Rural Quality Advisory Council
January 23, 2020

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).

Welcome and Launch of New Council Year
Review of agenda, and Council’s intent and purpose. Introduced Stratis Health Rural Quality Improvement Technical Assistance (RQITA) team.

2020 Council Member Rural Health Quality Priorities
Each member introduced themselves, including the organization(s) they represent, and responded to the following questions:

• What is the most important rural health quality or measurement issue in 2020 from your perspective? What are related opportunities in 2020?
• Of all the existing quality measures out there, which are the most relevant in your work (either internally, for care management and improvement, or externally, for telling your story), and why?

Themes and comments from the discussion are captured below:

• Capturing patient experience data with low-volume providers
  o Getting critical access hospital (CAH) buy-in on HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) - patient experience is really important but buy-in for very low volume hospitals with few surveys returned is a challenge
  o Developing a low-volume HCAHPS structure or option
  o CAHs find Emergency Department (ED) CAHPS or Clinician/Group (CG) CAHPS valuable for hearing from their patients (but ED-CAHPS does not have a standardized reporting mechanism available and CG-CAHPS is focused on ambulatory care and therefore not applicable to all CAHs)
  o Important to capture ED Turnaround time and satisfaction – allows CAHs to show the community that they provide excellent and timely care

• Challenges with manual and/or electronic health record (EHR) processes for documentation, data collection, and reporting
  o Overcoming the still manual process to report measures out of their EHRs, which is time consuming and expensive
  o Reporting measures manually and adequately from the EHR
  o Consistency and accuracy of data submitted

• Improving access and appropriate utilization, and integrating behavioral health
  o Decreasing ED utilization and increasing primary care
  o Developing navigator systems in senior care/assisted living rather than utilizing nursing homes
  o Integrating behavioral health and primary care (for example, for opioids and using telehealth)
  o Rural aging care, advance care planning, and serious illness care
Biggest challenge in substance use disorder (SUD) population – both prevention and treatment; alcohol and drugs of all kinds, including opioids, have been at peak
Mental and behavioral health
Readmissions - especially for our senior population
Follow up from ED discharges for individuals that have comorbidities

- Other topics discussed/raised:
  Maternal Health (3)
  Antibiotic stewardship
  Diabetes A1C, hypertension, and obesity – because they each directly influence outcomes
  Improving oral health particularly for maternal, children, and uninsured
  Provider burnout as an aspect of quality
  Rural social determinants of health are hugely impactful to rural population, no matter the measure – it is imperative we change the measures to reflect the influence they have on health outcomes and the social determinate of health.
  Swing Bed measures – need to allow for comparison with nursing homes
  Culture of Safety – allows for employees to gauge our effectiveness as a service provider, whether quality and patient safety are important or not
  HAIs – speaks to the quality of services being offered; less infections denote safer care

Several council members also highlighted challenges and opportunities related to the availability, use, and alignment of rural relevant quality measures:
- Integration of new models of care – how to better integrate MBQIP measures and other state quality measures into what’s coming from Centers for Medicare and Medicaid Services (CMS) for payment models
- Addressing the parts of rural health system that don’t have much information available on quality reporting, including rural health clinics (RHCs) and emergency medical services (EMS)
- Retirement of relevant process measures by CMS, often before CAHs have achieved targets
- Measurement of quality in environments with low resources, low volume, and maintaining relevance
- Ensuring measures stay relevant for rural providers and that providers can keep up with changes
- Breaking down silos between quality measures and how providers can use performance to help with financial and operational improvement
- Focus on low case volume scenarios to help with “fair comparison” for rural hospitals
- Need for population health metrics – broad measures that are applicable to all providers in a rural setting and measure the wellness of the community – obesity, diabetes, blood pressure, cardiac screenings, meds, vaccines
- Opportunity to enhance and modify “grading systems” to allow the primary care provider the ability to be evaluated on effort, not outcome and the patient to be graded on response and not a check box. Social determinants of health have more to do with health than provider effort, and we need to measure the response from the patient also.
- Access to care (referencing the NQF Rural Workgroup recommendations) and systematic access issues such as hospital closure, loss of obstetric services, etc. How do we measure quality that’s given to the whole community and potential regionalization of services?

CMS Quality Program Update
- The Network of Quality Improvement and Innovation Contractors (NQIIC) is a new program contracting vehicle under which all previously separate quality programs are being moved, including the Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs), Hospital Improvement and Innovation Network (HIINs), Practice Transformation Networks (PTNs), End-Stage Renal Disease (ESRD) Networks. 58 organizations were awarded NQIIC contracts, and are
eligible to bid to implement these programs, which are now called “task orders” in the new contracting structure.

- All task order programs implemented under NQIIC will address some combination of CMS’ 5 aims, with three cross-cutting priorities.
  - Aims:
    - Improving behavioral health outcomes (including decreasing opioid misuse)
    - Increase patient safety
    - Increase chronic disease management
    - Increase quality of care transitions
    - Improve long-term care quality
  - Priorities: Vulnerable populations, rural health, and patient and family engagement.
- NQIIC Task Order 001: QIN-QIO is the only program awarded so far, as of November 2019. Fairly significant changes in state coverage from previous scopes (22 states changed from incumbents)
  - Strong rural and medically underserved recruitment requirements for engaging community coalitions and nursing homes.
- NQIIC Task Order 002: Clinician Quality Improvement Contract (CQIC) is focused on improving clinician outpatient care. Not state-based; is a blend of former Practice Transformation Networks (PTN) with some former QIN-QIO work. Contracts are in active procurement now.
  - Similarly, strong rural and medically underserved recruitment requirements.
- Key messages:
  - The Medicare Beneficiary Quality Improvement Project (MBQIP) for critical access hospitals stays the same!
  - Hope for better coordination across and between CMS quality improvement programs
  - Opportunities to develop new relationships – new contractors for QIN-QIO and others forthcoming
  - Expect new hospital improvement program task order (currently, the HIIN program) in late 2020

Discussion:
- Interesting to see how things shake out in this transition period. Critical factor of where this is headed is in payment reform more than anything. Translation of quality metrics – pay for performance – need to get it right.

From the Field
- Kerri Cornejo reminded the group that some quality related rules have gone into effect as of January 1. In addition, CMS has recently put out several calls for technical expert panels (TEPs) - one still open for Total Hip/Total Knee. Please watch for TEP possibilities; important to have a rural perspective in those discussions!
  - Brock Slabach: NRHA is often asked to nominate people to serve on TEPs; may ask Council to see if anyone has interest in volunteering.
- Brock Slabach updated the group regarding NRHA discussions with CMS. Given the challenges of volume sensitive measures and retirement of measures, NRHA has been encouraging development of a Rural Quality Reporting program, separate from CMS IQR and OQR program. In recent conversation, CMS indicated that “this may happen sooner than you think” but need to continue to advocate.

RQITA Update
- New:
  - Measurement Plan and Tracking Tool for Quality Grantees – to support their grant and project related data collection; launched availability on a webinar to the grantees in December hosted by the Georgia Health Policy Center (GHPC)
o **Quality Improvement (QI) Basics Course** – Facilitator Guide & sample syllabus for those interested in convening their own peer sharing cohorts

o **EDTC Resources:**
  - Data Specifications Manual: EDTC Measure and related video
  - EDTC Data Collection Tool and Manual and related video
  - Hosted three national webinars through December and January for CAHs – well attended and well received

- In development:
  - Additional EDTC resources – frequently asked questions document and a non-macro version of the abstraction tool
  - **Virtual QI Mentors** – first “recorded conversation” is slated to be published in early April
  - CAH Antibiotic Stewardship Profiles – collecting currently for inclusion in **MBQIP Monthly** newsletter with plans for an eventual compilation to serve as a compliment to the resource: **Antibiotic Stewardship Implementation: Suggested Strategies from High Performing CAHs** released in Fall 2019.

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