NATIONAL QUALITY FORUM

Moderator: Rural Health
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3:00 p.m. ET

Shawnn Bittorie: Welcome to the Rural Health Committee Orientation Web Meeting. Please note today's call is being recorded and all public lines will be muted during the meeting. Committee members, please note your lines will be open for the duration of today's call, so please use your mute button when you're not speaking or presenting, please be sure to keep your computer speakers turned off if you have dialed in over the phone, and please do not place the call on hold.

If you need assistance at anytime today, please press star zero and the operator will assist you. For technical support with the web portion, you can also send an e-mail to nqf@compartners.com. Thank you. That e-mail address is currently displayed in the chat box area and will remain throughout today's meeting.

Today's meeting will also include specific question and comment period, you can submit your questions at anytime by using the chat box. Committee members will be part of the live discussion, just simply type your question in the chat box in the lower left corner of your screen. Please be sure to click the send button located next to the box. There will also be a designated public comment period, during which you'll have the opportunity to ask questions by pressing star one and these instructions will be repeated later in the program.

We'd also like to draw your attention to the links area located to the side of the slide. The links area contains links to presentation slides, agenda, materials and resource information relative to today's meeting. Clicking on the links

will open them in a separate web browser window and will not disrupt your viewing of the meeting. And now it is my pleasure to welcome you to today's meeting let's get started.

Severa Chavez: Thank you, Shawnn, and welcome everyone and thank you for joining us on this orientation or meeting for the Rural Health Project. For today's agenda after a brief introduction from NQF staff and members of the committee, we will introduce – we'll introduce – we'll provide (re-centered) orientation to NQF, review project goals timeline and material, describe relevant federal quality improvement program, provide brief overview of healthcare performance measurement, discuss key questions to further refine the ongoing environmental (scan) and sign the in-person happening next month. I guess I'll start the introduction.

My name is Severa Chavez and I'm the research analyst for this project. I'm mainly be providing logistic support along with research work to inform the environmental scan and the final report.

Unfortunately, Mitra Ghazinour, our project manager is not feeling well today so she's had to miss this meeting. And now here is Karen Johnson, the Senior Director for this project. Karen?

Karen Johnson: Thank you, Severa, and good afternoon everyone, thank you so much for joining us, for being part of this exciting work for us. My name is Karen Johnson, I am the Senior Director on this project, which means that I am providing content lead and just basic project direction for the project. So, in terms of your interaction with us, just consider us a full project team, you can send any and all e-mails to myself, to Mitra or to Severa and we are – we will look at those and we work together very closely on this project.

So, just to give you a little bit of background about myself, in case you're curious. I've been in NQF for three years now. Most of my work is with our endorsement projects but I have done some other kinds of work here at NQF. I'm a bit of a numbers nerd by training. For many years, I did a lot of (Epi) work and policy number crunching that sort of thing.

But I'm very excited about this project personally because although I have pretty much lost my accent, every now and again you may be able to tell that I come from a, part of the country, the Central Appalachian Area. So, very much a rural area with very specific kinds of rural issues, so in terms of healthcare in rural areas that's where I grew up and I understand personally some of the issues that are going on. So, again this is a very exciting project for me.

What we want to do in this first part of the meeting is, many of you guys I'm sure already know each other quite well because it is a little bit of a small world but we want to go through the full committee that were able to join us on the phone today and I'd like you to introduce yourself and just give a very brief description of what you work and maybe what made you interested in this project or what you hope to see done with this project or just, again something very brief. So, maybe a minute, a minute and a half per person if you would be so kind and I've put up the slide that shows our committee members and we'll just go in order that are on the slide. So, we'll start and see if Kelly Court is on the line.

Kelly Court: Yes I'm here, good afternoon everyone. So, I'm Kelly Court, I'm the Chief Quality Officer at the Wisconsin Hospital Association. I've spent the majority of my career as a quality leader in a healthcare system that include rural hospitals. At the hospital association here, we have a 139 hospitals in Wisconsin that are members, which is every hospital in our state. And of that 139, 62 of them are critical access hospitals. So, we publicly report quality measures here in Wisconsin, we've been doing that for over a decade and we work with our hospitals to improve qualities and many of them of course are rural hospitals.

I'm interested in this project, because as we publicly report and work with the rural hospitals, some of the existing measures that apply to PPS hospitals are less relevant to the critical access hospitals and rural hospitals. So, I'm very excited about being part of an initiative that could identify measures that are more applicable and relevant to our smaller members.

Karen Johnson: Thank you. Ira?

Ira Mascovice: Hi this is Ira Mascovice, I am a professor at the University of Minnesota School of Public Health and Director of the Rural Health Research Center that's funded by the Federal Officer Rural Health Policy there. And the main focus area for our research at the research center is quality of care in rural areas and I've been involved with many projects over the years that I have assessed the quality of rural healthcare. We've developed rural relevant quality measures for hospitals and I've been involved on a couple of NQF committees related to quality assessment and measurement. So it's a pleasure co chairing the committee with Kelly.

Karen Johnson: Thank you, Ira. (Anne)?

(Anne): Good afternoon, everyone. I am a little intimidated when I look at who's on this committee because I feel like I'm representing a very small sector of solo and very small practice physicians and hospitals. But I'm the director of three different organizations in small rural county in upstate New York. I run a rural health network of hospitals, small independent practice association of hospitals and physicians and we were – our subset of our IPA applied forum was accepted into the 2012 July cohort of the Medicare shared savings program and we are – all of our providers are very independent and want to stay that way and our interest is trying to figure out how do we, you know, raise the quality of the work that they're doing and keep them sort of practicing state of the art modern medicine and not get left behind.

And I think many reasons why I'm interested in this have to do with, I think someone before me so that, you know, are we asking the right questions and measuring the right variables for what is happening in the rural community and also trying to figure out how we can do a better faster job of getting doctors and hospitals engaged in the data, the data feedback – they are really new in many ways to the idea of using numbers. They collect them but they don't use them to feedback and do quality improvement, so I'm really interested in how we can move that forward, thank you.

Karen Johnson: Thank you. Michael?

Michael Baer: Good afternoon, everybody. I am a representative of AmeriHealth Caritas, my (inaudible) AmeriHealth Caritas, but I'm a part of the bigger organization of AmeriHealth Caritas which is a national health insurance company that mainly delve into Medicaid in different states and we have a very, very large rural network in Pennsylvania where I am the network medical director and we cover 42 counties, many of which are very, very rural.

So, from a Pennsylvania standpoint my personal job, I am interested in that because we as a Medicare organization and you have to report up to our health and to our, or I mean the Department of Health Human Services in Pennsylvania to show that there is all the quality of care going on in our counties.

In addition to that beyond Pennsylvania we have a presence in Nebraska hugely we're all there a number of other state, South Carolina, Louisiana, while there are pockets of, you know, highly dense membership we have rural membership in all of our states.

So, from an interest standpoint because we are so rural in many of our states that we cover, I though that should be a great committee to be a part of. I've been on one other committee previously with the NQF and having gotten my feedback was that, this is something that I feel is very cool to be a part of and I appreciate the opportunity.

Karen Johnson: Thank you. (Tanya)?

(Tanya): Good afternoon, everybody. I think I have a very unique perspective to offer being from Wyoming. We have a three provider clinic, my husband and I own the clinic. So, we're almost an extinct type of practice I think in the United States here anymore. We're 40 miles from the nearest other healthcare providers. So, when you talk about rural healthcare, I think we're the poster child for that and we're also within a rural state when our largest population in one of our biggest cities is about 53,000.

So, we are in the trenches of experiencing and living out through – here in rural healthcare but I appreciated and comment and I just want to echo that,

that we really strive to keep small practices like ours practicing by evidence based practice, reporting quality measures, using EMRs and really trying to stay up with what is current in medicine and healthcare.

Karen Johnson: Thank you. John Gale?

John Gale: Yes, good afternoon, my name is John Gale, I am a researcher with the main rural health research center with the University of Southern Maine. I work closely with a variety of small rural provider types such as rural health clinics and critical access hospitals. I currently have a project identify, two projects identifying performance and quality measures for rural health clinics and for rural emergency medical services agencies. Prior to joining the research center I refer to myself as a recovering physician practice manager. I spend in about 16, 17 years managing primary care and theatric practices.

Karen Johnson: Thank you. (Aaron)?

(Aaron Garman): Hi my name is (Aaron Garman), I'm a family practice physician out in Beulah in North Dakota which is a town of about 33,500 people. I work at a federally qualified community health center and I'm the medical director and have been such for the last 15 years. The interest that I have in this commission is that I live this and breathe this everyday. I work at a critical access hospital. I survive in a critical access environment and that's hard to do and so trying to make things a little bit better for us all, better practicing in the rural environment I think is very important, so that's my interest.

Karen Johnson: Thank you. Gregory?

Gregory Irvine: My name is Gregory Irvine, I'm an Orthopedic Surgeon at Saint Luke's McCall in McCall, Idaho which is a small town in the mountains of Idaho of about 3,000 people full time. I practice Orthopedics here, as the only Orthopedic Surgeon in a radius of about 150 miles. I see a lot of rural folks from ranches and farms in the area as well as recreationist and people that come to the mountains of Idaho. I represent the American Academy of Orthopedic Surgery, I'm a fairly rare individual and that I'm an Orthopedic Surgeon practicing in a critical access hospital by myself and have unique needs and concerns and that's why I'm involved in this committee.

Karen Johnson: OK. Jason Kessler?

Jason Kessler: Hi there, good afternoon, this is Jason Kessler, I am the Medical Director for the Iowa Medicaid Enterprise. I'm a pediatrician by training and have practiced in a wide variety of settings, including both, sort of urban and rural areas. As a state Medicaid Medical Director, I'm very involved in looking at performance and quality measurement for medical care across the populations within Medicaid and I've really discovered, Iowa is a largely rural state that there really are differences in looking at, in looking at practice settings in rural areas, in urban areas, suburban areas, all these different categories of things. But the rural settings tend to be, maybe the most diverse and difficult to really get a hand on, on what's going on there. So, I think that from my perspective I'm going to be looking at not only what we're measuring, what we're looking at but how we're measuring it and how we're – and how we're able to look at it and that is my perspective.

Karen Johnson: Thank you very much. Jason Landers?

Jason Landers: Yes, I'm Jason Landers, I'm the – just started a new position as the Executive Director of a Medicaid MCO that provider-owned. The previous three years I've spent doing PCMH program for Highmark in Highmark West Virginia and my interest in this is, in a PCMH program you have a lot of measures that are, maybe not as relevant to rural practices and that kind of become known as the, what about West Virginia guy because I'm perpetually asking that question. What about a rural area? And so, it's incredibly important to the entire state of West Virginia to have measures and programs that actually work in a rural area.

Karen Johnson: Thank you. Bruce, is Bruce Landon on the line? OK, we'll circle back and see if Bruce is able to join us a little bit later. How about (Jonathan Merrill)? OK, (Guy)?

(Guy Nuki): Yes, I'm here. Good afternoon everybody. I'm a physician, I trained initially in family medicine and after nine years of doing rural family medicine and then some academic, 10 years ago I switched to full time emergency medicine. I'm in Maine and I work for a private group of emergency medicine

physicians, we staff different hospitals, our most rural is a five-minute drive from the Canadian border and a two-hour drive from the next hospital.

I am most interested in this, because what I do in the smaller hospitals is try to improve the quality of care by, you know, putting together quality measures and trying to extract the data and then get, and change. And it's, it's fairly easy for emergency medicine because the docs all work for me and the – all buy into the philosophy. But what I found is that really what I need to do is me to spill over to the rest of the hospital, because I'm doing just emergency medicine I'm not really focused on any of the outpatient measures but there's a lot of challenges in getting this – getting of this quality measures and getting people to move forward in this in some of this smaller rural hospitals in town.

So, I think (Aaron) said it very well which is, you know, this is hard and if there's anything that I can do to make this easier and better that's why I've joined the committee.

Karen Johnson: Thank you, (Guy). (Kimberly), were you able to join us? I think (Kim's) flight was delayed and she's actually in the air right now instead of being able to be on the call. So, we would hear from her probably not in this call but in our in person meeting you'll get to meet her. (Robert)?

Bruce Landon: Hi, this is Bruce Landon, I'm here now.

Karen Johnson: Oh hi, Bruce. Go ahead and introduce yourself.

Bruce Landon: And I didn't realize my computer didn't have a microphone working.

Karen Johnson: Go ahead and introduce yourself, Bruce.

Bruce Landon: All right. So, my name is Bruce Landon I'm professor of healthcare policy and medicine at Harvard Medical School. I practice in the largely rural area of Boston. Throughout my career I've been mostly a health services researcher and I've done a lot of work in quality measurement, feedback performance reporting and the like, including both academic papers and working with some of our local health plans to develop strategies for performance measurements, feedback and paper performance for physicians

in the network. And in my head I see a lot of similarities between rural physicians and small group practices and individual solo practices, even here in the big city and they bring up, it raises a lot of methodological issues related to the way that we measure and report quality. These are some issues that I've written about and thought about it in a, I guess was after joining the community for that prior more methodological expertise.

Karen Johnson: Than you, Bruce. (Robert)? Are you on the line (Robert)? OK, how about Sheila?

Sheila Roman: Hi, this is Sheila Roman, I'm a physician endocrinologist, currently an independent consultant in performance measurement and quality improvement. I was formerly until January actually, a Senior Medical Officer at the Centers for Medicare and Medicaid Services where I was a Senior Medical Officer for 14 years and went to the agency when hospital compare was on initially started. So, I'm totally aware of the issues with measurement around hospitals.

I've also been involved in measurement in the physician quality reporting system, the outpatient quality reporting system and my most recent appointment at the Centers for Medicare and Medicaid Services was with the value based payment modifier. I have a lot of knowledge about performance measures and quality improvement and certainly the issues that come up when you try to measure both in rural and in small group practices. And my interest in joining the committee is to understand, help understand what measures are most relevant to rural medicine and to clearly identify the methodologic problems that surround measuring in this environment.

Karen Johnson: Thank you. (Susan)? (Susan Sanders) on the line?

(Susan Sanders): Yes, good afternoon, everyone. I am (Susan Sanders), I am a nurse midwife in Women's Health Nurse practitioner. Like several of the other practicing clinicians in rural health, my entire career has been spent in the Southeast, either Arkansas, Mississippi or Tennessee. And very (inaudible) and aware of the needs and the problems that face clinicians in rural health.

Currently, I'm with the healthcare system in Central – that covers Central Mississippi with several rural health clinics in critical access hospital. And I am looking forward to being a part of this project.

Karen Johnson: Thank you. Stephen?

Stephen Schmaltz: Hi this is Steve Schmaltz. I'm a trained biostatistician and I work at the Joint Commission in the research department. The Joint Commission beside accrediting hospital also is a big player in the measure development area and I work in the department that's involved with performance measurement. My interest in the project really came about through measure development effort at the Joint Commission and developing measures for critical access hospitals, that happened a couple of years ago. And I assume that a lot of the same issues brought up for critical access hospitals will also pop up for other healthcare organizations.

Karen Johnson: Thank you. Tim?

Tim Size: Hi, good morning or good afternoon. I'm Tim Size, the Rural Wisconsin Health Coop and the 35 years as their Executive Director. We're a shared service and advocacy collaborative of 39 hospitals, three quarters are (CAS), the quarter are small EPS, 20 nurse. I should add we have a very close collaborative working relationship with Kelly in the Wisconsin Hospital Association which is not always the case with group such as ours.

In addition to really long standing work and quality reporting improvement, we'll probably also bring to this conversation our experience, representing our members and negotiations with payers commercial Medicaid and others and particularly around increasing discussions around outcome metrics value base purchasing. I think for the reasons already stated – not only think, I strongly believe for the reason stated, the work of this committee is extremely important and I guess, I think personally I think somewhat overdue.

My real concern is that if we're not successful and I think you put together the right team to be successful, rural providers are just really going to be an

increased risk of being seen as a clinical back wood or end and I think that would be a real, a real injustice for those providers and the people they serve.

Karen Johnson: Thank you. Brock, I don't know if Brock has made it, I think he was going to come late to the call. Let me circle back and see if (Bob Brown), I see that you're on the Webinar, maybe you didn't have a chance to call in, so maybe a little bit later, those of you who didn't get to introduce yourself, maybe we will be able to hear from you or if not we'll meet you at the in person meeting.

So, I wanted to give you, I'm not sure I know several of you have quite a bit of experience with NQF but maybe not everyone does and not everybody knows what NQF is about. So, I wanted to give you a very brief overview of NQF and what we do and just because of time and because we spent a little bit more time getting to know each other which I think is very valuable. I'm going to roll through this very quickly but I'm happy to answer any questions or clarify anything as we go through and that's going to be the case. For all the stuff that I'm going to talk about and then the last hour or so in the meeting is only going to be discussion time.

So, let me just launch into this and feel free to interrupt if you have questions. NQF is a non profit non partisan membership based organization. We were established in 1999 and we have several unique roles. We see ourselves as a gold standard for quality measurements. We are a convener, and as such we feel that we actually bring together the key leaders in quality.

So, as a forum we have 420 organizational members and annually we have more than 800 folks, experts who are very busy, very well known, very proficient in their field. They volunteer to work with us in the ways that you guys are doing.

NQF is also committed to transparency, so everything that we do is open to member participation and a lot of what we do is open to just general public participation so you may or may not have noticed that this is a call that is open to the public. We encourage public comment, we make all of our transcripts and et cetera available to the public. So, just remember that our meetings and our deliberations are meant to be transparent.

NQF has a role and many of the pieces if you will of the performance measurement life cycle, we had a pretty significant role in providing input through our convening efforts into the national quality strategy. We endorse measures through our measures application partnership. We assist the federal government in the measure selection for the various federal programs, they are using quality improvement. And then we have another group within NQF that we think spurs action in that, this project kind of falls under that piece.

So, let me show very quickly through some of their activities. We have 600 plus endorsed measures right now across multiple clinical areas. We have 11 it handles standing expert committees for our endorsement activities and we're actually feeding two additional standing committee right now. Our measure applications partnership again as I mentioned advices HHS on selection of measures for federal programs for Medicaid and for health exchanges.

Our national quality partners is a convening of public and private stakeholders around critical healthcare topics. And we also do other activities, many of which are related to measurements in some way. So, we have a very diverse set of activities that we are engaged in.

For those of you who are not as familiar with NQF endorsement, it is an (eight- step) process, the endorsement process. It typically requires anywhere from 9 to 12 months to go through that process. Stewards bring their measures to us and when they do that they agree to certain things that they will do. And then we have committees of experts, people such as yourself with expertise in relevant areas that use our standard endorsement criteria or evaluation criteria to decide whether measures really meet the bar for NQF endorsement.

Why are endorsed measure and why does that matter? Well the main thing is because it gives providers a snapshot of how they're doing with the idea that, that kind of information should spur improvement. It also gives information to payers, it gives information to patients so that they in some cases can select the providers that they feel are the best for them and also standardized endorsed measures, hopefully reduce burden associated with having too many

measures out there that are very similar but just a little bit different and just creating resource waste almost in the home enterprise.

The MAP, the Measure Applications Partnership that is convened by NQF was created in response to the Affordable Care Act and we are the neutral convener mentioned in the act. And right now, the MAP volunteers comprise, I got a 150 individuals in 90 different organizations. Again, I've already mentioned that we, the MAP members provide input to HHS on measures for inclusion in the various public programs. They encourage alignment across public programs and also between public and private programs to the extent that they can and they also, also as needed provide input on other areas in HHS such as the health insurance exchanges programs for duals for example.

The structure of the MAP, we had it structured as four different work groups that work under one big coordinated committee and then has forces pull from members in a different work groups as needed for specific request. This why this shows very briefly how some of the programs, the federal programs that are considered in the MAP process are distributed amongst the various work groups. So, don't worry I went through that fast, there is not a quiz on this afterwards.

The other things that, some of the stuff that NQF does, we have the national quality partners group of organizations and individuals and they do action team, so that's what we have and basically they are a little bit more on the ground, they're not thinking about endorsing measures or about selecting measures but they're actually trying to spur improvement on the ground and right now we're gearing up to do a action theme on anti-microbial stewardship.

We also have different committees that are working on various different frameworks and guidance so we've listed some of our newer projects that we've had just kicked off recently. Health IT and patient safety, home and community based services and there's our project of rural and low volume providers. We also have work, quite a bit of work going on related to population health.

And then we also have some, some work dealing with measure alignment. So, with that let's – I want to talk a little bit more concretely about this project particularly. So, the goal on the project is to provide multi stakeholder information and guidance on performance measurement issues for rural providers. And when we say rural providers, we are looking at the ones that are on your screen here, critical access hospitals, rural, community health centers as well as small hospitals and small practice offices. So, we're interested in measurement of facilities and then measurement of clinicians who work in these kinds of facilities, either the hospitals or the clinics.

Part of this project, as I'm sure you can imagine will entail an environmental scan of measures and programs that are out there. We are, NQF staff are working on that right now. We will be getting from you as your expertise, the multi stakeholder input as, you heard we had a lot of different voices around the table already coming from a lot of different perspective, so that's what NQF does, we bring together the multi stakeholder voice. And then we will, at the end of the project we will have a written report of recommendations from you regarding performance measurement for rural providers and it's pretty much of the context of federal payment incentive programs.

So, the idea here is that with ACA and with the evolution if you will of how CMS and the country as a whole is looking at measurement, it's going along the continuum from reporting to public reporting to now programmed and folks are making decisions and actually affecting payment.

And as you know (inaudible) providers, particularly the ones that we are focused on the (CAHSR), RHC, CHCs had been excluded from most of the major programs, either because they are not paid through the prospected payment system or they aren't paid through the Medicare physician fee schedule or because of low volume problems. They're (filling) in different ways that a lot of the providers of rural side are excluded from these programs and but that will be changing as different programs evolves, more of the providers are going to be brought into, into these programs.

So, we will be getting recommendations from you on things including but not limited to measures then are most appropriate. How perhaps resources should

be used or in what ways they should be used to identify measurement gaps if there are any and we want to talk about the different challenges of measurements for these rural providers and think about ways that we might could mitigate some of these challenges.

The scope is a little difficult to scope this project but we want to think about various issues facing rural providers and there are many. One that we know for sure if the low case volume but we also want to think about others so it's not solely a methodological project. So, we'll be talking about other issues.

There seems to be possibly a little bit more information now about critical access hospitals. They have been able to participate in some of the federal CMS programs, there seems to be a little bit less knowledge and information about how measurement can be used in the outpatient setting and at the clinician level rather than just at a facility level. So, we do want to include facilities but we don't want to only focus on facilities and hospitals.

And then finally, we want to focus primarily on primary care and I think you probably realized that based on the committee members that we chose but that said we also realize that primary care practitioners work with specialist and primary care may mean different things to different people and rural health centers for example do a lot of different things, you know, even though CMS is concerned mainly with the older folks. They also have plenty of younger folks, under age 65 who has different kinds of needs. So, again we're going to try to focus primarily on primary care with the understanding that we may need to work outside that box to some extent.

The general timeline for the project, we actually began this believe it or not in September when we put out our call for nominations that entire process takes us about three months to put out the call and to evaluate the nominations and to actually (see) the committee. And we have began work at that time on our scan.

We are holding our web meeting today and we'll also be delivering our environmental scan and reports in a week or so to CMS. And then rapidly following we will have our in person meeting, after that we will have a report,

a draft report of the in person meeting and we will be asking you to opine on that draft report and help us to clean that up. So, that will be something your responsibilities as the committee members to help us with the report, and then we're going to put that out for public comment and actually ask folks in the public to comment on your recommendations and then bring those comments back to you once more as a committee and consider the comments and make any changes if desired to the report which we will deliver the final report to CMS in August.

So, hopefully you have been able to access the project materials and at this time I'm going to switch leadership or actually somebody's going to switch leadership of this to me and we're going to show you our project SharePoint page, that's how we will be in the future providing materials to you, you should have been given a username and password so that you can get into this.

And this is the page, this is what it looks like, you go in and your first page is the committee home and what you see here, we don't have too much at want right now but, so there if you will just kind of use the map and point out, we have some general documents there including the rural, the roster or city. If you want to look a little bit more closely at your fellow committee members, you can pull that up and look at it.

We will have – we will post meeting materials there. You can see that here is the agenda and the slides that you can take a look at. And we'll be posting the transcripts and that sort of thing there as they come through. And there maybe other kinds of things that we want to post here, so this is how we will be communicating with you. There's a calendar on there, there's some contacts that sort of thing.

So, again, I just wanted to make sure that you guys are familiar with this, not so much in the call right now but if you are having problems accessing this or finding your way around in SharePoint which is not always intuitive, please do let us know as soon as possible so that we can make sure that you have access to all of the materials that you'll need for this work.

And Severa, if you want to, looks like, have you given me leadership back for this, if you can make me leader again that would be great. All right.

So, let me stop there and see if anybody has any questions before we go forward. OK. So …

(Bob Brown): This is (Bob).

Karen Johnson: Oh yes, go ahead.

(Bob Brown): This is (Bob Brown), I'm sorry my microphone wasn't working earlier so …

Karen Johnson: Oh hi, (Bob).

(Bob Brown): I'm a family physician and chief medical officer at Rural ACO Primary Care (Round). So, my best interest is that we're actually using a lot of these quality measures and interestingly I was just at a meeting with Michael Baer's colleagues from Arbor Health Plans, Nebraska discussing our NQF members for our next contract. So, that's my background for this one.

Karen Johnson: It's a small world, thank you, (Bob).

(Bob Brown): Yes, pretty small.

Karen Johnson: And Brock, have you joined us? No, OK, someone else?

(Tim Size): Hi, I sent in two questions on the chat but maybe they didn't pop up. The first one is, could you just, I'm not familiar with the term you talked about, I think it was measurement steward?

Karen Johnson: Right, OK. Yes the measure steward is basically the organization or entity that owns the measure. Often the steward is somebody like CMS, you know, the people who are responsible for the measures and they may or may not develop the measure themselves. So, they may contract out with other organizations or folks to actually develop the measure. So, at NQF actually some of our legal stuff we actually deal with the stewards as a measure but often sometimes the developer is the steward. So, I can get more detail later.

(Tim Size): No, that's fine, I thought that maybe it was it, I wasn't sure. My second question, could you describe what you anticipate to be the process CMS will use once they receive our recommendations?

Karen Johnson: Let me see, you know what, I apologize because I meant to, in our introduction I meant to open the line of our CMS and HRSA colleagues were on the line, I know a few are listening in.

So, with that, let me stop, see if Marty, (Kurt) or (Derma) would like to introduce yourself if you're on the line and also see if you want to respond to this question or this might be something that we'll put on hold and come back to a little bit later. So I'm not sure if Marty, (Kurt) or (Derma) want to say hi?

Marty Rice: Hi Karen, this is Marty.

Karen Johnson: Hi, Marty.

Marty Rice: I'm Marty Rice. I'm with HRSA Federal Office of Rural Health Policy. My background is that I'm advanced practice nurse, I'm board certified in nursing informatics and we, the reason why we brought this – actually this whole request for this project came from the Federal Office of Rural Health Policy through CMS to, with the contract for the consensus base entity with NQF and CMS thought that this was worthy enough project to bring it forward. We saw a gap in the incentive program from CMS and, you know, hopefully we'll be able to look at, you know, whatever the results were going forward. (Kurt) do you want to introduce yourself and (Derma)?

(Kurt): Hi, this is (Kurt), I don't know if you can hear me.

Marty Rice: Yes, we can.

(Kurt): Yes, welcome everyone and thanks for participating. Yes, Marty described our purpose. I don't have a good answer for how CMS will use the recommendations though and I think it's probably as useful to get the CMS response to that. I don't know if there's anyone at CMS on the line on this point though.

Karen Johnson: I know (Cindy) and (Fiona) were not able to make the call, so I'm not sure if we have any other CMS colleagues on the call right now. That's something that we …

Marty Rice: We can't say how CMS is going to use it because we can't speak for CMS so you can go with the sister agency whereas but I think that we're trying to gather information on what is different about rural and bring it forward as a topic of conversation, say that the measures might not be a great or perfect fit for better use to the general populations in urban areas, be used in rural areas.

There's even basic misunderstanding, so what federally qualified health centers where some people think the federal qualified health centers were only in rural areas, they're all over the country, there's FQHCs in Downtown D.C. so I think bringing up the topic of what is different, what the patient mixes what, you know, especially what is the provider mix, you know, what type of providers – activities do you do that are different in urban facilities.

I mean it (equates) – I grew up in Baltimore City and education for myself to understand health – you practice, the practice of medicine in rural communities is absolutely phenomenal. I mean I have never seen better care anywhere. And we need to understand how that care is being practiced and how it's a little bit different to be measured that information forward. So, I think it's an information gathering pushing it toward and then usually some of the selection processes for measures being able to look at this information.

(Bruce Landon): I think the primary motivation as Dr. Roman can attest to is that most of the CMS focus on quality with respect to how they're going to use quality measures in developing the value modifier has been with larger group practices and that leaves the small practices out above urban and rural as well as most of what happens. A lot of what happens in rural areas because they just don't have the denominator to do some of the measures. So, the methodological issues as well as other issues that we're interested in.

Ira Mascovice: This is Ira, would it be within this preview of this committee then, to make recommendations how we think CMS should use the work of this committee?

Karen Johnson: And this is Karen and I think if the committee feels strongly that that's a recommendation that they would like to make then certainly.

Ira Mascovice: OK.

(Bob Brown): Yes, this is (Bob Brown), I'm going to actually second that, we have a mostly rural ACO and we're hampered by some of the requirements in the critical access hospital issues and so we'd really love if we could have some general recommendations in that area.

Karen Johnson: And just a little background from the NQF perspective. Often times when we pull together a multi stakeholder committees for our recommendations, you know, often there are, you know, they may – committees depending on the subject matter may end up with, you know, short term versus long term recommendation for, you know, measure specific versus programmatic versus policy types of recommendations. So, there is not always a box around what you can do it often can be quite broad.

Marty Rice: So, Karen, this is Marty again. I think that really the charge of this committee is to make recommendations and honest recommendations on what they feel is necessary and I think – scope and I don't know how you would like to frame that sentence.

Karen Johnson: So, you now, I think we definitely want to talk about measurement right? And to some extent maybe even quality programs, you know, and or effort. So, I think as long as it's a scope there, we're good. Again we do want to talk about primary care and practice so, and I neglected to say this earlier but some of the things, it may be easier to talk about what's out of scope.

So, like for example, even though it's probably a really big issue, access to care itself is probably out of scope for this project. So, we realized that there are issues about access but others and how that might mesh with types of measurement that could be used for rural providers that probably we would consider that out of scope.

And similarly measurement about or thinking about other kinds of facilities such as SNFs or hospice that sort of thing because we are focusing only on

certain kinds of clinics and the clinicians who work in those, those kind of facilities and therefore the measurement issue and rural issues around those would also be out of scope. So, hopefully that helped some.

So we can continue – oh go ahead.

Marty Rice: Speak to, a lot of the things that CMS measures weren't done in like emergency settings or in critical access hospitals that are in hospital compare and I think some of Ira's work, like the patient transfer measure from EDs, I don't think CMS really kind of understands the way rural healthcare does business and how, even though they provide excellent, excellent, excellent care, there's a little bit different – business policy when you're working in a rural community with only one orthopedic surgeon within a 150 mile radius. It's a little different.

Karen Johnson: Right, so let's go forward for now unless you have additional burning questions, but we can always come back and continue picking at this because I think what I learned so far is that, you know, this is a huge, huge, thing to try to wrap your mind around. So, you know, I think as we work through this we will land where we need to land but, but, you know, let's just keep talking about as we go through.

I was going to give you a little bit of information about the various QI programs that CMS has now, since we are particularly thinking about things in terms of paper performance but I'll just flash the slides up very briefly and kind of reiterate that CMS has different types of programs that do different things. So, some will pay for reporting only, there are some programs hospital compare and soon to be physician compare that are actually public reporting of performance rate and then other programs that actually have a monetary either incentive or penalties associated with them.

This graphic tries to give at least a flavor of the relationships between the programs, it's not completely accurate of how it works but I think the bottom line for this is even though there is a lot of measure and a lot of programs there is alignment to some extent with some of these programs.

And then the question that you guys have already alluded to on several occasions is, you know, are these the right measures, you know, are some of the measures that are used for example in IQR that may become measures that are used in (VPP), are those really the right measures for world providers?

And then these are the various programs for the clinician side of things, again pay for reporting, public reporting and (P for P). And then we also put in the Federal ACO Program which actually brings in facilities and clinicians and suppliers but that is another way to think about measurements and it's something that might be worth discussing among the committee in terms of, you know, what if you don't have enough numbers to work with clinicians. Are there other ways to measure quality of care and helps for improvement? So, we'll get into that discussion a little bit later. Again another way to show the relationship between the federal clinician programs.

And this is something that I think I'm going to maybe offline a little bit later, maybe Sheila will be able to help me with but we've already talked about this a couple of times, (CHS) are excluded although they can report on a voluntary basis to hospital compare that they are excluded from the (P for P) portion of that. Some programs, their, the non-PPS facilities are not included, clinicians who work in this kinds of programs may not be included in the federal clinician programs and even if the clinicians and we've alluded to this before. Even if clinicians aren't working this particular kind of facilities, if they're small practice, either small practice offices or small hospitals, just the small numbers problem is – can be a problem for our rural providers.

So, we'll come back with this, I actually have some question marks here, simply because legislation and programs evolve over time. So, there has been movement in terms of bringing some of these clinicians and or facilities into the fold of these programs and I'm still working on trying to completely understand that.

So, Sheila look out I might be sending you a question or two that maybe you can help me understand. And I'm going to pause just for a second before we go into the next session of our meeting. Brock you're online now? Can you

just give a brief introduction of yourself since you weren't able to join us earlier?

Brock Slabach: Oh, thank you. Yes, it can be, my name is Brock Slabach, the Senior Vice President of the National Rural Health Association and I am in the (Leawood Campville) office from our (group). We're a National Association that advocates and promotes leadership on rural issues and one of the – each of the work that we've been involved in of course has been the quality and quality reporting. So it's great for NQF to provide this opportunity to chairing the work on this group. I think it's going to be really good.

Karen Johnson: Thank you, Brock. So, I'm sure most of you know as much and probably much more about health care performance measurement but I thought it would not be appropriate not to put these slides up, measurement is used to quantify performance in different aspects of the health care system.

The goal is to improve quality of health care and ultimately the quality of our health in our nation. There are different types of performance measures and these are some of the issues that you may get in to in your discussions and deliberations. Outcome measures including patient reported outcome measures. We have intermediate clinical outcome measures process and structural measures. We have measures that look at resource use of our cost. We have measures of efficiency which is some kind of combination of quality in resource use and there's different ways that folks are combining these kinds of measures to be able to get a flavor of efficiency.

And then we also have, and I think of them a little bit differently, we have measures of population health. We know that under the ACA, the National Quality Strategy was born if you will, it was created. And the National Quality Strategy basically articulated three objectives or aims for health care improvement and fixed priorities for working on those objectives. So, the aims are better care, healthy people and more affordable care and then the priorities are as you see them in the diagram there.

So, in terms of thinking about measures that are available, we're going to use the National Quality Strategies in organizing framework just to use an organizing of the measures that are out there.

I will tell you that in our scans and measures that we've done so far, we've identified over 1600 measures that are in use right now in the various central programs or in some of the other shops if you will, and that is nowhere near a complete list of all the measures that exist. Lots of folks create measures for use in their own shops, for their own key-wide purposes. So we, you know, won't necessarily have those in our list but there's a lot of measures to choose from.

And again, the question will go back to you or, you know, are these the right measures for rural health care providers? If they're not, you know, can you tweak them in some way to make them better, what's missing, what should be there. Again, those are just some of the questions that you'll be thinking about through this project. There are, as you know, tensions in measurement. Some people would like to see a few good outcome measures and other people want to see a lot of specific process measures regarding improvement. There's tension between measuring at the clinician level versus at a system level, you know, or even somewhere in between a facility level.

Burden is a real issue. You want to minimize burden but yet you want to have enough information so that purchasers and consumers can make the choices and another one is obviously, and we've talked about this already, you know, do we need a course that really works for rural providers or that we want to think about, it's the idea of a library versus a library of measures versus a very parsimonious set of measures that might be it. So these are just some of the tensions and I think we've already touched on some of these as you start thinking about recommendations on how you want to think about what you would recommend the CMS.

You have to think about, you know, accountability and also the dual need for improving quality. So not just payment but for quality as well. Again, the types of measures, who's being measured, rural relevancy, that's come up already today, the methodological challenges has come up.

And then another thing that we are hoping to get from you on the committee is some lessons from other folks, you know, other folks are using measures, not just CMS and what have we learned or what do you know from interactions with other entities in measurements and how might some of those lessons be something that might be useful and informative to CMS.

So with that, and knowing that I'm actually a little bit behind time although we've already had some good discussion, I'd like to stop, but let Karen speak now and actually start listening to you. And I've selected several questions to just get us started. I'm not sure how far we'll get along with this but I would like to spend maybe 5 or 10 minutes, not very much time just maybe five minutes or so on what you can see as some of the key role issues that would impact measurement for rural providers.

Now, on the slide, I've shown up some that I've seen as I've done reading and thinking about this. These may not even be relevant anymore. They maybe used to and they're not anymore but if maybe some of you can just maybe throw out some of the key role issues that we would really want to keep in mind. I appreciate that.

(Bob Brown): Yes, this is (Bob Brown). One of our major issues is that our electronic record program just frankly just can't pull other quality measures and then the rural clinics often don't have a local I.T. person who can pull them. We have people who are very interested about the state of meaningful use, unfortunately it's not lived up the expectations and so, the ability to pull NQF quality measures would be helpful for the clinics to share the other EHRs.

Bruce Landon: So, can you clarify this, Bruce Landon. Can you clarify that a bit? So you're saying that a lot of the providers that you're familiar with have EHR systems but they just are up to the capability of doing sort of population health metrics?

(Bob Brown): Yes, all 12 of our clinics have EHRs, but not all EHRs are created equally. Some have well-recognized flaws in their programs. I think GE Centricity for example was known that although it passed certification, the measures

actually produced were not correct and so people had to manually recreate the pulling of quality measures because EHRs aren't in practice not – they can't really do it, so …

(Crosstalk)

Bruce Landon: … that's an issue that is not unique to rural areas.

(Bob Brown): Yes.

Bruce Landon: I mean it's actually imagination.

(Bob Brown): Yes, but the issue is that say Broken Bow, Nebraska, they don't have somebody who can – locally keeping those crystal reports and pull them out around the system whereas in Omaha, it's easier to find somebody like that.

(Guy Nuki): Right. This is (Guy Nuki). And, I want to second that. I think it's actually part of a larger issue which is just the support around the clinicians for, you know, the workforce capacity for QI as you had it written here. But it's the workforce capacity for all of the support that, you know, collecting data, analyzing it as well as just to support for the financial practice of medicine. It's not always there. It's very hit and miss.

Some communities, there maybe single individuals excellent at something and is able to solve those problems but in some communities, if you want to try to fix, you know, some problem, you know, do some problem-solving with your EHR, there's nobody in the community that can do that. So it's a lack of the personal resources that becomes a big issue.

Bruce Landon: This is Bruce again. Can I ask, is there any data that we can bring to bear that will provide us information at least on, you know, the state of EHR adoption and rural practices?

Karen Johnson: That's actually – This is Karen again, that's a question I was going to ask you because I think I saw this within the last couple of weeks, an article or two that says, "Hey EHRs are all over the place now even in rural areas." And it seemed to be a little contradictory to some of the other work that's still fairly

recent. So I was hoping that someone on the committee would have a good take on that.

Tim Size: This is – the same article but actually but I forgot the source, I can find it and send it to you. It actually said that the adoption rate was now higher in rural.

Karen Johnson: Yes.

Bruce Landon: Yes, higher meaning that there's a higher rate of uptake for those who don't have it or that they actually have a higher level?

Tim Size: That more physician practices had electronic health records.

Bruce Landon: So a higher level?

Tim Size: Yes.

John Gale: I saw that same study and there were some flaws in the methodology. What we've done – we have a study coming out on EHR uptake, adoption by rural health clinics. And what I've seen from some of the other literature is that the growth in adoption is greater among those small clinics and small rural providers that did not have any EHR but they're not exceeding other urban providers.

Tim Size: Yes, let me make …

Female: And so this is …

(Crosstalk)

Bruce Landon: Do we have any data on this for our community health centers and rural health centers?

John Gale: We have a couple of set. We have one study that have – based on small numbers and we're in the process of finalizing to send to (ORHP) on numbers from about 650 rural health clinics.

Tim Size: I wanted to just to add, I think the – obviously, this empirical question of hopefully we can answer, I think it's just – important early in the conversation to note the wide variability we've got and we've had I think somewhat better success with EHRs and maybe a couple of stories I've heard.

Although I know there's a lot of variability within our state and I think one of the challenges for this committee is you know, how do we recognize that diversity where people are at and not put too strong a burden or – a burden on people that they can respond to on one end or artificially hold back others who are ready to go on to the next level.

I mean I think an appreciation of this diversity is really important on almost every issue we touch on.

Bruce Landon: And this is Bruce again …

Female: Oh yes, I think the …

Bruce Landon: That's for the NQF staff that, maybe it might be worthwhile somebody touching base with someone in the ONC Office to see if they can provide any, you know, additional data to this issue to speak of that. I think this is going to be sort of a key piece of background information that we need to keep in the forefront as we consider, you know, all the issues that are going to come up.

Kelly Court: I think this goes – this is Kelly, I think this goes deeper though than whether an organization has an electronic record. I think the deeper question is, the rural practices in hospitals don't have an I.T. department and data analyst sitting around, waiting to extract data from the EHR, so first you have to have electronic information but more importantly, you know, do you have – there's lack of a support system to actually pull measures and then do something with the measures.

I think the other thing that we hear from the smaller rural hospitals is if the data collection data burden – so we're talking about departments that have one person. And so oftentimes, most of that person's time is spent collecting data, you know, abstracting measures versus actually using the measures for improving patient care and I think that's the problem.

And so the doability of – understanding these are scarce resources and we have to not spend all their time collecting and reporting data.

(Tanya Bartholomew): This is (Tanya Bartholomew) and I would second that. With a three-provider clinic, my patient care coordinators who was funded by philanthropic funds. This goes even deeper to the financial incentive.

If you're paying someone to collect and run data metrics, then you have to pay someone to use them. But the insurance companies are not paying for this service until you are either a PCMH or some sort of – you've been credentialed by some sort of formal body to demonstrate that you can help the insurance companies save money.

And so, I think that that initial financial burden is really, really difficult for small clinics to overcome, to even fund a position for someone to do the metric collection. I mean, my front desk girl does the care coordination. She checks patients in. She takes blood pressure. She calls patients to follow up with hospitals, I mean, there are just so many multiple hats that people have to wear in small clinics that we, you know, how do you get this achieved and where does the funding come from?

Ira Moscovice: Yes, this is Ira. I would say adding to the use issue, I think one of the important things this committee can do is to lay out a clearer framework algorithm, call it what you want, that smaller clinics, (CEH) and et cetera could really use in terms of – here are the metrics you should be collecting information on and here's how the canon should be used within your facility clinic, et cetera.

So that at least we'd use some of that work for these clinics that they focus on having the resources to kind of implement that plan rather than having this diversity of way that the information, potentially gets used or in the worst case, doesn't get used at all. You'd be collecting information but just don't know what to do with it. So I think that's – that could be an important role in terms of the recommendation they make.

(Guy Nuki): This is (Guy). I think that what you said is very important. There's a tension though between the rural communities where often people like their independence and have unique characteristics. And so how did those unique characteristics play into this, versus making a system by which you – there's – you require less, support less of an I.T. Department, less of a quality assurance department in your hospital so that you can easily do this and be compared.

I think that's the tension slide that I think was one or two slides before, brings that up quite clearly as well.

Ira Moscovice: Yes, I think that's a good point. I would go straight to the comments earlier that there's simply I think more and more facilities, clinics, providers are becoming aware that they just simply can't afford to do this whole process themselves and you know, my theory is that – where things are heading, that rural providers are going to be left behind and that could be the worst case scenario.

And I think being left out of all these programs is the worst thing that can happen. Rural providers, because it just sends the message out that quote, are not even good enough to participate in these set of programs. So I think we really need to figure out a way to sort of bridge that tension and you know, force it on people who are voluntarily, at this point, at the voluntary basis that they're reporting information.

But yet, show the value of what we're proposing and hopefully figure out ways to whether it's through hospital associations, other vehicles. Figure out ways to get that information out but there is good information out there that could be used.

(Crosstalk)

(Tanya Bartholomew): (Tanya) – sorry, go ahead.

(Bob Brown): This is (Bob Brown) in Nebraska, I previously worked for our Regional Extension Center so I can – the adoption issues depends on where you look, frankly and that's why people are getting mixed results.

If you're a medium-sized rural clinic, 5 to 10 docs that's independent, they have very high adoption rates. Rural health centers though are very low because of meaningful use – they have written now the meaningful use incentive programs so they didn't have the money.

And then when you're one to two docs, they didn't have the critical mass of the reason the studies are conflicting is because it depends on where you look essentially. And there are other regional extension centers like in Oklahoma. It's very common at one and two doc practices and they often didn't have the critical mass to afford an EHR, whereas the 10 doc clinic did. And so some of these things are created actually by Medicare because of rural health centers being written out of the meaning to these incentive programs.

Gregory Irvine: This is Greg Irvine in Idaho. I would like to also emphasize that the providers are very much in rural settings, struggling with the incorporation of EHRs. These have not been designed with rural medicine in mind, whatsoever. And if we reduce our efficiency by 40 percent as a practice, in terms of just providing basic patient care.

We struggle daily as providers with that input and other issues as well. And when our patients are screaming for care we're – depend to the computer.

Bruce Landon: Sorry, can you clarify why you think that's different in a rural setting?

Gregory Irvine: Well, I can because I came from an urban setting and I moved to this small town four years ago from Portland, Oregon where I practiced and have been involved in large group practice in that setting. And it's very different in a rural setting in that we just don't have the levels of support and we have – I have very different type of practice as an orthopedic surgeon in a rural setting than I do, did in an urban setting, right? I practice general orthopedics, you know, call 24/7, 365, if I'm in town, I have to be immediately available.

I can't have my production – my productivity reduced by that input and whatnot. You know, I don't have the support in a small town setting to make myself more efficient. So I find myself doing workarounds, sitting up with my working, observing the computer after I'm done serving my patients.

(Aaron Garman): This is (Aaron), if I can interject to your – there's also, I think, culture in the rural settings where we practice, where it's really hands on with our patients and unfortunately, we've gone away from the physician-patient relationship to the physician-CPU relationship. And I think that that has taken a toll on our patients as well. A lot of them don't like the fact that you're typing in a computer while they're in a room with you. But I recognize that it's the way that things are, and the way that things are moving. Unfortunately, if we keep doing this and focus so much on quality metrics as the primary endpoint, forget about our patients, I think, we'll be doing everybody a disservice.

Bruce Landon: This is …

Gregory Irvine: Well I think the other issue that really we're going to run into very soon, I think, is we have man power issues in rural settings as it is for providers, and attracting physicians to a rural setting has become increasingly difficult. With the increasingly burdensome requirements and whatnot, is it pertains to a variety of things that are being propped on our heads as we try to practice medicine in these settings. You know, physician satisfaction is plummeting, or provider satisfaction and we're losing people.

Early retirements are the norm in my community. Simply because physicians have become so frustrated with their loss of efficiency, their loss of economy, their loss of the physician-patient relationship that they entered medicine in the first place or, that we're going to see, you know, the losses of providers in these communities set, and they will become even more underserved than they already are.

(Crosstalk)

Bruce Landon: This is Bruce Landon again and obviously, I don't practice in a rural community and part of what's going to happen in this series of calls is that I will become more and more educated. But I'm not at all surprised to actually, you know, hear and I would echo every single thing that you're saying, and you know, the practices where I work in those that I know that are not in rural settings. So I think there's clearly some aspects of these that are probably unique to rural settings in the sense of potentially I.T. support, staffing

support, availability of other resources, and some of the issues that we're discussing now I think are relatively calm and across primary care right now and then – and sort of symptomatic of the ills of primary care these days.

(Tanya Bartholomew): This is (Tanya Bartholomew), and I would like to add to the list, managing chronic patients. I think, I don't know if this is specific to rural, maybe somebody else can comment on this, but when we are trying to run our registries and get people in for, you know, using epidemics-based guideline, do you need to have your A1c drawn every six months, and you're trying to get them in for the diabetic appointment? Well, they will only come in once a year, because insurance only pays for one moment's exam a year.

So that is a huge struggle, and reporting these quality measures is that we are accountable for getting these people in, most especially the chronic patient, through population health management, but the patients are refusing to come in because of the cost visit.

Tim Size: This is Tim Size, I wanted to make a point similar to that. I was very excited when last year NQF community work came out with what I guess I interpreted as a major policy shift in that they would begin to consider the importance of suggesting metric outcomes for sociodemographic factors, and I think that's a huge issue for rural. We have enough reporting going on in Wisconsin where I think we can begin to see. So then that's not just a rural problem, it can be an intercity problem, but it's certainly a smaller practice that's more likely to have a patient population that doesn't average itself out.

I think it's a huge policy issue, that one we need to address. I think the other thing I just do is support what Ira said that I think we're all familiar with the challenges that relate to primary care rural and urban, relate to smaller clinics of that I.T. support, but I think the challenge for us is to find a – response that environment that helps them move forward, and not just that are voiced to well it's OK to be left behind.

Karen Johnson: OK, and this is Karen.

Jason Landers: And I actually kind of – don't call in to interrupt me for a second. If this has been mentioned, I apologize, but we're talking a lot about the extract of quality measure data from an EMR, but what acted on, and again, I've done a lot of PC mates work with quality measures is that the – especially in the rural areas, care is provided in setting outside of the clinic, and the – giving the information from another setting into the EMR is the particular problem. And I'm thinking of a couple of examples.

One is just simply things like immunizations, where immunizations may occur and help departments or other places, and the information, just doesn't make its way back to that primary care office. And it – I would categorize this is kind of that I.T. infrastructure problem, but it is a real problem.

Karen Johnson: Well, thank you. This is Karen, and I, yes, you know, I always had to take the – to stick my oar in and stop the discussion, but we still have time for some other discussion, and you've touched on it a little bit, but I'm asking the question a little bit differently here, what are the key issues regarding the measurement for rural providers. So the SCS comment I think might be potentially one of them just because of the patient's characteristics in certain rural areas.

OK, again, I've thrown a couple things up on the slide. I don't know if these are the right things. I'm sure there are other things, but just in thinking about the types of measures that are used, are they the right measures, are they aligned so that there's less burden? What about load volume? And I'm sure there are other measurement issues. So thinking about the actual measures that are used for how those measures are potentially constructive. It had many ideas about those key issues.

John Gale: This is John Gale. One of the issues at least for rural health clinics that has to be factored into the mix is the different billing methodology used by clinics and to a certain extent, (FQHS) as well. And it's part of the reason why they've been left out of the PQRS and to a lesser extent, meaningful use. But they're not reimbursed. They're reimbursed from the Medicare B Trust Fund. However, they submit their claims to part A. And that's reality that has to be calculated into the – factored into the mix in terms of thinking about measures

and how clinics are encouraged to participate in some of the paper performance and measurement systems.

Karen Johnson: So John, just to make sure I understand, you're saying that the clinicians, they don't bill part B Medicare. They do get reimbursed through part A or you're saying the clinics themselves get reimbursed through part A?

John Gale: The clinic's bill submit their claims to – through part A …

Karen Johnson: OK.

John Gale: Using the (U.B.) form rather than the (HCFA) form, it used to be (HCFA) form the 1500s. They are paid to (peered) process from the part B trust fund. However, they don't – they submit revenue codes rather than CBT codes …

Karen Johnson: OK.

John Gale: … as a result. Now, they must be – they're cracking them, but I think it creates a challenge to think about how that reimbursement system, and how claims get submitted in terms of getting them to report.

Karen Johnson: And I guess that also could open up how measures are specified. Because generally, you see, often times CBT codes being used in, you don't see – I haven't seen revenue codes much in measures construction.

John Gale: Well, and I suspect, and I've been working on trying to get a straight answer on this one. This is most clinics do use the CBT codes, but they translate them into the revenue codes for – to submit their claims.

Karen Johnson: OK.

(Tanya Bartholomew): This is (Tanya), and we actually were a rural health clinic, and I grew up at my rural health clinic status. Actually in June of 2014, we do bill by CBT codes, but they are transferred over to the revenue codes. And you can't forget to add in the cost report along with the rural health clinic. It really complicates things. And there are a lot of care coordination codes that you can't bill for at the rural health clinic.

Kelly Court: This is Kelly …

Ira Moscovice: This is Ira.

Kelly Court: The other thing we need to be cognizant of is in rural areas where the physicians may be part of an integrated system, a lot of that billing happens as provider-based billing and I'm sure not the expert on that but it does add another wrinkle in how measures get specified.

Ira Moscovice: This is Ira and I would just add to the care coordination concept. You know what we're measuring right now is what's being done at rural facilities and I think the whole issue of transfer referral patients decisions that are made, we can do the kind of care that needs to be done locally versus are we going to be transferring patients out. And that whole interface is just a quality area that's not been looked at a lot and I think we need to think a little bit about in terms of how we might propose that need to be looked at, is it requires data collection from more than one facility and so forth.

But the decision about taking care of patient locally and not – is a crucial one in rural areas and something that we haven't spent a lot of time on.

Kelly Court: This is Kelly again. I think the other thing we need to – the low volume issue is really important. So, if one patient takes you from 100 percent to 80 percent in a quarter, that's a problem. I think at least the Wisconsin hospitals, the rural hospitals would support movement towards some kind of value-based purchasing or incentive programs but they also – so relevance of measures is important and we need to understand that what one rural hospital does is not the same as another and a challenge in some of the existing value-based purchasing programs is if you don't do measures in one set, it weights all the measures in other set heavier. So actually that can really have an unintended consequence then it'd be a factor in the small volume issue.

It can be devastating even for some of our smaller non-rural hospitals. So, as methods get developed here, we have to be cognizant that they don't all do the same thing. I was kind of intrigued by the thought that instead of core measure sets, there's menus to pick from. So, these rural smaller providers

could have some choice and I think that's part of the way the joint commission is going, which is quite attractive at least to our smaller organizations.

Marty Rice: Karen, this is Marty. I think what Kelly just said is it was the basis of what we originally thought when we submitted project and a couple of different pieces to this. One is there is an HIT issue which is quite separate but also integral into the conversation because rural facilities will probably have a much smaller HIT department to be able to pull adjusting measures out.

The second thing is that I think we're looking at quality measures and not look – not reimbursement, but we have to somehow look at it. So we have to categorize the quality measures which are based on just voluntary measures for the incentive programs. And then how do we and Sheila might be able to help us out in this – in the next conversation is how do you take reimbursement when you look at both quality and reimbursement together.

So there's really like three kind – three discussions here that we probably need to have at some point. HIT, kind of how does it affect rural areas much more so than in urban areas? Secondly, reimbursement and the other one is the quality measures in the incentive programs. Do they apply to rural communities? And we use them or some kind of recommendations we need to make. I'll drop it right there.

Karen Johnson: Thank you, Marty.

Tim Size: I would just (inaudible) that add to that list is the unique challenges with value-based purchasing if you're talking about safety net providers, cost-based and if someone doesn't do well you're actually taking money away from someone who's probably already struggling and actually needs more support not less support. So that's a tough question that we should address as well.

Marty Rice: Absolutely. You have – and Ira brought up when you transfer a patient to another setting because they need a different type of cure than what's available, have you transfer that, you know, how does that quality equate back to the rural provider?

Karen Johnson: Great. Any other issues we could bring up now or?

(Guy Nuki): You know one of the things that – This is (Guy). I mean, one of the things that I'm wondering, would it help if we try to outline what we think is unique in these rural and small settings so that we can utilize that to target what we're trying to do.

Karen Johnson: Yes. You know you're actually almost reading my mind because I think this conversation has been very helpful to me personally but also just to start getting these issues out on the table. I think one of the things that I might do and I'm going to allude to it a little bit more later but between now and our February meeting I will ask you guys to do some pre-work for me.

So, I might, you know, what do you think about that being one of the pre-work things that you try to do that individually and then that will be a point of discussion in the meeting. So, you know, it's kind of not fair for me to hit you guys with these questions on the call and expect you to necessarily be able to answer. You may need to think about it a little bit but does that sound like something that would be useful?

(Guy Nuki): This is (Guy). I think so. The other thing is that I think that it would be useful to have it written down in front of us. So, if we submit them to you and then you disperse that, that way it's – we can see them and sometimes we're repeating ourselves but using different words …

Karen Johnson: Right.

(Guy Nuki): … to prevent that.

Karen Johnson: Right.

(Bob Brown): Yes, this is (Bob Brown). Maybe everybody needs to have their top five or top 10 ready.

Karen Johnson: OK.

(Bob Brown): Something – no more than a page because there's what, 20 of us or something like that but.

Karen Johnson: Yes, we want it to be …

(Bob Brown): You might detect common themes that way and …

Karen Johnson: Yes.

(Bob Brown): … keep the discussion where it's more relevant because we all have our different issues but there are things I'm sure we all have in common as well.

Karen Johnson: Great. So I'll work on that the next day or two and get something out to you so that we can – We really don't have that much time between now and our meeting so I might be asking quite a bit of you.

Let me go to the next slide to (throw) up some additional discussion questions and we're curious about lessons and approaches that, from others that might be applicable.

So, and I don't know that we have a lot of times talked about this now but I think it's something we definitely want to talk about, you know, too and, you know, as we have and I've forgotten exactly who it was who is the medical director for the Medicaid NCO and I apologize for getting names and jobs confused but, you know, do you know something from your side of the world and the Medicaid side or the NCO side that might be of interest in terms of thinking about how to measure quality in rural providers or, you know, even going even further into the methodological issues, the small numbers and, you know, what's worked for other folks to get around this small number problem.

Jason Kessler: This is Jason Kessler here. I'm medical director for a state Medicaid program and NCO but, you know, one thing that just comes to my mind and I'm not sure if this is what you're looking for or not but at some point in time we were tracking a rate of event and I don't recall what that event was but it was, you know, how many of these events occurs in a year's time. And some of the, you know, it was – we had very small numbers that we could work with and we couldn't really crank out a rate for any given year. And if you change your emphasis a little bit to something like, OK, well, let's calculate event-free intervals and watch and see what event-free intervals do over time. That became a more effective way to measure a rare event.

And so to just bring this to mind is just an alternate way of looking at things when you've got lower numbers. I'm not sure if that's what you were looking for but perhaps that's an approach or at least a way to think about looking at some of the rural issues with lower volumes.

Karen Johnson: No, that's exactly the kind of thing that I think that I hadn't thought about that one.

(Bob Brown): This is (Bob Brown), we've had some back and forth with our Medicaid NCO as well and it sometimes depends on what you're looking at. So, hospital's critical access, they have census of 5 to 10. That's hard to solve. One thing that went wrong is they wanted to focus on asthma but the asthma numbers for avoidable visits were so low on the clinical level it wasn't worth looking at. But if they take other measures like for example flu vaccination, your sample size is pretty big and so they have to pick measures that are relevant on the clinic level at least. And so getting them to and some NCO people just don't like to think on the clinic level. We have to get them to think at that level.

Karen Johnson: Thanks, (Rob). Anybody else? I'm sorry (Bob) not (Rob). We have a Robert here that we call (Rob), so it's going to take me a while to …

Jason Kessler: Jason Kessler here. Again, from my own Medicaid, a couple of comments that I would just I guess throw out in that, you know, a comment that was made earlier about having a palette or a menu of things to choose from, it seems to me when, you know, make a lot of sense when we're looking at, you know, different areas who have different populations and one thing we see, and you know, we just start going out in these rural areas, your generalities go away because everybody is doing things differently and everybody has a different population. So being able to almost choose what you're measuring or how you're measuring based on specific investments makes a lot of sense to me.

Another comment that, you know, something you kind of don't think about until suddenly it becomes an issue but it does in these areas is when you're dealing with low volumes and we have some emphasis in our current measurement about looking for disparities among populations and

socioeconomic status and racial and ethnic things, the example I'll give you where that becomes an issue is, you know, if you're looking at a county and you're looking at diabetic care and, you know, how many of your diabetics have had their A1cs every six months and then you start slicing that and dicing it and you – OK, how many of our African-American population have had their A1cs every six months and you're looking at a county with one or two African-American family, suddenly you've got a confidentiality issue and that, you know, is a whole different range to throw into the, you know, you're trying to measure what's going on in those areas.

Karen Johnson: Thank you. So I am looking at the time and I – this time has just flown by for me. I hope it's been useful and informative and interesting to you guys as well. I think we're already hearing some initial recommendations. Now, they maybe, you know, put out by one person and that might not be where the committee lands but it sounds like you guys already have some good ideas about recommendations. We've already heard about measures, methodology. Program design to some extent we haven't really gotten very far into that but I guess the idea maybe even of a menu of measures is to some extent a program design potential.

I have philosophy in quotes there and what I was getting at there and I'm putting this out just for your thinking, you know, I think I've heard that if I want – you don't want the rural providers to be left behind and you want them to – you want measurement to apply to them and for these providers to reap all the benefits of measurements. But does it need to be and I'm throwing this out for you to consider, does it need to be individually – individual clinician measurement or for rural providers, does it make sense to think about more of a population-based measure system rather than individual clinician?

Again, I'm not saying pro-con, I'm just asking you to give some thought to that.

(Guy Nuki): This is (Guy). This is the sort of thing that I end up thinking about. I think it depends on the behavior you want to discuss on that. It's going to be dependent upon the behavior you want to change. So if you want to measure

systems, you're going to change system behaviors. If you want to change clinician behaviors, you're going to need to measure them.

Karen Johnson: OK. Great perspective. You guys have already come up with some ideas in terms of organizing the upcoming meeting. I think some of what you said here is helping me figure out how I want to split out our talking in the meeting.

Marty, I think you already gave us a list of three things and others added to it. So continue thinking about that. We have a little time to play with before we finalize the agenda so we want to make a meeting that is very useful with, you know, we're not just – we want it to be very focused so I will ask you to be thinking about that with me and I'll ask you to send in any suggestions or additional thoughts that you may have in terms of that.

And also, we've talked about additional sources of information. We are looking at our environmental scan. We have a fairly large library of materials and we've been looking at website reports, that sort of thing. And this is probably something that would be hard for you to respond to since you don't know what I've seen but if you know something that, you know, gets in the meat of a particular issue and you say, Karen, you just really got to read this and this encapsulates everything for you, you know. If anything like that exists, please just let me know so that we can consider that.

And I think with that I want to go ahead and pass this over to Severa real quickly. As I've said we do open our calls and meetings to public comment. So Severa, can you take us through the public comment, the next step piece of the program?

Severa Chavez: Thank you, Karen. I think our operator, (Cathy), please open the lines now for any public comment.

Operator: OK. To make a public comment please press star then the number one.

And there are no public comments at this time.

Karen Johnson: Thank you very much. Severa, shall we go to the next step?

Severa Chavez: Yes.

Karen Johnson: Oh, I still have leadership, that's fine. So you know, Severa, why don't I go ahead and just finish up here. Any additional thoughts, I'm going to be sending some e-mails out. You know, the idea, the top 5 or 10, I think has a lot of merit too and that will help us focus our meeting a little bit more. As I said, we will be continuing our environmental scan so that we have some information about the various measures that are being used out there. And, you know, kind of turn in to pre-work for you for the meeting and then we have our meeting in first week of February, the tail end of the rural health policy institute meeting. So I'm not sure how many of you are going to attend that meeting but it turns out that that meeting is right next door to the NQF offices. So if you're going to be in town for that one, makes it a lot easier to be in town for our meeting.

So with that – well, actually we have about eight minutes left, so let me just open up again the line to you guys if there's any issues that you think we need to consider that we haven't already touched on. Any questions that you have that I can answer in a short amount of time? I'll just open it back up because we have a little bit of time.

Kelly Court: Karen, will we get access to that environmental scan before the meeting in February?

Karen Johnson: You will. It's actually due to CMS on the 15th, I think. So the bulk of it I think is going to be – is the measures themselves and some of the background material about the federal programs and that sort of thing but yes, we will give you that. You just won't have much time with it, so …

Kelly Court: OK, and then my second question is a logistical question. As you post things to the SharePoint site, will there be an e-mail saying there's new things there or do we need to keep kind of going out there to look?

Karen Johnson: That's a great question. Actually, SharePoint has a utility or a function that will allow you, yourself to sign up for announcements and I'll have to look into the directions to tell you how to do that. But basically, you have – we can

try to remember to tell you that in general, there'll be new stuff any time there's going to be a meeting so always look then but in the mean time, if you want to sign up for announcements, the system itself will e-mail you. So that might be something you're interested in doing and we'll try to figure out how to do that. It's been a while since I've told anybody how to do it and I've forgotten how right now.

I think another thing that would be interesting, we haven't posted on the committee site the various papers and reports and I think that we're looking at, you know, it's not going to be a literature review like one we do for a dissertation or something like that. But if there's any interest in that, we could also post some of the materials and such that we're looking at but we wouldn't expect that you would necessarily read them but if there is interest we can post them.

(Bob Brown): This is (Bob Brown). I'd like to end on a positive note.

Karen Johnson: Sure.

(Bob Brown): In that despite of the obstacles which I know I've been there is that in our 12 clinic ACO, our clinic with some of the best quality of measures is our smallest, most rural clinic. So if we get it right, you can actually get better care in rural health care not worse, so anyway, just leave it at that.

Karen Johnson: Thank you, (Bob). Well, with that, cup more than half full. Any final thoughts?

Severa Chavez: Karen, this is Severa. If I may just mention that the travel memo from our meetings department should be going out tomorrow, at the latest Thursday, and that would have information on how the committee members can vote their airfare and hotel information as well.

Karen Johnson: Great. Thank you for that. And as I said before, if you have any questions or concerns about anything, please drop us a line. We are really looking forward to meeting you in February in four weeks. Thank you so much for joining us.

(Brock Slabach): Thank you.

Karen Johnson: Bye.

Operator: And this concludes today's meeting. Thank you, and you may now disconnect.

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