NATIONAL QUALITY FORUM

Moderator: Rural Health
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1:00 p.m. ET

Operator: This is Conference #: 88463024.

Male: Hello.

Operator: Welcome everyone, the webinar is about to begin. Please note, today's call is being recorded. Please standby.

Kate Buchanan: Hi everyone, this is Kate Buchanan from NQF. I want to welcome you to this web meeting. It's our 7th web meeting at the Rural Health Workgroup.

And this one is going to be a little bit different in format than the previous one. So there are a couple of housekeeping announcements I wanted to go through. So yesterday, all voting members of the workgroup should have received a special voting link from Eric Joy.

And we are getting a little bit of background noise. We're going to ask that if you are not speaking, if you wouldn't mind muting your phone. All right.

So everyone around 4:30 Eastern Time yesterday should have received a voting link from Eric Joy. We're asking you to use that link to log into the web platform. That will allow you to vote.

We're very thankful that some of our federal liaisons have been able to join us, but they shouldn't worry about it, because as federal liaisons, they are serving as non-voting members. So they can log-in the regular way. But if you have

not had an opportunity yet, I really encourage you to use your specific links that will allow you to vote.

Now, with that in mind, we know that some people are in cars, some people are using tablets which are not compatible with the voting link, and some people, they do not have access to the internet right now. So what we're going to ask you to do, when we come to vote is, is if you are able, we would appreciate you typing your vote into the chat box, in the lower left hand corner, or if you are not able to be on the web platform saying your vote aloud.

And that will be really helpful for us because it's really important that we obtain quorum on this vote. And so, in order to get quorum, we need 17 of our group members to be voting. And so every vote counts on this. So if you were not able to log-in directly into the web link to vote, we are going to ask you to either type it in, in the chat box, in the lower left hand or say it aloud, and then we will manually calculate the vote, and say it aloud on the phone so that it's on the transcript as well as the recording.

And so then, a couple other things as always, we have our meeting materials linked on the left hand side of your web platform, you can see it under link. And workgroup members receive the supplement with some of the public – with the public comments, while the workgroup comments on it, in an e-mail. We encourage you to reference that. That would be useful in discussion. And I think that that is all we have for the housekeeping items, so we can go through to the agenda.

So we have a pretty simply agenda today, it's going to be an overview of our public comments received on the report. As you know we have a 30-day public comment period. The workgroup will then be finalizing the core set recommendation, as well as the recommendations on access to care. And then we will hold our formal vote on the recommendations overall. So it will be one overall vote on the report in general.

And then, as I said my name is Kate Buchanan and I'm joined by my colleagues Karen Johnson, Senior Director; as well as Madison Jung, Project Manager.

And prior to conducting roll call, I wanted to ask our Co-Chairs, Aaron and Ira, if there are any comments or opening, welcoming remarks they wanted to make?

Ira Moscovice: No, I would say …

Aaron Garman: This is Aaron. Oh, go ahead, Ira.

Ira Moscovice: I was just going to thank everybody for their efforts on this. We know it's taking sometime but we think it's really important. And today's, you know, combination of all the efforts we have. And we'll be able to vote on recommendations for what measures will be in the final core sets. So appreciate your help with this.

Aaron Garman: Yes. Thank you all, I truly appreciate it. And I think it's a great outcome that we're going to have. And look forward to it. Madison, I do have a question.

Madison Jung: Sure.

Aaron Garman: Since I am traveling in rural Wyoming, if I do lose connection and I'm not able to reconnect, can I give my proxy vote to someone?

Madison Jung: Sure, sure.

Aaron Garman: I'll just give it to Ira since we've been on the calls together and co-chairing. If he is willing to accept that.

Ira Moscovice: Sure, that will be great.

Madison Jung: Great.

Aaron Garman: I planned to be on, but I don't know that I will be so.

Madison Jung: That's a great point. And then maybe as we go through for attendance, if you are one of the individuals who are not going to be voting via the web platform, just when we call out your organization or name, you just note that. That would be great.

Kate Buchanan: OK, all right. So now, we will go through the roll call. And I know that Kimberly Rask from Alliant Health Solutions, I know that she is on the line. She got disconnected so she's dialing back in.

Kimberly Rask: I am back. Thank you.

Karen Johnson: Great, thank you very much. I apologize for that inconvenience. And then, do we have anyone from American Academy of Family Physicians?

(Sandy Pagonas): Yes, hi. This is (Sandy Pagonas) sitting in for Dr. David Schmitz.

Kate Buchanan: Thank you. American Academy of Physician Assistants?

Ellen Rathfon: Yes. This is Ellen Rathfon sitting in for Daniel Coll.

Karen Johnson: Great. American College of Emergency Physicians?

Steve Jameson: Yes. This is Steve Jameson.

Kate Buchanan: Thank you. American Hospital Association?

Stephen Tahta: Yes, Stephen Tahta.

Kate Buchanan: Great. Geisinger Health? Health Care Service Corporation?

Shelley Carter: Hi, this is Shelley Carter.

Kate Buchanan: Thank you, Shelley. Intermountain Healthcare? The Michigan Center for Rural Health?

Crystal Barter: Good afternoon, this is Crystal Barter.

Kate Buchanan: Crystal?

Crystal Barter: Yes, Crystal Barter.

Kate Buchanan: Great. Minnesota Community Measurement?

Julie Sonier: Hi, this is Julie Sonier.

Kate Buchanan: Thanks, Julie. National Association of Rural Health Clinics?

Bill Finerfrock: This is Bill Finerfrock.

Kate Buchanan: Thank you, Bill. National Center for Frontier Communities? National Council for Behavioral Health? National Rural Health Association?

Brock Slabach: Good afternoon. This is Brock Slabach.

Kate Buchanan: Thank you, Brock.

Brock Slabach: You're welcome.

Kate Buchanan: National Rural Letter Carriers' Association?

Cameron Deml: Yes. Good afternoon, this is Cameron Deml.

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

(Marcia Ward): Hi. This is (Marcia Ward) sitting in for Keith Meuller.

Kate Buchanan: Thanks, (Marcia). The Rural Wisconsin Health Cooperative? Truven Health Analytics.

Cheryl Powell: Hello, this is Cheryl Powell.

Kate Buchanan: Thank you, Cheryl.

And then, I know that John Gale is having some difficulty calling in. Oh it looks like John …

John Gale: I'm on actually. They finally got me through. They just …

Kate Buchanan: Sorry about that.

John Gale: They didn't recognize the phone number. That's all right.

Kate Buchanan: We have John Gale. Do we have Curtis Lowery? Melinda Murphy?

Melinda Murphy: Yes.

Kate Buchanan: Thank you, Melinda. Ana Verzone?

Ana Verzone: Yes, here.

Kate Buchanan: Great. Do we have Holly Wolff? And then for our federal liaisons, do we have anyone from CMS? The Federal Office of Rural Health Policy?

Craig Caplan: Yes, this is Craig.

Kate Buchanan: Thanks, Craig. And the Indian Health Service?

So, it looks like we have 18 people which meets at quorum. It looks like not everyone has been able to use the voting link. So if you wouldn't mind, just letting us know if you're one of the people who is unable to use the voting link. You can either chat it in the box to us, just letting us know that we should expect a vote from you in the chat boxes through those links would be really beneficial to us. OK.

So with that, I'm going to turn it over to Karen.

Karen Johnson: All right. So again, thank you everybody for joining us this afternoon. We're pretty excited about this meeting. It is, as Ira said, the culmination of a lot of work on our part, and so kudos to all of us for hanging in there and in this work.

Informally here at NQF, we kind of think that this meeting as the post-comment meeting, because we always like to put our reports for public and member comment. And then, bring our groups back together so that we can really give these comments their fair hearing.

So the way that we set up this call today is to, first, summarize the various comments that we've received. And then, we will have specific questions for you that are based on the comments themselves.

So the – just so you know, we really kind of beat the bushes to try to get comments on this report. Because we – they feel that it is so important. And we were very pleased I think with the comments that we received back. First of all, from you guys, our workgroup, 10 of you gave us comments on the report are on the core set or, however, we gave you several options on how you could do that. And some of those comments were extremely detailed and I know you went to a lot of work to do for us. So we very much appreciate that.

Our CMS and HRSA comments also gave us some comments on the report and the content of the report. And I realized just a little while ago as I was going through my slides that I didn't actually create a slide that kind of summarize the comments from CMS and HRSA. But some of the things that they – couple of things that they really pointed out than I thought was really helpful is this – here and there, there were a few sentences that they just thought needed more clarity. And we always are looking for that kind of thing.

So I think we can really just add to some of the clarity (of their), some of our sentences on those. They also have suggested that we maybe add a little bit more in terms of our rationale for some of the measures. So I think maybe today we might get a little bit more on that. So, we'll see how it goes.

As Kate said earlier, we did put out the report for our 30-day NQF member and public comment period. And we received 14 comments from eight different organizations, and those represents a variety of stakeholders including QIOs and some state agencies, some hospitals, the AMA I think put in theirs as well. And as mentioned you have those comments and you can see who said what from this comment.

And also, we do take comments very seriously. Those comments will be published in our report. They will become the final appendix in this report.

So those comments will be there. But again, I just really want to acknowledge and thank a couple of you specifically for kind of publicizing the report. HRSA colleagues I think really tried to get comments for us as did NRHA and Brock you helped just get into your newsletter, so thank you for that.

Let's go to the next slide. What I want to do is, first, just very quickly go through the feedback from the workgroup and then we'll go into a little bit more detail on the feedback from the public and members. And then we'll get into our specific questions for you.

So in terms of overall feedback from the workgroup, in terms of the report itself, I think we've got support from the workgroup on the work and most of the report including the format. So that's always good when you read or so like that, you were able to capture most of the thought in a clear way, in an organized way. There was a comment that we'd like to see a little bit more narrative on non-physician providers. And I think we can maybe do a little bit on that.

I think the only kind of barrier to that is that we really were, in the core set, we really were poised to think mostly, not so much about physicians, but about the hospital and the kind of clinician setting. So that, I think by definition, limited us and I think that's why there is a little bit less in terms of some of the other types of providers such as hospice and home health and nursing facilities, those sorts of things. But we'll see and try to add a little bit more text if at all possible and I think we can do something there. Again, there were several wording suggestions, all of those are very much appreciated.

In terms of the core set, again, this is feedback from the workgroup. Nobody actually said, you know, on reflection I think you ought to had this one or take this one out. There were a few concerns voiced about some of the data collection difficulties of a few of the measures. So, those are there.

We don't really have a mechanism setup to put some reservations around measures. However, if we're thinking about that, if you feel like that that's something that we should add to the report, I think that would be on the table.

Other feedback from the workgroup is I think generally people are happy with the mix of measures that we have. So we have some process measures, some outcome measures. In terms of outcome measures, there are some patient reported outcome measures. So, some pretty good variety there which is what we were hoping for.

And it turns out even though we didn't talk about alignment at a core criterion for things going into the core set. It turns out that just about all of the measures that were identified for inclusion in the core set are aligned with either CMS federal programs or maybe HRSA specific programs or maybe a couple other programs. So the alignment piece kind of happened for us even though we didn't really focused on that per se.

In terms of the access to care portion of the report, feedback from our workgroup, there wasn't a huge amount but I think there was a little bit of discomfort in a couple of the places where we pretty much had said, you know, the committee or the workgroup wasn't able to provide some ways to address. And with that, what we're going to do is open up a few of the topic areas at the end of this call assuming we have time just to revisit that.

And I will give out kudos to Melinda who actually went back to a couple of transcripts and helps us pull out some things too, that would help us kind of beef up that section where, you know, it really was I think a little thin in some of our descriptions. So, thank you, Melinda, for doing that.

In terms of our feedback from the public and our members, first of all, supportive of the work the work overall, we are always very happy to see that. And we don't minimize that. So, even though we didn't get a lot of comments, the ones that we got I think were supportive overall, agreement with our criteria in terms of focusing on cross-cutting measures, the low-case volume question, and transitions.

And I think people also really like the idea of thinking more clearly about access and basically articulating those three domains of access. So, that was – we did get positive feedback on that.

In term of the core set, again, generally, positive feedback on the core set. You know, there were a few things, and we'll talk about them again as we go through the call. There was one comment. And, again, I think well-taken a desire for some specifics about how the core set would be used.

So, you know, basically we don't know how this core set would be use, so we can't give you complete, you know, kind of chapter and verse. But I think we can talk a little bit about, you know, potential (pieces) for core set. So we will try to address that in the report.

There was some concern, not so much now but maybe if going on in the future if we, you know, are able at some point to continue this work in the future, there's the question of shouldn't we be limiting to NQF-endorsed measures. So, again, that was a decision that you guys made early on. So the comment was, you know, there's other measures out there that may be worthy but maybe not yet NQF-endorsed or maybe never will be. So, you know, we won't lose sight of that comment.

And I think, you know, again, if we have future ability to do more, I think that question would definitely come up again and, you know, we may still land on speaking with NQF-endorsed measures. There's good reasons for that, but that question will not be taken off at the table.

We had the measure 1789. That's the all-cause readmission measure. So we had one commenter who suggested that we do include it. We also have another commenter or two who didn't want to include it. So we've got both sides of the coin there for that measure.

That one was one that we had talked about, I think, on a couple of different occasions. And the workgroups, after two different discussions of that, still we're kind on the fence about whether to include or not. So, when we wrote the report, we included it and we noted in there that there was still discussions needed, but it was included. And so today, we need to finalize as to whether it will be in there.

There were other comments in terms of recommendations to remove. So other than the all-cause readmission measure, we didn't have other

recommendations for inclusions, but several recommendations to exclude measures or take them off of the list. Almost all of them, as you can see here on the slide, almost all of them were hospital measures. So the exception meaning the optimal diabetes care measure. So again, we will talk about those in a few minutes.

In terms of public and member feedback on the access to care portion, again, supportive of the workgroup's recommendations. So again, that's a very a good thing. We didn't really get push back on that at all. So I think we can be proud as the work that we've been able to do on that.

Commenters did encouraged additional development of access to care measures. There was, you know, a noting of the utility of telehealth for improving access to care. And I think that actually came out quite strongly in our report as well that that delivering mechanism could potentially really help improve access to care.

There was some comments that made I think that these approaches suggesting these ways to address some of the challenges was well-taken, so people like that. There was an acknowledgment that, you know, providers maybe cannot control all aspects of cares, especially when you're looking at outcome measures that they can influence. But, you know, maybe providers don't always have to be held accountable.

So having a measure and holding them accountable for certain things, you know, some things might be more in the QI space. So that was somewhat acknowledged their paper and somebody caught that and like that.

Finally, one commenter noticed that the access to care domains actually do align with work of other agencies. So we're often thinking about access to care. So that's it, we've got face validity on those.

We had a little bit of feedback in terms of future directions. So, again, in this idea of the measure development space, either need for additional development and probably even more or so is this idea of modification of existing measures to make them more applicable to a rural environment.

So, you know, not so much a lot of detail on how to do that, and that wasn't in the scope of our work as the MAP workgroup to put forward those, you know, in the weeds recommendations. But, again, just a note from the field that, you know, that needs to be considered.

And finally, one of the commenters I think really like this idea of the core set but also suggested that we create measure set specific to major categories of provider types. And that, I think, comment resonated with me and it actually was very reminiscent of the 2015 work that the previous rural health committee did, and I know we talked about that way back when we first started this work. But that panel actually had recommended the identification of core set with measures as well as what we call the net report optional sets of measure. So I think really this comment from this commenter really aligned with those recommendations back in 2015.

That's a very quick overview of our comments and what came through. Again, in general, just support with just a few suggestions for removals of measures.

So this next portion of the call, we will work to finalize our recommendations. So, how this is going to work is Ira is going to facilitate this for us, and I'm going to, you know, just ask him to go through the slide so every one of the measures that we – or I can do it if Ira want me to go through them. OK, I can do that, Ira.

Basically, the set up, they all looks the same. So once you figure out how the first one works, all the other ones look the same. So basically, there is a slide that calls out a particular measure and it calls out and it's kind of tiny writing, hopefully that's OK, it remind you a little bit of the rationale that you had used when first selecting that measure.

We also added in any current use that we know about, particularly in federal programs. So that's gets us the alignment piece. And then we tried to summarize yet again in a little bit more detail some of the comments that came through. And since these were mostly recommendations for removal from the core set, you know, the kind of the main concerns.

So for each of these measures that we're going to go through, the basic question is whether you want these measures to remain in the core set. So we won't be voting on each one separately. What we will do is have the conversation.

So I want you not to be shy. I want you to feel free to make sure your voices heard. And we will, you know, once we had a little conversation, we'll just kind of see where the mind of the committee is going. And we'll just work our way through the list of measures.

So let me stop there. That's a lot of talking on my part. Does anybody have any questions? Anything you want to air now? Or do you want to go ahead and jump into the first measure?

Brock Slabach: Karen, this is Brock.

Karen Johnson: Hey, Brock.

Brock Slabach: Hi, there. I just have a question before we begin the voting and possibly more of a comment.

It would seem helpful to me to – if our report will issue a strong recommendation that this not be a static set of measures but that this will be an ongoing process hopefully through an NQF MAP that will continue to evolve these standards going forward. So, I don't want this to be the one and only shot at this, so it would help me, I think in terms of my voting later on in our session today.

Karen Johnson: Great point. Let me ask you this way. Does anybody disagree with putting forward that as a recommendation from the workgroup?

Hearing none, I think we will – we're very comfortable with putting that in as a recommendation. You know, the caveat is we would have to be funded for this, you know, by CMS, but hopefully that will be the case.

Brock Slabach: Well, that would be the recommendation to CMS at least in my mind. Yes, absolutely.

Karen Johnson: Yes, yes, yes, yes. And it would come, I think, probably at the report as is as draft kind of ended in a very kind of abrupt way because we weren't quite finished. So I think it might be kind of the – some of the wrapping up recommendations that we would put forward.

Kate Buchanan: And just to clarify, we won't be voting on the individual measures. We'll be coming to a discussion consensus. I just wanted to note that as well.

Karen Johnson: Yes, yes.

(Sandy Pagonas): Hi. This is (Sandy Pagonas), attending on behalf of David Schmitz. I do want to make certain I understand the results of discussion of the individual measures. You said we won't be voting on them, so what will happen – what will be the final status of those measures? Who will decide whether or not they're included in the core set?

Karen Johnson: Right. So, you will decide through your discussion, but it will be kind of an informal consensus.

Madison Jung: But in the same vein – yes. In the same vein as the previous webinars, we'll come to verbal discussion or verbal consensus.

Karen Johnson: Yes. But we won't actually ask you to click a clicker or a button on your screen for the individual votes. Instead, at the end, we will ask you one kind of up or down vote that would encompass all the recommendations of the report, and that would include the core set as well as the things that came in under the access to care piece. And Brock's addition here, making this an ongoing kind of living core set.

Brock, I will use – I didn't write down your language exactly, but the language that you put forward is what would finance the report as a recommendation.

Brock Slabach: That's fine. I think your summary was nice. So, thank you.

Kate Buchanan: And this is Kate. Let me go through the voting. Staff here is taking note as we go on, so we'll be reiterating what the decisions were made so that people

aren't just, you know, wondering what happen. We'll reiterate what decisions were made. And so that when people are voting, they have that one.

Karen Johnson: OK. Any other questions or are we ready to go in? All right.

So, Ira, you want me to actually go through the individual slides and then you'll facilitate our discussion?

Ira Moscovice: Yes. I talked with the staff earlier. I think that'd the best. I can offer a comment, after you go through if that's appropriate. But I think that'd be the best way to do it.

Karen Johnson: OK.

Ira Moscovice: It'd be quickest I think.

Karen Johnson: OK. Yes, happy to do that.

So, again, the first one is 1789 Hospital-Wide All-Cause Unplanned Readmission Measure. So that measure really the rationale that you guys used. And again, this one was more and where there was never a complete consensus among the work as to whether it should be in or it shouldn't be in.

So this was the only one that was kind of tethering on the in or out. But the rationale for in was that it is currently used for acute care hospitals. And it would allow, you know, the rural hospitals to compare nationwide, so as a measure that everybody would use

There was, however, kind of on the flip side, some concern about volume issues and also risk adjustment methodology. Again, we didn't go into specifics to the specifics of the adjustment methodology but I think, you know, there's just kind of always in general on that particular measure. Been a little bit of concern might be a harsh work. But some caution about the risk adjustment methodology.

It is – there's a lot of adjustment for clinical outcomes but I don't think that there are adjustment for sociodemographic types of factors. This measure is currently reported in several CMS federal programs including Hospital

Compare, IQR Program and the Medicare Shared Savings Program, which is the ACO Program.

There were two commenters who agreed that low volume could be a problem for this measure. As I mentioned earlier, there is the desire on some people's part including social risk factors in the risk adjustment methodology and right now those are not included in the risk adjustments. And again, there was one comments where (we) strongly encourage the inclusion of the measure. So I think two folks didn't want to see it, one did. The encouragement for inclusion aim from one the QIOs I believe who actually run – knows about how these work for critical access hospitals.

And we put their statements on the slide. In our last review of National Critical Access Hospital Performance on this measure, the majority of CAH did meet the threshold and cases to have this calculated.

So, you know, that piece of information may assuage the concern about low volume. So I think I will stop there. We'll go to the next slide just so you see the question that we really want you to decide on. Do we keep this measure, unplanned readmission measure in the core set or do we not?

So I'll open it up for a discussion.

(Sandy Pagonas): Yes. This is (Sandy Pagonas) on behalf of David Schmitz again. And I do – I would ask for one clarification. I apologize this has probably been discussed but I wasn't in the individual discussions.

This measure currently does not apply to CAHs and we are – and I have to wonder if a patient is admitted to CAH transferred out and comes back, and as readmitted to the CAH. Does that readmission go to the CAH or does it go to the facility that the patient will transfer to?

Karen Johnson: That is a great question. I don't know if I can answer it immediately while I'm looking. We could certainly see if anybody …

Kimberly Rask: This is Kim, yes.

Karen Johnson: Kim, you the answer to that?

Kimberly Rask: Yes, I do. Transfers do not answer the denominator. So if the first CAH to the hospital would not enter the hospital, and then being admitted to the CAH would count against the hospital who had discharged the patient before the CAH admitted them.

(Sandy Pagonas): Thank you.

Ira Moscovice: Any other comments from the group?

Kimberly Rask: This is Kimberly. I'll say, I really support the inclusion of this measure. I think that the concerns about low volume, the input from the QIO is encouraging in regards to that. In terms of the concerns about social risk factors that is a concern with a lot of the measurements. CMS is currently using dual eligible as a proxy for that and that could be an option for this measure also.

Ira Moscovice: Other comments? So hearing – Karen, let me ask you one question. I'm assuming with all these measures, if there isn't enough volume, it could be the OB measure, it could HCAHPS measures, at a particular hospital. Then you have a measure in the core set but it's not held against the hospital directly per se. In other words, the denominator where those hospitals have enough volume, is that correct?

Karen Johnson: I think that would be my operating assumption. You know, we don't know how CMS might decide at some point to use these measures. We have flavor of how they, you know, what their volume cut off et cetera or in other programs. But there's, you know, there's no reason to say that they would do the same exact thing if they did additional programs.

Ira Moscovice: So I think that's an important point to put into the final discussion piece at the end, in terms of recommendations from this group, about how we want that handled. So at least we can offer some guidance to CMS on that.

Karen Johnson: Can you articulate that a little bit for me, Ira, so I don't mess it up.

Ira Moscovice: Yes. I think what you would just said is if a hospital did not have the necessary volume as specified in the definition of the measure then the measure, then the measure is not applicable to that hospital and hospital will not be – well I don't know how you want to say that. The hospital will not be judged or measured on that particular measure or that'll be excluded from their measure.

Karen Johnson: OK. I think the way that would work well on this is really we've heard Kim kind of say that she isn't as concerned as maybe she might have and she'd like to see it in there. Ira had suggested a bit of the recommendation just to kind of, for this measure, and that same recommendation may or may not apply to other ones as we go through. We can certainly hear if anybody has additional comments on this.

Yes, included side but I'd really like to hear if anybody really has – really doesn't want to see it included. And let's make sure that we hear everybody who might have that opinion. So does anybody against including this measure, 1789, in the core set?

Ira Moscovice: Karen, just to be clear, I'm suggesting it'd be included in the core set but that were not – in terms of how it's used that's what my comments were trying to referred to.

Karen Johnson: Right, right. So, right. And it's really tricky because we don't know how CMS is planning to use anything, right? So we can't make specific recommendation. They have to be somewhat general as you have said, all right.

So I am hearing no disagreement about including this measure in the core set. So if anybody disagrees, now is the time to say otherwise we will go forward with it as included.

All right, so we will include this one in our core set. All right? Next measure.

The Emergency Transfer Communication Measure. So in terms of rationale of why this was considered in the first place, going all the way back to some

of our initial conversations. They desire to make sure that we have some measures about transition.

In the core set was one of the main selection criteria that we have. So we definitely wanted transitions and care measures. I think we ended up looking at three or four separate transition measures and this is the only one that was chosen by the workgroup for inclusion.

Another thing that came out in terms of really thinking about some of the more common measures of transferring at time and things like that. Those things have some drawbacks but this communication measure seemed important and having that communication seem like a really important thing to make sure that is being looked at. It is currently being reported in the MBQIP Program as a core measure.

We received two comments, two folks recommended removing it. And the recommendations had to do with reporting burden concerns. But there was the counter recommendation from another commenter to support inclusion.

And the rationale for that was that more than a thousand Critical Access Hospital already report in this measure, and also some indications of modifications of the measure underway. And those modifications could very well impact the burden concerns that were mentioned in the negative comments.

So with that, Ira, I think you're a co-chair but you also have some intimate knowledge of this measure. And so maybe go ahead and tell us anything that you can tell us about that. And then we'll open up the discussion.

Ira Moscovice: So my colleagues and I developed this measure actually. And over the past few years, we've heard people like the measure but it was too much burden in terms of the amount of measure was being asked. So Stratis Health, the part – as part of Stratis Health and activity they have underway in conjunction with our group convene the technical expert panel this year. And they finished their work about a month and a half ago and basically recommended that the measure moved down from 27 elements to 8 elements.

And so it's really been dramatically cut back and is focusing on items that expert panel felt were truly important such as medication administered in the emergency department, allergies and reactions et cetera, et cetera. And so it's been the recommendation is dramatically shorten the number – reduce the number of items. But the measure that exist endorsed right now has the larger set of items. We anticipate moving forward this fall with – asking for modification – endorsement of modification of this item from NQF. So over the course of next year I think the item is going to be dramatically reduced in scope.

And so, I'll just open up for comments then.

(Marcia Ward): Ira, this is (Marcia) at RUPRI. And so, what's the processes (inaudible), keep your same measure number and then be modified or is it a new measure number?

Ira Moscovice: I think my colleagues at NQF probably can answer that better than me.

Karen Johnson: Yes. Generally, what would happen is, it would keep the same measure number, probably the same measure title unless Ira and his group wanted to the change the title. But basically we have here what we call an ad hoc review process.

So if something really major changes about a measure kind of in between their usual maintenance schedule. We will actually go ahead and bring that measure to our standing committees and have them reevaluate the measure. So we'll go through, you know, pretty much the evaluation process again.

So it sounds like this is got off the presses but we would be slotting that probably in the spring of 2018. Assuming that Ira and his group were ready to bring it forward at that time, and assuming endorsements what's conferred on this new version, we would be looking at endorsement in late summer of this – our altered measure

Again, the caveat is, you know, it would to be approved and, you know, can't make predictions on that. But the measure would have already gone through with this element. The major pieces in terms of evidence and opportunity for

improvement, and some of other things, so adding element might be a harder thing to do than taking them out, but again no promises there.

Brock Slabach: Ira, this is Brock here. We're in favor of this in the set, so I think it's an important measure, and accurately or adequately describes what rural hospitals are doing. And I think the example of a continuation of our MAP process in the future is – this is an ideal example of the evolution of measure. And how this could be adopted as it goes along (inaudible) they were on MAP, so those are my comment on this.

Ira Moscovice: Other comment?

Steve Jameson: Yes. This is Steve Jameson from American College of Emergency Physicians. I think it's, you know, intuitive, this is one that needs to be on there, and it's already required under EMTALA Law that we have been communicating between transferring and receiving facilities. But it's the implementation of this I guess.

Let's see where we had comments that somehow the form is more onerous than what the EMTALA regulations already are that makes it hard to vote on exactly, you know, whether it's in right forms.

So I certainly wouldn't make anymore onerous that what is already required. What you're listing, Ira, as far as what's on there and what it's getting paired down to, I think is exactly what should be on there. I just hope that there aren't excessive amounts of data that would be required and then have you not meet the measure because of some, you know, minor technicality or other some minor issue that wasn't addressed.

Ira Moscovice: Yes, it's fair comment. We actually, you know, as someone pointed out the majority of Critical Access Hospitals are reporting on this measure already. And we've heard what they had to say and the technical expert panels, a few had been on, they literally went through every item and basically eliminated almost three-fourths of what we have collecting and it's paired down now, to what's essential.

And, you know, our feeling was that this is an important area to show that certainly rural hospitals are really dealing with the transfer process in appropriate way. And I'm hoping in the future, we can get more measures in this whole area of transitions in care.

Kate Buchanan: And this is Kate. John Gale just wanted to let us know that he doesn't support the inclusion of the readmission measure. He's in a public area, so he didn't want to unmute.

Karen Johnson: OK. In the readmission measure or this emergency measure?

Kate Buchanan: I'm sorry, the readmission measure.

Karen Johnson: OK.

Kate Buchanan: And the emergency measure.

Karen Johnson: OK.

Kate Buchanan: Thank you.

Karen Johnson: And just to be really clear, so that nobody is confuse about this, you will be – what we're talking about is inclusion of the measures as they stand now in the core set. We understand that this particular measure will morph probably over the next year. Maybe even faster than that. But you're not necessarily talking about inclusion of this measure assuming that it will morph, you have to think about in terms of what it is right now. So there's always timing issue about measures, but that's kind of what we need to do to make sure that that's clear.

Ira Moscovice: Other comments?

Kimberly Rask: And this is – yes. This is Kimberly, I support the inclusion of the measure for the reasons you all have discussed.

Karen Johnson: OK. Does anybody really want to make a case for not including it? OK. And we're looking at comments (on the slide). OK, all right. So from our perspective, we've got a yes we're going to keep this measure in the core set, all right.

So next measure is 0729, Optimal Diabetes Care. The rationale for this measure, for inclusion of this measure, is going again back to some of our very early conversations and noting that there are some chronic conditions that are particularly relevant for rural residents. And, you know, the desire to have at least a few (disease) condition specific measures and diabetes was one of those conditions.

So this is the only diabetes measure that is put forward for the core set. It is a composite measure and it's what we call an all or none composite, and basically to meet the measure a patient has to have all five of these things. And I've listed the description of the measure there.

The five things that are – that each patient has to have is A1C less than eight, blood pressure less than 140/90, a statin use unless contraindicated, tobacco free. And then for a patients with the ischemic vascular disease having some kind of aspirin or antiplatelet use unless contraindicated. So that is a measure that is currently being publicly reported through the Physician Compare.

In terms of comments received, this is a mistake on my part, I apologize. We've had one comment that recommended removal because of concerns with lack of risk adjustments. This is not a risk adjusted measure. It's a (straight) measure. And basically that lack of risk adjustment the concern is that, it would be unfair for clinicians with the more complex patients. For example those who have patients who may be have a harder time keeping that A1C level lower or BP level lower, et cetera.

That second comment there with more than 1000 CAHs already reporting. Strike that from your copy that was a mistake that is – that was true of the previous measure and I just neglected to delete that. So again one recommendation for removal because it's not risk adjusted and it may seem or be unfair for those with more complex patients.

Julie Sonier: Karen, Julie Sonier, I'm from Minnesota Community Measurement. And we are steward of that measure, so I have not sort of coded on this before but I do want to clarify that the measure is risk adjusted.

Karen Johnson: Oh it is risk adjusted. Is it? OK, my apology.

Julie Sonier: Well, some said it wasn't, but it is.

Karen Johnson: Do you recall what is included in the risk adjustment methodology?

Julie Sonier: Our risk adjustment methodology that we've used previously includes age, what diabetes types, so type 1 or type 2 and insurance type. We, for our own purposes, have recently added that social risk factors adjustment. And the measure is currently under review for re-endorsement. And I have to say that I'm not certain whether that last social risk factors piece is in there. But I believe the first three are.

Karen Johnson: OK. And when you say in insurance type, is that like Medicaid or is it commercial or something along those lines, OK.

Julie Sonier: Yes. Medicare, Medicaid, commercial.

Karen Johnson: OK.

Ira Moscovice: Or uninsured?

Julie Sonier: Yes.

Karen Johnson: So very much apologies for that. I did not remember that it was risk adjusted.

(Sandy Pagonas): Hi, this is (Sandy Pagonas) again. I would like to just make it known that in general the American Academy of Family Physician opposes comprehensive measures similar to this for a couple of reasons.

Primarily the difficulty in gathering all the data elements as well as the assumption that a patient or physician that is able to achieve four out of the five components of the measure is no better than a physician who achieves none of the five. So we feel that it's – it doesn't accurately reflect the activities and the efforts of physicians. And there are some components, three of those of the five components of this particular measure do rely on patient response to therapy whereas two of the five relies solely on what the physician does.

A measure like this we feel would be better addressed as accumulative percentage where you multiply perhaps the achievement rate of each measure, times the other achievement rates in order to get a final score that would at least get some credit to physicians that are able to achieve four or three or two of the components rather than none.

And we also question whether or not the status of the A1C less than eight as well as the blood pressure less than 140/90. Those two are really being contended right now and there's a lot of discussion of where those values should be.

So the final comment on the measure is tobacco free as we all know that the rate of tobacco use in rural settings is higher. And so, this would automatically penalize physicians in rural settings. So those are concerns that we have with the measure and we would oppose using this measure at this time.

Ira Moscovice: And this is Ira, you know, I just want to point out one of the last comments that was just made. This falls into the same category as the measure we're looking at emergency department transfer care and points out the importance of Brock's comment earlier. That this would be an ongoing process so that as measures change and as clinical standards change that we're able to adjust the measures that we're looking at, so I think that's a really important point.

Any other comments?

Karen Johnson: So is there any kind of – I'm going to use the word rebuttal to (Sandy's) positions. She lays them out very well and really just kind of not liking this idea of all or none. So just the way the measure is constructed in the first place really telling that some of it is, you know, docs can't control it.

There is – at least some of the clinical things a little bit in controversy now and then the tobacco free and knowing that tobacco is – tobacco use is more prevalent rural areas. What do others think? So this is where the discussion is going to have to kind of land as do we keep it? Do we not keep it?

(Sandy Pagonas): And I also – this is (Sandy), I'm sorry. I also want to re-emphasize the other point I made it that a physician that is able to achieve four of the five is rated no better or no worse – I'm sorry than a physician who achieves none of them.

Julie Sonier: So, this is Julian. I'll just speak a little bit to the historical context of the measure and why it was developed the way that it was. It was really, you know, the workgroup that developed it really felt strongly that if the measure really should be about optimal care because meeting all of those components is best for patients.

You know, certainly the tobacco one has been one of the more controversial pieces of it over time for the reason that (Sandy) mentioned just because providers can't directly control that although they can influence it.

And then, the A1C and the blood pressure in particular are elements that has been revisited at various points and the statin use used to be the national cholesterol level. So the measure certainly does get revisited on a regular basis. But the philosophy is that the goal is to reduce the risk for patients of an adverse events that this – that is associated with their diabetes and not to lose sight of that goal.

Bill Finerfrock: This is Bill Finerfrock. I'm sensitive to the observation (Sandy) has made. I mean, I'm troubled by the all or nothing nature of measures and not giving individual's points or value or recognition for either improvement or as was noted, you know, four out of five is treated no differently than someone who gets one out of five.

And this notion and we've commented on it before holding providers accountable for factors over which they have ultimately no control. There's no question that they can influence the patient's decision with respect to smoking and other characteristics. But at the end of the day, they have no ability to control that. I think the idea of holding providers accountable for the things that they don't have the ability to control we're troubled by.

Janet Wagner: This is Janet from RWHC. We have heard the same concerns after echoed by our people regarding the all or nothing aspect of this measure.

Karen Johnson: So I think we're starting to hear more concerns about including the measure than desire to keep the measure. So what do you think?

Ira Moscovice: This is Ira. See, it seems to me as Julie said, there's a philosophy behind this. And I think how people respond to this is a function of how might be use. If it were being used for quality improvement purposes, I think people might respond a little bit differently than if its being use for payment purposes.

And that's the tricky part as you say – as you said before that, (Karen), that we don't – we can't tell CMS how to use this obviously. But I think that kind of discussion we had (and) how we vote I think is an important …

Kurt Lowry: This is Kurt Lowry, University of Arkansas. I mean all of these things two-edge swords anyway, and shouldn't we be thinking about what's right for the patient. You know, we're coming up with these measures. I mean, how can you argue that this is not right for the patient?

Ira Moscovice: Well, that's the optimal care. It's the last piece, for sure.

Aaron Garman: Yes and I think – but I think, Ira, put his figure on what troubles a lot of us, is that at one thing if it's used as education, motivation, achieving, reaching for the optimal from a quality perspective. But when we know that at the end of the day that these are used from a payment perspective to say, "You're going to get paid more and you're going to get paid less," because, you know, you didn't achieve this, you didn't get all or nothing. I think that's where the hesitancy comes in that when you look at it from that operational perspective of what it means for the economic viability of the practice, is where these concerns come from.

Julie Sonier: This is Julie again. I'll just note that, you know, with all outcome measures, it's why the risk adjustment is particularly important, so it really is not – so that it doesn't penalize providers based on the characteristics of the population that they happen to serve, compared to (it). But I think it is in our community being used for payments without a lot of push back from providers but maybe that's just because they are more used to it.

Kimberly Rask: This is Kimberly. You know, as I think about it, I also think it matters to me – the question how it's used but also at what level. So from a public health perspective, it makes sense from a population you'd like to know this.

We want to know if there's a large rural areas where so few of the people has diabetes, are actually having all five of these, where – that we want them to be. And that would give us the ability to identify disparities and target improvement efforts.

So I see the value for that and I understand the concerns about, well, is a provider going to have their payment (docked). But I'm not sure that that perspective should overrule our desire to ensure that we know whether or not patients with diabetes are at the best as best they can be certainly if there are areas that are disparate. And the people living in those communities are not achieving the same results.

Cheryl Powell: This is Cheryl Powell from Truven-Watson Health. And I agree with that and I think too, for most of the measures, we can go back and have the conversation. It's a balance between payment perspective and a quality improvement perspective.

I think we don't want the payment perspective to drive everything. And I think maybe adding a paragraph or something in the report that talks about this sort of tension and balance that needs to be considered to drive towards the outcomes that we're really looking for. And how measures are used in that context, is incredibly important particularly in the rural setting. And that may help.

(Sandy Pagonas): OK. This is (Sandy Pagonas) again. And I agree with some of the discussion that's going on. Unfortunately, when NQF endorses a measure that automatically (means) it’s appropriate for payment. So this measure is endorsed, and now we're trying to decide if its good enough to be a core measure. And I guess that's where my objection comes in, is that people are still free to use this measure for quality improvement as they want.

But to put it in the status of a core measure, I think it's premature and I think it's – I think the measure could do better in terms of determining how well diabetes care is handled and what the public health focus should be.

Ira Moscovice: Yes. And I think you can't – I mean I appreciate the public health versus human policy discussion. But I just – no, I just don't think we can ignore it. I mean it's one thing to, if providers in this communities are doing good but they're not doing good enough to get what kind of payment or those subjects to a negative adjustments and it affects the economic viability to a point where the practice closes because these are not as what just noted used by Medicare but other payers as well.

Now, we've gone from a situation where we had a good provider. It may not have been at optimal level but was good. But because they were only good, they couldn't achieve the measure standards, they saw reduction in payment. And now the practice has to close. And so now we've gone from a community that has good care to a community that has no care. And I think that was – that has been part of that the whole access to care component of this and how this all ties together.

(Sandy Pagonas): I absolutely agree.

Karen Johnson: We have a comment.

Shelley Carter: This is Shelley Carter.

Karen Johnson: Go ahead.

Shelley Carter: I want to say, I agree with that process too, a good provider is beneficial to a community and to remove that provider because they did not – were not able to meet all these measures within this one measure limiting the population of their access.

Karen Johnson: So, we had a comment from John on the chat. Kate, would you mind reading that for us?

Karen Johnson: Sure. So John Gale was saying that he is sensitive to (Sandy's) concerns regarding the all or nothing nature of the measure as well as Bill's concern about issues within a provider's control. However, he is reluctant to vote against including it on the diabetes, including on the core set. And saying, perhaps we can recommend that the measure is only appropriately used for quality improvement or population health improvement efforts and not to be used for payment adjustment.

Bill Finerfrock: I would be fine with that, this is Bill.

Brock Slabach: This is Brock in NRHA. I would be happy with that addendum.

Crystal Barter: I think that's completely appropriate. This is Crystal from the Center for Rural Health.

(Sandy Pagonas): And this is (Sandy).

Kimberly Rask: This is Kimberly. I would go with that too.

(Sandy Pagonas): This is (Sandy). I think that would be appropriate but unfortunately that's not how it's going to be presented. People will look at the core measure set and it will be used as it is with no – there won't be any attention paid to the fact that there's a footnote somewhere, if the footnote makes it into the core set that it's not to be use for payment, and that's – and once NQF endorses that it's automatically assumed to be appropriate for payment. And simply by appearing in the core set will make it used for payment. That's my (inaudible).

Madison Jung: This is Madison. To clarify the current scope of work for our work group and how this core set is kind of identified is, our current charge is to identify core set of the best available rural relevant measures to address the needs of the rural population.

So I think we're getting a bit into the future state and which is rightfully so an implication that we should take into account. But I think these discussions could kind of fall under the recommendation of maintaining the core set for the future. But as the core set is currently defined, it is to – our charge is to

identify core set of the best available rural relevant measures to address the needs of the rural population.

So I just wanted to add that framing question moving forward because we are running a little bit behind.

Ira Moscovice: Yes. I think that's a good comment, Madison. And I think we do need a deal with the charge as its postured. And we can try to add something appropriate language that'll be run by the whole committee that NQF staff will come up with. That reflects the kind of comments we've been having.

Any other further comments on this one before we move on?

Julie Sonier: This is Julie. I'll just make one last comment. I think this conversation we've been having about the use of outcome measures for payments will be relevant with just about any outcome measure.

Ira Moscovice: And what I would add to that is the vast majority of measures that are endorsed by NQF are not being use for payment purposes at least at this point. Some are, but the vast majority are.

Karen Johnson: So what I want to do here is to actually – I think I heard a lot of people kind of liking John's suggestion of putting a footnote, as (Sandy) suggested, that might get us somewhere. Again, we don't know how this might be used in the future. All we're doing is kind of creating a list of measures that might be used in various ways.

So I think what I want to do is actually take an informal of vote on inclusion or exclusion of this measure. And if we did include it, I think we'd be OK with this little footnote that John had suggested. So it will go in with this little footnote or the other option would be not included.

So, maybe if – we don't want to go necessarily too far, too crazy on this but basically how many of you really want to not include the measure and not include the measure?

(Sandy Pagonas): Aye.

Karen Johnson: OK, that was (Sandy).

(Sandy Pagonas): Yes, that was (Sandy).

Karen Johnson: OK.

Shelley Carter: Shelley Carter.

Karen Johnson: Shelley. OK.

Bill Finerfrock: Bill Finerfrock.

Karen Johnson: Bill.

Janet Wagner: Janet Wagner.

Karen Johnson: Janet. Anybody else you want to (inaudible)?

(Marcia Ward): (Marcia Ward).

Karen Johnson: (Marcia). Anybody else? OK. That is – that's …

Female: Seventy-five percent.

Karen Johnson: Seventy-five percent with five of our 18 are …

Kate Buchanan: We now have 20.

Karen Johnson: We now have 20.

Kate Buchanan: We have 20 voting members.

Karen Johnson: OK, all right.

Kate Buchanan: And we have five of the 20 vote not to include.

Karen Johnson: Vote not to include.

Kate Buchanan: And to reach consensus on that, we needed agreement of over 60 percent of anything, and so five of the 20 does not meet the 60 percent threshold to (those).

Karen Johnson: Or to say the other way around 25 percent are OK with keeping it, would be the other way saying. With that, I think consensus on – from the panel is to go ahead and keep it with this caveat that John has suggested for the specific measure.

When we get to that overall vote, we'll see if you're still comfortable with going forward with the over all vote. That was a really good discussion though and, you know, it's kind of micro chasm of all the discussions that we've had on all of our calls. These are not trivial issue.

We are learning a little bit behind but I honestly think that those first three were the harder ones. So let's keep going. We have two measures to the Healthcare Associated Infection Measures, the Quality Measure and the CDI Measure. And the rationale we're kind of talking about this together.

Workgroup rationale was that for the quality measure, it is the most common hospital infection. And possibly resistant to low case volume the idea there is basically everybody in the hospital is in the denominator. And therefore is the measure applies to them not everybody will show up in the numerator obviously. And hopefully, we want very few to show up in that numerator.

1717, the CDI measure, again, a very common infection. They are being reported in a lot of the hospital programs and is also part of the MBQIP Program although as an additional measure not a core measure. We did receive three comments that they're recommending removal of both of this, and the concern again was low case volume.

So, again, I think this was the QIO who had looked at analysis of these measures and relatively few of the CAHs had enough cases to be calculated probably would actually reported quarterly and possibly even yearly basis. And the only thing I want to you remind of is definitely CAHs are part of our rural providers. But there are other rural hospitals out there that, you know,

might be affected either by the infections themselves for the low volume, not just the CAHs.

So, Ira, I'll let you facilitate that discussion. Yes.

Ira Moscovice: I would just add one comment that (Anne Quinsy) on the call from Stratis Health. But she suggested – she sent some comments and saying, they have concerns about the utility of the HAI measure that's currently calculated, but don't want to lose the context that they think it's a really important data for CAHs to be tracking reporting these kind of information. The issue is how to translate it into a meaningful metrics.

So once again, this can be relevant to some hospital, particularly some of the hospital basically some of the smaller hospital but not all. Open for comments from the workgroup.

Kimberly Rask: This is Kimberly. I think the low volume is an issue but as you pointed out, I guess, I kind of hate not having any infection measures in there to say are important. So I guess it would be that this is a measure that has value but for many rural providers, it will not be relevant.

Ira Moscovice: Other comments? Anybody who would like to make the case for removing either one of those two measures? OK. We're ready for the next one.

Karen Johnson: All right, so those two will stay. Our next measures is 0166 the Hospital CAHPS Measures. And just to be clear I don't think I was really as clear as I should have been in talking these measures. These all come under one NQF number, but there's really 11 measures that are calculated and reported out of this data.

So seven are what we call multi-item measures. They deal with things like communication with doctors, communication with nurses, responsiveness of hospital staff, pain control, communication about medicines, discharge information and care transitions. And then, those four additional measures that get at cleanliness of the hospital environment, quietness of the hospital environment and overall rating of the hospital, and a measure about recommendation of the hospital, recommending a hospital.

The workgroup rationale was that we really wanted a measure that captures patients experience in the in-patient setting. Kind of on the flip side is definitely the recognition about the burden of data collection, and a recommendation that CMS consider allowing data for the measures to be collected electronically and encourage more participation.

This measure is being currently reported in several programs including MBQIP from the public. Again, a couple of recommendations for removal and, again, the low volume issue especially some of the smaller CAHs not able to get the number of 25 surveys returned.

With that, I want to be sure, I think maybe – and, Ira, you can help me here. You had a late breaking comment from folks at Stratis Health. And it's kind of tricky in part with the way that we ask for a comment. But we actually ask, you know, do you recommend measures to be excluded and they actually have listed HCAHPS as part of that discussion. But I think based on a more recent e-mail, they clarified that they don't support removal of CAHPS from the core set just recognizing that the low case volume could be a problem for CAHs.

Ira Moscovice: Yes. I mean (Carlo Wang) basically in this update e-mail, just want to make sure that they felt it's really important to have some measure of patient experience. And this is the best one we have right now and we need to do more in this area. But she's saying Stratis does not recommend removal of that. That they feel it should stay in the core set.

Karen Johnson: The other commenter who recommended removal that one still stands. So …

Ira Moscovice: Yes.

Karen Johnson: Yes.

Brock Slabach: This is Brock here. I recommend that we keep this in the data set and there's not withstanding all of low volume issues. And I think that, again, you know, if this becomes – there develops a rural map, I would love to see it start evolving the HCAHPS experience of hospitals to change some of the

collection techniques which is what is severely limiting the return on this HCAHPS surveys.

Ira Moscovice: Other comments?

Karen Johnson: So we're hearing no suggestions to drop this measure? OK. Let's go to the next one, the VTE Measure.

The rationale, lots of risk factors for VTE and it can lead to very serious unintended outcomes, so an important measure from that perspective. There are two versions available, the kind of the original one and then e-Measure currently being reported through as I think more from the e-Measure side.

Two comments, recommending removal. One is low case volume, the second is just concern about the e-Measure reporting, and that might not look for everybody. They again, a really – there are two versions available of this one. So …

Ira Moscovice: Comments from the group?

Melinda Murphy: It's Melinda. Since I spoke about putting this one in early on, I've gone back and looked since I saw the comments. And this measure applies to virtually all hospital patients, it does not apply only the surgery as some people may have thought. And it applies day over day after hospital admissions so that picks up the medical patients or day of – or day after surgery in date – so it does also pick up the surgery patients.

There are a few exclusion that they are – I can go through them, there are few exclusions. I went back and looked at data that's been published articles that have been publish since this VTE 1 was endorsed. And there still is information about up to 900,000 people developing VTE annually.

And a number says I'm looking at the MMWR that was 2014, that said of whom approximately 100,000 died, and mostly a sudden death because the cause was unrecognized. So I would say I don't understand the low case volume comment based on the applicability of the measure. And given the outcomes of the measure, it seems to me it would be an important measure.

And also appreciating that prophylaxis can be mechanical or pharmacologic. So it seems to me that it – that the two comments sort of maybe due to a misunderstanding on the part of that reviewer.

Karen Johnson: Thanks for that.

Ira Moscovice: Any comments from the workgroup?

Brock Slabach: Ira, this is Brock here. NRHA and Rural Wisconsin Health Cooperative, would support hardly this measure (are abstracted). And the e-Measures that was already stipulated have a number issues and could be problematic, and actually using as a measure of quality of care. And then once that was protected then the e-Measure could be adopted.

Ira Moscovice: OK. Additional comments from the group?

Karen Johnson: I'm not hearing appetite for taking this off the list. All right, OK.

The next one, 0471 C-section Birth. Workgroup rationale, rural areas have a limited number of obstetricians. But that said it's still important to focus on best practices, including a reduction in C-section delivery. It is currently one of the measures in the Medicaid adult core set, not the other program but in the Medicaid core set.

We did receive one comment recommending removal. And really that was due to the limited proportion of CAHs who provide obstetrics services.

Ira Moscovice: Open it up for comments.

(Sandy Pagonas): Hi, this is (Sandy Pagonas). And I will not be able to state this with the eloquency and fashion that Dr. Schmitz I know has spoken about this measure with the entire committee, but I'll give it a try. He feels that this measure may very well have unintentional consequences mainly women losing access.

There are cases in rural America where a physician is called upon to make a decision if the baby is potentially in trouble, is the baby potentially not in trouble and if the baby is potentially in trouble, is it better to take the baby by

C-section then put the mother and baby at risk of delivering unexpectedly with the rural healthcare center 100 miles away.

So while he express that he's not aware that C-section rates are in fact higher in rural, he's not really sure. He does express that concern that we have to very vigilant about looking for intentional consequences of this particular measure.

Ira Moscovice: You know, Karen, I think that's an important comment in general for all the measure we have and something that really should get added in that final section in terms of making sure people hear that that's a potential concern of any of these measures really.

Kurt Lowry: Yes. This is Dr. Lowry. And I'm actually an OB-GYN physician. And so, again, it depends on how it's going to be used, right? So this is a problem in America is the number of cesarean sections which are going up. And this ends up creating long term problems women because in later pregnancies, they're more likely to have placenta accreta and placenta previa.

And so, it is something that where in the field of women's health, we're really, really trying to address those important measurement. But I agree with the comments that if it decreases the number of hospitals that are providing obstetric care in rural areas, which is a huge damn problem for America as well, because they're dropping like flies in the rural areas, but it is something we need the measure.

S, I mean, if it's used to penalize hospitals then no, we shouldn't do it. But if it's a measurement that's going to allow us to try to help to reduce this, it's a good thing. So, I mean, that's kind of what I think.

Ira Moscovice: Thanks for your comment. Other comments on this?

Brock Slabach: This is Brock here. I was struggling when I received the note of how this got into the core set. I'm kind of – my thinking that the core set would apply to all low volume hospitals and then either now or later at some point we would develop, I guess, I'll call them specialty services that are offered and perhaps

having optional sets of measures for different service lines that are being offered. And obviously obstetrics would be one.

So, I support this measure in a specialty subset, not in the core set. So I think that may be a distinction that's important to Medicare. I will just offer parenthetically that at the hospital I was at in (inaudible) our c-section at the national. So I think we found that we were doing really well in this metric with low complication. So we might find it actually this is better in rural communities, but we don't know.

Kurt Lowry: I think the data says that it's lower in rural communities mainly because they don't have surgeons sitting around on labor and delivery capable of doing something in three seconds. And so the delay often results in vaginal delivery just because they can't do C-sections as fast.

Brock Slabach: Good point.

Julie Sonier: This is Julie Sonier.

Ira Moscovice: Other comments in the measure?

Julie Sonier: One additional comment I think is that we don't really know what the right rate for this is and, you know, it's not clearly, you know, it's not – certainly not the lower, the better. To me that speaks to the measure perhaps having limited value because we don't know what to conclude from it.

Ana Verzone: I'm sorry. What's the – this is Ana Verzone. Was the comment that we don't know what the optimal rate C-section is?

Julie Sonier: Correct.

Ana Verzone: I believe the WHS says 15 percent is reasonable, like that's what to be expected in terms of optimal rate. And if it's less than that, then that is a sign of less access.

Ira Moscovice: Additional comments? Once again, Karen, you know, following up on Brock's comments, this obviously is only going to be relevant and applied to hospitals that deliver babies and, you know, particularly given the access

issues we're talking about hopefully in a minute. You know, the access to this kind of services, OB services is a really important policy issue.

But is impossible to split things? I mean, how would you respond to Brock's comment in terms of we know this measure is not applicable to all rural hospital?

Karen Johnson: Right. I'm not exactly sure. I mean, I don't want to put words in Brock's mouth. But Brock did served on our 2015 panel and that panel had suggested building core set or, you know, a core set of measures but then also having optional sets of measures.

We were not tasked to come up with a set of optional measures. But, Brock, it almost sounded like you would – if we had been tasked for that, you would see this as optional measure but not a core set measure. I don't know if I got you right or not.

Brock Slabach: You correctly summarized that. I would like to see this measure into a corpus of measures, not just one measure on prenatal care. But a grouping of measures that give a really nice reflection of the quality of the obstetrical services and (quality). But this just by itself just seem odd in the (inaudible) of majors that we see listed here.

Karen Johnson: Now, we could go back and apply just kind of across the board as we've already said that we would do. That, you know, obviously, you know, these measures would apply to the hospital that they apply to. So, I think we probably need to do for this one pretty much what we did for the diabetes measure, that just kind of feel very comfortable or as comfortable as we can about who would really be OK with this not showing up on the core set versus those who would really like to see it on the core set.

So if you would just call out your name, if you do not want this on the core set.

(Sandy Pagonas): (Sandy Pagonas) for David Schmitz. No.

Brock Slabach: Brock Slabach. No.

Karen Johnson: Brock, all right. And everybody else, it sounds like either you're on mute and you didn't realize it, or you're willing for it to go forward on the core set.

Steve Jameson: This is Steve Jameson. I'll just abstain as far as (ACEP). I don't really have an opinion in those particular area.

Karen Johnson: OK.

(Marcia Ward): (Marcia Ward) …

Ira Moscovice: You know, Karen, though I think – sorry.

Karen Johnson: (Marcia), you were a no? You don't want it?

(Marcia Ward): Correct.

Karen Johnson: OK. Ira, what were you going to say?

Ira Moscovice: I was just going to say, you know, the comments we're getting on this and some of the other measures point out the challenge of developing these kinds of measures for rural hospitals. And somewhere in the report I think we need to address that. And that this is a great start, but it's a start, it's not the end. And we've got work to do in a variety of ways to keep improving this list.

And hopefully these measures will improve over time. There's different reasons why people have some concerns about a couple of the measures, and we just need to clarify that. Rather than just saying in the report, here's the 18 measures. And I think staff can figure out, you know, a good way of doing that.

Karen Johnson: Yes, we can. So it looks like we have three people who really didn't want to see it on the list, but others are OK with it on the list for now. OK.

That brings us to the end of our measure by measure discussion. It took a little bit longer than I was anticipating, but I'm OK with that. The rest of the discussion in the few minutes that we have left, and maybe I'll just give it five minutes or so.

Basically, the idea was in our access to care portion of the report, we identified the three major domains of access and then the really important facets of access. We described some of the key challenges for rural providers and then talked about ways to address those challenges.

We had the report as written. Really had a little bit of thinness around ways to address the challenges related to provision of health information, having physical spaces, and then delayed care due to out-of-pocket cost.

And again, Melinda was really, really nice to us and that she went back and actually offered some things that you as the committee had said in terms of some of these challenges that we, staff, maybe didn't catch. So she actually was able to add in a little bit.

So for example, for health information, she had noticed that there was at least some discussion of expansion of remote access technology. So we can add that to our report. I think from you if anybody can give me a quick example of what that might look like, that would really help kind of be set up a little bit.

In terms of physically spaces, challenges, it's hard and expensive to retrofit. And then there was discussion about licensing options and definitions. I don't know that we really need to add anymore unless you can think of something else beyond that. I think we're good with that one.

And then finally, the delayed care due to out-of-pocket cost, you know, I think most of what we talked about was the challenges and, again, if people have any ideas on how to address those challenges, or seeing ways to bring down cost, I think that would be really great.

So if can you give me a quick example of remote access technology that might have addressed that, I just wasn't sure what that meant, and then any other ideas about how to address delaying care because of cost.

And, Aaron, I don't know if you're on the call or not. I know you were going to drop off, all right. Sounds like not. Ira, do you want to facilitate this or you want me to just keep going or how do you want to do this?

Ira Moscovice: You can keep going if you like, you're doing a great job.

Karen Johnson: I know we don't have a lot of time. It was really just to kind round up this discussions as best we could. So if we …

Kurt Lowry: Load access technology is sort of hand-held video conferencing, right? Cellphone, technology that allows us to now do video conferencing directly to the patient and to rural provider.

Karen Johnson: OK. OK. I really wasn't sure, when I saw that. I didn't quite know what that was. OK. So …

Kurt Lowry: I would also include remote monitoring devices such us continues blood glucose monitors and continuous blood pressure monitors that are now, you know, being deployed wholesale large – beginning do be deployed that are going to have an impact on patient management.

Karen Johnson: OK. So that the patient can see their thing right there in front of them.

Kurt Lowry: Right.

Karen Johnson: OK. Perfect. Thank you. How about the delayed care due to out-of-pocket cost? So we know that there's the network and adequacy, we talked about that quite a bit in the last time around because they are under insurance, higher deductible, those kinds of things. Are there anything that you guys know of that people are doing, kind of on the ground, to try to address some of these things?

Kurt Lowry: Well, I might say that the illustration of value-based care products as opposed to fee-for-service I think might have an impact on these sort of issues.

Karen Johnson: OK. So policy in general and DBP more specifically.

Ira Moscovice: Yes. I think you might also want to talk about efforts to try to preserve the safety net. And NASHP has a couple of good pieces out on sort of what the state is doing to try to help with that.

Karen Johnson: That was ASPI you said, Ira?

Ira Moscovice: No, the National Academy State Health Policy. And I think some of the PAs and NPs are looking at thing of allowing individuals to practice to the maximum extent of their education and credentials, recognition of PAs and NPs as part of panels by health plans. Medicare or Medicaid are pretty good with regard to recognition of PAs and NPs, but very often some of the either the value-based patient center medical home network will not often recognize PAs or NPs as panel members in their own right for the purposes of assigning patient.

Karen Johnson: Thanks for that. Anything else that can comes to mind real quickly?

Brock Slabach: Karen, I don't know if this applies in this area but I think monitoring the patient balances after insurance. Those are increasing significantly and metrics are used to document those. And I know if that's useful in this conversation. But I think that that rise is causing obviously increase numbers of (bad debt) and charity care being delivered. And obviously, inhibits the ability for patients to access care if that becomes a problem. So just to note there.

Karen Johnson: Yes. No, I think that definitely applied. Thank you.

Kurt Lowry: Should we say that the Affordable Healthcare Act? I mean, has that had an impact on rural health care delivery? It has in Arkansas. I can tell you that.

Brock Slabach: Well, it has and I think that it had kind of – this is Brock again. You're right. More people are insured in the States that have expanded Medicaid per the Affordable Care Act and then also have used that (just) to create exchanges is vital.

The problem is that, oftentimes that they're insured, there's insurance literacy which is a real problem for patients who haven't had insurance heretofore.

And then, the second issue is just that again that PBAI, the Patient Balance After Insurance, they may be selecting high deductible plans of $2,000-$5,000. And for all intents and purposes, many of these folks don't even need to be insure – I mean they don't have insurance because they – that immediate threshold.

Kurt Lowry: Yes.

Brock Slabach: So, it's a both (hand) and I think that PBAI statistic kind of gets that some of the other downsized effects of those programs.

Karen Johnson: Great. I'm going to do – thank you for that. I'm going to do two things, number one, Kate, keep me honest, did we take care of our comments here, is there anything else that we needed to do in terms of the measures or are we good?

Kate Buchanan: There's one more comment on the HCAHPS. And the suggestion was dropping the pain control measure, given concerns about opioid prescribing practices. And if that can't be drop, then we can't modify measures, so it can't …

Karen Johnson: Right.

Kate Buchanan: … drop. Suggesting adding language to highlight concerns with that specific HCAHPS element.

Karen Johnson: OK. So that's on the table. The only reason I'm hesitating on that one, John, is I think there may already be changes to that particular measure that may not …

Brock Slabach: I think patients have already been promulgated to make that change if …

Karen Johnson: Yes.

Brock Slabach: … I could be corrected on that. But …

Kimberly Rask: Right. Yes, this is Kimberly, that's correct. It's been moved to a communication about pain measure.

Karen Johnson: So that's kind of already happening and I'm not sure where it is again on the NQF endorsement timeline, yes. But yes, it's going from pain control for exactly the reason that John has suggested with the opioid problem. It sounds like that we don't need to put that caveat on there.

Kate Buchanan: So, I think we're – I think we're good.

Karen Johnson: You think we're good? OK. So we're going to swap things around a little bit. We're going to ask for public comments first, just so you get one more chance to hear any public comments. And then I'll let Kate walk us through our vote.

Kate Buchanan: Yes. So, (Cathy), would you mind opening up the lines for public comments? Additionally, if you are streaming but not dialed in, please feel free to type a comment in the chat box, staff will read it aloud. And we're going to ask the to hold the lines open for 20 seconds.

Operator: At this time, if you would like to make a comment, please press star then the number one.

At this time, there are no public comments.

Kate Buchanan: OK. And we also didn't receive any comments in the chat box. So now we're going to move on to the workgroup vote on recommendations. And so as I said earlier, for those who have signed in using their link, they should be able to vote. For those who have not, please free to either chat.

And I believe, Janet, I believe that you'll need to chat your vote into the box. And, Aaron, if you're on the line please state it aloud. If you are not, Ira is going to act as a Aaron's proxy. We have 20 people who are able to vote right now.

And so, one of the things – this is an overall vote. Just the vote on the core set as well the access to care measures in the entire report. And I do want to go through because we have a lot of discussion on some of the measure.

And so, there were no recommendations to remove measures that passed. So all of the measures discussed will be included in the final core set. I will say

though that there were recommendations to put caveat for a lot of the measures which staff will go through and do.

For example, 1789 Hospital-Wide All-Cause Unplanned Readmission, recommending that that if it doesn't apply to hospitals who can't reach the volume, which will be recommended for several new measures for their low cost – low volume issue. And additionally, that it not be used in a payment program.

And so that is also recommendation for 0729 Optimal Diabetes Care that it not be used in a payment program. And then, we did have – there were some concerns about the cesarean section measure, and while clarifying that it's only applies to hospitals that provide these services.

Additionally, we'll go through the notes that you guys had made on expanding upon the access to care recommendation and those will be incorporated in the final report. And so there are just a couple – those are the things that will be included. None of the measures will be removed. We'll be adding a lot of caveat based on the discussion today on the eight measures that we have. And the – this is one vote for the entire report.

So as it stands now, do you support both the reports recommendation for ambulatory care, for hospitals care, for access to care. And one of the things that I also wanted to add that that we'll be putting in our future steps is that, the workgroup recommends this be an ongoing process, and that CMS continue to fund the MAP workgroup so they can refine the core sets. So, that is something that will also be included.

But I do want to take a stop because I know it's the first time we're doing kind of a formal vote. And I wanted to know if people had any questions or if I could provide any clarity?

Male: So, as soon as we click the box it automatically records it and there's no additional thing that we need to do in terms of submit or anything like that, right?

Madison Jung: That's correct. Just select the box as it appears in your screen.

Male: OK. And how do we know that that vote has been tallied?

Madison Jung: Either if you see the number go up or down. I believe you can check and uncheck. You should or – operator, is there anyway for them to verify other than just seeing the number?

Male: Yes, I mean, I've seen the number go up. I don't know whether it went up when I checked the box or not. OK, all right. I'll just take your word for it. OK.

Madison Jung: Yes. We'll see when the tally comes in and we can always double check the center.

Kate Buchanan: So, Janet, I received your vote. Thank you very much.

Female: Do we have (inaudible) yet?

Madison Jung: We have not. We're waiting in the line.

Kate Buchanan: And John Gale, if you don't mind just voting via chat box?

Madison Jung: So, currently, we have 15. We are waiting – or 16 votes received. That means we're looking for four more. Is that correct?

Kate Buchanan: Correct.

Ira Moscovice: So Aaron hasn't contacted me yet. So that's probably one of them.

Brock Slabach: I think he gave you your proxy, didn't he, Ira?

Madison Jung: Yes.

Brock Slabach: So you vote for him?

Male: Right.

Ira Moscovice: Oh, I thought he was going to send me something. OK. Well, I can …

Brock Slabach: Oh, he might have. I just thought he gave you your – he gave you his proxy, so.

(Inaudible)

Male: But he trust your judgment.

Ira Moscovice: Yes, that's unfortunate. But I don't have a way of voting or I can't check it again if you have …

Kate Buchanan: Right. So you can say it aloud because we're doing a count right now, so I've received.

Ira Moscovice: All right. So, I think Aaron's vote approved then.

Kate Buchanan: OK, excellent. Oh, I'm sorry. My apologies, Ellen. So, it looks like – Ellen, I have received your – I received your vote via chat box. So I have that now. John, I have received your vote via chat box. I have Janet, and then I have Aaron's proxy. And then that means that we have – so that's an additional four votes we have and one vote to approve the recommendation.

So, I'm just saying this aloud for the transcripting even though everyone can see it. So, we had a total of 20 votes, four were conducted through the chat box, 16 were conducted through the voting links. Of the 20 votes, 20 voted to approve the recommendations and zero approved not to – and zero voted not to approve. So the recommendations will go forward to the MAP Coordinating Committee during the August 14th call.

And I think we can go to next steps.

Female: Excellent.

Karen Johnson: So, thank you.

Madison Jung: So, yes, congratulations, everyone. This was the last kind of decision you as a workgroup had to make. So, we're right on the dot at 3 o'clock. So, as always very impressive, your time and dedication for this work.

But in terms of next step for us, this was the last time we'll meet at a workgroup as a whole. The staff will work up on updating the draft report and finalizing that. And that will be sent to the MAP Coordinating Committee on August – by August 14th. They'll be reviewing it on their web meeting on August 14th. And they will review for approval.

Following their decisions that they have any stipulations to make, we'll make this update. So, other than that the final report will be submitted and posted by August 31st.

So in terms of next step for our workgroup, that's really it. Karen, did you want to say any closing remark or anything?

Karen Johnson: I just want to say thank you for all your hard work. And, you know, this has been great. It's been kind of a tough project for us because we were moving so fast, but I think we are proud of where we've landed. So, great.

And I wanted to hand it over to Ira to maybe close this out if you're OK with that. And, Aaron, if you're on, but I think we've lost Aaron.

Ira Moscovice: Yes, I think we have lost Aaron. But I just want to say a big thanks from all of the workgroup to the NQF staff. You've done a terrific job on this. And it's been a compressed timeframe as you all said. But I really think we have a good product and we're all looking forward to the final draft.

And once again, thanks to all the members. The work you're doing is terrific. And what we're seeing more and more is that, the quality issue in the rural environment is being looked at much more seriously now by people living in the community, by rural providers, by payers et cetera, and as we move towards the pay for value and God knows whatever else kind of environment coming up.

I think this is really a good first step in terms of making sure we have the data we need to let people know what's going well, what's working right in rural areas. So where we do need to improves, I really appreciate the effort of the staff and the committee members. And I'll sign off from here.

Madison Jung: Thank you so much.

Karen Johnson: So, again, if you are interested in listening into that coordinating committee call, feel free. I think you have the invite. So, you don't have to, but if you'd like to please join us. And have a great rest of your afternoon. Thank you so much.

Kate Buchanan: Thank you, everyone.

Ira Moscovice: Thanks.

Female: Thank you.

Female: Thank you.

END