Ira Moscovice: Just the point out I was trying to make was I thought the comments were good. But we're not going to have the time to stop developing new measures per se.

Karen Johnson: (Absolutely not).

Ira Moscovice: In these areas, either we have …

Karen Johnson: Yes.

Ira Moscovice: … the measures and you've gone through them …

Karen Johnson: Yes.

Ira Moscovice: … as best you can, particularly in the access area although, as you said on the next – in the next segment of the call we'll talk about access a bit more or we don't.

Karen Johnson: Yes.

Ira Moscovice: And are we going to have a measurement gaps section in the report, the current report.

Karen Johnson: Yes. So yes, to that question and I think in terms of gaps in the core set, it's probably going to be something along the lines of, "Gee, you know, we really, you know, for rural providers, rural residents, we really need a measure of something, and it just doesn't – it's not part of our 444. So we can't go in our core set yet.

Once it's developed and/or endorsed by NQF, it would be a (shoe in) to get into that list. It's kind of what I'm thinking in terms of gaps in the core set with the kind of a bigger question of gaps and measurements still kind of open.

Ira Moscovice: OK.

Aaron Garman: I appreciate all of the discussion. I think our time is up for that. And I would turn it over to Suzanne.

Suzanne Theberge: Great. Thank you. So, next we're going to spend a few minutes talking about the rural-relevant measurement topics. And as you know, we've discussed this briefly on each of our previous calls and – actually next slide, please.

We're going to really delve into this on webinar 5, and next slide again, which is on March 28th at 1:00 p.m. Eastern. And at that webinar, we're going to be discussing whatever talk that we have finalized and providing some initial recommendations. So, what we are hoping is that we can narrow that topic down either this call or the next call and kind of go from there.

Throughout our conversations we have been listening to what you have been saying and what we're hearing in the different piece of the conversations. And we're kind of – staffs have narrowed it down to two topics that we think that are a possibility, one being access to care and the other being swing bed quality. And of course it's still certainly up for discussion but those are two we want to propose.

So next slide, I mean, I think as we've just heard access to care is a pretty major issue. And we might want to think about how to think about measures and access relative for rural residence.

NQF does have a definition of access to care, and we define it as the ability to obtain needed health care services in a timely manner, including the perceptions and experiences of people regarding their ease of reaching health services or health facilities in terms of proximity, location, time and ease of approach.

Examples may include but are not limited to measures that address the timeliness of response or services, timely (inaudible) of available appointment and availability of services within a community.

So based on that definition, a kind of a minimum scope of access measures could be things looking at timelines and availability. And then more generally NQF would also look at access measures that address identified barriers are reasonably close to the access and that then will drive improvement in one or more of the six aims for healthcare quality.

So some of the questions that staffs have identified in the ways that we might think about access are the availability of services and some of it has been touched on in the previous discussion. What is a reasonable distance? Does that change based on what type of care you're talking about? What's the reasonable timeframe for care? Does that change?

Trauma care came up in last one, obstetrical care. Where does technology come in? Where does cost and affordability come in, et cetera? And then there are the other questions they have identified about who should be held accountable, et cetera. So that's kind of where what we were thinking about access to care.

Next slide, the other possible topics that we had identified is how we might measure to quality of care for swing beds. The University of Minnesota is working on this. And I am actually going to turn it over to Ira to expand on

that a bit and talk about how this workgroup might provide some input and build on that work. And then that committee can discuss. Ira?

Ira Moscovice: Yes, thanks. So we're currently working on a project that is looking at developing and field testing quality measures for critical access hospitals swing bed patients. And we basically identified comprehensive list of quality measures that are currently being used in post-acute care settings. We do an e-mail survey with all the state officers of rural health and like program staff, and had a series of key informant interviews with (Kahn) networks, (COF) consulting groups and did an online survey with those CH quality experts.

And based on that, we came up with a small set of measures that reflected the status – this chart status of what happened to swing bed patients but also then had a couple of measures that look at improvements, whether improvements and functional status.

So the kinds of measures that we've identified are the discharge disposition. Where does swing bed patients go if they get discharged back to home, which obviously is preferable with a transfer to a nursing home or transferred to a higher level of acute care. A second measure is – looks at basically readmissions at the CH swing – for CH swing bed patients who return to the (COF) either an inpatient admission or emergency department visit. So get that what happens after the discharge.

And then the last two measures look at risk adjusted changes in both healthcare scores and mobility scores during the time from when they're admitted to and when the patient are discharged. And we're in the process of setting up a field test with about a hundred costs.

And so, that part, so (the) under control, we think these areas are really important area simply because there really is very little information in the quality of care in swing beds. And the federal government and others are wondering what is the value of swing bed cares, are they cost effective compared to SNF care, et cetera, et cetera.

But there are a whole series of other measure or other components of this that could be looked at that we've just identified but haven't really gotten to one of which are the notion of CAHPS measures to swing beds, which don't exist right now. And we need to think about how we might adopt the existing measures.

Other issues such as skin integrity, medication reconciliation, incidents of major falls, the transformation of health information et cetera.

And so, there are variety of things we could look at, in addition to measures related to pressure ulcers, drug regimen review. And so, you know, if the committee wanted to I think look at these other components and offer some thoughts and have stay up work on that, I think that'd be real helpful because I think it's a really important area. So, I'll stop there.

Karen Johnson: OK.

Ira Moscovice: Would you like me to sort of start getting comments from the group?

Karen Johnson: Yes, yes, that would – that's really very helpful, Ira, if you would just kind of facilitate. And I think the only thing that I have to add is in both of these, if we end up going one way or the other, you know, we'd have to do a little bit of work of scoping it down to something that would be, you know, reasonable to do in the fairly short timeframe that we have to do it in.

The access topic area, you know, we certainly can't boil the ocean. And I think it would probably be almost the thinking piece of some short. It might not be, you know, concrete recommendations. It might be just laying things out, for example. That might be one way to think about it.

And you gave us great ideas about other components for swing bed. We, you know, there might be five different things that you know of. We may only be able to tackle one or two of them perhaps. But, yes, if you would facilitate this portion to get people's ideas, that would be super.

Ira Moscovice: Sure. And, you know, I would say just leading in, obviously, there's a lot of interest in the access area and I think that's great. So, you know, comments

relevant to either both of these, either these issues or is there a separate or another issue. We're not necessarily wedded to this. These are things that the staffs have come up with now, but we certainly are open to other topics.

I think Karen's point about making sure the scope is doable within a reasonable timeframe is important. So, I'll open the floor for discussions.

Tim Size: Ira, this is Time Size here. Yes, I know. I think what you said about the swing bed makes sense to me. On the access issue, notwithstanding how incredibly important that issue is. I'm having trouble getting my arms around how that's a metric owned by an individual provider rather than what you might call it, the regional ecosystem. I just – and maybe that's my own ignorance.

And that's before I get an issue like in our state in Wisconsin where we do have in certain instances active steerage away from a rural community by the health plan that then tends to undermine access. So, I just don't understand how the access metric fits into the core measure conversation.

Ira Moscovice: I guess one reaction I would have, Tim, is as Karen just suggested, I think maybe if we're going to move in that area in the access area, let's try to define a component of access that sort of passes your judgment test also about the ownership that it should really be, if not totally, at least, a decent amount owned by the individual provider. But we shouldn't start looking at measures as you're saying that really aren't under control per se of the individual provider. Other comments?

Karen Johnson: And, Ira, this is Karen. Just to get back to Tim's point, really we are thinking about this measurement topic area as really divorced from the core set work. So kind of two different projects if you will within this overarching project, one, to identify core set measures. Another to come up with the measurement topics that we want to delve into.

The access measure or the access topic with such a huge topic when we were talking about core set, then it became an obvious at least topic to consider for the measurement topic piece if that make sense. So I don't think it was on our original list, it may have been, I don't remember now. But that's kind of

intersection but they really are meant to be two separate pieces. If they intersect, great, but they don't have to.

Ira Moscovice: All right. Other comments?

David Schmitz: Yes. This is David Schmitz of the America Academy of Family Physicians. I would just say in addition to the comments of making sure that we don't have the unintended consequences of reducing access that's necessary with some of our quality indicators.

The other is to say – if we are going to look at outcome measures, the other group that group that did not receive care proximal to their geographic location. So perhaps at a tertiary center or had delayed care at a more urban center or a different center, you know, obviously, that's the other side of the equation around looking at what their outcomes were.

So I think I realize is probably impractical and improbable that one could look at, you know, essentially geographically coding the outcomes of where people originating from, where they live and that work is very difficult to see if the premature baby delivered in a rural setting versus the – whether they made it to the next urban hospital prior to delivery or as neonatal admission.

But that's just the dramatic and simple example of what that analysis would look like if we wanted to have outcome measures that described access. I just don't know that we have the ability to process that information nor mark those. But in that process that you described, that would be one logical way to look at quality et cetera.

Ira Moscovice: OK. Other comments?

Bill Finerfrock: This is Bill. Are you looking for feedback on the question of, you know, where does distance come in and where does timeframe come in? I mean, time and distance are typically the proxies for access of care. So if you look at, you know, how do we designate, a shortage area, we look at, you know, the primary care and population ratio within an area. And then, if you look at network adequacy, from health plan perspective, it's a time and distance, I'm not sure what you're looking for here.

Karen Johnson: So this is Karen. Just so you know, we're not sure what we're looking for either. So, one of the things Suzanne read you out, our definition in access and it's quite broad. So maybe one of the first things we would do is take a hard look at that definition and see, you know, does that same to work for rural area? That might be the first piece.

And I'm kind of making this up as I go. If it does make sense for rural, that's great but, you know, if it doesn't, what might be the sticking points or would it work in some things or for some good versus others.

What might the pros and cons of measuring things in a particular way. And apologies, I forget to mention, you know, maybe the, you know, if you improve one thing, you might maybe not so much – you might hurt something else, so what are the balances, so what we do have to think about before you would develop these or implement these kind of measures, so …

Stephen Tahta: Karen …

Karen Johnson: Does that make any sense? Yes?

Stephen Tahta: Got it. Sorry to interrupt. This is Stephen Tahta. Can you just clarify a bit, again, your comments about separating out access in terms of measurement from our – from the core set because, I don't know if anyone else is confused but I'm confused. We talked about whether access was represented in the core set, did I misunderstand something there as supposed to now you're talking about two separate parts to this project.

Karen Johnson: Yes. So, let me try again. When we were given this funding to do this project by CMS, they asked us to do two things. One thing was to identify a core set of measures that could be used, you know, for rural providers. So that's one piece. And then, totally separate from that. They wanted us to identify a measurement topic area of the interest to rural providers and start exploring that topic.

And we had actually in our proposal to them when we wrote the proposal, we had – we actually did I think throw out the idea of access to care but other

things that we talked about were swing beds. We talked about, you know, should we look into the post-acute care because our core set is focused on inpatient and ambulatory. We have purposely set aside post-acute care for now, right?

Stephen Tahta: Right.

Karen Johnson: Thinking about potentially appropriate comparison groups with another idea we had. We had talked about, you know, should we think about access to care and what that might look like in rural areas and are there measurement issues there. So those are just the few of the topics that we had proposed to them. And what we're doing now is trying to get from you guys and, you know, you're feeling about the topic that you would like to address, you know.

And since going back to how it relates to the core set, we've talked a lot about, you know, measures of access and, you know, what that means and how important that it is that yet, we probably don't quite have this on the core set.

So that particular topic area would over lap a lot where as if you decide to do, you know, post-acute care measurement, or something like that. That wouldn't intercept at all with the core set and that would be fine as well. So, does that help you any …

Stephen Tahta: Yes, I mean, if we decided to do a deeper diver or focus on access to care, we've – we don't have to worry as much about making sure access is represented in the core set.

Karen Johnson: No and yes, exactly. As a matter of fact, one of the nice things that might come out of it depending on how, you know, how we spoke this out, it might be on here's the thing that you have to be careful of or you have to think about with access to care, the rural measures. And, you know, we're not there yet and that's why they're not on the core set. I mean, it might work out that way, I'm not saying it would but it could be very well.

Stephen Tahta: Yes, OK. Thanks.

Ira Moscovice: Other comments about the rural-relevant measurement topics?

So this is, to me, at least it appear that it's pretty wide open. The people have thoughts about, yes, we really should go into the access area and try to narrow it down. And it would be useful to understand the intersection between access and quality as part of that. Would they prefer something more specific, whether it is swing bed quality measures or other kinds of quality measures?

Bill Finerfrock: This is Bill. I'd say access.

Ira Moscovice: OK.

Stephen Tahta: Yes. This is Stephen Tahta, I would say access too. I think it's important.

Aaron Garman: And you know, this Aaron. I would say access as well.

Ira Moscovice: OK.

Kimberly Rask: Kimberly Rask, I agree.

Ira Moscovice: All right.

Mark Greenwood: Mark Greenwood, I agree.

(John Gale): I'd say I have to agree as well but I recognize the difficulty.

Ira Moscovice: All right. Well, I think what we're coming up with is access is the area we want to go into here. And I think staff and all of you think about how do we narrow that down to make them equal. Who was that?

Tim Size: Ira, it's Tim again. I just – yes, access is a huge issue. I just want to reiterate my concern about ownership and I remain concerned to this lengthened report that’s (seen) and was driven by the responsibilities for ownership of quality by rural providers. So with that significant caveat, I'm comfortable as well.

Ira Moscovice: OK. Staff, do you have what you need on this or are there other questions you want to ask the group on this one?

Karen Johnson: I think right now, we have what we need and just to address Tim's concern. Tim, I think, your concern may actually be one huge piece of what we might,

you know, talk about on this. Because when you do think about access, you also often are thinking about it, more of a geographical kind of level in a population based level, not an individual provider. So what are the pros and cons of doing that?

And, you know, they're telling you two different things. So I think if, you know, sounds like we are going to do access. I think your concern is something we would have to hit head on in this work in some way.

Kimberly Rask: This is Kimberly. I think adding onto that, I think it also provide an opportunity to think about some of these measurement differently. So much of the measure specification for hospital specific measures for example, really, you know, excludes transfers, exclude certain disposition because they're trying to attribute things very narrowly to one provider. And thinking about the rural question access and thinking about population-based measures, there maybe opportunities to tweak some of the inclusion and exclusion criteria that already being use in existing measures to reflect more population, care management across sites of care. And it's particularly relevant to the rural but it also is kind of an interesting way to be thinking about some of these measures. It could be applicable in other arenas later on, really getting at what happens to the patient not what did one individual provider do.

Ira Moscovice: OK. Any other final comments from this topic? Then I'll turn to …

Karen Johnson: And I'm sorry. Sorry, Ira, it's Karen again. I think probably what we will also be doing with you guys, maybe not in the next few days that's pretty quickly is on kind of polling you to get your ideas about materials that you may already know about in terms of access and measurement in the rural areas.

Though we haven't really started doing a dive on this, so if you guys know of, you know, the obvious frameworks or, you know, a paper or a report that's been written, et cetera, et cetera, we might ask you to let us know about those kinds of thing. But, again, probably not in a couple weeks that we would be coming to you for anything that you know around that area.

Ira Moscovice: OK. It’s good conversation and we'll turn it now back to the operator to open the line for public comment.

Operator: And at this time, if you'd like to make a public comment, please press star then number one on your telephone keypad. Again, that star one to make a public comment.

And we have no public comments at this time.

Ira Moscovice: OK. I'll send it back to Madison, who's going to talk about the next steps.

Madison Jung: Great. Actually, we do have one comment that was chatted in. From Sophia Chan at CMS and this is kind of in relation to our discussion previously when we're discussing the core set, about the outcome measures.

Her comment is CMS encourages the development of more outcome measures decision, outcome measures. Decision related to the inclusion or removal of process measures will be done on a case by case basis. We welcome public comments and inputs. So that was just a comment that was chatted in.

Now, onto next steps. Up here, we just have a timeline of our report. So, as Karen mentioned, we'll definitely be sending out some communications, whether it be SurveyMonkey or kind of a list of questions and more topics for you to further explore and get your feedback on.

Our next webinar will take place on the 14th of February. On that webinar, we will review the draft report and get your feedback on that. And also, you know, give you finalized list of the draft core sets and the measurement gaps that we had discussed today.

The report will be posted on February 28th. It will not be post to the public comment but it will be able to be viewed by the public. Webinar 5 is March 28th, we'll review the progress on the measurement topics, identify the date and provide the initial recommendations. And then on webinar 6, April 25th, we will work to finalize those recommendations.

Again, here's our contact information, feel free to e-mail us maprural@qualityforum.org or give us call if you have any additional questions.

With that, I'll turn it back over to our co-chairs for some closing remarks to adjourn the meeting.

Ira Moscovice: Well, this is Ira. I'll just say we, you know, really had a good conversation today. Great input from the group and staff have been working really hard on this. And we will definitely incorporate the thoughts people had and looks like we're going to – it sounds like we're going to get an e-mail tomorrow from staff asking us, take a little bit of a close looks. And by Monday get some feedback to them in terms of any other feedback we have about to draft core set. So I really appreciate everybody's effort and I'll turn it over to Aaron.

Aaron Garman: Yes. Thank you all, it was an excellent discussion today. We have some homework ahead of us to try and fine tune this strawman set a little bit better. But I think we've laid an excellent foundation and staff like Ira said is working really hard on this, so I appreciate their effort as well. Thank you all.

Karen, any thoughts?

Karen Johnson: No, just we will be sending an e-mail probably tomorrow and give you specific directions about what we'd like you to do with that e-mail. And then, we'll probably follow up very quickly with that with some kind of a SurveyMonkey that we'll get into little bit more detail. So, there will be – it will be a fairly fast turn round time again just because there requirement to get the draft reports drafted so that we can talk about it on our next call.

So moving fast, but thank you guys so much for your – all your help on this. It's been a really good call today and I appreciate it very much.

Aaron Garman: Sounds great. Thank you all.

Male: Thanks, everybody.

Ira Moscovice: Thank you.

Karen Johnson: Thanks.

Male: Bye-bye.

Male: Thanks all.

Male: Thanks. Bye.

END