NATIONAL QUALITY FORUM

Moderator: Rural Health
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OPERATOR: This is Conference #: 88453539.

Kate Buchanan: Hi all, this is Kate Buchanan from NQF. Welcome to our sixth web meeting of the Net Rural Health Workgroup. What we're going to do is we're going to provide some introductory comments to go through the agenda, roll call and then have our co-chairs, Ira and Aaron, providing the additional welcoming comments. And they're going to really get into the crux of the call.

Just a couple of housekeeping items. Please make sure you have also, in addition to streaming in, have dialed in. That is the only way that you'll be able to participate in the conversation. The number is in the chat box, but it is also 855-307-1903. Additionally, when you are not on – if you're not speaking or asking a question, please keep your line on mute, so that way we can minimize the background noise.

So with that, we can go on to the next slide. And here we have our agenda. The main purpose of our call today is finalized our discussion of the access to care through the rural lens. And so that's really what we're going to be doing.

We'll be building up both the work that we have during our previous webinar as well as the feedback that you all provided to us in between last webinar and this webinar. And then we'll just end the call with some next steps.

If you go on the next slide, you can see here is our project staff. I'm joined by my colleagues Karen Johnson and Madison Jung. Suzanne Theberge is actually on the maternity leave, she'll be returning in August.

So before I conduct the roll call, I wanted to turn it over to our co-chairs, Aaron and Ira, to see if they had any opening comments and welcoming remarks.

Aaron Garman: This is Aaron, I just want to thank you all again for your time today. NQF staff has been doing a super job and working really hard. So I look forward to this meeting.

Ira Moscovice: And this is Ira. I also want to thank you for your substantial efforts in responding to the access to care matrix. And look forward to a good discussion in terms of trying to understand how access fits into the rural health quality environment.

Kate Buchanan: Well, excellent. And so we'll begin with the organizational members. So if you are representing any organization even if you are not the major representative listed here. Please let us know if you are an attendance. First is Alliant Healthcare – Health Solutions?

Kimberly Rask: Hey, this is Kimberly. Good afternoon.

Kate Buchanan: Good afternoon. The American Academy of Family Physicians?

David Schmitz: Hello, this is David Schmitz with AAFP. Thank you.

Kate Buchanan: Thank you. The American Academy of Physician Assistants?

Daniel Coll: This is Daniel Coll for the American Academy of Physician Assistants. Hello.

Kate Buchanan: Thanks, Daniel. The American College of Emergency Physicians?

Steve Jameson: Yes. This is Steve Jameson representing ACEP.

Kate Buchanan: Thank you. American Hospital Association? Geisinger Health? Healthcare Service Corporation? Intermountain Healthcare?

Mark Greenwood: Hi, this is Mark Greenwood. Good morning from Utah.

Kate Buchanan: Excellent. Thank you Mark. Michigan Center for Rural Health?

Crystal Barter: Good afternoon. This is Crystal Barter with the Michigan Center for Rural Health.

Kate Buchanan: Minnesota Community Measurement?

Male: Yes.

Julie Sonier: Hi, this is Julie Sonier, Minnesota Community Measurement. Thank you.

Kate Buchanan: And then the National Center for Frontier Communities – oh, sorry, no, missed one. National Association of Rural Health Clinics?

Bill Finerfrock: This is Bill Finerfrock on behalf for National Association of Rural Health Clinics.

Kate Buchanan: Thank you, Bill. The National Center for Frontier Communities? National Council for Behavioral Health? National Rural Health Association? National Rural Letter Carrier's Association?

Cameron Deml: Good afternoon. This is Cameron Deml.

Kate Buchanan: Hi, Cameron. The RUPRI Center for Rural Health Policy Analysis?

Keith Meuller: Yes, this is Keith Meuller.

Kate Buchanan: Thank you, Keith. The Rural Wisconsin Health Cooperative?

Tim Size: Good afternoon. Tim Size here.

Kate Buchanan: Thank you, Tim. And then we have Truven Health Analytics?

(Heather Brand-Hasgrove): Hi, good afternoon. This is (Heather Brand-Hasgrove) for Cheryl Powell.

Kate Buchanan: Thank you, (Heather). We're glad you're able to join us. And now moving on to our individual subject matter experts, John Gale?

John Gale: Yes, I'm here.

Kate Buchanan: Thank you, John. Curtis Lowery? Melinda Murphy?

Melinda Murphy: Yes, I'm here. Thank you.

Kate Buchanan: Thank you, Melinda. Ana Verzone?

Ana Verzone: Here.

Kate Buchanan: Thank you, Ana. Holly Wolff? And then for our federal liaisons, do we have anyone from CMS on?

Susan Anthony: Hi, it's Susan Anthony.

Kate Buchanan: Great. Thank you, Susan.

Mary Botticelli: Mary Botticelli as well.

Kate Buchanan: Thank you. The Federal Office of Rural Health Policy?

Craig Caplan: Hi, Craig Caplan.

Kate Buchanan: Thank you, Craig. And the Indian Health Service? And is there anyone who I missed? OK.

Well, with that, I will turn it over to Karen to get us come into the crux of our work.

Karen Johnson: And thank you, Kate. Let's go to the next slide. So I hope, number one, that I can be very brief in my introductory slide so that we can get to some good conversation. So again thank you for joining us.

I told the team as I came in my head just doesn't seem to be in this call as much as I normally am. So if you're like me, I think going through where we've been so far in this topic, will help us kind of get our heads in the game. And we'll be able to make some good progress. So what we hope to accomplish with today's discussion is we like to identify the key facets of access to care that are particularly salient for rural residents.

So we've talked about a lot of pieces of access. But some may be really, really more important than others. Let's make sure that we can identify those.

We'd like to know some of the challenges to measurement. We've already talked about some of the things already. But if we've missed some or there's new ones to think about that we'd like to get those aired. But probably the most important thing that we'd like to do today is identifying some in the ways that we can address the challenges. So there's definitely difficulties with the access for the rural residents. But there's probably some things that we can all do, I'll say (inaudible).

So we'd like to get those out there. And I think that will help us, you know, move the needle forward a little bit on this and we realize it in two webinars we're not going to solve the problem of access to care for rural residents. But we do see this is foundational work and, you know, to the extent that we can be very definitive and concrete in some of the recommendations that you have, I think it would really be helpful for the field. So that's what we are hoping for today.

Just a reminder NQF does have a definition of access measures. I'm not going to read it out here. I just wanted to put it in here mostly for completion. But really the idea is to be able to obtain healthcare that's needed in a timely manner. And so, you have this idea being able to get the care in a timeliness of care is in there, and the definition also talks about experiences of care. So that's gets us into types of measurement and realizing that there are things like proximity and location, time and ease that are also very important and needs – and it needs to be considered when we think about measuring access to care.

Again, this is just a reminder in our last webinar. We actually talked quite a bit about some frameworks that have already been created to think about access to care and measuring access to care. And we settled on one that was taken from NQF health equity framework. So to fully understands and be able to measure and improve health equity folks around our tables said that access to care with a big piece of that, so access to care with a subdomain for health equity.

And then there were actually subdomains access to care that they identify. They are availability, the accessibility, affordability and convenient. And this – that committee did not invent these, they drew on lots of previous work that's been done even by some of you online. So we talked about that a little bit.

We also talked about the framework that NQF Telehealth Committee created to think about access, specifically in relation to telehealth. And there was a lot of overlap, not surprisingly. So the telehealth framework actually had an extra subdomain in there that talked about the – I think it was acceptability of telehealth. And that was a little bit too specific for what we're doing today, which is a more broad kind of treatment of access to care.

So we (stopped) with the framework with the four subdomains. That said, we realized and we talked a little bit the last time around about some other things that probably do fit under here, that maybe needed to be called out a little bit more specifically, and those had to do with – there were several. I'm not going to through all of them, that one that really comes to mind with access to information. And I think that one actually came through from the telehealth work that's done.

So again, there is, you know, there have been red blocks that are on the screen. There's a lot of details that kind of comes in under those things. And we talked about a lot of that the last time around.

So in the last meeting, it was a very – I think, it was a dense, doesn't sound quite right. But we talked about a lot of things in the last meeting. And I think we made a lot of progress. But it helped me to actually sit down and try to bullet out some of the things that I felt like I heard in that last meeting. So we presented you with several questions, and I'm just going to remind you of what – it makes what I think we heard the last time around.

First of all, how our access and quality related? Well, I think everybody agreed that they are very much related and it's so hard to tear them apart. But given that, there was a little bit I think of disagreement between the committee. Disagreement might be too strong word but there is this idea that

access equals quality or maybe the better way to say is, you can't have quality if you don't have access. But then, there was also this realization that just because you have access doesn't guarantee that you will have quality. So there's – they are very much related that probably not exactly the same thing.

There was also a lot of discussion I think the last time around about potential unintended consequences. And probably one of the biggest ones that we want to make sure that we recognize and kind of guard against is this idea that a two-tiered system where we would accept lower quality in order to have access. And we can certainly talk about that more later if people have ideas on that. But I believe that something that we want to kind of, again, guard against.

We talked about specific challenges to validity of measurement. A lot of examples you guys gave us, and that was very helpful to hear those examples. We also talked really, briefly about payment program structure. And without going into too much of that, we realized that these are definitely challenges. They definitely affect this whole idea of access to care and measuring access to care. But we also recognize that it's not our job and we've never be able to do it anyway, in this project to fix some of these things. But we do recognize some of that challenges.

We talked about who should be held accountable. And this is something that even though we were talking about specifically in terms of access to care, we – this idea of clinician control versus clinician influence has been something that we've been talking about, really since the beginning of our work together. And I think we realize that, you know, for some measures, there are things that physicians or other clinicians can control. In other cases, there are things that clinicians can influence, but maybe complete with control.

We also talked very briefly about attribution and realizing the attribution is big nut to crack, and then it can be difficult. And in some cases depending on the data source, you might not be able to get the individual, well individuals to be able to attribute quality of care. And we realize that team-based care is another viable way to think about who would be held accountable.

We also talked about higher levels of accountability. So I think sometimes we kind of tend to talk about, you know, individual clinicians or maybe even groups, or maybe even specific hospitals, but we're reminded that plans, health plans, delivery systems, even programs or even – I don't have it on the slide, populations might be the more appropriate level of accountability. Because it's always have to be an individual clinician being held accountable for some of these things. And I think that's especially true for some of these facets of access.

And then, finally, there is a need for I called it "thinking outside of the box" to address barriers. And we had some examples of some of that that's going on. And I think that is where we're going to try to go in today's conversation when we talk about how can we meet some of the challenges, and address some of those challenges.

Our next question that we had is, can we prioritize certain of those subdomains for the rural population. And I didn't hear an actual prioritization last time around, but we did talk about lots of things. We specifically talked about timeliness of appointments especially with specialist. We talked some about language and literacy, and also about insurance and different – the differences in insurance and affordability for rural providers.

And I think the other thing that came up a lot in a lot of different ways, with this whole idea of geography and especially, you know, what happens when you have to travel a long distance. And so, it affects lots of different things, a lot, you know, that came up under several of those subdomains of access. We talked about – we connecting, resonates to local payer.

If you have to kind of go outside the local area or specialty care for example, how can we make sure that, you know, when that's kind of done that people are connected back in a reasonable way, so just to guarantee good follow-up care. Again, this idea, digital or health information access, and then we also talk a little bit about perspective. And it can be difficult to prioritize because different folks will have different things that they would like to kind of lays to the top.

Our next question was, are value comparison is possible, either between rural providers to each or other or between rural and non-rural? And in general, I think everybody agreed that it can be done. But again, going back to this idea of accountability, some comparisons maybe more appropriate at a higher levels of analysis, not the individual clinician.

And then, maybe also specially for the rural versus non-rural, things in terms of timeliness and number of visit, I think we're a couple of the examples where it seem like people were maybe a little bit more concerns about rural versus non-rural comparability. And again, I think that gets us back to some extent, some of the examples that we were given, really work its way back to geography, on some of those. Not all of them but some of those.

Finally, we talked a little bit about measure construction. And that one – that little affection actually went really fast but a lot of the discussion before hand, I think fed into this one. Again, is this idea that there's going to need to be output risk adjustment. And we talked specifically about social deterrence of health and, again, here we are transportation, again, as one of the rural specific access. Not necessarily saying that every measure needs to be adjusted for these things, but at least it needs to be considered and thought about, and maybe brought into the mix.

Also, this idea that measures just really need to be flexible enough to allow various loads of care delivery. So that got us into some of the telehealth discussions. There are maybe other modes of care delivery. So the idea being that when it comes to access, you know, how care is delivered maybe less important in terms of the specific mechanics. But we need to make sure that measures allow for ones that are reasonable.

After our webinar, because we had such a broad and varied set of input on that last webinar, we did what we've done several times with you, guys. And we asked for yet another quick turnaround set of feedback from you. We gave you a sheet that had different subdomains and some examples, and ask you to let us know if, you know, what the appropriate levels of analysis would be for the various examples, to add example if you could, and also to really start

putting out the rural lens for the various examples. So we call this cautionary tales.

And we were very pleased with that with responses that we received. Fourteen of you, we're able to send that feedback. And I forget how long we gave you, but it was three or four days or something like that. It wasn't very long, three days. So not only did many of you provide feedback. That feedback was (succinct). It took us and hopefully make you feel well, it took us a long time to get through everything because it was so (succinct). And we really appreciated, you know, work on that and some of you, you work is – and I think we fed that back to you. So you have seen that feedback, so you know what in your colleagues mentioned. But in case you haven't had a chance to look at that, we did give some extra examples and suggested some additional levels of analysis.

Some of you really talked about the impact of lack of access. So that was something that you provided. That was free. We didn't ask you for that but you gave us that. And so that was really interesting. And also some of the challenges and those were interesting.

The challenges I think were real. But I think a lot of them and looking at some of them probably not necessarily intractable. So that's where we want to go today. These are rural challenges but how can we, you know, we get around those or address that in such a way that we can have valid measurements, that would really help improved access to rural providers or rural residents, I'm sorry.

And so for today's, I'm almost done and I'm going to hand it over to Aaron and Ira to facilitate the rest of the call. But what we're going to do is the rest of this call is going to be looking at what we're calling our Access to Care Matrix. It looks a lot like the matrix that we sent out to you for feedback.

Again, we're going to ask you to identify the key facets of access. If there's some measurement challenges that are really key that you want to bring out, let’s do that, but even more important. Let's talk about how we might address some of these challenges.

And wanted to put a few ground rules in and, you know, this is, you know, let's do our best with this. We want the rural resident to be the focus, not the provider. So we realize that measurement affects providers in a lot of ways. But to the extent that we can, let's try to think about, OK, what do we need to think about (to) measure so that we're going to help improved access to care for rural residents. So that's we want to focus on the residents.

We, again, realize that individual clinicians may not be able to solve or control, but this idea the influence. So again, how telehealth might – clinicians or hospitals or other accountable entities address these challenges?

There's no way that we would get through everyone of those examples from all of those different subdomains of access to care. So we started with the "most important". And that was to some extent, arbitrary decision on my part. But I think I've picked the ones that we got a lot of feedback on. And either that or that really came up in some of the previous discussions.

That says there's several more kind of facets, examples that we could bring out. Feel free to do that as we go through because what I kind of started "most important" may not actually be. So if I missed something and you want to bring it out, feel free to do that.

So again, key facets measurement challenges and most importantly how do we address these challenges. Those are our main questions. And then as we go through and it's just few other questions that kind of keep in mind are the ones that we listed here are important for rural patients. Again, we'll keep in our mind of the residents, which are the most important.

Anything particularly unique to rural, because some of the challenges that you guys told us about, I think were challenges across the board for rural and non-rural. So anything that's specifically of rural challenge I think it would be useful to know.

And in terms of level of analysis, we're going to turn that on its head, so any particular level of analysis maybe not appropriate. So – and rather than trying

to, you know, for everything with everything that might be. If there's a particular thing that maybe shouldn't be done in a particular level maybe we can point that out.

So with that, I'm going to do two things. I'm going to see if anybody has any question for me that was and really, I know I talk fast sometimes. Hopefully it was understandable. Just a review of what we've done to date. And if no questions, I'm going to hand it over …

Tim Size: I have a question. This is Tim Size. I have a question.

Karen Johnson: Yes. Go ahead.

Tim Size: And I may not be right. I guess my impression was the original charge to the committee, was somewhat focused on metrics in terms of quality metrics around clinicians to providers. As we got in to the access conversation, rightly so I think – we had more and more conversation yet the appropriate level of analysis could be, you know, the health plan or payer level. Will the report be able to be as robust about suggesting metrics of that level as for providers?

Karen Johnson: I think the short answer Tim is not really. So let me explain that. We really had two distinct tasks that we were trying to do with this project.

So task number one revolve around identifying core measures for the inpatient setting and ambulatory setting. So from that perspective, that's most of what we've done and probably from what September through February or something that's – that was what we worked on.

And then a second task, which was really not meant to intersect necessarily with the first one, is to discuss and make some recommendations about a measurement topic area. And it became very clear as we were doing the first task that access to care, that something that just really resonated with everyone. So it's, you know, we didn't have to (buff) too much about, you know, what was going to be our topic, our topic is definitely access.

But with that said, access we can certainly be much broader. So whether they're limiting ourselves to the – sorry, the inpatient and toward the ambulatory setting, you know, in clinicians only the way we had to do with the core set we can be much broader with access. So in that way the access piece can be very much broader.

But we are not going to be able to go back and say when we think about the core set of measures we're not necessarily going to be able to say, hey, you know, what might be the core set for home health agency for example or at a county level. We're not going to go to that. I think we're not going to be that broad for the core set. So …

Tim Size: OK.

Karen Johnson: … does that make sense?

Tim Size: Yes. And actually kind of validate to my concern and let me – I'll be explicit because in the context because how you describe their work which is consistent with what I thought the charge was. I'm just, you know, just kind of putting a parking lot a cautionary note. And there are some access metrics that may agree are in fact appropriate at the provider level.

My own sense is that when I look at where at least the challenges we face here a lot of the access is use also need to be own but their health claims – plan and that gets into network adequacy standards and stuff like that. My concern is, is that – it's almost an unintended consequence to the way this committee has been structured that we could end up having a report that comes down heavy on certain access standards for providers. And we acknowledge but it's more like in a footnote or smaller font size that is in equally important set of metrics that for the good of the population being served needs to be considered that relate to health plans and payers. But it's just my concern.

Karen Johnson: And you know, we will actually make sure that we somehow another quick back in there, Tim. And what it may be is a next steps or, you know, what would be the next thing. I will go back and say that some – a very few of the metrics that we talk about I think that people like toward the core set. We had this level of analysis problem where the, you know, the measures weren't

really endorsed at a particular level of analysis that are being used that in the field that way.

So we're going to kind of deal with that as part one of our task. But to your point, and maybe you can help us write this part up because you're definitely going to be able to see our draft report and comment on our draft report. And we want you guys to be very happy with the kind of the final product of this.

But maybe that's, you know, a next step that we could put forward as a recommendation from the committee that CMS consider funding in the future. And I'm just …

(Inaudible)

Tim Size: Yes, I agree. I'm just concern – I've been around long enough that may have gotten a little cynical but I think so few people read beyond the first page or two.

Karen Johnson: Yes.

Tim Size: And so all the wonderful nuance frequently gets lost in the subsequent conversation.

Karen Johnson: And that's I think a very valid point, yes.

Ira Moscovice: Karen, this is Ira. I will just state one thing to Tim's comment. When I give initial feedback to NQF staff, what I think is going be really important is not in the footnote but upfront before the discussion of the access framework and measures. That we really make it clear to everybody what the purpose of looking at the access area is in the context of quality. And I think one of the points that you've highlighted, Tim, should be upfront in that discussion in terms of what the matrix does do and what it doesn't do. And how it can be useful and how it can't be useful.

And I think we need to lay that out carefully upfront rather than just putting that in a footnote. So hopefully, if people are interested in the access area,

they'll have a chance to try to understand those, sort of why we're getting in this area and how we're reviewing it.

Melinda Murphy: Karen, this is Melinda.

Karen Johnson: Hey, Melinda.

Melinda Murphy: Hi. One of the things that occurred to me as I was looking through in preparation for today, was some of the things that we think about measuring would focus on clinicians but then as I continue to think that, that it was – but that may be perfectly appropriate when the endpoint are exactly with.

Sometimes what we're looking at with respect to the provider has a direct and important impact on the patient, and that maybe a way to also frame some of the information.

Karen Johnson: OK. And I will probably e-mail you separately, Melinda, to make sure I'm tracking with you. And if you have a quick example or if you just want to talk about a little bit more offline.

Melinda Murphy: Sure. One example that I had was for the patient who is not able to have a permanent care provider in a small community because the providers are – have such a large group of people they're trying to serve, that they cannot be the coordinator of care for individual patients or at least not be able to do it very well. And how if you're looking at what the providers are able to do, or how you're looking at what are providers handle, or workload in some way is addressing or deals with. That has a very important impact on what they're able to do for individual patients in terms of coordinating the care.

Karen Johnson: Got you. And I think maybe when we get into the – how do we address some of these challenges, we might be getting into where you're going with this I think. But, let's see how it goes, and then we can talk offline and see if I got it enough from you. Is that OK?

Melinda Murphy: Sure.

Karen Johnson: OK. Any other questions before we go then? All right.

So, Ira, I'm going to hand it off to you, and I'm going to let you just kind of walk through. I kind of had thought that you can do this however you want, we could go through each example separately or you could just ask and let people tell you which ones they want to concentrate on. I don't know we necessarily have to go through every one of these.

Ira Moscovice: Yes. And I think we'll sort of go through – let me give me a brief overview of the examples and then just open it up and we'll take comments on which every examples people want to look at.

But basically, and you've seen the broader set of items that were laid out in each of these components for availability that staff basically identified three main examples of availability. One of which is just, are you able to get an appointment, the second one – which is access to specialty care, the third one is the timeliness of care.

And you know, the challenges that came up relate to the existing full schedule of many providers. What about emergencies, and the challenges in terms of contacting patients for appointments for access to specialty care. It's usually not local and that – then led to a whole host of issues in terms of how we could try to address that. And this whole notion of care coordination whether it's through referral relationships with telehealth what we're really looking at trying to identify some best practices here.

Then the last area relates for the timeliness aspect. And that clearly ties into the whole notion of geography and distance. And with timeliness not just for primary care but for specialty care, across the whole group continued both acute care, et cetera. And the whole notion of certain parts of varieties are popular. And so – and some of that can be gender base. The challenge is with recruiting providers in rural areas et cetera, and the suggestions about addressing it initially related to care coordination as (inaudible) referral relationships. And how do you develop partnerships with transportation agencies and the whole notion of where this telehealth fit into all of this.

But we didn't have any main issues that we identify in terms of how do we address the appointment area. And so, what – once again, when Karen

through the slides, she talked about trying to understand, you know, these key facets of access to care and the availability side, are there other examples that we should point out that don't fit into these three. There are challenges we have left out and most importantly, how can we try to address these issues.

And so, I'll just open it up and we really do want to get your input on these, and specifically I think the other thing that Karen mentioned previously if you have comments on the challenges with measuring any of these areas. We really want to hear about that.

So, I'll open the floor now to talk about any of these areas just to identify which area – which example you want to talk about, and particularly if you have some strategies for addressing it that could go into the report, that'd be great. So the floor is open.

Tim Size: Could someone elaborate on what you mean by how can we address?

Ira Moscovice: I think the – I'll give my sense of it and then I think if NQF staff want to chime in, that's fine also. But I think the – in the report, what we're – it seems to me the point of this whole exercise and the access area is in comparing rural with urban. It's really trying to understand, to let people understand the access to care in rural environments. And sort of what can be done, what can't be done in the challenges that are easy to overcome or not easy to overcome.

But what is always useful in the NQF reports is not if we just identify the issues and the challenges but more importantly, how can we – through the public sector, private sector, or any other way, try to overcome those challenges, try to deal with things. And so, for instance on the matrix with access to specialty care. You know, most especially there isn't provider locally and so what do we going to do about that?

And so, in our previous discussion the notion was, we need to really improve care coordination or referral relationships, and take more advantage of telehealth. And so the notion of how do we address this and where would resources go to attempt to overcome those challenges, is what we're trying to get in that list. I don't know if NQF staff want to add something there.

Karen Johnson: No, I think that's pretty much it. I think I will say it for the appointment and, you know, there was a lot of challenges and nobody really talked to much about how to address. But I think there's probably things that people can do that is more than just adding more hours to providers a day, which is probably not the best way to tackle on this one. So if it's not just, you know, making your 10-hour day, 14-hour day, what else can we do that would actually help rural residents. And so, I – that's I think where we want to get to.

Tim Size: So, OK, who's the "we" in we address?

Male: Yes.

Tim Size: Because I think there's a lot of things that we can do. If we – if the we is only the providers, the availability matrix and particularly appointments, it has the feel of blaming of the victim. And I think there is that thread in the detailed responses. I mean, obviously, greater state in national investment and workforce, issues around payment, proclamations working rural area, the big two huge wave that would address the appointment issue.

Ira Moscovice: You know, from my perspective, maybe we should call the column how can this – should be address and let's get out of the blaming framework. And it could be address by public policy makers. It could be address at the local level. I don't think we want to say we can't do anything up front for some of these issues but there's no question. It's not just on the provider shoulders, from my perspective. NQF?

Karen Johnson: Agree, agree. Yes.

Ira Moscovice: So let's just take out we and say how can the issue be addressed? And so, Tim's come up with, you know, some broader public policy strategy, with this.

Aaron Garman: Ira, this is Aaron. I guess, you know, at first the charge was to look at improving access to the care for rural residents with keeping them as the focus instead of the providers as the focus. So I'd like to circle back to that a little bit and say, you know, the biggest concern as far as schedules and burnout is people want to access to their provider, and how can they get access to that provider.

One of the things that I see happening in at least my area of rural health quick care is team-based care where we're really trying to lean more heavily on teams, and trying to develop people so that they can practice to the highest level of their ability. Whether it's an RN, whether it's a care coordinator, whether it's MA, and be able to provide some of the loads that they can take some of that load off of the providers.

And so I think one of the – one of the things I'd like to say and how can we all address this or how can this be addressed is improvements in team-based care.

Ira Moscovice: OK.

Tim Size: I would add too that we're working the same domain here in Wisconsin, but I'm still shock by friends who I have respect for and who are educated, who still have a lot of prejudices about matching the doctor in all situations. So the whole issue would be another addressing this is we need to get a lot better at educating our people that everyone doesn't need to see a doctor. Often, it's better to see someone other than the doctor. And I think that's probably even a little bit more of a challenge, you know, in some of our rural communities that tend to run a little more conservative.

Ira Moscovice: And who would you say Tim Size doing that education?

Tim Size: I would say, you know, the health plan level. I would say at the provider level. I would say at the state and national level. I mean, it's kind of – we need a more conscious movement to change the paradigm away from the (doc will be) which is still pretty dominant.

Ira Moscovice: OK. Other thoughts on the – around the appointments area? Any thoughts on that area?

Bill Finerfrock: Yes, this is Bill Finerfrock. I want to just reinforce or chime in that I think the notion of allowing practitioners to work to the full extent of their education is critical that includes, you know, the supervisions, what collaboration, requirements for PAs and NPs. And recognizing that that, you know, with an

addition to just getting more workforce out there allowing them to work to the full extent of their education.

Ira Moscovice: So, other comments on the appointment issue?

Melinda Murphy: It's Melinda. One other thing with respect to what's just been said, is that there should also be an educational effort to let the consumers know what are the levels of expertise of the non-physician providers. So that whenever they – a patient in a rural setting or any settings is going to an NP, they know what NPs are prepared to do some way. And I know it's not as easy as I'm making it sound, but we'd be able to provide information to consumers about what are the abilities of those people at various levels other than physicians or maybe including physicians.

Ira Moscovice: OK.

Daniel Coll: This is Dan Coll from …

Ira Moscovice: Just go ahead, sorry.

Daniel Coll: This is Dan Coll from American Academy of Physician Assistants. I think there's – at the practice level at this – the regional level, state level, and federal level. There's a lot of – to the point about practicing to the top of your license. There's a lot inconsistency between the states and the scope of practice and what's requirements are for privileging for collaboration for supervision whether an NP or PA. And that's one of the pushes of both (oncologists) is to make more consistency across the state.

So, if you are able to say, well, in this state, you can prescribe, and all states can prescribe all scheduled 235. And I think that contributes to some of the confusions for PA and NPs level of practice. But I can tell you in our rural community as well, it's been very successful, educating. It does take a lot of effort. We have a PA who has a very strong endocrinology background. And the physicians of the community have educated the patients. This is our resource in the area for the strongest endocrinology care, and she's really became a leader and that's actually shifted attitude for many patients as to the different types of providers.

And it would be interesting to hear in areas that we're currently working on our rural health clinic status. But if you look at staffing level for many rural health clinics, up to – the averages I've seen after 50 percent of their providers are PAs and NPs, and that really helps those rural communities as well become more comfortable and educated to the scope of practice – and for PAs and NPs. And I'm not sure how many of the colors are working in rural health clinics, you can speak to that but I know that's one of our goal as well as we look at the smaller community, how we can increase our patient access through appointment times it does to go to rural health clinic models, and is also adding more non-physician providers.

Ira Moscovice: OK.

Steve Jameson: I'd like to make a comment if I could. This is Steve Jameson from ACEP. Dovetailing on what you're saying, Dan, I agree entirely. We have a large group of PAs and NPs that work in our larger urban areas. And we have a number of them that we collaborate within our rural emergency departments that run those departments. The issue, though, when we talk about scope of practice with APPs, is that they don't come out with a consistent training.

I mean, as you alluded, you have someone who happens to have a background in endocrinology. When someone finishes a residency in endocrinology, you know what their scope of practice is. When someone finishes as a physician or residents in emergency medicine, you know, their scope of practice is.

When someone graduates as PRMP, they're not ready to practice in a particular area until they develop that expertise. And so having a blanket statement as the scope of practice is really difficult to create unless there is a consistency with transitioning to a practice in a particular specialty area. And even in emergency medicine, that's not consistent. Some are resident or some are going to fellowship training. Some are going through just on the board – on the job training.

So it's – it becomes very difficult to really to say what a specific scope of practice is for broad number of APPs without having a consistent educational program.

Daniel Coll: I would say that the (RTPA) might have a slight disagreement with you and I'd love to carry that conversation on offline. But PAs have over thousand of required didactic hours and over a thousand required clinical hours. They come out on average of the 2,200 to 2,500 between the clinical and the didactic nurse practitioner programs average approximately 500 of didactic and approximately 700 for their licensing requirements for their clinicals.

So I would say that the consistency of their education is there, I think what you're speaking to is not consistency, but you're speaking to specialization and that's a different conversation and what their baseline a primary care skills are.

Steve Jameson: True, but …

Daniel Coll: So I think that – so when we're talking about go practice and privileging, we're talking both at facility level which extend many, many – accredited at time and inconsistent privileging processes and scopes for practice at a facility and what they're bylaws are and the medical staff requirements then you can talk about state level regulation.

One of the biggest issues right now for PAs and NPs across the country though is state-by-state inconsistent licensing and credential and processes by individual medical boards or PA boards or some nursing boards. And one of the biggest discussions for PAs and NPs across the country is how do we make the requirements for practicing in individual states consistent so that actually whether you're a supervising physician, whether you're an employer, you can understand and that in all of states that they have a similar scope and practice.

And until we have that consistency across the country, it's going to continue to be a question or an issue when there are states that had severely restrict DEA licenses or have inconsistent levels of what the level of supervision is, or how many providers can be supervised and whether the physician needs to be physically present or not.

There's just a lot of inconsistency. And so if you look at the American Academy of Physician Assistants, and you look at the nurse practitioners,

there's been a lot of work done on just simplifying and making more consistent, the optimal team practices so they can issue over the physician assistants right now. They have the seven essentials for clinical practice.

But like I said, this is a discussion we can carry on offline. But I would tell you that the baseline training goes back to the origins of the profession which is primary care. And is the same nurse practitioners who have chosen to go a different path, where they limit the scope and you have the pediatric nurse practitioner, a certified nurse midwife, they have other specialties in how they focus at curriculum.

But the family nurse practitioners and the physical assistant I think will tell you that overall they consider their training and their breadth of knowledge in primary care to be very consistent and similar.

Ira Moscovice: OK.

Steve Jameson: I agree.

Daniel Coll: Like I said, I could go a long time on this. So I'm going to go offline on this, thank you.

Steve Jameson: I agree, I agree. This is, you know, get too aggressive. But I think the key is and you're alluding to it, is the transition to the practice of whatever they're going to do in that specialty. There is a foundation but that transition to the practice and being able to articulate that to a population becomes a bit more challenging, but yes we can take the rest of the discussion offline.

Ira Moscovice: OK. Before we move on to access to specialty care area, is there any – anybody have any other comments on the appointment example?

Julie Sonier: This is Julie Sonier at Minnesota Community Measurement. So in addition to all of the options that we've thrown out about sort of different options for in person, you know, another one to think about would be how to take advantage of telehealth and some of the virtual consultation that many health clinics are covering now, sort of where that's appropriate. And specifically, I think this

would get the after hours issue and it also is relevant to the convenient momentum that we'll talk about later on.

But again I think when we talk about those kinds of solutions that we also need to think about, you know, all of the coordination issues that's in fragment – potential fragmentation issues that that raises. I think it should be on the list.

Ira Moscovice: Yes. And I think that's good. I know in my health plan, they started to do that now. I haven't heard much about how much of it that's going on in the rural environment. But I think it's certainly a good area to look at. Other thoughts on the appointment area, before we move on? OK.

When we move on to access the specialty care, and most of the comments really deal with the fact that most of this are not going to come local and have – can we make sure those relationships that first off, we can get access to specialty care when necessary. And secondly, how do we coordinate this with – clearly a big issue being that patient comeback for their primary care provider, once they've got in there specialty needs met.

And so, comments here in this area above and beyond – or details about how to improve referral relationships or how we might better use telehealth, or there are other suggestions about how to ...

Tim Size: Ira, can I just add a caveat maybe, I think this is – access to specialty care very a fair amount by the size of the rural provider community, and also by the market and historically like in our state, we had a substantial amount of specialty out reach clinics, so many of our rural communities that within an hour or hour and a half of an urban areas benefit from that. And then some of our larger hospitals and clinics in rural areas have a substantial number of specialty, so this is one area that does a fair amount of intra-rural diversity.

Ira Moscovice: OK.

(Inaudible)

Aaron Garman: Oh go ahead.

Ira Moscovice: No, please go ahead, Aaron.

Aaron Garman: I was just going to say one of the challenges that we face of – if I look at endocrinology for example, our closest endocrinologist is three hours away, and the site of booking probably four to six months out. So it's great to have good relationships, but again I would even say that availability of specialty providers due to lack of workforce in rural states is a huge issue as well.

Ira Moscovice: OK. Someone else have a comment there?

Daniel Coll: Yes, I heard. This is Dan Coll, AAPA. So to speak to that, definitely we have a referral issues to our large tertiary referral centers and academic centers to the point we even skip over the closest one that gets there with many rural and send – often applications have to go to little further away to a more urban site that actually has more openings and the closest referral center just because they are getting so many rural referrals to enter the U.C., health system for our California residence or California ensured patients that require a California facility.

But secondarily, in our community in our outline communities, we have specialty providers who are willing to come in for the site visits and clinics. But on a very limited schedule, and when they're – so we have intermittent local or in – I would not full time local coverage, but when they're out of the community those patients if they're having an issue they have to go out of the community for care.

So what do you want to say, the challenges it's not local or it's inconsistent coverage. I think there's many communities where you see these docs are willing to travel and come in, but they're not able to support full time practice in those areas. So coverage can be inconsistent or not full time which is the other challenge for those communities for the service maybe needed, but they're not there all the time, that's all thank you.

Ira Moscovice: OK, other comments?

Bill Finerfrock: This is Bill Finerfrock. I think also in the telehealth area, the limitation that is not often impose and you can only do a telehealth connection with a provider who is located in the same state as the patient, the sole issue of state licensure I think continues to be a major barrier to the effective use of telehealth.

Tim Size: Ira, it's Tim here. On the telehealth issue and we had spend the last three years developing a tele-behavior health network. It's great technology, it reduces travel time of either the patient or clinician, but it doesn't create more clinicians. And I am thinking particularly around behavioral health issues, we have just an incredible – I would say crisis in shortage of behavioral specialist where they'd be PAs, the NPs or physicians.

And so that gets us right back into a major workforce and what we value, what we pay for. Because I would argue, you know, behavioral health specialist, we really need to have them as much as humanly possible out in as part of that local and rural team. Right now, our payment policies, our workforce supply is not supporting that, so I would definitely include that as things we need to address.

Ira Moscovice: OK.

John Gale: Sorry.

Ira Moscovice: No, whoever was ...

John Gale: It's John Gale.

Ira Moscovice: I was going to say we've talked a little bit about how to improve referral relationships and telehealth aspects, are there any other kinds of strategies that would be – we should be considering in this report in terms of trying to address the specialty challenge?

John Gale: I was going to say, Ira, and this relates both to telehealth and use of specialist in general. I mean the assumption that telehealth work as Tim has accurately mentioned not just in behavioral health but across the board, assumes there are sufficient specialist sitting somewhere else to – with time in their hands to engage in telehealth and we know and in many specialists, that's not true.

To me, a lot of this gets back to thinking differently about how we configure teams of care. So we know there aren't enough psychiatrists, we'll stick with mental health, it's an easy example. And much of what a patient – most people need to pay their health services doesn't really require high level specialty care.

So how do we get the primary care physicians, our nurse practitioners, our PAs, specialists and others working in a way that better conserves those kind of resources. So instead of behavioral heath primary care just wanted to hand off patient with relatively routine depression to a psychiatrist to a social worker because it takes a lot of time just thinking more about how we configure and get those teams to work more effectively. I think the telehealth or having specialist on site in a limited basis is critical.

Ira Moscovice: OK. Any other final comments on the specialty care area before we move on to timeliness? OK. So why don't we move on to the last aspect that's been identified under availability. And so, obviously, important issue of timeliness which takes on special interest in rural areas and, you know, the comments where about distance and the recruiting difficulties.

And the solution or the strategies for addressing it that we need to focus on, care coordination partner with support services such as poor transportation which bring up the issue of respond, you know, is this the primary care physician or providers responsibility for instance, and then the Hoyer of telehealth.

So what comments the people have on this area and, you know, other strategies that can be used to address the challenges of providing timely care?

Bill Finerfrock: This is Bill Finerfrock. I think Tim may have raised this earlier, but I think network adequacy plays into this in terms of how many providers per population where there's primary care specialty claims being or believe is appropriate. And I think those numbers are far below what most people would consider to be necessary to provide reasonable access to care. So I think looking at network adequacy plays into all of this.

Tim Size: Yes, this is Tim. And a variation on that team which we also face here, is the whole issue of health plan and credentialing. So we routinely have rural communities that do the hard work of trying to anticipate retirement or growth that clinicians in the community. They have a successful recruitment and then they go to get them a credential. Then there's one or more health plan that have a ownership or regional affiliation with a tertiary or quaternary in an urban area who have some excess capacity. So they'll refuse to credential, then saying that there is enough capacity in their network, but it's not where that person need is.

Ira Moscovice: OK.

Daniel Coll: To echo that as well, this is Dan with the AAPA. We heard the orthopedic surgeon in our community to join the practice, malpractice. He's eight months now in after starting the paper work for Medi-Cal for California Medicaid and we cannot – we're still waiting for his approval to see patients.

It's the timeline to put credential and not just based on what the variety or density in that community, the area is but also just the timing as for getting providers setup and actually working under those plans is a barrier as well.

Ira Moscovice: All right. Other comments?

Karen Johnson: This is Karen from NQF. Just a quick question, when you say credentialing, it sounds like you mean a health plan agreeing to pay somebody to see …

Daniel Coll: That's correct.

Karen Johnson: … their patient. OK, not like being more certified or that sort of thing OK.

Daniel Coll: Not facility credentialing. Credentialing with those insurers and there's things like Medi-Cal doesn't credential PAs based – take the bill for PA service met one of the variances of California Medicaid. They take the billed service underneath the supervising (physician). So when we're working – we can't necessarily generate services under the supervising (physician), when they're working because they're not a credential provider yet and we have to work with one of the partners. It's just an administrative difficulty. But also this

individual is not working to capacity seeing what makes up in our community between 20 to 25 percent of our patient population, is not able to see those patients right now.

Because the practice in the facility, the hospital district won't get reimbursed for those services unless it's an absolute emergency.

Ira Moscovice: OK. Any thoughts on this concept of partnership, developing partnership or enhancing partnerships with support services such as transportation or other kinds of support service? Any comments on that, specifically about how to address that?

Daniel Coll: It's just – Ira, for us, it's very challenging and this is Dan with AAPA again. I'm in a community – a Mountain community with bearable weather, and the funding for public transportation is very minimal given the size and the distance between communities. So our care coordination navigation program has been trying to work on things like Lyft and Uber and even in a rural mountain community with lots of resorts, those services as well are very limited. And so then you're looking at do you employ a driver or how do you go about augmenting, transporting those patients, so.

Aaron Garman: Ira, this is Aaron.

Ira Moscovice: (No) health plan level, there are several states for instance that have founded to be quite cost effective for Medicaid clients to preview providing transportation and services for them, so they don't miss appointment et cetera, et cetera. And they have found a real return on the investment for that, but OK, I think it's probably time we've taken a good shot of time on the availability issue.

At this time, I'll probably turn it over to the – to Aaron and go over the accessibility area.

Aaron Garman: That was great. Thanks, Ira. So again, today, we're talking about the rural resident in focus on accessing accessibility of health cares. So the examples were interpretation and health literacy, getting there and health information

challenges bilingual staff is hard to recruit. Fewer public options, distance, I would include weather to that, health information, connectivity, getting connected to resources and then technology we don't often have support.

So how can we address tele-access to interpreters? I assume that's either through iPads or various other means, phone services. Telehealth partnerships and then there wasn't anything less than under health information. So in the same spirit, I think we'll open it up and we can see if there's any other thoughts regarding the interpretation and health literacy issue.

Any other thoughts? OK.

Then we'll move on to getting there. This is the fewer public options, distance. We've kind of talked about that in the last little bit. One other thing that I would say as we drafting this is that, one of the things that we've done in our community is most of our healthcare organizations need to do a community-based health needs assessment, and then working with our Center for Public Health or Center for Rural Health at the University of North Dakota.

We've combine this as to – into an entire community project. We've included our hospitals, our nursing home, home health, all of the different entities to come up with a truly a community-based needs assessment. And that includes transportation for various things and that's allowed us to at least open up points of communication between organizations and perhaps shared services that can help move patients from one venue to another. So it's just the idea of how this can be addressed perhaps at other levels.

Any other thoughts on getting there?

Julie Sonier: This is Julie Sonier. One additional though would be, some greater use of options like community paramedics. And like, you know, I don't know how probably this is being use in rural communities, like it maybe makes more sense in urban. But it is, you know, sort of the flip side of getting there, which is going to patient, you know, where that's appropriate.

Aaron Garman: So, I guess (inaudible) and say team-based care also with community health nursing et cetera, or the paramedics. That's a great idea. Any other thoughts?

Daniel Coll: I came from district – this is Dan with AAPA. I saw some recent articles about organization that are looking at and exploring self-driving vehicles to be able to go and actually pick patients and bring them back. I mean, there's a disrupted technology element out there whether that's urban setting or a rural.

I wasn't quite clear on the how can we address partnerships and what specific partnerships other than you mentioned the (EMS), was there any other thoughts on what that partnership meant? Are you getting there?

Aaron Garman: I think one of the things for instance in our organization that we do as we partner with our local busing service. We have a community bus service that typically doesn't run to healthcare their facilities. But in working with them in a partnership, we pay a voucher rate for our patients to be able to be brought up for the clinic for instance.

So, I think, it's just opening up different lines of communication between organization to try and establish partnerships for – to allow the ability for a patient to be able to be seen. That's my interpretation.

Karen, do you have any other thought from that?

Karen Johnson: That was a great example. I think the example of partnerships that people mentioned on the phone and the feedback after the last call. With that, the Uber-Lyft partnership was I think the main example but that was just the idea. That you can go outside of the traditional thinking to figure out how to make it happen.

Aaron Garman: Any other thoughts? Hearing none, we'll cycle through and go to health information with technology and connectivity. Any thoughts on this, on how we can better address this?

Tim Size: I would add under health information. This is going to be open up a larger discussion at least in my mind. The quality of information that people get or

don't get from the insurer or the health plan, how obvious it is? Who is in or outside of network and what situation?

Having said that, I'm a little confuse because I'm just being going back and forth. Like a supplemental file, I guess, we got mayor yesterday, and there's a lot of rich discussion on issues around network adequacy and the rural health plans and payers that relate accessibility. Some of that almost maybe misfiled on their availability but some others under accessibility and none of that is in this slide or the prior slide.

Because for me there's a lot of the – these are important access issues that are on the slide. But the ones we are overwhelmingly more face with our picked up into discussion, you know, supplemental packets that aren't on this slide.

Karen Johnson: So, this is Karen. And it's just my fault that if I missed something major that needed to be there. So, by all means, I'll mention it and we'll make sure we give it, you know, need to do.

Tim Size: Yes. I mean, if we go back of supplemental things, a couple of categories. There's a lot stuff going on or access, assessment of access to quality care and geographic service area, available specialty care that gets into some of the same issues, the whole discussion network adequacy.

Again, those things that are one level above the individual community. And I know that gets back into my original questions, original conversation. And this is actually an example. Because if I'm reading the report that's structured here and I'm – or anybody in my board or the co-op, and they were just pleased when the three issues meant on accessibility. They would accuse me for being sleep at the switch here, because we have spent so much energy and trying to figure our, and get help finding cooperation in terms of the network adequacy issue. And that gets in the (pain into). I mean, but there's a rich body of remarks I put in the supplemental package.

Aaron Garman: Can someone explain what technology (doesn't) support means on challenges? What it's meant by that? So, I'm clear of what I think it means versus what …

Karen Johnson: Yes. This is Karen. So, going back to one of the comments that came through. There was the idea that some rural providers may have EMRs for example that don't support portals, so that kind of thing.

You know, there is some electronic capabilities but may be not as much as you might like to be able to fully support patient information.

(Heather Brand-Hasgrove): This is Truven Health Analytics. Some of the feedback that we had provided was also just acknowledging that at the patient level, there could be issues with either continuity of phone service or internet service just for them to be able to access critical information online, health information, health record anything like that.

Aaron Garman: Wonderful. Thank you. Any other thoughts?

(Inaudible)

Aaron Garman: Go ahead.

Tim Size: Well, I'll just say, on accessibility issue, obviously another piece that isn't so much, you know, health plan malfeasance which I'm kind of been applying. But the whole shift to higher deductible plans and/or the still poor economy in rural communities gets into just the fundamental issue can – you can have a great clinic. They can have an open slot. But if you can't afford the appointment, you can't afford the deductible and copay, that's not accessible to you. So again, it's the very much still work in progress in our country of making sure everybody has access not limited by their ability to pay.

Ira Moscovice: So, that would be on the next discussion in terms of affordability.

Tim Size: OK. I'm sorry. I forgot we had that on Aaron's slide.

Aaron Garman: Yes. I would say on that information is expanded use and availability of remote access technology. I understand the internet connectivity issues but to the extent that, there going to be greater utilization of remote access, monitoring equipment. It can help address some of the access issues.

Aaron Garman: Great. Any other thoughts on this?

Daniel Coll: This is Dan Coll. I was just reading to the supplement as well. The only other one I can notice was this physical accessibility of facilities, offices and those settings. And I know, that's definitely been a challenge in our community with our multiple clinics attempting to find clinical space. And getting clinical space that with our patient have easy access and still meet total licensing and requirements, it can be exceptionally expensive. And that's definitely a challenge for what type office space, clinical space we can use in a half.

Aaron Garman: Yes, great point.

Karen Johnson: So, how do you address. Sorry, this Karen. Have you had success? I mean …

Daniel Coll: Well, it's gotten some creative relationship in the types clinics where licensing as 1206(b)s versus 1206(d)s. What is considered a hospital outpatient clinics versus what we can lease or let someone else to operate. I mean, there's a lot of different ways but it's incredibly challenging.

Aaron Garman: Wonderful. Any other thoughts on this?

Tim Size: Just one last point under getting there. I know, (ARP) has been the one – National Organization has really put a lot of emphasize on critical role of unpaid family caregivers. We are frequently in the people rural areas and urban areas that provide transport. And again, it's another major workforce issue because that population is aging out of being able to do that work.

And so public policy conversation, which have begun but are not very robust yet, about how are we going to deal with the decline and then relative proportion. I think it's like from eight to one to three to one. By the time I'm 80 in nine years, is going to down three to one. That’s a huge public policy challenge that we're not really talking about so I, you know, that's in a rural area going to be really a lot about how people get there.

Aaron Garman: Excellent. Any other thoughts on this?

Karen Johnson: So this is Karen. Backing up just really quickly to the language, nobody really talked about that. So I guess my question is, since people didn't really talk about it, is that something we need to really key on for rural or is it something that we know is important but maybe not as important as getting there or these other things? How do I interpret the silence?

Tim Size: OK. We'll I haven't been generating much silence so I …

Aaron Garman: This is Aaron speaking from some of the practices in the rural, you know, we have access to this and maybe not everyone does, and maybe it's education of rural providers on being able to have access to tele-access to interpreters. But I don't know that it's a bigger of an issue as the others stuff is that we've talked about personally.

Bill Finerfrock: Yes, this is Bill. My sense was that there is pretty, again, that is not the judging the connectivity issue despite that tele-access to interpreters was pretty widely available and seem to be significant way of addressing those issues. I thought that how can we address response was the appropriate response.

Karen Johnson: Right. Thank you.

Aaron Garman: Anything else Karen, you want to respond?

Karen Johnson: You know, in thinking about it, I kind of wish I have and put interpretation and health literacy in the same box. So I guess, is there anything particular about the health literacy that anybody wants to talk about.

Tim Size: Yes. You're right. Once you pull it into a separate box, I nearly go back to the IOM report on health literacy. And how a real (seminal) I think core concept in there was that healthcare is a partnership between commissions and patient-family. There still a lot of people don't understand that on both sides of that aisle.

And so – and in fact that IOM report was right and I think they were dead on right. We have a lot of work to have our patient populations and some of them are maybe conservative clinicians understanding that they're really not

getting to the heart of their healthcare if they don't conceptualize it and view it and actively engage as partners for that. That opens up a whole other domain I think of conversation.

Karen Johnson: And so, this is Karen. Again, I know we're looking at time here so we don't probably have time to delve into that. But would you, based on your response, it sounds like that is something that in future, we'd want to delve into a little bit more?

Tim Size: I think so. I mean, we talk about physician nurse engagement, how much we talk about patient engagement.

Aaron Garman: Absolutely, great point. Anything else? Anybody else on this slide? If not, I will turn it back over to Ira.

Ira Moscovice: OK. We're going to look at the affordability area now and there were three examples, delayed care due to out-of-pocket costs, going without other necessities in order to get care, and the total cost of care came up.

And in the earlier feedback that was given, there are couple of items that were raised in general, one of which is are these areas or ways to measure things should really be doing that in terms of looking at measuring provider performance or these really more community level issues. And then really the – in particular with total cost of care which, you know, would remind people for every study that's been done so far for similar patients.

It cost less if they're rural base and if they're not rural base, so this is a measure that rural is going to look good on. But the trade off here and someone suggested in a smaller volume, lower volume providers are not able to negotiate crisis as well. It's higher volume. We need to look at the outcomes which so often are somewhat similar. But this trade off between being nearer the patient versus the deals folks can get on prices.

There's a lot of trade-off in terms of the kinds and ways we want to look at this. And so – and this starts getting into going without, the sense this sort of gets into social determinants kind of issues and the mention was to make sure we try to risk adjust appropriately.

So I'll open it up how do – what people think about the affordability component and the kinds of examples, there? Are there other examples we might be interested in looking at and what kinds of strategies could be used to address these areas? Folks, comments?

Craig Caplan: This is Craig. In terms of total cost of care, I was thinking more in terms of out-of-pocket cost for the beneficiary or the enrollee not so much of the total cost of care. So what the beneficiary or enrollee pays.

Ira Moscovice: OK.

(Inaudible)

Tim Size: Yes, I ran a little, yes – this is given observation, and it's kind of implicit in when I spoke up earlier. These type of things that I tend to think more typically are found in the accessibility bucket. And then typically this would be amount of affordability that cost, which then gets into the provider's responsibilities at a cost effective, which is then more of an interest to payers but not one that necessarily affects accessibility. I'm struggling a little just with the fact that the way we divided the bucket.

Ira Moscovice: Well, I'll give my reaction, others can talk about. I mean, on the total cost of care, the issue is cost to who. And as Craig pointed out and certainly, you can look at it from the cost to the system versus the cost to a particular resident of the area or consumer services, and the business travel cost certainly usually get pin down to – it's not just out-of-pocket cost in terms of services being delivered but also the challenges and the cost involved with getting to providers.

And this is, you know, I think we've debated this at NQF in terms of where those cost come in and this is dimension of access. And if it is, how do we lay it out, I mean some of you are suggesting maybe it's a subcomponent of the availability and accessibility dimensions.

Other thoughts folks have on this affordability? Should we keep dimensions in separately as an important and …

Bill Finerfrock: This is Bill Finerfrock. And I absolutely think it still needs to be in there. I mean, I think that there's in my mind, there's no question that high deductible plans, the patients are making decisions based on the out-of-pocket cost for going to the doctor or whoever their clinician is, and that that's impacting decisions they make. And delaying care or not seeking care, I think this ties into something Tim talked about a couple times which is network adequacy.

But component of that is, even if numerically you – for your service area, you have what might be deemed inappropriate panel of providers relative to the population, the time and distance of two and to the provider who's in-network. And if you are in rural community and your provider is not in-network, and the nearest in-network provider is some distance away. You're going to have to go to that individual if you want that "convenience", go to an out of network provider which is going to cost you a lot more. So, I think all those tie into the affordability of care and needs to be part of that conversation.

Ira Moscovice: OK.

Daniel Coll: This is Dan Coll of AAPA. The other thing on affordability which I don't see as much in here but where in my more administrative had, is the supply side operational cost to the facilities for items where they don't have the purchasing power of the volume. And that cost just over to their – the payers and the patients. And in rural settings and in method (to) billing and under rural health clinic reimbursement, hospital-based clinic reimbursement, the reason we're getting paid more is they're understanding that it cost more for us to render that care.

And I know you mentioned some of those projects looking at cost. But I would tell you that there's a flip side to that is in some ways, don't shoot me for saying this, but there is reimbursement for folks being less efficient and not lowering their cost at care in rural environments when they're on (inaudible) reimbursement. And so capitated payment had forced the providers and facilities to become more efficient at the cost of care, the actual cost to rendering that care to keep their margin on their capitation.

Whereas, in rural environments, some of the reimbursement structures could argue – be argued that they are based on maintaining the cost at a higher level so they get a higher reimbursement. And so, it is a very challenging situation to be in but there is definitely the reimbursement structure for rural facilities on method two and other – some of the other reimbursement structures almost, I would argue, promote higher cost of care.

I'm not sure how you control that in there but this definitely how to incentive or how to support rural facilities in staying financially solvent, but also reducing their cost of care, the same time reducing the cost of care.

Tim Size: And I think was that the last speaker's comments that we lead me to think their at least consideration of putting things related to cost in affordability bucket and accessibility bucket. Because I think affordability bucket, it comes – you tend to look at the question more in the total cost to insurance plan, the employer. But have the (inaudible), the accessibility is more of the patient focus, how costs are keeping them from accessing care if that's available. And then ...

(Inaudible)

Tim Size: So, I just think the attribution of what the root causes are, is can be quite different. And I think we – yes, I think to (inaudible) piece of the pie, and I think put the things that affect patient behavior more in accessibility bucket, and put the ones that relate to overall system behaviors in the affordability bucket. Make some sense to me.

Daniel Coll: Makes total sense. My mother-in-law doesn't have secondary insurance for Medicare so she shops and she – and I have patients who will leave our community to save money. And so however you want to attribute that, the affordability patients definitely are – it does impact the patients as well because they have their shared responsibility depending on their payer and coverage. So, I definitely agree with your statement.

I'm just not sure also as well where that comes a direct attribution but cost is definitely an important component. And rural communities have had some

protection but it also doesn't – it protects them for their financial solvency but I'm not sure that it always makes care as affordable, accessible for patients.

Ira Moscovice: So I will make one final comment and turn it back to Karen for a response, and then we can turn this – we have five minutes left for the last, I think convenience. But when Karen's started out the discussion, she said we're trying to identify the key facets of access to care for rural residents. So this really should be a rural population focus and not a focus on the provider side per se.

But I'm just wondering given the comments you've heard from a variety of folks, any initial thought, Karen, about how you want to pitch this affordability bucket, do you want to combine it? With the accessibility or availability buckets before this or you want to more time to think about that?

Karen Johnson: So this is Karen. I definitely want some more time to think about it but I think one of the key things that I'm hearing is that we can't just pluck this matrix in the report, and then feel like we're done. Even if we leave this stuff in affordability which we may or may not, the point is that there's kind of the system/payer side and there's the patient side. And that doesn't really come out in how I have it here. So at minimum, we want to be able to distinguish those two and realize that there's differences.

I'll probably go back to the original framework from the equity side and see how they defined affordability. I suspect that they put all the money stuff under affordability, you know. And you know, from my perspective, I don't know that it matters to me because I had trouble even with the convenience one because the convenient one to me, you know, we talked about access and hours under availability but that's also convenient. So to me, I won't necessary care too much where we put things as long as we have the key things somewhere. But sounds like Tim feels pretty strongly, so. And Tim there, I respect his opinions a lot.

Ira Moscovice: OK. Any other final questions on affordability before we move out to convenience?

Julie Sonier: This is Julia. I just wanted to sort of to make a point that I think the affordability dimension from an individual rural resident perspective, is really distinct from accessibility. So one is about the services, the other one is can I pay for them. And the items that I think we have here about delayed care due to out-of-pocket cost, those are very much individual based. So I just wanted to get that viewpoint out there, but I think it still belongs as a separate categories.

Ira Moscovice: I think the total cost of care so that is what makes things a little bit murkier, as compared to the first two which really are the individual level. So – and under there, I wouldn't say control but and hopefully respond, (come to) strategies for individual to respond to them.

Well, why don't I turn it over to convene …

(Heather Brand-Hasgrove): Hi – oh sorry.

Ira Moscovice: No problem, what were you going to say?

(Heather Brand-Hasgrove): Hi – so for this is for Truven Health Analytics. We did have one comment to add for affordability and that was just to tease out that there's other indirect cost that are associated with healthcare for people who have to seek care and travel in a rural environment. So things like hotels, lodging, you know, food, anything related to car, transportation and that's kind of a special consideration that we think needs to be highlighted in some way.

Ira Moscovice: Yes. And when we're talking about travel cost there, it does reflect more than just certainly the vehicle cost, getting to a place for sure.

Why I don't I turn it over to Tim – to Aaron and we can talk about the convenience there.

Kate Buchanan: This is Kate Buchanan. I just wanted to take a quick pulse check. Since we're having such rich conversation, we want to make sure that we're able to capture it. So, Aaron, kind of – we're thinking about maybe just wrapping up the conversation a little before 3:00 so we can do a quick next step but we don't

want to limit or inhibit any conversation around convenience. So just a little before 3:00 is our goal now for ending this.

Aaron Garman: Sounds great. We can move on next to convenience then.

So under these, we have the examples of distance to care, utilizing telehealth and transportation. The challenges is distance can be unique to rural (inaudible). And I would say, it's more unique to rural. How do we – how can this be addressed, appropriate risk adjustment, telehealth, support services, utilizing telehealth, challenges are connectivity, cost to implement technology, trust issues. And then under transportation, we don't have any challenges listed but how do we address these collaborations public or other funding?

So let's start with the top one, distance to care. Any thoughts on challenges – addressing this issue? I think we've talked somewhat about this but any other thoughts on that?

I'm not hearing anything, we can always circle back. Utilizing telehealth, any thoughts on how we can address this or challenges associated with it?

Tim Size: Yes, the comment I made earlier is, the easy part of telehealth is the mechanics of getting the connectivity, the computers, the protocols, the credential and all that stuff. The hard part is, it doesn't create more providers. And I think that's particularly true in behavioral health.

So I would say the address thing and, again, we haven't double down on growing the work force for those professions that are particularly applicable for telehealth and methodologies.

Bill Finerfrock: This is Bill Finerfrock. I would say that one of the challenges too and utilization of telehealth is that, we often at least for Medicare and Medicaid, I don't know so much about commercial insurers, but often required a patient to still have to go to the medical practice in order to be able to utilize the telehealth arrangement. So, instead of the patient being able to stay at home for Medicare for example and engaging into telehealth arrangement with specialist, that individual has to get to the – in the case, so let's say rural health

clinic where they can then make the connection to the specialist and that present barriers.

So, improving the ability of the patient to more efficiently access to that telehealth system without having it go through an actual visit to the – physically go to the providers location in order to do that.

Aaron Garman: That is definitely is a challenge.

Tim Size: Bill, I think you're right on that. And let's also not forget that there's a second cost component of telehealth that patients will bear and that's the originating (Site C). It's not – hey, it's a barrier. So, yes, there is a reduction in cost to travel issues if you're using telehealth, but there is out-of-pocket cost, but it is there.

Mark Greenwood: This is Mark Greenwood. We also have a lot of issues with third party payers still not paying for telehealth care.

Aaron Garman: OK. Any other?

John Gale: And I think, you know, I agree with Bill and Tim on this one. I think it's important that we begin to rethink what we mean by telehealth and how to use it in improving access. And how to use Medicare reimburse – Medicare rules which drives much of this, really envisions this as for lack of a better way of phrasing, a virtual office encounter, it replicates the face-to-face encounter just using technology rather than physical space in one setting.

And there are a lot of things that are going on that could be done to improve access. But we need to think differently and outside of traditional models.

Aaron Garman: One of the other things that I think is a challenge anytime we're talking about health technology is who is going to be doing the work in the providers' office themselves. You know in my office, I end up being IT half the time, while if I'm being IT, I can't see patients. So, just because you have access to the technology doesn't necessarily mean you have qualified people to implement that technology as well. And perhaps better education for office staff or

improvements in outreach for education could help address some of those issues as well.

Anybody else with thoughts regarding telehealth or technology for that matter?

Bill Finerfrock: I will reiterate comment I made earlier, this is Bill, with regard to the impediments of state laws why right now the states take a position that if I were to sit in Virginia and engage in a – or telehealth visit with a provider who is in Pennsylvania, the interpretation is that that provider in Pennsylvania is going electronically to Virginia and therefore must be licensed in Virginia in order to engage in that.

It's equally valid to say that I'm traveling electronically to Pennsylvania to receive care and there is no state licensure issue. And I think we need to address these state licensure issues which to me present artificial barriers.

Aaron Garman: Excellent point. Any other thoughts?

Cameron Deml: Yes, hi. This is Cameron Deml from the National Rural Letter Carrier's Association. We have been – if you remember my very first introduction, I'm in-charge with the rural care and benefit plan. And we actually have a telehealth benefit. And knowing that cost might be a barrier, we offered free of charge.

But the one thing I will say and I think this is kind of articulated is that, you know, people don't use it as much as we'd hope. And I think the biggest barrier for us has been education. And just getting people comfortable with the kind of premise of telehealth, what value that can bring and really just kind of demonstrating the use. So, if anything, I'd really highlight education familiarity is probably the biggest hurdle we have seen because we've had that benefit in place for the past year and a half.

Aaron Garman: Great, thanks for the point. Anything else on telehealth?

Not, we can sure move down to transportation and I think we talked about this. But does anybody have anything else to add regarding challenges

regarding transportation or thoughts on how we can address transportation issues for our patient's convenience?

Tim Size: I will just reinforce the growing crisis I mentioned before and the declining proportion of population or around these tele-caregivers that's particularly acute I think in rural. And that's probably at least for our elderly Medicare beneficiaries is often the source of transportation.

Ira Moscovice: So, Karen, this is Ira. I think we need to carefully think through for instance we've had a conversation of all these dimensions under convenience in the previous three slides. And so, I think we really need to carefully think through where – I don't think we want the dimensions to overlap as much as they are right now. We need to think through where we do we really want to discuss some of these issues.

Karen Johnson: Yes, I agree. And actually, I was going to also ask, you know, I only pulled three that seemed to jump out. Are there other things under convenience that I'm just missing? I know we talked a little – we got some feedback about safety surrounding environments under convenience, but I didn't put that in here, maybe I should have. Or just convenience kind of go away because I think it's back to Ira's question.

Ira Moscovice: This is Ira. And I think that's a really good point. I would say convenience somewhat going away because it is covered in most of these other areas.

Karen Johnson: So this is Karen again. I will go back. We'll look again at what was covered under the convenience subdomain from earlier work and see if there was anything that, you know, I missed bringing forward to you. You know and we can figure out from there.

I think I agree that there is no point in kind of mentioning transportation 15 times in the section. I think that the point is, it's a big problem for rural and it hits in several of these things. And there are things that we could probably do to begin addressing it.

And then I think the next piece to the measurement part is, you know, once these things are in place, you know, we could think about how would you

measure progress in those things potentially. So, we haven't really talked that much this time around about measurement, but I think that, you know, being NQF, that's what we like to talk about, so.

Aaron Garman: Sounds great. Anything else you'd like to cover on this, Karen? Wrap it up and move on to the next?

Karen Johnson: I think we're ready to wrap up. I guess all I would say is, if anybody thinks of something specific to convenience that you feel like we haven't covered and should have, if you could just drop this a line and we can talk about that and think about that.

Kate Buchanan: So, this is Kate. And I believe our next are going to go to public comment. So, (Kathy), if you won't mind opening up the line and holding it for 20 seconds to see if we have any public comments.

Additionally, people who are streaming but have not dialed in, please feel free to type a question into the chat box and staff will read it out loud. But we could open for public comment now.

Operator: OK. And all lines are open if you like to ask a public comment.

OK. There are no public comments at this time.

Kate Buchanan: Thank you very much. And I'll turn it over to my colleague, Madison, for our next step.

Madison Jung: OK. OK. So, for immediate next steps, I think we're all – there's consensus in the room over here, NQF is that you probably won't need to send a follow-up exercise, follow-up to this exercise. I think we're really pleased with what we've heard, so thank you so much for all of your participation and (thoughtful) for conversations.

For upcoming deliverables from our end, we are currently working on the draft report two. And in that report that will include all the recommendations to date as well as core set to date. And I know you haven't seen that yet, but we are planning to send that you either tonight or tomorrow morning. We

held off just for purposes of, you know, cleanliness of the mind, keeping things separated and (concizing) your mind. So we'll send the core set to you following this webinar either tonight or tomorrow, so keep an eye after that.

We're not going to request your feedback just yet on the specific configuration of the core set, we will do that prior to our webinar on July 19th. But for now we're sending it along just for you to take a look at. We'll follow up with another sort of either survey or communication, take or gather results on that.

But back to the draft report two, that report will be posted on May 31st for a 30-day public comment period. Other than that, that's all we have for immediate next steps. As always, feel free to reach out to us via e-mail or phone at maprural@qualityforum.org.

Oh, sorry, one point I missed back to the next steps, just to keep on your radar. We will have a Map Coordinating Committee that will take place sometime in August. But that calendar invitation be coming your way. And during that meeting, the coordinating committee will review our final report. This meeting is optional, but just wanted to let you know for clarification purposes that this invitation will coming your way. But for our workgroup, it's optional.

That's all I have from our end, if you have any questions, please feel free to reach out. Just a huge thank you from the NQF staff for joining us today.

Ira and Aaron, do you have any closing remarks or thoughts that you want to add?

Aaron Garman: Just thank you all, it's been a rich discussion and I really appreciate it.

Madison Jung: All right. Well, thank you everyone and have a great day.

END