NATIONAL QUALITY FORUM

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Suzanne Theberge: Good afternoon everyone and welcome to the MAP Rural Health Workgroup Webinar, what we're calling Webinar 4.5. We appreciate you joining us today on short notice and this last minute addition to our schedule. So next slide please.

What we have on the agenda today is just finishing the discussion from our last webinar in February. We're going to through the remaining topic areas on the core set and discuss which measures the workgroup would like to include, so we've got about 35 measures in 10 topic areas to consider.

We have decided to make a slight change to the process and try to make things run a little more smoothly this time. What we are thinking is that we've asked everyone who RSVP to the meeting to act as a lead discussant. And what that means is that, it's modeled after something that we do in our CDP meetings or our measure evaluation meetings and we'll just ask those lead discussants to kind of kick off the discussion of each batch of measures and provide some initial thoughts if you'd like to do so. And if not, we'll just turn it right over to the group to discuss. So we're hoping that might – make things run a little better and just kind of kick start the discussion for each topic.

So basically, we're just going to do a quick roll call and then we'll get started on the topic of today's meeting, so next slide.

Brief reminder, this is your project team Karen Johnson, myself, I'm Suzanne Theberge, Kate Buchanan and Madison Jung. And then next slide, we're going to do the workgroup roll call and is there – if there is somebody here from each organization please let us know that you're here.

We know that Aaron Garman, our co-chair, is not here but Ira?

Ira Moscovice: Hello. It's Ira Moscovice.

Suzanne Theberge: Thank you. OK, do we have someone from the Alliant Health Solutions? American Academy of Family Physicians?

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

Suzanne Theberge: Thank you. American Academy of PAs?

Daniel Coll: This is Daniel Coll with the American Academy of Physician Assistance.

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

Steve Jameson: This is Steve Jameson with American College of Emergency Physicians. I'll just be on the phone today. I don't have internet access, I'm sorry.

Suzanne Theberge: OK, thanks for letting us know. American Hospital Association?

Stephen Tahta: Yes, Stephen Tahta.

Suzanne Theberge: Thank you. Geisinger Health? Health Care Service Corporation? Intermountain Healthcare?

Mark Greenwood: Yes, Mark Greenwood.

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

Crystal Barter: Good afternoon, Crystal Barter is here.

Suzanne Theberge: Thank you. Minnesota Community Measurement? National Association of Rural Health Clinics? National Center for Frontier Communities?

National Council for Behavioral Health? National Rural Health Association? National Rural Letter Carriers' Association?

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

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

Marcia Ward: Hi, Marcia Ward taking the place of Keith Meuller today.

Suzanne Theberge: Thank you. Rural Wisconsin Health Cooperative?

Tim Size: Good afternoon, Tim Size.

Suzanne Theberge: Thank you. And Truven Health Analytics?

Cheryl Powell: Yes, hello. Cheryl Powell is here.

Suzanne Theberge: Great thank you. And next slide, I just want to do the roll call for our individual subject matter experts and our federal liaisons. John Gale?

Female: He is on the line and dialing in right now.

Suzanne Theberge: Great, thanks. Curtis Lowery? Melinda Murphy?

Melinda Murphy: Yes.

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

And our federal liaisons. Susan Anthony? Craig Caplan?

Craig Caplan: Hi, this is Craig.

Suzanne Theberge: Thank you. And Juliana Sadovich, all right. And did anyone joined while I was doing the roll call and missed to introduce themselves?

John Gale: Yes, this is John Gale. I'm sorry I was on hold with the operator waiting for the call.

Suzanne Theberge: Great, thanks for letting us know, anyone else?

Shelley Carter: This is Shelley Carter, and I was also on hold with the operator.

Kate Buchanan: And Suzanne, this is Kate from NQF. Kimberly Rask is currently also dialing and so she's here, And Bill Finerfrock for the National Association for Rural Health Clinics is dialing in so he will be here. So we have two more people.

Suzanne Theberge: Fantastic. Thanks. Go ahead.

Susan Wilger: Susan Wilger with National Center – Susan Wilger with National Center for Frontier Communities, I was also on hold. Trying to dial in.

Suzanne Theberge: Thank you everyone for joining us today especially on quite short notice. And with that, I will turn it over to Karen and Ira to begin our discussion today.

Kate Buchanan: And this is Kate. Just a friendly reminded, if you are not speaking to please put your phone on mute we are getting some background noise. Thank you.

Karen Johnson: And thank you, Kate and Suzanne, and workgroup members. Again, thanks from me for joining us on our 4.5 webinar. We really appreciate your flexibility in coming together to try to finish the work that we started last month, but weren't able to finish.

So just to reorient everyone to the work, we're in a middle of trying to come to consensus on some measures that we think should be included in our draft core set. We have organized the various measures that we are considering according to condition or topic area and the last time we were together we made it through on about half of our topics, so still have a ways to go.

And we put things – we put some information on the slides to give you a flavor of some of the feedback that we have gotten about the measures. So on the slide here, readmission is the first grouping that we'll cover today and what you see there in the percent yes, nos and maybes were based on a survey, I think it was a SurveyMonkey that we had people do.

And basically, the idea is, you know, those of you who are responding, do you think it's definitely should be, definitely should not be or perhaps should be in

the core set and there – it turned out that there wasn't, for the most of the measures, there wasn't overall consensus very much at all, so a lot of kind of variation across people's opinions there.

So we're showing that as well as several other major things came through in the qualitative feedback, so we wanted to at least reflect in general some of the feedback that came through. So for example in the readmission measures that you see here, the feedback on that SurveyMonkey was these may be problematic in terms of low case volume.

So what we'll do and we're just kind of go through these as Suzanne mentioned were we've asked for lead discussants, so that all I think be helpful. And the other thing that I'll be doing is just reminding folks of level of analysis and that sort of thing.

So for the readmission measures, those as you can see there were two of them that people wanted to consider. Both of them potentially have issues regarding low case volume, both of them would be looking and honing hospitals accountable.

The other piece of information that I'll give that we didn't put on the slide, but it came through when we talked to the various MAP workgroups which we did back and I think in December. I think we told you guys that we were doing this. We basically went to the other MAP workgroups and the coordinating committee and said, "Hey, we exist. This is what we're doing." And trying to give them a flavor of the work that you're doing, and then also tried to ask them, you know, do they have any input or advice for you guys as you're doing your work and most of the conversation in those different meetings was somewhat general.

It's interesting pretty general. For the readmission measures, there was one very concrete piece of feedback for you. And I don't remember which workgroup it came from, but it was a reminder that the way these readmission measure generally are constructed, they often basically do this statistical thing where – when you have small volume providers, the expected value or the

value that shown in the measure, can't take on what looks a little bit more like the average.

So it's a statistical thing that's happening, but it takes into account, volume. So again, it's kind of another way of saying these may not if you have low volume hospitals, these measures may not allow as much differentiation as you might (thought).

So with that – and Kate has something she wants to interject. So, Kate, go ahead.

Kate Buchanan: Yes. So thank you so much for that contact setting, Karen.

I just wanted to remind everyone, participating that the attached to the outlook invite are resources to help with the discussion including the supplement A, which has draft core set, which has more detail about each of these measures. Additionally, we think that it would be sort of reference for supplement C or supplement B which has some of the comments from workgroup members based on their feedback, so this is were going through this conversation.

And as Suzanne said earlier, you know, we are trying this lead discussant thing, we didn't get confirmations from everyone that they would be, you know, wanting to present. So what we're doing is for just saying, you know, here's we have – we thought you may be a good lead discussant if there are any opinions you would like to start off to open the conversation, please feel free to do so. If not, let's open it up to the whole group, that this is kind of a new way we're trying it.

And, Kimberly Rask, I know that you were trying to get on the – I know you're on hold for a little while. I don't know if you've been able to join us. And if you have …

Kimberly Rask: I have.

Kate Buchanan: Oh wonderful. And I didn't know if you wanted to open with any thoughts or if you wanted to kind of just have the group start to discuss.

Kimberly Rask: Sure. Well, I'm happy to share so I did take a look at both of the readmission measures. And I think what I would note is, you can see from the percentages, the split and the yes, maybe, no as is on the slide. And taking a look at the comments, they're appeared to be more concerns about low volume relative to the pediatric, all condition readmission rate.

One that I thought was very well-articulated is, pediatric hospitalizations are rare and readmissions even rarer. I'm not a pediatric specialist but I thought that was an important point, and then raising the concerns about low volume for critical access and rural hospitals.

In terms of the Hospital-Wide All-Cause Unplanned and Readmission, there was always one comment about sample size. It look like the – I think the other common has said, no coma claims measure. I think meant that they have no concerns about it. That's how I interpreted that.

A few thoughts, the Hospital-Wide All-Cause Measure – Readmission Measure is currently being used for acute care hospitals. It reflects 65 and older fee-for-service Medicare from the previous rural group. We had often talked about the importance or the value of having rural hospitals have a time to have a ramp but be able to, be moving towards some of the same accountability measures at acute care hospitals we're currently participating in. And on that rationale, the 1789 hospital-wide all-cause would a comparable measure to what acute care hospitals are reporting. So those are my thoughts.

Suzanne Theberge: And Ira is going to walk us through facilitating the discussion about the measures. So, Ira, I'm handing off to you.

Ira Moscovice: OK. I think Kimberly gave a good summary of the comments. And so, the floor is open for those on the line to add some comments to this.

Marcia Ward: This is Marcia. I'd say the low volume of the pediatric would be a big concern in rural.

Ira Moscovice: Other comments?

Mark Greenwood: Mark, I tend to agree.

Ira Moscovice: Any other thoughts?

Tim Size: Ira, this is Tim.

Ira Moscovice: Hi, Tim.

Tim Size: I guess, I mean, the low volume is somewhat of a concern to me even with this one. And I think it's because my hesitancy about the degree of control of small rural hospitals is going to have and some of the positive resources that they face, and that those things kind of come together in my mind.

I'd be curious to hear from others why even though the pediatrics seems more intuitive, has more nos, it also has more yeses where some distributions, this response is quite different. And so, a third of our group was saying only maybe for this one. So I would like to hear more about that.

Kimberly Rask: This is Kimberly. One thing I'll say is, for both of them, there were 11 responses for the pediatric and 10 responses for the hospital-wide, if that influences.

The other thing I would add is, if in the – thinking about how on the acute care measures – I'm sorry, the acute care readmission measures, they are now being required to stratify readmission rates for example, by (tertile) or how many dual eligibles are in the hospital as a measure of socioeconomic disparities.

And I wondered about something similar with this, if you had a measure like the hospital-wide all-cause unplanned readmission measure, but if it was being used stratified where rural hospitals are being compared to rural hospitals, would that help address some of the differences in terms of environment.

Tim Size: But then, it would further complicate the low volume issue, right, that stratification wouldn't it?

Ira Moscovice: So this is Ira. I can tell you for sure the numbers just aren't there for the pediatric all-condition measure. I'm not saying it's not an important measure but we simply don't have the volume. And that's from ourselves and others who have looked at that issue.

On the all-cause, we certainly can't afford to stratify anything. And so, I don't know for the previous comment, Kimberly, if you were saying, is there really stratification or if you basically "trying to risk adjust in some way."

Kimberly Rask: Not really. I guess what I was trying to say is that, if it were being used to compare, it's still (inaudible) being use. If the rates are being compared to other rural hospitals, could it be of information, could there be value in that.

David Schmitz: This is David Schmitz from the American Academy of Family Physicians. I'll make a couple comments regarding the pediatric all-condition versus hospital-wide.

I think there – I really valued Tim's comment about the hospital resources. I'll give you a couple examples. Some rural hospitals I'm aware of may have, for example, the resources around the physician treating a pediatric patient. Many pediatric patients however might have exhausting respiratory demands, specifically respiratory illness, so respiratory therapy resources can become an issue if there's only one or one-and-a-half FTE for a whole hospital.

I've also encourage hospitals that have nursing limited resources with regard to caring for either obstetric or pediatric patient, and I've seen that be an indication for patient transfer.

The other is that, for example, some pediatric conditions may cause more frequent readmissions so chronic asthma, other pediatric conditions and/or a referral to a tertiary center. And so, they don't have the same sort of resources at rural facilities.

And the last would be, as a family physician, I can say these kids are on the brink of being really sick, so (proximal) access to a pediatric intensive care units, sometimes again, where pediatric patients are admitted, rural versus not.

So those are some of the distinctions around hospital-wide versus pediatric admission decisions.

Ira Moscovice: Any other comments on this one?

Tim Size: Ira, this is Tim again. It is (decent) either or, do we have to have a readmission metric in our mix?

Ira Moscovice: No. I think we're going to, you know, we're voting separately on each of the individual measures. So, I don't think anybody is to be determined that we have that one. I think the point that was made though which is that, this is an important measure for acute da-da-da. Do we want to enable that comparisons between (CHs) and other hospitals comes into play?

OK. Karen, are you ready to move on?

Karen Johnson: I guess I'm hearing a definite no on pediatrics. I guess I'm still not sure kind of what people are thinking about hospital-wide. Is it in general – a yes or are is there enough concerns to not want to include the hospital-wide in the core set? And Ira, maybe you got a better take than I did with the measurements.

Ira Moscovice: Well, there were discussion on both sides of it.

Tim Size: Ira, what I was trying to say, I mean, 30 percent yes is not an arousing response if that's actually what the group thinks as a whole.

Ira Moscovice: No, absolutely. I'm just wondering if anybody remembers if they put in the maybe category, maybe want to speak up.

Daniel Coll: This is Dan Coll with the American Academy of Physician Assistants. I do think it's a beneficial look on the all admissions. The pediatrics, I would agree with all the other speakers. Their challenges also with what provider resources are available is that patient being treated by family practice, pediatrics, who are the special if they're available to care for those patients. But for all-cause hospital readmission, personally, I feel there is some benefit to compare ourselves across the board to other facilities but that's just (my sense).

Ira Moscovice: Any other comments? You know, my sense, Karen, is that this measure in general has some value we're hearing but we have some concerns still – related to both of volume and when you want to call it risk adjustment or the rural context in terms of (trying) to patients, and the availability of resources. And so from my perspective, have we done just yes or nos or do we have maybes still in there as a decision?

Karen Johnson: We've got a few maybes that are still kind of outstanding. And I think we will have to have those results. We probably can't get to those completely today. I think we'll probably resolve this on our very last call with the group.

Ira Moscovice: I might put this in that category and do we – I'm hearing a good rationale for why we need to think twice before we put this measure on the list but I'd put it in the maybe category now and come back to it after we have all …

Karen Johnson: OK. And we are going to be sending this list out for public comment so maybe particularly on the maybes, might be a place where we really invite public comment to see what people are thinking.

Ira Moscovice: OK.

Karen Johnson: Yes. OK. Next group, Perinatal.

So, four measures that come under that one, the only one had pretty high level of yeses and that original set a feedback that we have. And just to be clear, the reason that we are putting that information out but not really, really emphasizing the numbers is that there were only 10 or 11 responses of the people who were able to feedback. So, you know, these numbers reflect about the feelings at the time of the back half of the grid. So, still useful but probably not a complete picture of what people might like.

And the last three measures on the list, the level of analysis in hospital. So, in terms of what we'd be looking for, we would be looking for potentially these measures. The first measure at the top level of analysis is facility health plan and population. So nothing there on our list that would look at the ambulatory side of the house. So everything is from the hospital side.

And there were concerns for the feedback about the low volume in the last three. With that and the – there was some concerns on the first one about unintended consequences for the contraceptive care measure from the rural perspective. And I don't recall exactly what the – if there was a lot of detail from the feedback about what that was. But that was something that came up then.

And I think our lead discussant is not – wasn't able to make the call. So, I think with that, I'm just going to hand it back over to Ira to facilitate the discussion of these measures.

Ira Moscovice: OK. So in the perinatal area, we have four measures that we're talking about. One, got a lot of yeses, the other three got a mixed respond, comments on any of these measures. Why don't we do one by one and I restart 2903, might be a little bit more organize. On the Contraceptive Care Measure, comments from the group?

So it looks like yes to me, is anybody want to speak up against it being included at this point? OK. So that's one a yes. On the next three got pretty much similar comments back from the group, and the votes are a little bit more positive for the elective delivery but the volume issue came in certainly. So, comments on any of these three measures? Elective Delivery Cesarean or use of steroid?

David Schmitz: Ira, this is David Schmitz with the American Academy of Family Physicians. I'm going to just take the three with the same rationale.

I've often thought cesarean birth rate would be higher in rural facilities, because of reasonable management of a labor may involve looking at your resources, such availability of neonatal intensive care unit or other resuscitative resources typically for the newborn.

And so, I thought rates would be higher, I often find they are not. But it does concern me that you just don't have the sort of back up resources during a labor and I do obstetrics for example during a labor in a rural area. So I'm not excited about cesarean. I'm at least happy about cesarean birth.

When regard to elective delivery. I have the same concern regarding unintended consequences. I am aware of some hospital facilities that sometimes are able to deliver and other portions of a week for example do not have the resources and divert their obstetrical services even in one instance, a couple of hours distance frankly.

So, there may – it maybe more reasonable to consider what would typically be considered a non-medical induction for delivery in certain settings, although we try to avoid that for premature deliveries risk, of course, where in other settings or more urban settings, it wouldn't be driven by the resources that are available only intermittently. And then didn't see that problem with antenatal steroids so I thought that that might be an indicator that would be OK.

Ira Moscovice: OK. Other comments on these three measures?

Daniel Coll: Dan Coll again, AAPA. Just back to the prior comments on what resources are available. It would also be interesting that this measure could be able to – one of the concerns is who are the providers? And in the situations that are leading to these results are – is it obstetrician, is it family practices, is it a certified nurse midwife and how do we stratify the – what resources are available of these facilities which are leading to their elective delivery rate or a C-section rates in there transfer for those services.

So I just – I definitely have that concern with the measures the least the way they read to me is how you stratify who's providing it and therefore what level of providers yield in those results?

To differentiate, we have OBs at our facility but at a local hospital, we have – they only practice managing on the deliveries and a general surgeon doing the C-sections in one of the rural communities in the mountains to the north of us.

And so, it is a differentiator, not everyone is aware of those structures in the urban setting, you just don't see that any longer. And so, to compare us with other benchmarks or to other obstetrical services might not be apples to apples or orange to orange. So thank you.

Ira Moscovice: OK. Are there comments on these perinatal measures?

Mark Greenwood: This is Mark Greenwood, Intermountain. I appreciate those comments, although I guess I'm just still not understanding why these different staffing discrepancies would justify premature elective deliveries. It seems that's the best practice that we should structure our care around of these three. I like that one the best. It seems like we should include that something obstetric in our metrics.

Ira Moscovice: And so, you know, I should mention in the comment, I would suggest that if we were going to have OB measures in here, we probably, of these PCO-01, 02 and 03, we probably most want to have one of those. And I think that's reasonable even though we have a limited number of measures we're going to have in the set.

I'm hearing a little bit that if we we're going to include one of the measures elected delivery, hold in terms of the votes and the comments seem a little bit, a more positive reaction. But – any final thoughts on this?

Cheryl Powell: This is Cheryl Powell from Truven and I would agree. I think of the three, the elective delivery certainly, the one that we would want to put forward. And I think it's an important measure for the set.

Kimberly Rask: And this is Kimberly. I agree and I also like that it's, again, parallels, a measure that you're seeing in acute care hospitals.

Stephen Tahta: And this Stephen Tahta from the American Hospital Association. I would support that as well.

Ira Moscovice: And, you know, we just need to remember that the substantial number of cause don't do OB work at all. And so, they wouldn't be measured on these measures.

Karen Johnson: And this is Karen from NQF. And I want to publicize my ignorance honestly on anything to do with deliveries. But the three in the measure descriptions, the measure assisted patients with elective vaginal deliveries or elective C-section deliveries at – between 37 and 39 weeks of gestation. Just going back to the comments about kind of early delivery, I don't think this is the measure

that gets to the early delivery. So, I just want to make sure that everybody – unless I'm just completely wrong, the 37 to 39 weeks, does somebody? I'm sure somebody know any better than I do, is that early? Is that kind of a normal?

David Schmitz: So, this David Schmitz with the American Academy of Family Physicians, and I'm not putting my medical license out there, but I do obstetrics, delivered a baby last weekend.

So, yes, so, this is the point. So, if you have somebody who is 38.5 weeks by what we call good dating, so first trimester or early ultrasound, which gives you the greatest confidence interval about the preparedness for the newborn to do well outside of mom. And they're not diabetic because that will cause respiratory system immaturity, and there's not other risk factors, it maybe very reasonable to do "elective induction" which would be differentiated from a medical induction. A medical induction is when, there is like say a maternal complication that wants – make you want to deliver the baby early.

So, if mom had preeclampsia or some other diagnosis or if you had intrauterine growth retardation or a reason for a baby to come out early, that's a medical induction. So, we're not talking about that.

So, elective isn't necessarily that mom, you know, wants the baby out before the tax year expires or something, although we sometime see that in medicine. So, my point is that, there may be no reason that it would be – that the mom wants an elective delivery, but there's a hospital I'm aware of, for example, that has an OBGYN in town about half the time.

The other time, the other situation and, again, this hospital is very remote. So, if you say, "No, you're not allowed to that." She's probably going to have the baby, if it's her fourth baby and she's got a history of prior complication, let's say a shoulder dystocia or something. She's probably going to have the baby in the emergency room of that the same hospital because she's not going to make it to an urban center and a helicopter can't get there fast enough either.

So, these are very rare but there are situations where perhaps it would be very reasonable for that patient to be delivered electively when the OBYGN or C-

section capable person is in town at 38.5 weeks. So, that's the ethics of the situation for me. I'll admit it's probably unusual.

And if there are other people who know more about OB, I'm happy to have them comment to that type of scenario. And if you want to pass this measure you can, I just want to let you know that there will be a small unintended consequences potentially. Hopefully, nobody will ever make that decision, they'll just do the right thing for the patient and violate the measure.

Stephen Tahta: Does anybody in the group know what the percent of critical access hospitals that do not do any of obstetrics at all?

David Schmitz: I can tell you, I did a study. This is David Schmitz of American Academy of Family Physicians. I did a study looking at hospitals in Idaho a number of years ago. And the number of physicians was about 50 percent during vaginal deliveries and about 30 percent doing C-section that was family docs in rural counties, but I don't – maybe the hospital association can comment.

Stephen Tahta: Well, that's me. But, you know, I'm in Montana and I can tell you that most of the critical access hospitals I worked with do with obstetrics. You're right, you know, not everyone on the medical staff, but most of the hospitals do deliver baby.

Ira Moscovice: This is Ira. I believe it's about – it's close 40 percent that don't.

Stephen Tahta: That don't?

David Schmitz: OK.

Ira Moscovice: Yes.

Karen Johnson: So this is Karen. I think I'm hearing at least right now that people are still pretty happy with the elective delivery measure.

Male: Yes.

Ira Moscovice: Yes. I think the last two are nos, elective delivery is a yes. I think the only question is, as David pointed out, is it's not a comment occurrence. So, the sample size is going to be small here.

Karen Johnson: OK.

Ira Moscovice: OK? So, you want to move on the Pediatrics, Karen?

Karen Johnson: Yes, so pediatrics, sorry I was writing notes. So, pediatrics, we have four available to us. The Weight Assessment one, the first one, and the Well-Child Visits in the First 15 months, those are both level of analysis, health plan and integrated delivery system. From our discussion, the last time, I think we had decided that unless a measure had a level of analysis at the clinician group or individual level, or hospital level that it would not be appropriate for inclusion in the core set at least at this time.

Now, there was a discussion on that. And we also talked about maybe potentially having a very few measures that did have levels of analysis. And, you know, even though, they don't quite meet what we're looking at for. So, I just wanted to remind you that we've tended to not want those measures, but pretty vocal group that kind of thought maybe it will be OK for a small number.

With that, there were concerns about potential data collection problems for the well-child visits. I think mainly because of people maybe coming in and out of catchment area. Also concerned about potential topped-out-ness, it's not a word but you know what I mean, for the late assessment measures.

So, with that, I'll hand it back to Ira for discussion.

Kate Buchanan: And we actually – and, David, I don't know if you would want it to open it up as the lead discussant …

Karen Johnson: Thank you.

Kate Buchanan: Or if you want to just open it straight to the group?

Karen Johnson: Sorry, David.

David Schmitz: Not particularly, no.

Kate Buchanan: OK, great. So let's just open to the group now.

Tim Size: Hi, this is …

Marcia Ward: This is Marcia from RUPRI. And we've been looking at the first measure as applicable in school-based health clinics and it's a measure that's been endorsed by their national association. And it says topped out but since this measure now is recommended measure that includes three components, I'm doubting that it's topped out since now it concludes three different aspects to it.

I think maybe a topped out want to included just weight assessment or one of those. So, anyway, to endorse measure by that group and so I would support it.

Tim Size: This is Tim. I have question and it goes back for this – the issue of the level of analysis being the health plan integrated delivery system. And I like some of those metrics and I – it seems to me dependent on our – how we frame our recommendation, if we're seeing a recommendation going forward at something of a portfolio that people can choose from, then it make sense to have these measures if you're in an area where (inaudible), we're just a strong health plan that you're working with, it's going to fit.

But if we're conceptualizing these as being mandatory across the board, then they don't fit as well. And I forget if we discuss that those two options or is that not yet decided?

Karen Johnson: This is Karen from NQF. I feel like that's not decided. We're kind of talking about core measures but we're talking about that outside of any particular program. And so, you know, CMS could decide to use these, you know, across the board and existing programs or they may create some kind of program from scratch and would potentially use these.

I think the idea of core set was that, you know, measures with – would be used across the board and to be able to compare providers, you know, definitely rural. And also, you know, are they reasonable for, you know, non-rural providers as well.

So I think the jury is out on the actual use and what would happen there. I think the, you know, I know that some of the measures that people like the best were the ones that have the health plan and integrated system level of analysis which kind of put us in a tough spot. What do we do with those?

And we could, you know, one thing that we could do is highlight, you know, if we stick with it and say, you know, they haven't been specified and tested for these other levels of analysis that were particularly interested in, you know, and point that out, you know, that might spur a little bit of potential work on the measures to make them specified and tested for those areas. So it's kind of unknown what would happen. So I don't know if I completely answered your question but …

Tim Size: Yes. And I did – so just means we need an asterisks on the asterisks?

Karen Johnson: You're probably right. Yes. So the way that we – we have conceptualize it so far is that the – it seems like maybe a few more people, they're not wanted to not include those kinds of measure. A few people wanted to include them with an asterisk saying, you know, we realize that they're really not tested in specified in the way that we would, you know, theoretically be using them and, you know, that's a caveat, a major caveat in the measures.

Cheryl Powell: This is Cheryl from Truven. I'm wondering if we couldn't have a section of recommended health plan measures just, you know, in addition to our other – I don't see what the harm with me I guess in saying, for health plans that operate in rural areas, these are measures that we would recommend when it fits the circumstances. And I think that – and not only provide those entities something to look at but then also provide direction to CMS on – and others on where development might be helpful, you know, these are great measures.

We think they work really well in a – at a health plan level and it may spur a little more innovation in that world. And it would also be great if there were other levels of analysis really too, but it might be helpful even I think of it that way.

Shelley Carter: This is Shelley from HCSC, Health Care Service Corporation. And I just want to say that when we're looking at these measures, I look at them as a HEDIS measure. HEDIS is collected by health plans for their total population. It's not segregated for rural or urban. So when they collect the measures.

So I understand the desire to identify health plan measures but it would be very, very difficult for health plan to specially in large states like Montana and New Mexico and even in Texas to say, OK, part of our – the majority of our state is rural, part of it is there have been – but we've really want to look at the HEDIS measures from a rural standpoint. You would have a huge mix of population in there.

So, I'm concerned about the use of this type of it. I like the data. There's no question about whether I like it or not. It's great data but it does it meet the rural health needs, I'm not sure.

Ira Moscovice: So we have some comments on both sides of the issue with the health plan measures. Anybody else want to chime in on that? Any other comments on any of the pediatrics measures at this point?

So, at least from the comments and everything else, I mean, from the SurveyMonkey, 1516 I think is a no and the data collection issue over that longer period is what people were suggesting.

And, Karen, we're going to need to make a decision on sort of the health plan issue. You're free to decide to ahead whether they do like the comment that you could be either – couple of measures could be set aside into discussion to talk about the importance of things at the health plan levels. But recognizing for instance, the constraints that the last commenter made about, well, 10 health plans, you know, separate these out.

And my response is if there's an incentive to do it, they'll do it. It's not that they can't do it, it's just that they – there's no reason for them to do it right now. And so it's a little tricky. I think on the – my sense in this group, I mean, because we're not going to take too many from pediatrics in the sample size issue still exist for some of these measures.

What I'm seeing as, you know, is that the weight assessment one is the one we might seriously consider. And the other two underneath of the asthma and well-child visits, best there in the maybe category, and unless someone really speaks up for including it or someone speaks up for not including it at all. But I think the weight assessment probably the more likely candidate from this group. Any comments from the group or others about that?

Karen, are you comfortable with including the weight assessment measure in this in describing the health plan issue?

Karen Johnson: I think probably what we would do is it doesn't seem – it doesn't seem quite right to include this one as a definite yes. If we don't do some of the other ones that we discussed the last time around. So I think maybe there needs to be either something along the lines of what Cheryl was suggesting or maybe some thing a little bit maybe along the lines of we really like this measure but we know it doesn't have the quite right level of analysis and be consistent.

There were a couple of cancer screening measures and I think an immunization measure that's kind of the same kind of thing. So it would – I think it was seem odd to have this. This is a definite yes. So, however, we classify those other ones, it feels like this is how we would classify this one as well.

Ira Moscovice: Yes. I think having a separate category is a good idea and the issue is that we still need to think through after this call, how do we exactly want to categorize, this is what you're saying?

Karen Johnson: Yes, yes.

Ira Moscovice: OK. And I would put – I would put notes on the other three there unless there's argument against that. OK, I know we move on to Palliative Care.

Karen Johnson: OK. So for palliative care we have three measures. So this one we don't have a problem with levels of analysis, so Advance Care Plan and the Pain Assessment and Follow-Up, both are ambulatory measures so can be used by clinicians, and then Treatment Preferences measure is a facility level measure that can be used both in hospital palliative care programs as well as hospice.

There was a little bit of concern about the potential unintended consequences for the pain measure. I think that gets to the idea of some concern about a risk of opioids and with that would use of that measure in rural areas exacerbate that problem I think that was the question.

So with that, Ira, I'm handing back to you.

Oh and I'm sorry, I keep forgetting we have this lovely lead discussant and I keep forgetting to ask for a lead discussant. So it's Crystal. Did you want to start us off or did you want to just bat it to the full group?

Crystal Barter: Oh, thank you very much. I appreciate the nice summary so I didn't have to do that.

All I would say in terms of comment is that, I think that these are really great measures when it comes of end of life care. And when we think about our rural population and the demographics of them, we really need to consider at least one measure in this group.

And I guess, we're just going off of opinions and some research we did at the state level. It seems like 0326 would have the most relevance when it comes to the work that we're trying to accomplish in this workgroup, when we think of crosscutting resistant to low volume, and then addressing transitions and care. So that would be my opinion.

Ira Moscovice: OK. And yes, and I should mention the comments that came back from the original survey, sort of followed up on that and said, you know, they weren't quite sure if we should put the measure like this in our first "limited set", which suggest that if we're going to choose one of the measure of palliative

care, we'll just choose one of these I don't think we want to – we have the space for multiple one.

So I'll open it up and see if people agree with Crystal just – her comments on the advance care plan, as being the one we should push forward. Thoughts, reaction?

Tim Size: This is Tim, representing net demographics, and what I think is new standard of care and somewhat of an advantage in Wisconsin because it's been an emphasis at (Inaudible) in the State Medical Associations. So I do think, yes, (been there).

Ira Moscovice: Other comments? OK. What I would propose as what Crystal suggest which is we include the advanced care plan and don't include the other two.

Male: Sounds good.

Ira Moscovice: All right, Karen.

Karen Johnson: Sounds great, thank you.

Ira Moscovice: And let's move on to Patient Safety and Falls.

Karen Johnson: And before we do that we did have a – just a comment from our CMS colleagues and we want to make sure that I didn't lead anybody astray when – in reply to Tim's earlier question about how these core sets will be used and I'll just read directly from the comment.

The workgroup make sure – the workgroup measures, CMS will review the final report that we're going – that will come out of this work, and seek comments from across the agency on next step. So this has to do, you know, how theses measures might be used in various programs.

And also that CMS sees these core sets as critical elements for consideration in CMS programs. If CMS knows that these measures are critical for rural providers, this will weigh into the decision for potential use. So hopefully that's clear, and if you have any questions, we can go into that a little bit more maybe at the end of the call.

So now patient safety, so we had the three options, the first one is screening risk assessment and plan of care, so that's a clinician level process measure, a few concerns about whether it is topped out or whether it could really – would that really actually affect outcomes. Other two are actually outcome measures and both of those are – both the clinician and facility level of analysis.

And for this one, Marcia, I don't know if you wanted to provide any comments on this before we kind of push it off to the group.

Marcia Ward: Yes. The main comments from the group were that the bottom two were redundant. And there is clearly a favorite in terms of falls with injury and I would endorse that. And looking at this during little research I was surprised to find out that 30 percent of impatient falls result in injury. And obviously, that can have caused morbidity, mortality and everything associated with it.

The nice thing about this measure is their outcome measures, and I think we're probably a little shorter on outcome measures than process measures. And so given the redundancy in the topic, I would definitely support the falls with injury over the just plain fall rate.

In contrast to that, the top one didn't receive as many yes votes. It is a process measure, the bottom one is mostly in patient based, the top one is broader than that. And so if we were looking for measures that were – if we were top heavy on impatient measures for example and looking to balance that out, we might keep that inconsideration, but I don't know where we stand on that. So that's just a note.

Ira Moscovice: And why don't we open up to the group then. Comments on the four measures and the patient safety measure, and the thought are if we're going to include one from this group which one will we include?

Daniel Coll: This is Dan Coll. Fall with injury is definitely my preference to the group, thank you.

Kimberly Rask: This is Kimberly, I agree.

Cheryl Powell: This is Cheryl, I agree as well.

Ira Moscovice: All right. Any other thoughts from folks on not agreeing with the falls with injury?

So what we're going to suggest is, Karen, that the falls with the injury be the measure here that gets included.

Karen Johnson: Great.

Ira Moscovice: OK.

Karen Johnson: All right, going to more patient safety measure.

Ira Moscovice: Right.

Karen Johnson: I'm sorry, Ira, did you have something else or? OK.

The Patient Safety Measure, the first four of these are – I believe these are all hospital level measures. Somehow another I think I've lost that. The last one is clinician level of analysis.

All of them I think there were potential concerns about low volume in rural areas. And let's see Cheryl, you were topped to discus these. Do you have anything you'd like to pull out about these measures?

Cheryl Powell: I have struggled to come up with a positive thing to pull out, about how the team feels (in my view). And, I mean, I feel like the first four really are – it would be very difficult for these particular measures to get around the low volume issues. And I think it would be helpful if anybody, you know, has ideas for whether the low volume issue on any of those four is really a non-issue. Is there anyway to mitigate that low volume issue?

And then on the last one, I liked the concept that it – with across a variety of conditions which I think is something that many of the measures focus on a specific thing and we've heard in previous conversations it would be great to have something that works across.

I think, though, with that, it was a heavy lift for the team as far as the burden and that likely burden – and at that level of folks – that it looks at is at the clinician level. I think those are the two things that they were struggle.

So it looks like from what we have, really we would not recommend including any of this. But if anybody I think feel strongly about including any of this or ways to get around some of those challenges that were brought up that would be particularly helpful.

Ira Moscovice: That's good set of comments. Let open it to the group. Any response …

Melinda Murphy: Sorry, it's Melinda, Melinda Murphy, a couple of comments. So first one about the VTE measure, I kept looking at why the discussion was around low volume when the measure looks at patient who have received prophylaxis or who had documentation why no prophylaxis was given. And that is applies to both medical and surgical inpatients, though, there are some exclusions.

So I guess I am trying to respond to the commenters remarks about how to get around low volume, because if this is a measure that opposed to essentially every one in the hospital, I'm struggling with why it's low volume. That's my comment to that VTE measure.

The other one is about, boldly about the National Healthcare Safety Network measures. And my understanding is that many or maybe all of these measures are required reporting, and that is – there is any difference in what the NHSN requires and what the measure requires that you might have additional or different kind of data collection for one versus the other that could be problematic. Those are my comments.

Ira Moscovice: Anybody in the group want to address the VTE volume issue?

Kimberly Rask: This is Kimberly. I really kind of agree with remark. I mean, it should be generally applicable to anyone who is hospitalized. So I'm not sure. If this one appears to be less prone to low volume, I think that many of the other one we've looked at.

And then secondly, the NHSN antimicrobial use measure. I'm trying to look up the specifics on that certain – many of these NHSN measures are now being reported out of nursing homes as well as hospitals. So, you know, it does feel like this is a kind of thing that rural providers are likely to be expected to be accountable on the events may not be so rare as to make it unable to be reported.

Ira Moscovice: Other comments from the group?

Marcia Ward: This is Marcia Ward with RUPRI. And as I'm reading the measure for the first one, I agree if it's including all in-patients. We shouldn't have horrible problems with volume. I'm familiar with the fourth one, 0531, and it is a whole bundle of postsurgical complications. But it's in-patient surgeries and in critical access hospitals that's a pretty low number. So I think we do a volume issues for that one.

Ira Moscovice: Other comments? What I'm hearing is there's some support for 371 for the VTE prophylaxis. And I haven't heard large support for any of the other measures.

Male: I agree.

Ira Moscovice: So unless we hear otherwise, why don't we say yes to 371 and then no for the rest. OK?

Male: Agreed.

Ira Moscovice: Okeydoke.

Karen Johnson: OK.

Ira Moscovice: So now we move on to, Karen, Healthcare Associated Infections.

Karen Johnson: Yes, and I think we're doing pretty well on time. I'm getting a thumb's up from Kate. Healthcare Associated Infections, so we have four of them. These are all hospital level measures. And I think the question was mainly or the concern mainly was potential low volume. And it looks like one was pretty well supported in our initial feedback, but not so much the other one.

So we had, Cameron, would you like to make any comments on these measures or would you prefer just to hand it off to the group?

Cameron Deml: Yes, sure. No, I'll make a couple of comments. And I think you can – you hit on (bigger), and the biggest one on all four of the measures that looked at in the comments was that low volume issue and just kind of how that would shake out. You know, another concern as well, looking at each of those is, you know, the potential further additional resources to be able to measure that.

On the flip side, as we're kind of heard in the last comment and in the comments with each of these measures, they were saying that there's already plan of experience with acute care hospitals and nursing home reporting. So, while low volume might be an issue, you know, there may not be that additional resource needs because this is already, you know, prevalent. That it's already being measured, you know, for all four measures.

So, you know, certainly good comments there, by no means in my down at this level as far as being a provider. So, you know, certainly, if there's somebody who has more experience here, you know, certainly in time in. But kind of overwhelmingly and overwhelmingly with an asterisks, that first one on the list, 1717, you know, had just about all yeses, you know, one maybe and zero for nos. The other three were little murkier, you know, kind of going down the list with that last one.

Seeing more maybes than nos than anything. So those are kind of the general comments, you know, as far as if we'd be happy to, you know, or for force to decide on one, I think it's a bit obvious to go with that 1717. Probably to do is kind of the relevancy and the work that we have to do. I feel that that one is a little more broad based and maybe a little more applicable, you know, for what we're trying to get done.

But like I said, I'm certainly not at the provider level, so if anyone who has experience that wants to comment, it is all yours.

Ira Moscovice: So I'm hearing the support for 1717 and not for the other measures in this group. Anybody want to speak up with a different opinion.

Kimberly Rask: Hey, this is Kimberly. I would say two points. One is that the way this NHSN measures are reported, they are a ratio of actual to expected and they do report them. You have to have a minimum of having had an expected rate of one infection. So where I would be concern about is not so much to low volume as whether or not if they're really such a very, very low rate of events, then you're not going to be able to discriminate between providers very easily if that's your purpose.

But just reporting, it bothers me a little less than some of the other measures. And then, also to go with that, then I would say the first two are the – while the – although 1717 was rated more popularly, 0138, CAUTIs, are probably a more common event of any of those infections would be the most common one. I believe in a hospital settings, so that one would have the more volume than the others. And so I would consider that those first two could be candidates.

Ira Moscovice: OK.

Male: I would agree with that.

David Schmitz: I agree. This is David Schmitz. I will just say that, I think both of the 1716 and 0139 would have low volume issues and also represent generally a sicker patient set. And so which might be less frequently found in rural, so more supportive of either the first two.

Ira Moscovice: So we have a suggestion of including both CAUTI and CDI here. The people – other people's thought about (recently) suggested, you know, the 90 percent one, 1717, do we want – thoughts on including both? Other thoughts on it, 1717 and 0138?

Daniel Coll: This is Dan Coll. I support those two of the four.

Crystal Barter: This is Crystal from Michigan. I do as well.

Mark Greenwood: Mark Greenwood, Intermountain, I do as well.

Ira Moscovice: OK. So we're hearing, Karen, let's put 1717, 0138 in the set and the other twos are no, OK?

Karen Johnson: All right. Next set. Emergency Department Timing.

We had three measures for those and these are all of course ED measures. I think part of the concern was potential unintended consequences and a little bit, and I think that kind of arises from the, you know, this is somehow another rural going to be treated unfairly if they are compared to non-rural providers. And also I've guess some concern about, you know, will these really effect patient outcomes at the end of the day?

Also, some concern about risk adjustment for the first one that, that didn't seem to come through on the other two measures. And David, we have you down as our lead discussant, do you feel comfortable taking it from there?

David Schmitz: Definitely. So I think when we look at – when we look at decisions of the metric tier that are in place, you can see that there's quite a spread with regard to both the yeses and nos, and so I think I'll just open it for open ended discussion. Thank you.

Ira Moscovice: OK. So the floor is open and, you know, just remember that, you know, we're talking 10 people responding so you have like four in each group or so, in terms of yeses and no's and so – but it's split. Suggestion from the groups about do we want to include any of these and if we do want to include the time measures in the emergency department. Is there anyone that's standout as a better measure?

Marcia Ward: This is Marcia from RUPRI. And I just don't think these are real important for rural. I think they are important for overcrowded urban. But somebody with more clinical expertise could certainly counter that.

Stephen Tahta: Yes. This is Stephen Tahta and I would definitely agree with that. I mean, as a physician that works with multiple critical access hospitals as well as PPS hospitals in Montana, I question the value of these, you know, based on the volumes that I've seen out of the ED.

Ira Moscovice: Other comments?

David Schmitz: In this – this is David Schmitz. I didn't want to lead with this, but it's just one person's opinion and also representing at this time that American Academy of Family Physicians. I also think there could be significant unattended consequences with regard to this including admit decision time, so I'm not excited about this.

Ira Moscovice: Overall, I'm hearing the committee say that we weren't going to include any of these three measures, 0495 through 0497. Anybody not comfortable with that?

Tim Size: I agree with what you said, Ira. This is Tim.

Ira Moscovice: OK. So, Karen, will put this in the no bucket for now. We'll go onto Post-Procedure Outcomes.

Karen Johnson: All right. Post-Procedure Outcomes. So, this one has a lot of check marks across the board, so I think maybe some concerns for all three of these. These are all hospital measures make sense if we put it in post-procedure outcomes. And it looks like low volume is potentially a real concern for two of the three, but then risk adjustment across the board and still concern about whether this would really affect the outcomes.

So, Cheryl, would you like to last speak about these measures?

Cheryl Powell: Sure. I think you've covered it so well I'm not sure if there's much more for me to add at this point. But I think, again, the questions for this is, is do we want to include one at all or given that we have such a low. I think that the rates for approval range from 50 – about 55 percent down to in the 30s for the yeses, and have some pretty strong nos. So if there wasn't not as far as neutral and a couple of you.

So, some of the concerns also related to, you know, does this meet our priority. So I think for the discussion, it's really – is an important for us to include one of these three and if so, which one? And then do this meets are

priorities and do this seems to be something that would be meaningful. I think that's pretty much all I would all add.

Ira Moscovice: OK. Let's open it up to the group for discussion. Do we want to include any of these? If so, which one would you focus on?

Kimberly Rask: This is Kimberly. I don't like any of them.

Ira Moscovice: OK.

Kimberly Rask: I'm just being direct, I'm not …

Ira Moscovice: That's all we want. We want to get through this by 4:00, so we got 40 minutes left. We're doing great.

Cheryl Powell: This is Cheryl. From reading the comments and the responses, I would say that a lot of people feel just like that but may not have wanted to say it like that. So I think that's where we are with this one.

Tim Size: I'd agree.

Male: Yes, agreed.

Ira Moscovice: OK.

(Inaudible)

Ira Moscovice: So it's a no for all of these, OK. Karen?

Male: Agreed.

Karen Johnson: Wow. You guys …

Male: Thank you, Kim.

Karen Johnson: We're getting faster as we go. Now, the next slide is that wonderful Other (summary).

So these were the ones that we had left. You'll see that one of them is high blood pressure. That one is another one of those where the level of analysis is not clinician or facility. So if we did pick this one, it would probably go in that other category yet to be determined what we would call that one.

Discharge on statin medication, both of those high blood pressure statin medication, I think getting through the idea of the chronic conditions that sometimes maybe higher in rural areas. The same for heart failure, the third one and actually for strokes, so all of them has to do really with those condition specific things that people thought might be helpful, you know, include but not so much cross cutting.

So in a couple of cases, low volume might be a question, lack of risk adjustment for the controlling high blood pressure and potential unintended consequences. And there's also clinicians on the line, will know that there's some controversy right now on guidelines for high blood pressure. So I'm not sure how much that should or shouldn't come into your discussions.

I'll leave it at that and our lead discussant was not able to attend today's call. So I'll hand it over to Ira to facilitate these measures.

Ira Moscovice: OK. Let's open it up for the four measures. It looks like controlling high blood pressure in a strong yes vote. How do people feel – my sense would be given everything that we've include control in high blood pressure but not the others, but were open for discussion, comments.

Kimberly Rask: This is Kimberly. One thing, I think we've put that high blood pressure, we'd have to either – we're facing that issue about the health plan level of analysis again. So, either of those two get put there or I would somehow have to address that.

Ira Moscovice: Yes. And that group of measures of that, they're going in pot, seems to be growing. And so I think the NQF staff need to – well, need to carefully think through exactly how we're going to posture this if we include these measures. Clearly, a lot of measures at the health plan level and integrate delivery system level resonated with the group.

Tim Size: This is Tim. This is Tim. I just would agree obviously. It's an interesting, we're learning from this process that in fact the way we look at quality, and the way we look at metrics, maybe needs to be update a little bit. And maybe it's the issue that we're beginning to understand that kind of no island onto itself and we need to look at quality in different way, I mean, that's kind of my takeaway.

Mark Greenwood: So this Mark from Intermountain. I agree with those comments. I'm just curious why the oppositions for you that are opposed to that CT or the brain imaging for possible stroke. I've worked a lot of rural ER, that's a fairly common scenario that people come in with possible stroke and rapid imaging is the best practice. It should be done and encourage.

I'm curious, the opposition to that measure, is it concern about lack of availability for imaging in some facilities.

Ira Moscovice: Anybody from the group want to respond?

Kimberly Rask: This is Kimberly. I actually didn't – now that you discuss it that way that does sound like it maybe an event that's common enough. I think when I was looking at it before, I was thinking about it as of more in terms of the specific is – does someone – does this measure require someone who've had a stroke to answer the measure. I guess maybe that's the way I have been interpreting it as opposed to being speed of a diagnostic testing done.

Mark Greenwood: My intuition of it is that it's the speed of the imaging that's being measured obviously because of the, you know, the limited thrombolytic time window if it comes back, you know, if indeed they're having a stroke.

David Schmitz: And this David Schmitz, American Academy of Family Physicians. It reads MRI scan results who received so my understanding is that this is not door to imaging, this is imaging the result. I could be misreading that. But regardless, I think most rural facilities these days have a pack system and are getting quick reads. And if you're, you know, so I don't have a big objection to the measure. I'm OK with it.

We should probably clarify the measure before we agree on it or disagree on it though.

Ira Moscovice: I think that's a good comment. I mean, my interpretation was I think a low volume related to the number of cases for a specific diagnosis. But what I'm hearing people say is, yes for the high blood pressure and no for 0439 and 2455. And we need to get a little bit more information, Karen, about what this measure exactly is before we should do a final yes or no.

Karen Johnson: Yes. I'm waiting on the denominator statement for that measure. It's number of emergency department acute ischemic stroke or hemorrhagic stroke patients arriving at the ED within two hours of the time last known well with an order for a head CT or MRI scan. So, I would interpret that as it's people who actually were diagnosed with stroke or either type of stroke. And then the numerator …

David Schmitz: (Inaudible) …

Karen Johnson: I'm sorry. The numerator, the order from – basically, you're looking at time from ED arrival to interpretation of head scan. So, it's when somebody comes in the door to interpretation of scan for the numerator.

David Schmitz: So this is David Schmitz. So there'd be two components of that. Obviously, getting the scan done and getting it red which are two separate process points.

While I've got the floor, I also just say, I am not adverse to 0439. And the question was do guidelines change that change both with regard to blood pressure stats and other things too. So, I'm not opposed to 0018 or 0439 just to clarify from the clinical standpoint.

Ira Moscovice: Other comments on the group on 0018, 0439 or 0661?

Daniel Coll: This is Dan. I definitely support 0018 that quite – it sounds like we need some clarification on supporting 0661 or understanding before otherwise that from – in discussion, I would support it but I need to make sure we're all talking the same about what the expectation is on that one.

Karen Johnson: So, this is Karen. What exactly can I clarify for you?

Daniel Coll: Yes. So …

Karen Johnson: So I know what to look for, yes.

Daniel Coll: So from the previous discussion, I'm sorry. I lost the responses there but the question was from door to arrival to scan, and then from scan to interpretation. It says, interpretation, scan interpretation within 45 minutes. And I'm sorry if I miss that but it is definitely very separate. The door to actual imaging and the imaging to interpretation, which allows treatment within the window of optimal time, could you clarify that or with this – (with the) …

Karen Johnson: Yes. Let me read out the numerator statement. Number of ED – acute ischemic or hemorrhagic stroke patients arriving at the ED within two hours of last time known well, with an order for a head CT or MRI scan just time from ED arrival to interpretation of the scan is within 45 minutes of arrival. So …

Daniel Coll: OK.

Karen Johnson: So, yes, it's …

Daniel Coll: So (wrapping) these two processes.

Karen Johnson: Yes. It's two processes and right – yes. Yes.

Daniel Coll: OK.

Karen Johnson: And the way that I interpret the dominator and I am pretty sure I'm correct because I think these are used – I think these are mostly claims data. People could come in and maybe who don't have a stroke but I think this would be calculated for people who actually have a discharge diagnosis of stroke.

Daniel Coll: It did sound like confirmed stroke, not suspected stroke could be the denominator.

Karen Johnson: Yes.

Ira Moscovice: Yes.

Daniel Coll: Yes. So it would eliminate – it would definitely drop the volume significant – potentially, significantly as well for rural facilities if it's only for actual confirm stroke versus the evaluation of stroke, OK?

Male: Correct. Although obviously, the ones who had the stroke or the ones who already mattered that they got it, and there would certainly be a way to message or encourage or drive that best practice.

Daniel Coll: I guess maybe the rural emergency room physicians and family practice can comment more on, that would be helpful for me.

David Schmitz: This is David Schmitz. Yes. So, I'm not sure. I know how many hospitals have teleradiology reads and I don't know what time the other end of that contracted – typically contracted service. So for example, some will use a radiologist in Australia who will read in the middle of the night. Some will read, utilize the radiologist who might be in their same state care in the United States but has to get out of bed and read it from their homes.

So, the variability of teleradiology services to rural hospitals is one-half of this two-step process. So, I'm more excited about 0018 and 0439. I don't know that there's many family physicians who are reading their own CTs or MRI, and then administering ischemic stroke medications without a radiologist read but there might be – I don't know.

Daniel Coll: Right.

David Schmitz: I think with their own interpretation, they're in the ER of the CT films themselves without a radiologist or neurologist over read the interpreted as interpretation and build that way, I doubt it.

Daniel Coll: Right. I know in our rural area that at night, our ER plain films are read by the staff which can vary from family practice to emergency room. But the CTs, they have remotely over read which could exactly as you said, be very

far away or could be local or we may call a radiologist at home if we don't like our night scan service. And that's when to over read even the NightHawk Services.

So, I definitely – I'd say, I agree with you. I'm more excited about 0018 and less about 0661 in a rural application. Thank you.

Ira Moscovice: So it sounds like removing away from 0661 being on the list. David brought up, he has mentioned 0439 as being relevant. Any other comments in 0439? Any support putting that on list?

OK. What I'm hearing then is definitely putting in 0018 and I'm not hearing substantial support for any of the other three measures. You OK with that, Karen?

Karen Johnson: Yes. And this is Karen. Just a couple things, kudos to Madison for pointing out the 0439, the discharge on statin medication, I think this will underscore your decision here. That is meant for stroke patient. So that isn't really come through in the measure title as well, but it is one of the stroke measures from the Joint Commission. So there is that.

Also just Curtis had actually joined us he just isn't on the phone, but he did wanted us to make sure that for our 0661 that telemedicine can make this possible even in rural areas. So – and his statement is, it is not low volume, it's important telemedicine, makes it essential and can be done with support. So I'm not sure if that – I think you guys talked a little bit about telemedicine already, we wanted to make sure that Curtis' comment was heard by the group.

Ira Moscovice: OK. I want to move on to Diabetes, OK. Karen, you want to take the lead on this one to start?

Karen Johnson: Yes. So diabetes, really quick right here, we have already taken care of this one in the last webinar. However, one of our HRSA colleagues actually had pointed out and it turns out that we had a bit of a database problem with 0059. So to remind everybody of these three measures here, the optimal diabetes

care measure was the one that was selected by the group to – for potential inclusion in the core set.

And the poor control measure was possibly looked at scans because we thought that that one was health plan integrated system level of analysis, not clinician. Turns out it is clinician, so it is I think back on the table for you guys, we wanted to make that correction. And then based on that, did you want to consider including that in the core set?

So I'm not sure if I stated that very well or not, but last time around we didn't think that clinician was one of the levels of analysis, it actually is so does that change anybody's opinion about whether this one should be included in the core set?

Ira Moscovice: So what we have here is the original decision was 0729 was in and the others weren't. Based on what Karen said, any reactions, any changes in consideration?

Male: Can you remind us what 0729 was measuring?

Karen Johnson: Yes. And, (Julie), is not on to remind me. It is an all or none measure that looks at – that I think there were five components in there, oh and Madison has it up, let's see if I can remember what they are.

One is blood pressure control. The other one is blood glucose control. Third one is tobacco use and that component is the most controversial component of it. I believe aspirin use and what's the fifth one, I always forget that fifth one. It is – So yes, we had blood glucose, blood pressure control, statin use, so statin use is the other one.

So let me say it again, blood pressure control, blood glucose control, statin use, aspirin use and then finally tobacco use. Again, the tobacco use one actually was a subject of one of our commenters last time around, that one is – it's basically not – counseling about tobacco it is if somebody has tobaccos then if the patient is a tobacco user then the provider does not make that measure, it's a pretty strict measure.

Mark Greenwood: This is Mark of Intermountain. In general, I love the concept of the bundle to define diabetes care. Admittedly, I don't really like that bundle primarily because smoking in the aspirin, is there either a different bundle we could choose from or we stuck with these options in which case I guess I'd lean towards narrowing to the glycemic control.

Ira Moscovice: Other comments?

Karen Johnson: And this would be clear with the bundle – we don't have another diabetes bundle so the bundle is what it is. It is a measure that used quite a bit, I don't remember if it used in federal programs at this point. That one might have been when that was up for consideration this year I think, but I might be confusing it with another. And apologies if I am.

The middle one …

Female: Yes. There are Medicaid programs that use it.

Karen Johnson: More than 60?

Female: I'm sorry. I said there are Medicaid programs that use it.

Karen Johnson: Oh I'm sorry, I misunderstood what you said. In the state of Minnesota uses it, I think statewide.

Ira Moscovice: Yes.

Karen Johnson: Yes.

Ira Moscovice: Other comments about 0729 or the other two measures?

Kimberly Rask: This is Kimberly. I am a fan of 0729. I'm not a fan 2363. I think some of the concerns in older folks and stuff – and I do like 0059.

Ira Moscovice: Comments?

John Gale: This is …

Female: And I agree with Kimberly.

John Gale: This is John Gale, and I agree with the first and third.

Male: Same here.

Female: Agree.

Tim Size: Same here. It's Tim.

Ira Moscovice: So we're hearing that we want to include two measures for diabetes 0059 and 0729.

Karen Johnson: The only thing, this is Karen. Just one thing to keep in mind since the actual diabetes care measure has in it, a blood glucose control. It's actually kind of the flip of it, are you in control as oppose to be in poor control. One could argue that 0059 is a little bit duplicative, not completely of 0729.

Female: Yes. The only reason – the reason that I don't – I totally hear what you're saying there is, I think they do something a little different. I think they tell – they give you different information. So because the optimal diabetes has all those other pieces and it's an all or nothing, if you fail you could fail for any of the other reasons.

You might have great hemoglobin A1c and bad smoking, bad aspirin. 0059 is a little bit – it tells you something about – more about degree of control of the diabetes itself, as opposed to overall clinical management.

Male: I agree.

Karen Johnson: Perfect, that gives something right in that report which is wonderful. OK. So we're hearing – knowing that 0059 is now – we know can be used at the clinician level that we will include that one as well in core set. OK, Perfect.

One more, let's go to the next slide. Into the little bit of a repeat and this is our last one, the Transitions. You guys may remember that for the three item care transition measure, the consensus was not to include that measure in the core set. And I think part of that discussion was, it felt like does that measure itself

is included to some extent in the hospital CAHPS measure because there is, you know, those items are in the hospital CAHPS.

And we look into that later on and pretty much I think that in general it was true. And I think the difference there is hospital CAHPS has sent out to a sample of people who are hospitalized. Whereas the CTM-3 measure, there is no sampling requirement there. So this measure could be use for everybody who is in the hospital not just people who are sampled.

So I guess my question for you is, it would definitely be – if you decided to include it would be duplicative for the folks who were given the CAHPS survey but it's not necessarily duplicative for other people. So knowing that is there any appetite to include that measure.

I'll just leave it with that. Any – and it's fine to say no, I just wanted to make sure that we were clear about how that measure actually differs from the portion of the CAHPS measure.

Ira Moscovice: Any comments? OK, I think we can move forward as is then. And it looks like the rest – it's the same issue we have that included in the draft core set, but there are some issues that have come up. So let's move forward with Mental Health.

Karen Johnson: And I think what the rest of them remind me, I don't think we need to – maybe let's just go real quickly. I don't think we need to address the mental health ones. No. Substance Use, no.

Well, we have a few minutes, a couple of minutes, on the Substance Use Tobacco, the last time around, there was not complete consensus whether we should or should not include the measure that's looking at help with quitting among adolescence.

I think there was some pros and cons of both. I believe this is the one that people really would like to gotten our hands on the measure and made more measure that looked at everybody, so that you would get adolescence and adult all-in-one measure, but we don't have that. So maybe we should just see – does anybody – this is a maybe on 2803.

Do we have any boning arguments about why we should or perhaps we should not include the measure for tobacco use screening and helping quitting for kids?

Tim Size: Well, this is Tim. And I'll just jump in with no knowledge at all. I guess, I keep on thinking we're actually going to end up narrowing this down to a relatively small sets for inpatient and for outpatient. And so I just – if we have what measure we feel really good about that relates to tobacco.

The other one is important, but ultimately it's going to be competing for non-duplication in that pool than the smaller number. And I guess at an intuitive level, it may not be telling the truth that I figured – I would hope that if one is doing well, with 0028, which is going to have a larger population, folks will also be doing well with 2803. Let's not speak against the importance of this issue with adolescence, but just a few random thoughts.

Karen Johnson: Thank you, Tim. Anybody who want to rebut Tim's idea and really argue for including the adolescent measure or decide to not include it?

Male: Yes, I agree with Tim.

Tim Size: Always a safe move.

Karen Johnson: All right. Let see, Madison, let's just run through the rest, I don't remember if we had one more set that we wanted to talk through?

(Inaudible)

Karen Johnson: OK. So let's talk about Immunization, let's go to that one.

So what we're doing now is revisiting a couple of things that we didn't kind of tend to find a consensus on. I think the immunization question is the one that everybody really like was that one at the top. It is the one that, again, that level of analysis problem came in. So we've decided we're going to do something special with those.

What we're going to do is yet to be kind of fleshed out a little bit. But I guess, the question in terms of the other ones this immunization for flu, looks like there is four of them. We wouldn't want all four of them, do we want any flu immunization measures is the question in front of you.

Male: I would say yes. But I have a hard time knowing which one.

Karen Johnson: Yes. So the – looks like the immunization for adolescence, so 1407, we have the level of analysis problem for that one. Again, we can deal with that in the ways that we're going deal with the other ones if you want that one. It is limited to adolescence, so maybe that give respect to what Tim's suggestion was that we just talked about for our tobacco screening does that apply for immunization as well.

0041 is a clinician level measure and then of course 0431 is as well, but it's focused on having your staff immunized.

Male: So why …

(Inaudible)

Karen Johnson: I'm sorry can you repeat that? What was the question again? I'm sorry.

Tim Size: Why is 41 a data collection issue?

Karen Johnson: Do we have that up, does any remember why that was …

Tim Size: I mean I think we know people are getting their flu shots at Walmart and this from that and the other, but that wouldn't relieve the physician who from at least asking a recording that, "Oh yes, you got it done, right?"

Karen Johnson: Right. And I think you're exactly right. That was the question. You can get flu shots lots of different places, yes. And I'm not sure if I'll be able to bring up in time.

Kimberly Rask: So I think the issue is how also – with a lot of these, how you measure them because you're right, the problem is with the claims measurement of flu shots – right, so really tough. It doesn't seem to be so good or it doesn't seem to be

very good. So is this doing chart review or is that the reason why it's checked under data collection?

Karen Johnson: And we're madly trying to bring up that measure and some of their materials here. Kate, have you found it?

Kate Buchanan: Yes. So the data source for 0041 which is the preventive care and screening, influenza immunization are both EHR as well as registered data.

Madison Jung: Yes, we have a note – this is Madison. We have a note here that we have previously discussed that you'd noted that it's difficult for states without registries or less well-maintained registries to report on this.

Tim Size: Except if – I mean – this doesn't require that the clinic to give the shot, it only requires the clinic to know that the shot has been given right?

Karen Johnson: That is correct. The measure description is percentage of patient six months and older blah-blah-blah. He received the immunization for flu or who reported previous receipt of influenza immunization.

Tim Size: And I – I understand that it's easier for state with a registry but it doesn't – in my mind relieve that primary care provider in a state without a registry from asking that question.

Male: Right.

Tim Size: And somebody is going to require some chart review, I guess, or have we ruled out chart review?

Karen Johnson: There's been no – yes, nobody has ruled out a chart review.

Tim Size: I mean most – well, I guess – I mean, this is something that typical EHR would tell you?

Karen Johnson: Is that a question for the group or is that …

Tim Size: Yes. That was a question, sorry, I didn't raise voice enough.

Kimberly Rask: Only if somebody has entered it. I mean, because it's probably not going to be linked to the other source of where it could've happen. So it's similar to written medical record, is somebody proactively taking the time to mark that.

Tim Size: Yes. And I guess I think for something that's the responsibility and that – otherwise we're arguing that we're just (need) to claims data. And we just had flu for four weeks I think this is an important issue, so I should probably not vote and a conflict of interest. But I got my shot anyhow, but it was still (awful).

Kimberly Rask: Yes. And I think if I'm looking at it, I think I'd be – would tend to lean more towards 0041 over 1659, but at the level of a hospital – just thinking on the population based public health part, what you want is it to be as part of preventive care not necessarily at the level of the hospital dealing with an acute thing. Although I know we do hold hospitals responsible for that, but if looking at the two I guess like public health focuses 0041 models the behavior we're trying to encourage.

Karen Johnson: So I think I'm hearing some appetite for going ahead and adding in 0041?

Male: Yes.

Female: Yes.

Karen Johnson: OK.

Male: Yes.

Karen Johnson: So we're going to have a flu measure in our core set potentially. OK. One more and then we're going to head off to public comments, this is I think the last one that we said – last time around that we would like some further discussion.

It was experience with care, and the – we have three different flavors of CAHPS and this hospital CAHPS clinician group, HCAHPS and then child hospital CAHPS. All of them are of course Experience with Care measures,

outcome measures and I think probably that the biggest concern was child hospital and if, you know, the low volume problem for that one.

So I think we just didn't settle which if any of these we would choose. So does anybody have a flavor you want – any of them none of them, do you want one hospital for adults but not kid. For all of them, of course, they are surveys, so there is, you know, cost involved with those.

Crystal Barter: This is Crystal. And I think it make sense to have some patient experience surveys from both inpatient setting and outpatient setting that child CAHPS is the low volume concerns, so I would not recommend moving that one forward.

Ira Moscovice: Agreed.

Kimberly Rask: This is Kim. I agree.

Karen Johnson: So it sounds like – did anybody have any hesitation with including both Hospital CAHPS and clinician HCAHPS, so the first two.

Male: No.

Karen Johnson: OK. So OK, we were just looking – we had a comment come through I think – let me hand it off to Kate or Madison to get us through public comment.

Madison Jung: Great. So now is the opportunity for people on the phone or on – to type in a text questions. We're going to ask (April), our operator, to open the lines and hold them for at least 20 seconds. (April), if you won't mind providing instructions?

Operator: Yes, ma'am. For this question and comment it is star one on your telephone keypad, again that is star one.

And I do have one from the line of (Jill Arnold). Please go ahead.

Jill Arnold: Hi, can you hear me?

Madison Jung: We can.

Jill Arnold: Can you hear me? OK, good. Hi, this is Jill Arnold with the National Accreta Foundation in (Centerton), Arkansas. So I was looking – so for 0471 which is PC-02, it looks like it meets 11 of the 13 principles for selecting measures that affect rural providers. The only ones that people think to have issue with are the low case volume challenge, and then which I guess leads to then is not facilitating their comparison for rural providers.

I just pulled up real quick 2015 AHA data, it's a little old, but at the rural CBA – I think it's CBSA type hospital, I think that's a column. It looks like only a quarter of them were under that Joint Commission threshold of 300 (verse) that are required for reporting on that measure. And I know this isn't Joint Commission and, you know, it's not like everything that works for them works for everyone else.

But, you know, I'm just wondering if the committee would consider looking at the actual birth volume data of the rural hospitals that we're looking at before making a decision on 0471.

Karen Johnson: And thank you for that comment. And to be clear the 0471 is the C section measure. So we will make sure that the workgroup can actually see your comment and think about it a little bit more offline. And so, that comment has not gotten lost, but we will put the committee on the spot right the second to talk about that one.

Jill Arnold: OK, thank you.

Madison Jung: Are there any public comments either on the phone or via chat?

Operator: I have no more over the phone line.

Karen Johnson: OK. We have two minutes left, but we did have one question from Mark who wants us to go back and rethink real quickly and we have about a minute and a half to do this, the depression measures. So that was early on, can you find that quickly for us, Madison, Madison is very good with measures.

So depression measures, we had said yes for a screening measure as well as an outcome measure, readmission at six months. In Mark's point was maybe we should rethink that we actually had average disposal too, depression remission measures both outcome measures, one of them six months, the other 12 months. And Mark has pointed out that the 12-month measure is actually being used in – he thinks MIPS.

So I guess one question would be are other and, Madison, maybe you can check and just verify use of one or the other of those in federal programs. And if so, would that's way you for moving part of the 6-month to the 12-month measure.

Kate Buchanan: This is Kate again. I just want to clarify. Mark is correct that in both 2017 and 2018 MIPS, that's depression remission at 12 months.

Karen Johnson: So the 12 months measure is being used. OK, in the MIPS program or for MIPS. It's not the MIPS program

Kate Buchanan: I believe they're both designated for – I'm just looking at the (QPC) website for the MIPS program. And we actually have 6 months and 12 months as of I'm not sure when they last previously updated this. I don't think it included this past 2017 year pre-rule making, but right now it has depression remission at 6 months and a 12 months designated as in use and included.

Karen Johnson: So both of them are being used. We think – or at least will be, if they're not already, they're going to be.

Kate Buchanan: Yes, they're included in the program.

Karen Johnson: OK. So knowing that at least both them are used in that program, is there any reason, anybody would like to switch from the 6-month measure to the 12-month measure?

Male: No, that's fine, thanks for the clarification.

Madison Jung: And this is Madison. And we should note that we do plan on webinar 7, incorporating of formal vote at some point from getting your official opinion

so far, but prior to getting your official opinion, we would – we are planning on sending out a more detailed spreadsheet of kind of where we are in a update summarizing what we have. And also a lot of our colleagues in the other organizations have pointed out, they would really like to see where we align with other programs such as the AHIP core collaborators.

So we do plan on noting things like that and the specific federal programs, the CMS quality payment programs that these measures are being used in, so that'll give everybody a better flavor for alignment.

Kate Buchanan: OK. With our last minute, are there any next steps we need to go for Madison?

Madison Jung: Let me just pull up the – just a brief timeline, but any committee members have any final lingering thoughts or questions before we head out?

OK, hearing none. I'm just quickly reviewing when our next webinar is. We'll see you in 14 days. But on this webinar we plan to review – get started on guiding into our measurement topic. And David Schmitz and Julie Sonier have been gracious enough to give us some initial recommendation and some thoughts, and we'll be reviewing kind of the next steps and potential directions that we would like to head into.

The next webinar after that, webinar 6, which is April 25th and we will further to dive into those and hopefully finalize these recommendations and these will all be captured in draft report too. So this webinar our kind of update on draft to draft core set and our decisions and thoughts on the measurement topic will be included in draft report too.

But those are the immediate next few months of things to come. Other than that, any closing words from you, Ira?

Ira Moscovice: Yes, the only I would say is, you know, we've been sort of going yes-no on these measure and somewhat independently of each other. I think it really will be – when we get – "Well, here is what the group agreed to for the list," at least the initial draft. I think you're going to get some feedback from the group saying "Well, do we want two measures in this category, do we have

enough in that?" So I think it can be really helpful to sort of get a summary of decisions we've made so far.

Madison Jung: Sounds great. Yes, we definitely plan on sending that along to you guys.

Karen Johnson: All right. Well, thank you so much for joining us this afternoon, we used every minute and a couple others, so thank you for patience and we will talk to you again in a couple weeks.

Ira Moscovice: Okeydoke.

Male: Thank you.

Female: Thank you.

Female: Thank you.

Female: Thank you so much.

Male: Thank you. Bye.

END