NATIONAL QUALITY FORUM

Moderator: Rural Health
December 13, 2017
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Operator: This is Conference #88437591.

Welcome, everyone. The webcast is about to begin. Please note today's call is being recorded. Please stand by.

Madison Jung: Hello. Welcome to the second webinar for the MAP Rural Health Workgroup. My name is Madison Jung. And I'll be reviewing some of the agenda items to come up.

So, for today's meeting, following the welcome, we are going to do a welcome and review of the agenda items. We'll be doing a longer introduction. So, workgroup members, please make sure that you dial in via phone so we can hear you. In addition to those introductions, a longer version of them, we're going to ask you to do a fun fact. So, also prep for that.

Following the introductions, we will start reviewing some of the work that's been done to date, an update on the environmental scan of measures and also an update on your – the results of the survey that you filled out last week. And thank you for your quick responses. We very much appreciate it.

Following that, we will review the preliminary selection criteria and update on where we are, the project team, with that. Then, we will discuss – have another discussion on the rural-relevant measurement topics and have a discussion on the Measures Under Consideration list and, then, close with the public comments and next steps.

Kate Buchanan: Great. Thank you, Madison.

This is Kate Buchanan. So, as Madison said, we're going to be doing some introductions. So, the way that we're going to have this kind of flow for the next couple of minutes is that I will introduce staff, staff will talk a little bit about their roles, say one fact about themselves. Then, what we're going to do is I'm going to pass it off to our acting senior vice president for quality measurement, Elisa Munthali, to a couple of the remaining DOIs. Following those DOIs, we are going to actually do our longer introduction starting off with our co-chairs, Aaron and Ira. So, that's just kind of a little bit of a flow for the day.

So, my name is Kate Buchanan, as I said. I am a project manager here working on the MAP Rural. And I would say I think my interesting fact is that I've never been a morning person. And evidence of this is that when I was in high school, I accidentally pierced my own ear getting ready for school in the morning.

So, I will turn it over to Karen.

Karen Johnson: And it's hard to compete with that. I am Karen Johnson. I am the senior on this project and had, as you know, the opportunity to lead our work on rural health a couple of years ago. So, again, really looking forward to carrying that forward. My fun fact is actually one of the things that I'm most proud of being able to do. And that is twisting balloon animals. That is a wonderful skill that I absolutely love having.

Kate Buchanan: Suzanne?

Suzanne Theberge: This is Suzanne Theberge. I'm the senior project manager on the team. Following in Karen's lead, I think my big skill outside of work is making pie. I'm extremely good at making pie. And my husband actually asked me to put – that I would make him pie regularly in our wedding vow. So, we eat pie around here.

Kate Buchanan: Madison?

Madison Jung: This is Madison Jung, project analyst. I'd say my fun fact is, in a former life, I was a division one field hockey player. Not exercising so much now, but I'd like to just throw that out as I was once athletic.

Kate Buchanan: Elisa?

Elisa Munthali: I'm laughing. That's a fun fact. This is Elisa Munthali. I'm acting senior vice president for the Quality Measurement Department and oversee our work around MAP and also endorsement. A fun fact about me is, you know, not – I love dancing. And people wouldn't believe that, but I used to win a lot of competitions back in the day. So …

Karen Johnson: Well done. So, with that, we will actually turn it over to Elisa for the DOI.

Elisa Munthali: Great. Thank you.

Again, this is Elisa. We went over DOIs from the majority of the workgroup. But, there were few that we missed. These were really related to the co-chair and another subject matter expert, Curtis Lowery. And, so, I just wanted to give you a few reminders before we go through the oral disclosures.

We are really interested in any of your professional activities as it relate to this work – so, any presentations that you've given, grants, consulting and not just those that you've been paid for, also those that have been unpaid or you've been volunteering for. I also wanted to remind you that you sit on this committee as subject matter experts as individuals. You are not representing your organization or anybody who may have nominated you for the workgroup. And just because you disclosed does not mean you have a conflict. We do this in the spirit of openness and transparency.

And, so, I will call on Aaron first, if you can let us know if you have anything to disclose.

Aaron Garman: I do not have anything to disclose.

Elisa Munthali: Thank you, Aaron. And Ira?

Ira Moscovice: I have nothing to disclose.

Elisa Munthali: Thank you very much. And Curtis?

Elisa Munthali: OK. It doesn't look like Curtis is with us. And we may catch him later on in the call. I just wanted to see if anyone else on the workgroup had any questions for Aaron and Ira while they're on based on what they just disclosed. And I don't think you would because they had nothing to disclose.

And, so, I'll turn it back to Kate. Thank you very much.

Kate Buchanan: Thank you, Elisa. So, with that, we are going to begin our introductions. So, we're going to start with Aaron and Ira and ask them to introduce themselves, you know, what they do, what drew them to participate in this workgroup and, then, we're going to ask them to share one fun fact.

So, Aaron, I will turn it over to you.

Aaron Garman: Sounds great. Thank you.

My name is Aaron. I'm a board-certified practicing family physician in rural North Dakota. I'm in a town called Beulah. It's a town of about 3,500 people. I'm also – have my Certificate of Added Qualifications in Hospice and Palliative Medicine. I've been a medical director for an FQHC for the last 15 years, medical director of a rural ACO for two years, and I sat on the 2015 NQF panel for low-volume and rural providers. I'm excited to be a part of this process as this work actually will directly impact my patients and my practice.

A fun fact about myself is I used to love to play college tennis. I played in the NAIA National Championships when I was a senior in college. And I played tennis twice since. So, I don't even know (what) my racket is. So, it's great to be a part of the group. Thanks.

Kate Buchanan: Thanks, Aaron. Ira?

Ira Moscovice: Hi. Ira Moscovice. I'm a faculty member in the School of Public Health at the University of Minnesota and have directed a federally-funded rural health research center for about 25 years now with a focus on quality. I was one of

the co-chairs of the 2015 Rural Quality and Low-Volume group that Aaron referenced. And much of our interest really relate to trying to figure out can we develop quality measures that really makes sense for rural providers and can we encourage and incentivize and get rural providers to report information on the care they are providing so that we can help improve the population's health out in rural America.

Fun fact is I very much like antique wall clocks. And it seems when the system – when seasons change, as they are just about now – we have a little bit of snow on the ground in Minnesota – somehow for – the six wall clocks in the house aren't working right now. So, always an interesting scenario we get through winter. But, I'll stop there.

Kate Buchanan: Thank you, Ira. And, so, we're going to go through with our organization members. So, as we – I will say the organization and if the organizational rep could introduce themselves?

Alliant Health Solutions?

And I think some people are on the line. I don't know if you're on mute or if you're dialed in to the webinar but haven't dialed in to the phone. But, just as Madison said, please dial in 855-307-1903 to make sure that you are both participating online and also on the phone.

So, we'll go on to the American Academy of Family Physicians.

David Schmitz: Hello. Thank you. This is David Schmitz. I am also a board-certified practicing family physician. I'm located in Grand Forks, North Dakota, where otherwise I'm the chair of the Department of Family and Community Medicine representing the American Academy of Family Physicians. Thank you.

Kate Buchanan: Thank you. And is there a fun fact about you that you would like to share?

David Schmitz: I once lived three miles up a dirt road and couldn't get Internet access. So, when I first became a teacher, I hadn't done a PowerPoint ever. And that was in 2005.

Kate Buchanan: All right. Excellent. The American Academy of PAs?

Daniel Coll: Yes. Hi. This is Dan Coll. I'm a physician assistant (inaudible) California up in the Sierra Nevada Mountains. And I was nominated by the American Academy of PAs. I'm a member in (inaudible) in the rural community.

Kate Buchanan: Excellent. And is there anything – yes?

Daniel Coll: Fun fact – so, I don't have any of the NCAA college sports portfolio. I made my way through college as a river raft guy (in) summers and ski patrollers in the winters. And I've got 23 years still ski patrolling (inaudible).

Kate Buchanan: Excellent. American College of Emergency Physicians?

Steve Jameson: Yes. This is Steve Jameson. I'm a board-certified emergency physician. I represent the American College of Emergency Physicians for this project. I work in a level two trauma center in Central Minnesota and I also do rural health care in some smaller rural facilities in the region.

Fun fact – I am a (inaudible) water skier. I taught my kids how to do it, but I cannot compete with them any longer.

Kate Buchanan: Wow. Awesome. American Hospital Association?

OK. Geisinger Health?

Karen Murphy: Good afternoon, Karen.

Kate Buchanan: Yes.

Karen Murphy: This is Karen Murphy.

Kate Buchanan: Great. Karen, would you mind introducing yourself, what your role is at Geisinger?

Karen Murphy: Sure. I'm the chief innovation officer at Geisinger.

Kate Buchanan: And is there anything about – what about this workgroup kind of drew you to it?

Karen Murphy: I'm very interested in rural health. I was the former secretary of health for the State of Pennsylvania, where we worked on the Pennsylvania Rural Health Transformation Initiative for the last two years. So, I was – and Geisinger has a few hospitals that would be considered rural. So, I'm very interested in rural health. So, very interested to participate in this.

Kate Buchanan: Great. Health Care Service Corporation?

Shelley Carter: Hi. This is Shelley Carter. I am a senior accreditation director for Health Care Service Corporation. And I've had a long history with rural activities in New Mexico for health care. For my master's degrees, I was the first to put together a community and regional planning and public health profile for my studies, and that was of greater interest. A fun fact – I used to be a co-owner of our music store as well as an ice cream store.

Kate Buchanan: OK. Very cool. Intermountain Health?

Mark Greenwood: Hi. Mark Greenwood. I'm a board-certified family physician. Grew up and then practiced for 15 years in Richfield, Utah – it's a town of about 6,000 in Central Utah – doing full-spectrum family medicine and now for the last year and a half have been over quality improvement and primary care for Intermountain. Obviously, with both hats, very interested in quality and metrics and improvement for family care and rural in particular.

Fun fact – I grew up riding (Chilean) horses. And when I was a sophomore in high school was the (inaudible) state champion all around for showing horses.

Kate Buchanan: That's awesome. The Michigan Center for Rural Health?

Crystal Barter: Good afternoon. This is Crystal Barter. I'm the director of performance improvement at the Michigan Center for Rural Health. So, under that rule, I manage the State Office of Rural Health – the State Office of Rural Health program, the Medicare Rural Hospital Flexibility Grant program known as the Flex program, the (SHIP) grant and, then, we have a few subcontracts with

our hospital association and some local think tanks here in the state of Michigan surrounding quality improvement that I manage as well.

A fun fact about myself is that I got my foot in the door, the rural health door, as an AmeriCorps member. That's how I started my career.

Kate Buchanan: Very cool. Minnesota Community Measurement?

Julie Sonier: Hi. This is Julie Sonier. I'm the president at Minnesota Community Measurement. We are a multi-stakeholder, nonprofit health care quality measurement and reporting organization. Our interest in this work is that we have been collecting and reporting quality measures on a statewide basis for many years. So, we work with providers all across the state, including rural providers, on doing that.

We are also a measure developer. And I'll mention that I'm unable to be online for the full meeting today, and so Collette Pitzen, who is our lead measure developer, is also on the line for – so she can cover the part of the conversation after I have to leave for a board meeting.

A fun fact about me is that I love to cook and experiment with new recipes. My most recent achievement is making Christmas cookies that don't look like they were decorated by a five-year-old.

Kate Buchanan: Very nice. The National Association of Rural Health Clinics?

Bill Finerfrock: Hi. This is Bill Finerfrock. I am the executive director of the National Association of Rural Health Clinics. I'm also a co-founder nearly 30 years ago. I've been involved in rural health work and policy work for a long time. My fun fact is, however, despite that, I grew up in – just outside the city of Philadelphia. I had to learn rural. I didn't live it. And I'm an avid sports fan of any team from Philadelphia.

Kate Buchanan: Excellent. The National Center for Frontier Communities?

OK. The National Council for Behavioral Health?

Sharon Raggio: Yes. Hi. This is Sharon Raggio, and I am representing the National Council for Behavioral Health. We are out in Western Colorado in rural frontier areas and have a psychiatric hospital as well as outpatient clinics across the western part of Colorado, which is all rural and frontier.

Kate Buchanan: Excellent. The National Rural Health Association?

The National Rural Letter Carriers' Association?

Cameron Deml: Yes. Hi. This is Cameron Deml from the National Rural Letter Carriers' Association, NRLCA for short. I'll be brief. NRLCA is a – it's the union arm of the Postal Service for rural letter carriers and represents 114,000 members. And what I'm tasked with is I'm in charge of the health plan. And the Rural Carrier Benefit Plan is a – it's one of the plans in the Federal Employee Health Benefit Program. So, I'll spare you all those acronyms. But, we have a contract with the Office of Personnel Management to have – you know, essentially have and offer a health plan to our members. And, so, our direct interest is that, you know, we're moving into an environment where we're directly kind of compensated, graded upon and measured by HEDIS metrics and a variety of others –CAHPS metrics. And, so, that is our unique interest. Obviously, the well-being of our members is a – is a strong interest as well. So, that's the really quick one for you.

A fun fact – I currently live in Alexandria, Virginia just outside of D.C. And just because there's so many of my Midwestern folks – I'm a – originally, I'm a native Minnesotan. So, you'll hear the accent come out from time to time.

Kate Buchanan: Excellent. The RUPRI Center for Rural Health Policy Analysis?

Keith Meuller: Hi. This is Keith Meuller. I'm the director of the RUPRI Center and currently an interim dean in the College of Public Health at the University of Iowa. Our interest in this project stems from long-time work in both access issues in rural areas and, more recently, looking at changes in health care delivery organizations and the payment policies related to those changes. And, clearly, the arena of developing quality measures is vital in all of those considerations. We've also done work in telehealth where we helped with development of quality metrics.

A fun fact is I started out my academic career in urban politics and teaching urban government, having worked for the mayor in Milwaukee. So, I am all things Wisconsin and Milwaukee in athletics – in competitions. So, we can get into a fight with my colleague from Philadelphia.

Kate Buchanan: The Rural Wisconsin Health Cooperative?

Tim Size: Hi. Good afternoon. Tim Size. I've been executive director of the Rural Wisconsin Health Coop for 38 years. I helped start it. And that's a collaboration of 40 local hospital health systems. I had the honor, privilege and fun of serving on the Institute of Medicine's Future Rural Health Committee a number of years back and was also on the 2015 NQF initiative. I strongly believe that rural needs to be part of quality improvement as well as public reporting. And if we're not in totally, we just fulfill people's expectation that we are just backorder medicine.

My fun fact is that I've known and been a friend of Ira's for 30 years and I just found out we have the same fun fact. I also have – my collection is a little bigger than his of antique clocks. But, I have exactly the same problem when the weather gets cold.

Kate Buchanan: I had no idea this was a thing. This is great.

The Truven Health Analytics?

Cheryl Powell: Hi. This is Cheryl Powell. I'm a vice president at Truven in the federal consulting area. I am – have a past around rural health, having my route (then) and having grown up in rural Missouri and worked for the last 20 years in Medicare and Medicaid policy and quality and financing in the Chicago Regional Office-(led) Medicare services – Medicare beneficiary services across the five states there with a strong focus on rural.

My passion is around the user – we get quality right, the right meaningful quality measures that truly drive what's important on improvement, particularly for populations that sometimes get left behind like rural populations. And I was also a deputy director of (inaudible) Office for

Medicare, Medicaid and (Rural Lead) and just have a strong passion on (inaudible) get it right for those types of populations.

My fun fact is I just adopted a thousand-pound baby. I have an (inaudible) thoroughbred that I'm now learning how to train. And she trains me as well. And I realized I need to reach out to you, Mark, to get some help.

Kate Buchanan: Wow. And I know Kimberly Rask from the Alliant Health, you've been able to dial in.

Kimberly Rask: Yes, I have. Thank you for giving me a second try. I'm a general internist by training and I work for Alliant Health. And Alliant is the QIO for Georgia and North Carolina. And we also have two end-stage renal disease networks across the southeast and Texas. And we do a lot of work on quality improvement for Medicaid programs across the southeast. And our interest in this and my interest in this is that many of our providers are in rural communities and very under-resourced communities. And, so, recognizing the challenges that they have trying to participate in national programs, we really are focused on what are the ways that we can be helpful to them but also how can measurement be something that really does improve and promote quality care rather than simply being a bureaucratic checkbox.

In terms of a fun fact, in my moments of free time, I love to quilt. But, I have moved from traditional quilting to impressionist landscape quilting, which – the benefit is I get to always what it's supposed to represent even if it doesn't look like it.

Kate Buchanan: That's awesome. And I want to acknowledge our colleague Susan Wilger, who is having difficulty joining us. Susan, we are working with you on this. Thank you so much for your patience. We're very apologetic about that. But, she is online from the National Center for Frontier Communities.

So, we'll move into our individual subject matter experts.

John Gale?

John Gale: Yes. Thank you. I am a senior research here at the Maine Rural Health Research Center at the University of Southern Maine. I've been here for 18 years and have a broad portfolio focused on rural health clinics, critical access hospitals dealing a lot with performance measurement not just in quality but community services and others. I have also done a fair amount of work with emergency medical services and quality metrics, behavioral health and substance use. Prior to that, I managed large physician groups in primary care and behavioral health.

My fun fact is I am an open water marathon swimmer. Still swimming twice a week year round in the winter in Maine without a wet suit. And I've just secured a date to swim the – swim the English Channel.

Kate Buchanan: Whoa.

John Gale: Attempt to swim the English Channel. We don't know until I drop.

Kate Buchanan: And, then, Curtis Lowery, I hear you're on the phone now. So, I'm also going to ask Elisa to do the DOI. But, I just want to double check that you're with us.

Curtis Lowery: Yes. Can you hear me?

Kate Buchanan: Yes, we can.

Curtis Lowery: OK. Yes.

Kate Buchanan: Hi, Curtis.

Curtis Lowery: Yes. So, I have two companies. One is called AirTOCO, which is a – it's a disposable uterine activity monitoring device. And the other is a company called Angel Eye, which is a nursery camera system for mothers to see their babies from a distance in the high-risk nursery. So, those are the two companies.

Kate Buchanan: OK. Great. Thank you for disclosing that. Excellent.

Curtis Lowery: Yes. And …

Kate Buchanan: And, then – yes. And, then …

Curtis Lowery: And yes. I am a – I am a maternal fetal medicine specialist chairman of the OB/GYN department at the University of Arkansas for Medical Sciences, which is the state's only teaching – Arkansas' only state teaching hospital or any teaching hospital for that matter. And I grew up in rural Alabama. And we started telemedicine here in the site through the formation of the Center for Distance Health, which I also direct.

We obtained $105 million under President Obama in the BTAP proposal to build a very extensive telemedicine program to that goes all over the state of Arkansas, including all hospitals, rural health care clinics, health departments, (AHECS), and now, with handheld devices, in the direct patient's home. And we started with the (Angels) program, which manages high-risk obstetrical patients throughout the state and now has expanded into aspects of health care, deploying a systems approach to patient management.

Kate Buchanan: Excellent. And is there a fun fact about yourself that you'd like to share?

Curtis Lowery: Yes. Well, I have two – it's fun for me. I've got two kids graduating from medical school this year finally. And, then – but, then, I fly fish. I like to fly fish. (I have time-owned flies) and, you know, the whole – the whole shebang. So, if anybody has a good place to fly fish, I'd be willing to come there and give a talk.

Kate Buchanan: Excellent. Melinda Murphy?

Melinda Murphy: Hi. I am an RN who spent – my clinical practice over the years have been primarily in rural health settings in either Kentucky or Oklahoma with the exception of a few years spent I spent in San Francisco. And I worked as a clinician, as a nurse administrator and as a medical center director and spent about 10 years in the Department of Veterans Affairs Central Office in Washington, retired from VA and went to NQF, where I worked primarily in projects looking at measure endorsement and safety projects and related to measures. Fun fact is that we just recently returned from Maui where we were

able to have both our children and all of our grandchildren with us for Thanksgiving luau.

Kate Buchanan: Very nice. Ana Verzone?

Ana Verzone: Yes. Hi. I am board-certified as a family nurse practitioner and I'm a certified nurse midwife. I currently live in Alaska and work for the Rural Anchorage Service Unit at the Alaska Native Medical Center, where I provide primary urgent and emergent care in rural Alaskan native villages. And I'm an assistant professor of nursing at the University of Alaska, and I teach clinical and didactic courses for their master's and post-master's DNP program. And I'm helping to develop an interdisciplinary course there in rural health care. So, it's going to be offered to advanced practice registered nurses, physician assistants and medical students. And my recent doctoral project focused on rural emergency transport in Nepal. And my interest from this work stems from all the experiences I'm having in Alaska and the challenges we face and the unique rural environment that we have here and just really wanting to influence that with a more broader – more broad approach.

And a fun fact – I used to be a professional Alpine mountaineering guide in the Himalayas and other international locations. And I lived out of my car as a climbing bum for seven years. And in fact, I saw that the rep from the PA group is in the Sierras. That's where I did a lot of that.

Kate Buchanan: You guys are crushing these fun facts.

Holly Wolff?

OK. We'll move on to our federal liaisons. Do we have Susan Anthony from CMS on?

Susan Anthony: Hello. My name is Susan Anthony. I am at the Centers for Medicare and Medicaid Innovation. And I work – and I'm the model lead for the Pennsylvania Rural Health Model. I guess a fun fact about me would be that I also like to cook. And I've actually recently gotten to – gotten into like cake

decorating and I took a class to also not make my cakes look like a kid made them.

Kate Buchanan: Excellent. The Federal Office of Rural Health Policy – Craig Caplan?

Craig Caplan: Hi. This is Craig. And I am a senior advisor in the Federal Office of Rural Health Policy. I've been here three years. I came from CMS, where I was – for about seven years working on Medicare Value-Based Purchasing. I guess the fun fact – my daughter is – until this year, she was in ballet – taking ballet and then this Russian ballet studio – and a couple of years ago, they – the studio issued a desperate plea for fathers to be in the party scene of "The Nutcracker" and I volunteered. I thought I'd just going to be standing around eating crackers and cheese, but I actually had to dance in "The Nutcracker." So …

Kate Buchanan: That's awesome.

And I don't believe that Juliana from Indian Health Service is able to join us. But, is there anyone that I have missed who is online?

OK. So, if we go on to the next slide, we have just a timeline of our project activities. Here, you can see we're on our second webinar. We'll be meeting again on January 25 and working – releasing two draft reports during the course of the next eight months. Our final report will be released on August 31.

And so, with that, I'm going to turn it over to my colleague Suzanne.

Suzanne Theberge: OK. Thanks, Kate.

So, I'm going to talk briefly about the team's progress on the environmental scan of measures that we're doing. Next slide.

So, this is something that we've been working on and there's still more work to be done. We started with the scan from the 2015 rural health project, which included our portfolio, other measure sets et cetera. There was a – it was a large scan. Excuse me. I apologize. Another not-so-fun fact is that I have

cold. So, apologies. The other measures sets that we looked at for the scan included the AHRQ Measure Repository et cetera.

So, this scan included some tagging. We tagged measures for CMS programs. We tagged some other relevant measures for small hospitals, critical access hospitals and rural health clinics, as well as tagging for topic and condition. So, we started with that. And we have been working on updating that with measures that have been endorsed in the last few years since that scan was run. We also look at our framework projects, which you can see listed on the slide, and have added in additional information that we've – that we've gathered.

Next slide. So, the original scan from 2015 had over 1,200 measures on it. But, there was some duplicates in there and there were measures that are for other levels of analysis than the ones we wanted to include here. And, then, we found that our other scans that had been completed in our other projects also have had quite a few – quite a few measures. The home- and community-based services project had over 300 measures. Telehealth had 73. Medicaid accelerated projects had over 300.

And so, these – so, we were taking all this information. We look at it. You know, it's a ton of information. It's a lot of measures. And so, we – looking at the formats (that we held), we were not going to merge these scans together. But, we're going to be using them to inform the scan that we're pulling together and we'll be pulling in information as needed.

We are going to reach out to you all in addition to help us think of other sources, other measures that we should be considering. And I know in our – in our pre-meeting call our co-chair Aaron had an idea here. So, I wanted to just pause and see if we he wanted to talk about out here before we move on to the next section.

Aaron?

Aaron Garman: Sure. Thank you. One of the things that I look at when I think of all these metrics is perhaps we don't need to reinvent the wheel. Maybe we need to look at what's already being done. For instance, in my clinic in rural North

Dakota, I'm a part of an FQHC with 17 metrics there. We participate in a rural ACO. We have 34 metrics. And, then, we also participate in a third party ACO. And that's 10 metrics through them. So, all in all, they have anywhere between 58 and 61 metrics that my clinic is already participating in. So, perhaps, if we look at what's already being done out there and gather some of those rural-relevant metrics and then assess them, maybe that would be able to fine tune or focus our group a little bit faster.

Any thoughts?

Melinda Murphy: It's Melinda. I have a question for you. Given that number of metrics, can you talk about them just a little bit in terms of the buckets they would fit into?

Aaron Garman: Absolutely. So, we have quality-based metrics which include diabetes metrics, hypertension metrics. We also have access-to-care metrics. We have cost metrics. So, I think in the metrics that I am talking about for my clinic at least, we cover a broad range. And I think, especially in the ACO world, you are going to see that because ACOs, obviously, are not only reflective of quality-based care and look at quality-based care but they also are really concerned with cost. So – and, then, FQHCs are concerned with access to care. So, I think some of these metrics and groups of metrics can be identified and perhaps even fined tuned a little bit faster by looking at, like I said, what's already been done.

Bill Finerfrock: Bill Finerfrock. I would concur with that. And, John Gale, I don't know if you want to chime in, but a few years ago, with the Federal Office of Rural Health Policy, we endeavored to identify quality metrics relevant to rural health clinics. And part of that process was how do we use current measures that are being adopted by others so we weren't duplicating or triplicating whatever work on behalf of rural health clinics. As we look at these, I would definitely say let's look at what's being done so we're not creating new or additional work on the part of folks but rather piggybacking on some things that have already been identified.

John Gale: I'd agree, Bill. Thanks. And, actually, just before the call, I pulled up the policy brief and sent it around to the group, which detail what we were doing.

We did had much of the same process – so, looking at what was being done, looking at PQRS measures and other things for primary care and really think that our best bet is not to reinvent the wheel.

Melinda Murphy: It's Melinda. I have one more question of those of you who have just spoken. Are any of those activities or measures that you are using now coming out any population health work that you've done in your communities?

John Gale: It wasn't specific to population health when we put these together. But, our metric set that we identified with a panel of rural health clinical experts had focused heavily on chronic conditions and diabetes and hypertension. So, I would say, yes, it has a grounding in population health.

Aaron Garman: I would agree. This is Aaron again. And I would absolutely agree. A lot of what we do is change our focus from individual care to more of a population health focus. And I think that's a good thing.

Suzanne Theberge: Thank you, everyone. So, we'll be working on this more in the coming weeks and you will hear more about it. We'll be – we'll be – we'll be sending along much more information as we continue to develop it.

So, I will this over to Karen for our next topic.

Kate Buchanan: Thanks, Suzanne. And this is Kate. I just wanted to quickly interject. It looks like we now have our representative from the National Center for Frontier Communities on.

Susan, would you mind just providing a brief introduction? And we can't thank you again enough for your patience.

Susan Wilger: So, no problem, and I'm glad I finally connected. Susan Wilger. I'm the executive director with National Center for Frontier Communities. If you are looking for a fun fact of the top of my head, for 14 years, lived in very rural New Mexico. We had to cross a river to get to the house, sometimes flooded out for up to eight weeks. But, it really allowed me to connect with nature.

Kate Buchanan: Wow. Yes. Thank you so much, Susan. We appreciate it. And Karen?

Karen Johnson: Thank you, Kate. And just to circle back real quickly to the idea of Aaron and possibly others having list of things that you're already reporting on or working on for various programs, if you would be so kind as to send us those or tell us where to find them, that would be much appreciated and I think especially if you are doing – you know, we have already in-house the various measures that are used in the CMS programs. It's OK if yours overlap those. But, if you're doing programs like specifically for certain private carriers or for the state that might be a little bit different, that would be interesting as well.

And what we will do, just to – excuse me – to follow on, some of Suzanne's discussion there is we will tag things. And I think this tagging is probably – and when I say tagging, I mean just, you know, indicating in a spreadsheet probably the various different ways that you can kind of slice and dice these measures. You know, we will – we will continue to do that. And I think that will help us kind of winnow down from where we are right now because, again, you are right, we don't want to reinvent the wheel.

So, this section here is to talk about our feedback to date – so, what we think we've heard from you. So, so far, we've heard from you in our November 29 webinar. So, we went to you and said, "What do you think about sticking with NQF measures trying to make sure that we address low case volume and look at or limit to cross-cutting measures?" So, that was kind of our straw man for you.

And we think that we heard that you support starting with NQF-endorsed measures with a caveat that we may need to look elsewhere for specific topic areas, you know, and we may not. So, let's see. We must address low case volume. And we also need to make sure that we include measures that assess care transitions. So, that's what we heard on the call.

We also heard a keen interest in measure of access to care. So, that came up several times in the conversation and, with that, probably a little bit of – there maybe – I think it was Ira and maybe I'm misremembering who talked about it, but there may be a little bit of discussion back and forth before we finalize things as to whether that actually makes sense for core measures or not. They

are not actually quality measures. And that's fine. So, anyway, more to – more to come on that one.

I think we heard that you are open to consideration of cost measures. So, it didn't feel as quite as much of a directive. But, it sounds like if there's some that's available that we could, you know, use, then that might work for us. Care coordination is a key rural issue – so, the idea of transitions, which came through, and collaboration between providers.

We heard that feasibility is definitely important but, also, this idea of some measures are so high-value that we might be willing to live with less feasibility. And, so, we need to be careful to make sure that everybody understands that, yes, it's maybe a little bit less feasible. It's little harder to do. It's a little more burdensome. But, this is why we think it is so valuable.

And then, finally, we think we did hear some disease-specific measures might be reasonable to increase in a core set. So, even sticking with the cross-cutting idea, there might be some specific conditions that we want to look at.

So, not too long after the call – I think maybe a day or two after the call – we asked you to respond to a SurveyMonkey for us. And, basically, we just wanted to quantify what we thought we heard. And in terms of NQF-endorsed, low case volume and cross-cutting, most people either, I think, agreed or strongly agreed. There were a few that were a little neutral of low case volume and cross-cutting. And, really, that 4 percent there is one person, if you knew our denominator there. So, for the most part, we think that we – the survey kind of underscored what we thought we heard on the – on the call.

Also, on our survey results, kind of the same thing. The cross – you told us again on the survey cross-cutting measures are necessary. But, there does seem to be some appetite for chronic or disease-specific or even chronic condition measures. We heard from you guys that the measures that we picked for the core sets should be relevant to unique rural health care delivery challenges and travel distance, transportations and those kinds of things came up.

We – at least one person said, "Don't forget patient outcomes." I think probably what that person meant – and if I'm incorrect, you can feel free to correct me, whoever made that comment. I'm kind of assuming there that you meant patient-reported outcomes – so, even – and that would be actually an example of a measure that might be a little bit more burdensome that might really be high-value. And, then, just a reminder, let's not lose sight of actionability and usefulness of measures for internal QI.

And, then, we asked about topic areas and disease conditions. So, this is a graph that kind of shows where people landed in terms of agreement and with use of these conditions in a core set. And what you see there is, again, access to care really came up really high. Cost of care is less high, but it's not zero. So, we have that. Well, I guess it wouldn't be zero given we use electric scale.

The next – Kate is laughing at me. The next slide is probably more informative, I think, because it really reflects that Strongly Agree column, which we thought was pretty interesting. So, again, access to care really showing up. So, people think if there is an access measure or two, we have some appetite for including that in our – in our core set.

Transitions of care not quite as much strong agreement but, overall, a lot of agreement. And we are also seeing diabetes and hypertension. We did get agreement there for those two conditions, some agreement of hospital readmissions, a lot of neutrality on the readmissions measures. So, that might be a topic of discussion if we want to talk about, you know – it kind of sounds like several folks, you know, could take it or leave it. Cost of care kind of the same thing there.

Again, going to the next slide, mental health – that one really came up as something that we want to do. Things you just have to do such as med rec – a little bit more neutrality there maybe than we had thought after hearing discussion on the phone. And, then, the perinatal and pediatrics group topic areas – a little bit more neutrality on those topic areas than with some of the others.

So, we also, you know, had an open field where people could tell us other topic areas. So, things that were mentioned were geriatric measures that really apply to the geriatric population knowing that rural areas often have a relatively higher prevalence of older folks. Outcome measures, again, care coordination across multiple providers – so, kind of a similar idea but maybe a little bit different.

Preventive actions came out. We talked a little bit in the first call about immunizations. But, other preventive actions such as prevention of obesity or diabetes came out as something we might want to think about. Provider competence and credentials, trauma and emergency services, cancer are and swing bed quality also were other ideas that were tossed out in that survey.

So, with that, I'm going to hand it off, I think, to Ira – no – Aaron. I'm sorry I don't have the agenda in front of me, which I should have. Aaron is going to facilitate a discussion here. So, this is – this is what we've heard from you so far. You've had a couple of weeks maybe to think about this a little bit.

So, I think the – some of the questions that we want to think about – and we will have time a little bit later on in the discussion as well to talk about this. But, is there any – especially anything about other conditions that you think might be useful? Still feel pretty confident about inclusion of access measures? What do you think about readmissions, perinatal, pediatrics kind of measures? Those seem to be a little bit more on the neutral side.

So, Aaron, I'm handing it off to you to facilitate this portion of the call.

Aaron Garman: Wonderful. One of the things that struck me when I saw this is it really didn't surprise me. However, one of the concerns that I do have is painting rural health care with a broad brush stroke and saying that we provide all these things. And I think it's good to look at all these topics. But, I'll just pick on telehealth, for instance. Telehealth ranks pretty highly as far as our group goes. However, as a rural clinic, I don't provide telehealth. And, so, to be able to use that as a metric moving forward, I think my clinic would really struggle with that unless we implemented a whole new program.

So, I think we need to have some discussion about are there topics that we're missing or are there topics that we can maybe take out if we are looking at the entirety of rural health care. And with that, I'll open it up for comments.

Crystal Barter: This is Crystal Barter with the Michigan Center for Rural Health. To piggyback off of the telehealth comment, I believe that my organization answered either disagree or strongly disagree for that one mainly because we were thinking about those certified rural health clinics across the nation. And it – they have a distinct disadvantage to providing telehealth services just due to the payment structure right now. So, I think as we look at these measures, if we can look at it from a more holistic perspective and really understand what some of the barriers to providing those services are for specific populations. That would be helpful as well.

John Gale: John Gale. My concern with telehealth is that it's a vehicle, not a service. And by that, I mean it's a way of replicating, at least in terms of Medicare reimbursement policies, the face-to-face encounter using tele – using the technology. So, any quality metrics related to telehealth has to be around the use of the technology and access rather than individual services because the quality of metrics for behavioral health or substance use are going to be different than neurology or stroke care. So, the challenge for me with telehealth is it's a piece of the puzzle, but it's not really a quality metric per se.

Curtis Lowery: Well, this is Lowery in Arkansas. And, you know, we use telehealth. You know, I think it's more, I guess – you know, as we move to value-based care delivery, it becomes a necessary part of the service delivery. And a lot of what CMS wants to see at a national level is that how is it being used, can you encourage its use and does it affect cost of health care delivery. So, if it could be approached from that point of view, it might be what people are getting at, I guess.

Shelley Carter: And this is Shelley in New Mexico. And I was wondering is connectivity any issue with telehealth? It was in the past. But, is it currently an issue?

Curtis Lowery: Well, I guess the technology has evolved to where there are not many places that you can't utilize it anymore. A lot of the issues are how do you teach people to use it, why would they use it in a – in a fee-for-service world. And, you know, payment, as we know, is so fragmented. I mean, in – you can make money in one area and lose money in another area. But, if you look at the entire system of care delivery, you know, a connected technology embedded system makes sense to drive down health care spending. But, in each individual pocket of money, it may not be saving or necessarily beneficial.

What I mean by that – if you're – clearly, most of these programs have driven down the need to travel long distances. We've certainly done that in Arkansas. But, that didn't save Blue Cross Blue Shield or CMS any money. But, for the patient, it's high – you know, it's very important.

Aaron Garman: So, are there any other topics in all of these areas that also raise any flags for people that may be an issue? One for me is perinatal health. My – we haven't delivered a baby in my community for the last 14 years. So, talking about care of the infant after deliver is fine. But, hospitalized and, you know, lower birth weight infants and those kinds of things – it really becomes a challenge for us even tracking down the data or the information. So, are there other topics on here – telehealth, those kind of things – that can be – that we may want to look at a little bit harder or with a little bit more microscope?

(Nathan): This is (Nathan). I'm the alternate for the National Association of Rural Health Clinics. Bill had to step off. Can someone clarify for me are we trying to develop one measure set for all rural providers regardless of like cost to FQHCs or RHCs to fee-for-service clinics to Indian health? Or are we looking – are we going to develop several different measure sets for each of those entities?

Karen Johnson: Hi. This is Karen from NQF. That's actually a great question. And it's a little bit undefined, but where we're thinking we're going to go is to suggest a core set maybe for the hospital and inpatient side and for outpatient – so, more like an ambulatory side. And, so, not so much the specific types of those but just the overall general thing. That's what we are talking now.

(Nathan): Yes. I think that before we dive into what topics are useful, we should say what – we should – say, we're talking about inpatient now, we're talking about outpatient later because we're going to always say, "Well, that's relevant for the critical access hospital but it's not relevant for the rural health clinics." And I would suggest you might want to consider separating out FQHCs and maybe RHCs from the fee-for-service outpatient side. Could I – am I the only one that feels that if we talk about this kind of stuff now – like telehealth probably means a lot of different things, depending on what type of entity you are.

Male: Yes.

Karen Johnson: So, this is Karen again. I think it's great. And I would definitely want you guys to talk. That's a great question. Can we talk about kind of topics overall and then we'll delve down and we can show you, you know, inpatient, outpatient – that sort of thing.

Just to go back really quickly just the telehealth and not get too bogged down on telehealth, you know, I don't know that there are specific – as John said, you know, it's a vehicle, it's not a service. So, you wouldn't be measuring necessarily telehealth unless you were doing some kind of a structural measure, which wouldn't apply.

But, NQF fairly recently did some work through a HRSA funding, I think, looking at a framework for telehealth measurement. And as part of that work, what they have done is they came up with an initial set of measures that could potentially be used to assess the use of telehealth. So, it's kind of a little bit different way of thinking about telehealth measures. It's something that we could flag for you so you can look at them.

But, just as an example, there is a measure about controlling high blood pressure. And I think what this report was saying is that could be done through a telehealth means as well. So, if you were really interested in slicing and dicing, you could do it that way. So, I won't say any more about that.

We'll make sure that we get that report posted for those of you who are particularly interested in that.

But, let's go back to (Nathan) – I think, your name – (Nathan)'s question. Is it reasonable to talk about just kind of general ideas knowing that we are going to get down to specific measures and we can talk about, you know, which – you know, would this measure work for RHCs versus FQHCs or something like that? Can we do that a little bit later?

Susan Wilger: This is – this is Susan Wilger at National Center for Frontier Communities. I was looking some data on the different – you know, the growth and certain health indicators with urban versus rural. And one area that we saw incredible increase over the last 20 years was COPD. And I didn't see that. And is that something that we need to look at because we are seeing an incredible increase especially in rural?

Aaron Garman: This is Aaron. I would absolutely agree with that. I think, you know, right now, COPD is, I believe, the third leading cause of death in the United States. So, I would concur that that should be added to the topic areas.

Any other thoughts?

(Nathan): This is (Nathan). Just to re-emphasize the point, rural health clinics cannot be the distant site in a telehealth visit. So, when you – that's why, you know, when I saw that, I said, "Well, this is not a relevant topic area at all for rural health clinics." But, it might be for fee-for-service clinics or other types of entities. But, I mean, you have to – you have to kind of take – before we talk about topic areas, we have to assess can that entity even participate in that area altogether like (inaudible) ...

John Gale: Well, I think what's worth – this is John Gale – worth raising a question about telehealth is remembering there are two sites. The two pieces of the telehealth encounter is the distant site where the provider sits and the originating site where the patient sits. And on the Medicare policy, the site of service is where the patient sits. So, while RHCs cannot be a distant site provider for purposes of rural telehealth, they can be an originating sites. So, there are issues of quality from that facilitation aspect.

Susan Wilger: Yes. And this is Susan Wilger. And I'm actually based in New Mexico. I was recently talking with one of the quality people up at the state level, and they were tracking access via telehealth. And I think that for me, the telehealth was more almost is an access issue. Is there any way that we can monitor who is using it and who is not using it and why? Because if states are looking at – they said all the rural areas in New Mexico have access to telehealth. And how accurate is that as a – and maybe it doesn't fall into quality but it certainly is related to access.

Ira Moscovice: So, this is Ira. I think we're getting bogged down in micro-level details right now and the NQF staff are asking us to look at one layer above it. I think what we are being asked is what are the areas we want to look at in terms of trying to define quality indicators.

And, then, once we look at those areas and try to start throwing out some indicators, putting some out on the table, some of them may be relevant for critical access hospitals, some may be relevant for FQHCs. We certainly are going to say, "Here is a set for all providers." I think it's a mistake if we start out and saying, "Here is the four providers we want to look at," particularly when we start talking about things like care coordination or access.

And the three areas that come up in my mind, at least in terms of the first few slides, one of which is we keep talking about addressing low case volume. As we go through this, I think if we're serious about that, we need to try to define what that really means in the context of whatever measures we are looking at. And whether it's COPD or perinatal, you know, what do we really mean by low case volume? And are we looking at these issues for internal quality improvement or are we looking at it for external purposes in terms of comparison, reimbursement or whatever else?

I guess the second area – this notion of interest in measures of access to care and the scenario that Aaron mentioned earlier. From our perspective, we've sort of been interested in this in the sense that many hospitals, for instance, aren't delivering babies any longer. And the issue is how do the people in that community – how do they have access to obstetrics services? And to me, that

is really linked to a – it's a quality issue. Can you get to a place that's going to be able to deliver a baby in a reasonable timeframe et cetera, et cetera. And there are – obviously, a lot of factors introduced that. But, I think those are the kinds of access issues looking at, as I'm thinking about it, compared to did it take 20 minutes waiting time in the doctor's office or whatever else.

And I guess the third point I would raise is the whole issue of, you know, we were all – a lot of us were interested in coordination of care, transfers et cetera, et cetera. And I just, you know, reiterate that – so, that doesn't involve one provider type. That really involves multiple provider types, usually. And, so, if we're interested in coordination of care, there could be some measures that we think about for each site and may be the same or not the same. And there could be some measures that really are more system-related.

And, so, I am hoping we could hear at this point right now discussions not about specific measures per se or even specific diagnoses but the notion should we look at specific diagnoses as – or we are going to rule that out because of the low case volume issue? And if we do look at specific diagnoses, then I think we – maybe we could start talking about some of the issues that people have been discussing so far.

David Schmitz: Thank you, Ira. This is David Schmitz at American Academy of Family Physicians. And I'm just going to pick that up because that's exactly I think what at least I was trying to and I think several others were trying to articulate in our first webinar and on the follow-up survey. So, let me just give you one concern and then one example.

The concern would be that we drive measures which actually create a perverse incentive. So, in the state of North Dakota, especially with the oil boom, we actually have seen an increase in births in some of the rural parts of the state. But, we have also seen hospitals stop doing deliveries. So, if there was, for example, a difficulty with a quality indicator regarding being a hospital that was providing obstetrical delivery services and not just prenatal care, you could imagine that they might do better if they "stop doing deliveries." However, the quality of care has actually gone down, even though perhaps

that particular provider or setting might be paid more of have a better report card because they dropped that class. And that's my analogy.

So, I think we want to at least avoid unintended consequences. The extreme I saw this was some research that I did with the University of Melbourne in Southern Australia, where they actually have rural hospitals that, because of the payment system, which is they pay hospitals separately than they pay physicians – the states versus federal government in Australia pays the two separately – physicians didn't take call at rural hospitals at certain times like nighttime or weekends. And if you arrive to the emergency room, they'd simply call an ambulance to take you to the next hospital because even though there were local physicians, they didn't necessarily provide care after hours.

So, my point is that, sometimes, depending on reasonable payment systems and how we construct what it means to have access, there can be unintended consequences that can affect not only facilities but very determinately affect access to care probably more easily seen in OB than other services but many of them being vulnerable.

Male: Hi. This is …

Curtis Lowery: Yes. This is Curt Lowery in Arkansas, and I'm an OB/GYN. And that's exactly right. Maternal mortality rates in America has gone up over the last 10 years. It's the only industrialized nation where that has happened. And it's mainly in the rural areas. And the truth of the matter is that labor is unpredictable and women are going to go into labor in the rural areas and they are going to deliver. And if there is not an obstetrical unit, they are going to deliver it in the ER, which is worse.

So, I think this is a real problem for America. And we need to be kind of measuring and get – and seeing if there is something that can be done to influence it ultimately. But, if you don't have a good measure, you don't know what's going on and you don't know if your intervention changes anything. So, I think it's very important.

Tim Size: This is Tim Size. I'm following actually maybe the last three speakers. And maybe this is too far off our charge, but are we absolutely (wed) to be only provider-centric in the measures? Should we also have to be patient-centric?

And what made me think of that among other things said was, you know, we – if we just look at the quality of people delivering at the rural hospital, is that as important as looking at the quality of outcomes from women who deliver who live in that rural community? Because, obviously, there is – there is some risk to a woman if she has a long travel time because there is no care.

So, I'm not sure I was clear as I need to be. But, I think the ultimate thing is what's the quality of outcome in the example of a woman delivering. That's a more important question than solely a piece of it, which is what is that quality of the care at a rural hospital.

To take it one step further, are there certain – and this has come up in my mind a couple of times when we reference the access quality measure. To some degree, the way I often look at that is that's not so much provider at all but health plan.

So, if we're looking at health plan serving in rural areas, is that outside the scope of this committee to have quality measures we think that they should be addressing that's maybe more population health-based or in the instance of access to case-based?

Karen Johnson: Tim, this is Karen from NQF. That's actually a really great question. And I think it's something we'll have to struggle with a little bit especially, I think, if we go to access kinds of measures. Many of those are a little bit more population-based or, as you were saying, health plan-based. So I think our initial cut was to look at things that were – the acute care hospital, which is probably the level of analysis or the – or a clinician or a clinician group would be.

However, that said, if we want to go to certain kinds of measures, we might need to say, "Hey, this would be at a health plan level or population level or

that sort of thing." So, it's not off the table completely, although I, you know, kind of scooted it over to the edge a little bit to kind of work that metaphor.

Tim Size: Yes. I mean – I love scooting over the edge. That's great. I do think, though that if it turns out for research constraints or timing constraints we don't get to them, I think we need to be clear in our report that we acknowledged that there's other very critical ways to look at quality in rural that aren't as provider-centric as we may end up in our report.

Karen Johnson: Absolutely.

David Schmitz: And David Schmitz, AAFP. Also that we state that there can be unintended consequences of such policies without such considerations. I think that's important.

Ira Moscovice: Yes. This is Ira. I would just follow up and say it's – you know, what I was trying to say earlier – and Tim has moved it forward. I think if we're going to – from my perspective, the whole access to care issue – perhaps that's a separate sort of side module saying – we could say the committee had real interest in this and there are some really prime examples that are very important, whether it's obstetrics or other kinds of services, that we feel really do relate to the quality outcomes. But it – these are more population-based in terms of whether people have access to certain services et cetera, et cetera. And they are not – these aren't really hospital-centric measures.

And, so, I think perhaps having a separate module that looks at those population kinds of measures – which I think this can be a lot – it will be very important but a lot trickier for the NQF staff because, you know, a lot of the work that's been done in the past has been on the – has been related to provider – specific provider types et cetera, et cetera. But, I think as we go through this, we should just keep that in our minds, how we want to deal with those kinds of issues.

Daniel Coll: Hello. This is – this is Dan Coll, physician assistant. I work at a critical access hospital (inaudible) (15,000). And looking through the measures as well and talking about provider-centric, I just wanted to raise the point brought up last week a little bit as well. It's that many of the services that are

provided by physician assistants may be billed underneath a physician's name. And, also, the EHR systems that are out there may attribute those services even to the physician over the provider at the bedside.

And, as we talked about actually tracking quality and outcomes and performance, there is a key challenge in the design of how we go about tracking who provided the actual service and how we attribute the quality of their care. And in many rural environments, as we know, those services are being provided now more and more by physician assistants and nurse practitioners. So, I just – I just want to raise that point as I look through these measures.

My other question, not to dive too far into the measures, though, is what levels of service we really are talking about, what types of communities. We consider ourselves very advanced. We have a lot of services in orthopedic surgery. We are doing joint replacements. We have a cancer center. But, we don't have labs to do PCI. We don't have labs to do revascularization service. We don't have outpatient ambulatory surgery centers doing spine under these measure for considerations.

And we do have an ambulatory surgery center. But if you look at the data, only about 10 percent ambulatory surgery centers in the rural areas. I just want to make sure we're focusing on our efforts on services that are going to be measured in those communities and the outcomes that are appropriate for the communities (what they're) providing.

Karen Johnson: So, this is Karen from NQF. And this has been actually a great discussion. I hate to cut it off. But, just looking at our time, we have a couple of things that we have to get through. I think we can probably circle back and talk about some of these things a little bit more in this call. But, let me show you where we've landed so far just looking at our measure set. And that may – I think I have some questions.

But, actually, it's quite encouraging so far. So, we started out with many, many, many measures. But, if you'd say let's start with NQF-endorsed measures, we have just over 600 of those. And, then, if you drop out, which I

did for this initial cut, measures that are specific to nursing homes, inpatient rehab, home health, psych facilities and hospice – so, that kind of long-term care piece, which is really a little bit out of scope for this project – you know, hopefully, we'll be funded for future MAP workgroups. We might be able to get into these. But, if you cut those out, that takes us down to a little over 500.

And, then, I did admittedly a very quick cut and landed on a 140 measures that I thought were cross-cutting. And when I say cross-cutting, you know, I don't have a formal definition of that. And maybe one of the things that we can do for – when we write this up is to actually get a good formal definition of what we mean by that. But, in my mind, it was something that either – that crossed lots of patients and potentially lots of conditions. Right? So, just as an example, a readmission measure – an all-cost readmission measure would be a cross-cutting measure in the way that I set this up.

So, the good news here – and I'm not going through all of these – and they don't add to 140, so don't try to do the math because I didn't put every one of them down. But, I feel like that we have – in our NQF portfolio, we do have several measures that we can look at more closely that deal with transitions, certain types of emergency services, immunizations, med recs.

You can go to the next slide. Again, I'm not going to mention all of these. We have some outcome measures that are patient-reported. Those I think specifically get to that idea of patient-centric measures. We've got screening measures. We've got some measures that are – I've called them structural measures for lack of a better word. It's that skill mix, nursing hours kinds of measures. We've got some ped measures – hacks.

So, let's see. Next slide. It looks like this might be a little bit of a duplicate slide. So, apologies for that. Let's go to – yes, that one. We also have lots of measures related in some way to diabetes, not quite as much for hypertension, although that one seems a little odd. I think there's probably at least two or something close to that. With – we have some cross-cutting cost measures and access measures. I didn't have any that I tagged as access measure.

So, if we end up doing access as part of core sets, we'll have to probably look outside of – either look outside the NQF-endorsement or maybe more accurately is to really understand what we mean by access measures. And it may turn out that we have some of those. It's just a little bit of different flavor like it's – like Ira was saying earlier, you could talk about wait times in a doctor's office as an access measure and I would consider it that. But, that might be what we're talking about.

So, the long and short of it is that most of the things that have come up, I think, on the call so far and in our surveys – we will at least be able to have some to choose from, which is great. The idea of COPD – I know we have at least one or two, even though that wasn't on our original list.

So, our questions to consider – and, again, we've already been talking about this. Any other specific conditions – so, if anything else you think we should at least pull for a closer look. Any specific procedures of interest? So, you know, by definition, I pretty much said all of the surgery measures that we have – and we have many – are not really cross-cutting per se. So, I didn't include those as part of the 140. I didn't know what to do with dialysis facilities. I don't really know if that's some – is that a topic that we need to be thinking about? My initial feeling is that's out of scope, but I want to know from you guys. And, then, we're back to this access question, which I think we've already hit to some extent.

So, maybe we can spend maybe – let me look at the – we'll spend 10 or 15 minutes, I think, on this. We have to absolutely get to the Measures Under Consideration list. We are contractually required to talk about those a little bit. But, let me stop here, hand it over again to Ira to help facilitate this portion of the call.

Ira Moscovice: So, I'll just open it up. I think we've talked about the access question a bit. So – and my own feeling about dialysis is that is assumed – I assume it's out of scope. If others feel it should be in here, I guess they should bring it up. But, I guess it's the first couple of questions that I'd be great to get some feedback committee members on, any other specific conditions or procedures of interest.

Male: What about anything upstream or preventive like obesity?

Ira Moscovice: Any reactions to that?

Susan Wilger: This is Susan Wilger, National Center. That's another area where we are seeing an increase over the last 20 years in rural. So, I would be interested in seeing obesity measures.

Ira Moscovice: Any reactions from NQF staff on that one?

Karen Johnson: Yes. I know we have at least one, and it has to do with BMI screening. So, I probably have initially tagged it as one of the screening measures. I don't know that we have – I'm not saying we don't. I'm not sure that there is other obesity-specific measures, but we can certainly go back and look.

Ira Moscovice: Other thoughts on other conditions of interest or specific procedures?

David Schmitz: This is David Schmitz, AAFP. I'll just say in my experience looking at, for example, critical access hospitals in 10 states or so, dialysis is very unlikely to be provided. There's rare instances where it is. So, I agree that may not be the highest priority. As far as looking at other measures which are, I believe, particularly important, certainly mental health and treatment of psychiatric conditions would rank highly.

Shelley Carter: This is Shelley Carter. And I also agree that mental health and behavioral health would be an area that needs to be addressed.

Ira Moscovice: And is that more of an access issue in this context we were talking about or is it more in terms of the quality of services being provided?

David Schmitz: So, this is David Schmitz. I'll give you an example. When I was practicing in our critical access hospital, who had a patient who required psychiatric admission. So, it was very difficult to make the transfer to a state hospital and the hospital had to reconstruct a safe room so that the patient could not injure themselves while the patient received relatively limited services. So, it was access but also – otherwise, sometimes these patients end up in the – in the –

unfortunately in the prison system or in other situations where they are – the outcomes are not good.

So, I do think that if someone has a diagnosis of schizophrenia, bipolar disorder, some specific psychiatric conditions, we can't see what their outcomes look like. And that would be not only an issue of access but appropriate treatment, which hopefully changes and gets better with telemedicine et cetera and the things that we are intervening since the late '90s.

Male: Ira, I would say it's an access issue, although it would also fall into the area of screenings, our patients being evaluated – screened for either behavioral health or substance use issues are part of their daily – their day-to-day primary care.

Daniel Coll: This is Dan Coll with one additional suggestion, possibly fragility fractures. A lot of patients who are repetitive – they are not getting screened. And even after a similar event, they may not get treated for osteoporosis and there's secondary fractures. So, definitely a point of concern for us in our area and a challenge with our resources.

Melinda Murphy: It's Melinda. I have a comment and probably a question. Screening has been mentioned a number of times. Prevention has been mentioned. And I wonder if anybody is doing screening in a truly structured formal way to evaluate new patients as they come in to determine what are the things to be addressed through preventive measures. And if so, are those being done in some kind of age or stage of life-relevant ways. That to me seems to have some merit to think about.

Ira Moscovice: Any other thoughts on this one?

Steve Jameson: This is Steve Jameson from ACEP. You know, thinking of quality care, I guess we (only) think of the providers. I don't know if there is a quality measure. But, is there a way to survey for Certificates of Added Qualifications for those that are doing particular service in rural health? And I guess I am thinking specifically in emergency department. Maybe I had asked Dan from, you know, the PA organization as well.

I mean, is that something that – particularly in emergency medicine, should there be a threshold that a provided should have before they can go and practice emergency medicine, you know, because as it stands, anyone with their license can just go and practice in any area they like and it's up to the institution or the health system to decide it's their – if they meet credentials but should there be something more formal, you know, for a particular area that that provider works in.

David Schmitz: Well, this is David Schmitz with the American Academy of Family Physicians. I'll just say I've done some research in the area of staffing of critical access hospitals, recruitment retention of provider teams. And the structure of who is providing front billable care like front-line care and what their support systems look like is so varied. I think that would be challenging and possibly, again, could have negative unintended consequences. So, I would be cautious.

Daniel Coll: This is Dan Coll as well. There is the discussion of (inaudible) physician assistant world of Certificate of Added Qualifications quite contentious at this point. I have a strong background in orthopedics and only about 1 percent of people have pursued a CAQ and there is absolutely no data in the current CAQ process to show that it improved care. So, it's a bit of a challenge there.

And my colleagues who are in the nurse practitioner world I know are discussing the ARPN consensus model, which is a discussion on who should be practicing in what areas of specialty based on their training. I'm definitely not an expert on that and I defer to my nursing colleagues on that call. But, there is – there is a lot of challenges as far as designating a true certificate that actually shows improved quality at least from my profession at this time.

Kate Buchanan: And this is Kate. We had a comment in our chat box from a member saying that they would like to suggest using the PHQ-2 as a standard part of vital screening. It should be done when checking blood pressure and temperature. So, I just wanted to say that was another comment from the workgroup.

Aaron Garman: This is Aaron. We actually utilize the PHQ-2 in our day-to-day work in screening every patient above the age of 12 coming into our practice. And, subsequently, if it's positive, we refer to the PHQ-9. And we actually picked up a 30-percent increase in picking up people who have depression. So, it does make a big difference.

Karen Johnson: This is Karen from NQF. Thank you for that, Aaron. I wasn't sure what the PHQ-2 was, but I know about the PHQ-9. We actually do have several measures that are based on the PHQ-9, including one that just asks if the screening is being done. Is screening for depression something that's of interest to the group?

Male: I would say so. Yes.

Male: Yes.

Tim Size: Yes. Tim. Yes. I mean, if we're all not depressed in these days, but I'm not sure screening is going to help that.

Male: Right.

Karen Johnson: One more thing that came up in – we had a really nice discussion this morning with the PAC/LTC MAP Workgroup. And one of the things that they mentioned that they thought might be useful – and it kind of touches a little bit on the credentialing and is a little bit different – is the idea of workforce. I don't know yet because I didn't – I don't think I have workforce measures as part of NQF-endorsed list. But, if I did or if we could find some, does workforce issues rise to the level or core set or is that something that we could think about later for optional perhaps or just something else completely? I'm just mentioning it because that was feedback from them this morning.

Male: I think workforce measures are very important just because of the difficulty in getting rural area staff.

Daniel Coll: I agree as well. My wife is a chief medical officer for our system. And recruitment is not always an issue for us, but it is retention even in the – considered a resort community. And I think the workforce (inaudible) is

retention and recruitment and the types of providers are very, very important (for you) – to know what's sustainable in the market (inaudible).

Ana Verzone: I agree as well. This is Ana Verzone in Alaska. And I would say that's one of our main challenges here for sure. And recruiting people experienced enough because a lot of people coming to Alaska are new grads and the type of care we deliver out here (inaudible) for a new grad. So, (we have) similar challenges as well.

Tim Size: This is Tim Size here. And we do a lot of work in workforce. And I guess this goes – my comment in part goes back to Ira's earlier. (A reminder is) – because I'd even answer this differently if we're talking public reporting versus best practices. I think it's a best practice to be surveying your clinicians and your employees about their engagement. I am much less comfortable making that part of public reporting. And for the issue – if it's public reporting, who is accountable, who is responsible. I think it's much more a systemic issue than almost anything else we've discussed.

David Schmitz: And this is David Schmitz again with the AAFP. And having done some research, again, with some folks here on the phone looking at recruitment and retention, I just think that, again, we have to be careful about unintended consequences – so, who is rewarded and who is penalized and how does that affect access. I also think workforce analysis has to be done very carefully with regard to how you count providers, how you count provider engagement, number of hours worked versus patient contact versus availability for particular services.

So, one example would be you can count the number of patients seen in a clinic in a week. Another would be you can count the number of hours providing backup for C-section call in a rural area with low-volume OB. So, both the analysis around workforce assessment as well as the implications or possible unintended consequences on those facilities that need to continue to be reinforced for being there.

Kate Buchanan: Yes. I think that's a – these are all really good points. We really appreciate those feedback and really helpful. In the interest of time, we are going to

move on and we are actually going to skip ahead to discussing the Measure Under Consideration list. We will come back to the rural-relevant measure topic if we have time. But, this is something that we contractually need to do during this call.

So, for that, I would like to turn it over to Karen.

Karen Johnson: It's mine again. Great. So, hopefully, everybody had a chance to take a look at the 2017 MUC list. We love our acronyms. So, there we are. And we are joined in case we have questions about this whole thing by Erin O'Rourke, who is our senior director here at NQF kind of oversees all of our MAP work. So, she can answer any of those kinds of pesky policy questions if you have them.

Just very briefly, we didn't have as many measures submitted this year as we have in years past. So, only 32 measures being looked at by the various committees. Most of them were clinician-level measures for the MIPS or MSSP programs, nine for hospital programs and then one post-acute care measure that was put forward.

So, what we are trying to get from you guys is, to be honest with you, a bit of a general gestalt about what you think about the measures that were brought forward. So, we are certainly not going to go down measure by measure list. But I did (inaudible) the list. And I kind of did a first cut and I said, "Well, gee, these are the ones that, to me, sounds kind of like they might be really relevant." And, you know, even as I was doing that, I was realizing that I – we had never really defined what we meant by rural-relevant. So, it's something else that we probably want to do as part of this work. But, my working definition is relevant to and appropriate for rural providers. So, need to work on that definition.

But, the ones that I brought out specifically were the Hospital-Wide All-Cause Risk-Standardized Mortality measure. So, really, there is really two all-cause mortality measures that were brought forward, one based purely on claims another kind of a hybrid that looks at claims as well as information from EHRs to kind of beef up their risk adjustment model.

There was – for the SNF program Short Stay Discharge measure, Unplanned Readmissions for Cancer Patients, two composite measures, Optimal Diabetes Care and Optimal Vascular Care. Those are both what we call – all are non-composite measures. So, there is five, I think, components in each one. So, you would have to basically meet all five of those components for your diabetes patients. And, finally, Zoster Vaccination measure which – I'm not sure where that finally landed. But, we did learn that new guidelines came out for shingles vaccine. So, that measure would have to get – it had to be re-specified, I think, a little bit to take into account that new work.

But, I think – so, a question for you guys for the next 10 minutes or so, if we need that long, is just overall comments with the current list. These that I picked out seem rural-relevant. If not, you know, there were a lot of very specific measures. So, I think somebody actually referred to those – that list a little bit earlier. There are a lot of surgery measures on that list, I think. So, let me just stop there and see what the general gestalt is.

Kate Buchanan: And this is Kate. I just wanted to let everyone know that the Excel sheet with the MUC list is attached to your meeting invitation. So, if you're wondering where – if you're having trouble finding it, if you open up your Outlook invitation, you will see the Excel sheet that has the MUC list as well as the specifications.

Melinda Murphy: It's Melinda. I have looked at this a little bit and wanted to make a few comments. On some of the disease-specific measures, it was seen that it would be – let me back once. So, I'm thinking in terms of a set of core measures which would talk about the 10 to 20, a second group of measure that are rural-relevant but might be in a second tier. So, in thinking that way, I had first a question about the Short Stay Discharge measure because, as I read, that it looked like skilled nursing facilities, so I wasn't sure it fit.

The other in terms of diabetes care and vascular care – it seems like that would be in a second tier if it were low volume to move up into an upper tier, if it were actually adequate volume to evaluate it. And, then, in thinking in that way of disease-specific that might be cross – that would be cross-cutting but volume would play a part in whether they went to first tier or second tier.

It looked to me like that A1C control, ischemic vascular disease and use of aspirin antiplatelet, the prostate symptoms with diagnosis of BPH, simply pneumonia with hospitalization – all could be considered as potential relevant for either a first tier or second tier depending on volume. And, then, I thought maybe HIV screening would go up into a core set.

Ira Moscovice: This is Ira. I think the volume issue is really important when we consider these. For instance, the 30-day unplanned readmissions for cancer patients – you know, the group really wasn't that keen on the readmission measures. And I'm just wondering do we have enough volume there to really be able to look at that measure if we wanted to. And, so, I think population-based measures are – like the shingles vaccination – obviously for a certain age group. But, those – that's a broader denominator, so to speak, and we just need to keep that in mind if we really are serious about the volume issue.

Karen Johnson: Great feedback. Melinda, just to your question about the SNF measure. It wouldn't really be relevant to the core sets that we kind of have in front of us going forward but, just in general, a feedback to the Coordinating Committee that that one seem like it would fit. And I think a lot of these – you know, I pulled – the ones that I came up with – I was really thinking a lot about the low volume.

And to be honest with you, Ira, your point – I actually have no idea if there is enough cancer patients. I know cancer – certain types of cancer are – have higher prevalence in certain rural areas but not all of them. So, maybe even that one would suffer from the low volume problem.

Ira Moscovice: I mean, that's one of the advantages of – if we have a separate module for access that's population-based, I think we – for some measures, some of the ones we've been talking about today and probably others, you can get the volume there. And, so, I think, you know, we've got to need to balance things – the best way to put it – in terms of what we've historically looked at versus what really is important in the rural context and what can we do in that space.

Aaron Garman: This is Aaron. I agree with you, Ira. One of the other things that can happen often with rural cancer patients is that they get gobbled up into a bigger

system and do not fall back into that rural practice. And as such, we lose track of those patients or lose, you know, activity with those patients. And, so, I don't know how we'd necessarily be able to impact that as a rural provider.

Ira Moscovice: You know, Karen – this is Ira – I'm not trying to make the work of you and your colleagues challenging. But, maybe one hallmark of what we are doing is going to say, you know, you look at this in "the traditional way" and some things might be relevant. But, we also need to look at this in a little different way if we really want – if we are serious about "developing rural-relevant measures." And that different way can be in terms of what's in the denominator. It can be looking at a range of kinds of access issues that aren't as much an issue perhaps in urban environments but that might distinguish this report from some of the other kinds of reports that have been – (John), we want to ask who is that.

Daniel Coll: This is Dan Coll jumping in. As far as the MUCs from the list of 32, the other – I do agree with the general list that was described at the beginning for relevance but also hospital harm performance measure for opioid-related adverse respiratory events and the simple pneumonia with hospitalization.

To the other speakers' points earlier about the variability in providers in the rural centers, we have several smaller hospitals that (feed to us) and have a very broad mix of the physician types and specialties they practice in and also the advance practice providers. And I think that the variability in how we care for these patients is those two measures have some relevance for adverse narcotic use and the – or, sorry – negative effects that require reversal. And, then, the simple pneumonia with hospitalization is definitely, I think – goes with – show up as relevant.

Karen Johnson: And this is Karen. Just real quickly, the opioid measure that you just mentioned is – do you think that one would suffer with the low volume problem or is that not so much the opioid use but the actual focus of the measure has to do with – I think it's – correct me if I'm wrong – continuation of their therapy?

Erin O'Rourke: This is Erin. There are actually two. One is under consideration for MIPS, which is about continuation of therapy.

Karen Johnson: Yes.

Erin O'Rourke: One is for, I believe, the IQR program for hospitals that has to do with an adverse event in the hospital, I believe, if the patients receives too many opioid and needed Narcan while hospitalized. But I don't have the list in front of me, so correct me if I'm wrong.

Karen Johnson: I've got the list and I can't find it. So …

Daniel Coll: I was referring to the latter on page 43 of 95 in the very small box (inaudible) that we've got (inaudible).

Karen Johnson: OK. So, you think that it wouldn't – there wouldn't necessarily be a low volume challenge on that one or maybe for some but not all?

Daniel Coll: There may be. But, I definitely think the variance in the staff and the providers in the rural centers just might be something to discuss. But, I definitely think the pneumonia one has an applicability or more flexibility than that.

But I'd just say that we received from multiple facilities with general practitioners, family physicians, for medical grad and just a lot of variability in who is staffing the rural centers not just advanced practice providers and family practice physicians. But there's definitely variability into our hospital system as well where we have some hospitalist – formal hospitalist trained, but the majority of our hospitalist are family practice and internal medicine and we have some – majority emergency medicine physicians in our ER. But, we also have some family practice providers in our ER and our sister critical access ER.

So, anyway, I just – I thought those two stuck out for me when I think of things that I see on a day-to-day basis and sometimes the variability also in our nursing staff. And that can be – that can be part of it as well when see excess narcotic administration (inaudible).

Karen Johnson: Thank you.

John Gale: John Gale here. You know, in thinking about the issues around opioid use disorders and prescription, I think about working a little lower on the food chain, for lack of a better way to describe it. It's really around prescribing and utilization and prescription patterns rather than – so, that measure on the first page of the MUC list for continuity of psycho pharma therapy – pharma (inaudible) medications for opioid use disorders really is a question for me. It's not an uncommon problem in rural areas. But, the question is are the rural providers managing patients or are they more urban?

So, again, I think of some of these measures as I look at them, thinking really about what are the underlying issues that drive the problem might be a little better. Some of them strike me as being fairly low volume and at a level that's not likely to be monitored or being treated by rural (inaudible) or as often at least.

Karen Johnson: Great. Anybody have any other kind of general reactions to the list?

(Nathan): This is (Nathan) again. And I'm trying really hard to not harp on this. But, for instance, the death – the mortality rate. That wouldn't be a relevant measure necessarily for the rural health clinics – so, the FQHCs – especially if it's calculated on fee-for-service claims because rural health clinics and FQHCs don't file fee-for-service claims. Right?

So, it's hard for me to look at these measures. It could – that could be relevant for our coop or, you know, someone who is billing fee-for-service. But, that is not relevant for rural health clinics, for example. So, that's kind of what I kind of keep coming back to as my confusion, I guess.

Karen Johnson: Well, thank you, (Nathan). And this is Karen. Just to clarify, this is actually one time where we would – we are actually paying attention. As you had asked earlier, we are paying attention to setting an even program. So, these two mortality measures are created and developed and specified for hospitals, not for clinics. So, it wouldn't be an appropriate measure without additional work anyway to even think about for clinics.

(Nathan): Right. But, then, it would go into our overall recommendation or our core set?

Karen Johnson: No. So – and my apologies. Just so everybody is clear on this, the core set work that we are doing – you know, that we started in the last call and we're going to – it's going for a few months on this is separate really from the measures under discussion. CMS had asked us because you guys are so new, we really didn't have a chance to bring you guys aboard to participate fully in the discussions of the other workgroups. So, they just asked us to get kind of a very high-level feeling from you guys about the MUC list.

So, this is a separate conversation from the core set. That said, Melinda's comments earlier still fit even though she – (you put them), Melinda, in this idea of core set. We can – you know, it was a wasted effort on your part, but it's really two separate question that we were trying to ask you. And I apologize for that making that more clear.

Erin O'Rourke: And this is Erin. Just to piggyback on what Karen was saying, we're really (inaudible) your feedback on these measures. The process is that the setting-specific workgroups gives each an up or down vote for the specific program they are under consideration for. However, we wanted to run this list by you to see if what stuck out to you as particularly relevant to rural providers and residents or if there is any of the cross-setting concerns you wanted to bring forward. I think, Ira, your point about moving to more population-based measures really resonated with me so that we can bring this all to the Coordinating Committee as they finalize the recommendations.

So, we take input from a number of sources and bring that all to the Coordinating Committee. So, this is great feedback for us to share and to include to our report to CMS as an input to what measures they may want to move forward with or not. So, thank you for all your work to review it and for your discussion today. And I'm not trying to wind it down if people have more. But, I did just want to piggyback on Karen and clarify the process on how we'll be using your input today.

Karen Johnson: Thank you, Erin. I think, just look at the clock, man, two hours goes by really fast when you are doing interesting stuff. Suzanne, I think you were going to talk just a little bit about our measurement topic. So, we're going to go backward a little bit.

Suzanne Theberge: Yes. So, we did briefly discuss this on the last call. As we discussed, one of the other topics that this group is going to be considering is weighing in on measurement topic. And we had suggested some ideas on the last call. And what we heard was some concern with the inclusion of telehealth, advanced care planning and swing beds. But, again, as we've already discussed some interesting access to care leveraging public and private resources for quality improvement efforts, appropriate comparison groups and post-acute care in rural areas.

So, we had hoped to have a little bit more time for discussion on this today. But, again, we just wanted to put that out there to see if you had any further thoughts or suggestions. We are going to be discussing the whole measurement topic question in less more detail early next year. I think it's on the agenda for our February 14 call. But, we do want to start narrowing down the topics, selecting the topics sooner rather than later. So, in the – in the next couple of minutes before we have to finish up today, I just wanted to see if you all had any further thoughts or anything you want us to add to this list.

Melinda Murphy: It's Melinda. I think you heard some of them in the prior discussion in terms of drugs and alcohol, mental health, depression, obesity. So, I think you'll pick them up from some of the earlier discussion.

Mark Greenwood: This is Mark. When you say swing beds, what are you referring – looking at measuring specifically?

Karen Johnson: Ira, do you want to take that one?

Ira Moscovice: Well, we view swing beds as it's one of the ways to look at the transition or care coordination issue, i.e., from the time that a patient would go into a critical access hospital, then they are transitioned to a swing bed as they need less acute care and then, hopefully, ideally, they are transitioned back to the

community. And that whole process and particularly what goes on in the swing bed is very – there's very little known about it.

And, so, we have viewed this as a gap. We are actually working on a project now. But, we have viewed this as a gap because there's been a real move. Most CAHs have swing beds. And there's been a real move to question whether we need them or not from the federal government. And I think we need to start measuring what's going on and are they having good discharge patterns back to the community and is the readmission late low for swing bed patients and do they improve functional status, for instance, of clients in there.

And those things are being measured because they're required by CMS for SNFs. But, they are not for CAHs. And I think that it's time that we start thinking about – hopefully, in the end game here, required – making that required. So, I think when we talk about care coordination and transition, we need to think about different scenarios for how that might play out and the kinds of measures that are appropriate for those scenarios. This is one example of a care coordination/transition issue.

Tim Size: Yes. This is Tim Size. I just wanted to echo and say I totally agree with what Ira said at this time on swing beds.

Male: I agree.

Suzanne Theberge: So, we don't want to ...

Cheryl Powell: This is …

Suzanne Theberge: Go ahead.

Cheryl Powell: Sorry. This is Cheryl Powell from Truven. And I just wanted to capture I think (our team) that has run through the discussion, which is as focused on population health how are we doing for the population within rural communities as well as in different band, how are rural providers doing. So, I think that focus on population health would be important to highlight too.

Suzanne Theberge: Thank you. So, I don't want to cut off the discussion, but we do have to do a public comment period and we're almost out of time. So, I think we need to move in to that.

Operator, can you open the lines for public comment?

Operator: My pleasure. If you have a public comment, please press star, one on your telephone keypad. That is star, one to make a public comment.

And there are no public comments at this time.

Suzanne Theberge: All right. Great. Well, I think we can move into the next steps.

Madison?

Madison Jung: Great. Thank you, Suzanne. So, for next steps, the next webinar we have is January 25. In that webinar, we'll attempt to – well, we'll see where we get after all of your feedback. It's been great today. But, we hope to finalize methodologies for selecting measures, review and revise a draft core set and identify and prioritize measurement gap areas.

Following that, we'll have a webinar, webinar four. That's February 14. On that, we'll review the draft report and solicit your feedback. And we'll hope to finalize the draft core sets and prioritized measure list. And, then, February 28, we will have the draft report – our first draft report out to you.

As always, this is our contact information. Feel free to reach out if you have any other thoughts or additional suggestions. Our email address is maprural@qualityforum.org. Workgroup members, feel free to utilize the SharePoint site. If you have issues accessing that, just let us know.

And with that, just a big thank you from the project team here at NQF. Your discussions are always great and we always run up to the last minute. So, it's always great to see that.

Karen Johnson: No. I think the only other closing remarks – we're going to decide whether we need to come back to you in the next few days or weeks with another SurveyMonkey. We're not sure yet if we'll need that input from you. But, if

– in the meantime, if you have brilliant thoughts that you want to share, please feel free to do that.

And, then, I think we're not going to be talking until after the holidays. So, happy holidays to everyone.

Madison Jung: Thank you.

Female: Thanks to you too. Thank you.

Male: Thank you.

Male: Thank you. Happy holidays.

Male: Thank you.

Female: Thanks. Goodbye.

END