NATIONAL QUALITY FORUM

Moderator: Rural Health
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OPERATOR: This is Conference #88446403.

Kate Buchanan: Excellent. Thank you all very much. This is Kate Buchanan from NQF. And I want to welcome you to the fourth webinar of the MAP Rural Health Workgroup. We are pleased that we have or joined by so many of our workgroup members, members of the public, as well as our CMS and HRSA our colleagues.

Before we begin, I do want to do just a couple of housekeeping announcements. As a reminder, in order to participate verbally in the call, we need you to dial in. So please an addition to streaming in the webinar, dial in to 855-307-1903. And with that, I will actually go through and look at our agenda today.

So, as you can see, we have a very packed agenda. Our main goal today is to review the draft report that we sent out as well as the draft core set measures. All attachments are in the Outlook invitation that you received. And so we encourage you to have those available and ready. So what we will do first is to review the report structure then we will discuss the measure selection criteria and methodology. We will review the draft core set. And then finally we will review and prioritize some measurement gap areas.

I'm joined on the call today by my colleagues, Karen Johnson, Suzanne Theberge, and Madison Jung. So – and we're going to do a brief roll call. But before doing that, I want to open it up to our co-chairs, Aaron Garman and Ira Moscovice, to provide any opening comments.

Aaron Garman: This is Aaron. Hello and thank you for your time today. Happy Valentine's Day, everyone, and I know your heart is in rural health care. So I hope this is a great meeting. Thanks.

Ira Moscovice: And this is Ira. I just want to thank everybody for the effort they put in, in a very short turnaround a little while ago to provide really good input to the process. So we look forward to continuing to move that forward.

Kate Buchanan: Thanks. Excellent. So I'll go through now – we'll go through our organizational members first. And even if you're not the primary person, if you are substitute, please identify yourself. We really appreciate it.

Alliant Health Solutions?

The American Academy of Family Physicians?

David Schmitz: This is David Schmitz with the American Academy of Family Physicians, present.

Kate Buchanan: Thank you. The American Academy of PAs?

Daniel Coll: This is Daniel …

Kate Buchanan: The American …

Daniel Coll: Yes, Daniel Coll for the American Academy of PAs is here. Sorry, I was on mute.

Kate Buchanan: Oh, no worries. Thank you. The American College of Emergency Physicians?

Stephen Jameson: Hi, this is Steve Jameson.

Kate Buchanan: Thank you for joining us. The American Hospital Association?

Geisinger Health?

Health Care Service Corporation?

(Shelley Carter): Hi. This is (Shelley Carter).

Kate Buchanan: Excellent. Thank you, (Shelley). Intermountain Healthcare?

Mark Greenwood: Yes, this is Mark Greenwood.

Kate Buchanan: Welcome, Mark. And Michigan Center for Rural Health?

Crystal Barter: Good afternoon. This is Crystal Barter.

Kate Buchanan: Good afternoon. Minnesota Community Measurement?

Julie Sonier: Hi, everyone. This is Julie Sonier.

Kate Buchanan: Thank you, Julie. The National Association of Rural Health Clinics?

The National for Frontier Communities?

Susan Wilger: Yes. This is Susan Wilger.

Kate Buchanan: Thank you, Susan. The National Council for Behavioral Health?

The National Rural Health Association?

Brock Slabach: Good afternoon. Brock Slabach here.

Kate Buchanan: Good afternoon, Brock.

Brock Slabach: Thank you.

Kate Buchanan: The National Rural Letter Carriers' Association?

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

Kate Buchanan: Thank you. The RUPRI Center for Rural Health Policy Analysis?

Marcia Ward: Hi. This is Marcia Ward covering for RUPRI today.

Kate Buchanan: Thank you, Marcia. The Rural Wisconsin Health Cooperative?

Tim Size: Hello. Tim Size's here.

Kate Buchanan: Hi, Tim. And then we'll go on to our – oh.

Female: Truven Health.

Kate Buchanan: Oh, sorry. Truven Health?

Cheryl Powell: Hi. It's Cheryl Powell. I'm on. Thank you.

Kate Buchanan: Thank you, Cheryl. We'll now move on to our Individual Subject Matter Experts. John Gale?

John Gale: I'm here. Thanks.

Kate Buchanan: Oh, great. Thank you, John. Curtis Lowery?

Melinda Murphy?

Melinda Murphy: Yes, I'm here.

Kate Buchanan: Hi, Melinda. Ana Verzone?

Holly Wolff?

And then move on to our Federal Liaisons. Do we have representative from CMS?

(Susan Anthony): (Susan Anthony) is on the line.

Kate Buchanan: Thank you, (Susan). From the Federal Office of Rural Health Policy?

Craig Caplan: Hi. This is Craig Caplan.

Kate Buchanan: Thank you, Craig. And Indian Health Service?

Juliana Sadovich: Hi. This is Juliana Sadovich.

Kate Buchanan: Thank you, Juliana. Is there anyone that I missed or have not called yet? Additionally, if you're on but haven't called in yet, feel free to type in the chat box if you're here and we'll mark that off.

So I'm going to pass it off to my colleague, Madison, to review the report structure.

Madison Jung: Great. This is Madison Jung, Project Manager. I just want to briefly go over what our deliverables for this project are. First off, I just want to start off with a huge thank you for all of your feedback. You provided some detailed and in-depth feedback. We, from the staff perspective, really appreciate the time you've put into (it). The work wouldn't be possible if (inaudible). So thank you so much.

Just to go over the timeline for our next deliverable, first deliverable is really, is this draft report one we'll be reviewing today. It is due to CMS, our funder, February 28. As we've stated before, the purpose is to describe what our selection criteria are for the core set that we've developed and present what we have so far on the draft core set, and identify and prioritize list measurement gaps.

Our second deliverable will be due on May 31st, and that deliverable will be an iteration of draft report one in addition to the measurement topic that we'll be discussing on webinar five and six. And then the final deliverable, all the way in August, at the end of August, will be a finalized version of both reports.

So that's where we are. Just to go more in-depth on what our draft report one will contain. We want to review the structure of it. We'll start off with the introduction, purpose, background info – background information. We'll then go into the core set. And in that core set section, we have broken down the measure selection process, and that's something we would like your feedback on today on the definition (we define), what your thoughts on how related (they) are, are there things that you can move around or put together. I would really appreciate to hear those thoughts. And then as well as the draft core set, which we will following this call update and adding your input in the report.

Lastly, in the report, for content-wise is the measurement gaps. These are the ones we've identified from our discussion so far, but we would like to take the time today and go through, and further refine and prioritize these gaps. And then the report closes out with a conclusion and looks towards next steps.

Does anybody have any questions about where our workgroup is going and the timeline that we need to do this in? Any questions at all?

OK. We're hearing none. I think we'll just move right on all along. I believe, Karen, you are up next for now.

Karen Johnson: Suzanne.

Madison Jung: Suzanne.

Suzanne Theberge: All right. Good afternoon, everyone. So, I'm just going to remind everybody about how we selected this core set of measures just briefly go over our criteria and methodology, and then we'll get in to the actual discussion.

So, next slide. So, we've started – what we're trying to work towards are two core sets of measures. One that is appropriate for the hospital inpatient setting, particularly critical access hospitals and small rural hospitals and the second from ambulatory care settings, particularly rural heath clinics and federally qualified health centers. And we're looking for 10 to 20 measures for each of these two core sets.

So the draft selection criteria on the next slide, this is what we've started with. First, we limited it to NQF-endorsed measures, and then we took your feedback and ranks. We came up with four tiers based on how important various factors the workgroup identify. So, first year included measures that we're crosscutting, resistant to low volume and transitions of care. Ad then tiers two, three, and four cover different topic areas that the workgroup members felt were important.

On the next slide, you can see our scoring method. So staff went through the measure sets and rated through the kind of (world of) measures that we had

and then rated each of them as a yes or no for the six components, assign the percentage weight to each of those components based on how important the committee, the workgroups itself that component was, and you can see our rating system on the slide. And then we sorted by the score and pick everything, apply to cut point at the 75th percentile. And then we went back through and just kind of look to make sure that what we saw in the core set kind of reflected what we had heard and what seem like should be included and came up with a straw man core set for you to review.

So, on the next slide, you can just get a sense of how we narrow this down. We started with 608 NQF-endorsed measures. And then we further narrow that down to the appropriate levels of analysis, we got 444. Our selection criteria and cut point got us down to 119 and then staff further refined that to 44.

So, then we sent that group of 44 out to you and asked for some feedback, asked you to give us some information on what you thought was missing. And on the next slide – and you sent us back an additional 30 measures. And so, we have ended up with 74 measures in our current draft core set.

So, then as you recall, we sent those 74 measures back after you left back and forth with the team here and asked you a few questions. We asked you – the next slide – you can see the questions. Should those measures be included in the core set, yes, no, or maybe, and then we ask for some qualitative feedback, questions that came out of our January webinar and things that we wanted to know from the workgroup members around what your overall thoughts were on the measures, what concerns you might have had about ease of use and feasibility, potential for unattended consequences, and whether you (knew) if the measures were being used.

So that's how we landed on these 74 measures that we have today. And I will turn it over to our co-chair, Ira, to facilitate any discussion or questions that the workgroup members might have before we actually dive into the core set.

Ira Moscovice: OK. Thanks. So we have a few minutes for comments from our members of our workgroup in terms of the measure selection criteria, the methodology.

So the floor is open. Any comments from folks in terms of the selection process and the methods used?

Craig Caplan: Hi, this is Craig Caplan from FORHP. I'm just wondering, are these measures intended for Medicare or Medicaid private insurers? Just wondering what the payer type that these measures are being developed for? Thank you.

Ira Moscovice: I'll give an initial reaction and then maybe staff wants to offer others, folks want to offer. But for instance, some of the measures are related to pediatric population, and there are obviously volume issues we expect to some of those measures. But clearly that's not the Medicare population. Other measures were certainly much more oriented to the Medicare population less to child health. And so, we're that I think orienting towards anyone particular third party payer. But from my perspective, we want to make sure whatever measures get into the core set really do reflect the kinds of patients that are seen in a reasonable number of instances by whether it's the rural hospitals or the rural providers. So the most important thing is that they are relevant and one of the considerations are they're seeing enough of those kinds of patients. I don't know if others want to chime in from staff before we open a backup.

Karen Johnson: This is Karen from NQF. No, I don't want to add anything.

Ira Moscovice: Any reactions to that from workgroup members or suggestions?

Craig Caplan: Is it indented solely for the payers or is it indented for the public as well?

Ira Moscovice: Once again, my reaction, it's not certainly just for payers. I mean it was – the question was raised in that context, but these measures – when I think about rural relevant measures, it's both for – we were talking about payers, but it certainly for providers and certainly for the public, for people who lived in rural community. So, it's for all the above.

Staff, any thoughts?

Karen Johnson: This is Karen. I would pretty much agree with that. I think a lot of the measures that have already been kind of selected in draft forms are being publicly reported; not all of them are. And measures are endorsed by NQF the

idea is that they will be suitable for all different types of accountability programs. So that way it includes public reporting as well as other types of uses. So, I think if they are not being publicly reported the idea is that potentially, they could be.

Kate Buchanan: Sorry, this is Kate. I just want to make a housekeeping announcement. If people are not currently talking, if they wouldn't mind muting their lines, we're getting a clicking sound from someone. And we would really appreciate it. Thank you very much.

Ira Moscovice: Other comments, questions from the workgroup on the process used? Well, I'm not hearing any others. I'll turn it back to Karen and we can move to the meat of the discussion in terms of the specific measures, so.

Karen Johnson: Well, thank you, Ira. So, this next part of the call is going to go really fast mainly because there's a lot we want to get through it. So, just to amplify a little bit when we got – when we asked you guys for feedback on that draft core set giving you the 74 measures, we had almost half of the group who are able to do that and that was really fast turnaround time. So, we've got very detailed feedback from 11 or 12 people.

And at first cut, when we first started looking at it, we wanted to see if we could do any kind of just overall cut. And what we realize is out of the 74 measures, there's still a lot of variation, I guess, between workgroup members as to whether they think it belongs to the core set, whether it doesn't belong, or somewhere in the middle. So, only 14 measures received support for inclusion at 70 percent or higher of those 11. Five measures receive 50 percent work for exclusion. So, in other words, half thought that it should not be included.

And then like I say, everything else a lot more non-uniformity between those. So, in the following slides, when we get into these details, we're showing you these percentages so you can get the flavor of the yes, no, maybes. But probably more interesting than just the yes, no, maybe responses was the types of feedback that we received. And it really fell in several buckets. And I think before we get into looking at things kind of group wise, it's wise to

spend a little bit of time thinking about the themes overall. So, we probably want to allow maybe 10 or 15 minutes, no more than that, unfortunately, just to talk about some of these big pictures items.

So, one of the questions or one of the things that came through was about the size of the core sets. Should we choose one or two measures per area? So, a lot of people pointed out, hey, you've got five depression measures. Do we really need all five? Should we – do we really only need to pick one? So, my answer from the staff view point right now is that, there really is no rule in terms of what we're expecting. The 10 to 20 measures per inpatient and ambulatory setting, that was a guideline or recommendation from the rural health workgroup from two years back. And it makes sense in a way that you want your core set of measures to be fairly small. These would be measures that everybody, potentially, would report on. And then the kind of accompanying recommendation from that report was – there should also be a menu of optional measures. So we're not –in this project we're not touching that question about optional measures. But the idea was you've had a small set of small core set and then a much bigger list of optional measures because so many things maybe work for one provider but not for another.

So, the way that we've laid this out for discussion is that we have grouped these measures by topic area, and that will allow you to see a little easier. Yes, we do have five depression measures, and it may help you decide whether you want all five of them, whether you think one or two maybe lie to the top, that sort of thing. But there's no (fit) rule about you have to have one in each of these groupings that we're going to present to you or you can only have one. So, hopefully that makes sense. And then we can see where we're at the end of the day. If we cut too many, we may we'll see what happens.

Another major thing that I think it worth some discussion is some of these measures may not be under the control of the provider being assessed. And that is certainly true, and that is almost always going to be the case for any outcome measures. At NQF, we actually have stated preference for endorsing outcome measures because we realize that different providers have different things going on in their own shop, that they may need to focus on, and another provider might need something else to focus on. But the outcome measure

could be the same. So we talked about whether or not a provider can influence the outcome as opposed to completely control the outcome. But I think that might be something that the workgroup needs to work through and see if that is actually a sticking point.

Let me go quickly through the rest of these. Several of the measures or feedback was that they're may be low volume concerns. So, to get us through this list of measures, one of the questions might be for you, we already that low volume is a concern that needs to be addressed and we want to try to have resistant to low volume measures in our core set. So, one way to quickly run through things might be if this really is going to be a problem in terms of low volume for most or even a big chunk of rural providers, then maybe it doesn't belong in the core set, and that might help us knock things off of that list if they need to be knocked off.

Almost a similar kind of thing in term of topped-out measures. Those are measures where performances already either very high because you're looking for something to happen or very low, you hope it does not happen. And the idea there might be if that's the case or if we think it might be the case relatively soon, do we want that in the core set? There were many concerns about risk adjustment and particularly the lack of risk adjustment. And I know people weren't able to look at the details of measures. We can provide you a lot of detail if we really want it, but most outcome measures usually are risk adjusted but they – each one has a different set of risk adjustment factors that are included.

The next one gets to data difficulty, costliness, time consuming to collect. This gets to the burden issue. And it came up a lot on our last call. So it's something that we really want to think about when we look at this list. Finally, does it really affect the patient outcomes? Is this is a really meaningful measure? Or this is more of a checkbox kind of measure that really won't drive improvement? And then, finally, any unintended consequences for rural providers or residents. Both of those think really came up in our last call.

So, going to the next slide just real quickly. What we're going to ask you to do, we're going to go back to these themes in just a second but we've grouped our measures by condition or topic. We've color code it to show you where there's really strong agreement about either exclusion or inclusion. As I said, there's really no rules on how many measures you should or shouldn't use. You can choose as many as you like.

We've noted in these following slides many of the concerns that came through in terms of feedback, but those – you can actually see the feedback that came through on the Excel file that we sent last week if you want the details. We probably didn't capture everything on these slides. It's a little difficult to do. But some of the main things are there.

We've also noted the level of analyses or setting for many of the measures. That's important because we are desiring core sets for both the inpatient and the ambulatory setting. In some cases, we may have topic area but all we have is hospital measures. We don't have them for the ambulatory side or vice versa. So we've tried to put that in there. And then, of course, we can't spend a lot of time on each measure. So, what we're really looking for is, I think, things that you either you feel strongly that should be included or you feel very strongly that it should not be included. And we're going to try our best to start getting rationale.

So, if we can go back to the theme slides for just a couple minutes. And, Aaron, I think you're going to help us facilitate. Let's talk a little bit about the themes and maybe talk specifically about measures being under the control of the provider; make sure we're on the same page in terms of what we're looking for there, the low volume, the topped-out, and the risk adjustment especially.

Aaron Garman: All right. Thank you, Karen. One of the things that I would like to comment on first is that just to remind everybody, as a primary care provider, I practice in primary care everyday. I've done it for 20 years. And the game has really changed. We've gone from kind of solo or siloed providers taking care of patients to where now we're providing care coordination and population health. And so, the game of primary care really has changed.

That being said, it hasn't necessarily trickled down through all of the rural populations. So, when we talk about these themes, I think it's very important but we need to realize that, again, the game has changed and it's changing. So, we want to be a little futuristic in our thought and think about how we can set this up within future to be successful.

So let's talk about the first one. Control of provider being assessed. How important or concerning is this from the group or feedback from the group regarding this.

Tim Size: This is Tim Size. I think it's pretty important, and I think it overlaps with the issue around risk adjustment. Karen did mention that many of our metrics do have a risk adjustment. And I guess my follow-up question was how am I actually – are we at the point where we're really adjusting for very significant variation in socioeconomic condition because that would fall in to the category something kind of – at least in the short-run and having them on (run) outside the control of the provider.

Karen Johnson: And this is Karen. So for the last – about two and a half years or so, NQF has made a concerted effort that, outcome measures that come to us, the developers at least consider either conceptually or empirically the need for adjustment for sociodemographic factors or rather social risk factors. So, what we've seen in the last couple of years is the movement. People are actually looking into that. In some cases empirically looking and seeing if it makes a difference, and the outcome of the measure sometimes they choose to go ahead and include some of those social risk factors. Sometimes they decide not to depending on what they're seeing empirically.

One of the big drawback is the wrong word, but one of the big limitations of that work to date is that don't often or always or consistently have social risk factored data to include in these risk adjustment models. So, just for example, one easy variable to look at is dual status, if somebody had dual eligible or not. And that can be – you can look at that as a proxy for insurance status or for poverty to a certain extent. But it's not a great proxy for either of those two. It tells you a little bit of something. But if you really think it's a the disparity or the thing that you should be controlling for is income, that

variable may not be getting to what you really like to be controlling for and we just don't have that.

So, the (SDS) work that we've done, I think, has really highlighted the need for data but we're not completely there yet. So, I don't know if that …

Tim Size: Well, I'm aware of that certainly, and I very much support NQF's change in direction to really dive into this. My concern would be at the end of the day, if we end up with a core set, that largely isn't yet evolved from the point of considering that. We run the risk of penalizing those very providers who are made a commitment to really work in significantly underserved or disadvantaged communities.

So, at some – and I also would add that I understand the distinction that we don't want to adjust the way through differences. But to a degree, these measures are used in combination of financial incentives or public reporting, I think we have to be careful and deeply concerned. So it's not clear yet how we incorporate that into our work.

Aaron Garman: Thank you. Any other thoughts on provider control?

Cheryl Powell: Yes, this is Cheryl Powell. I just want to highlight. I think that that is important, but I also go back to our charge, which is to identify the core set if that's available; basically rural relevant measures to address the needs of the rural population. And I think there is a balance between control of the provider and what reflects what's best as a population, and I just want to make sure that we keep that in balance. So we don't put too much of a stress on control by the provider that it takes away from the ability to see what's happening really with quality for the rural population. So I would just highlight I think there's a balance and as a danger to stress going too far in one direction given the charge that we have.

Tim Size: Yes, this is Tim. I totally agree with the last speaker. But that's why – I said I think we had to be very clear about the purpose of the metrics because I don't think for internal quality improvement, we should ever in any way adjust the way the problems. And that is in fact – it's for financial incentives or comparison with other clinics who may be working in more advantaged areas.

I think that is something that we really do need to keep in mind. So I don't think it's an either/or, I think it's a both.

Mark Greenwood: This is Mark Greenwood. I would echo that. And there's a difference between control and influence. We may not be able to control, but we are ultimately influencers and we can influence a lot that we can't control.

Ira Moscovice: So this is Ira. What I would just add is I think no matter what we come up with, there's a core set. This issue and this theme, and the discussion we're having really is an important part of whatever we come up with. And I don't think we're going to have the ability to not consider any measure if it's not risk adjusted already because I think that will reduce the number of measures we have considerably.

But on the other hand, I think we, at the very least, need to identify where we think there may be some issues. And just be clear that the discussion we just had really is an overarching theme for whether it's rural relevant or relevant for all providers, whatever else. It's there and we're moving towards there, but we're certainly not where we need to be at this point.

Aaron Garman: Thank you, Ira. Any other thoughts or comments regarding the provider control issue? If not, let's move forward to low volume concerns. Any other ideas, thoughts regarding this? Comments?

OK. The topped-out measures or soon to be topped-out. Any other concerns, thoughts, points of clarification that people want to bring up?

Female: This is …

Brock Slabach: Aaron, this is Brock here. I just – and I think this is kind of an overarching set in my mind that I wanted to enunciate because I think it's – and I want to get some clarity on this. I don't look at this as a static set of measure so we're going to come out with some thing that I think is going to be implemented or put into a report that's sent to CMS. But my hope would be is that this would be implemented and then some kind of map workgroup would be ongoing into the future that would be making assessments on all of these questions and

continuously updating this set as we go forward so that it's relevant not just today but also a year from now and five years from now.

So this is like an issue of topped-out measures. What may be in the set today or maybe two years from now is topped-out, then the rural map then if I'd stood to eliminate it and then go to something else. So, that would help me and maybe NQF or CMS kind of respond if that's hopefully maybe one of the intentions of this going forward. That this isn't going stay (this set) forever.

Karen Johnson: So this is Karen from NQF. It is, of course, our hope that your vision is the same as the CMS vision. We have no guarantee that CMS will continue to fund this MAP Rural Health workgroup, but we hope that they will. And I think that would be – it would – looking at core sets and kind of seeing what's happening with them, how they're being used, how they're being implemented, any difficulties, topped-out, all these kinds of things. We've seen kind of that behavior with MAP workgroups over the years especially with the Duals workgroup and the Medicaid Adult and Child Workgroups that we have. They've done exactly that sort of thing.

Aaron Garman: Excellent point, Brock. I appreciate that. Anyone else?

John Gale: Yes, hi, it's John Gale. I agree with the need eventually to phase out measures that have topped-out or soon to be there. I would argue for a transition process as we were to bring in providers that have not typically reported, and I'm thinking – or at least that we don't have data on the extent to which they're reporting some measures like a rural health clinic is having that transition period to use the measures over time as they gain experience with quality reporting and improvement until such point as they – we can – they come up to speed with some – the other providers as they've been doing this longer. I think cutting them out all together at one point doesn't really give much of an entry paths for providers that have not traditionally worked in this area.

Aaron Garman: Thank you. Anyone else on topped-out measures?

Julie Sonier: This is Julie Sonier. And I'm one of the people who sort of made the comments about the topped-out measures, but at the same time – and this is kind of a concern sort of throughout, which is that we know sort of what we

have today that in the existing system, PQRS, MIPS, all of that, are really (flood). So a lot of people think that it's in over reliance on process versus outcome measures, and we've got a lot of topped-out measures in there.

And so, as I was going through, I made those comments to say it's not a great measure. But at the same time I think that it's – part of the question is we're developing a measure set that we think is a good measure set, but we need to be careful to not develop on that whole rural providers to a much high standards than others are already currently being held to. So it's kind of that balance. So if you come up with something that you think is less than ideal, I think I agree with the comments about there needs to be a path to something that is more meaningful.

Aaron Garman: Excellent points. Anyone else with the topped-out measures?

Next theme is concerns with risk adjustment. We somewhat touched on that earlier but are there any other thoughts on the risk adjustment issue?

Hearing none. Data, too difficult, costly, time consuming, did you want to go through that one as well, Karen?

Karen Johnson: I think just in general, maybe what's the idea there. I mean we won't have time to talk about each measure just one by one necessarily. Is there any overarching theme, I mean if we feel like someone thinks that this is really hard? Should that be kind of a spur to the group to say, no, let's leave that off the list? Or how do you want to think about that as we go through the list?

Aaron Garman: Any thoughts on that? I think it's always challenging with the number of electronic medical records out there in their abilities or lack of abilities in most cases. So, it's, I guess, really challenging to lump everybody into a group saying every measure is going – or specific measure is going to be difficult for everyone because some people won't be – some people would be incredibly challenging. So, I think that's a real hard one.

Any other thoughts on that?

Marcia Ward: Hi. This is Marcia from RUPRI. And I think if there are still some measures in there at the population level or you would need a registry in order to be able to complete them, those we might be sensitive to being particularly challenging in rural settings.

Aaron Garman: Absolutely. The other challenge I see, too, is that oftentimes providers are their data experts as well. They don't have IT staff so we have to bear in mind, I think, the time aspect for providers is very challenging. Any other thoughts, ideas?

Next bullet point is does it really affect patient outcomes. I think this one is really important from my standpoint. I'd like to see meaningful, actionable items instead of ideas that really don't impact my patient population. But are there other – any thoughts out there regarding this and concerns or questions?

All right. Any evidence of unintended consequences? I know Dr. Schmitz is very passionate about unintended consequences. And so, perhaps he has some thoughts regarding this theme for the workgroup.

None? All right. Anything else on any of these that you can see that you're seeing something on the themes that you're concerned about? Hearing none, I guess, I'll turn it back to Karen.

Karen Johnson: Yes. So, let's give this a shot. We've got a lot of slides to go through. So let's see how this works with transition. So maybe what I'll do is Aaron and I will go back and forth. So, I'll just give you real quick rundown of what's on the slide in front of you. So this is measures that reflect transitions in care. You can see that we have three of them there. One of them had a pretty high yes rating from the supervisor feedback.

There was some concern about the one on the bottom in front of low volume, risk adjustments, potential unintended consequences. All three of these are hospital measures so that the – that's who would be held accountable. I will also point out that the three item care transition measure is a patient reported outcome measure.

So, I guess let's see how this would work. Aaron, I would think maybe to see if the group has …

Aaron Garman: Yes.

Karen Johnson: … has ideas about do they like any of these, do they particularly like one or the other, do they particularly don't want one way or the other.

Aaron Garman: Right. We have three items here.

Kate Buchanan: So – oh, I'm sorry.

(Inaudible)

Aaron Garman: Go ahead. I'm sorry.

Kate Buchanan: Oh no, I'm sorry. I just wanted to – as we're going through this conversation, want to just direct people Supplement A that's attached to your invite has more information of the measures. Additionally, supplement B has some of the comments we had laid out as the measures are reviewed just so as guidance document as we talked about these. Thank you, Aaron.

Aaron Garman: No problem. So, yes, there are three items before us. All of them received relatively strong yes votes, some stronger than others and some kind of moderate no votes. Are there – is there one measure here that stands out that everybody would like to see? Is there two? Is there – are all three of them important? What's the wishes of the group?

Stephen Jameson: Can we clarify the emergency transfer communication measure? This is Steve from (AAFP).

Karen Johnson: Yes. Ira, you know about that measure, right?

(Inaudible)

Ira Moscovice: Yes. When you say clarify you just want a definition of what it is or?

Stephen Jameson: Well, an example perhaps of what might be measured or how that would impact the rural provider and how that's going to be helpful for the receiving facility.

Ira Moscovice: Yes. So what this is, is it's really – I view it as a coordination measure. And what it's trying to do is to say for emergency patients who are transferred to another facility is the right information going from the ED, from that facility to the trend, to the facility where the patient is transferred so that the providers that, the receiving facility are able to move forward with appropriate care for the patient.

And so, it's been NQF approved and endorsed. And it has range of components -- did you send all the lab X-ray information, did you send the physician notes, and a variety of different areas. We're trying to get it to make sure that you have complete information that's available at one facility transfer to the other facility as the patients moved over.

Stephen Jameson: Some of that is already a federal law under EMTALA that you have to do appropriate transfer and make that communication. But, yes, things do fall through the cracks, and I guess having this as measure is reasonable. And anything that involves emergency care certainly I would be in favor of.

So, I think I was just wondering if it – if you have the same medical record as the – whether receiving referral hospitals do that process is easier. If you don't, then you need to send those records along and then somehow – otherwise communicate those. So, anyway, all right, but thanks for your clarification.

Ira Moscovice: Okeydoke.

Aaron Garman: So, again, I post this to the group, is there one measure out of this in this transitions bucket that we like better than the others? Or should we look at including all three of them? We're trying to whittle this list down to the most important measures that we can.

Tim Size: And this Tim Size. Two things. One is that I really think given a core set, having the diverse array of metrics is important. So I'm kind of coming to this

with a bias against duplicating with any one area, unless something really distinct has been added out by the second metric.

But I have a global question I think as we go through this because it's different ways to sort this out. One, I suggest that as we look that what gets the highest member of yes votes, perhaps it's interesting or equally important is what gets the lowest number of no votes? And so – and this slide is good compared to the first metric with the third metric. And I'm not – it's not clear to me which is the right way to go.

Aaron Garman: That's why we're asking the question.

Tim Size: But I mean this is in criteria, not this particular example.

Aaron Garman: Right, right.

Tim Size: My bias probably leans a little to – closer to consensus where we have only 9 percent in opposition.

Aaron Garman: Any other thoughts from the group?

Melinda Murphy: It's Melinda. A comment about communicating information versus the actual time it takes to make a transfer. And I recognized that 290 is maybe a little more circumscribed. But I wonder how those of you who are working with this everyday feel about the importance of the actual time of transfer versus communicating information.

Stephen Jameson: I think it's really good point. That same issue comes up with admissions to the hospital. You make a decision to admit. By the time the patient actually gets there, that's the difference. And that's true in the rural setting as well where you may have issues of weather, you might but not be able to fly, you may not be able to even get an ambulance. So I think it's your decision to transfer. It's probably the more important one and how you – and how you've done that to the communication.

Aaron Garman: So I'm hearing the emergency transfer communication measure may have a bit more weight. However, Tim was concerned about the no vote. My biggest

concern, this is Aaron, is the low volume status of the acute coronary interventions. If we're going to not have actionable data out of this measure, I don't know that it should be included anyway.

Tim Size: Yes. This is Tim. And just to be clear, I am not taking position on one metric over the other, but just trying to have a clear sense of where the group would prefer. Are we mostly going to focus on the one that got the most yes votes? Or are we going to pay attention to those that got small number of no votes?

Aaron Garman: Any thoughts on that?

Karen Johnson: So this is Karen from NQF. And our initial try was to be able to say, hey, these were the ones that we're strongly supported, these were the ones that we're definitely not supported. And what we found is there was just a lot of kind of non-uniformity across that yes, no, maybe. So, I'm not sure, Tim, that it's going to be possible to be consistently through all of these to say let's look at the ones that are mostly yeses or the ones that are lower nos. Does that makes any sense? I think it's not quite that easy.

Tim Size: Well, no, I'm not suggesting it's easy. I'm just suggesting, I think, in the real world of trying to get change, I think, to a degree where a metric has less opposition, that has a certain degree of attraction. But I just raised the question. I'll leave it alone.

(Inaudible)

(Jill Oesterle): This is (Jill) from Michigan Center for Rural Health. Just a bit of an add-in and maybe this is too simplistic. But when I look at the measures and as I reviewed the information of yes, no, and maybe, what helps me decide yes was did it impact a larger percentage of patients? Was this a measure that we could hit a larger percentage of patients versus another measure knowing that our providers and our staff are going to focus on making sure that measure is doing well? Maybe it's too simplistic.

Aaron Garman: And I agree. I think that has to do with the low volume issues; so, absolutely. Any other thoughts on this? What direction will the group like to go on transitions?

Julie Sonier: This is Julie. And I would just like to speak in favor of the three – patient reported outcome measures, the three-item care transition measures. So, I looked at the supplement to see sort of – I think the concern or the no vote seemed to be about whether it's implicative of the HCAHPS Survey, which I don't know that most of us are really in love with. But one of the things I like about this measure is that it really gets at something that is going to affect – it's care coordination related and it affects the degree to which there might be readmissions or complications. And so, that's one of things I really like about it as a really meaningful patient-reported outcome.

Akin Demehin: Hi, this is Akin Demehin with the American Hospital Association. Can you all hear me?

Aaron Garman: Yes.

Female: Yes.

Akin Demehin: Oh good. I'm subbing in for Dr. Steven Tahta who has unable to join today. Thanks for letting me join in. Just another comment about the Care Transition Measure 228. That measure is a part of the HCAHPS Survey in the IQR Program. I think conceptually it certainly assessing some stuff that's pretty important. I guess my concern about it would actually the more of an implementation concern because it's a survey base measure and because it's built in to the HCAHPS, it actually has to have enough completed surveys in order to get a reliable measure score that maybe quite a challenge for some rural hospitals.

So, as a sort of internal quality improvement type metric, I could see it having a lot of value. It's a part of something that's more accountability based, I could foresee some real issues.

Aaron Garman: Any other thoughts? Karen, does that give you enough you and your staff enough ideas on this one? I don't think we've come to a consensus on any of this. Or have ruled out any of these, but they were all learning towards yes in the first place, so.

Karen Johnson: Yes. Well, I think and this one is a good try for us. I think probably we had a little bit more leaning towards the first one, then maybe the second one. If I understood Akin correctly, he's thinking that the CTM measure is actually included in the HCAHPS and the HCAHPS come along later as a suite of measures for you guys to talk about and under patient experience types measures.

So we may not need the CTM-3 if we end up going with HCAHPS. So, I think Melinda's questions about time to transfer, it's tricky because what we didn't know, we want core set measures to be applicable to a large number of rural providers. So, do you see a lot of ACIs in small rural hospital? If not, then that low volume I think really comes out and it might be a disqualifier if it – if we think that it's really going to be hard to get enough numbers for this one.

I think there was also some concerns about potential unintended consequences, just because of travel distance and time and with that unfairly penalized. And some of these is getting into details of the measures that we can't delve into, so I know it's tricky. But I think right now, I think I'm hearing yes for 0291 and no to the next two.

Aaron Garman: Any reactions from the group on that? Hearing none. I think we should move to the next topic.

Karen Johnson: OK.

Aaron Garman: Mental health …

Karen Johnson: Mental health.

Aaron Garman: … or depression.

Karen Johnson: Depression. So just real quickly, these are all ambulatory measures. You can see that a couple of these had really high yeses on there. I think the concern of the four measures at the last four were all about data collection.

The 0418e signifies that it is the eMeasure version of the one ahead or the one in front of it. So, you may want to perhaps shy away from an eMeasure version, that would be fine. The depression response and remission measures all are – these are patient-reported outcome measures so they require use of the PHQ-9 instrument. So that's I think where the data collection concern came in.

So maybe we can get a flavor of, is there one or two or three that people really like or things that people would really not like. And just reminding people, we still have a lot of things to get through but we also have more time after this. This is going to go out as the draft report but we still have plenty time to look more closely at these. This is just yet another iteration of our work.

Aaron Garman: So any thoughts on that? Any preferences from the group? Do you like the two yes? The 0418 and the 0711 as our two metrics that we choose out of this group or just one of them, what's the preference?

John Gale: This is John Gale. I would lean towards 418 and 711. I agree with the idea of not including the eMeasure. They are pretty similar otherwise, so I'd go with the first.

Twelve months, you're starting to, I think get out a little bit further, but I like think 6-month measure myself and then the depression remission 12-month had a fairly lower percentage of yeses, but a high percentage of maybe, so. I think 711 and 418 would be the two I would lean towards.

Aaron Garman: Any other thoughts? OK, hearing none. I think we can move.

Karen Johnson: OK. So the moral of this story is you have to really talk fast if you want to get your opinion heard on this. And again, remember that these little checkmarks here are at least giving us a flavor of what some of the feedback was.

So the next one, tobacco measures, looks like we have four of them. Two of them are hospital level measures, we've noted there with the star and then of course the other two would be ambulatory. So one question for you might be do you want – we want to make sure you have one in both settings, at least one of the both settings perhaps.

I think the first two there, there were some concern about being topped-out and I think the concern really of 0028 was more about is that – is it more of a check box measure, is it actually going to drive some improvement and outcomes?

Aaron Garman: All right, reactions from the group on substance use? Which ones do you like? Or absolute no's that you do not like?

John Gale: It's John Gale again. (Echo), I would lean away from those that are hospital specific, so 1651 and 1656. But the challenge I have with 28 – 0028 is obviously it's actually two measures, are they screening and if they screen positive, are they offering intervention. So that one is always one that's I think important to look at is two – measuring two separate concepts.

Aaron Garman: Great points. Any other thoughts?

(Shelley Carter): This is (Shelley), and I would happen to agree. But I'm with (HCSC) and 1651 and 1656, I don't think can be that supportive for sustainability. I don't think that we would have screening and treatment use of treatment on discharge would lend itself to a long term effect.

Aaron Garman: All right, excellent point. Anybody else?

Susan Wilger: This is Susan Wilger from National Center for Frontier Communities. We're doing a lot of tobacco prevention. I'm curious, one thing we're trying to emphasize is not only tobacco but tobacco products would have been possible to include tobacco products, like eCigarettes?

Karen Johnson: So this is Karen. We could certainly take those kinds of recommendations from the committee. And as a matter of fact, if these measures don't include tobacco products that might be what you would characterize potentially a gap in measurement. But right now, these measures are as they are. These are the endorsed measures that you have available. So, we can't (quiver) too much with what's in them and how they're specified.

Susan Wilger: OK, thanks, Karen.

Karen Johnson: Sure.

John Gale: It's John Gale again. I do have to say, I'm a little bit surprise that the low percentage of yes votes on 2803. Just thinking about the use of tobacco by adolescents in rural areas. I think this is an important one. And I (inaudible). Be in favor of keeping it. But I was a bit surprised that it was – the support rate was fairly low.

Aaron Garman: Any other thoughts on 2803? Or any of the other measures?

Akin Demehin: So this is Akin Demehin with AHA again. I do have a little bit of perspective on 2803. There's a part in me and maybe I have to take a closer look at the measure specifications, but there's a part of me that wonders if 2803 is actually duplicative a little bit of 0028? Or it – maybe 0028 is something that could be easily adopted to capture the adolescent population. That way you get a measure that's little bit broader.

Then in terms of tobacco one and tobacco three, I'm inclined to agree with the votes here around kind of a (threat) or tepid support. I guess another reason why those two measures may not be particularly useful, those rural hospitals that are accredited by the Joint Commission maybe reporting on these measures as a part of their (org) set already. They've been around quite a long time. And the last time I saw any data on performance, it was looking pretty topped out. So, I definitely don't think there's a whole lot more one can get from those two measures.

But 0028 and maybe some modification of it to capture the population in 2803 maybe a great way to go here.

Aaron Garman: So I'm hearing 0028, is kind of the preference for the group, any other thoughts or ideas on substance use tobacco?

Karen Johnson: And this is Karen from NQF just to reply to Akin's observation. The 0028 is specified right now only for 18 and older. So if you don't choose the adolescent one, then you would have no tobacco of measure that looks to kids.

Aaron Garman: Thoughts from the group?

(Shelley Carter): I think – this is (Shelley) from (HCSC). I think the 2803 is important to have in there with adolescents.

Crystal Barter: And this is Crystal from the Michigan Center for Rural Health. I would second them.

Susan Wilger: And Susan Wilger …

Tim Size: Did someone.

Susan Wilger: … from the National Center for Frontier Communities. So I would third that.

Tim Size: Did someone speak to the high level no votes for 2803?

Mark Greenwood: From my standpoint, it's just that it's such a narrow band of population and if we have a small number of measures to choose from to pick the measures that – for including the most people.

Aaron Garman: So what I'm hearing from the group is that 0028 is a definite yes include the next 251 and 56 are no. And then the 2803 is a probable yes, but we need 28 and refine the metrics later on. Does that – or measurement core set later on? Does that sound fair?

Tim Size: I'm not sure I agree with that, I mean 45, 6 percent saying, no, I would say maybe it's a probably no, but maybe not rule it out yet. OK?

Aaron Garman: OK. Any other thoughts?

Mark Greenwood: Agree.

Male: Agree, yes, sounds right.

Karen Johnson: And this is Karen. What we will try to reflect in the report is things like your recommendation, right now to cover everybody, you would have to have both of those measures. In the future, it would be nice if there could be one measure that would look at adolescence as well as adults.

Aaron Garman: Everybody OK with that?

Male: Yes.

Aaron Garman: Wonderful.

Female: Yes.

Aaron Garman: Any other thoughts on substance use tobacco? Hearing none, substance use alcohol and other drugs. It's our next slide.

Karen Johnson: So this is Karen again. Just to give you a little bit of flavor. The last two measures on this one are the health plan, we have a lot of analysis on the population state and region. So this two, I think were probably brought in as one of the 30 that people like. But a caution, these have not been tested and shown to be reliable at a clinician level. So, at – like a clinic level necessarily. So, there could be problems with that trying – trying to use the measure that would specify for one setting and another. So, just a caution there.

Aaron Garman: All right, any thoughts regarding the alcohol and other drug measures?

(Jill Oesterle): This is (Jill) from Michigan Center for Rural Health. I actually – Crystal and I were one of the ones that had look at 0004 and then 2940. Mainly for that opioid screening or some measure that looked at substance abuse disorders or risk substance to the peers. And really we could not find a measure that met that well. So those were the two that were closest that we could find.

Karen Johnson: So what we maybe saying is if you don't want to go with the 0004 and 2940 because the level of analysis isn't appropriate. A gap would be a good measure of opioid use to abuse.

(Jill Oesterle): Yes.

Karen Johnson: Is that fair?

(Jill Oesterle): Yes, I think that's fair.

Aaron Garman: Any other thoughts on the measures that are presented under this?

John Gale: It's John Gale again. I am struggling a little bit. I'm really a bit surprise of the alcohol use screening, the 2152 that such a low yes response rate. Opioids during the news, its important problem, alcohol remains biggest abuse and misused substance particularly in rural areas. So, I would argue that we would need a good screening measure, but this one seemed to be fairly heavily weighted a lot – about more than half of a no vote, so I was surprised with that.

And I agree with the comments on the (latitude) of 0004 and 2940, given the level of analysis. But I guess I'm concerned that we don't have a good screening measure overall, and whether we use that was solely an alcohol or included alcohol and other drugs. I think it's important to have something here.

Aaron Garman: Other thoughts from the group?

Cheryl Powell: I'm wondering – sorry, this is Cheryl. I was wondering if something like 0004 or others were worried about the level of analysis, where we could say we like those measure it should be part of core set. And would recommend it being build out in the future for other levels of analysis, instead of excluding it all together because of that different level, that rather in stay, we like this and we think more should be focus on this at different levels to help you get at this issue.

Akin Demehin: This is Akin Demehin. I like – I kind of like that idea for the last two measures. There's a part of me, I agree that there's clearly a gap in a kind of shovel ready measure that captures opioid issues. But there's also part of me that wonders if this does reflect performance that the health plan maybe it could be used as a surveillance measure that shared with hospitals and public health departments so that they at least have a sense of what's going in their communities.

And with respect to the alcohol screening measure, 1661, John, it might actually ease your mind a little bit and that you can't actually calculate 1664 without calculating 1661. These are another one of that Joint Commission core measures that are available to Joint Commission accredited hospitals.

And this kind of build off of each other, so you have to do the screening in order to do the drug use, disorder treatment provided and offered measures. So it's sort of built into that measure in some ways, is just not explicitly reported that way.

John Gale: Thank you. I do appreciate that. My concern with 1664 is it's hospital specific and this is an area where primary care and ambulatory centers need to be engaged as well.

Akin Demehin: Yes. We've always had a little bit of – this actually gets to a little bit of the kind of attribution conversation we were having earlier. A lot of the really strong evidence around offering substance use really does focus on primary care. And it's – which is not to say that hospitals don't have a role here, it's more that degree to which the intervention is tied to better outcomes is not quite as clear cut.

John Gale: Agreed.

Aaron Garman: Any other comments, thoughts?

Karen Johnson: This is Karen. Quick question for people. You got the screening in the hospital, you got the potential treatment in the hospital. 2152, the second one on the list is for the ambulatory side, but there were a lot of no's on that one. So does the group agree that that should be a no? Even though that's the only one that really reflects an alcohol measure for the ambulatory side?

(Shelley Carter): This is Shelley with (HCSC). I'd like to know what the no comments were about on this one, because I see it as a positive, but obviously others did not.

Aaron Garman: So the two-step measures, are much harder to gather the data and collect to document that you've both the screening the intervention, and then capture the data.

Karen Johnson: I will point …

(Shelley Carter): Yes, it is.

Karen Johnson: … out from NQF perspective, we actually like these multi-step measures because screening by yourself is good to do, but this is – if it's (screened) positive then you would offer the brief counseling. So it gets you a little bit stronger measure from our perspective. So I hear that it's a little bit harder to – you're actually capturing data for two different things that from our perspective, we actually see this as a stronger measure than having one separate one for screening and then another one for counseling.

(Shelley Carter): And this is (Shelley) again. And my organization in –my previous organization was part of a pilot study in Northern New Mexico on screening – alcohol screening and brief counseling. And the outcomes were quite significantly positive. That it really had a huge impact on the population. Now, that of course, went on for over a year, so I understand what you're talking about with data collection.

Julie Sonier: Well, this is Julie and I'm just remembering a comment that was made, early in the call about a provider centric measure versus one that is more sort of population health centric. And I think that's really the question here.

So do the issues of burden, sort of get balanced out by the fact that this is such an important public health issues.

Aaron Garman: Other thoughts from the group? Karen, how are we doing on time for this?

Karen Johnson: We're not doing too well. But …

Aaron Garman: That's what I thought.

Karen Johnson: I think at minimum, let's keep going till 2:30. That doesn't give us as much time for prioritization. But I think we can we can get somewhere. And then, we'll have to figure out what we can do post-call to get through the rest of this. Unfortunately, this is the kind of stuff the really needs discussion, it's hard to do this kind of one off on e-mail so to the extent that we can, we'll keep going.

I think what I'm hearing, unless there's major disagreement, I think I'm hearing that the first two of the measures would be yeses, at least for now because that gives you something on the hospital side and the ambulatory

side. And then, some discussion about gap in terms of opioid and levels of analysis for the last two, it's a little bit kind of unclear about the third one, the 1664. That one is treatment, so it goes further than the screening.

Aaron Garman: Clarification on 1664 from anyone? Would you like to see it? Add it, not add it? Thoughts?

Ira Moscovice: Well, this is Ira. I think it's a bit much to have three measures on, in this – from this category.

Aaron Garman: Any other thoughts?

Holly Wolff: This is Holly from Ashley Medical Center. And from hospital perspective that also have ambulatory, I would prefer the 1661 and the 2152, so that we could get both, versus having two that maybe are just hospital. So I think my providers would be supportive of that and I'm speaking for them. But I think we'd want to know from the ambulatory side that we could capture that regardless of the hospital.

Aaron Garman: Thank you. Any other thoughts?

Akin Demehin: I would agree with that.

Male: Agree.

Ira Moscovice: All right. Before we move on, Karen, this is Ira. I think that we should spend the vast majority of the rest of this call before we get to public comment on making sure we get through all of these categories. I really do believe we can do the prioritizing the measurement gap issues. We could do that by e-mail, after the call. But I think this kind of discussion we're just not going to be able to have by e-mail. And so, I think my suggestion would be that we try to go through all these categories as far as we can.

Karen Johnson: OK. I think I agree with you Ira and thank you for that. So let's try to do that as we go through, I'll try to summarize very quickly what we're seeing here. And maybe, maybe just call out things that you really don't want to see. Maybe that would be the way to go or let's just see how we go.

So medication use review reconciliation, we have health plan and integrated delivery system and facility. So nothing looks like there's a couple here that are ambulatory side. Real quick question, now and maybe somebody can help me with this. Would you consider rural health clinics or FQHCs, would those be considered an integrated health system? Generally, I don't think we think so, but maybe that would open it up if you could consider those.

Male: I'm not sure that I would consider them as integrated delivery system.

Karen Johnson: OK.

Male: Yes. I don't think that I would either. Yes.

Aaron Garman: I don't believe either, yes.

Karen Johnson: OK. OK. So, that limits us to so really nice measures. But that have been, at least, tested and shown to work well at a higher level of analysis. So, with that discussion, anything you really like, really don't like?

So, if we can't use the level of analysis as health plan and integrated delivery system, that actually takes the first two off the list. Even though people like that high risk medications measure. That would leave us with documenting medications in the medical record and reconciliation post discharge on the ambulatory side. And then for the hospital you got the unintentional medication discrepancy.

Mark Greenwood: This is Mark. If we can not use those first two, I would speak to 0097 from a safety standpoint of the transition that, Karen, and mistakes in medication due to lack of medication reconciliation have the potential for a lot of patient harm.

Tim Size: I agree, Tim.

John Gale: Yes, I would too. This is John.

Daniel Coll: And this is Dan Coll, I agree as well, that's a common source of errors.

Karen Johnson: OK. Let's go to the next one. We're getting through. And if you guys have push back on the integrated delivery system and health plan let me know. But I think it's the safe way to go in terms of saying that this we want to be able to implement measures in the way that they've been specified and tested.

But we also realize and you guys can certainly let us know if you are suggesting recommending that certain ones that you really like going back to what you said before. I highly encourage those to be tested and other levels of analysis so they can be used.

So, screening, we have four measures of screening. And unfortunately three of those that people liked quite a bit are, again, at the health plan and integrated delivery system levels of analysis. So, again, that means that they have not been tested and shown to work at hospital level or at a clinic level, clinician level. And that really gets to the idea of reliability, you know. And it's related to low volume problem.

Male: I find that very unfortunate. I wonder exceptions could be made in this case. It just philosophically seems difficult to me to be saying we're defining quality metrics or rural outpatient medicine and not including cancer screening.

Karen Johnson: Thoughts from other people? I mean, this is where the rubber meets the road so you could certainly include it in your core set with the understanding that it has not been tested in that – at that level. And I can certainly go back and check and make sure that we haven't mess this up. But …

Tim Size: Well, Karen, how big barriers is testing, are we talking six months or three years or?

Karen Johnson: It's really not so much time. It's more what the developers themselves are interested in doing. So, some of these measures are probably developed by people who are often times looking at health plan assessed measurement.

Tim Size: I guess, given our charge, I'm uncomfortable with having metrics in it that we really couldn't immediately proceed to implement.

Karen Johnson: Yes. I mean …

Tim Size: (Inaudible) charge.

Karen Johnson: … to be honest with you, sometimes people use measures in ways that they have not been specified and test before. And NQF certainly does not recommend that. We try to warn against that. But it is done. So …

Ira Moscovice: So, this is Ira. I guess where I'm coming from on this, I understand where you're coming from Karen. Having said that, if we want to, perhaps, push things then for people to learn from the set of measures we develop for rural, the hospital and the ambulatory side providers, I won't be upset if we had a couple of measures that clearly indicated they were tested for integrated delivery systems to make sure that this is being done at some point of the process. But we don't have as many integrated delivery systems in rural areas.

And so, I think, there is a case to say we need to adopt this. I think in fact, I hope if we develop these measures set that we have some sort of field testing after this to see if you can really collect these measures. And are they a problem so forth and so forth. So, to me, that's a logical next step after we develop the measures to get them used.

And if for instance, we wanted to eventually get all these measures, the set of measures endorsed by NQF, I hadn't really thought about all this, but we need to have some kind of field test to see, can you really do this. So, in some sense – we don't want a ton of measures of like that, but I guess the first person comments about – gee, it does seem like we're missing the boat here if we don't do anything. I'm not sure we want to go with all three measures. We can talk about that. But it seems a bit that we're losing something. And I think we just need to put the right caveats in there.

Cheryl Powell: Yes, this Cheryl. I think I agree and we actually have some success on a duals workgroup in getting the measure stewards to go back and look at things and make them more inclusive by putting the measure on our list, but indicating that there were improvements that were needed.

For example, the breast cancer screening and, I think, the colorectal cancer screening. There was a time were only specified for 65 and above because

they were focused on Medicare population. But the stewards themselves based on the comments from the committee went back. And as you can see, actually, changed the specifications because we were highlighting the fact that there are lot of Medicare beneficiaries that are under age 65 and they were excluded and that was a problem with the measure.

So, I think for something that as critically important as cancer screening, it maybe worth it for us to highlight that as so critically important. We put that on the list. And hope that it promotes future development and testing in other levels and for other setting.

Julie Sonier: This is Julie, I'll (inaudible) that we've been doing – we've been publishing at the clinic location level, the cervical cancer screening, colorectal cancer screening, the breast cancer screening in Minnesota for many years, state wide.

Akin Demehin: Yes. And this is Akin. I guess I have a question for the NQF staff about the filtering process for these measures. I wasn't as closely following this at the time. But my first reaction when I thought this particular measures was I'm really surprised that there aren't many – any measures of these that are not specified at the clinician level.

Where we looking only at NQF endorse measures, because there's a part of me that wonders if measures like this specified at the clinician level may have been NQF endorsed at one time? And for whatever reason are no longer. Do you have a sense of whether that might be the case?

Karen Johnson: Great question, Akin. We're really just going off what our database is telling us in terms of how it was tested in. And yes, we did limit only to NQF endorsed measures.

Akin Demehin: OK.

Karen Johnson: These typical ones, I don't think were ever looked at a different level of analysis. All of this developer sometimes does do clinician level and going back to Julie's comment, Julie, did you say all three of those cervical,

colorectal, and breast cancer screening you've done at a clinician level and feel comfortable with that?

Julie Sonier: We don't do any at clinician level, it's a clinic location level is the lowest that we go.

Karen Johnson: OK, clinic level, OK. OK, for all three of them?

Julie Sonier: Yes.

Karen Johnson: OK. So that could be kind of that bridge, really what Ira is suggesting for a few, some critically important. And there is at least some experience from the group that it does work in these other places.

Akin Demehin: Well, it makes me wonder if maybe there's a little bit of a bridging strategy that one could suggest here. I mean I happen to agree that using measures at the level at which they've been tested is a really, really important thing to make sure that what you're actually getting is reliable and accurate.

But kind of like, one of the other measures we talked about earlier, if these are specified at the health plan level, it makes me wonder how hard it would be for somebody like CMS to run it on their own data set and provide hospitals with reports. So that's – or clinician offices with reports I guess would be more appropriate in this case.

Knowing that more testing would need to happen in order to actually make this accountability measures but at least making sure that people have an awareness of what these measures look like in their population. I don't know how easy or hard that would be for CMS to do, but it might be a way of bridging the gap here.

Karen Johnson: Yes, it's tricky and to be honest with you, I don't have in front of me who the developers are. So it may not even be CMS team, but I'm not sure.

Female: NCQA.

Karen Johnson: Yes, the NCQA yes.

(Shelley Carter): And you have to remember, this is (Shelley) with (HCSC) with NCQA. These measurements here are sample measurements, so it's not total population and it would be collective for the health plan for the entire areas. They cover not specifically to rule. So there would have to be a lot of teasing out data.

Akin Demehin: That's important.

(Shelley Carter): It's not to say that you can't tease out the data. It's just it's not an automatic.

Akin Demehin: Yes, yes, sounds complicated here.

Karen Johnson: So maybe going back, what's the consensus about 0421, keep or not keep?

Akin Demehin: Keep.

Karen Johnson: OK. The next three level of analysis isn't quite right. They're all important though. We could make an exception or two for Ira's suggestion trying to limit that. That also being very clear. If we did that, would you want all three of them, just one of them, what do you think?

Tim Size: Well, again, I think we have to pay attention to the high number of no votes for 2372.

Mark Greenwood: I agree. I'd love to see that colon cancer on there, biggest gap in terms of potential lives that could be saved and we need cancer screening as part of our assessment of quality.

Karen Johnson: So stick with colorectal, not the others.

Mark Greenwood: That would be my proposal.

Akin Demehin: So this is Akin. Others may feel a little differently about this than I do but the notion of exceptions does make me a little nervous because I suspect that we could make that same argument about a variety of other measures and areas where we know how important it is. And just aren't able to measure it in the way that we should be able to yet.

It makes me a little nervous to move in to the space of letting some measures in that just it may not really be right for prime time yet. So I would urge some caution as important as I think addressing these topics is.

Ira Moscovice: This is Ira. The only thing I would push back on that, I hear you but we just heard from Julie Sonier saying they're collecting this at the clinic levels and doing it successfully over multiple years. So we do have some evidence that at least for these measures if not the other ones that they can – this could – it looks like you can collect them.

Mark Greenwood: I believe most of us collect them at clinic or – yes, clinic and provider level already.

Tim Size: Yes, I mean – this is Tim, I hate to say this but I mean I think – I mean I just feel we're going back and forth with some inconsistency, so to get a solution that we kind of want but our very first screen was NQF approved and if the level of analysis is wrong, it's for our purposes and the charge is committed, it's not NQF approved. So I'd be much more comfortable having this in part of a narrative that says there's important work need to be done in the following areas. But I think when we start mixing and matching in our primary core, we're sending the mix message.

Karen Johnson: Sure. I think what we have here is consensus that these are important, but probably our measure isn't quite what we need. Let us work on the staff side to see how we might be able to show this, maybe it is a – just a different way of reflecting like you were saying Tim as part of the narrative or maybe a second table that has measures that would have been in the core if the level of analysis have been right, something along those lines and see how that looks.

Mark Greenwood: I can live with that.

Karen Johnson: Let's talk immunization. I think we might be halfway through, I'm not sure. So kind of at the same problem with immunization in terms of the childhood immunization status, everybody love that measure, it's not quite at the right level of analysis. So does anybody I guess have any personal experience of applying it at a lower level of analysis in clinic? And then what do you think

about the other measures? Looks like most of them are – a couple for flu and then adolescent.

Aaron Garman: This is Aaron. We do report out our childhood immunization status to our state registry all of the time and get graded on it at a clinic level.

Crystal Barter: This is Crystal in Michigan. We can echo that sentiment for the clinics that we work with at the state level.

David Schmitz: This is David Schmitz with the American …

Julie Sonier: This is Julie in Minnesota, we do childhood immunization and the immunization for adolescents at the clinic level state wide.

David Schmitz: David Schmitz, American Academy of Family Physicians. We had some difficulties with this in Idaho at least when I was in that state because immunizations were being provided at settings other than – and especially in rural areas and settings other than the primary care office. They were being provided at district health offices and numerous intermittent statewide purchasing of immunizations which actually reduced the available stock of childhood immunizations and certain provider settings. And also the legislature had repealed, legislation regarding a state registry. So in some states there can be difficulties in reporting a particularly rural settings.

Karen Johnson: So this is Karen. Julie, how hard and if it's way too hard or extensive or whatever, feel free to say so, but do you think it would be possible for you guys to run some data from Minnesota at the clinic level for some of these this – demonstrate maybe a reliability and validity, would that be …

Julie Sonier: Well, let me talk to staff before I commit to that. But we've – so, like in – so for the childhood immunization and the adolescent immunization, the way that we're doing that is that health plans are running the data on our behalf and then we're aggregating it so – and you get much more reliable results at the clinic level. But there is also a way in which the data from the state immunization registry comes in to it as well. So the combination of data source that I'd be happy to facilitate that conversation with staff, so that you

guys can understand exactly what we're doing and to address that question of feasibility.

Karen Johnson: OK. So is there a flavor of – we've got a couple of options for flu vaccine, do you like those, any of those? And David, you talked about immunizations overall. I didn't get the impression you were talking specifically about flu immunizations but maybe I was incorrect.

David Schmitz: No, that's correct. I just want to give some caution with regards to the –the registries are not universally accessible information in each state. But no, I – (Caroline) support these measures.

Mark Greenwood: It looks like pretty good consensus for the first three.

(Shelley Carter): This is (Shelley) with (HCSC). And I have one issue with 41 and the fact that in many rural areas, pharmacies provide influenza vaccine which is a great thing, but I don't know that it is reported or where to report it.

Mark Greenwood: Can you tell how pharmacies to report to the registry?

(Inaudible)

David Schmitz: … in states – in states again without registry, I think it's going to be more difficult. You'd have to get that secondarily entered into your record from a oral history or some sort of referral – referred history from the pharmacy.

Karen Johnson: And we at NQF can look at this a little more closely and see if patient report pharmacy immunization count. It might. I'd have to look more closely the specs at this. I'm sorry, I don't remember.

I noticed we're getting very close to time. We still have many more pages to get through. Let's see how many we can get through in the next 10 minutes. This may or may not be fairly simple, probably not.

The next one is experience with care, so these are all hospital level, the first one is the hospital CAHPS, the second is the adult and child clinician CAHPS, and then the third is the child hospital CAHPS. So I guess the concern there of course is extra step, it is a patient reported outcomes and the survey had to

(fielded), there's cost associated with that. I think with the two pieces of especially about the child hospital CAHPS, the concern there might be low volume for sure since it's not too many kids are hospitalized.

Madison Jung: And this is Madison. Maybe a way to frame or looking at this is do you have strong feelings of agreement with what the vote is on the slide or strong feelings of disagreement. I just want to put out the caveat, but again this is not our final iteration of the core set. We do have time to revise. So with the time we have, maybe just getting out the strong feelings either way might help speed things along.

Akin Demehin: So this is Akin Demehin and I – so I don't have any objection to HCAHPS or CG-CAHPS being a part of the list at this point. But I do have a caveat in particular for the HCAHPS. I guess the thing that would worry me the most about this measure is the data collection and just how much resource it takes to actually collect these data.

I would also worry a little bit about the facilities against which rural and critical access hospitals would be benchmarked, because you need to have a certain number of complete surveys to get reliable data that makes me a little nervous to compare HCAHPS results of larger volume and smaller volume hospital side by side because I'm not sure you're entirely comparing apples to oranges.

And the last thing and this is more of a long standing gripe of ours with how the surveys implemented, but I think would really behoove CMS to address if we are going to move in a direction of measuring in rural areas, but the only two ways to get data on these measures is by telephone and by mail and I think in the 21st century we really need to start looking at electronically enabled surveys done via e-mail, done via apps. That would actually help address some of the sample side issues that we sometimes see with HCAHPS. But again, no objection to it being on there, just some worries about how it actually gets implemented.

Ira Moscovice: Yes. This is Ira. Those were terrific comments. The only thing I would add is without introducing any bias, we know from experience that for those

facilities that at least that are provided, are responding to HCAHPS. This is one measure where rural facilities really do look better compared to most any of the comparison group you want to compare them with.

And so, I've always felt it was really foolish for rural facilities not to participate in this and – but we know that there are large number of rural hospitals for sure that don't participate in HCAHPS and it's due to the cost and et cetera, et cetera. And so I think the suggestion that was just made should really enter our report in terms of moving CMS to electronic data collection on this type of measure and that really would I think help improve response rate et cetera, et cetera. And make it a hell of a lot easier to feel.

Karen Johnson: How about the clinician and group CAHP, CG-CAHPS in general, yes? Anybody object to that one?

Akin Demehin: No objection on my end. The one thing I will note about the CG-CAHPS survey, at least how it's been implemented in the MIPS program and prior to that, the PQRS program, it is long. And so, it may be worth a review of the survey instrument in implementing this to make sure that we're really asking just the questions that we need here.

Karen Johnson: OK. Child hospital CAHPS, yes, no? OK, let's go to the next one, cost and resource use. We have two, both of them are clinician level, clinician group. One is total cost of care, the other is total resource use, so kind of getting at both flavors, and a wide variation here, cost is important, it's come up in the past, but we don't have a lot to choose from. Do we want both, do we want neither, can you pick one?

Mark Greenwood: I have concerns about both having done cost of care work, the data collection is cumbersome, its often and accurate, attribution is difficult. I think we could be – do more good in other areas, not that this isn't important, but I'm not sure it's feasible and meaningful and actionable.

Julie Sonier: This is Julie. One thing I'll note and I do like the idea of having a cost measure here. One thing that I'll note and we do this in Minnesota statewide is that for rural providers especially if they're not part of an integrated system, there's a lot of part – there's a lot of the cost that they don't control. And then

– and they can tend to look highest cost if there's like less availability of things like urgent care clinics, fewer alternative to an emergency department in a rural area.

Cheryl Powell: Yes, this is Cheryl. I like the idea of a cost measure, but I don't like the reality of the cost measures. I think it maybe one of those aspirational that we would like to see something in the future, and give a time for measures to become more meaningful and actionable and then when there's something potentially in the future, it would be included within the list. But I just feel uncomfortable about the quality measure related to cost with where we are with those measures right now.

Karen Johnson: OK. And this is Karen. Just a reminder those two cost measures are based of claims data, so that might be another reason that we might not be quite ready to use this. Yes, for rural, let's do – let's do it one more.

Daniel Coll: This is Dan …

Karen Johnson: Oh, go ahead.

Daniel Coll: Sorry, this is Dan Coll. The other concern about rural facilities is the difference with method to billing and how they'll appear on the cost centers. And a lot of them don't necessarily have access to a GPO or other group purchasing. So their supply chain cost can be significantly higher. I definitely share some of the other callers concern about how that will reflect on the provider and how you can attribute the provider and separate provider cost versus healthcare organizational costs with rural healthcare.

And the provider may look more expensive just based on their organization's ability to cost control on their supply side as well. So I think it is a great aspirational one, as one caller said, I think it's important, but it's also one that's very difficult at this point for smaller organizations to adjust nearly as much as a larger organizations then to have access to GPOs or their own distributorships.

Karen Johnson: Thank you. Let's do one more and I dare say, it won't be easy but let's try to get it in right before we do public comments. We have three measures that

look at diabetes. So the first one, the poor control is the health plan integrated system measure. That one had a lot of support but again, not quite the right levels of analysis.

The second one is the hospital level measure. And then the third one is a composite measures and all or none composite measure. That looks things like blood pressure control and blood glucose control when submitting status, I think a couple of other things from there.

Mark Greenwood: So 0729 is basically a diabetic bundle, if you will?

Karen Johnson: Yes. I used to k now what the components were and I won't put Julie on the spot to tell us what they are, but I think there is five different components in there and you have to do them all to get credit for the measure.

Mark Greenwood: I would voice support for measure 0729.

Crystal Barter: This is Crystal Barter in Michigan and we would second that support for 0729.

Karen Johnson: OK. Any conversation about the poor control measure? Again, level of analysis is not quite right for what we're looking for, but maybe it's important enough to think about in some other way. And as now you think on that one and then other one is hypoglycemia in the hospital, (let's say).

Akin Demehin: Karen, this is Akin. I think I would probably tilt a little bit more towards 0729 than 0059 because of the level of analysis issue. The glycemic control measure, there was a lot of conversation about this one at the Hospital MAP Workgroup when it appeared on the list last year or the year before. And I think there are some pretty significant data collection challenges that maybe associated with this particular measure. It has not been implemented or even proposed at this point for the hospital IQR program.

So scalability with something like this does give me some pause. Not that glycemic control isn't an important issue, it's more – is this one really ready to go?

Karen Johnson: Thanks, Akin.

Cheryl Powell: And this is Cheryl. I would highlight my support of the three would be also for 0729.

Karen Johnson: OK. Well, we didn't do as well as I'd hope, but we got through several things. We'll confirm with Aaron and Ira a little bit right after a call. And again how we can get through the rest of our measures. It might be a very quick turn around for you guys maybe by tomorrow or something like that just to get some feedback. And we'll also be working with you on the prioritization piece.

On the bright side, a lot of what you've talked about has actually given us some things to write up and think about and discuss in our gaps section, because what you're – sometimes we think about gaps, is we don't had any measure at all for this thing. When in reality, the gap might be – we don't quite have the right level of analysis or it's not quite a patient population that we're looking for that sort of thing.

So let me hand it back to you, Kate, who will take us through comment and next steps, et cetera.

Kate Buchanan: So we are now open the lines up for public comment. (Bridget), if you wouldn't mind opening up and hold for 20 seconds. Additionally, if you have public comments that they would like to chat via chat box, type via chat box, please do so, and staff will read them.

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

And you do a public comment from (Sandy Pagones).

Kate Buchanan: Excellent.

(Sandy Pagones): Yes, hi, this is (Sandy Pagones). I'm with the American Academy Family Physicians. And I do want to make just a couple of comments on some of the slides – we, at the AAFP, you do promote use of the core clinical, the core measures of collaborative measures set. And I just wanted to bring to the

attention on slide 22 within the core measures, measure number 710 and 1885, the depression remission at 12 months and progress toward remission have been in – have been identified as part of the core measure collaborative. So that's a little bit different than the direction the committee went with as far as the six-month measure.

Also I wanted to mention that for the screenings that are used, the cervical cancer, colorectal cancer and breasts cancer screenings, I think the real issue here even though they are part of the core measure collaborative, the real issue is that clinics aren't or individual's physicians aren't able to get the data. And so that results and either spending in an or – not amount of time chasing reports from specialist or being satisfied with the lower score on the measures.

And I think that's why those measures have been introduced at the health plan level or integrated system delivery level is because it's more of the chance that they have an integrated data system, so the physician's don't have to waste their time trying to chase down some reports.

I also wanted to mention that the CG-CAHP and HCAHPS, those surveys have to be done by a certified survey vendor. It can't be done by individual facilities. So that is where the costs of that does coming in.

And then finally, just on the most recent measure that we looked at for – I'm sorry diabetes, we traditionally opposed all or none measures such as 729 optimal diabetes care and that's because we feel that physicians do need to get credit for what they do. The components of that measure include A1c screening less than 8, blood pressure, less than 140 over 90, statin use and daily aspirin if the patient has (ISV). But they also include that the patient is tobacco free. And we just feel that that particular component of that measure is really outside of the control of the physician and so tobacco users are automatically going to get a zero for that measure. And we don't really just feel that so – their way of measuring as physician work. So thank you.

Kate Buchanan: Thank you very much, (Sandy), for your public comment. We really appreciate the information. Are there additional public comment?

Operator: We have no further public comments at this time.

Kate Buchanan: Great. So I'm going to turn over to Madison to quick, quick next steps.

Madison Jung: Only three, just a more in-depth look at our timeline in terms of the next few months. The next webinar – or the report will be due as I've said before on February 28th, we'll correspond with you to get those last items. We'll debrief as a team and decide what the next best immediate steps are. But in terms of the report, it's due at the end of the month. The next webinar we have will be at the end of March and then the webinar after that will be at the end of April 25th and Webinar Five in March I said before will be going more in-depth into the measuring topic area and getting some hopefully initial recommendation from you. Webinar Six, we'll finalize these recommendations and I said at the beginning of the meeting, Draft Report Two will be a combination of Draft Report one and the feedback from those two webinars.

As always, there's our contact information, you can reach us maprural@qualityforum.org or reach us at our website or our committee SharePoint sites for your workgroup members. Other than that, thank you very much for your time today. We really appreciate all the thoughtful contributions you've made.

Anything else from my fellow staff, Ira, Aaron, any last words from you?

Aaron Garman: Thanks for the hard work.

Ira Moscovice: No. Sounds good.

Madison Jung: Great. All right. Well, thank you, everyone. Have a great day.

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