NATIONAL QUALITY FORUM

Moderator: Rural Health
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OPERATOR: This is Conference #: 88449934.

Suzanne Theberge: Good afternoon, everyone. And welcome to this webinar for the MAP Rural Health Workgroup.

If you are dialed in and on the webinar, please turn your computer's speaker off. Thank you. To reduce the feedback, and mute your line as well when you're not speaking.

So next slide, and next slide to the agenda, we're just going to – I'm just going to briefly do a roll call and discuss our agenda. And then we'll dive right into the content of today's call.

So in our last several webinars, we've very briefly touched on the measuring access to care topic as we narrow down what the (measure and) time issue was going to be for this project. And we landed on access to care. And now as promised, we're finally going to be discussing that and that's going to be the meat of today's discussion.

So I am just going to quickly introduce the project team, and then do the workgroup roll call. And then, Karen and Ira will lead us off in the discussion. So next slide.

Just as a quick reminder, your project team is Karen, Kate, Madison and myself, Suzanne. And now I'm do the roll call for the workgroup roster and if

each organization to let me know if you have a representative attending today, that would be great. Thank you. Alliant Health Solutions?

Kimberly Rask: Good afternoon, it's Kimberly.

Suzanne Theberge: Thank you. American Academy of Family Physicians?

David Schmitz: Hello, it's David Schmitz in attendance.

Suzanne Theberge: Thank you. American Academy of PAs?

Female: So Daniel Coll is in the process of dialing right now. He's having some technical difficulties.

Daniel Coll: Yes. I'm actually was connected eventually, thank you. So Dan Coll from the West Coast, so it's good morning from my side of the country. Thank you.

Suzanne Theberge: Great, thank you. American College of Emergency Physicians? American Hospital Association? Geisinger Health? Health Care Service Corporation?

Shelley Carter: Good afternoon, this is Shelley Carter.

Suzanne Theberge: Thank you. Intermountain Healthcare?

Mark Greenwood: Also good morning. Mark Greenwood.

Suzanne Theberge: Thank you. Michigan Center for Rural Health?

Crystal Barter: Good afternoon, this is Crystal Barter.

Suzanne Theberge: Thank you. Minnesota Community Measurement?

Julie Sonier: Hi, this is Julie Sonier.

Suzanne Theberge: Thank you. National Association of Rural Health Clinics?

Bill Finerfrock: Good afternoon. This is Bill Finerfrock.

Suzanne Theberge: Thank you. National Center for Frontier Communities? National Council for Behavioral Health?

Sharon Raggio: Yes. This is Sharon Raggio.

Suzanne Theberge: Thank you. National Rural Health Association?

Brock Slabach: Good afternoon, Brock Slabach here.

Suzanne Theberge: Thank you. National Rural Letter Carriers' Association?

Cameron Deml: Good afternoon. This is Cameron Deml.

Suzanne Theberge: Thank you. RUPRI Center for Rural Health Policy Analysis?

Marcia Ward: Hi, this is Marcia Ward.

Suzanne Theberge: Thank you. Rural Wisconsin Health Cooperative? And Truven Health Analytics?

Cheryl Powell: Hi, it's Cheryl.

Suzanne Theberge: Hi, thank you. And anyone I missed or who joined while we were doing roll call and didn't get to say hello earlier? All right.

And we are joined today by one of our co-chairs, Ira. Aaron will be joining us hopefully a bit later. And he got called away suddenly. All right. And now to our individual subject matter experts, John Gale?

John Gale: I'm here, thank you.

Suzanne Theberge: Thank you. Curtis Lowery? Melinda Murphy? Ana Verzone? And Holly Wolff? All right. And finally, our federal liaisons, Susan Anthony?

Susan Anthony: I'm here, hello.

Suzanne Theberge: Hello. Craig Caplan?

Craig Caplan: Hi, this is Craig.

Suzanne Theberge: Thank you. And Juliana Sadovich? OK. Anybody else? Great.

With that, I will turn it over to Karen to launch our discussion today. Karen?

Karen Johnson: Thank you, Suzanne, and thank you everybody for joining us this afternoon. We appreciate your time.

As usual, how we're going to go through this next couple of hours is – I'm going to start. I'm going to present a few slide to kind of get everybody on the same page of what we're thinking about. And then, we'll hand off to Ira to facilitate discussion between the groups.

So just a reminder, access to care, this is the special topic that you guys wanted to delve into. So we're – that will be the topic for this call as well as our next one. So we have two webinars to try to make some progress in the area of measuring access to care.

And our goal is to consider measuring access to care from the rural perspective. So I think we just have to kind of keep that in mind. There's going to be lots of things that we want to talk about. So if we can always just kind of bring ourselves back to the idea of measuring access to care, and that idea of the rural perspective.

So excuse me, rather than just delving directly into the topic, what we want to do is learn a little bit from what others have done in this area. Obviously, this is not a new topic. There's been much, much worked on access to care and how to think about it by lots of others. But again, we're going to be doing it from the rural perspective so that's going to give us a little bit different flavor than maybe some of the work that's been done.

For today's discussion, I want to start this off and concentrate on work that's been done by NQF in this area. So there's a couple of reasons that I've done this. First of all, NQF is all about performance measurement. And again, it may feel like a bit of a new ones that we do want to remember that we're talking measuring access to care.

So as we have this conversation, we're going to talk, I'm sure, there will be thing about the delivery system, about healthcare policy, all kinds of different things will come in. But again, we always want to bring our minds back to the idea of measurements, what we need to be measuring, which are the most important to measure, how can we measure those kinds of things.

And then, secondly, NQF has actually done a lot of thinking about measurement, of course, we're NQF. And some of it has been related to access to care. It's not been a huge topic that we cover, but we have done some work in this area. And I'm going to show you a few of our efforts to date. And some of it will be very familiar to you because few of you I think actually participate in some of these activities.

So first of all, we have a definition of access measures, so what is a measure of access of care? And we believe that they assess the ability to obtain needed healthcare services in a timely manner, including perceptions and experiences of people regarding their ease of reaching health services or health facilities in terms of proximity, location, time, and ease of approach.

So just a couple words in that definition that I feel like our key words, and we'll talk about this probably a little bit later. The word obtain needed healthcare. We see the word timely manner, and ease of approach, and there's a lot of examples there.

And also this idea of including perceptions and experiences, that's getting to this idea that there – thought there's different kinds of – there's different ways to measure. And measuring and assessing people's perceptions and experiences is an important thing to measure. So now, of course, this is not the only definition of access. And it actually incorporates some definitions of access that are out there and it doesn't exactly incorporate some others. But a few that – a few other definitions and I apologize, I was fine until two minutes ago. So hopefully, I won't have to keep saying excuse me.

Other definitions of access that we know of and, again, I'm sure there's many others get to the idea of use of services. Some gets the idea of reaching services of being able to afford them – thank you. Kate just brought me

water. That's so sweet of you. This idea of access being the fit between population and things that they need, and providers and the things that they supply.

So this – and that's kind of an interesting way to get to it because, you know, it kind makes you think, "Well, you know, you could have an overabundance potentially." And maybe that's something to think about too.

Another definition that I thought was kind of an interesting one, the provision of the right service, at the right time in the right place. So there's lot of different ways to think about access.

So if we – yes, thank you. Next slide.

This is a diagram of a recently developed framework for measuring health equity. So this was done, just last year, it's still fairly new. We're still kind of getting our hands around all of the stuff what was done in this work. But it was done by our Disparity Standing Committee. And again, they were looking at – they were trying to come up with a framework for assessing equity in healthcare.

So before we get into the specifics of what they did, I wanted to make sure, just to make sure everybody is on the level playing field and hopefully nobody is completely bored by this. We just wanted to make sure everybody understood some definitions of some of the words that I'm using.

So a framework is really just, in my view, is just a way to organize ideas. And usually frameworks show high level ideas, not every little tiny detail that you could have in there. So it's a way to organize your thinking.

So when we say a measurement framework, we're organizing our thinking again about what we think should be measured, what are the important things, maybe how the measure. There are no rules about what a framework has to look like. This is a very basic one. It's kind of a not very pretty table. And this is no offense to our team. We actually have a pretty table it. And for certain reasons, we had to make it not quite as pretty.

But, you know, sometimes you'll see framework that have all kinds of shapes and colors, and all of this kind of stuff and that's fine. But they all have this idea. They are organizing ideas. And often at NQF, we develop frameworks and our frameworks usually have what we call domains of measurement. So when we say a domain of measurement, those are the key concepts that we feel like should be measured?

So for example, here for health equity, if you really want to be able to measure health equity, you need to make sure that you consider partnerships and collaborations that you consider culture, structures. You want to make sure that you quality is high for everybody. And also, why I have it in this presentation, there's an access to care component.

So all of these things together would give us a flavor of healthcare equity, these are the key concepts. And then, often, we have subdomains. So the subdomains are just smaller categorizations of concepts that fit within those bigger key categories.

So later on, when I kind of laps into my usual NQF speak and start talking about domains and subdomains, you'll know what I'm talking about. So this framework again, it's for measuring equity. There is the Disparities Committee conceptualize five domains. So in other words, if you are in a measure, this concept has helped equity, you need to look at all of these things. And you'll see there that, again, access to care is included. Let's go to the next slide.

We're going to talk a little bit more about what the equity or what the Disparities Committee did. This next slide is another framework. And again, this will probably be familiar to some of you on the call. This is the measurement framework for telehealth. And this also I think was developed last year by a convened telehealth committee. And again, what you see here are domains and subdomains. So again, the idea here is how do you measure, what do you need to measure when you really want to know about telehealth.

So that group said, "Well, you need to measure and make sure you know about effectiveness of the care that was provided. You want to know about

the experience of care. You know, the impact of in terms of cost and financial impact." And then, of course, that kind of went backwards, the access to telehealth is also something had to be – needs to be measured if you really want to think about measuring around telehealth. So I how would you think?

So now, I'm going to flip us back to the framework for healthcare equity. So what we showed you a couple of minutes ago was the overall framework and the five domains. This slide shows you the subdomains that the Disparities Committee came up with under access to care.

So, they – what they've done is, they've given the subdomains and then several different examples. So, remember again, this is part of the measurement framework for health equity so the domains and subdomains that you see here, reflect the things that when we need the measure to understand performance around equitable access to care. So that lens, again, is equity but the subdomains will have availability.

Things like is there care to a particular geographic area, what about specialty care? They put timeliness of care, and after hour access under availability. Accessibility, you know, thinking about people with disability is or language barriers, and how does that, you know, is that being taken into account. Affordability, that's the financial piece that we heard about in a little bit earlier in one of the definitions.

And they have some interesting examples here because they kind of – are going beyond just, you know, dollars that Medicare for example pays. The thing about total cost, thinking about do people have enough money after they pay for basic supplies to cover healthcare services, you know, do you pay for food and your rent, and that sort of thing. So a lot of things could be under this affordability subdomain. And then, they have this idea of convenience, getting at distance, flexible scheduling, even safety which is kind of an interesting place to fit the idea safety, but it's the idea those environments.

So a couple things that these subdomains are kind of – they're probably not surprising to people. These have been around for quite awhile I think in some form or another. And, you know, the example here, you know, one could

quibble a little bit about, well, I would have put, you know, flexible if appointment schedules under availability instead of under convenience. You know, we're not trying to quibble about any of those kinds of things. These are just example.

But the question that we'll post to you guys is, you know, are these, you know, some of the rights of domains that we're talking about from a rural end, and from a rural end, there might be different examples of things that we would want to look at. There might be different things they have to really consider very carefully under availability, under accessibility, et cetera.

If we go to the next slide, what I'm showing you here are the subdomains for telehealth. So, the telehealth committee basically came up with three subdomains around telehealth. And they said, "Well, you need to make sure that you measure access that the patient or family, caregiver have." But there's also access that the care team has to have and then there is this idea of access to information. And then they – their frameworks even went a little bit of further and had these considerations.

And the considerations, no surprise there. The first four there are the same four that we saw in the framework under the equity domains or the equity framework. And then, again, no surprise. All of this work is being built on work from others. But they also, in thinking about telehealth, actually has this other idea of acceptability. And acceptability, according to the telehealth workgroup, was this idea of do patients and members of care team accept the use of telehealth as a mean to care delivery?

So what they're basically saying, hey, you know, when you're thinking about telehealth and you're thinking about access, this is other kind of whole component that needs to be measured and consider from both the patient, the care team and an informational perspective.

So – and just so you know, access to information, gets with the idea of the – both of the care team and the patient having access to things like clinical information so that patients can be informed for care team. They need to have

information so that they can provide, you know, the right care, so this idea of actionable information.

So, just a bit of nuance as I mentioned a couple times before. Frameworks are specific to of particular topic areas so I have given you examples of access in relation to equitable care and equity in healthcare as well as access in relation to telehealth. So what we're going to ask you guys to talk about and think about is access and measuring access through the lens of rural, through the rural lens. So, let's go the next one. Yes, that's the one.

So, we're going to start off with the subdomains from the equity framework. And I'm going to through this next couple of slides really quickly. I choose the equity framework over the telehealth one because it seemed a little more broad to me. But it still may not be complete in terms of what we want to think about from the rural lens. So there are some other concepts that maybe are included under those four domains availability, accessibility, affordability and convenience. But maybe they're not quite there. And maybe they should be there when we're thinking about access to care from the rural lens.

So, we have this idea of accommodation. That one idea came from the telehealth side and some other work that's kind of in process here at NQF. It's not ready for prime time. But some of the thinking there is accommodation could be even more broad, maybe then what the folks on the telehealth committee we're talking about. You can think about language, you can think about culture and accommodating for culture, literacy, unmet health needs, transportation.

Acceptability that's, again, from the telehealth side, do the patients in care team accept the use of telehealth. Maybe there's other things that need to be accepted potentially. Access to health information, things like knowledge of insurance eligibility, access to patient portals, access to medical records, and again, we could think about from the patient side as well as the provider side.

There's this idea of frequency of care or follow-up care, you know, if you can get – if you are an allergy sufferer and you get one appointment to have your allergies taken care of, is this – that doesn't mean you have access. But, you

know, what if you need to be seen a lot more times or you need follow-up if you have some sort of a mental health issue that you need some follow-up care for. So that's another way to think about access.

We could think about it in terms of types of care or types of utilization. So for example, you know, is there access to prenatal and child care, how about chronic disease? How about dental? Emergency care or even usual source of care, so might be another way to think about access. Next slide.

And there's a lot of concepts. So again, I'm not going to dwell on this. I'm going to ask you guys to think about these things.

We could also think about geography. That's probably really big in our minds when we think about rural. But one could think about geography even in terms of barriers, so are there barriers in terms of distance or travel time, or even availability of transportation.

We have this idea of timeliness of response or service or this temporal side of things. We could have or realize that there could be barriers to access because of cognition in some way. So the example is interpretation services and we've talked a little bit earlier about literacy but this is more in language I think. And you could even take it further, you know, is there access to care in a – an appropriate way for patients with dementia. So there may have, you know, cognitive barriers.

Financial, we've already talked about a few of those, but underinsurance might be another way to think about it. Digital access, telehealth is more of an option but it's probably not the only one, electronic connectivity, age and gender sensitive care, and then finally proximity, location, time and ease of approach. And I think that one came more than the definition.

So, I really went through very quickly a lot of ideas. And what we're going to do in pretty much the rest of our time is to go through some questions. And so if we could go to the next slide.

We'd like to talk about maybe a couple of really big topics first, and then work are way down and talk a little bit more about domains, subdomains, et cetera, of access to care through the lens.

So, first of all, it would really be helpful for us to think about how access is related to quality. Not the same thing or is it? If it's not, how is this different? And, again, through the rural lens.

Who should we held accountable? Is this, you know, should individual clinician to be held accountable for specialties and availability of specialist in a particular area? Maybe not, but there might be some things that individual clinicians could be held accountable for, for example, you know, having flexible appointment times.

Can we prioritize certain domains or subdomains for rural population? So if we ended up going back to the slide 11 which shows us the subdomains and that's OK, we don't have to do that. And then slide 13 and 14, that's some concepts that we could talk through. So maybe we'll go back and talk through some of those, or some of those really important for us to think about through the rural lens, or some more important than others.

Can we make valid comparisons between providers for those various domains, for those various concepts? Are some of those particularly problematic might be another way to think about it. You know, so if you think about this (for) one of them, the geographical barriers and transportation is that something, you know, what from the rural lens do we need to think about in terms of measuring access to care.

And then finally, and we're not going to get through all of these today, we'll have the next webinar to talk about this as well. We might even be able to get to the idea of, you know, how can we construct measures to ensure the validity of comparisons across providers?

So maybe there are certain things that we would recommend in terms of, you know, exclusions in certain cases or, you know, who should the target population to be for some of these domains or subdomains, or maybe we want

to talk a little bit about risk adjustment and things to think about if we want to risk adjust.

So, that was a lot of talking, I feel like very quickly by me. I'm going to hand it over to Ira. And I think, Ira, if you want to just start with how is access related to quality and we're just kind of work our way through, or how are you, feel like we should do this?

Ira Moscovice: Yes, sure. We have five questions and we have more time in this call that we've had on previous calls, I think, to try to start grappling with these. So – and I would say we have up to, you know, at least 15 minutes for each of these questions right now if we're going to deal with them. But let's just see if the first couple take the whole time, that's fine. You're saying we have the next seminar or webinar where we can deal with some of the other issues. So we'll do it one at a time.

But I think the point that was made up front that's really important is to understand that a lot of people have been thinking about this issue but no one's really made it terribly clear in terms of how access actually does relate to quality in the real environment. And many have suggested that it's quite different than in the urban environment. And I think we want to start off with just a free flow conversation from as many people as possible in terms of their views on how is access related to quality particularly in the context of the rural environments.

So I'll just open it up for the floor and I'll just facilitate discussion. So, is anybody want to start off with this broader question about their thoughts on how access is related to quality in the rural (aspect)?

Bill Finerfrock: This is Bill Finerfrock. I'll kick it off. I mean, I think, I'd share with folks an article earlier but like Dr. (Kareem) joined (MADOCS). And at the end of it, I ended with something my children would be happy with which is the hashtag, which is that access is quality. And so, I think that it's not related to quality, it is quality. And if you don't have access to care, you don't have quality care. So I don't think that you can de-link the two. But that also doesn't mean that we want a two-tiered system of quality which, you know, you want to avoid.

It's finding that balance between ensuring that individuals have access that if you are using quality measures, that you take into account, that the providers who are in more challenging environments where geography, finance, health disparities, health risk, comorbid conditions, that maybe very prevalent in rural communities are not deemed to providing poor quality because there are things that are outside of their ability to control, that are impacting other measures you have and that they get some level of credit for trying to deliver care in a more challenging environment.

Ira Moscovice: OK. Other thoughts on what access the whole notion of how is access related to quality from individuals in your perspective? Who else would like to chime in?

Marcia Ward: This is Marcia Ward from RUPRI. And I wanted to give a perspective since Karen went through the slides having to do with the telehealth framework and I was privileged to chair that. And as we were charged with coming up with the framework, so we didn't dig down into measure specifically.

But as we were charged with coming up with the framework and talking about access, we actually had two face-to-face meetings and at one of them, somebody said and I don't remember who it was. "Well, you know, there's the five A's of access," and we went, "Huh?"

And so that's where the five different, affordability, availability, accessibility, accommodation, acceptability came from as components of access in the telehealth framework. Now, we don't have a quality domain and the way the telehealth framework folks thought about that was quality is embedded in all of this. So, we sort of came – you know, they weren't two separate things I think is what we were saying just like Bill just mentioned. That access and quality were the same thing and effectiveness and quality are the same thing.

So we may have punched it on that but that was the position out of that workgroup to come up with a telehealth framework.

Ira Moscovice: So let me make a comment and get people's reaction. I really do appreciate what Bill and Marcia has said. But it is one thing to say, well, if you have no

access obviously don't have quality, it's another thing to say but access doesn't guarantee quality as Bill suggested in term for the two-tier system, et cetera. And so from my perspective at least using those two statements, I mean, access isn't quality. It's just the very strong determinant of quality in certain environments.

And I'm – what I'm thinking about is how do we really answer this kind of question in our report in terms of laying out, is there a difference now in terms of access relationship to quality and is it just the timeliness component, or there are really other major components that people always think about rural access and I think about geography. Maybe they're thinking about insurance but it's a lot of other items that have been described in the slide.

And I'm just wondering people thoughts on sort of this relationship and how the NQF staff can really try to capture that from a rural perspective? And I guess one possibility it isn't any different in rural than urban and that's something we should talk about what do people's thoughts about this relations, what does it mean for rural?

David Schmitz: Ira, this is David Schmitz with American Academy of Family Physicians. I'll make one quick comment. I think avoiding unattended consequences with our actions and specifically what we'll be doing here as a body with NQF. So, it's very difficult to account for the quality that you don't measure or the outcomes you don't measure in the numerator or the denominator.

So for example, if a baby is delivered outside of a hospital because a hospital was not reimbursed for during a low volume of deliveries and therefore stops doing obstetrics or for whatever reason, that it's very difficult to measure for example infant mortality rates. It's very difficult to associate that with the neonatal intensive care unit, administration at a tertiary center. It's very difficult to track that back to a lack of access.

So, we can measure health outcomes and quality related to performed and measured outcomes of health care delivery. It's more difficult to measure the outcomes of the null set, which is when the access either went to away or wasn't developed or isn't there.

So, I think that may be qualitative not quantitative caveat statement that we may want to deliver because their can be unintended consequences of this, some of this quality measurements that do not account for the lack of access. And access in my mind would be time to care. We talked about safety, you know, and we talked about physical surroundings of safety and that can include icy roads for example. And I think there are several concepts there that apply to rural, the last being scope of services provided.

So, some of that can be done with telehealth such as telestroke and other more physically performed procedures as I mentioned several times, are less likely to account for, but must also be watch for with regard to the unintended consequence. Thanks.

Ira Moscovice: Thanks, David. I'm just wondering can others think about examples of the unintended consequences that David just mentioned. And I think it's in an important point and we talked about on the (obstetric) side. Are they any other examples, people can think about in terms of unintended consequences?

David Schmitz: And. Ira, I'll just mention too. One is ER services and the other is colonoscopy screening services. Those are three particular areas that are rural sensitive in my opinion.

Ira Moscovice: Well talk about the ER services one.

David Schmitz: So, if a hospital closes for example or if a hospital is – is staffed in a particular way that it can provide a certain set of services but not others procedurally, so for example managing trauma. If you look at the golden hour or you look this sorts of things.

These have been chronically addressed looking at, setting up state-wide trauma system for example and what it means whether a car accident patient should be transferred to the local facility or helicopter directly to a tertiary facility and how those decisions are made. So, I think that's one example especially around procedural trauma management.

The other colonoscopy frankly, it's because it's difficult to be prepared for colonoscopy and travel at the same time. So, it's just a particularly interesting

or salient point around you. We necessary think that we're all patients with health difficulties. But if we can't afford a hotel room and they have to have their preparation colonoscopy for example. That may be less likely to get that screening. But it's not available more locally.

So, these are just some of the geography travel time dependent either screening or treatment mortalities.

Ana Verzone: (And you see) – this is Ana Verzone from content experts from Alaska. And, you know, all of the things that you just mentioned, we experience out here in Alaska. And even when we have, you know, specialist going out to the bush and out to these rural communities, we have to be careful about timing. When it's not fishing season or when like depending on what the community is sort of centered around and having to time everything that way. And then building the trust with different providers. But it's very hard to have providers in the area that people trust to do a colonoscopy. And then, they're having a high turnover rate.

And so, there's an addition to everything you're talking about. I mean, we see all of that here in Alaska and a lot challenges with timeliness and even just access to finding patients and communicating with patients because in a lot of our areas, there's not reliable internet or telephone to even contact people.

Ira Moscovice: OK. Other thoughts from committee members in terms of how the issue of access is related to quality?

Kimberly Rask: Hey, this is Kimberly. And a couple of things that you all have said have really resonated with me. And one of them is the notion that as you said that access is one component of quality. And thinking about it that way, I think also really help clarify for me what we're struggling with in trying to define it in this area that it's particularly the interplay, and the access issue in rural communities make this particularly important. But I would argue, we would also – we could also, you know, have mixed of similar arguments in much of the disparity to work for differential access impacting quality.

And as we think about it from the measurement side, it makes me think that – because our purpose here is to identify measures that we want to be careful

not to define access measures, in a way that imply a particular structure or particular way of delivering services because that's where you can end up with those unintended consequences. And that what really matters is the more subjective end of the day, patient's satisfaction and more difficult holistic measurement of patient outcomes.

And maybe in the rural settings, we need to be more focus on those patient specific measures, unless – how care is delivered because we – believe that it may be very idiosyncratic depending upon local environment.

Ira Moscovice: OK.

John Gale: Ira, this is John Gale. Thinking about it from a system of care perspective rather than say the individual patient level, the failure to provide to certain services or the failure – or the lack of access to behavioral health complicates. It's physical health care. We know that folks who have unaddressed behavioral health issues, depression, anxiety, those sort of things.

Have higher utilization of physical health services, more greater – report greater levels of pain and other issues that complicate the delivery of physical healthcare. So, in that way not addressing that's specific services. I think negatively impacts the quality of primary care and physical healthcare.

Ira Moscovice: OK. So, we've been hearing form folks that the unit of analysis is something we need to think about carefully whether it's on the patient perspective, whether it's from the provider perspective or the population perspective. Other thoughts about this broader of issue of access as relationship to quality?

Shelley Carter: This is Shelley and I'm in New Mexico. And I remember from several times in previous experiences, it wasn't just colon cancer that was difficult, it was also not breast screen but follow through with any type of chemotherapy with the difficult to rural patients. And also children chronic disease, that's been very difficult for those patient to receive care locally in the rural areas.

Ira Moscovice: OK. I'm just talking notes also. Other comments from committee members?

Craig Caplan: This is Craig Caplan, (inaudible). Just quick comment that – because rural areas folks tend to have less likely to have employer-sponsored health insurance, and more likely to have less generous coverage so they may have less access to a portable high quality care.

Ira Moscovice: Push back a little bit, Craig, and say, well, insurance coverage though, doesn't necessarily imply. You can have access to, you know, high quality providers obviously depends on the network, et cetera, et cetera. And so, but that whole notion of may not be just lack of insurance but under-insurance et cetera, et cetera. The insurance, you have the characteristics …

Craig Caplan: Yes. Yes. And I've been thinking also about the Medicare beneficiaries like their rural beneficiaries are less likely to have employer-sponsored retiree coverage, for example, that is more generous. And so, the, you know, urban beneficiary, Medicare beneficiaries with generous employer-sponsored retiree coverage can have much more generous, much cheaper out of pocket cost for coverage.

WILLIAMS: OK. Other comments from committee members on the first question?

Susan Anthony: Hi. This is Susan from CMS. And I was (inaudible) rural health model, we also have like the (STIP) demonstration that go on in rural communities. And I think there is component that is related to systems that playing to quality, and looking at how just kind of the financial stability of some of our rural hospitals.

And I think if you could apply, what is that, Maslow's Hierarchy of Needs like healthcare systems, and these healthcare systems are struggling. And so, therefore, offering services that – yes, they are locally available and convenient. But perhaps, more ambulatory care should be provided locally and they do need to go an hour to have that knee replacement or hip replacement surgery.

But then, they can be managed locally or use more telehealth services and just kind of looking at how kind of financial help of a hospital system place into that quality of care that they're receiving. Because if a hospital is kind of

struggling to keep their ER open, they can't really focus on what those true needs are of the patients and of the local community.

And perhaps, I think, when we think quality in rural communities, we also have to think about that kind of financial strength of the hospitals and kind of looking how that plays on the services that they provide but then the outcome of those services, if that makes sense.

Ira Moscovice: OK.

Bill Finerfrock: I mean – this is Bill Finerfrock. I recognize that this is a measure group. But I think what I find of concern is how those measures would be used and therefore how it translates into what those providers are going to get paid. And to the last person's comment.

So, you know if I make good hospital but I'm not an exceptional hospital. I'm a rural hospital. I'm providing good care based on the measures, I've come out – I'm doing good but Medicare turns around or payer turns around and says, "Well, you're not great. And therefore we're going to, you know, you're not going to get increase in your payment or you're going to get penalize percentage point on your payment because you're not at the upper end of your group." That further makes it difficult for that institution or that facility to maintain itself financially.

I don't know whether anything that can be addressed to the measure of process but, I mean, that's really what I'm concerned is that these measure at some point are going to be translated into the dollars. And how you come out based on the measure will dictate what kind of dollars you get and that the rural providers who are good are not going to score well enough to get the kind of resources they need to maintain and sustain there systems. And it may be completely off topic but, you know, that I just wanted to get that out there.

Ira Moscovice: And, you know, Bill, I think it is on topic and I guess what I take out of it is no matter what kind of access measure we decide on down the road as a group. That step in the report need to make it clear how we think these measures, you know, who should be using them and what kinds of ways? I

think that is a very important point that hopefully, we'll be able to highlight in the report. I think it's a good point. Other comments?

Cheryl Powell: Yes. This is Cheryl Powell. And to me, I think the most compelling focus of in giving all of the concerns and all the caveats of this types of measures for access really in population, health and population, measuring at that level is somebody doesn't have access or only has access to poor quality of things. Is it truly – are they truly able to get high quality care?

So most in a population contest they make – context it make sense for me because I can't see divorcing access from quality of care from a beneficiary's perspective or the concept just someday reaching out to get there and either not being there, or only being low quality. And then, I see the application of that could be either in programs design or incentive, or at the payer level and otherwise. But I do think it's access is a very tricky thing but I think divorcing it entirely from quality is very – would be tricky. But you also do want to avoid those unintended consequences.

So, it something to grapple with, because I think the population health aspect is a compelling area to think about how to incorporate access in a meaningful way.

Ira Moscovice: OK.

Ana Verzone: This is Ana Verzone. Do we have past data about the, I guess, what is the standard deviation for like with rural areas versus urban areas would increase access and how that could affect pay? Like is there a market difference like, have there in past studies about this that the topic that Bill is speaking to in terms of, you know, our people getting paid less for just slightly substandard care, suboptimal care? And is there a way to account for that?

Because I do feel that it would be ideal to have a little bit of a "credit" applied for rural areas if we can quantify that through past data to see, you know, if there is sort of unfair distribution of funds because of some of the challenges of delivering care in rural areas.

Ira Moscovice: I don't know the answer to that and I would throw it back to NQF staff or CMS rep if they have any thoughts or response?

Karen Johnson: So this is Karen from NQF. First of all, actually I don't have that data. I don't know if anybody has it. (Alisa) shaking her head. It's not something that we would know off the top of our heads.

I think one of the things to be a little careful about is, you know, sometimes programs, especially payment programs, are built in certain ways and they do some certain things from a program perspective. And so, we don't want to completely conflate the measures with how a program is constructed, if that makes any sense then. So we would want to be sure to have …

Ana Verzone: Yes.

Karen Johnson: Yes, measures that are, you know, as fair as they can be for the measurement side recognizing that there still may not be, you know, there still may be things in the way that our program is constructed that might hurt rural providers or other kinds of providers. Does that make sense? Hopefully it does.

Ana Verzone: Yes.

Ira Moscovice: Yes. I think though the point when we get down to deciding what measures we think will be useful to look at, I think the point of including in the report if we have any data related to those kinds of measures would be useful, rather than just sort of our brainstorming conceptual. It would be, you know, if we know that there's certain measures that we have some data on or something related to. I think that would be important to include in the report.

Other comments before we move on to the next question in terms of how would access related to quality? OK. This has been a reach initial discussion, I'm sure we'll come back to this as we move forward with NQF staff.

The second bullet question is who should be held accountable? And does it vary according to the domain or subdomain? And remember, in earlier webinars, you know, we had arranged of opinion as to well, yes, what you –

it's only the access issue but on other issues and certainly access issues also. You should I, as the individual provider, whether I'm a physician, they – or other help professional. Should I be held accountable for these kinds of access issues?

And, you know, if you look at the list and the domains, there's certainly whether it's health ensured, access to health information, you know, the geography involve, you know, how do we deal with this whole accountability issue, particularly in the context of the specific areas or domains that it seems that really do lead to accountability more or so than other domain.

So I'll open it up in terms of the whole issue with people's thoughts on the accountability issue. How we want to frame that in this report?

Bill Finerfrock: This is Bill Finerfrock. I mean, my general philosophy on this is that you only hold a clinician, or physician, or PA nurse practitioners, so I come ever accountable for those things which they are able to control. And if there are things that the patient – and it's a fine line, I don't know where that is. But, you know, if there are things that the patient is doing, or the environment, or the geography create a strict situation that make it challenging to meet a particular standard, you know, we're talking about, you know, like things were a follow-up (occurs) within or such inside occurs within so much time.

I'm not sure how we can hold the individual clinician who is the direct provider of care accountable for things that here she just simply does not have the ability to control.

Ira Moscovice: Reactions to Bill's comments or other thoughts on this issue with accountability?

So I have one reaction. I hear you, Bill. But it seems to me …

Bill Finerfrock: You say that a lot, Ira. I hear you, but.

Ira Moscovice: Well, I'm a professor, so we try to keep conversation going. There's no easy in any of this.

Bill Finerfrock: Yes, absolutely.

Ira Moscovice: So the question to my mind is, these are traditional view of the fee for service clinician and what they I think we're doing and perhaps could be held accountable. And now when we start talking about population health and we start talking about social determinants of health. It seems to me the relationship between providers and patients is changing over time. Certainly, much more emphasis on that.

And, I guess, when I hear – think about accountability, I think about in terms of that changing relationship. And do we want to change the behavior of clinicians in terms of that relationship by saying you're going to be held accountable and that sometimes that can be harsh in terms of reimbursement, et cetera, et cetera. But somehow, this broader concept, it's not easy to find which – what you can directly control and what about the things that you can have an indirect effect on and, you know, what role should you be playing in this.

Bill Finerfrock: Yes, and I …

Ira Moscovice: So think about the various roles and Bill can start off with, what should be the various rules of the clinician versus the patient versus, you know, other actors, other stakeholders.

Bill Finerfrock: I hear you, Ira. But the – I think in that middle area that indirect control is really where you struggle, you know, because there are ways in which our clinician can influence a patient, the decisions they make, the actions they take. And I think whatever you come up with, you want to encourage the clinician to engage in that. It's not a, you know, everything isn't just, you know, so strictly black and white that it is, you know, you can control it or you can control it versus what can you influence.

The other thing I worry about in how to build this in is that, we're not providing care to the test. In other words, things that are important in the clinician patient relationship that aren't necessarily measurable yet short trips and get ignored or discarded, or disregarded by the clinician. And they're solely focus on meeting the measures that they're being tested on because

ultimately that determines their viability of the practice. And how do you build that as well into your measure those intangibles that are difficult to measure, but are perhaps important to the patient.

Ira Moscovice: I think that's a good point and I know we have several clinicians on the workgroup, any thoughts from our clinicians about this accountability issue? OK. How about non-clinicians, any thoughts about the accountability issue? Or we could move on if that …

Shelley Carter: This is Shelley.

Karen Johnson: Sorry, this is Karen from the NQF. Just to make sure everybody is tracking with me, given the example I think of individual clinicians that, you know, you could think about it in terms of, you know, hospitals. You know, what's fair to hold hospitals accountable for. What's fair to hold health plans accountable for or what's fair to hold kind of a population of some sort, state a community that sort of things.

So doesn't have, you know, the conversation doesn't have to be about individual docs versus not.

Ira Moscovice: That's a good point.

Bill Finerfrock: Yes.

Shelley Carter: This is Shelley. And I was going to say I understand what Bill and Ira both are stating. I think those that in some point in the future, we have to look at it in a different light as well. One of the things that HCS is trying to do is look at transportation (inaudible) for healthcare. We have partnered with Lyft and the Blue Cross Blue Shield Institute to match providers and members with transportation need.

So this, I mean, this is just a very small example but what I'm trying to drive towards is the fact with the collaboration between many to address an answer. It's not just one – it's not just one – it's not just the clinician who's trying to address some answer. It's not just the health plan, it's the collaboration of many and I think that's where a direction meets in the future that we will need

to consider is how can we collaborate with other partners in our community to make things happen.

Ira Moscovice: And so, I think there is some good examples around the country of, as you said, the group of stakeholders trying to work together so it's not just on one individuals back or even one hospital's back. But, you know, whether it's linking with social services, education, Department of Transportation, state agency et cetera, et cetera. It's a good point, Shelley.

Other thoughts on this whole issue of accountability?

Cheryl Powell: Yes. This is Cheryl Powell and I would agree with the last few points in particular. I think there are places where you're looking at maybe an integrated health plan and integrated health system. I think there is a need to hold, you know, accountability even to the programs to Medicare and Medicaid.

And without measurement, it's very difficult. Without a quality measures being looked at related to this areas and hopefully in collaboration across multiple providers and within healthcare systems without that, it's difficult to hold the programs that are supporting people accountable for how well they're serving the individuals in the rural health communities as well as how well resource the providers are to provide that care, and able to provide that care in those areas.

So I think that's a – thinking that there's higher levels and not at the individual level of accountability might help with that momentum towards bringing some collaborations together and figuring out how to really tackle this difficult issue.

Daniel Coll: Thank you. This is Dan Coll from the American Academy of Physicians Assistants, PA. The other thing that – in some of the prior calls I've mentioned, a real concern for physician assistants and also nurse practitioners and collaborative relationship says attribution of services is actually often difficult to track down to it as practice providers or CMS as non-physician providers. Because many electronic health record and also billing systems,

when bills are ultimately drops to the attribution of services may go to the supervisor in their collaborating physician, depending on the infrastructure.

So even though the care may have be directly attributed to a PA or NP as a best guide when the documentation is completed, that service may appear to be provided by a physician supervisor or collaborating physician. So when I think of how you will design and collect this data and where you maybe hard to see it from – I just want that really high on everyone's list of the issues.

That came out in the American Academy of Physician Assistants recommendations for optimal, electronic medical records help feel with EHR's on attribution of services as one of their primary concerns with many EHR system and the integration with PA practices and households that use in PAs and NPs. So thank you.

Ira Moscovice: And so, Dan is pointing out the whole data aspect of this and, you know, if we're going to hold people accountable, we've got to have good data that …

Daniel Coll: Well, Ira, it goes even more than that to be honest is, someone who wears two hats as an administrator both in the critical access hospitals and the PA. When people ask how to explain our services, many of our services literally can disappear underneath the supervising physician or a bundled payment and it's a very much an issue for our professional organizations in a practitioner's to show what their actual contribution is, and be very challenging depending on how you're tracking that what – and I can see and what you guys are talking about as well that that data might be challenging or I would argue inherently flawed and diminish the contribution of non-physician providers in that tracking. And we know in rural facilities, rural health clinics critical access hospital that non-physician providers are often a large contributing portion is not the majority of the medical staff in those facility.

Ira Moscovice: On mute I guess if not speaking. So we're going to have to deal with that issue one way or another, Dan. I think it'd be great to get your input as we talk about the attribution issue. Other comments about this accountability issue that we've been discussing?

Julie Sonier: This is Julie Sonier at Minnesota Community Measurement. And I agree with the comments that have been make about sort of, you know, these sort of access concepts really being almost about system level performance. But I wonder if there's contribution that this group can make by thinking about, you know, some of the individual component. Some of the barriers that exist, you know, are more immutable to action by some sort of stakeholders than others.

So like the slides that's up on the screen right now. I can see thing, see things that are kind of amenable to action by physicians like physical accessibility, the facilities or hospitals. And some of them are more payer related.

And I wonder if part of what this group could produce that would be value added is kind of discussion about what those barriers are particular to rural areas. And sort of who has a role to play in resolving those barriers whether it's a direct role or an indirect role. So, for example, through, you know, loan repayment programs to address workforce shortages and those kinds of thing.

Ira Moscovice: OK. And I think that ties in nicely with the comment Shelley made earlier about having to do with this collaboratively. So that's one way I think of trying to address this. I don't know how NQF staff, do you have any thoughts about that reactions?

Karen Johnson: That's exactly kind of what we were thinking I think in terms of asking, you know, a certain subdomains maybe a more amendable to accountability for certain groups, and other as not. So being able even to say, hey, you know, consider creating measures at this level of analysis for this kind of thing. But for this thing over here, it really need to be more of a system's approach or team-based approach that sort of thing, perfect.

Ira Moscovice: Yes and I think the most specific we can get vis-à-vis the kind of measures we define, you know, the better use it will get in terms of getting folks to try hopefully start working together. Any other final comments on the accountability before we move to the next issue?

Bill Finerfrock: Just real quick. This is Bill Finerfrock. I mean, I think that this discussion about health system is really relevant and moving it out of just to discussion about an individual clinician and looking at access as part of their

accountability at a system level. We saw not too long ago where some large systems announce that they were going to close some of their outlier facilities because it just simply was not as efficient to maintain those clinics in smaller communities. And so they were going to close those and move folks to larger facilities located in larger communities which meant greater travel time, distance created barriers, doesn't seem that there was any qualitative consequence to those systems for doing that.

And if there was a way to build access in, we may be able to resource some of that to prevent people from closing facilities that are on the outer edges of their system as a consequence of trying to maintain access if they're going to be measured on that.

Ira Moscovice: OK.

David Schmitz: Yes. And this is David Schmitz with the American Academy of Family Physicians. I'll just really echo many of the other comment saying that again, I'll just have – I guess, on unintended consequences.

But if we have both – if systems have both economic and other motivations to reduce rural access with providers have the same. So if providers are going to take measures that are negative, well, they just go to where it's easier. And from a practical standpoint, they are more rewarded to do the easier thing.

So, again, I just want to – I just – I'm not sure that maybe if you're going to roll these measures to define quality access in rural, but at least we can have measures that don't incentivize, limiting and reducing access.

Ira Moscovice: OK. Why don't we move on to the next question? Which talks about are we able to prioritize certain domains or subdomains for the rural populations? So the broader domains on that previous couple of slides were the issue of availability, the domain availability, accessibility, affordability and then convenient. Any thoughts about peoples, their reactions to prioritizing those domains or if there are subdomains underneath them?

Karen Johnson: And Ira, this is Karen. Also not just those but the next two slides, I had all those other concepts that maybe are included that perhaps are not included, those with the – on the table as well.

Ira Moscovice: Sure. On page – slide 13 and 14, right?

Karen Johnson: Right.

Ira Moscovice: Yes. So if we look at those domains. Let me start off by a colleague, Melinda Murphy was on the committee of – wasn't able to make it but she sent an e-mail this morning from her perspective. In terms of whole availability area, she thought timeliness of appointments with specialist in particular is a problem for rural settings that don't have, you know, all these specialties with an easy commuting distance.

For accessibility, she thought the language issue can be a real problem. Not so much necessarily in terms of the language spoken, but also in terms of the sophistication of the population in terms of understanding medical (records) et cetera in terms of health literacy.

Affordability, she thought has certainly become more difficult as insurance has become more expensive, and coverage is less broad. And then finally, the convenient side, you know, basically, she said it's a significant issue when going beyond primary care. It's not unusual to have some travel with couple hours with specialty appointment such as OB, cardiology, pulmonary services, et cetera.

And so those are her thoughts but what are people's thoughts in terms of whether you feel all the priority in terms of the domains with the specific areas on slide 13, 14 is for rural.

Marcia Ward: This is Marcia Ward from RUPRI. And sort of tying the last topic of who's accountable and the comments were made, it's particularly about population health. I'm now looking at these – trying to think, do they really tap into the concepts of population health or systems, and with the examples that are given, they seem to fit more with a lot of them, a fee for service type of system in the examples.

And so, I'm thinking back to what we've already done in terms of our ratings to the different measures. And I remember thinking a lot about the feasibility of different measures and I was really comfortable with those process measures that were really, you know, a particular clinician who's accountable for them. I was most comfortable with those measures knowing there's a lot of evidence. They were feasible, doable.

And so I'm feeling likely we've got a core set that are maybe a little old fashioned based on what we've been living with in terms of the measurement world, and may we need an aspirational set that lose more towards the world of population health and Accountable Care Organizations in the future.

Ira Moscovice: Appreciate your comment, Marcia. What are the people's reaction to Marcia's suggestion?

Karen Johnson: So this is Karen from NQF. And I actually I think I get what Marcia is saying and I would probably agree. So the question maybe that we are trying to ask and apologies if I haven't ask it exactly in the best way. But if you were going to try to get for those measure and ones that really would be effective and helpful, what kinds of things would it cover? So that gets us back to these domains.

So we're not asking you to kind of come up with individual measures necessarily, but, you know, if we were going to say, hey, we really need this measure access in rural environment and the key right now is affordability, you know. Or maybe you would say, "They're all really important so we can't prioritize one over the other or, you know, I think that's at least to some extent what we would like to hear from you guys.

Bill Finerfrock: This is Bill Finerfrock. I think that for me that two that standout and I would kind of – that the way the federal government has historically looked at availability of health care is either a function of a time and distance which is reflected in large measure, the health professional shortage area designations, what is the service area, what's the time and distance to a provider or in that case a physician, a primary care physician, so using time and distance as a measure of accessibility.

We then also have the medically underserved area – medically underserved population designations that use socioeconomic, demographic and economic measures as a proxy for determining whether or not an individual may have challenges as far as accessing care. So I think at a core, it has to incorporate time and distance to a provider clinician and, you know, that could be – this is historically been only a physician.

But I think, you know, it could be expanded to include PAs, nurse practitioners for primary care and other mental health professionals for mental health behavioral healthcare. And then all the various socioeconomic demographic characteristics will have to be part of that as well.

Ira Moscovice: Thanks, Bill. Other comments on or prioritizing?

John Gale: You know, Ira, I think that the ability to prioritize any of these really depends on what perspective we're looking at. So if it's a – if it's a patient – patient's perspective, it may be affordability or convenience. If it's from a system of care where you want to see what's of it – whether are certain essential services, the community needs primary care, behavioral health, substance used, long-term care whenever.

Then it's really more about the availability and of the service, if it's from the perspective or the third-party payer or an ACO, you maybe looking at time and distance in terms of measuring access. So much as I'd like to – myself, I tend to lean towards making it a bit more – be a bit more simple and just – and look at availability as the primary and the most important of the domains.

Ira Moscovice: OK. Thanks, John. Other comments on prioritization? You know, one thing from the time distance stand to certainly has been the guidelines we've been using up to now. Somehow, I'm hoping as we move forward towards the future that we also start considering whether we want to call the digital access, health information access, et cetera, et cetera, that seems to me at least we're saying a larger role that has in the past and we'll continue.

And when we talked about accountability and if we want to get patients more involved, I think that access to information et cetera is going to be really important. So that's one other thought I have on it.

Before we move on to the next question, any other comments folks have on the prioritization of those domains or subdomains?

Julie Sonier: So this is Julie Sonier and I just wanted to make one additional comment. You know, particularly thinking about – and it kind of depends as someone just said, how we're going to use this. But if you think about, you know, which of the challenges are particular to rural areas, the one that jumps out of me is availability. And, you know, with the discussion about time and business is, you know, I think particularly relevant in the sense that we have some opportunities to think about availability in different ways than we have in the past.

So particularly for people who are at a great distance from care providers, you know, there's lot of ways that we can use – remote monitoring in telehealth, and creative ways that improve outcomes for people. And I'd love to see something that includes that.

And then the other dimension, what I don't actually see on any of these slides but I think is also really one of the unique rural challenges is about sort of handouts and coordination, particularly if people need to leave the community for highly specialized care, how do you connect back to the local community, and how do you sort of make sure that people leading can get appropriate follow-up care as close to their home as they can.

Ira Moscovice: Thanks for your comments, Julie. I think – let me ask NQF staff, if the care coordination point I know is an important point. Have we thought about that in the context of the access domains?

Karen Johnson: I think probably the closest – there's a couple there. The second bullet from the bottom on the slide in front of you, get to that follow-up care, so one could argue that a little bit of it there. And the other frameworks with those domain, I don't know that it's really been pulled out. So that might be kind of a – get, probably is quite the right word, but maybe that's something that really would

be a recommendation from you guys that, you know, that's a really important piece for the rural side and somehow another, it needs to be reflected and measured.

Ira Moscovice: Yes, we said affects a lot of the items that we're talking about in sub-bullets here in terms of just the accessing information. If we have multiple providers in terms of the types of care people are getting, as you said, the follow-up care. Just the timeliness of as you pointed on a couple of slides.

So I think one way or another we need to think about that in terms of how that's going to fit into this picture, where there's a broader concept, do we want to really have that as a separate bullet or even possibly a separate sub-domain, that's a particular interest in importance to rural.

Other comments on prioritization of these domains and subdomains? OK. Why don't we move on to the next question which is, can we make valid comparisons between providers i.e. rural and non-rural for the domains and sub domains?

Karen Johnson: And this is Karen. I should have also on that slide said even between various for rural providers as well. So if you think about availability and you had a measure of – sorry, I'm looking through my notes. You had a measure getting at the just the types of providers. And, you know, could you really compare provider A to provider B, no matter who that provider is. Is that fair, is it not fair to do, is there a way to work around it if it's not quite right, is there's something we could do to make it more fair?

Ira Moscovice: And I think Bill made some comments particularly relevant to this fairness issue that you raised. Bill, do you have some bullets on this one?

Bill Finerfrock: Not at this point. I'm still thinking about this. Just the way that you got it framed here I'm not – I don't know if I'm just not tracking with you what you're trying to get on this slide.

Ira Moscovice: Let me ask Karen, why is it important to make these comparisons across the geography of providers?

Karen Johnson: Well, in any accountability program, you know, especially the big federal ones, where, you know, providers are being, you know, held accountable for certain things. You know, there's going to be comparison. So I think what I was trying to get to this and in this question is, you know, are there kind cautions that you guys want to make sure that people are thinking about in terms of, OK, if we were measuring after hours access let's, you know, let's say we have a measure of that.

My question for you might be well, is that something that I could compare across the board, is there something, you know, specific to rural that would make that – this kind of in general something that you wouldn't want to ever measure and compare across. And if so, what might that be? So, you know, I think that's where I was trying to get to.

Ira Moscovice: OK.

Karen Johnson: And I do apologize. I know that this is not the best way to present. To be honest with you, I couldn't come up with a better one. So hopefully our next webinar might be a little better because we'll be able to take what you've said so far, and maybe feed it back to you. And in the meantime, you can cogitate in that sort of thing, but just appreciate your patience.

Ira Moscovice: Sure. Any thoughts about the comparison issue?

Mark Greenwood: This is Mark from Intermountain. I think there are things that you can compare for, instance, do you offer appointments outside of usual hours? Do you have, you know, access through a portal, an electronic portal or not? Do you offer televisits or not or what percentage of your visits are televisits? So maybe some are in terms of price, or geography, or wait times, but I do think there are some areas where you could have comparability on certain standards.

Ira Moscovice: OK.

David Schmitz: This is David Schmitz for the American Academy of Family Physicians. I think at a systems level, we could have comparability and we do, right, many people on the call are familiar with some of the access measures for FQHCs or

for rural health clinics. I think at a provider level, there could be unintended consequences.

So in my practice, I was both in the clinic and calls for the ER. So if I was providing that scope of care on a given day because I was on call to the ER which was right down the hall from the clinic, walking distance, my patients that day might have bigger waiting times. And that would be an unintended consequence of removing this from one or the other, and potentially removing me from the clinic which would actually inadvertently reduce access.

So that's jut one real life example where perhaps wait time in the clinics would not be – it might be comparable, but (not without) unintended consequences, at an individual provider level.

Ira Moscovice: OK. Other thoughts on the comparison issue?

Cheryl Powell: Yes, this is Cheryl Powell. I just wanted to have a highlight. I think some of the very critical issues around access are actually in different provider types in those that we have been focused on. In particular, I'm thinking home health, maybe transportation, I think it's easy in Medicaid with home- and community-based waiver services which I think are – there's a critical lack in many rural communities of provider's ability – available to do it and the availability of the services.

So I think that there are some thinking to be done there around how do you, again, really at the accountability level how to look at that from a system level or from our program level, and how to think about program design, and support to improve access there.

But also, it maybe difficult when it comes to access, you wouldn't want to fault the only home health provider in an area that's trying to cover hundreds or thousands of people more than could possibly be covered well. You know, you don't want to fault them and compare them to another one that's in an area where there are many available home health agencies on things like how long it takes them to get somebody there or how often they can visit and things like that.

So in those instances where there is a scarcity of maybe other provider type, I think we would want to think about it's critical to know that how that information would be used and how you would compare that with maybe more populated areas with just more availability of those types of providers would be an important caveat.

Ira Moscovice: Thanks for your comment, Cheryl. That raises to me an important issue which is underneath this availability issue is what are we going to do about the access and, you know, you can't make valid comparison as we're seeing. And I think in the report whether we do it through vignettes and lay that out, or we directly take this head on and look at certain services that it would be important to include things we can't make valid comparisons across and highlight how we want to look at those issues when we do have, you know, a lack of rural availability. So I think that's an important point.

Other comments on valid comparisons between providers? You know, in many ways the comments you made, Karen, about it is important probably to look between rural providers just because of what Cheryl just said. As necessarily just comparing urban rural that the variation across rural is probably just as important, if not, more important so.

Male: Yes.

Ira Moscovice: And if there are places that are doing or able to overcome some of these issues that would be great, although this is a measurement report of the – as I said whether through vignettes or elsewhere, I said, it would be interesting to understand what that variability is about and how people are addressing it so. Other comment?

Bill Finerfrock: As our good friend (Denise Stanton) like to say ones you've seen one rural community, you've seen one rural community.

John Gale: And there's a – and I like to say I call BS on that with myself. Because I think it's both true and not true, and I think it becomes a bit of a red herring. You have to really look then at what are the resources that are available in the context with the community.

One of the issues I was thinking in terms of this access and the distance issue, at least certainly in substance use and behavioral health, but I suspect in other parts of the – an acute primary care, one of the distance issues that we see often is that treatment completion is incredibly – is very heavily linked to travel distances.

So for their travel distances tend to use those that finished appropriate courses or treatment which obviously is a very clear quality issue. So that maybe one of the comparisons you could do between urban rural areas.

Ira Moscovice: OK.

Bill Finerfrock: John, could you elaborate on that a little bit, I'm not sure if I understand …

John Gale: So for example, if someone has to travel 50 miles to – for substance use care or mental health care, they are less likely to complete the recommended course of treatment. They tend to drop out and not finish their course of treatment.

Bill Finerfrock: Oh, great. So how does that – how would you then factor that – how might that be used in a measure?

John Gale: Oh gosh, it's a – yes.

Bill Finerfrock: I mean I don't – yes, I'm not trying to – that's what I'm …

John Gale: No, no. I know what you're saying and I'm trying to think. I think that at least in terms of rural communities it's …

Ira Moscovice: The one way might come up, Bill, from my perspective just hearing this is if we have all or none measures?

Bill Finerfrock: Right.

Ira Moscovice: Somehow, I could think depending on what the components are. It might be really hard for – in rural environment to get the all of the above measures and, you know, you get a one, that is compared to a zero if you happen to be missing one of them. And I think it would depend on which measures we're

looking at. Because I don't know any measure that look at exactly a treatment completion. I think we'd have to break that down a bit more.

Any thoughts on the comparisons between providers? So we have five minutes left before we open this back up to public comment. And the last question which link certainly to the one above is how measures be constructed to ensure the validity of comparisons. And we've been talking about that a little bit, do we want to add any comments to that in terms of where do we need to take into account?

And we mentioned the whole notion or risk adjustment being a part – important then. And to me the whole focus on social determinants now and if rural environments, rural populations really are different, and transportation concerns, education concerns, et cetera, are more important, so more prevalent in a rural areas, somehow it seems to me that we do need to be thinking about that when we start making comparisons across different kinds of environment.

Other comments, thoughts, folks have on this last issue?

Bill Finerfrock: I agree with you, Ira. I think that that becomes critically important. What I struggle with is how do we – we know that those fact – those things, you know, social determinants of health and other whether it's comorbid conditions, race, ethnicity impact these measures or these outcomes. I don't know what I'm always told is, we just don't have a data to be able to do that as accurately as we'd like.

So I think we definitely have to acknowledge it. I'm just not sure if anybody knows how to do it.

Ira Moscovice: NQF desk? Karen, you want to talk about that at all or?

Karen Johnson: Well, I think we would agree with you. In our previous work on out SDS trial and, you know, one of these findings and not surprising is that, we don't have a lot of the data that we would like to have, you know, for adequate risk adjustments. And so, I think by focusing more on risk adjustment we'll kind of bring into the light something that a lot of people knew already. But, you know, it's really bringing out the idea that we need more data.

I think the other thing that came out that I thought was really interesting is, sometimes some of that data are available. It's just a little bit different. You might not think, oh, I could go buy some data over here and construct that measures, you know, you're not always just limited to the claims that you've pulled from Medicare. You know, there's other data so that this making people think outside of the box, if there are other ways to get data that's – (might) could be used in measure construction. So yes, I'd agree.

Ira Moscovice: A couple of minutes left. Any other comments people have about ensuring validity of any comparisons we want to be made? OK.

Hearing no other comments, I'll turn it back to Karen and NQF staff to get public comment there et cetera.

Kate Buchanan: Great. Thank you so much, Ira. And this is Kate. And we're going to ask the operator to open the lines, she will provide instructions, provide public comment.

Additionally, if you have questions and you're not connected via phone, please feel free to type those questions into the chat box and staff will read them aloud. We're going to ask the operator to hold the line open for 20 seconds if there are any public comments.

Operator: If you have a comment, please press start then one on your telephone keypad. Again, that is star one.

There are no questions or comments at this time.

Kate Buchanan: Thank you very much and I'll turn over to my colleague, Madison.

Madison Jung: Hi, this is Madison Jung, Project Manager here at NQF. And I'm just going to review our immediate next steps for our webinar schedule and our report schedule. The next webinar will take place, if you can believe it, it's our sixth webinar. It will take place at the end of April in the 25th and on that webinar, we'll continue this conversation. And hopefully, get closer to finalizing some recommendations on this topic.

That feedback as well as the update of the course set that we're still working on, will be summarized and put into the draft report two which will go out for public comment at the end of May. Following that public comment period, we will again review the comments, summarize the comments, and incorporate them into our report. And you'll have the opportunity to review that on the webinar seven which is in mid-July.

Just as I've said about the draft course set priority, we're still working on summarizing all your feedback and everything just to give you a little preview. We counted about 25 measure in the course set total, but we're still working on getting in-depth into those use in federal programs, use in the core, quality – core measure into quality collaborative.

So we're still working on those details more to come on that, we'll be reaching out to you again within the next few weeks, hopefully, to get more input. But from the internal staff side, there is more to come on that and more discussion to be had.

As always this is our contact information, so please if you have any questions about the next steps or just additional thoughts, please feel free to reach out to us.

Other than that, thank you for all your participation today, really appreciate it, great discussion. Karen, do you have any closing words you want to share?

Karen Johnson: I think the only thing I would ask is, I know this was a lot to throw at you and kind of difficult question. So if you're like me, you'll probably be thinking about these as you go on through the next few days. So if anything occurs to you and you just want to share it, make sure to e-mail us and let us know. And we'll be figuring out how to make this conversation kind of come out to where we need it to be and have a nice structured call the next time around. But thank you, I think we're going to give you back 14 minutes of your day, so found time, enjoy it.

Male: Wohoo.

Female: Bye-bye.

Female: Bye, thank you.

Male: Thanks again.

Male: Thank you all.

Male: Bye

Female: Bye.

END