Rural Quality Advisory Council Meeting Summary
Thursday, July 6, 2017

Please refer to agenda and PowerPoint slides as additional resources. This summary is intended to capture the questions, input, and ideas received from Council members (not to recap the entire meeting).

As noted in the slides, we started with a review of the Council purpose and focus, and provided brief highlights from the April Council discussion.

Beyond the NQF Low Volume Report: What's Next

Yvonne Chow and and Curt Mueller from FORHP are presenting the NRHA Quality Conference on July 14 on efforts to date to advance the recommendations made in the 2015 NQF "Performance Measurement for Rural Low-Volume Providers" report. They shared highlights of their presentation, and sought ideas and reaction. Discussion highlights:

- Nearly 2 years since NQF Rural Report was released (September 2015), in which the overarching recommendation was that CMS make participation in quality measurement and reporting be mandatory for all providers (including low-volume and rural), but in phased approach
- The NQF expert committee, and FORHP, don't want rural providers to be left behind in quality, nor for it to be incorrectly interpreted that if low-volume/rural providers don't have scores, it indicates low quality
- Since the report, CMS has put changes in place in a variety of payment and reportings programs which begin to account for rural/low volume, for example: new volume/dollar thresholds for providers and potential virtual group reporting for QPP/MIPS, and risk adjustment methods with extra quality points when it comes to performance ranking. In addition, NQF recently released report on framework for telehealth recommendations, which was one of the recommended areas for focus in the report.
- However, core payment, incentive, and reporting issues related to CAHs, FQHCs, and RHCs and participation in programs still has not been addressed.
- MBQIP was developed six years ago as a voluntary program providing support and incentives for CAH quality reporting (CAHs required to meet minimum reporting thresholds to access Flex support). Majority of measures are CMS metrics (with the exception of EDTC). FORHP has been able to use the NQF report as a tool with HHS partners such as the CMS IQR and OQR programs and CDC, which has helped open some doors related to alignment and support linked to HIINs (Hospitals Improvement Innovations Networks).
- FORHP has some optimism in terms of moving forward with recommendations from the report. CMS appears to be aware and willing, but operationally a lot of barriers and the burden is high.
- Of note, MedPAC recently included a statement in one of its report that MIPS as presently designed is unlikely to succeed. June 2017 MedPac Report, Chapter 5: http://www.medpac.gov/docs/default-source/reports/jun17_ch5.pdf?sfvrsn=0
- Comment period on QPP proposed rule is open until August 21st. To read the proposed rule, and for instructions on commenting: https://www.federalregister.gov/documents/2017/06/30/2017-13010/medicare-program-cy-2018-updates-to-the-quality-payment-program

New MBQIP Measures

FORHP is considering the addition of three measurement areas for inclusion as Core MBQIP measures, which would take in effect in FY 2018 – 2021 (starting in September 2018) -- antibiotic stewardship, ED throughput, and health care acquired infections (HAI). FORHP has been seeking comments, and is seeking feedback and input from the Council members (the changes will be finalized shortly after the Council call).

1) Antiobiotic stewardship: 26% of CAHs successfully implemented in 2015, CDC developed a guide specifically for CAHs which will be released in July.
   Comments:
   - Flex programs already work closely with the HIINs (concerns over overlap/duplication)
   - Evaluation component was a primary question. Measurement likely to be Annual Facility Survey completed as part of annual NHSN reporting process.
   - CDC is very supportive
2) ED-1 and ED-2: Currently 'additional/optional' MBQIP measures, so this would be a move to become core. Complimentary to Outpatient ED Throughput measures. About 40% of CAHs already reporting.
   Comments to date to FORHP were mixed bag of supportive and not supportive.
   - Not too much of a 'lift' to add this reporting, but some concern that timeliness is not really a concern in hospitals with low ED volumes.
   - FORHP exploring options for using eCQM reported data in the future
3) Hospital Acquired Infection (HAI) measures CAUTI, MRSA, CDI: Broad Federal initiatives focused on HAI
   Comments:
   - Reporting burden is a concern. Some HIINs don't require NHSN reporting for CAHs (can just submit numerator and denominator to meet HIIN requirements).
   - Standardized Infection Ratio (SIR), the primary HAI metric calculated by NHSN, can't be calculated for most CAHs due to low volume.
   - Logistics of NHSN reporting takes a lot of support in small facilities.
   - Mixed feedback – important, but challenges with reporting process and burden.

Additional Technical Assistance Needs for MBQIP and SCHPQI

The RQITA Cooperative Agreement will be up for competition next year, and FORHP is seeking input and ideas. Discussion:

- With less emphasis on inpatient care and increased emphasis on SNF, ambulatory, outpatient, what are the likely areas for QI measurement and focus in the future?
- Collaboration with other quality programs – align with other programs and support (e.g, HIIN, QIN-QIO)

If Council members have additional input or feedback, please share it at mbqip@hrsa.gov

From the Field

- Star Rating Technical Expert Panel – CMS issued a contract to Yale for review and to make recommendations for changes to the Hospital Star Rating program. The first meeting occurred in June, with about 30 representatives. Brock participated, and shared feedback that the program does not work very well for smaller hospitals. The TEP discussed reducing the sensitivity thresholds so that all hospitals will receive a star rating, but it's unclear if that is a better option than current state where so many small hospitals are left out of the ratings. Another meeting of the TEP will be held later this year.
  - If lower sensitivity, there will be winners and losers based on nothing but statistics of low volume. This would need to be footnoted carefully.
  - Many of the measures are only calculated on Medicare FFS, so patients on Medicare Advantage are not included, which is also an issue for bigger facilities.

    - Issues for consideration: social determinants, outcome vs. process measures in calculation
    - TEP will do 'impact' report before making changes based on recommendations (distribution of star rating calculation based on changes)
- Aaron Garman is meeting with Senator Heidi Heitkamp (ND) tomorrow for a couple of hours to discuss health care policy from a rural standpoint. Let him know if have anything to pass on.

RQITA Tools and Resources

Briefly introduced newly released RQITA tools and resources:

- Interpreting MBQIP Hospital Data Reports for Quality Improvement Supports use of Medicare Beneficiary Quality Improvement Project (MBQIP) Hospital Data Reports to support quality improvement efforts and improve patient care.
- Study of HCAHPS Best Practices in High Performing Critical Access Hospitals Identifies improvement strategies and effective best practices for each component of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), collected from high performing critical access hospitals(CAHs) across the US during a series of focus group interviews.

Described RQITA tools in the development pipeline:

- Updates to MBQIP Reporting Guide, CAH QI Guide and Toolkit
- Using EHR Effectively – Resource Packet (SHCPQI focus)

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