NATIONAL QUALITY FORUM

Moderator: Rural Health
November 29, 2017
1:00 p.m. ET

OPERATOR: This is Conference #: 88425392

Operator: Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

Kate Buchanan: Thank you all very much. Good afternoon – oh, good afternoon, everyone. And this is just a friendly reminder that we can hear some background, so if you won't mind just muting your line when we're – when you're not talking, that would be greatly appreciated.

My name is Kate Buchanan. I'm the project manager here at NQF, working on the MAP Rural Health Workgroup. I would like to make a couple of quick announcements. In addition to logging in to the website, please call in in order to participate verbally, the number is 855-307-1903. Once again, that is 855-307-1903.

And I would like to introduce my NQF colleagues here with me today. We'll go around the room.

Karen Johnson: Hi, everybody. I'm Karen Johnson. I am a senior director here at NQF and really looking forward to (work).

Madison Jung: Hi, my name is Madison Jung. I'll be the project analyst for this workgroup.

Shantanu Agrawal: Hi, I'm Shantanu Agrawal, I'm the CEO of NQF.

Kate Buchanan: And then Suzanne.

Suzanne Theberge: Yes, this is Suzanne …

(Inaudible)

Suzanne Theberge: Suzanne Theberge, the senior project manager on the team.

Kate Buchanan: Great. And I'd also like to welcome our CMS colleagues who are working with us on this project. You wouldn't mind introducing yourself?

Male: I'm sorry?

Kate Buchanan: I think I heard (Gurma) earlier.

(Gurma): Yes, this is (Gurma) from HRSA.

Kate Buchanan: Great.

Megan Meacham: Hi, this is Megan Meacham from HRSA's Federal Office of Rural Health Policy.

Kristin Martinsen: And this is Kristin Martinsen from the Federal Office of Rural Health Policy.

Steve Jameson: I'm Steve Jameson from the American College of Emergency Physicians.

Kate Buchanan: OK, great. And I'd also like to welcome members of the public for joining us, as well as our workgroup members.

On this current slide, you can see today's agenda. The meeting objectives are to provide introductions and disclosures of interest. Familiarize everyone with the priority of NQF Rural Health Work. Review and discuss the project scope and objectives, and provide feedback on the preliminary measure selection criteria and discuss rural relevant measurement topics.

Prior to digging in today's content, I would like to turn it over to our president and CEO, Shantanu Agrawal, to provide some opening remarks.

Shantanu Agrawal: And there's my picture. Thank you very much. And it's really great to join you all in this call. So welcome to the Measure Applications Partnership Rural Health Workgroup.

As you all know, this is a new MAP workgroup that we have just started this year. And we are really looking forward to the recommendations of this committee, this workgroup. So as you are probably all aware, the recommendations that come out of this workgroup will go to the MAP Coordinating Committee on performance measures to improve the quality of care provided to more than 59 million Americans who live in rural areas.

That mission alone, I think, is just extremely exciting and I know the team here is very excited to get the work off the ground and really execute this first year of the vision of the workgroup.

The workgroup, interestingly, really is based on a recommendation from a 2015 rural health project that we convene to identify challenges in health care performance measurement for rural health providers. And those recommendations were really focused around how to meet those challenges particularly in the context of CMS pay-for-performance programs.

That earlier, committee recommended that rural health providers be integrated in the federal quality programs and that HHS convene a MAP workgroup focused on rural health, and we're obviously thrilled that CMS and HHS have taken up that recommendation and we are very much realizing it today.

So, the focus of the workgroup this year is threefold. First, we will work to identify the best available measures to assess care and drive improvement, in care provided in rural areas. Second, the workgroup will identify measurement gaps for rural hospitals and clinicians. And third, you will tackle a specific measurement topic area relevant to rural residents and providers. And I believe that topic area is still yet to be determined but will be determined by the committee.

Just a word about the co-chairs, we are really pleased that both Ira and Aaron have agreed to co-chair the workgroup. They have a lot of expertise, as you

all know, in this area. They have served on prior rural health committees at NQF and elsewhere. And really gives us continuity for this foundational work to proceed and be connected to the good work that had been done before.

I'll let you – I think you've got access to their bios and everybody else's bios on the committee, so I'll let you take a look at those. But really excited to have them be co-chairing.

And finally, just about the workgroup itself, we are really pleased with everybody that's on this workgroup, I think there's a great diversity of representation, lots of different organizations that really understand this area very well that have worked directly in it. We are thankful and grateful for all your perspectives. This work really happily, I'll tell you from my standpoint, is great because it's also allowed us to bring new people to the table that have really never participated in NQF work before. And it's always exciting when that happens.

I don't think the team ever thought – I certainly never thought that we would get to work with the Rural Letter Carriers' Association. So, not to highlight anyone, but that is just really exciting that, you know, our table is always expanding and it is great that it is.

I also want to just highlight the federal liaisons that are working with this workgroup. CMS, particularly the centers – the Center for Medicare & Medicaid Innovation, HRSA, of course, and particularly the Federal Office of Rural Health Policy and the Indian Health Service.

Again, I think between the federal liaisons, all of the diversity on this workgroup, the co-chairs and all of the new faces. It is just a really exciting piece of work to get off the ground. So with that, I will thank everybody and turn it back over.

Kate Buchanan: Thank you so much, Shantanu. So, with those welcoming introductions, we will also move on to our co-chairs. I know that one of our co-chairs just got disconnected so we will work with him on that. But Ira, I believe that you are

still on the line to provide some opening comments?

Ira Moscovice: Yes, I'm still here. It's just a real pleasure to be co-chairing this workgroup and I think the important part is – for all of us to understand is that it's really terrific that CMS and others are looking to us in terms of trying to understand how can we best measure rural health quality. But doing it in a relevant way, a way that really is meaningful in terms of what goes on out in rural America in terms of the interactions between patients and providers.

And so, this is a great opportunity, really, as Shantanu said, the natural follow up to our previous work, where we really didn't get down to any specifics, but really looked at the issue from a broader perspective particularly for low-volume providers. And I'm really excited to be working with you on this and look forward to a whole series of webinars that are coming up. So, welcome.

Kate Buchanan: OK. Thank you so much, Ira. And I believe Aaron is still working on getting reconnected. But I will turn it over to our acting senior vice president for quality measurement, Elisa Munthali, to do some of our disclosure of interest.

Elisa Munthali: Thank you so much, Kate. Again, I'm Elisa Munthali. I'm so happy to be here for this first webinar. And what we're going to do is combine disclosures of interest with introductions. And so, we'll divide the disclosures of interest into two pieces, because we have two types of workgroup members, organizational and subject matter experts.

The disclosure is different for these two groups and I'll start with the organizational members. And the organizational reps represent the interest of a particular organization. We expect you to come to the table representing those interests. And that's why we selected you to participate on this workgroup.

So in light of your status as an organizational rep, we ask that you only, you know, that you – we ask you only one limited question regarding your involvement in other commitments that are related to this work. We ask you to disclose if you have an interest of $10,000 or more and an entity that is

related to the work of this committee. Please tell us who you represent and if you have anything to disclose.

So, we will go down the list and I will name the organization and whomever the rep is, if you can tell us if you have anything to disclose, that would be great.

So, we'll start off alphabetical order. Alliant Health Solutions?

Female: You're going through the list and asking them to disclose verbally.

Elisa Munthali: Hi, is anyone from Alliant on the phone? OK, I don't think so. The next organization is the American Academy of Family Physicians. And perhaps, you're on mute, we can't hear you.

OK. So we'll go through our third organization, the American Academy of PAs?

Dan Coll: This is Dan Coll as a nominee, I have no disclosures.

Elisa Munthali: Thanks, Dan. Next, we'll go to the American College of Emergency Physicians?

Steve Jameson: Hi, this is Steve Jameson. Yes, I'm representing the American College of Emergency Physicians. I've been working for the past year and a half or two to develop educational programs for providers and rural health, along with the (CALS) organization, we have not sold any product yet. (CALS) is a non-profit that's looking to develop a – or a fundamental scores for providers in rural health. So, I don't think that there's a conflict of interest. I just wanted to disclose that I'm working on educational product that was designed to improve rural health care, so. That's all.

Elisa Munthali: Thanks, Steve, and welcome. The American Hospital Association?

Stephen Tahta: Yes, hi, this is Dr. Stephen Tahta and I have nothing to disclose.

Elisa Munthali: Thank you. The Geisinger Health?

Karen Murphy: Hello, this is Karen Murphy and I have nothing to disclose.

Elisa Munthali: Thank you, Karen. Health Care Service Corporation?

Shelley Carter: Good afternoon. This is Shelley Carter and I have nothing to disclose.

Elisa Munthali: Thank you, Shelley. Intermountain Healthcare? OK, it sounds like we don't have anyone yet. Michigan Center for Rural Health? OK. Minnesota Community Measurement?

Julie Sonier: Hi, this is Julie Sonier, and I have nothing to disclose.

Elisa Munthali: Thanks, Julie. National Association of the Rural Health Clinics?

Bill Finerfrock: Yes, this is Bill Finerfrock and I have nothing to disclose.

Elisa Munthali: Thank you, Bill. National Center for Frontier Communities?

Susan Wilger: This is Susan Wilger and I have nothing to disclose.

Elisa Munthali: Thank you very much. The National Council for Behavioral Health?

Sharon Raggio: This is Sharon Raggio and I have nothing to disclose.

Elisa Munthali: Thank you, Sharon. The National Rural Health Association?

Brock Slabach: Hi, this is Brock Slabach and I have nothing to disclose.

Elisa Munthali: Thanks, Brock, and welcome. The National Rural Letter Carriers' Association?

Cameron Deml: Yes, hi. This is Cameron Deml and I have nothing to disclose.

Elisa Munthali: Thank you. RUPRI Center for Rural Health Policy Analysis?

Marcia Ward: Hi, this is Marcia Ward filling in for Keith Meuller, and we have nothing to disclose.

Elisa Munthali: Thank you, Marcia. The Rural Wisconsin Health Cooperative?

Tim Size: Hello, this is Tim Size, nothing to disclose.

Elisa Munthali: Thank you. Truven Health Analytics?

Cheryl Powell: Hi, this is Cheryl Powell and I have nothing to disclose.

Elisa Munthali: Thank you very much. So that completes our organizational representatives, but I did want to go back to see if others have joined that have not orally disclosed. Alliant Health Solutions?

Kimberly Rask: Hi, yes. This is Kimberly Rask and I have no conflict of interest to disclose.

Elisa Munthali: Thank you, Kimberly. The American Academy of Family Physicians?

(Inaudible)

Female: Hello?

Elisa Munthali: Hi. Is that the American Academy of Family Physicians? OK …

Female: No, sorry.

Elisa Munthali: OK, that's fine. Intermountain Health?

Mark Greenwood: Yes, this is Mark Greenwood. I have nothing to disclose.

Elisa Munthali: Thank you, Mark. Michigan Center for Rural Health? OK.

Kate Buchanan: And I know that David Schmitz, who is the organizational rep from American Academy of Family Physicians, is trying to call on. Dave, are you – have you been able to get through?

Elisa Munthali: I know – so I know (inaudible), so maybe at the end.

Kate Buchanan: OK.

Elisa Munthali: We'll go back.

Kate Buchanan: Yes.

Elisa Munthali: And so thank you again for all of our organizations who went to the disclosures of interest. And now we'll move on to disclosures for our subject matter experts. Because subject matter experts that – on this workgroup as individuals, we're asking you more complete information, more detailed information about your professional activities.

When you disclose, we don't want you to recite your very impressive resumes, instead we're very – we're interested, in particular, in the activities that are related to the subject matter of this committee. And so we are especially interested in your disclosures of grant, consulting or speaking engagements, but only if they're relevant to the workgroup's work. So just a couple of reminders, you received this in the paperwork that you got when you were named to this workgroup.

You sit on this group as an individual. You do not represent the interest of your employer or anyone who's nominated you for this committee.

The other thing that I wanted to mention is that we are not only interested in your disclosures of activities where you were paid. You may have been a participant or a volunteer on a committee where you work, the work was relevant to the work in front of us. And so we're asking you to disclose those types of activities as well.

And just because you disclose does not mean you have a conflict of interest. We do the oral disclosures in the interest of openness and transparency. So, please let us know who you are, your name, and who you're with, and you have – if you have anything to disclose.

And so what I will do is because I have your names here and you're not in front of us, I will go ahead and call out your names in alphabetical order as it's listed on the screen. And we'll start with John Gale.

John Gale: Yes, good afternoon. My name is John Gale. I'm with the Maine Rural Health Research Center at the University of Southern Maine. In terms of disclosures, we have grant and contractual funding with both the Federal Office of Rural Health Policy within HRSA and with the Centers for Medicare & Medicaid Services to work with rural measurement issues both in the

(FCHIP) demonstration with rural health clinics and critical access hospitals, but I have no conflict of interest.

Elisa Munthali: Thank you so much John. Next, we have Curtis Lowery. OK, I don't think Curtis has joined us yet. Melinda Murphy?

Melinda Murphy: Hi. Yes, thank you. I have experience as a nurse administrator and as a medical center administrator primarily in a rural health setting. I spent a career with the Department of Veterans Affairs in the (Inaudible) Central Office, and in medical centers as a medical center director most recently. And I worked in that capacity with Indian Health Service primarily Cherokee Nation, including as a member of an advisory committee for them for a few years. So, I have no disclosures. Thank you.

I should also have said that I did spend a bit over a decade working with NQF.

Elisa Munthali: Yes, you did. Thank you. Nice to hear your voice, Melinda. Ana Verzone?

Ana Verzone: Hi, yes. I currently work for the Alaska Native Medical Center in the University of Alaska. And the only thing I could think of is a course that I'm hoping to develop on rural health care that we received some funding for grants. The specifics of which I'm not aware but I don't think it's a direct conflict of interest.

Elisa Munthali: Great. Thank you, Ana. And last, we have Holly Wolff.

Holly Wolff: Hi, Holly Wolff. I'm with – the CEO of Ashley Medical Center in Ashley, North Dakota. And I don't believe I have anything to disclose.

Elisa Munthali: Thank you so much. And so next, we'll go to our federal liaisons and we'll just ask you to introduce yourself. We'll start off with CMS.

Susan Anthony: Hello. My name is Susan …

Elisa Munthali: Sorry, Susan. Go ahead.

Susan Anthony: Hi. My name is Susan Anthony. I am at CMS. I work at the Innovation Center on the Pennsylvania Rural Health Model.

Elisa Munthali: Welcome, Susan. And next, we have the Federal Office of Rural Health Policy out of HRSA.

Craig Caplan: Hi. I'm Craig Caplan. I'm a senior advisor in the Federal Office of Health Policy. And I've been here for three years. I previously was at CMS.

Elisa Munthali: Thanks, and welcome, Craig. And lastly, we have the Indian Health Service.

Juliana Sadovich: Hi. This is Juliana Sadovich. I am the director of Quality Management in the Indian Health Service. We provide health services to our 566 tribes across the nation, either directly or providing funding for services that they provide themselves – each tribe provides themselves.

Elisa Munthali: Thank you so much. And so I will go back – I understand we have the American Academy of Family Physicians on the call.

David Schmitz: Yes. Thank you. Sorry, I was having difficulty being admitted to the phone call. My name is David Schmitz and I am the chair of the Department of Family and Community Medicine at the University of North Dakota. I'm also president of the National Rural Health Association this year, but I'm representing the American Academy of Family Physicians in this group, and I have no disclosure of conflict.

Elisa Munthali: Thank you so much, David. And before I leave, I just wanted to remind you that if you believe you have a conflict at any time during this webinar, please speak up. You can send a message to our project team via the chat box. And you can also send a message to the chair. And I think all of the individual names of everyone who's on the webinar is on there.

So, I will pause now. Oh, I understand also, sorry about that, that the Michigan Center for Rural Health is on the call. So before I close, finally, I'm going to ask you to introduce yourself and let us know if you have any disclosures.

Jill Oesterle: I will go ahead and disclose for Crystal Barter from Michigan Center for Rural Health. This is Jill Oesterle. She is on the call, but I believe she's having trouble get called in. And there's no conflict of interest.

Elisa Munthali: Great. Thank you so much. Anyone else before I close that haven't spoken up, introduce yourself or orally disclose anything of interest to this workgroup? Do you have any questions of each other that you would like to ask based on the disclosures you just heard?

Doesn't sound like it. Thank you. Have a great webinar.

Kate Buchanan: Thank you very much, Elisa. And so, here, you can see the project staff's smiling faces. Since we won't be able to meet in person, I thought it would be good to be able to see who we are. And Karen, I wanted to turn it over to you, to do an overview of NQF's previous rural health work.

Karen Johnson: Sure. Thank you. And Shantanu has stolen my thunder (inaudible) …

Shantanu Agrawal: Oh, no.

Karen Johnson: … but that's great because repetition is always good. And several of you – I, you know, recognize a few old friends because several of you helped us out on this last project that we had. So, we wanted to make sure that all of you kind of started with the understanding of what we did a couple years ago because that work, as Ira mentioned, was quite broad but very foundational, I think, to where we are going and where we need to be for this project.

So, just a reminder of the purpose of that project a couple of years ago, we (seated) folks, I think we had 20 members of a rural health committee that came together and gave us some guidance on performance measurement issues and challenges for rural providers.

So, part of the work that we did was really to try to understand, you know, what is different about rural or is there anything different and how does that affect measurements, and what recommendations can we make particularly as Shantanu mentioned, this was in the context of potentially being included in CMS pay-for-performance programs.

And the – what is really interesting for us was the – we're able, in that work, to bring together folks who traditionally have not been included in a lot of the CMS programs, specifically the rural health centers, some of the FQHCs. We have the – we had critical access hospital representation who work with the CMS programs kind of on a voluntary basis but at the time weren't mandated to be included in those programs.

So it's really interesting, I think, and helpful to just learn about other folks who are working kind of in other delivery model, I guess, is the way to say it. It was a great experience for us.

Let's go to the next slide.

I think the – what was very helpful and what put us on a really good footing was understanding some of the key issues that rural providers face. And not every rural provider faces all of these, but these are some of the key issues and they are, to some extent, interrelated.

So, this idea of geographic isolation, when you're isolated, you know, you have maybe fewer providers to work from. You have things like transportation issues and those can impact measurement in a variety of ways. I.T. is always a bit of a problem. And also, potentially some limited support, just all kinds of support not just other docs, but support in terms of knowledge and referrals, things like that.

Small practice size can go with geographic isolation, but it can be separate as well. Couple things on that, when you have a small practice (inaudible), you don't have the resources and time or staff or finances, sometimes the DQI and the whole point of measurement is to improve health care. So, there's limitations there. And I think that really came through quite well and we need to think about that as we think about core measurement and what we're going to do in this project.

We have heterogeneity across rural areas. So, one of the things – I still remember Shantanu asking, what do you mean by rural. And I said, well, we didn't really define rural in that project and he wasn't necessarily happy about

it. He's a little surprised, I think, but rural means different things to different people.

You know, we could be talking about, you know, really isolated frontier areas or really rural areas that are quite close to some bigger towns and cities, so – but different issues and different impacts potentially for measurement. And also along with that is different patient populations knowing that these kinds of things have implications in terms of risk adjustment, reliability of measurement and how measures can be used.

And then finally, low-case volume. So, what happens when you don't have enough people in your denominator to have a reliable and valid measure? It can be a problem. So there's things that we can do, but there is a fairly limited number sometimes of the things you can do.

You can add time, you can add providers and we talked about all these different things a couple years ago. But in terms of thinking about measures for selection, the idea there is there may be, you know, some measures that are being used in programs that just won't work for these low-volume providers. So, it was really helpful to understand the challenges for rural providers.

The overarching recommendation of that committee was to make participation in CMS quality measurement and improvement programs mandatory for all rural providers. That was a really important recommendation, and to be honest with you, somewhat surprising recommendation. But it got support of the group as well as support from the broader community because the idea that you don't want rural providers to be left behind. You want to showcase your ability to provide high quality care.

Potentially, you want to share in some of those incentives payments that might be available in these kinds of programs. But with that came the idea that there should be a phased approach in any kind of incorporation of all rural providers into the various programs.

And let me make sure that I am clear here. The current programs that we have, you know, may not work for all rural providers. At some point, maybe there'll be other programs that are created for rural providers. You know,

that's yet to be determined by others at some point in the future. But just again, the idea that there should be programs for rural providers and that allowing a phased approach really to work your way up to being able to participate most fully in those.

Along with those – that overarching recommendation, the committee put forward several supporting recommendations. So, one of the ones was we really need to develop some rural relevant measures. So, of course, you know, a favorite recommendation is somebody needs to fund this development.

And along with funding kind of de novo measures with the idea that there is, you know, often measures out there that exist, maybe they don't quite work for the rural providers or populations. So, what do we need to do to think about modifying those that they do work better?

We talked a lot about sociodemographic factors and making sure that, you know, the factors that affect rural residents are included so that measurement is fair. If the measures are going to be using accountability programs, we need to make sure that they adequately adjust for the patients that are being seen.

And of course, thinking about low-volume providers and low volume all the way around that it really comes up and kind of showed its head when you think about composite measures and some of the measures that are used in the programs. And sometimes they're not always – some of the components of the composites are not always useful for rural providers. So, how do we address that?

Another thing that came up with is this idea of alignment. And we're pretty used to thinking about alignment for measures themselves. But the committee also talked quite a bit about alignment of data collection efforts as well as alignment of technical assistance and other informational resources. So, realizing that, you know, there's a lot of help, there's a lot of efforts out there and it can be a little bit mind-boggling. So, if we get some alignment there.

Measure selection. The committee actually spent quite a bit of time, and we're going to talk about this a lot in this meeting today. When it comes time to participate in programs, what measures would be used for rural providers.

So the committee developed a set of guiding principles for selecting quality measures that would work for rural providers. And again, we're going to talk about those in detail a little bit later. The committee recommended using a core set of measures, along with a menu of optional measures, for rural providers.

And again, we're excited because this work is specifically tackling this recommendation because we will be trying to identify core sets of measures for rural providers. We talked about measures that are already being used in other programs such as the PCMH models. So, making sure that we don't forget about those kind of measures. And as we've mentioned a couple times already, creating the – this MAP workgroup. That, again, was a direct recommendation of that work back in 2015.

There were a few other recommendations around payment because it was done in the context of pay-for-fee programs for CMS. And I won't go through those there. They're not as relevant, I think, to our work this time, but they were included.

Hopefully everybody has had a chance to log in to our project SharePoint site. And no worries, we're going to make sure everybody knows how to do that. But the report that came out of that work is included on that site. If you haven't had a chance to look at it, it would be great if you would maybe carve out a few minutes to glance at it and just kind of see. Again, it's good – it was great foundational work and it's good context for what we are doing in this project.

I am going to hand this over right now in a minute to Kate to talk about this project. But before I do that, let me just open the line real quickly. Was there any questions that anybody had about our previous work, not getting too much of the details but if there's just something you – burning, feel free to ask. And

what we'll ask you to do is just, when you speak, if you would just give us your name, that would help us.

So anybody have any questions?

OK, hearing none – oh, go ahead.

Susan Wilger: Just one quick question. This is Susan Wilger with National Center for Frontier Communities. Is the document of that final report available on the website?

Karen Johnson: Yes. Yes. So, towards the end of our call today, we're going to make sure that everybody understands how to use SharePoint, that's our document-sharing utility. So we're going to go through that and we'll point out where it is on that site.

Susan Wilger: Excellent. Thank you.

Karen Johnson: OK, Kate.

Kate Buchanan: Great. Thank you so much, Karen …

Karen Johnson: Oh, go ahead. Hi, Melinda.

Melinda Murphy: It's Melinda. Hi. I wanted to say I did scan that document this morning and I believe that it'll be truly very helpful to everyone to scan that both in terms of helping frame some thoughts and questions but also answering some. So it – I think it's an excellent document.

Karen Johnson: Thank you, Melinda.

David Schmitz: And this is David Schmitz for the American Academy of Family Physicians. Just a quick overarching question. Thank you for the prior work that's been done. Has it been considered with regard to access in geographically isolated areas in a sense that if something is being provided in a quality way, that's one fact. If a service is not available, that's another fact. So, for example, safe obstetrical delivery being not available in a geographically isolated area, does the committee address that question at all in any way?

Karen Johnson: Yes. And we'll go through that just a little bit later, but it definitely came up when we talked about what would a core set look like. And I think one of the things that came up and there's probably other things as well, but it's – this is the one that's coming to mind is, you know, the core set of measures really needs to be applicable across most, if not, all rural providers and patients.

So, you know, knowing that, you know, certain places don't offer certain services means that some measures are kind of out of the running as part of our core set. So, from that perspective, it definitely came up.

David Schmitz: Thank you.

Karen Johnson: Anything else? All right, and we will definitely talk more about the – some of the work that came out of that – in that report. So, Kate.

Kate Buchanan: Great. Thank you so much, Karen. So I'm now going to do an overview of who we are at the National Quality Forum, an overview of the Measure Applications Partnership. And then also really get into our workgroup's charge here.

So established in 1999, NQF is a non-profit, non-partisan, membership-based organization that is recognized and funded in part by Congress and entrusted with the important public service responsibility, of bringing together various public and private sector organizations to reach consensus on how to measure quality and health care as a nation and how to make it work better, safer, and more affordably.

We have approximately 430 organizational members and it's a really diverse membership including hospitals, medical groups, health plans, physician societies, nursing organizations, purchasers, patients to consumers among others.

We also work with our federal agency partners. And some of whom are on our call right now. We are a forum, so it's really – we really value – everything we do is open to member participation and all materials are

accessible to our website. So we are very transparent. And that's something that we really foundationally build ourselves upon.

So if we go on to the next slide.

And here, you can see some of the activities NQF (gate us in) around quality measurements, including our performance measure endorsement, the Measure Applications Partnership, which we shortened to MAP. And the National Quality Partners among other activities. We will go in to more detail on MAP in the following slide.

So, MAP was created under Section 3014 of the Affordable Care Act, which requires that HHS contract with the consensus-based entity, in this is instance National Quality Forum, to convene a multi stakeholder groups to provide input on the selection of quality measures, for public reporting, payment and other programs. And you may often refer – you also refer to this as pre-rulemaking and this input that we provide to HHS refer to as our pre-rulemaking process. So that's kind of how we get that terminology.

And MAP engages in several activities in pursuit of the National Quality Strategy, including providing input to HHS during the pre-rulemaking – pre-rulemaking on the selection of performance measures. And identifying measure gaps, as well as encouraging measurement alignment.

On the slide, you can see a diagram of how we organize the MAP. The MAP includes the overarching body, the coordinating committee. And then we also have here, we have six workgroups and then there are also opportunities for time-limited task force. Now, there are three settings specific workgroups on this image, the hospital, clinician, and PAC/LTC. And those are the workgroups that convene in our December every year in order to provide input on the measures under consideration.

In addition, we have this newly created Rural Workgroup. And then we have the Adult Medicaid Workgroup, and the Child Medicaid Workgroup. And those moved from a task force last year and this is their first time as a workgroup.

So we will talk a little bit about the MAP rural workgroup's interaction with some of these other workgroups in the coordinating commission – committee as we go on. But this is just an illustrative example of how we organize this work.

As Elisa mentioned earlier in the call, there are three types of MAP members. And so this is a little different than the first people who have participated in some of our other type of work, like our standing committees or other time-limited works. We have organizational representatives who make up the majority of MAP membership. And they include those affected by or interested in the use of measures and are chosen by their organization to be seated on MAP. The organizational representatives represents entire constituency and can send a substitute to meetings if they identify one in advance.

And I believe there's some machinery going on. If you are in a busy area, if you won't mind muting your line, we would appreciate that. Wonderful, thank you.

We also have subject matter experts, who serve as individual representatives that have content specific knowledge that they offer during MAP deliberations. We also select our co-chairs in this category. And unlike other MAP organizational members, they cannot send substitutes to meetings that they are unable to attend.

Lastly, we have our federal government liaisons who are non-voting, ex-officio members, who speak to the government's perspective during deliberations. And if we look on the next slide, we have some of the roles and responsibilities of these various members.

So, each of the three types of representatives provide a unique role. Organizational members represent their entire organization while subject matter experts are neutral content experts, they do not speak on behalf of a stakeholder group. Both organizational members and subject matter experts are voting members, while federal liaisons provide in-person – input during the discussion. They do not vote on any recommendations.

Our co-chairs, Aaron and Ira, will advise and assist staff to achieve the goals of this project, help facilitate our webinars and represent the workgroup at the coordinating committee meetings in addition to participating fully as subject matter experts.

And then we, here at staff, prepare materials for our webinars, facilitate meetings along with Ira and Aaron, and produce our workgroup report to describe the work and recommendations of the group.

So, as we mentioned, there are several other workgroup in coordinating committees involved under the Measure Applications Partnership. The MAP Rural Workgroup will have some interaction with these pre-rule – pre-making rural workgroups and coordinating committee.

Staff will introduce the rural workgroup and act as a liaison between the rural workgroup and the setting specific workgroups during this December in-person meetings where they review the measures under consideration. We will also act as liaison during the MAP Coordinating Committee in-person meetings that happen in January.

Further, during our December 13th web meeting, the rural workgroup will provide a very high-level input on the measure under consideration list. And the MAP Coordinating Committee will consider this input during their January in-person meeting. Finally, in August, the coordinating committee will review and approve the rural workgroup's recommendations.

So now that we've kind of discussed the rural and what MAP is, really getting into what the work of this workgroup is. And so in the course of our work, we will develop a set of criteria for selecting measures and measure concepts. Identify some core sets or a core set of best available, in other words, rural relevant measures to address the needs of this population. Identify rural-relevant gaps in measurement. Provide recommendations regarding alignment and coordination of measurement efforts across programs, care settings, specialties, and sectors in both in the public and private field. And address the measurement topic relevant to vulnerable individuals in rural areas.

And so I just want to take a pause here on this slide, and ask if there are any questions about the specific objectives of our workgroup here or anything that I reviewed about MAP and NQF. Just want to take a (pause) and see if there are any questions that arose.

OK. Well, if there are any questions arise during the remainder of the meeting, please feel free to ask.

On this slide, we have an outline of our meeting schedule as well as a brief overview of the meeting objective. And so you can see on the December 13th meeting, we'll be discussing the environmental scan, input on gap analysis, and review the draft measure selection criteria. In January, we'll be finalizing the measure selection criteria, reviewing the updated environmental scan, and looking at the draft core set of measures.

We also have – you'll see that we have draft reports that will be released throughout the project as well as our final report being due on August 31st.

And then on the next slide, we have kind of a visual representation of the project timeline. As you can see, we have – we're not meeting in person, but we have a lot of opportunities for these web meetings, so we can really be able to get a lot of work done. So I'm really excited that we'll be interacting so often with the groups throughout. I think there will be a real opportunity for kind of development and creativity.

And before I turn over to Karen, I do want to see if there are any questions about anything.

Steve Jameson: Yes, this is Steve Jameson from ACEP. Are we going to open it up for discussion as to what we see as the primary drivers for improving health care, or do you have a pretty specific area that you want to look at?

Karen Johnson: That's a great question. I think in today's discussion, we'll probably maybe not limit, that's not the quite – the right word, but we need to get to these core sets, that's kind of the deliverable that we need to provide. So to the extent that kind of talking more broadly will help us get to those core sets, I think we

could certainly do that. But we have to be careful that we don't get too tangential and too broad.

So, I think, in general, it's open but just being careful not to, you know, not to get too far off. And apologies, I know that's kind of a vague answer.

Kate Buchanan: And then – Karen, this is Kate. We also had a question that wanted to know how we would define alignment as we intended into the objectives of our workgroup.

Karen Johnson: Oh, right, that's a great question. You know, alignment came in different things. The alignment that – and we can certainly talk about this as we go forward in this project. But I think the alignment that we had talked about a couple of years ago in terms of alignment for rural measures is the idea that you might not have the same measure being used across settings, because sometimes, your data sources are different and, you know, the actual specifications of a measure may change, but the idea of alignment at least in topic areas.

So, for example, you know, if you feel like MedRec, Medication Reconciliation, is something that needs to be done, you know, the measure itself might not be the same across settings but the focus of the measure might be the same. So, I think that's where we're headed in terms of alignment. And that is, to some extent, I think we'll tackle that as we walk through.

Kate Buchanan: And I know that some people have had difficulty being cut off with the audio. So if you want to type a question into the chat box, we here at staff will read it and have it answered. So we apologize for the difficulties, but we do want to answer any questions you have. So please feel free to type them in the chat box as they come up.

Susan Wilger: This is Susan Wilger with National Center for Frontier Communities again. And I know that you're looking at health and well-being measures, but can you clarify, are we talking primary health, oral health, behavioral health or are there any limitations in terms of how we're defining those measures.

Karen Johnson: Right now, I'm going to say that we are not scoping down, that's actually part of what we'll be discussing today and probably the next call. Because again – and I think this maybe will become clear – clearer. We're going to try to get core measures. And we'll go into a little bit further into the talk, you know, what would be a core measure and what did the committee from last time around think about the core measures. And what you said is our jumping-off point. And then we'll broaden if we need to or narrow if we need to.

Craig Caplan: This Craig Caplan. This is a related question, are you going to focus on both quality and cost measures, or just quality measures?

Karen Johnson: Both. If you think …

Craig Caplan: OK, thank you.

Karen Johnson: Yes. If you think that it's needed, you know, when – and again, you guys have some great questions and I think as we go forward, we'll probably touch on some of the things that you're curious about. But you know, part of what we try to do is align with the National Quality Strategy and, you know, affordable care is part of that.

So the question might not be so much, you know, should we be measuring cost in some way, but in terms of core set, is there something that we could use that would work for rural. And maybe the answer is yes and maybe the answer is no, but certainly not off the table because it is part of the NQF.

Kate Buchanan: Excellent. Well, speaking of discussing potential measure selection criteria, Karen, I'll turn it back over to you.

Karen Johnson: Thank you. So this next section is really – we talk about the work from a couple of years ago definitely foundational work, but we – I mentioned that the committee at the time articulated several guiding principles for selection of rural-relevant measures.

So, we find ourselves here today being tasked by CMS and HSS to think about what would be core sets of measures. We are going to scope it down a

little bit and for the most part, we are going to limit our discussion to the hospital setting and the outpatient setting.

So even though we totally realize that, you know, there is – there are measurement needs for a long-term care side and more specialty kinds of facilities, that sort of thing, we can't do it all in this one. So, you know, we hope that there would be future work that we might be able to go forward for that. But we're taking the work from two years ago as kind of our jumping-off point, our foundational work. We don't want to start from scratch.

So, this piece – and we're actually running a little bit early, which is unheard of. What I'm going to do is just kind of walk through the guiding principles that we – that the committee, the last time around, provided for us. And as we do this, and this isn't going to be all me talking, we can certainly have discussion around these points. It can't be totally long drawn out discussion, because we have a lot to cover.

But what we're suggesting is that we use the guiding principles as a base, we'll talk about them a little bit, let you start processing them, thinking about them, and then we're going to come back at kind of towards the end of the hour and say, "OK, there is a lot of principles that were provided, some other input from other folks. Let's start narrowing this down." Because to get to a core set, we need a fairly tight set of principles we think so that we can actually bring ourselves down to something that resembles a core set.

I will tell you, and I don't think anybody will be surprised, you know, we've already started looking and gathering measures. And you know, we've got a list already of over a thousand measures. We're not going to have a thousand measures in our core set, right? So how do we work our way down in some kind of systematic way that feels right to people and get our self down to something reasonable for core sets?

So that's what this discussion is going to be. Again, just type in if you have a question or a comment as we walk through some of these. And you guys are doing great, you're remembering to tell us your name. I really regret that we have to do this, only through webinars that we can't meet in person. So

hopefully, we'll get to know each other's voices and get to know each other a little bit better as we interact in this call.

I'll also really encourage those of you who were in our last work. And I – Aaron and Ira, of course, Tim Size, Brock, I hope I'm not forgetting, John Gale. Several of you were on our project the last time around. So, you may have insights or things that you want to mention from that time before that I may forget to mention. So certainly, feel free to jump in.

So with that, let's just go through this – the guiding principles first. So, number one, address the low-case volume challenge. We know that sample sizes are going to be a problem for some, not all, rural providers. So, we want to make sure that that is addressed. And the principle that came through is that measures used for rural providers should be broadly applicable for most rural providers.

So we realize that, you know, it's not going to – we may not have measures that will work for every single one, but for the most part, we're looking for broadly applicable measures and working for most rural providers.

One thing that I neglected to mention earlier, the guiding principles that the committee articulated a couple years back, they were for selection kind of in general. And you'll see this as we go through. And when I say selection, I mean selection into programs potentially.

We didn't split out at that time, you know, some of this may be really relevant to a core set, whereas others may be relevant to the optional set that was also a recommendation of the committee. So, just try to keep that in mind and we will revisit that a little bit later.

So, this idea of broadly applicable because that's – we don't want measures that, you know, the denominator problem is going to rear its head. Facilitate fair comparisons for rural providers. So, this gets into the idea especially of risk adjustment.

So, measures, particularly outcome measures, although other types of measures can be risk adjusted, you know, we want to make sure that the comparisons are as fair as they can be because we expect these would be used in accountability types of programs. So just thinking about the risk adjustment and making sure that that seems appropriate for rural providers.

Address areas of high risk for patients. And I actually took this directly from the report. Some care processes should just happen. So the example from last time around was medication reconciliation. So, there's probably some things, and I think that gets to one of the earlier questions. There might be some just obvious things that need to go on this core set. So, be thinking about some of those that we might have.

The next one is a little, arcane is not quite the right word, but the idea there is to support access to local care or local access to care. The example there was telehealth measures or maybe even more appropriate is to make sure that measures, you know, allow for care to be provided via telehealth or telemedicine. But there was – there were some discussion, and the idea there is that you don't necessarily want to have measures that require going outside the local area. So how – you know, let's think about how we can choose measures that support that local access.

And I think the feeling of the committee at that point was this kind of measures, if any exist even, might be better suited to higher levels of analysis, health plans, ACOs, and more population-based measures. So, this principle may or may not be something that we have to worry about quite as much for core sets for hospitals and outpatient side, but again, we can talk about that.

Before I go onto the next slide, let me just open it up real quickly. Do these ring true so far, any concerns with anything that we've said so far?

Susan Wilger: This is Susan Wilger again, National Center for Frontier Communities. On bullet number four, support local access to care, in dealing with rural health care, something that we've heard over and over again through decades across the nation is the – is transportation is a huge barrier. So I was wondering if

maybe that could – I just wanted to make that comment because it is a huge issue in terms of a barrier to access in care.

Tim Size: Hi, this is Tim Size. I just wanted to speak up on one issue semantics that showed up a late earlier in the slides. I know we're all about low volume, but I think when we talk about low-volume providers, that may be a little misleading in some circumstances. So, obviously, small rural hospital would have a low number of cases. But if we're talking about individual clinicians, there's nothing of low volume about their daily work. It might have a low number of patients fitting into a particular category, but they themselves as a provider are not low-volume providers.

Karen Johnson: Thanks, Tim. You're right.

Melinda Murphy: And it's …

Bill Finerfrock: This is Bill Finerfrock.

Melinda Murphy: This is Melinda …

Bill Finerfrock: Oh, go ahead.

Melinda Murphy: I want to just reinforce what was just said about the volume that an individual provider may seed, maybe double or more what a provider in an urban setting would see for a variety of reasons.

The other thing I want to make a comment on the – what was mentioned a bit ago about access and about the telehealth measures. My understanding is there are still issues about coding to be able to have credit or get telehealth procedures recognized. So, just comments.

Karen Johnson: Thanks, Melinda. So we'll have to be careful if we – you know, we can certainly talk about that as we go through. I think we probably want to be real careful once we get to some kind of a draft core set that we look at it and make sure that, you know, it kind of passes the test to telehealth or if it doesn't, you know, maybe make recommendations for how it needs to be modified perhaps.

Bill Finerfrock: And this is Bill Finerfrock with the National Association of Rural Health Clinics. I just want to reinforce that local access to care to me is critically important. I feel that too often, access to care is ignored as a quality measure and I think that has to be there.

And then with respect to telehealth, I think it's important to note that that requires a local originating site. So, in order for telehealth to work, you have to have a medical clinical, a rural health clinic in many instances in those underserved areas. So if you don't sustain local access to care through a facility, you lose a telehealth option as well.

Ira Moscovice: This is Ira Moscovice. And I just wanted to follow up on the comments on access to care. I think the committee is going to need to grapple with the issue that quite honestly the previous committee grappled with and the MAP has grappled with, which is when thinking about quality, how does access and the cost issue that was raised earlier also, how do they fit in for the quality paradigm. And if we're going to have a modest set of core measures, i.e., not a thousand as was suggested earlier, do we want to allocate some of those measures to the areas of access and cost. So that's something that we're probably not going to settle on today but it – I think we'll – we need to think about as we move through this process.

David Schmitz: And this is David Schmitz with the American Academy of Family Physicians. I appreciate that comment, and again, just wanted – I wasn't sure if my prior question was interpreted in this way, but it is about that local access to care. So if you have a critical access hospital and a team of physicians, per se, delivering 60 to 80 babies per year, if that hospital and those providers do not provide that access, the babies still delivers in the same hospital's emergency department perhaps, and what does that mean with regard to these measurements. So, just taking that into content.

John Gale: This is John Gale from the Maine Rural Health Research Center. And one of the issues that I've been thinking about certainly in relation to selecting measures is the idea of selecting measures that can be applicable not just to an individual provider, but thinking more about team-based care. We have been

trying for many years to solve the issue of provider supply and distribution in rural communities. I wouldn't – I would argue that we're not nearly as far along in that respect as we would like. So, how do we select measures that allow for a more efficient team-based care that can provide services and use our resources better?

Karen Johnson: Thanks, John. Anybody else? We have several more slides, but I'm going to pause after each kind of slides to – for people to kind of cogitate on the things on that slide. Anything else, or are we ready to go on?

Steve Jameson: This is Steve Jameson with ACEP again. I think John just raised a very good point and it has to do with the availability of providers. ACEP has focused on the facilities where emergency medicine-trained physicians have been for a long time and now recognize that there is an obligation across the entire continuum of emergency care, and want to reach out. And one of those ways is with telehealth and other ways is expediting transfer of very sick patients to the higher acuity or higher level trauma centers.

And I guess I just don't see those issues being addressed with these measures. And I think that's just a real key to improving rural health care, is how you have that collaboration between the rural centers and the larger facilities. And I'm just trying to wrap my head around where we're going with this, and if we're really going to, you know, improve that relationship and somehow improve patient care and not just measure what already exist.

Karen Johnson: Thank you. And actually that's a great segue, I think, to the next slide. Another of the guiding principles, so again, there were several of these. The committee, a couple of years ago, thought that we should address actionable activities for rural providers.

So again, this has come up a few times already. So, just as an example, you know, do we need to think about specifically triage and transfer, perhaps that is more common amongst rural providers. Do we need measures, or do we have – it's probably more fair to say, do we have currently measures that would look at that in some way and would that be reasonable for core set.

There was not complete agreement, you know, I think different people have different philosophy sometimes when it comes to measurement. You know, some people want measures to be in the complete control of the provider, whereas others are willing to understand that providers can influence things but maybe not have complete control.

So, this idea of process measures which often is, you know, definitely under the control of the provider compared to outcome measures. So some people, a couple years ago, really wanted, you know, mostly process measures because of that control. Others were willing to say influence is good. And we should be measuring that as well.

The next one is dear to NQF's heart. We want measures that are evidence-based. So, we want empirical evidence to link this – the clinical effectiveness to desired health outcomes. So, any measures that are chosen for core set should be evidence-based, or at least that was the guiding principle from, again, the previous work.

We should address areas where there's opportunity for improvement in rural areas. This is often something that if you're familiar with NQF's endorsement criteria, you know, we do look at opportunity for improvement. We want to make sure that there's really a quality problem that needs to be solved.

So, we think that NQF-endorsed measures do have that. But sometimes, you know, a national number may actually hide opportunity for improvement on the rural side. So, you know, it may look pretty good overall, but if you start delving into, you know, stratifying your data and looking at rural areas, you know, things may not going as well as it may appear just by looking at one summary national number. Or it could be the flip, the rural folks could be doing a better job than other areas. So, we want to make sure that anything in the core set really reflects opportunity for improvement on – for rural areas.

And then, to some extent, a very similar idea, we want to select measures that are suitable for internal Q.I. efforts. And to some extent, I think this might get to the idea of, you know, sometimes especially for the small practices, there

might be, you know, limited resources to be able to do Q.I. in competing folks, competing activities in terms of measurements and reporting.

But again, measurement is a tool for Q.I. So we want to make sure that anything that you use were really at the end of the day improve the quality of care.

So, let me stop there to see what folks think about this portion of the guiding principles. Are these ringing true? Do you have any kind of rise in the top and really jump out at you?

Tim Size: This is Tim Size again. And just a comment from what I remember of our discussion last time on this whole issue of control. I do think concerns about that 10 to less than, and we get – begin to get more comfortable with outcome measures to the degree that the field is able to robustly move forward on adjustments for social economic differences amongst populations. I thought there was a strong correlation there.

Karen Johnson: Thanks, Tim.

Kimberly Rask: Hi, and this is Kimberly from Alliant Health. And I think all of these areas are important. But as you noted earlier, given the large number of measures and a focused approach on what we are looking to achieve, I would probably put suitability for internal quality improvement efforts as a wish for or would like to achieve. But (think) that some of the other ones are a little bit higher priority to be sure that we could nail them down. Thank you.

Karen Johnson: Thanks, Kim. And yes, sorry that I missed you in our list. Kimberly worked with us in our last project as well, so.

Susan Wilger: This is Susan Wilger of National Center for Frontier Communities. And my thought – I think this fits under address areas where there's opportunity for improvement in rural areas. But it's having that connection between measures that are coming from the clinics versus the community health measures and population health measures.

In other words, are they in alignment or do they need to be adjusted – do services need to be adjusted to match community needs?

Karen Johnson: OK. Thank you. I have to think about that one a little bit. We're taking notes, by the way. So, if we don't always comment exactly, it's we're very busily writing your thoughts down. Anybody else?

Melinda Murphy: Karen, it's Melinda. A couple of comments that Tim and Kimberly made triggered something for me in terms of looking at these principles and questioning what staff has in mind in terms of how the principles would lay out as the group begins to narrow down. What would be in a core set?

For example, are there some that the group might say, if this isn't there, it doesn't go forward no matter what else, for example, evidence-based. Has there been some discussion about arraying the principles and then putting evaluation of measures within that context?

Karen Johnson: Absolutely. And as a matter of fact, a few slides forward, we'll give you our thinking about what this process might look like. We could blow it up. That might not be what we end up doing. But absolutely, that's where we're going. Yes. But we need the workgroup to basically prioritize those things for us, I think.

Let's go ahead to the next slide. I was just looking at the clock and I need to speed up a little bit here. So, some of the other principles, flexible data collection by rural providers. So, I think the idea there is, you know, you don't want all your measures and your core set to be, for example, paper-based chart measures where, you know, the same person in the office have to go do a lot of hunting and pecking to find stuff out of charts. So, having – you know, being able to have different data collection method, so it doesn't all fall on one person.

Excluding measures that have unintended consequences for rural patients. And that – again, the particular point of concern there was access to care in rural areas. Being suitable for use in particular programs. So, at the time, again, the consensus was, you know, we should – and especially for P for P kinds of programs, we want the strongest measures. Strongest maybe in terms

of evidence, reliability, validity, other things perhaps. An idea that, you know, depending on the program, we should make sure that there are a diversity of types of measures. So, you know, having some outcome measures perhaps along with process measures, maybe even instructional measures, that sort of thing.

Diverse in terms of data collection burden, that kind of goes back, again, to this – the feasibility of data collection. And if we're thinking about, you know, if the program happens to be a public reporting program, then we want to make sure that they are meaningful for the consumers and purchasers who would be using the results for decision making.

So, that kind of adds another little nuance, you know, because it's easy to say core set but then we have to say, well, core set for, you know, are we talking about a P for P, are we talking about public reporting. So, we have to – we're going to have to grapple with that to some extent.

Let me go ahead to the next slide. And then we'll open it up real quick. Other guiding principle is alignment with measures used in other programs. We've already talked about alignment. And then I support the Triple Aim of better care, healthy people in communities and affordable care. And I think we've already discussed that a little bit today.

So, let me open it up, again, just a minute or two. Any reflections on these particular principles?

And again, let me just reiterate that the idea here is the committee, a couple of years ago, has already done this work. We think that we can take this work and narrow it, extend it, whatever we need to do, but we're not starting from scratch. So that's what this discussion is about.

And sorry to have interrupted you. Go ahead.

Julie Sonier: Oh, no problem. This is Julie Sonier at Minnesota Community Measurement. And I want to make a comment on, it's on slide 33, it’s the second to last bullet point about measures being diverse in terms of data collection burden. I wonder if a better way to say that or what's really intended might be about –

well, in general, right, you want to minimize burden. But if you're going to have a measure that is higher burden, then it needs to sort of have also a stronger demonstrated value. Because I don't think diversity a burden in itself as a goal, but it's really about the value of the measure being worth it for measures that might be higher burden.

Karen Johnson: Yes, I think that's a really good point. You know, we talk about feasibility here at NQF quite a bit. And you know, sometimes we want – we need to measure things that are more burdensome. But you know, we want to minimize that. So I completely agree.

Dan Coll: This is Dan Coll, the Physician Assistant. And I just – I wanted to add too, when we look at the – we talk about affordable care, the rural facilities, one of the challenges and health care in general, you know, our two highest costs are labor cost and then supplies. And supply chain is something that rural communities, without pulling their purchasing power, often are at a disadvantage compared to larger networks.

And so, it's been a real challenge for our facility to control supply cost, even using organizations like group purchasing organizations and others. So I just want to put that out there. When we're having that discussion, affordable care, one of the big challenges really is supply side as well not just our labor cost but the role of facilities. We're at such disadvantages with our purchasing power. And I just want to put that out for the group as well.

Karen Johnson: Great point. So when we start potentially talking about cost measures, we have to grapple with that, right?

Tim Size: And maybe implicit – this is Tim Size again. Maybe implicit in what we were discussing under kind of the types of measures in terms of collection burden. But clearly, one of the challenges we have is the diversity of electronic medical record. And I don't mean just those who have and don't have, but amongst those who have, there's the diversity of systems out there which may or may not be able to give the kind of data that we think is relevant without a fairly high cost to the provider for reprogramming.

And so, in certain instances, it may actually make sense for us to have a bias away from EMR. But I just think the whole cost to facility of being able to get the data, I think maybe making a little bit more explicit would be good.

Karen Johnson: Thank you.

Male: Yes, so …

Bill Finerfrock: If you go back to – this Bill Finerfrock, to slide 34, the last bullet there. The Triple Aim.

I hate to be the dead horse, but I think, you know, in talking about better care, healthy people, healthy communities, affordable care, accessible care needs to be one of the aims there as well. I just have always felt that that was part of what was – it's, you know, affordable, (A plus) quality and accessible. So, the triple As for me, access is part of that.

Tim Size: And it's Tim again, I totally agree. We need to talk about the quadruple aim.

Bill Finerfrock: Yes.

Karen Johnson: We're actually going to see it, yes. It's not going to get lost. So, yes.

Dan Coll: This is Dan Coll.

Shelley Carter: This is Shelly. Oh, go ahead, Dan.

Dan Coll: Sorry. Sorry, just on the EMR point, our facility as rural hospital literally spent millions of dollars on one EMR and we just dumped it and had to purchase an Epic – hosted Epic with Mercy out of St. Louis.

So, I definitely think the challenge for rural hospitals on what's available to us directly and other creative ways to get better EMRs for facilities would also be a great part of this discussion, because the lack of the infrastructure and support staff from any rural hospitals requires you to look at outside host and how you set up those relationships. And then you're bound also by those relationships on what they can or cannot offer because it's not our primary

source EHR. So it's definitely a reality for my facility that we just went through. So, I appreciated that point and want to reinforce it.

Karen Johnson: Thank you. And one more comment ...

Shelley Carter: This is Shelley. I agree with Dan on his point about EMRs in rural communities. But I also want to make a statement about the quadruple effect, or quadruple aim. Are we going to be defining each one of those? I'm concerned about defining because we use the term better care. And in many cases, rural providers provide remarkable care through the equipment that they have. So, what we are talking about when we say better care?

Karen Johnson: You know, not going too much into the NQF. I think the idea of the National Quality Strategy is it's a blueprint for where we want to be. So, when it says better care, we're saying, hey, we want to do measurement so that we are improving care. So, that's how I look at it. Elisa is shaking her head. So …

Elisa Munthali: (I'm on) agreement.

Karen Johnson: She agrees with me. That's what I think we are interpreting the better care.

Shelley Carter: Can we have those definitions established as written?

Karen Johnson: I can find for you the National Quality Strategy information. We can make that available to you. But we kind of assume – and maybe it's a bad assumption, we kind of assumed that people are, you know, familiar with the NQF and its purpose and what have you. But that may not be the case. So we'll make that available to you.

Shelley Carter: Thank you.

Karen Johnson: Sure. Again, you know, I'd love to have like four hours to talk about this today but we don't have it. So, I'm going to go ahead and go to slide 35, I think. Let me put my glasses on so I can read here.

Other recommendations from the rural health project. So I'm just going to go through these pretty quickly. Again, one was, we should identify core set of measures. So, lo and behold, that's our task for this work.

So the core set, the committee, a couple years ago, actually had quite a bit to say about what this core set might look like. Again, we're not bound to what, you know, was said and recommended a couple years ago, but it's worth it. But you know, we had put a lot of thought into.

So, one thing is, you know, we wanted to be a minimum, 10 to 20 measures, probably maximum. And with that idea, the idea was we are looking for cross cutting rather than disease-specific measures. So, things like screening might be a reasonable thing to consider, measures that look at screening.

Again, I've mentioned this before, should apply to majority of rural patients. And we know that there's certain measures that are used in PCMH delivery models. We want to make sure we look at those. Alignment across settings, we've talked about what alignment means, at least in topic area.

Measures in the core set may also be appropriate for non-rural providers. And I think that was a nuance that we actually had comments on from people out in the field when we put our recommendations out a couple of years ago.

We're not saying this core set that we come up with is a core set that is only applicable to rural providers. And therefore if it's, you know, non-rural people, we don't want it. That's not what we're saying. And as a matter of fact, the idea of being able to actually use measures that are being used by non-rural providers maybe a plus because that way, you could, you know, compare apples to apples, you know, rural to the non-rural providers.

And then we're back to this idea of a variety of measure types. And we talked quite a bit about what we're – this is NQF acronyms here, PRO-PMs, these are patient-reported outcome-based performance measures. Those are ones that often are based on surveys or other kinds of tools or instruments.

And they are great because they're very patient centric, you know, experience of care and those kinds of things, and functional status and symptom burden, those things are things that we really do want to measure. But there's the flipside of the cost and burden to feel with those kinds of surveys. So, just

realizing that there are great kinds of measures that can be expensive or, you know, resource incentive in other ways.

The next slide also shows some other insights from the project from a couple of years ago. We talk some about, you know, some topic areas just in general that the committee felt were really relevant to rural areas. But I think we landed for the most part on this is where there's probably some gaps in measurements.

So, you know, we might think that these are really relevant topic areas. We might not have the measures yet. So we'll be looking at this in this project, but things like patient hand-offs and transitions, drug and alcohol treatments, telehealth, telemedicine, there's access. And believe me, access is going to come up multiple times before we finish today. Timeliness of care, cost of care, population health types of measures. And then advance directives, care planning and end-of-life care, those kinds of things.

So, again, these are topic areas that seemed really important for rural providers and patients. We might be in the – not the right place of saying, we don't have measures that we can actually use on the core set. So these might be gaps from the core set that we would like to see (filled) as we go forward.

I'm going to spend just a very short amount of time just introducing you to some other efforts that have been done. So, we spent most of the time talking about what a rural health group did a couple of years ago. Other people have been thinking about, you know, what's a meaningful measure, right? So, I just want to introduce you very quickly just to kind of broaden your thinking just a little bit.

The IOM, a couple of years ago, came out with their Vital Signs, Core Metrics. We have – here at NQF, we have a newly minted prior organization criteria and framework that we think is a way to think about measurement and how to prioritize measurement in gaps.

And then, hot off the press, CMS's meaningful measures initiative. And I think that's been out for, oh, four weeks maybe, it's really brand new. These are not efforts that are – we don't have to go very deep into them. But they are

– there's a lot of synergy and a lot of overlaps to some extent in some of these things, but the Vital Signs, Core Metrics.

Those in general, they didn't really talk about measures like we talk about measures. They were talking more about topics areas, and you can see here well. You can see it, you might not be able to read it, the different priority areas that they discuss in that work.

Going very quickly, and again, I'm looking at time because I really want to get to the questions that we want a little bit more info from you on. NQF has – as part of our strategic goals, we want to start really trying to identify what we feel in a meaningful measurement and being able to prioritize in a systematic way, which measures would be the best for, you know, accountability programs, et cetera.

And the criteria that we have come up with and it seems to be working in resonating across is outcome focus. So we've already talked about that, this actually match up very well with the guiding principles, so outcome focus either outcome measures or other kinds of measures that have a tight evidence link to outcomes and/or across.

Improvable and actionable, we've already actually talked about that as far as guiding principles. Meaningful to patients and caregivers, this is particularly – if we end up landing on measures that rely on patient report, we want to make sure that if you're burdening patients and caregivers to tell you things that they find what they're doing to be meaningful and valuable.

And then, we were looking to support systemic and integrated view of care. So, we are, at NQF, really interested in measures that span settings, providers and time. And those, you know, we have a few of those probably, but not always – not all of them.

We have priorities that we're particularly interested in and I'll just list them here. Outcomes of – the health outcomes, patient experience, we've already talked about those, preventable harms and complications, so the safety side of things. Prevention, total cost of care and then kind of a flip of it, low-value

care. So, other things that, you know, that we're doing that maybe we shouldn't be doing, you know, that might a way to think about cost.

There's access again. So we certainly feel that we need to measure access and then as well as equity. And we've talked about equity already in terms of adjustment potentially in certain measures that there may be, at some point, I don't think we've really have much there now of actual measures of equity.

CMS's meaningful measures framework. Again, they have a beautiful diagram here. I'm not going to go through all of these, but you can look at these more at your leisure. I will point out that improving access is a big piece of this wheel here. And to some extent, their work, I think, really goes well with the NQF criteria.

Getting to Melinda's – and I've realized I'm going fast, and this is a lot for you to kind of try to assimilate. Getting to Melinda's question, what's our initial thinking? How do we think we're going to, you know, start out with 1,200 measures and land on 20? How do you do that?

Well, we want to try to create some kind of a systematic approach to do this. And that's where we are today and we will be in the next few weeks. So what are the most important criteria? So, we have – giving you many optional criteria, many based on work from the last time around those guiding principles.

So the idea is – and we'll see how this goes, and maybe you think this is a bad idea. But we were thinking that we would identify the criteria first. So what are the three or four or five or whatever we land on criteria that we think we have to have this in order to make it to a core set?

We need to come up with some kind of a rating scheme for that criteria. So maybe the rating scheme are really simplistic one. If evidence base turns out to be one that you think is critical, you know, the rating scheme might be one if it's evidence base and zero if it's not. So, we want to be able to somehow another quantify these things.

We might need to (weight) things, because, you know, there might be four or five things that you land on that are the criteria but maybe you think one is really, really important and one is important but maybe not so much. So, we might need to wait a little bit. And then we would basically try to apply this thinking quantitatively to our list of measures and rank them and see where we land, and maybe pull the highest scores.

Again, this may or may not work, but this is our initial thinking. And then once we get to something reasonable that we can actually talk about, we would have more discussion in a more qualitative way.

And let me go on to the next slide. The next slide takes those guiding principles and a couple other things and a couple of those other recommendations. This is just my thinking here. This is not from the recommendations from the – two years ago, the panel two years ago.

But I look at those guiding principles and I think pretty much all of them apply to core measures and (some level), I'm seeing like they apply maybe more to the optional fit, which we're not worried too much about optional fit. If we end up with some optional measures, that would be great, but that's – that wasn't our charge from HHS for this work.

But it feels like, you know, we want to be sure that our core measures address low-case volume, the denominator problem. We want to maybe – and this is – think of this as my straw man and you guys could destroy the straw man, that's fine. The high topic areas, you know, these things just – you just need to be doing this.

Cross cutting, we want to make sure that we limit unintended negative consequences so that's that access question again. The feasibility of a data collection and alignment with other programs. So these – it's not to say that these other ones, we wouldn't be concerned about, but maybe they don't kind of rise to the top as the things that we are concerned about.

If we go to the next slide, it actually – once I started thinking about these, some of the guiding principle is suitable for particular programs, meaning the Triple Aim, supporting local access to care. Some of these things feel like

they're more applicable to the set. So what we may need to do is say, "OK, let's get a draft set and then we'll go back and check and make sure that we're hitting, you know, the Triple Aim, that sort of thing.

We want to make sure – I think that, you know, we hit the rural-relevant topic areas if things exist and alignment with the other schemas, the NQF schemas those kinds of things is, again, more of a set thing maybe than a – we would need this (before). But again, all of this is up for discussion.

So with that, and knowing that we don't have a whole lot of time left, I'd like to get your initial thought on a few things. So, here are some questions for you to consider.

Some of the guiding principles was, you know, we probably – for the core set, we're interested in cross-cutting area. Does that mean that we are not at all interested in specific conditions? So that's a question for you. Our question kind of related to that is, are there rural-relevant conditions that you might want to consider? So, you mostly want cross cutting but maybe you're willing to think about some kind of a diabetes measure, for example.

Would NQF endorsement be a reasonable first cut? That would actually help us winnow down, and that would hit several of the guiding principles if measures are NQF endorsed, we know that they, you know, have a strong evidence-based that there is opportunity for improvement, there's a good demonstration of reliability and validity and feasibility, that sort of thing. So, is that a reasonable thing to use as a first cut?

Or if not completely, you know, would NQF endorsement plus or, you know, other measure set, so some measures are used in PCMH, I think, that maybe are not NQF endorsed but yet they're strong measures, certainly if we think they are. So maybe there's a way to winnow down in that way.

Not so much for discussion today but something to be thinking about, you know, do we need to change the selection criteria for inpatient versus outpatient? My gut feeling is, no, I think they're probably broad enough to cover but we might need to tweak a little bit. You know, administrative

claims-based measures are very feasible. They're easy to use. But for many rural providers, there might be some difficulties in relying on claims data, especially if you're based – paid based on a cost-based reimbursements scheme as opposed to, you know, a DRG type scheme. So, do we need to be careful about measures that are claims based and then, is there anything else, you know, we've thrown out a lot at you. There might be a few other things.

So I'm going to stop now. I'm going to give us about 10 minutes for you guys to – if you can just give us your initial thoughts and if you can just be really quick in giving us your thoughts.

Kimberly Rask: Hey, this is Kimberly, I would like to endorse the – using NQF endorsement as a reasonable first cut, recognize that we are likely to find that there are gaps, but that that would give us a quick way to be looking at measures that have already been validated and studied. Thank you.

Karen Johnson: Thanks, Kim.

Marcia Ward: This is Marcia Ward from RUPRI, and I agree with that, although I think we're going to run into the low-volume issue. And so, if we could look at the NQF endorsed and then do a quick clearing out of the ones that are going to be very susceptible to low volume and that hits on the first point about rural – the specific conditions, a lot of the NQF-endorsed measures are specific to a condition and we know that those are low volume in rural hospitals and practices. So, if we can make that sort of a cut to it, I think that would get us to a reduced set that is practical to look at.

Karen Johnson: Great. Other ideas?

Susan Wilger: This is Susan Wilger, National Center for Frontier Communities. Because a lot of the remotely rural health care settings may not have the inpatient, so some type of criteria that measures transitions between inpatient and outpatient settings might be helpful.

Karen Johnson: And that would be a cross cutting too, because I get – and I'm asking this, even if you're not remote, transitions is something that other rural providers

may need to do at times, right? I mean, I would think. Other ideas? Other thoughts?

Bill Finerfrock: This is Bill Finerfrock. I think – I know you've got John Gale as the subject matter expert, and John was very involved with the rural health clinics initiative in looking at this very issue and this goes back, we started this in 2012 with the Federal Office of Rural Health Policy in identifying what we thought to be rural health clinic relevant measures. And I think, ultimately, you know, decided on a number of NQF measures.

So I think, you know, looking at NQF is an appropriate place to begin the conversation. I think with regard to the claims issue, I think you made an appropriate point and one that would have even been more relevant about a year or so ago in terms of claims data. I will say that within the last year, CMS has began having rural health clinics, report CPT level data on their cost-based claims, which had not previously occurred, which is a major impediment to doing reporting because it was claims based.

So, we're getting better and the rural health clinics community is getting better at being able to report data on the UB-04 claim that would be more typical of a 1,500 claim. So – and hopefully, that will continue to improve. But I think at least using claims data helps to reduce administrative burden of some type of separate claim – data reporting initiative as part of this process.

John Gale: Yes, hi, this is John Gale. I completely agree with Bill on that. And it goes back to one of the comments made earlier regarding the challenges of using electronic health record data and the fact that not all electronic health records are created equal.

And so, one of the things that we found in that report was that the – they had varying levels of abilities with extract information from their data sets without incurring additional costs.

I'd also support the NQF endorsement. And I think one of the things that we came down – we really thought hard about was the idea of using rural-relevant conditions. We know within rural areas, there are high rates of diabetes,

hypertension and other chronic conditions. And I think that's going to require some consideration whether we do screening or to look at specific conditions.

Tim Size: This is Tim Size. I can save time and just say I agree with everything John Gale just said this time.

John Gale: (Inaudible).

Karen Johnson: What's that, sorry? Any other thoughts here?

Steve Jameson: Just briefly – this is Steve Jameson again from ACEP. You know, in my mind, I guess quality care comes down to making the proper diagnosis in a timely manner in providing the proper treatment. Is there a way to really measure some things rudimentary? You know, is it as basic as in a particular health system or in a particular emergency department, we measure morbidity or mortality and look at patient-specific outcomes, is there any way to really measure something, you know, as granular as that?

Karen Johnson: That's a good question. I mean, I think we have some measures that really get a proper treatment. My favorite example is the clot busters after stroke. But actually, there are many others. I think – you know, is that what we want – do we need, you know, is that something that would work for the core set? So strokes are very common, so maybe, yes. But that maybe most people just triage, so maybe no. So, not sure if I'm quite answering your question but I get your point.

In terms of proper diagnosis, there's been some foundational work that NQF has actually done on accuracy of diagnosis. But I don't know that we are any – I don't know that we have any of those measures. I don't think we have any. So, people are thinking about it but I don't think that they've actually been created yet or certainly not come across our desk in terms of endorsement.

Steve Jameson: Do you look at, like, return to the emergency department within 24 hours or 48 hours? Do you look at, you know, death within a certain time or leaving the emergency department? I mean, those are pretty objective measures and, you know, that may not be any fault of the provider or the institution but it

might be something that is a red flag to look at. Well, it's an example of a measure that's used in the emergency departments.

Karen Johnson: Yes, we do have all-cause readmissions in certain specific condition readmissions. Usually, those are 30-day readmissions, I think. So we have a few of those kinds of – a lot of people call this utilization measures.

And you know …

Craig Caplan: Hi, this is …

Karen Johnson: … arguably, we would call those cross cutting as well, right? So, I think that hits the cross cutting kind of checkmark.

Craig Caplan: Hi, this is Craig Caplan. And regarding the NQF endorsement being the reasonable first cut, I'm just – I know we want a wide array of measures, of different types of measures, and so I'm just not sure how many cost measures or access measures, for example, are NQF endorsed. So, I just want to make sure that the range of measures is not – you know, is going to be sufficient with the NQF endorsement being the first cut.

David Schmitz: And this is David Schmitz with the American Academy of Family Physicians. Just sort of making the same point, I think, with – from a different angle is that the access measures are critical.

So, for example, the State of North Dakota has the highest incidents of colorectal cancer. But if we don't – if those people don't initiate claims because they didn't have a screening colonoscopy, the mortality factor is never understood, it's never appreciated. And access to screening colonoscopy, for example, can be very challenging in a remote area depending on what type of provider is providing that, because people don't necessarily take their colon prep and then drive for several hours. It can restrict even recommended therapy. So that's just one rural-relevant measure, maybe a very specific one, but we don't see the consequences of mortality unless we look for it.

Karen Johnson: And thank you for that. You know, I think what we're thinking is we're going to take your first cut of what you think is important to see where we land.

Where we land maybe glaring that we're – we don't have any cost measure or access measures, and there could be a couple of reasons that there might not be any that exist, or we might need to say, hey, we need to broaden our criteria just a little bit because, you know, we really think that these are very important.

So, what we'll do on our next call is bring back kind of where we land based on this conversation. And I think once we start getting more concrete, it'll help too, this is all very theoretical to some extent.

Now, looking at the time, I've now put us a little bit behind. Thank you so much. You guys have some great ideas and we're going to probably follow up a little bit. And Kate and Madison are going to tell us about that. But I hand it off now to Suzanne, I believe. Suzanne?

Suzanne Theberge: Yes. Good afternoon, everyone. Next slide. So, as you know, we are also going to take some input from the workgroup on the measurement topic that's relevant to rural health in addition to the other topics we've discussed.

So, as we were planning together this project, the NQF project team has a number of topics to propose. And so today, what we're going to do is just quickly review each of these topics and see if the workgroup members have any other ideas they wanted to propose or any immediate yeses, immediate nos, any kind gut responses to these ideas. And we'll ask you to think about these over the next few weeks and then we'll discuss again on our next call.

So I would just quickly summarize our topic areas and then go back to you all for some – a minute or two of input. So, our first proposed topic is measuring access to care. And this would be reviewing measures and measure concepts currently available to assess access to care, and to provide input on what's needed to adequately measure access to care for rural (initiatives).

So we can focus this discussion on what types of measures are needed, such as patient-reported measures, or we could focus on specific settings where access measures are most desired, or we could also look at how these kinds of measures can be implemented and used to increases access in rural areas.

Our next proposed topic is telehealth. And as was mentioned earlier, NQF has already done some work on telehealth. So we would have you review the current work and consider the measurement framework in gap areas through a rural health plan specifically. We could focus on one domain in the telehealth framework or we could look at all of them, and kind of continue with their current work that's happening.

Our next proposed topic is leveraging public and private resources for quality improvement efforts. As mentioned, NQF's previous rural health project noted that a key measurement challenge for rural providers is the lack of alignment of measures data collection effort, and improvement and informational resources across both public and private sectors. So, we would ask you to provide recommendations on how to address this challenge.

We also could look at advance care planning, and basically just ask the workgroup to provide recommendations on how to measure and promote use of advance care planning among rural residents. (Fifth) topic proposal is appropriate comparison groups and here, we would ask that your committee continue to work with the previous rural health committee by considering how peer groups of rural providers could be defined and used for comparison purposes, such as comparing measure results between providers.

Swing beds is another possible topic. We would ask you to discuss the impact of swing bed used by rural providers and offer some recommendations regarding measurement for this topic area.

And then, finally, post-acute care in rural areas. So we would ask you to discuss the challenges relevant for the provision and measurement of post-acute care, such as home health and skilled-nursing facilities in rural areas, and potential discussion topics in this. This one could include but wouldn't be limited to data collection challenges, implementation of measurement programs and/or quality improvement efforts in these settings.

So, I realize that was a very quick high-level summary of these topics but we just wanted to get that out there so you all could start thinking about it. And I know we're very short on time, so I'll just pause and see if anybody has any

additional ideas or reactions before I turn it back over to Kate for a public comment period.

Melinda Murphy: It's Melinda. I have a question and maybe I missed it. How was this list developed and was it developed specifically with rural health in mind, because there are a couple caveats already about telehealth that you can pick up from the discussion? I'm going to say this, and I'm not where anybody can hit me, so it's really hard for me to see how advanced care planning comes to the top of a list of proposed topics for rural health per se. (Get those) swing beds in some ways.

Suzanne Theberge: Sure. So, as the project team was kind of framing out this project last summer, these are some topics that we came up with based on previous work at NQF, just ideas that came up in discussion. And we kind of expected that folks would really not like some of these ideas, or they would have other ideas that we can consider. So, I'll see if Karen has anything to add but this was just a – was specifically generated for this project by staff …

Melinda Murphy: OK. Thanks.

Suzanne Theberge: … based on some previous work. But Karen, do you have anything to add there?

Karen Johnson: No, nothing to add.

Marcia Ward: This is Marcia Ward from RUPRI. And I had the privilege of co-chairing the Telehealth Committee for NQF that worked last year. And I think a theme that came out of that is that the care that's delivered to telehealth really should be the same and the measure should be the same. And so – and also, if there's, I think, some continuation of that activity going forward, I wouldn't want this group to, you know, leapfrog some other effort or come up with something that may not be consistent with other NQF efforts, and that's why I would throw that out as a point of caution for focusing on telehealth as much as I love it.

Suzanne Theberge: Thank you for that. So we're pretty short on time, so thank you for those two comments. And what we'll ask is for you all just to think about these

ideas and, you know, if you have a burning thought to share, please do e-mail us and we will discuss further next time. So I will turn this back over to Kate for our public comment period.

Kate Buchanan: Thanks so much, Suzanne. (Crystal), would you mind opening the line for public comment and we'll hold the lines open for about 20 seconds, if you won't mind?

Operator: If you would like to make a public comment, please press star one on your telephone keypad. Again, to make a public comment, press star one.

And we have no comments in queue at this time.

Kate Buchanan: Thank you very much, (Crystal).

Operator: You're welcome.

Kate Buchanan: I'll turn it over to Madison to go over some of our very quick SharePoint overview and our very quick next steps.

Madison Jung: Yes. So we have the next steps. So, we'll start off just by doing a quick SharePoint overview. All workgroup members should have received their SharePoint credentials from – someone from our office, our nominations office. The link – one of the – the link is displayed here on a page, but also if you look to the left of the webinar, if you signed in online, you can see there's a link to click on it for the committee SharePoint. And under that, there's a public-facing output of the MAP Rural Workgroup project page as well, that all members can access and all public members can access.

So, what you'll find on that SharePoint page is you'll see just some general documents we have in this very tiny screenshot. But there's background materials, there's last year's report on there, as well as some bios and bios and names of our committee members. And for committee members, you'll also find the meeting materials posted here. Meeting materials will also be posted on the public site, but this is just one consolidated place for you. As well as on this page, you'll find on the left-hand sidebar, once you log in, our calendar of events, some links, and the roster and as well as staff contacts.

Just something to note that sometimes these pages look like they're not displaying any content but they're actually this very tiny plus and minus sign. And once you drop on there, they open up the content and documents.

For next steps, we'll be sending out a SurveyMonkey most likely, just getting your thoughts that we have previously mentioned that we wanted to solicit. We just like to caveat that we have a very short turnaround time between the webinar number two, which you can see is on December 13th. So we asked that, once you receive that, you try and complete it as quickly as possible.

After that, the next webinar we have is the January 25th webinar. Those are all for the next few months, but here, displayed is our contact information. Again, there's that workgroup SharePoint site, the project box is the maprural@qualityforum.org and the contact information for staff members is also listed on this slide.

Other than that, if there aren't any questions, any questions about the SharePoint process or next steps?

OK. Hearing none, thank you very much for attending from the NQF staff.

Male: Thank you.

Female: Thank you all very much.

Male: Thank you.

Male: Thank you.

Male: Thank you, (very cool).

Male: Have a great day.

Male: Thank you.

Male: Bye-bye.

Male: Bye-bye.

Operator: Thank you.

Male: Thank you, bye.

Operator: Thank you. This concludes today's webinar. You may now disconnect.

END