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
Review of agenda and roll call.

MBQIP Strategic Planning
The Federal Office of Rural Health Policy, with the support of the RQITA team, is engaged in a process to determine whether or how MBQIP needs to change to support and demonstrate CAH efforts to improve quality and safety, in light of:

- Eroding availability of nationally standardized quality measures relevant for CAHs
- The rapidly changing quality reporting environment
- The national and state Flex program shift towards improvement activities now that most CAHs are consistently reporting at least some quality data.

The team shared an overview of the process (SWOT, scenario planning, and action plan), how key stakeholders will be involved, and next steps.

Council Discussion:
- In recent years, there are fewer and fewer measures that are available and relevant for CAHs. There has been a shift in reporting environment, and a shift to improvement not just reporting.
- As a CAH, it is helpful to have MBQIP as a core set of measures. There are lots of non-relevant Hospital Compare measures – it helps show impact.

MBQIP Performance Standards
The comment period on the MBQIP Performance Standards (reviewed in detail at the August Council meeting) was August 12, 2019. Highlights and themes from the feedback received and next steps were reviewed.

Primary areas of feedback included:
- Methodology – needs to be some way to accommodate or account for lower volume CAHs (e.g. HCAHPS may not have as many data points); considerations for inconsistent reporting if a CAH misses a quarter
- Utility – lots of great feedback; people think these will be helpful for measure and identifying opportunities for improvement
- Resource Needs – reports for state and CAH level; messaging in terms of what they are used for and why they are important
- Direction of MBQIP – strategic planning, how does this fit into where MBQIP is going

Council Discussion:
- Performance standards make MBQIP a little bit more marketable with high performers (leverage competition); scores are reflective of what they knew to be true regarding performance levels in the state; however, there are hospitals that know how to make their data look good. Data are not necessarily representative of the good work hospitals are doing outside of MBQIP (e.g., HIIN, operational improvements, additional MBQIP measures).
• For Hospital Compare, data is risk-adjusted (patient mix and underserved areas), does that need to be taken into consideration?
• Desire for measures that are more indicative of a culture of quality (falls, ADE, patient safety culture, AS); address low-volume and reporting.
• When I look at some of these measures how would the Federal Office educate the public on quality of care based on influenza vaccination for health care personnel, emergency department transfer communication, and small to no numbers in HCAHPS at times? I look for quality outcomes such as efficient and effective discharge planning, no readmissions, no HAIs etc. I look for measures focused to our CAHs such as Outpatient Patient Engagement surveys; Swing bed surveys and outpatient services which is where patients are headed. If our CAHs want to remain viable, we must find a way to speak to the communities and why we are Provider/Hospital of choice.
  o Education and messaging are important so that the public understands why different measures are used.
• NRHA is encouraging a Rural Quality Reporting (RQR) program through CMS separate from (or overlapping with) IQR and OQR program (raised with CMS, hopeful that the NQF rural workgroup might discuss too).
  o programs are CMS’ domain
• Not enough measures that are relevant with enough volume given CMS availability.
• Would encourage swing bed quality measures in RQR, managed and maintained by CMS?
  o Want it to be quality driven not just finance.
  o Swing bed comparability and quality/cost compared to SNF competitors continues to be an issue/concern
• General public doesn’t understand that viewing quality is somewhat related to volume of procedures at an organization – saying a hospital doesn’t do enough of something to qualify for a measure has the potential to make people nervous.
• We’re measuring what’s available, and what’s available is missing a ton of what a CAH does that’s important.
• Don’t have any data on RHC quality, even comparable to FQHCs. As hospitals become more ambulatory, this becomes important. There have been some efforts in this area, but need a broader focus and consistency in measures across platforms.

From the Field
Policy and Regulation Update
FORHP provided a policy and regulatory update (and these were shared via email immediately following the call):

FORHP developed summaries of the two CMS Final Rules here. Links to the CMS announcements about those final rules are below.

- **CMS Issues Omnibus Burden Reduction (CoP) Final Rule**: system-wide integrated QAPI, antibiotic stewardship, and infection prevention. Includes specific changes in requirements for CAHs.

- **CMS Issues Final Rule on Discharge Planning Requirements for Hospitals, CAHs, and HHAs**: Discharge planning with patients moving from inpatient. Specifically, a new standard saying hospital must assist family etc. by sharing data relevant to quality.

NRHA CAH Conference
Multiple members of the Council participated in the NRHA CAH conference in September. Highlights included:
• Discussed ICD10 utilization and ability of rural to appropriately reflect. Meeting had three separate coding/billing/documentation breakouts. It’s important for CAHs to get this right.
• Attended a session focused on a CAH working on sepsis. Potentially relevant measure for many CAHs (presenting hospital realized they had many more cases fall into the measure population when they started focusing on recognizing and coding sepsis appropriately). Operations, quality, and financial improvement all associated with sepsis.
• Ellenville highlighted for opioids work at NRHA and in National Rural Health Resource Center’s Rural Route publication.

RQITA Update
Karla Weng from the Stratis Health RQITA team shared new and upcoming resources:
• Posted this week: Antibiotic Stewardship Implementation: Suggested Strategies from High Performing CAHs. Released out of focus groups from last spring. 34 CAHs across 4 focus groups. Disseminated with yesterday’s MBQIP Monthly newsletter.
• Online QI Basics Modules: Facilitator guide coming soon for cohort approach to modules. Anticipate use by both Flex and Quality grantees. Will be offering another facilitated cohort for new quality grantees in 2020.
• Developing a new tool for SHCPQI measurement planning and tracking (for new grantee cohort that started in August 2020).
• Emergency Department Transfer Communications Measure Specifications Manual and Data Collection Tool: Will be publishing in late November/early December
• Virtual QI Mentor Program: In-person kickoff for CAH QI staff mentors at NRHA CAH Conference with eight mentors. Disseminating their expertise through newsletters, podcasts, and their other ideas. Mariah Hesse (on RQAC) is also a Virtual QI mentor.

Wrap-up
Thank you to outgoing Council members -- Kathie Alkire and Carrie Fortune

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