Rural Quality Advisory Council

April 13, 2023

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

How are quality measurement and improvement changing in the context of value-based care and payment, and what are the implications in rural?
Guest presenter: Dr. Michelle Schreiber, CMS

Key presentation points:

- Quality and safety have not really improved over the past 20 years even with intense efforts
- COVID has distressed the U.S. healthcare system across multiple areas
- Health equity is a high priority
- Resilience of the health system is a new focus
- Interoperability and fully digital quality measures are priorities
- The Universal Foundation is a set of measures intended to align across CMS programs (Aligning Quality Measures across CMS — The Universal Foundation | NEJM)

Council discussion:

- Feels like rural care delivery is getting more fragmented, particularly with OB being removed from some communities.
- Workforce remains a significant concern in rural.
- Rural hospitals struggle with EHRs – the EHRs are not meeting the needs, they are expensive, and many are unable to capture data and workflows needed. Many hospitals are also changing EHRs which is very disruptive to staff.
    - Most EHRs started off as billing systems and now need to focus on clinical workflow. Acknowledged the costs and that EHRs don't connect with other EHRs (even within Epic). While sympathetic to the situation in rural, still need to push to be digital, with standard data definitions. It may force some hospitals to align with bigger systems for EHR support but HIE is part of the solution to fragmentation.
- Low numbers are a big struggle for us. We try to participate in lots of quality projects, but our data often gets excluded. For rural, measurement over time is important.
    - Low numbers will always be a problem for some. However, one person with multiple hats can be good as they see multiple aspects of quality and care delivery. The only way to perfect measures is to use them; people need to be comfortable with the data and where it goes.
- Birthing-friendly hospital designation will be helpful in rural, as will potential age-friendly designations.
- For independent rural hospitals, seeking changes we can make relating to workforce challenges in order to proactively align with quality and safety, in addition to orientation with new staff and onboard new staff regarding quality.
    - Standardization is needed (like the auto industry); it allows a workforce that comes and goes from one hospital to another. Hospitals could have similar or the same processes. We have to be more standardized as a way to deal with the changing workforce.

- It is challenging to provide technical assistance for data collection and quality measures when the data requirements are not the same. We need a standard for how to deliver safe care, including hospital community engagement.
    - There are efforts underway for more alignment across federal agencies. There are some key principles that everyone understands, yet quality still needs to be local and influenced by the local community.
- The addition of value-based care and payment approaches to long-term care facilities is stressful. Our rural clinics and hospital have done well with value-based care, but for our long-term care facility it will be a big challenge to tackle for an already financially- and staffing-stressed department.
    - The SNF VBP program will impact payment. The expansion of VBC into post-acute care will push the systems. The program is intended to make the systems accountable for their performance. Federal programs often start with rewards and then move to penalties.
- Risk adjustment is important but can mask performance, and we need to understand the impact in rural health.
    - Clinical risk adjustment is still important; the question is when to do risk stratification rather than risk adjustment. Stratification helps with equity, and CMS will probably expand its stratification programs.

From the Field, including Policy and Regulatory Updates

- CMS is seeking comments on the Inpatient Prospective Payment System (IPPS) proposed rule for hospital payment, comments are due June 9. Federal Register: Public Inspection: Medicare Program: Proposed Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals; etc.
    - Fact sheet: FY 2024 Hospital Inpatient Prospective Payment System (IPPS) and Long-Term Care Hospital Prospective Payment System (LTCH PPS) Proposed Rule - CMS-1785-P | CMS
- Medicare Advantage final rule recently released - adds a health equity index to the Star ratings. Medicare Advantage changes are increasingly important for rural as the percent of Medicare beneficiaries covered by Medicare Advance continues to increase, now to nearly 40% in non-metro counties. 2024 Medicare Advantage and Part D Final Rule (CMS-4201-F) | CMS

RQITA Updates

- Co-hosted with TASC and FMT a critical access hospital Quality Infrastructure Summit in March. A report will be coming out late spring/early summer.
- Working with FMT partners on a CAH Quality Assessment.
- Updating the QI Basics course.
- National Virtual Rural QI Mentors' QI stories highlighted starting in May in the MBQIP Monthly.

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