NATIONAL QUALITY FORUM

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MULTISTAKEHOLDER INPUT ON PERFORMANCE MEASUREMENT FOR RURAL SMALL-PRACTICE AND LOW-VOLUME PROVIDERS
RURAL HEALTH COMMITTEE

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FRIDAY
FEBRUARY 6, 2015

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The Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:37 a.m., Kelly Court and Ira Moscovice, Co-Chairs, presiding.

PRESENT:

KELLY COURT, MBA, Co-Chair
IRA MOSCOVICE, PhD, Co-Chair
ANN ABDELLA, Executive Director, Chautauqua County Health Network
MICHAEL BAER, MD, Network Medical Director, AmeriHealth Caritas Pennsylvania
TONYA BARTHOLOMEW, OTR, Registered Occupational Therapist, Platte Valley Medical Clinic
JOHN GALE, MS, Research Associate, Maine Rural Health Research Center, University of Southern Maine
AARON GARMAN, MD, Medical Director, Coal Country Community Health Center
GREGORY IRVINE, MD, St. Luke's McCall Orthopedics Clinic
JASON KESSLER, MD, Medical Director, Iowa Medicaid Enterprise
JASON LANDERS, MBA, Director of Provider Strategic Initiatives, Highmark West Virginia

BRUCE LANDON, MD, MBA, MSc, Professor of Health Care Policy and Medicine, Harvard Medical School
JONATHAN MERRELL, RN, BSN, MBA, IA, President, Profound Knowledge Products, Inc.
GUY NUKI, MD, Regional Medical Director, BlueWater Emergency Partners
KIMBERLY RASK, MD, PhD, Chief Data Officer, Alliant Health Solutions
ROBERT RAUNER, MD, MPH, Medical Director, SERPA-ACO
SHEILA ROMAN, MD, MPH, Consultant
SUSAN SAUNDERS, MSN, CNM, WHNP-BC, Rush Health CNM, American College of Nurse-Midwives
STEPHEN SCHMALTZ, MS, MPH, PhD, Associate Director and Senior Biostatistician, The Joint Commission
TIM SIZE, BSE, MBA, Executive Director, Rural Wisconsin Health Cooperative
BROCK SLABACH, MPH, FACHE, Senior Vice President, National Rural Health Association

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
SEVERA CHAVEZ, Project Analyst
MITRA GHAZINOUR, Project Manager
KAREN JOHNSON, Senior Director
MARCIA WILSON, MBA, PhD Senior Vice President, Quality Measurement

ALSO PRESENT:

GIRMA ALEMU, MD, MPH, Health Resources and Services Administration
CURT MUELLER, PhD, Health Resources and Services Administration
MARTIN RICE, RN, MS, Health Resources and Services Administration *

*** Present via teleconference**

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P-R-O-C-E-E-D-I-N-G-S

8:37 a.m.

MS. JOHNSON: Well good morning, everybody. Thank you for coming back to Day 2 of our Rural Health Committee Meeting, and thank you for your patience.

I know we started a little bit later than we had initially planned on. I hope most of you at least got our email. We decided that after everybody had scattered yesterday afternoon, but that gave us the time, the Committee and the Co-Chairs and I, to get our ducks in a row and get something set up so that we can respond to things.

So Kelly is going to go through in just a second. We're uploading our new slides, our additional slides, but we've modified the agenda somewhat to take care of the things that we think we still need to discuss, so a lot of this morning I think is going to be making sure that we understand the things that you said yesterday. If there's still questions or a

little bit more meat on the bones that we need to add, we'll try to do that.

And I may interject on occasion just because in writing the report I need to make sure that I completely understand what you're thinking and saying, so I may kind of jump in on occasion. I'll try to keep that to a minimum if I can.

So as soon as we get our slides for our Day 2 Agenda, I am going to hand it over to Kelly.

CO-CHAIR COURT: Thanks, Karen. Good morning, everyone. And I said to Ira, I'm glad everybody sat in the same spot because I was kind of learning the names.

So today what we're going to do is we're going to spend really the morning looking back at what we think were the consensus issues from yesterday, but we want to do that very thoughtfully and carefully to make sure that the three of us captured it correctly and we didn't miss something, so we won't rush through that.

MS. JOHNSON: Sorry, that's

yesterday's agenda. We have changed it, so sorry about that, Kelly.

CO-CHAIR COURT: Great. I think I said the right thing but the slide wasn't right.

MS. JOHNSON: Yeah, yeah, that will throw you off, so --

CO-CHAIR COURT: So it was like, whoa. Okay. So recap, like I talked about, and then after the break, we're going to talk some more about the SDS discussion and exactly what we want the report to include on that, and then we'll have Helen or Karen or someone is going to talk to us about just an overview of what the MAP process is because it sounds like we all don't have the same understanding of how that works, and it's in one of our recommendations, so we want to make sure that we know what we're recommending.

Then we'll take lunch at noon, and then we're going to kind of wrap up today round robin, making sure everyone has an opportunity to again reflect on the recommendations, future

work, just kind of give everybody one more opportunity to make sure we didn't miss something important. We'll do wrap-up and next steps, and we'll be done by 2:00.

CO-CHAIR MOSCOVICE: We're going to start with a discussion of our summary, at least, of what we heard, and the point of this is this is a learning opportunity for us, and so if we didn't get it right or we really discussed something yesterday that's not there, let's, you know, talk about that. Feel free to just buzz any time as we go through this. We really want to spend enough time so we get it right.

And there may be things that we all don't agree upon. There are a couple that we've noted that we need to discuss a bit further, both today and later on.

Ah, and we have a new guest with us, Curt Mueller, so why don't you introduce yourself to the group?

DR. MUELLER: Okay. My name is Curt Mueller. I am from the federal Office of Rural

Health Policy, and I've done -- I did some work with Marty on trying to conceptualize what this might look like, so I'm excited to see what you guys did yesterday, and looking forward to today.

CO-CHAIR MOSCOVICE: Okay. And so we heard that there were four main areas in terms of the challenges, the broader challenges that we face, one of which was the whole issue of low case-volume, and we'll have slides on that as we move forward. Second was the need for meaningful measures for rural providers, and that really related both to our discussion on the relevancy of measures, but also the gaps, and it was interesting, as we all went through our notes last night, we probably did more in gaps than I would have guessed, and there was a lot of discussion on that, so that's great, and we'll get to that later.

The whole issue of alignment came up across sectors and even within sector. We'll be discussing that. And then the notion of voluntary versus mandatory participation, and a

lot of rich discussion on what appeared, I think, was a consensus in terms of focus on mandatory participation.

So why don't I stop there, and if anybody has any comments on that slide, we'd love to hear them.

(No audible response)

CO-CHAIR MOSCOVICE: Okay. And so we moved into low case-volume discussion, and the way we summarized it is as follows: broad set of measures that would be applicable beyond condition-specific, and not that we won't have some condition-specific measures, but that what's clear in rural because of the low case-volume, we need a broader set -- we need measures that are more broadly applicable than to one condition.

Having said that, Bob I think suggested yesterday there are some good measures out there that he has to report on, but there are others that aren't as good, and the ones he mentioned that were quite useful that they were using were handwashing, vaccinations, blood

pressure control, diabetes control, medication reconciliation. And I'm just wondering in terms of these broadly applicable measures if people have comments on that or thoughts about that, how they would like that introduced.

DR. RAUNER: Just to clarify, the handwashing was just an example from the Peter Provonost central line --

CO-CHAIR MOSCOVICE: Right.

DR. RAUNER: -- but we actually don't use handwashing, just to clarify that.

CO-CHAIR MOSCOVICE: That the broad set of measures must be relevant to the rural environment, we want to consider measures that also reflect the community good, so we had a small discussion about that as we were going through that, particularly as we move towards population health indicators, this notion of community good, measures can become more useful at that point.

Focus on outcomes, but consider other types of measures: we had a discussion at various

points about the patient-centered medical home and the measures that they're using and being mandated to report on. Perhaps some structural measures in -- the example that was brought up was the value of the AHRQ Culture of Safety Survey, and I'd like some discussion in terms of sort of how you think we should address this in the report in terms of outcome measures certainly are useful, but there are really sets of other measures that are quite relevant for rural environments. Any thoughts on that? Steve.

DR. SCHMALTZ: Outcome measures are desirable, but there's really a lot of technical difficulties in how you risk adjust because most outcome measures require some kind of risk adjustment. We had talked about social demographic factors as far as risk adjustment, but you really, for a number of outcome measures, you also need to adjust for severity of illness, and that type of data is not usually available through administrative data, you have to go in the medical record for it.

CO-CHAIR MOSCOVICE: Is there a rural context for that, or is that just really something --

DR. SCHMALTZ: That's across the board. I think it would be even more difficult for a rural, given their difficulty in doing data collection.

CO-CHAIR MOSCOVICE: All right. Other thoughts? Yes, Tim.

MR. SIZE: This is maybe just more of a question of context, but also, I think, to the rural issue: in our conversation about metrics, I realized in the call-in meeting it had a lot to do about informing CMS on pay-for-performance, but it seems some of our conversations, we might be hesitant to make a proposal that this is a metric to be part of a pay-for-performance, but we might be very comfortable with it being something as part of public reporting.

And like maybe what we were talking about yesterday in terms of advanced directives might fall into that category. So I just -- if

we can try to tease that out at the appropriate point.

CO-CHAIR MOSCOVICE: Yes, I was going to say to Karen, actually, if I recollect, in the slides, we don't really talk -- I don't think we've addressed the whole focus on pay-for-performance perhaps as much as was originally suggested. That's something we might, as a group, want to talk about.

DR. BURSTIN: Just a quick add-on to that because that's a really good point, Tim, we're increasingly trying to think about measures for intended use. So I think what you're really saying is there are some measures that may be appropriate for different uses, but maybe not all. And sometimes there's a shift over time. A measure that might be appropriate for public reporting with greater comfort, and over years of seeing there's not unintended consequences could move to payment, but I think perhaps reflecting that transition in intended use in the report would be useful.

MR. SIZE: Yes, and I think the real hook on that is that -- at least my impression is we still have less hospital clinic integration in rural areas, and I'll hear some of our rural hospital CEOs, well how could I possibly be held responsible for that because that's the doctors?

Now the response is, you know, you're going to rise or fall as a team, and whether or not you're corporately integrated or not really isn't the point. But as a half-step, I think public reporting versus pay-for-performance opens up the conversation.

CO-CHAIR MOSCOVICE: Yeah, Bob.

DR. RAUNER: Yeah, I was just going to use an example on what -- I think what you're talking about with the socially economic risk factors, and I also have sort of a question that maybe you guys can answer.

Two communities we have, McCook and Lexington, Nebraska. Similar size, similar practice, same electronic medical record, but one is a town that's fifth and sixth generation

German and Swedish immigrants, the other one had a meat packing plant move in 25 years ago, so it's about one-third German and Swedish fifth generation immigrants, about one-third Hispanics that moved in with the first wave, now first and second generation Hispanics, and another third that's more recent Somali. So very different on the sociodemographic side.

From our Blue Cross data, we actually risk score each town based on our Blues, and most of the -- most of our clinics are 0.9 to 1.2 on their risk score. Lexington with the meat packing plant, it was 1.7 something. I'm not sure if the risk adjustment captures all of that, or is there even more based on all these cultural things?

Those are some things I think that -- and listen, I may be raising more questions, a lot more questions than answers, but it's an issue, and I don't -- we're struggling to --

CO-CHAIR MOSCOVICE: I think it's central to the SDS discussion we're going to have

this afternoon, so we have, I think, an hour for that.

Other comments on this? Okay. Kelly?

CO-CHAIR COURT: So on the second bullet point, "Must be relevant to rural environment," how would we coach CMS to make sure that that's done correctly?

CO-CHAIR MOSCOVICE: Yes, Brock.

MR. SLABACH: You asked on the rural relevancy? Yes, I guess I'll reiterate and it may be in another slide, but I think a MAP process for small volumes would be an appropriate way for that adjudication to be made going forward.

CO-CHAIR MOSCOVICE: And we will be discussing that a bit later, but I would agree that that's the way to move forward.

What about -- you know we had the discussion about patient-centered medical homes, and I know in our state, in Minnesota, they're certified by the state and there's a mandate to report certain data elements, and Tonya certainly

was advocating for this yesterday. How -- I mean are there specific measures that are well accepted across the patient-centered medical home movement in the U.S.? Is it -- could we identify in the report, here's the ten things about patient-centered medical homes that quite frankly, even if you aren't a patient-centered medical home but you're doing primary care, it would be useful? Bruce.

DR. LANDON: So the issue with PCMH is so there's this very involved recognition process that was created by the NCQA. It sounds like Tonya actually went through that and filled out that application, which has a reasonably high fee, and it takes many man hours to complete it.

So a lot of places where they're trying to go toward the tenants of the patient-centered homes, they've not either had the resources or the time to fill that out.

A lot of states are taking their own independent approaches to certifying medical homes. For instance, the DPH in Massachusetts is

developing their own sort of gliding path where people aren't required to do that.

There are other assessment tools from TransforMED and others that try to do this in the sort of simple way, and there are a few other states that are doing it as well.

I'd say, you know, the one nationally recognized thing is NCQA, and NCQA has issues.

CO-CHAIR MOSCOVICE: Okay. And I think maybe for the final report, it would be useful if Karen and staff talked to Bruce, to maybe get examples of good state efforts in that arena.

So I have Jason, then Bob again, and then Tonya.

MR. LANDERS: Again, I've spent the greater part of the last three years establishing Highmark Quality Blue PCMHs, so I'm fairly passionate about it.

Your specific question was what are the measures that work or are generally accepted? I would say that most -- the most generally

accepted measures are those ones that are very, very steeped in good medicine, good science, you know, things like -- and things that are very evident that they can clearly be successful of their own accord: the cancer measures, breast/cervical/colon, things like that, that they -- there's good science behind it and all I have to do is draw those people in to get them.

The things that are very unaccepted are the things like -- and that's why I mentioned yesterday antibiotic usage, because the things that hold a provider accountable for something that may happen in another setting -- we were talking about retinal eye exams, but even in a different way, periodic screening because what generally happens is mom just wants the kid to get better, she goes to the primary care physician, primary care says let's not give you an antibiotic right now, he'll get better in two days anyway, she leaves there and goes to an urgent care. Well I capture all that data as an insurance company, so that's a ding, and things

like that are the things that are really -- where it's out of their control, those are the things that they don't like.

But the things that -- I've got to bring someone in and do a fall risk assessment, okay, I get that. I can do that. I can build that into my annual well visit, or I can -- but the things that fall outside of their scope are the things that they really kind of --

CO-CHAIR MOSCOVICE: Okay. Tonya?

MS. BARTHOLOMEW: I guess what I was really trying to emphasize with looking into the PCMH model is that we were talking about both clinical and non-clinical measures yesterday, and truly, that model of care captures everything that we discussed. So I think it would be interesting to look at the PCMH model and see that they do want us to track access to care, they want us to track overutilization of labs and imaging, ER readmissions within 30 days, the preventative care measures with your cancer screenings, chronic care measures.

So it really does a good job of capturing both clinical and non-clinical measures, and I think that would kind of be a nice guideline to look into.

CO-CHAIR MOSCOVICE: Okay. Bob?

DR. RAUNER: Yes, I'm really a huge fan of patient-centered medical home, but not a fan of the NCQA certification process.

And then some of you have probably read studies where they show that it doesn't seem to correlate, and I think the problem is that the NCQA certification is so broad that it under-emphasizes some of the key points, and there's a great editorial by Barbara Starfield like five years ago basically criticizing this exact factor.

A lot of states -- I think that's why they've developed their own processes. The one I know of that's the most mature and most solid and broad is Michigan's, and they specifically have their own process as well, and there's a gal, her name is Mary Ellen Benzik, who has been really

involved. I would actually highly recommend contacting her because she can talk a lot about the same issues.

They've actually started where they -- they started where you have to certify, then they moved to outcomes, and once you've got your outcomes, they actually kind of give you a gold card status and they don't worry about the certification anymore, and that's kind of what we've sort of done. And, you know, Nebraska developed its own criteria, again, just because the NCQA is too cumbersome and costly to do.

So I'd recommend -- I'd study, like Bruce was saying, each state -- a lot of states have done their own. Michigan is the one, I think, that I -- that I'm aware of is most advanced. But to really study those core things, and they boil down to things like access -- the Barbara Starfield things, that's what it really should be, not the whole NCQA, everything-including-the-kitchen-sink approach.

CO-CHAIR MOSCOVICE: Okay. I have

John and then Tim and then Brock.

MR. GALE: I agree with you completely on the NCQA process. You know, I kind of look back, and PCMH was really evolved as a way of sort of reasserting the core values of primary care, but to the extent that NCQA and others are beginning to overlap with meaningful use measures and others, I think if we do anything from that set, that we look to make sure that we're pulling those that are most representative from multiple measure sets so that we can maximize that, and then focus on the things that are core and central to good clinical medicine.

CO-CHAIR MOSCOVICE: Okay. Tim?

MR. SIZE: Yes, I'm a little confused. The focus on outcomes, I thought we were talking a lot yesterday that while that is nirvana, that with the low-volume issue, we frequently are going to be dependent on process measures. In fact, I just counted up all the process versus outcome measures in here, and it's like three-quarters process and one-quarter outcome, so I

don't understand your header.

CO-CHAIR MOSCOVICE: And so, yes, I think the issue is how we word it. I think we agree with what -- my sense is that we agree with what you're saying.

Outcome measures, well, let me throw this out, are preferable, but it's going to be difficult to do because the low-volume issue.

MR. SIZE: I think we give a nod to the field, but then you didn't make the argument why here's our constraints, and where possible, we like outcomes, but we frequently can be more dependent on process -- okay.

CO-CHAIR MOSCOVICE: Brock?

MR. SLABACH: So I like the direction on the PCMH. In our presentations from our association, in terms of transitioning to population health, we use RPRI panels. The RPRI is the Rural Policy Research Institute. And their recommendation is the entry point to population health could be for many rural communities the PCMH model. So I think that this

sends us into the direction of that reaching set of standards that could help make some of those transitions possible going forward.

I am in complete agreement on NCQA. I do not advise members in my presentations to pursue NCQA certification, and not to be daunted by going the whole hundred yards, but just download the materials that are freely available on the website and begin the process of studying what that is, and that's the entry point, then, to population health.

CO-CHAIR MOSCOVICE: Tonya?

MS. BARTHOLOMEW: I think something to be encouraged by, feeding off of Brock, is that I think in speaking with NCQA and a lot of people in my state, they do understand the amount of time and work it takes to be NCQA certified, and so I think they are looking into more of phasing those infrastructures in, and you don't necessarily have to be certified, but the more that we can include meaningful use requirements, PCMH requirements, all of those reporting

requirements, going back to alignment into one place, same measures, I think you're going to have more participation.

CO-CHAIR MOSCOVICE: Okay. Some more on low case-volume in terms of measure construction. We brought up the whole issue that some of the measure specifications include exclusions at this point that make it difficult for rural providers to reach the necessary volume, and whether it's on CAHPS excluding discharges to nursing homes and so forth, so forth, that we need to think about that carefully in the context of rural environments.

We would like more measures that are continuous. Examples that were brought up yesterday were timing measures, but they may not always be optimal. They don't -- quicker isn't always better. Most of us think the less time we spend to get something done is better, but particularly if you have issues like weather conditions or other factors in rural environments that you don't control, the notion is that there

may be a good reason why something didn't get done as quickly as one might like. It's also not easy to necessarily collect the timing measures as readily as they did it, happen or not.

And then finally here we said consider the social determinants of health and the implications for risk adjustment, and we'll have a much broader discussion of that in the afternoon with Helen. But in terms of these final comments on low case-volume, any thoughts about the comments here? Okay, Guy.

DR. NUKI: So we talked a lot about, and we did not come to an agreement, about whether we pool data across clinics or across systems.

CO-CHAIR MOSCOVICE: We're going to come to that.

DR. NUKI: Okay.

CO-CHAIR MOSCOVICE: Okay. Yes, that was one of the main areas that we need more discussion on.

I guess another slide on low case-

volume. In the context of the level of analysis, and this is what Guy just brought up so we'll come back to it, and we couch it as people saying that we need reporting feedback at the clinician level, but payment could be at higher levels.

Discussion of perhaps allowing informal grouping of providers for payment, and there was a give-and-take on that. Thoughts were, that came out yesterday, was that this should be voluntary. Encourage neutral learning opportunities between providers. And that smaller facilities for hospitals or physician practices should be allowed to opt in, i.e., it's not just focused on CAHs or Rural Health Clinics and community health centers.

Comments or thoughts on this slide, reactions to it? Yes, Steve.

DR. SCHMALTZ: Actually a comment on type of measures. Another type of measure we haven't considered yet are ratio measures where the numerator is not necessarily a part of the denominator, an example being bloodstream

infections, where the numerator is the number of bloodstream infections and the denominator is -- might be device days or something like that. Or in mental health, we have a couple of measures that look at seclusion time versus number of patient hours.

So those type of measures tend to have big denominators, and if we can find something with -- where the numerator is relatively high, then I think you would kind of circumvent the small sample size issue.

CO-CHAIR MOSCOVICE: Okay. Other thoughts on this one?

(No audible response)

CO-CHAIR MOSCOVICE: Okay. And so one of the issues we discussed yesterday was what are the criteria that underlie meaningful or relevant measurement development and use in rural environments? And some of this obviously overlaps with other environments, but a fairly rich list here, and it makes you wonder if we have any measures that address all of those

bullets, but let's go through them, and your thoughts about which are most important, et cetera, because we probably want to winnow this down a little bit.

That they be evidence based; support the triple aim; address the low-volume problem; the data availability issue, i.e., the data is feasible to collect; they're relevant internally for providers for quality improvement purposes; they're relevant externally for pubic reporting; focus on outcomes, and we have question marks there, and it relates to Tim's earlier comment; we talked about comparability across relevant peer groups, so we can accomplish that; that they're actionable, we can do something with these measures; they address areas of both risk and opportunities for quality improvement; and that they support local access to care. And that is the end of the list, yes.

So thoughts on these, which are quite important. We'll start with Greg and go to Bob and then come around.

DR. IRVINE: I am going to have another contrarian point of view in terms of focusing on outcomes, in that even though it's hard to do and statistically difficult to correct for, sometimes we risk becoming paralyzed by process if we focus too much on process.

A good example is the timeout in the operating room, which has become first one timeout, then two timeouts, then mark the patient, and pretty soon the nurses are spending all their time and I'm spending all my time doing the timeout. I've threatened to just come in and do a timeout and leave, forget the operation, it's safer that way.

We sometimes -- when mistakes keep happening, we think that the response is to add more process. And that, adding more process, sometimes causes people's eyes to glaze over and to stop thinking. And if we focus more on outcomes, we avoid that issue of too much process.

CO-CHAIR MOSCOVICE: Bob?

DR. RAUNER: I guess kind of along that line, too, I do think things get sometimes too cumbersome, and that's the problem with the NCQA process. It got too crazy cumbersome.

On the other side, I do think -- you know, to cover all of this, I liked the concept of the balanced scorecard where you have a mix of one or two from here, one or two from here, not 100, but maybe 10 to 20ish, where you can have a little bit of patient experience, which I think is very valid; some revenue and utilization, like complications and total cost, which I actually like in the Medicare Shared Savings Program because we get, really, a pretty good balance to compare ourselves, which is helpful. Even though individual measures I have criticisms with, overall, it achieves a really good aim, and it has process, like screening, but even outcome, like was the blood pressure actually under control? And I think maintaining that mix is really helpful because it gives you the broad view of you compared to your peers, and it's

really been helpful for us, so I guess walking that balance and fine line between enough but not too much is hard.

CO-CHAIR MOSCOVICE: Tim and then Steven.

MR. SIZE: To that point, I mean, I actually agree with both of you, but at least when I spoke up before, it was in the context where there is not an outcome measure available, then we would consider a process measure.

I mean, I wish we lived in a world with no process measures. That would be ideal for me. But the reality is because of our low-volumes, there's frequently domains where we simply can't show the outcome, so we default to process, and that's a slightly different context than I think you were alluding to.

The second thing is, and I think the wording is important, there is no reference to metrics appropriate for P4P or whatever, and that was one of our reasons we were called, and that's certainly what I'm having to deal with locally,

so that seems to be oddly missing on the list.

CO-CHAIR MOSCOVICE: Yes, we -- my sense was we didn't really address that bullet a whole lot yesterday in terms of the focus on P4P, and so you're suggesting maybe we want to add that to this list in the context of what the charge was to the Committee.

MR. SIZE: There may be parts of our work that we're not able to complete even in a rough draft version here. I just don't think we can be silent on it since it's (a) one of the main reasons we were called together, and (b), it's something many of us are having to deal with.

MS. JOHNSON: So I have a question. I guess, in my mind, I'm completely opposite of Ira's perspective or perception. I guess I was thinking that this measure selection principles was only in the context of P4P, so then my question would be would the list be different if it's payment versus public reporting or something even just reporting? So now I'm a little bit

mixed up, and I'd like to --

CO-CHAIR COURT: I think it's the same list. Now but it --

MR. SIZE: It needs to be explicit because it's -- implicitly, you're saying our work is related to that, I mean --

CO-CHAIR COURT: Well I think the criteria are the same, however, how they get used over time may start as reporting, and then eventually it becomes pay-for-performance.

MR. SIZE: There's a logical inconsistency -- then you've got to take off the "relevant internally for providers," "relevant externally for public reporting," because those are other uses.

CO-CHAIR MOSCOVICE: So we need to think through exactly how we want to present this because yes, I put those forward, and that's just in a much broader context. So it's a fair point.

I had Steve and then Guy.

DR. SCHMALTZ: I think another principle you need to add is that you need to

exclude measures that have unintended consequences. An example would be antibiotic timing for pneumonia where hospitals were rushing to give antibiotics where it wasn't appropriate.

And I think maybe in the rural setting, because there are so many other considerations, you might have more of a danger of having unintended consequences.

CO-CHAIR MOSCOVICE: Guy?

(No audible response)

CO-CHAIR MOSCOVICE: Okay. We have John, Tim -- John and Kelly and then Tim. Tim put it down. John and Kelly and then Brock.

MR. GALE: In thinking about the mix of measures, we're obviously going, at some point probably likely to have some process measures because that's what we have, and in thinking about how you use some of these measures in a low-volume practice in disadvantaged rural communities, at least to my way of thinking, some of the process measures ought to be almost in some ways a threshold characteristic. You know,

there are certain things that we expect practices and providers to do. They ought to be doing the med reconciliation. There are other measures that just, if they're not doing it, or they're performing poorly, that's a problem.

But in thinking about moving towards some outcome measures, one way of looking at pay-for-performance in the outcomes is to measure changes in performance over time. Now it doesn't help so much if you're trying to compare urban practices and rural practices because you've got the case mix and the complexity issues, but looking at rewarding them, I think you almost set a threshold and a bar on the process measures and then start looking at a select number of outcome measures that you can begin tracking improvements in performance to combine them.

CO-CHAIR MOSCOVICE: Kelly.

CO-CHAIR COURT: I think Jason, excuse me, made a really good point earlier that if this is a phased approach, I think the initial measures need to be ones that are totally within

the scope of what the rural provider can control, and then Karen and I had a little side conversation that, you know, about care coordination, and, you know, you need to -- it's really, I think there's a lot of debate about no we need measures that you're influencing beyond your, you know, your four walls, but I think -- and I agree with that, but I think those come later, and initial measures need to be ones that you can control.

CO-CHAIR MOSCOVICE: Okay, I have Brock and then Susan.

MR. SLABACH: I'm not sure if this is the place for this, but I'll say it and then we'll place it where it needs to be, and that is a timely loop of data reporting and feedback to the provider for relevant performance improvement, so whatever we develop and however the data warehouses are set up, I think it's important to see that we shorten that turnaround time.

And there was something else I was

going to say, but I forgot, so I'll stop there.

CO-CHAIR MOSCOVICE: Susan.

DR. ROMAN: Okay, I'm going to put a little bit different hat on for a moment. As we look at measures, I think as we collect them and put them forth, we've got to stop and think who is going to be doing the work of the collection or the implementation? And, you know, just to kind of put the nurse, former nurse manager hat on, and like Greg says, if we put forth five new measures and the burden of work falls back to nursing or falls back to one individual group when it comes down to the implementation, have we accomplished anything, you know, for relative good for the overall, for patient safety?

CO-CHAIR MOSCOVICE: I have Guy and then Aaron and then Jason.

DR. NUKI: I guess I'm trying to get my head around this as a presentation to CMS, and the way I would see it is what's here on this slide is a list of criteria of an ideal measure. It's a little bit like a pharmaceutical company

trying to create an ideal drug. The ideal drug will never cause an allergy, you can take the same dose no matter how old you are, renal failure doesn't matter -- you know, there's no such thing as the ideal drug, but you, as you design the medicine, you come as close as you can to that.

And so we have these lists of things that we find important when you're creating a measure. An outcome obviously is great, but not all measures are going to be able to be done in outcomes.

And then I think that the whole pay-for-performance thing is -- I think what this group said yesterday was there's pretty good agreement that at the individual level, that should not be pay-for-performance, not now, and not in the future. We may want to start off with some of the system-oriented pay-for-performance as a pay-for-reporting and move that into pay-for-performance or something like that.

Maybe I misheard the group, but that's

-- now I would be very worried about saying okay, we're going to march these things forward, and then all of a sudden, at the individual level, we're doing pay-for-performance over vaccinations, and that might not be where we would -- it sounded to me yesterday, and I personally believe, that paying physicians for performance measures is not necessarily the way to go. Reporting, yes.

CO-CHAIR MOSCOVICE: Reactions to Guy's comments? And I won't forget the two of you over there, but reactions to what Guy just said? Yes.

DR. ROMAN: Yes. I, too, am a little bit confused as to whether we're talking here about a transition from public reporting to pay-for-reporting to pay-for-performance or whether we're just talking about rolling right into pay-for-performance.

I think that there's a lot of pressure at the national level to move very quickly to pay-for-performance, but historically, the

programs for both hospital and physician have taken years to move into pay-for-performance, and I think it's worth some discussion here as to -- and I think this is relevant to the point you were making, Guy, what are we talking about here? Are we talking about measure criteria for pay-for-performance or for pay-for-reporting? And are we talking about a transition, or are we just jumping into pay-for-performance, and if we are, what kind of parameters are we going to put on that for local providers in rural settings?

CO-CHAIR MOSCOVICE: And so I am -- we have it on a later slide, but the discussion -- let's keep the discussion going now, and we'll get to the later slide.

What do people think about that? Because the charge was, you know, to focus on pay-for-performance relevant measures, but certainly we can feed back to CMS we think this needs to be a planned transition, and here's where we are now, and so forth, so forth. Anybody not want to talk on that?

(Laughter)

MS. JOHNSON: Can I --

CO-CHAIR MOSCOVICE: At least on this it's --

MS. JOHNSON: Can I interject --

CO-CHAIR MOSCOVICE: Sure.

MS. JOHNSON: -- just real quickly? P4P is not here yet for the CAHs or CHCs, but for the small hospitals and practices, it is here already, right? So maybe we need to have this conversation about split between, but I think definitely it's on the later side, as Ira said, this idea of an approach, a phased approach. But again, it's already here for some of the providers. That's part of our scope today.

CO-CHAIR MOSCOVICE: So let's get the comments now, since it's of interest, and we'll go down that side, and then we'll come to this side. So why don't we start at the back. Jason? What do you have?

MR. LANDERS: I -- this may not be the right place either, but this notion of these

underlying measures come up, things like med rec. Would it be appropriate to have those base, underlying measures that are weighted more heavily, then you could augment with the other measures?

That's just kind of a thought, because certain things really make sense across the gamut for all practices, and you know, if you're doing one patient or ten patients, it always makes sense.

So that's just a thought, and to just briefly comment on what Sheila said, the one thing that I always see is that being on the commercial side, we tend to try to jam things down people's throat. It does take time, and there's a real art to reporting, as you well learned in your PCMH process, that you kind of have to learn how to report from a practice, and so it does take time.

I don't know that it necessarily has to be a step-step-step process, but you probably have to acknowledge that, and at least initially,

the standards may be a little different, or the data collection may be a little different, and then it kind of ratchets up as it goes, but it does take time, and it is a skill that has to be learned.

CO-CHAIR MOSCOVICE: Okay, Aaron had his card up for a long while.

DR. GARMAN: One of the things that I don't see on this list that I think is very relevant, and I think it was really stated well yesterday, is alignment. Unless we have alignment of measures and have one core set that we can report to the federal government for everything, I don't think we should look at pay-for-performance.

CO-CHAIR MOSCOVICE: And so we have some discussion later on alignment also, but that's clearly an important part.

Michael?

DR. BAER: Yeah, just for the phased in concept, I think we need to remember also something happening in the very near future which

could have a huge impact on this potentially would be the implementation of ICD-10, and so you know we're going to be struggling, providers will be struggling, hospital systems will be struggling with trying to learn, you know, what the new law is for CMS while at the same time they're going to be struggling with ICD-10, so to pay for reporting might be, you know, I think a great way to start and take the -- take it sort of in a quantum step-like fashion where, you know, pay-for-reporting and then pay-for-performance later, but I think we need to keep that in mind too.

CO-CHAIR MOSCOVICE: Okay. Bob?

DR. RAUNER: I guess kind of like some similar comments: we essentially are already in this world, some of us -- Ann and I with our ACOs, we're already in pay-for-performance. I am happy with it on the ACO level, actually. I agree that I don't think it should be done on the physician level, actually, because of the local factors, the uniqueness. We as an ACO decided

we're not going to do it on the clinical level -- on the physician level, but the clinic itself may decide to do that. I think there's enough unique things that frankly I probably can't account for those, but the people within the clinic probably could.

I am worried this year, actually, because we are potentially going to go to pay-for-performance on the clinic level. We've actually written that into our previous discussions. So if we get a bonus from Medicare, part of that is contingent on the clinic's performance, and some people may get more money than others, and I'm worried that that could pull us apart, actually. So I honestly don't have the answer here.

I am fine with it on the ACO level. I think we're there whether we like it or not already anyway. I really think we have to be careful about ever going to pay-for-performance on the physician level because of the bad unintended consequences. On the clinic level, I

will have to say I don't know yet, and I'll -- maybe a year from now, I'll be able to answer how well that went, but so --

CO-CHAIR MOSCOVICE: Greg.

DR. IRVINE: Just a brief digression, going back to Guy's comments about using process versus outcomes.

At least in surgery, I constantly tell patients that I shoot for zero, I never achieve zero, when it comes to potential complications. We try very hard. We keep our processes correct and whatnot, but we're never -- you know, statistically, we can never achieve zero.

Going back to pay-for-performance, I see this -- these measures as being something like an unfunded mandate. For small hospitals like mine, at least, we're financially on a knife edge. We're constantly battling over budget items and how we're going to afford to keep the place open, and it's a month-to-month financial struggle.

We sit in meetings and talk about

whether we're going to buy an incubator or a pediatric fracture set, and when that included -- that discussion includes whether we're going to hire another nurse to do data collection, it gets very real, and that's something we have to think about when it comes to PFP. If CMS is going to have us give them more data, they at least need to fund it.

CO-CHAIR MOSCOVICE: Kimberly?

DR. RASK: Two points. First, on the terms of the phasing in approach, I think that the phasing in approach has been very wise for what has been done for hospitals, and speaking, thinking about the small rural providers that we've been talking about and the issues with infrastructure as well as the issues with measurement, I think doing phased approaches is really wise. Otherwise, we run a risk of unintended consequences that hurt, disproportionately, small low infrastructure entities.

Secondly, the other thing that I think

that we ought to think about is that to the extent that we at the federal level have payment programs in place to identify particular providers as being somewhat essential community providers and reimbursing them in a different mechanism specifically for that reason, like our CAHs, our Rural Health Clinics, our Federally Qualified Health Centers, then I think we need to be really thoughtful about why we think we want pay-for-performance, unless pay-for-reporting and pay-for-performance is going to include measures that capture that community benefit that we are supporting them for.

It is not just the same as doing the stuff we've done in other places and applying it to them. This is a group of institutions that we as an entity, as a federal government, have decided needs support in a particular way in order to perform a particular community function, and however we choose to measure them, we need to include that in our measurement and weigh however we measure them appropriately.

CO-CHAIR MOSCOVICE: Okay. Brock and then Tim.

MR. SLABACH: So my support for pay-for-performance would be I think predicated upon the entire corpus of the conversation that we've had over the last couple of days, and that is transitional, assuming some kind of selection, criteria selection process that makes relevant measures for our providers and provides technical assistance to be able to make that transition happen.

So assuming all of those predicates, then I think we could move into pay-for-performance in a transitional method down the road.

Having said that, I think -- so I just wanted to be clear about what I mean by transitional. Secondly -- I mean pay-for-performance. And I think it's another important conversation in terms of picking up on what Kim said, and this is relative to what type of pay-for-performance, and I think that we should be

looking at bonus up, not penalty down.

So if you perform well, you get additional cost-based reimbursement, for example, in the CAH setting, not going below cost-based as a penalty. And that preserves, I think, the safety net notion that we're talking about, that at least we're not going to be having unintended consequences that I think are all too important.

CO-CHAIR MOSCOVICE: Tim?

MR. SIZE: Yes, I strongly agree with actually Brock, Kimberly, Greg, and Bob. It's like a home run thing.

But I want to bring another issue up. Maybe it sounds like an infomercial, but I'm doing for HRSA a webinar in a few weeks on network adequacy, which I think is one of the great sleeper issues for rural -- not frontier, but what I would postulate as where most rural population in that they're close enough where there's competition going. And as more and more closed networks get started, that's going to be a bigger and bigger issue. So that's why we're

really focusing on network adequacy standards being something that thinks through it from a rural perspective.

Having said that, they are already, in the Wisconsin marketplace, you know, and I mentioned it briefly yesterday, metrics being used not to penalize but to actually exclude. So it's very important to me on the alignment issue that we do the glide path, but inherent in the glide path is you know where your eventual goal is, so at least we know what metrics, you know, are going to be prominent in Medicare so then when we negotiate in work structures with commercial insurers, we're kind of talking the same thing -- so again, we get that alignment and we get that focus. But this is much bigger than pay-for-performance for many rural communities.

CO-CHAIR MOSCOVICE: I have Jason and then Ann.

DR. KESSLER: Do you ever feel like you turn your little thing up and the conversation has gone, you know, completely

different directions since what you thought you wanted to talk about?

But I am going to kind of go back in time, I guess, for a moment to kind of discuss some of the relevancy of some of these measures because there were a few comments a while back about measures that might be beyond the control of a provider. And I'm -- I would be really hesitant to throw out a measure for just that reason.

And the reason for that is that providers underestimate what's under their control. And I realize this would be an unpopular statement with many providers, but the example Jason had given earlier in the morning of the mom who, you know, brought her kid in with a sore throat and was reassured and then went to another provider -- urgent care clinic, to get an antibiotic. I would make the point that if the first provider had adequate -- had given adequate education at the onset, that that second visit would not have occurred.

But a better example that I can give you is something that happened in our first patient-centered medical home program that we did in Iowa. One of the things we were scoring providers on was getting patients in the door, getting their members seen, and the providers were saying well that's not -- it's beyond our control who walks in our door. But lo and behold, after a couple months, two of our centers figured out that they can pick up the phone and call people and say we'd like to see you, and that will increase their rates by a whole lot.

So that was just a point that I wanted to make as -- and there may be some measures that don't fit in that category, but I would be very cautious about excluding any measure for that purpose.

CO-CHAIR MOSCOVICE: Ann?

MS. ABDELLA: At the risk of stating the obvious, I want to hitchhike on what I think Greg and Susan were after, and it's implied there in the data availability, but the data has got to

be easy to collect. And in the day of the electronic medical record that we're wanting and hoping and praying that all of these rural providers will adopt, it needs to be -- starting off in this phasing process, I think it needs to be structured data that they're learning to enter, that they can use to easily report, and that most importantly they can keep track of themselves.

And I mean, this is -- this feedback loop that we're all trying to deal with in quality improvement is about giving our own selves report cards, teaching ourselves to use our electronic tools and registries to keep up with our patients and do the care coordination. So if we're sincere about wanting to do this, keep it simple, use the technology that's been forced down our throats, and make part of that that learning curve, to use the data in a timely manner and not wait for it to come to you two years later.

CO-CHAIR MOSCOVICE: Okay. It's been

a good discussion. Why don't we go on to the next slide?

So we're going to talk a little bit about program design. Participation in programs should be mandatory, and TA, as was pointed out, needs to be built into this participation.

We need for a phased approach -- and so that's the discussion we've just been having.

Allow a menu of measures to choose from, such as perhaps by service line. Set up a waiting scheme so that scores are not dependent on just a few measures. Facilitate a faster cycle time between performance and use in the programs, and include a component for improvement, not just meeting a threshold.

So why don't we open the floor for discussion on some of these themes and anything people would like to add, edit, technical assistance. Brock.

MR. SLABACH: Somebody must have been typing awfully fast after that last conversation, because I think it, just to -- it mirrors exactly

what we just talked about, so that's good to know.

I guess it's maybe an important moment to offer a perspective, I think, that just hit me yesterday evening, and that is that we have a real opportunity, and we don't want to lose this moment in terms of our reporting to CMS about an opportunity that we can design something in a tabula rosa form because CAHs and RACs are completely, you know, outside of a lot of these programs. And we can actually build this, I think, in a way that will make sense rather than kind of the hodgepodge growth of pay-for-performance reporting that's occurred over the last decade or so with the other federal programs of reimbursement.

And I think giving CMS an opportunity to learn from the mistakes that they've made in other programs and then build that and learn from that in this, I think, is really important. And they only get a chance to do this once, so let's do it right.

CO-CHAIR MOSCOVICE: Yes, I think that's a really important point that we discussed. That we don't feel that the constraints of sort of here's what we have now and how do we fit into it? I think what you've said, Brock, is right on, and I think it will be an important part of the context of the report.

I have Tim.

MR. SIZE: Yes, two things. It relates specifically to what Brock just said, but also, Ira, what you said at the end of our call we had a month ago, and that was -- well I guess maybe our first recommendation is to be recommending to CMS that they do something.

So we -- I guess we had a -- it's either now or for after lunch, what would be evidence that CMS gives respectful consideration over recommendations? I mean, how do we know if we're successful in what we've done? I mean, we're having a great conversation and stuff, but we came here for a purpose, and it's dependent upon CMS at least actually reading our report,

and then hopefully acting on it.

So what are our indicators of success that our mission is completed in terms of at least getting the ideas -- appropriately, respectfully, considered. How will we know we've done that?

CO-CHAIR MOSCOVICE: Yes, all I can say at this point is that we have heard back from CMS that they are going to be looking at this, this isn't just let's do something for the sake of doing something, and that my sense is that CMS right now is more open to rural considerations than they have been in the past, but I don't know if we can just have a list of criteria that CMS has to meet so that we're comfortable with appropriate use, but I think we --

MR. SIZE: I mean I know they're masters of intimate lip service --

CO-CHAIR MOSCOVICE: Yes, no --- you've got that down?

CO-CHAIR COURT: By Tim's eyes.

CO-CHAIR MOSCOVICE: But two things.

I think, you know, a lot of us know that it's taken a while to get both NQF and CMS and others interested in the rural issue, and I think that it's just much more open as we need to figure out perhaps a strategy we can lay out in the report that at least some of the recommendation is clear, either you're moving forward or not, and the timing aspect is probably as important as are you going to do it, i.e., we want it done in our lifetime, so --

MR. SIZE: Yes, all right.

CO-CHAIR MOSCOVICE: We need to have some --

MR. SIZE: I leave that in your hands, good.

CO-CHAIR MOSCOVICE: Yes. It --

MR. RICE: Ira?

CO-CHAIR MOSCOVICE: Oh, Marty.

MR. RICE: Hey, Ira. One of the things that -- and I'm sorry I'm not there today, but I am listening and it sounds like a really good conversation. There are some really --

there are some processes that you can get involved with after this is over with. Also you can get measures into what they call, as bad as it sounds, it is a real project, the MUC list, which is Measures Under Consideration.

And there are some processes to get measures that you recommend into the hopper to be considered into the federal incentive programs. So that's something we can make sure happens.

CO-CHAIR MOSCOVICE: That's a great point --

MR. RICE: My dog. He says yes, too.

CO-CHAIR MOSCOVICE: I think that's a good point, and we will duly follow up on that one.

I've got -- that's what -- I didn't realize you were on the phone, Marty, but we're glad to have you, and we'll go from there.

I have Michael and then Greg.

DR. BAER: Oh, going back to Tim's -- or I forget who just made that comment. Maybe what would be a good idea is if when CMS is going

to be debating or creating this program, if there are public meetings that we could attend that we could be made aware of those meetings.

Would that be something that the Chairs would do for us? If there are open meetings for CMS when they are going over this, if you become aware of them, that you would make us aware of them?

CO-CHAIR MOSCOVICE: Yes, I'm not exactly sure of the process, but I think what we're hearing is we don't want your involvement to end just --

DR. BAER: Yes. And if there's a public forum where we could be a part of that, you know. If there's interest, and it sounds like there's a lot of interest in that group, that maybe if we knew about when it's happening, that could be something we could do.

CO-CHAIR MOSCOVICE: Okay.

MS. JOHNSON: And I can go out on a little bit of a limb here, Marcia, I hope this is okay. We are piloting, and it's more for

members, I think, NQF members. But we're piloting some of what we're calling network groups, I forget what our name is, where we want to build communities basically within our membership about certain activities, and rural health might be one that would be an option.

So that, again, that's kind of a membership thing, but we could at least play with that as a way. And then, of course, if you know members or you are a member, then you could --

DR. BAER: Yes, I'm just aware that there are, you know, a lot of federal meetings. You know, when they're developing CPT codes and stuff like that, so -- that are open to the public, but to find out when they occur is the difficult-type thing.

CO-CHAIR MOSCOVICE: Okay. And I think there really is a partnership ORHP and CMS in terms of this activity, and whether it's webinars or other potential joint efforts, and we need to get the word out, is what I'm hearing you say. Greg.

DR. IRVINE: I'd like to make my hundredth plea for flexibility, the -- in other words, emphasizing the allowance of a menu of measures to choose from, making that as flexible as possible. If there's anything I've learned yesterday about this group, it's how inhomogeneous where we work is, and I think that's true having worked in both an urban and a rural environment.

I think one thing that makes rural environments very unique is our diversity. We're not much like each other in a lot of ways. Each hospital has a unique personality, each clinic has a unique personality, each population base has a unique personality, and we need to be able to allow for that, and the only way you're going to do that is with flexibility, being able to choose from what measures make sense in your community, because the last thing we want to do is be doing a bunch of meaningless busywork again.

CO-CHAIR MOSCOVICE: Okay. Why don't

we move on to the next slide?

So a few more issues on program design. One dealing with our discussion about peer groups, and for quality improvement and benchmarking, use like-to-like comparisons. It could be across service lines. It could be across the type of facility or the capacity or capability of the facilities. For payment, not so clear if peer groups are needed, and we'll get into the SDS discussion in just a little bit.

And there is some math stats science to this, and there hasn't really been all that much done on the quality side with peer groups, and so I think the sense I have is the report is going to bring it up. But not that we have a definitive answer to this, but just that we need to do some work on this.

Comments, thoughts on the peer group issue? Okay. Ah, yes, Tim.

MR. SIZE: I mean it's complex stuff here.

I guess for payment unclear if peer

groups needed, there is a reference I think made by Helen about their interpretation that CDS would include maybe distance. But I think we know the more remote the facility, the higher the standby cost, and so I don't know how you wouldn't have peer groups for that.

And then, and maybe I'm misunderstanding the prior bullet, for QI, use like-to-like comparisons. Where -- or I guess I'm still back on -- I mean, I guess I'm living -- because I live in a market where rural is frequently compared to urban, in general, we need -- we're looking for quality metrics where that can be a fair comparison because that's what our people are looking at, do I stay local, or do I migrate?

CO-CHAIR MOSCOVICE: And so I think I would agree with what you were just saying. And I think one of the points being made is for places that don't have the same kind of market concerns that your hospitals have --

MR. SIZE: Yes.

CO-CHAIR MOSCOVICE: -- we don't want to compare them with your hospitals, that just that's not a fair comparison either. And so there may well be different peer groups, obviously, in terms of these like-to-like comparisons. We need to just get more explicit about that.

MR. SIZE: Yes.

CO-CHAIR MOSCOVICE: Because I think the markets you have are perhaps a bit different than some of the other places -- well certainly is --

MR. SIZE: No, I mean that's one of my takeaways is --

CO-CHAIR MOSCOVICE: Okay.

MR. SIZE: -- exactly the same thing. I mean, we -- a lot of this conversation divides very differently in a more frontier area --

CO-CHAIR MOSCOVICE: Yes.

MR. SIZE: -- versus where I work.

CO-CHAIR MOSCOVICE: I have Bruce, then Tonya.

DR. LANDON: So I reiterate that I know nothing about this, but I -- for the peer groups in the first part, I actually thought we explicitly said yesterday that we didn't think that CAH/non-CAH is a meaningful differential, but rather it's, you know, do you have a small rural CAH that looks like whatever and a small rural non-CAH that looks very similar? Those can be compared together, I thought.

CO-CHAIR MOSCOVICE: And so you're suggesting --- where it says "type," it's not necessarily the acronym you have. It's what the facility is --

DR. LANDON: Well that's what I felt --

CO-CHAIR MOSCOVICE: -- capable of doing.

DR. LANDON: -- we explicitly discussed yesterday.

CO-CHAIR MOSCOVICE: Okay.

DR. LANDON: Unless I'm wrong?

CO-CHAIR MOSCOVICE: Okay. We're

getting to the -- we're getting to that discussion in a little bit.

MR. SLABACH: For Tim's benefit, we prefer not to be referred to as frontier, we prefer to be geographically challenged.

CO-CHAIR MOSCOVICE: I have Tonya, who comes from a geographically challenged area.

MS. BARTHOLOMEW: I was just going to say exactly what Bruce said, but one other point, please don't make us regionalize.

Going back to Greg's point yesterday, there are so many differences in places nearby that we don't want to be compared to, or not necessarily compared to, but I have the exact same problem. I have patients who say they would rather die at my clinic than be sent to the hospital 40 miles away, and when you're talking about regionalizing that for pay-for-performance, that really scares me.

And then I think you also have to go back and consider what Bob said about being careful to look at those socioeconomic

demographics, and usually you've got the same facilities, but two very different communities, so I think this is going to be hard to define.

CO-CHAIR MOSCOVICE: Other comments? Okay.

So the alignment issue that's been measured, we need a uniform measurement set across HHS, payers, governing bodies, et cetera, develop a standardized process so that data are collected and reported just one time.

We need alignment of measures, as we've been discussing, across sectors. So not just within the hospital sector, but the linkage to ambulatory or primary care.

And then improvement resources such as technical assistance should be aligned also across HHS.

And so on the alignment issue, do people have any thoughts or comments about that? Bruce, I assume yours is down, right? Okay. So I have Bob, and then Tim.

DR. RAUNER: Yes, I think we kind of

touched on this a little bit before, but I think as much as possible, if these things could promote collaboration as opposed to competition.

So for example I've talked to some folks lately about how the -- the uniqueness of the advanced payment process we took actually made some of the hospitals not like us because they saw us as competing when we didn't even want to compete, and you want as much as possible to avoid some of those reasons to not like each other. And if the more you can put people in the same boat by aligning them around what's best for the patient, like, I think, medication reconciliation and the vaccination measures.

Those would promote cooperation between the clinics and the hospitals and everybody else because if we all benefit by that getting better, it helps us work together and not have any, you know, destructive things that some measures have caused. That there's been some of the unintended consequences of this ACO we joined, unfortunately, is it caused some fights

in some of our communities that we didn't want to happen, but just because of the structure, the money changed, and it did push us into competition we didn't want.

So by aligning some of these things, it can help get around some of that and get people focused more on the community good rather than us trying to take each other's money and fight for the same piece of the pie. And so I think, you know, like med rec, flu shots, if we can find measures that promote alignment of the systems and efforts to improve the community, I think that helps.

CO-CHAIR MOSCOVICE: Okay. I have Steven, then Tim, then Brock.

DR. SCHMALTZ: Alignment, if it's done right, is really a continuous process, so I think it will encourage cooperation. It's not a one-shot deal.

CO-CHAIR MOSCOVICE: Tim.

MR. SIZE: Maybe it's elsewhere and I wasn't focused on it, but when I started thinking

about alignment -- it's the first bullet. Some uniformity, but also then the question is just how many measures are enough for -- I mean, because you could create an infinite number of measures, and there's some evidence that we've been doing that as a culture. But if we're going to get this right, I mean, there's a lot more in life other than measurement, and we need to take this seriously, but how much is enough?

I mean --

CO-CHAIR MOSCOVICE: I believe that was --

MR. SIZE: I don't know the answer to that, but it --

CO-CHAIR MOSCOVICE: -- the discussion yesterday about having a core set that we really thinking everybody should be reporting on, and then these flexible modules --

MR. SIZE: Yes.

CO-CHAIR MOSCOVICE: -- and Greg will say coming here will have been worthwhile if we get

-- ever get to that point.

But these first couple bullets, I mean, if we -- and I can't say we're going to get down to one measurement set across every payer, and HHS, and so forth. But if we really can reduce that dramatically, and we really take into account this notion of reporting ones, and having a vehicle to transmit that information to these various sectors, that would be worth all of the time we have here, it really would be, and so that's -- I mean I think that's one of the --

MR. SIZE: No, I like your language. Just to add, and it's -- implicit to me when you said core set was something other than 350.

CO-CHAIR MOSCOVICE: Absolutely.

MR. SIZE: But I think maybe we need to be explicit at least in order of magnitude of what, when we're talking about a core set, what we think would make sense. And this gets to Brock point of view of a statement about the entire system and not just the rural piece.

CO-CHAIR COURT: So -- and I think Tim

makes a good point, let me jump in here, Ira.

I think the PPS hospitals are subjected to it was at one time over 100 measures, mandatory measures, so what do we think is a good number? Because if we say reasonable number, what's reasonable to CMS might be different than what's reasonable to us.

So I'll throw out, I mean just ballpark, ten to 15 --

MR. SIZE: That's what I think because I think --

CO-CHAIR COURT: -- or no more than ten to 15 measures.

MR. SIZE: I think beyond that, payers and public's eyes glaze over.

CO-CHAIR COURT: Well, and the resources get limited, and providers don't know what to improve because there's too many, and it just becomes an academic exercise then.

CO-CHAIR MOSCOVICE: Okay, and I can say, in the work we did about three years ago, we came up with -- with an expert panel, came up

with about 20 measures. So I mean that's the sphere we're talking about, we're not talking three digits. It's certainly low two digits. Okay.

I have Ann.

MS. ABDELLA: Just to clarify, would that include the rural PPS hospitals? Are you thinking that they would be able to ratchet down from what they have to collect? You know, is there a new definition of rural, and who is included in that bucket -- rural PCPs and -- ?

CO-CHAIR MOSCOVICE: I think we're talking about the concept applying to all providers, not just what we can accomplish, that's a different issue. But I think the concepts should apply not just to CAHs or one group, it should really be -- that's important for everybody.

I have Brock, Kimberly, and then John.

MR. SLABACH: I think to correlate to the conversation on the number of measures, I believe that it could be tended to through a MAP

partnership workgroup because it's not only just that you have existing measures, but you need to retire measures that are no longer relevant and perhaps topped out. So in other words this is an ongoing process that has to have some way to make that happen.

I want to go back, and I think it's also in this category as well, when I talk about bonus up. When we talk about alignment, I think that it needs to be clear that we don't intend and I don't believe that it's possible for this to be budget neutral, and then that goes to the discussion about what somebody gets in a bonus, then is taken away from somebody else in order to make this work from a federal budget. So that's an important notion, I think, in the context of this discussion.

CO-CHAIR MOSCOVICE: Kimberly.

DR. RASK: In terms of the number of measures, I think you can also take as a parallel what CMS has been doing with the hospitals and that there were a large number of chart-

abstracted measures, and now they're down to 46, with an increasing number of measures that are being captured and calculated from claims and fed back to hospitals.

So -- and they're also moving towards more electronic submission of measures so that it's not requiring the kind of chart abstraction that it did in the past, and so I think a recommendation in terms of -- or even some clarification from our side, when we say -- are we talking about chart-abstraction-type measures that we want a limit of 10 to 15, but if we want to capture some of those aspects of coordination of care, there are opportunities for CMS to use their Medicare data to be able to track people across sites of care and say something about access, readmissions, use of post-acute services that might be helpful, informative, and relate to quality as it relates to rural providers without asking the rural providers to collect that data.

CO-CHAIR MOSCOVICE: Okay. Karen wanted to jump in.

MS. JOHNSON: Well thank you. Just a couple points.

One, just to let you know that there's work happening now, and maybe many of you already know about this. I don't know much about it, but the IOM is actually working to come up with a core set of measures, so I'm a little curious if you guys have even heard that that work is going on. It was supposed to be released, I think, at the end of last year. It has not been released yet, so we don't know what that is going to look like, but other people are thinking about this.

The second thing is more of a question, and it came up yesterday, and I was a little confused, and it's probably a rural issue. It gets to Brock's comment about the topped out measures, and someone said yesterday they might be topped out in urban but not in rural. So maybe somebody can explain that to me just a little bit. If you're looking at performance of 95, 96 percent from across the board, how is rural not topped out? So --

CO-CHAIR MOSCOVICE: So I was the one who mentioned it, and if you look at individual measures that are in Hospital Compare, so many of -- for some of the measures the urban facilities are at 95, 96 percent and the rurals have improved over time fairly substantially, but they're still, say, in the high 80s. And there's more room for improvement left there.

And, I mean, CMS, obviously relating to the comments here, they don't want to just keep enlarging the data set. And so they've sort of been trading, getting -- they're retiring one and bringing on a new one.

The other part of it is the new measure often is not relevant to rural at all, and they're taking out measures from pneumonia or from other areas that are more relevant, so that's the trade-off.

MS. JOHNSON: Okay, so I get it. It's the idea that if CAHs aren't reporting, then CMS thinks that things are topped out, and there's this hole right now. That's what I was missing

in my --

CO-CHAIR MOSCOVICE: No, but the data I'm giving you is for the CAHs that are reporting.

MS. JOHNSON: Okay.

CO-CHAIR MOSCOVICE: And they're not quite at the level that other facilities are --

MS. JOHNSON: Okay, okay.

CO-CHAIR MOSCOVICE: -- it's going up, but they might need a little bit more time, and some of us feel that when you don't have to report, guess what, you don't pay as much attention to these measures as if you do.

But there's a trade-off. We want to keep a core set at a reasonable scale.

MR. RICE: Ira is very correct about that. We found that out in the MBQIP program, and what they're doing is the inpatient measures, they're retiring, but they've left them open so that we can still use it in the --- our MBQIP program for a short period of time, but they will retire them eventually.

CO-CHAIR MOSCOVICE: That's a good point, Marty.

Bob, Michael, and then Kelly.

DR. RAUNER: Somewhat tangential, but I would ask if in addition to sending this report to CMS, if we could also send it to ONC, because going back to Ann's earlier comment, still --- I said this kind of yesterday so maybe I'm being redundant, but the biggest failing of meaningful use is they didn't get interoperability fixed out, and they didn't get registries and reporting fixed in our EHRs.

This would -- if we could get those two things fixed, it would make this so much easier and turn meaningful use from a big load off our backs to something actually helpful. And so if we could cc the ONC, I'm not sure if we could do that, but I think that might help.

CO-CHAIR MOSCOVICE: We can certainly disseminate the report to ONC, not a problem.

Michael and then Kelly and then John.

DR. BAER: This goes back to Bruce's

comment yesterday about aligning across HHS payers and accrediting bodies, that's nirvana.

But looking at -- in AmeriHealth Caritas, who I work for, is strictly Medicaid and a little Medicare. So you know, I think aligning the feds is probably a little bit easier than pulling in the commercial.

So I don't know how, you know, the -- how we can wag that dog, but if there's any way to somehow -- and this would not -- this would not be for those insurers who don't get federal dollars, but if they get federal dollars, is there some way to ensure better alignment?

CO-CHAIR MOSCOVICE: Kelly.

CO-CHAIR COURT: Just something we need to think about is as measures get retired, it doesn't always reduce the data collection burden. So for instance, if there's five pneumonia measures, five heart failure measures, five acute MI measures, and five skip measures, so the burden doesn't necessarily come from the number of measures within a group, the

burden comes from the number of groups of measures.

So for every clinical condition or -- it's the how many different denominators do you have to collect that creates the burden. And so if we still have one measure in each of those groups, you have a very similar data collection burden as if you looked at four or five measures.

So I don't think enough consideration is given to the different populations we have to look at. So until you retire all the pneumonia measures, all the heart failure measures, that data collection burden stays somewhat similar -- so if you have to look at all your diabetics, all your hypertensives.

CO-CHAIR MOSCOVICE: So John will have the last comment on this slide.

MR. GALE: This one will be very quick. Have we -- and I apologize if I missed this, but have we missed the concept of keeping a recommendation of core measures in an optional subset? I don't know that we've explicitly

stated it in these slides, and I think we should.

CO-CHAIR MOSCOVICE: Yes, I think it was on a previous slide.

MR. GALE: Oh, okay, just making sure.

CO-CHAIR MOSCOVICE: But we'll certainly make sure it's there. Okay.

Okay. We're running a little bit over, but we'll get there soon. So in terms of gaps, we had a rich list starting with more measures about handoffs and transitions, including the timeliness aspects. Alcohol and drug screening was mentioned. Telehealth quality issues as measurement needs.

Access and timeliness issues in terms of just the broader notion, as was discussed I think, by Kimberly, recently. Are you serving your community? Can the community get care in a timely manner, and as we move towards population health, those measures certainly are going to be important. The relationship, access to care and cost measures to this whole issue of gaps in quality measures. We talked about population

health just now.

For hospitals, some people pointed out the lack of measures for specific procedures and the challenges there with OP/PT imaging. We had a pretty rich discussion yesterday about advanced directives and end-of-life measures as an area that's important for us to consider. Appropriateness measures, alignment with choosing wisely, and there's a couple question marks there, and to be honest I'm not 100 percent sure what that one's about, but we can -- we'll talk as a group.

And then I think several folks said, you know, there's a lot of focus on the primary care side, but we really, other than a few specialties like oncology, cardiology, there's really a need for more measures with respect to specialty care.

I don't know, is there another slide, or was that --

MS. JOHNSON: Yes, there's one more.

CO-CHAIR MOSCOVICE: On gaps, or -- ?

MS. JOHNSON: Yes, Helen gave us a list that came out of the MAP that if -- it's the next slide --

CO-CHAIR MOSCOVICE: Okay.

MS. JOHNSON: -- for your consideration. There's some --- a little bit of overlap here, but there's a few different things there --

CO-CHAIR MOSCOVICE: Is this just one slide or -- ?

DR. BURSTIN: Hi everybody, sorry for popping in and out. We have three meetings this morning.

So this is a list of the measurement gaps that have been identified actually by the MAP that we'll be talking about later this morning as well. Very high level across with a view of the National Quality Strategy, and again, they were not developed with a sense that these are particular to a given community or rural or not, but I thought since these are the ones we all have identified as being really important

ones broadly, it might be helpful to get a sense from the rural community in particular, do some of these rise to the top in particular through the lens of providing care in rural communities?

So first of all, again, this sense of it's really difficult to look at measures that relate to patients with multiple chronic conditions. We're still very condition focused. As you mentioned on the prior slide, a great deal of interest in end-of-life care and in inappropriate non-palliative services.

Appropriateness we talked a lot about yesterday as well. There are almost really few if none measures of diagnostic accuracy and a lot of concerns about diagnostic errors.

From the purchaser perspective, concerns that there aren't measures that really reflect lost productivity. So as we think about our broad-based view of -- I see Ann shaking her head there, but for example, days missed from school, days missed from work due to illness, for example.

Patient out of pocket costs has been one that keeps coming up. And then there are key areas like -- just two examples I pulled here: Alzheimer's, where we have really very few therapies. So not very good in terms of effectiveness measures, but might there be opportunities around quality of life or experience of care including with caregivers.

Outcome measures for cancer, including cancer in a stage-specific survival and patient-reported measure. Really very few systematic ways of getting at adverse drug events, and a great deal of interest in pain and symptom management and patient-centered care planning.

So you'll see this a lot here that kind of come from the voice of the patient or family in particular. So I thought we would just put that forward and see if any of these sort of raise discussion among this group as well.

CO-CHAIR MOSCOVICE: Since we are on this slide and there are certainly some that overlap and there are a decent number that don't

overlap with the comments we had, let's focus on this one first.

Are there areas here that we didn't mention that you think really are important in a rural environment? We'll start with Kelly.

CO-CHAIR COURT: Not that question, but I think the second bullet point there, and we've studied this in Wisconsin, that end-of-life care in the rural setting happens differently than it does in the urban setting.

So there's less access to hospice care and other alternatives. So it's more common for -- and the cultural differences of dying at home with help versus coming back to the hospital to die. So mortality rates, we've studied that really carefully, and it's different in rural. So access to resources at the end of life is very different, and that needs to be considered.

CO-CHAIR MOSCOVICE: And we had that on our list also, so that's clearly an important area. I've got Tim, Tonya, and then Bob.

MR. SIZE: A serious question, I'm not

meaning to be cute, what's the relationship of this conversation with the one we just had around smaller, more finite number of core measures? How do we integrate the two conversations?

CO-CHAIR MOSCOVICE: Well, I think we need to prioritize is what I'm hearing you folks say.

I think it's important for NQF to hear from us in terms of what are the areas specific to rural that we think really need to be looked at further, and the reality of it is you're going to have a finite number, you're going to have to be retiring some and replacing with others.

So I think it's good for us to at least identify the areas that we think are important, and then the decision is going to have to be made down the road about which are the ones that are most relevant. Ten years from now, it might be a completely different list up here.

So we're not just saying add to it, but I think in terms of research that needs to be done et cetera, et cetera. So that we have a

menu of important areas, I think that's the purpose of this rather than simply saying we're going to triple the list of measures. But I hear your fear --

DR. BURSTIN: And just to add to that, I'm sorry, some of these -- I mean most of these, have not been developed yet. So there is a pretty significant lag to get them out into the field.

So again, it's more so a sense of if some of these were developed, which ones would be of highest value? Again, hopefully, to a parsimonious list of core measures, you might take some others off the list if some of these are perhaps more relevant.

And again, this is not meant to be exhaustive, but just to give you a sense across the major National Quality Strategy areas where we know there are important gaps.

CO-CHAIR MOSCOVICE: So I have Tonya and then we'll come down this side.

MS. BARTHOLOMEW: Two comments.

First, to just reiterate what Kelly said about end-of-life care. In a rural setting, it is very, very different. We do not have the money to pay to hire a social worker, and all of the staff that are required to become hospice certified.

So what happens in my clinic is that my husband goes and sets up a hospital bed at home and sits with the patient and family. It's very, very different. But like Kelly was saying, people want to be home. They don't want to go to the hospice center. They don't want to go to the hospital. And so I think that's something very important to consider and something that I think we can highlight as rural areas and be proud of.

The second thing is the patient out of pocket costs. I know when it comes to measurement, especially clinical measures, now with the new high deductible plans, it's very, very difficult to get our patients to come in. For example, diabetic patients to come in every six months for their A1C.

We run our registries, they're due for their labs, they're due for their office visit. Not coming in, I have to pay for it. So that is a huge barrier I see to collecting and reporting good measures and having an impact on these patients because you have to get them in the door first, and that's -- the out of pocket cost is a huge challenge and barrier to that.

CO-CHAIR MOSCOVICE: So I have Greg, Guy, and Bob.

DR. IRVINE: To the third -- the next-to-the-last bullet point regarding pain management. I think we need to use great caution with trying to objectify pain management with pain scores and the like.

Pain management as reported by patients, all the rage a few years ago was that pain was the fifth vital sign, and pain management has probably as much -- as much to do with the art of medicine as anything we do. It's very difficult to objectify, and I think making pain the fifth vital sign has had the unintended

consequence of leading to what we're now seeing with this prescription drug epidemic that we see a lot in rural areas.

And I think trying to objectify this and make the patient have the right to have their pain controlled and therefore throwing narcotics at it, for example, creates horrible unintended consequences.

CO-CHAIR MOSCOVICE: Guy.

DR. NUKI: I think I see our job here today as taking things off this list.

And so just -- cancer patients, that's not a rural issue. I mean, we help in the care, but we're not managing their care. I mean, there might be some rural communities that have an oncologist, but I -- that's going to be so sparse that it's --- that's not worth it.

And so things like that -- I think the patient out of pocket cost should probably come off the list. Measures of lost productivity: I don't think that the volume is going to be there to really be very helpful.

Measures of diagnostic accuracy, are you talking about under- and over-utilization of diagnostic testing? Is that what that refers to?

DR. BURSTIN: Somewhat, although it's intended to be broader than that. I mean, we really have very few measures that begin with a symptom and consider whether the diagnosis was correct. There's actually a whole IOM committee working on this right now.

DR. NUKI: That actually, I think, would be interesting work, but obviously, this has a lot of work, yes.

DR. BURSTIN: Oh yes, sure.

CO-CHAIR MOSCOVICE: I have Bob and then Bruce.

DR. RAUNER: This is actually kind of a question in response to clarifying something you said, and that is, is the end-of-life care really worse in rural areas? I know the resources aren't there, but my gut feeling as based on an n of 1 is despite the lack of resources, when I was in my hometown, I thought

the end-of-life care was a lot better than it was in the urban area I am now, although some people might not consider Lincoln urban.

So -- because there's a lot of rural measures where people assume it must be worse because they don't have as much stuff, yet despite it, because of the resourcefulness, the cohesiveness of the community, the outcome actually ends up being better despite the lack of resources. So does anybody have any solid data on end of life, whether it's better or worse, rural versus urban? So it's I guess more of a question.

CO-CHAIR COURT: Well I think the work we did, and it was actually with a purchasing group. So they were using mortality as like an ultimate quality measure, but what we helped them understand was the mortality rates in our rural hospitals were higher partly because of low volume and partly because there was a lack of -- I mean, that's what the patient chose.

So it wasn't a measure of the quality

of the death, if you will, but it was like the patient died in the hospital, therefore you are a bad provider. And so I think we need to make sure that the measures reflect something that's truly meaningful.

CO-CHAIR MOSCOVICE: Okay. We have Bruce and Brock, and then we're going to move on.

DR. LANDON: So I didn't -- I wasn't planning to comment on the end-of-life issue, but, you know, it wouldn't surprise me if end-of-life care was better by a lot of objective measures, i.e. less intensive use of resources and whatnot in these areas. And probably worse if you're going to count something like, you know, enrollment in hospice because of not good availability. But as Tonya was mentioning, that sort of hospice care by a non-hospice, I mean, it's sort of the same thing.

What I was just going to comment with on this list. I guess to me this list is sort of orthogonal to the main issues that we were discussing yesterday, and in fact all the main

issues sort of apply to all of these things. Like, you know, so the paramount one that we spent a lot of time on yesterday was, you know, basically just low-volume services. So you can apply that to each one of these going down the line.

So -- and I think we should understand, obviously, we're looking, you know, for better measures and whatnot across the board and in here, but I think the job of our Committee is more to sort of think about the special circumstances related to measurement in rural low-volume settings as they apply to any potential new measure and existing measures.

And someone mentioned this a little bit. So, to me, patient out of pocket costs would be -- well first of all, you know, for the Medicare program or for the Medicaid program, that's going to be relatively somewhat standard, not exactly for Medicare.

And second, I would consider that, if anything it would be an adjustment thing, but not

a measure in and of itself, right? Because that's not -- yes, that's going to be a function of whatever someone's insurance coverage is, and that's not something that can be influenced by the rural provider.

Now if in fact there are more -- there's a higher prevalence of people with high deductible health plans, and we're talking about commercial and Medicare and Medicaid measurement and not just Medicare and Medicaid, then that could be an adjustment factor, but it's not a measurement itself, I don't believe.

CO-CHAIR MOSCOVICE: Okay, Brock has the last comment on this one.

MR. SLABACH: I think it is important to note, and I don't believe we had a specific conversation about this yesterday or this morning, and that is multiple chronic conditions. And in my work around the rural community, more and more providers are moving into chronic disease management and trying to move upstream on the correction of those before they become acute

exacerbations of disease -- of that disease.

And so -- but I've heard there's a dearth of measures that provide guidance in terms of whether these programs are successful and how do they compare with other programs of such.

So I think for the rural community, the only thing really on this list that I see that's probably a major gap that we haven't discussed is the measurement of chronic conditions and the treatment of those.

CO-CHAIR MOSCOVICE: Okay. Let's just go back to our list that you folks came up with yesterday, and we are going to take a break by no later than 10:30, promise. We will wheel through this.

But are there any other comments about the gap list we put together that you'd like to offer at this point? Kelly.

CO-CHAIR COURT: I just have concerns about population health measures in a pay-for -- even pay-for-reporting or pay-for-performance attributed to a provider group.

So the group in Wisconsin, the Population Health Institute, has got some really good data that says when you look at the health of a population, the providers, the care provided only contributes 15 percent to the health of the population.

And so there's so many other social determinants and behaviors that are -- and things like water and, you know, that just the providers don't control. So I think we have to be very cautious what we mean about population health measures.

CO-CHAIR MOSCOVICE: Any other comments on this one.

MR. SIZE: On that one? Yes, and I mean, I've been on that Institute since the beginning, and I agree with what Kelly said, and it's in part what I was thinking before, the importance of being clear about what metrics for what purposes.

And I am not uncomfortable with provider-specific metrics being reported for this

as part of awareness. And the reality is in rural communities, providers are a core if not dominant part of leadership. And so I'm not so hung up on -- if we're talking about public reporting of areas where you have influence but not control, then hospitals don't control all the elements in the community that contribute to 30 day return rate. So we've already set that as a precedent.

So now having said that, I mean, the same Population Health Institute with major funding from Robert Wood Johnson, we put out the County Health Rankings. So in fact, this stuff is already out there, probably at the level that is meaningful. We've got some other projects that I'm starting with Karen on next month in terms of going down to sub-county levels, but that's really below the radar of metrics.

CO-CHAIR MOSCOVICE: Okay. Brock?

MR. SLABACH: I wanted to make a comment about the transitions of care and the measurement of care coordination, and it may be a

good place to insert --- and maybe if we're going to make a comment to CMS. They have not figured out where Rural Health Clinics and Critical Access Hospitals fits in terms of care coordination reimbursement in the new codes that have been established.

And so, again, this is kind of a deficit of where Critical Access Hospitals and Rural Health Clinics kind of get left out of the conversation. And because of their payment types, the application of those payments are not considered, and then afterwards, they --- oh, it's like, now what are we going to do? And they have to find ways to work around.

And I think that, again, that care coordination payment would be critically helpful to being able to provide the resources to make this happen in these rural communities.

CO-CHAIR MOSCOVICE: Okay. Tonya.

MS. BARTHOLOMEW: Brock just sparked a thought in my head about the care coordination fees of Medicare and the difficulty to accomplish

what is required to get paid for those care coordination fees. I don't know how many people have looked into that, but is it a long laundry list of things that you have to complete in order to get that $46?

I don't know if rural clinics -- again, we're talking about those infrastructure abilities and technology abilities, having an HIE. All of that stuff is required to get that care coordination fee, so I don't know how feasible that's going to be for small rural places to collect that.

CO-CHAIR MOSCOVICE: Okay. Last comment on this slide, from Bob?

DR. RAUNER: I am going to dovetail on that because that's one of our core issues right now, is how do we make that happen? You know, I was talking to Bruce about this last night, that potentially, this is a huge sustainability thing for the clinic if we can get it to work, and can we make that sale to the patient that it's worth paying $8 a month out of their pocket for this?

And so we're actually trying to figure out how do we make that sale? Because we're going to have to package it in such a way that the patient is getting something they really want.

Is it a gold card with direct access, phone number, to the care coordinator that their daughter from California can use? Or the -- you know, the doc in Arizona when they're snowboarding down south can, you know, get their -- I mean, are there things that we can provide to convince enough patients to sign up for this? I think that's our biggest problem, because it pays for the documentation, actually. When you run the numbers, we can have -- we thought it was probably 80 to 100 -- if we got 80 to 100 patients to sign up for this in a clinic, that alone would fund a full-time care coordinator.

So -- but again, can you make that sale to the patient that it's worth $8, another $8 compared to everything else they're spending on health care? I don't know yet. We'll --

again, we'll find out in about six months whether we can make it work.

CO-CHAIR MOSCOVICE: Okay. So just a couple of other additional recommendations the group made. Create a MAP workgroup for rural providers, and Helen is going to talk a little bit in general about the concept of MAPs, a little bit later.

Relax requirements for use of vendors for the CAHPS surveys, or offer alternative data collection mechanisms similar to a CART tool for hospitals, given the cost of all these things; and then there's a point which I'm not sure what it means, is allow access to Medicare claims data.

So -- but those are three things on this chart, and Brock seems to want to go first.

MR. SLABACH: Well to add to the third point that I guess -- so Medicare Insurance Savings Program has produced data sets that are incredibly valuable to providers that are participating in accountable care organizations,

and that data allows them to see the patients in their service area and the sources of care and the locations of care that they're receiving.

We know providers -- I know providers, I know Bob and Ann as well, but when they have access to this information, they can rapidly improve the care of the coordination of those patients and reduce the overall cost to Medicare, in this case, for the care that these patients are receiving.

We have anecdotal evidence at the same time. We don't have -- I know it's not researched yet, but we have anecdotal evidence that it's also increasing the volume in these rural community hospitals and clinics because patients are now staying closer to home rather than getting turned into urban systems of care.

So if we could find a way to use Medicare claims data maybe outside of -- I mean, using Shared Savings data to improve care beyond just, say, the ACO context, I think it would be incredibly valuable.

CO-CHAIR MOSCOVICE: The timeliness issue comes into play here. Having a one-year timeline is not going to work for this. You're almost talking real time or very close to real time.

MR. SLABACH: I'm not sure what the lag time is on the production of that. I think once you get the data from CMMI, I think then if you have to have a data vendor that translates it for you, and I -- apparently, no matter what the time lag is, it's still very valuable information.

CO-CHAIR MOSCOVICE: Okay. Really, it's only -- any other comments on this slide?

Okay, the last slide before we -- oh, Tim.

MR. SIZE: Sorry, it's just a quick one, that Medicare -- I mean, you know a lot of us drool when we hear Bob and others talk about their access to Medicare data. We all in our states, with other similar groups around the country, have been fighting to try to get access

to Medicare data. So we have a totally contradictory public policy going on.

In our state, for a number of reasons, rural I don't think fit as neatly into rural ACO, and we've been looking for the WHIO to be successful --- and our state medical society is fighting for it --- and I think we ought to just call that out. That's a major policy that is affecting a lot of us that's just stupid.

CO-CHAIR COURT: So WHIO is an all-payer claims database --

MR. SIZE: Yes.

CO-CHAIR COURT: -- that has most of the commercial Medicaid, no Medicare yet, and none of the self-insured plans.

You know, so I think we need access to data like that, you know, so it's really difficult for providers to use that data because there's -- and for looking at quality, because there's no Medicare data. And so, you know, I don't know what the answer is, but the challenge is to have all this data segmented in different

places to try to use it either for creation of measures or when pay-for-performance is judgment, it's very difficult.

MR. SIZE: And it's -- yes, I mean WHIO has its problems, but in our state, it's a major player, which rural are largely locked out of because without the Medicare data being part of that all-payer system, it's not particularly meaningful.

CO-CHAIR MOSCOVICE: Okay. And the last slide, further discussion, and we'll be able to address this at the end of the day also.

We need to discuss a bit further the aggregation issues that were brought up earlier in a good conversation and the appropriateness of doing this at the particular levels. We've talked about this in terms of measure retirement and new measures, it creates a bit of instability to look at things longitudinally.

We mentioned this also, and we'll be talking about this a bit I think in the SDS, relationship of quality to the access and cost

dimensions. Part A and B difficulties, there could be a lot under that, I'm not sure what exactly is meant by that, but we can address that a bit later. Technical assistance across entities and concrete suggestions.

And so these are all things that we're not going to discuss right now, but it's on the list, and I think as we get towards the end of the day, we can come back to this in terms of additional responsibilities.

So it's 10:29. Why don't we take about a 15 minute break? We'll come back, and then we'll split up about -- oh, it's about 80 minutes or so, it will be between the two topics, the SDS and the MAP. Okay? Does that work for you?

(Whereupon, the meeting went off the record at 10:29 a.m. and resumed at 10:51 a.m.)

MS. JOHNSON: Helen is here and she's ready to give us a primer on NQF's SDS work. Hopefully that will be interesting to you. And then that will help kick us off and we can talk

about specifics on SDS and rural issues.

Okay, SDS first Mitra?

DR. BURSTIN: So, since we had some of these discussions have sort of peppered the conversations for the last couple of days, I thought it would probably be useful just to go over where we are in terms of this risk adjustment for socioeconomic status and other sociodemographic factors.

There is a final report from August 15 on our website. I was also a coauthor on a paper with the co-chairs. That was just a JAMA viewpoint, just right before the holidays on To Adjust or Not to Adjust, that is the Question. They actually let us call it that.

So a little bit of background. Part of what we've been trying to really understand has been whether particularly given the way measures are used these days and particularly these higher stakes financial uses associated with measures, whether it was time to take another look at how we adjust measures.

So, fully recognize there's lots of these patient -- and it really should be patient and community factors, that clearly influence outcomes through a lot of different pathways. The concern has also been some of these very factors may be the reasons related to disparities in health and healthcare as well.

So there's always been somewhat of a concern that if we consider these factors in risk adjustment, we would mask disparities. And we were like that was one of the driving forces of not doing this for years.

So to date, our policy has prohibited the inclusion of these factors in risk models. And just definitional here, we actually ultimately called it SDS although that doesn't roll of the tongue quite as easily as SES, mainly because SES is really quite limiting in terms of income, education, occupation.

And we're really thinking about the broad range of factors, both individual and patient. And this is just a short list. I went

back through the report this morning, we have a very long list of variables.

And, in fact, we really didn't have any discussion of specific factors around rural care. In fact, there was much more an urban disparities, racial optic disparities focus. So I'm actually really glad we have an opportunity to talk about this, because it was really not very much present in the report, but something we knew we wanted to get back to. So I think this is a good opportunity.

Ultimately what the report said is that this should really be on an individual, measure by measure determination. It's not a blanket. Not every measure should be adjusted for SDS.

And really, they should really only be adjusted if there's a logical rationale or a theory of why these factors would influence the outcomes. A conceptual basis, as we called it. As well as empirical evidence, meaning you could actually look at data, put those variables in a

risk model, and in fact see there is a relationship.

We gave the example of -- for example, central line infections in a hospital probably wouldn't really have association with patient level sociodemographics. It was not a conceptual -- yes?

(Off mic comment.)

DR. BURSTIN: Well, I'd love to hear more about that. But in general, things that happen inside the walls of a hospital. There was a sense that many of those other factors probably are not as relevant. And, as opposed to measures like readmissions or something where there's 30 days when somebody leaves the door of a facility and a whole lot else happens when they leave those doors.

And again, the recommendations were not just for hospitals, though I think that was a big part of the focus, particularly around readmission and cost measures. But really, thinking about it across the board, health plans,

facilities, individual clinicians, et cetera.

So ultimately, what we decided to do, is the report came out from the expert panel saying you know, adjust with these caveats when appropriate. But ultimately, the Board decided that it was really most appropriate that we do this in a pretty measured way. And we've now undertaken a two-year trial period that's already launched, as of January 1.

We will be accepting measures that come in that now have these sociodemographic adjustments. And really begin a process of comparing and understanding what the differences are really between the usually clinically adjusted kind of risk factor models versus ones that then also include adjustment for SDS. Part of what we'll also do for transparency, and really hopefully so we can all learn a lot, we'll actually endorse one measure. But it will have multiple required specifications.

So we'll be able to see in fact the risk model that is adjusted for SDS. A risk model

that isn't, that's just clinically adjusted, as well as stratification. To be able to see the differences by whatever group it turns out to be significant in.

Bruce already has a comment. Do you have a comment about this in particular? Okay, that's fine. It's almost done. Next slide.

The other piece of this is we'll be convening a new Disparity Standing Committee to help us implement this revised policy. And a whole lot of important issues like how do you stratify, what sample sizes are sufficient for a strata, things like that. And we'll look to that group to help us think it through.

But I specifically wanted to focus in on one of the other recommendations of the expert panel, which is that there should be a group of sort of national leaders and others who would come together to think about what is a standard set of these sociodemographic variables, both patient and community level, that should be made available to really make us -- help us understand

what these differences are?

And as I mentioned, I looked through it and there's really nothing that I could see that really called out, in particular, what would be unique community level variables from a rural perspective. So I thought that might be a useful discussion for us to have today. So with that, Bruce?

DR. LANDON: So I just wanted to ask, so one of the issues that at least I've noted in my own work is that the relative lack of availability of reasonably good measures of this. You know, so often we end up sort of adopting the mean income or racial classifications and the CTSA, ZCTSA, whatever those things are. And to me, that's always been a relatively unsatisfying thing.

We do often have data about whether someone qualifies for Medicaid or not. Which is again, okay, but a little bit unsatisfying. The one exception I would say where I think we could do a reasonably good job is like on survey

measures, like on CAHPS. There's at least a question about education, which is their proxy for SAS. And there's some health status stuff. But, in general, I've been pretty frustrated with the ability to do this. And I was hoping you would comment on this just where do you think the measures are going to come from?

DR. BURSTIN: Yes, so this has been an issue. There's a limited amount of these data you can certainly get from claims. Which is where a lot of the measures in question are still pretty -- relying on hospital claims in particular.

And that's been part of the reason for thinking about it being not just an individual level characteristic of a patient. But also thinking about community level factors. And that's where I think in fact the urban-rural kind of issues are particularly interesting, and whether there are variables.

So we had, one of the members of the panel was the CEO of BJC Health System in St.

Louis for example, who presented some work they had done looking at -- within their system. They have got hospitals that are in you know, pretty high end communities. They've got very urban hospitals.

And even within their own hospital, they had pretty significant differences in readmission rates that they didn't think had anything to do with. You know, they had the same systems, they had the same doctors, they had the same providers.

And part of what they were able to do was actually use census data. And one of the most important factors they found was as an example, factors like being in a community that has a high rate of vacancies. You know, lots of boarded up places. People are kind of --

So again, there may be other creative ways to think about what are factors that perhaps give a sense, particularly at a community level, of vulnerability, of lack of access to resources, perhaps lack of access to what you might need to

have sufficient support to avoid bouncing back in the hospital, to make sure you can get your prescriptions filled, make sure you can in fact buy your fresh fruits and vegetables.

But it's going to be a complicated issue. No question. And I think the fear is going to be, there will be a lot of measures that people will say conceptually, these make sense. We should adjust them, and then we're not going to find the data yet to say which variables you would use, because they're just not reaching the collected. Which is why thinking about what the standard set of variables would be, and including the rural perspective would be very useful.

CO-CHAIR MOSCOVICE: So we have Greg, and Bob, and then Tim.

DR. IRVINE: Going back, I'm sorry I interrupted you earlier, by the way. It just -- when I was an attending at the University of Michigan, I was assigned at Wayne County General Hospital, and I actually wrote a paper on complications of central lines in surgical

patients. And our number one cause for catheter sepsis at the county hospital were visitors coming in and injecting the catheter with drugs. Like, usually, heroin. So there are socioeconomic factors, even on hospital acquired circumstances. But that was our number one cause of catheter sepsis, so.

CO-CHAIR MOSCOVICE: Bob?

DR. RAUNER: I have a question and a side reflection. One question is to the statisticians is that you correct for stuff to remove as much other explanation as possible. So going from zero to 100 does for example, the risk adjustments like Lexington where it went up, the risk score is 1.7, does that remove, say, 80 percent of the variable with only 20 percent residual left over?

And then by adding socioeconomics, do you get rid of say another ten percent, almost all the rest? Does anybody have any sense for that? Like how much more are we explaining by adding these? It's obviously statistically

significant, but how clinically significant is it?

And then some reflections. Is that there are measures we can pull. The problem is they are not in claims. So, with meaningful use we now capture race and ethnicity, for example, but that's probably not in claims. How are you going to merge some of these things which you might be able to do on a community level? But it's better if it's on the patient level.

And then I would argue for this, because I do my ACO job half time. My other half time I work with our school system. And we pull in a data set that includes -- it's mostly around obesity and fitness. We pull in ethnicity, free meal cost lunch data, which is our socioeconomics, academics, everything. And you -- and a lot of our racial disparities go away with correction for free meal cost lunch, but not all.

And then sometimes there's granular things such that, for example, we don't see

gender disparities on the overall level. But on the ethnic level, we still don't see them for Caucasians and Asians, but we do see them for Hispanics and African Americans, but in opposite directions.

And so sometimes there is a lot of uniqueness in there. And I think you are going to have to look at them individually. Some things it may not matter, where others -- and you may get conflicting results too. So, but it gets complicated. But the stats guys, do you know what -- how much is explained away by just actual risk adjustment? How much more is explained away by that? Is there any sense for that?

DR. SCHMALTZ: I think you'd have to give a range, because it varies widely by what type of outcome measure you're looking at. I mean, you can go from three percent to 15 percent from what I've seen. That could be explained by other factors, such as severity of illness, which tends to be the highest.

DR. BURSTIN: And I'll just add, when

we look at the R-squares of models submitted to us for measures, oftentimes it's very disturbing to clinicians and others when they see in fact, how little is explained by the -- what the clinical factor is in a model.

So there's always a lot of concern. Some of that could be the actual of care provided, and I think some of it is also one of these other factors that we're not measuring. So I think that's part of what we're trying to learn through this trial period is in fact, what is the additive effect of adding these variables in? And how much more of the explanatory variation can you look at?

DR. RAUNER: Yes, but I think -- there was a Health Affairs article about four to six months ago, where they actually added, it turned out that marital status was huge for readmissions, especially if you were an African male with no wife. It was very high. I mean it was -- I was really surprised at how much I didn't realize that made that big a difference.

It was kind of eye opening.

CO-CHAIR MOSCOVICE: I have Tim, and then Guy.

MR. SIZE: As some may have, the careful listener would have noted, I have interest in this issue.

(Laughter.)

MR. SIZE: I just, I think this arguably may be the most important work NQF has ever done. I think that's my feeling on how important it is. I go back to IOM Health Literacy Report, because a friend of mine, Dave Kindig chaired it. And my favorite part of that report I think is relevant, because he talks about the concept of co-production of care. And that's -- it's our arrogance as providers that you know, we're just helping them out and then we zap people and they get better.

Well, the reality is it's not that way. And I served for years on the Crowley Committee, the HMO we started years ago. And we did some studies about you know, what the

compliance was. And this was for a relatively diverse population across the SDS background -- on you know, the patient following through and actually taking the whole line of medication they were prescribed.

For a lay person, it just blew me out of the water. And my sense is from that study that it did have SDS implications. So anyway, really, really, important work. I think it's really relevant to rural. And it came to me in some of our work in Wisconsin as we've started to get public reporting with smaller clinics.

I mean obviously, as you get a smaller clinic, the randomness of them having to be -- with a patient population that's you know, well off suburban, versus struggling rural. I mean, those things really start to matter and get amplified.

And I mentioned to Ira in the break that right before the break we talked about the gap. Well I think actually it's going to be the gap in those metrics that we adjust between the

adjusted metric and the non-adjusted metric will then create a whole other sense of one, if we're judging physician to physician behavior, I think it's very -- just to be fair that it's SDS adjusted.

But if we're looking at what are the ethical and professional responsibilities of the hospital and the clinic to try to address the unique issues of the population, you look at the other metric and you look at the gap. So it's going to create a whole other major gap opportunity. But I'm really, really glad you're doing this work.

CO-CHAIR MOSCOVICE: We have Guy and then Aaron.

DR. NUKI: So one of the things that we talked about yesterday was the peer group. So this is a risk adjustment, a measurement adjustment. You get numbers different, as opposed to using SDS for developing peer groups. Which is really a very unique rural issue. And I think that's going to be very important that we

figure out what are the most important you know, environmental factors, is almost maybe a better way to put it to create those peer groups.

DR. BURSTIN: And do you have a sense of what those might be, from a rural perspective?

DR. NUKI: Clearly distance to referral hospital. Income you know, of the -- general income of the region. I mean some of the just pretty much basic things. I wouldn't make them -- I wouldn't have 50. I'd have a few that we think are important. I think size of the medical staff, population size, distance to the hospital and the average income. Percent of Medicaid patients, percent of no insurance. Average education level. I think the more you throw in, you'll start to get -- because we want to clump them, then, into groups.

So you'd have to figure out, do we create a score? Or is it you know, one group is between the -- you know, in this economic you know, at this economic level from average income being from $20 to $30 thousand. Plus hospital

being more than 60 miles away or something like that. I'm not quite sure.

CO-CHAIR MOSCOVICE: So one of the things I was going to ask you Helen, is the distance issue. Because you didn't discuss that in urban, or in these other things that you mentioned are discussed with urban. Do you see distance as a central part of this discussion?

DR. BURSTIN: So everything you said over the last two days, it sounds like the answer is yes. And I guess the question is distance to what? If it is a referral center are there other considerations as well? And rural communities where that may actually be almost a bridge too far for some.

CO-CHAIR MOSCOVICE: Yes, I would say to a referral center. But I'd also use size of medical staff. Because if you have six people on the medical staff, that's very different then if you have even 15 or 20. I mean it really, that changes what the hospital -- the resources and what the hospital can do.

DR. NUKI: Does it matter who is on the medical staff as compared to how many?

CO-CHAIR MOSCOVICE: Probably. But I'm not sure how you would -- you'd have to think, how would you, you know, I don't know how you'd divide that up. That would be tough. Okay. Aaron?

DR. GARMAN: On somewhat of a clinical note regarding this, as you know, I belong to an FQHC, and I mentioned the UDS. The UDS collects a lot of demographic data, and it breaks it down by race and ethnicity. It could be a starting point at least to look at that data. And perhaps give you some better ideas of where to focus your attention.

CO-CHAIR MOSCOVICE: We have Kimberly and then Tonya.

DR. RASK: I think the other piece that could come in is some of the -- along with distance, the availability of other healthcare resources in the area. Are there any PCPs in the country? What is the density of PCPs? Is there

home health in the county or whatever region that you're in?

Are there long term care facilities? All those other things that would be other potential sites of care or referral of care that may or may not be available to whatever provider. And I think you could really think about those, not just at the hospital level, but also at the practitioner level.

Because to you know, go with what some of what Tonya said, part of what you're picking up is a PCP who's in an isolated rural community, is going to have a broader scope of practice, because they're doing all those other things that elsewhere might be referred to hospice, home health or other options which are simply not available.

CO-CHAIR MOSCOVICE: And so, do you -- and I'm not putting you on the spot. Just your gut reaction, the supply side issue, you view as part of this. Once again, very different for rural then urban. And so we're not talking about

patient characteristics as much as really the environment output.

DR. BURSTIN: Absolutely. And I think more on the urban side there was a lot of discussion of neighborhood or census track. So you know, it's basically this is sort of a macro, blowing out that from a very urban perspective to something a whole lot bigger.

But I still think you know, the question is, are they directly effecting the outcome measures we'd potentially be using for accountability for rural providers. And more than anything else, I think we just want to make sure that as you know, we start thinking about some of these measures coming forward, that might ultimately get used in these communities, how do we make sure that in fact are getting fair comparisons?

CO-CHAIR MOSCOVICE: Okay. I had Tonya then Brock.

MS. BARTHOLOMEW: I know I sound like a broken record, but we were talking during break

about how, you know, Greg and I come from very, very unique areas where we're not only a rural community, but we are rural states. The State of Wyoming doesn't even have a psychiatrist, okay.

So when we're talking about telemedicine, we're talking about all of the stuff that distance is tied to access. So when we're talking about getting these patients these services, they can't afford to drive to Salt Lake City, four hours away, to Denver, Colorado, four hours away, to get mental health services.

And so, going back what Kimberly was saying, our scope of practice is so much bigger. But when you're talking about you know, ability to get access to services, I think you really have to even broaden your perspective of what rural communities are setting in rural States, which are settings set in rural regions. And it becomes an access issue.

CO-CHAIR MOSCOVICE: Okay. And Brock?

MR. SLABACH: One possible designation that could be capable of making, maybe, some of

these distinctions, because I'm -- my quandary here is data collection and how is all of this achieved through reporting. The HPSA, the Health Professional Shortage Area, medically under-served areas, and medically under-served populations are three designations that HRSA uses and defines, that could be a way to distinguish this.

Also, I know Greg doesn't like the term frontier, we can call it geographically challenged, but there are frontier definitions that are used in Federal policy that could be used to distinguish those that are more remote, in terms of their access to other services, or more distance shall we say. So going back to your census tracks, it's a similar notion except only in the rural context.

Again, I'll echo, I mean this is an incredibly important piece. My work in Mississippi as a rural hospital administrator with a 70 percent, 60 to 70 percent African American population, it was extremely frustrating

to have applications of certain measures, perhaps, that wouldn't be possibly comparable in a real literal sense to another location. When we closed our OB program in 2003 that didn't stop our delivery of babies, because they came to the emergency department. And so we were delivering a fair number of babies in the emergency department because they didn't have rides to get to the urban area.

That was a reality that we had to deal with. So you know, it -- were we going to turn them away or not serve them? Of course not. And I think that's really what we come down to in terms of the reality.

CO-CHAIR MOSCOVICE: Kelly?

CO-CHAIR COURT: Brock stole my first point, so thank you. The second point though is distance isn't always distance. And so 30 miles down the interstate is different than 30 miles up over the mountain pass on a two-lane highway that's maybe not so great. But it maybe needs to be time of travel. Yes, by time versus by miles.

And I know we've talked about that in Wisconsin with the critical access designation and the miles limits. So that's something that probably should be considered.

CO-CHAIR MOSCOVICE: I haven't gotten to the big mountains in Wisconsin. But I look forward to seeing them.

(Laughter.)

CO-CHAIR MOSCOVICE: We talk about those hills in Minnesota also. And seasonality also is certainly an interest.

CO-CHAIR COURT: If you have to cross country ski there, you're in trouble.

CO-CHAIR MOSCOVICE: Other comments? So, what about the other side of this? So this has been a real debate in general, in terms of should we be using these kinds of variables in terms of how we pay folks?

And on the one side, what everybody's been saying, it affects. We believe it affects outcomes. The other side is, well if we do this, you know, there are some people saying well, you

know, what we're saying is, it's okay to have disparities and that we're going to create disincentives for people to try to overcome that. I'm just wondering what, sort of how NQF has responded to that.

DR. BURSTIN: Well, that's been the crux of the debate from day one of the question of you know, is this appropriate because for fairness, versus you know, what's the potential downside. Which is ultimately why we decided to study it for a couple of years and not just whole hog say we're just doing it in all measures, will be SDS adjust it?

And frankly, we want to be able to see what those differences are. I mean, we honestly don't know what that gap will be, to the question raised earlier between the measures that are clinically -- you know, usually adjusted, versus those that add in these factors.

So you know, it's still early. And I think the thought was, given the complexity in this day and age, to simply say we won't look at

it, didn't make sense anymore. And it just seemed like it was time to look. And that's been part of the reason as well for saying, you should also have the stratified result. Because then if you have the SDS adjusted result, you'll then be able to look at whatever those significant factors were in the model.

I mean, if distance or time was the significant factor in the model that's being adjusted for, you'll then be able to see what the rates in fact were. So it's that transparency we hope will help.

CO-CHAIR MOSCOVICE: And how does that interact with the low volume issue we talked about? When you talk about stratification, et cetera?

DR. BURSTIN: It's going to be even harder.

CO-CHAIR MOSCOVICE: Okay.

DR. BURSTIN: Yes, it's going to make it you know, small cells even smaller.

CO-CHAIR MOSCOVICE: That's tricky.

DR. BURSTIN: So, it's not going to be easy. I would be very -- it would be very interesting for example, to look at some of the measures that are you know, pretty controversial.

The HRRP and IPPS/LTCH for example, the readmission measures. And see if you know, I'm not sure I've ever heard this researched, or has anybody actually been out there looking at some of these measures and seeing whether some of these kind of more rurally oriented factors would have made a difference in those rates and the penalties?

CO-CHAIR MOSCOVICE: I mean, to get the low volume, aren't we talking about all cause readmission as compared to you know, particular backgrounds?

DR. BURSTIN: Right. We've got that measure now, of all cause. So that's an interesting idea.

CO-CHAIR MOSCOVICE: All right. I have Bruce and then Bob.

DR. LANDON: So just in response to

your last comments. One of my colleagues and a fellow are looking using HRS data, that model readmissions including all the stuff available in HRS like cognition, social supports, and whatnot. And actually, I haven't looked at the most recent version, although it's pretty close, and my understanding was that in a fairly saturated model with sort of clinical predictors and whatnot, it added less than we would have thought.

And it does improve the R square, but didn't actually change around the possibles all that much in another way. More importantly though is you know, I think there are a lot of challenges to doing this. And I think one of the things that where this is particularly relevant as sort of getting at the way control groups are compared to groups.

So for instance, if you know, being in a rural area is a big disadvantage in terms of distance and access to specialists versus an urban area, and I buy that, then that's one of

the reasons why we want to you know, compare small rural hospitals to one another, instead of to the big academic tertiary medical center.

And I guess I'm worried about all the sort of complexities and really lack of good data on some of these things, such that my preference would be to try to take care of as much as we can of this issue using appropriate comparator groups, instead of putting additional data in the model.

CO-CHAIR MOSCOVICE: So I can't pass this opportunity to simply say some of your colleagues at Harvard don't get that, in terms of some of the work they've been doing over the last couple of years with the critical access hospitals. I'll just leave it.

(Laughter)

CO-CHAIR MOSCOVICE: I think you know the names. Bob.

CO-CHAIR COURT: I even know the names.

(Laughter)

CO-CHAIR MOSCOVICE: All right, Bob then Tim.

DR. RAUNER: This is something that I think style of practice has a huge effect on this. And that one of the reasons our ACO has very low readmission rates. But I think is partly an effect of cherry picking. And that the people who we asked to join us, who we start off with are all physicians who do their own hospital work.

And several of them, not only do they do their own hospital work, they also cover the ER. So there is no handoff essentially. And I actually think that is the main explanation for our low readmission rate, is because there's just less opportunity for things to not get handed off.

I mean, and our ER load utilization is very low as well, because they can call in. And then when they call in, they call their own doctor who says, no, see me at 8:00 tomorrow morning. And so our ER rates are also really,

really low compared to our peers.

And it's that style of practice which, unfortunately, is starting to go away more and more where they're getting the hospitalists and then random contracted ER people coming in from who knows where. That's something that has to be studied actually, because I think it is why some of our results are what they are. It's that style of practice. And that varies from community to community.

CO-CHAIR MOSCOVICE: That's an interesting point, but I would assume you don't do that as part of it as well.

DR. BURSTIN: Not part of it, but it's a really important issue. But obviously effects measurement. I mean if you're doing all of it, you don't have handoffs, you're going to -- it just logically makes sense your rates would be better. But how do you operationalize that across the U.S.? It would be pretty hard to do in this day and age, so.

CO-CHAIR MOSCOVICE: Oh. And Jason

back there.

MR. LANDERS: But wouldn't you measure against your peers that maybe aren't part of your ACO that maybe do send their patients to the hospitalist and don't have total control over them? And I mean, that's I think they would be factored into your peer group.

DR. RAUNER: That's a matter of intense debate internally right now. Because we have -- we've just added a practice that doesn't do that. And we're not sure that they're going to drag us down because of that.

And so, it doesn't necessarily call -- and actually the case that I told you, the three -- the care coordinators who had those three problems within one or two weeks, they're that new group that doesn't do their own hospital, and doesn't do their own ER. And that's maybe why the found so much so fast. And so it's hard. We are struggling with that. Do we let those people in, because we know they're probably going to have higher readmission rates and higher ER

utilization. And I don't know.

MR. LANDERS: For the success of your ACO it makes sense, but for regional measurement, it -- cherry picking was the right word.

CO-CHAIR MOSCOVICE: I have Kimberly, Brock and Tim. And Bruce, I assume yours is? Kimberly?

DR. RASK: And then the only other point I bring in from the QI perspective is in terms of either finding good comparators, or doing great risk adjustment. There are reasons to do it for methodologic purposes, and for the scientific validity.

The other thing is with all of the stuff when it's reported publically, or if you want people to act on it, they have to believe in what they see. And if people believe that they're different, and if people believe that they're being unfairly compared, it's really difficult to motivate them to accept the data that you present to them. Or to motivate them for change.

So, even thinking about what we've heard in all the discussions and to me if there's one theme I've heard over this last day, is there's a gigantic heterogeneity issue with these very small volume providers all over these 50 States.

And so if we don't have a measurement process or a reporting process that at least acknowledges that, even if over time we are able to say no, actually it turns out you all are the same, you're just wrong. But, if we go in with that attitude, it's going to be difficult to have all of these individual providers really believe that they have been appropriately assessed.

CO-CHAIR MOSCOVICE: And I think the other thing I want to point out, as Helen mentioned, we all have our preconceived notion about how this is all going to work out. You know, guess what folks, it might not. And you might not like the statistics. You might not like whatever, you know, how we conceptualize it. But we also all have to keep an open mind that as to

you know, how this all plays out. We -- it's one of the reasons to study it. Tim?

MR. SIZE: I tell you, I mean there are initially winners and losers, and I know in our -- my own state included. I have just a couple of comments that you know, just comparing like CAHS to CAHS, or rural center, that doesn't get it.

I mean, I just know the variability in small towns I work with. And some are actually pretty middle class. And others are really, really struggling. And so, same -- they're going to have the same provider types, but very, very different population and at least on my hypothesis is very different compliance rates on a whole bunch of stuff.

I think the other thing I like about it from a population health perspective, and I'm not talking about the medicalized population health definition, but the more traditional David Kindig kind of population health thing. Is that we actually then start to see provider specific

metrics. How they're affected by the community.

And I would never say well, they should be responsible to control the unadjusted score. But at least they could start to manage the gap and ask questions where they have the opportunity to influence the community to improve actually the raw score. And I think that's going to be very, very powerful.

CO-CHAIR MOSCOVICE: Brock?

MR. SLABACH: I agree with Kim completely, that the conversation would be why we're different, and not the focuses on improvement. And I think that's critical. The unintended consequences, and we talked about this about not doing SDS adjustment, I was struck really profoundly when I was listening to a professor of medicine at the University of -- is that Pittsburgh? University of Pittsburgh or University of Pennsylvania at Pittsburgh, one of those. Anyway, someplace in Pennsylvania.

(Laughter)

MR. SLABACH: And she was -- and she

was at our multiracial, multi-cultural conference, and she was giving a direct impact of this problem. That she was being asked to discharge patients from her practice because they weren't compliant. And they were not going to meet the physician reporting requirements in terms of standard. And they did not want to be counted down in their practice as a result of this population of patients that they had.

So this is the profound impact of how these things translate into unintended consequences. And there's beginning then a struggle in the department about whether that's in fact ethical and should that be the process that they undergo their practice operation.

CO-CHAIR MOSCOVICE: Yes, and the other side of that is, I know rural clinicians, family physicians who basically say I'm scoring low on terms of how I take care of you know, diabetics. Well guess what? Here's the four people, it's of low volume, that I take care of who are out of control. Two are homeless, one

will not comply with anything I say.

But out of the kindness of my heart, when they show up, I don't say I'm not going to see them, I try to do what I can. And you know, that's the way it is. And I know what I can do if I want to look good, just get rid of those three or four people from my panel, and I look good. And in the rural environment, it's even more telling because of low volume issues Greg and Brock, yours is okay. So Greg?

DR. IRVINE: This is just real quick. We actually see patients in our family practice clinic being transferred from provider to provider so that the numbers look better. And we all in a small town know who the noncompliant people are. And they're like a hot potato, they get passed around.

CO-CHAIR MOSCOVICE: Any other comments for Helen on the SDS issue before we move onto the MAP, or all the MAPs in deliberation?

MS. JOHNSON: I have a quick question.

And this is just out of curiosity about data availability. Where I'm from, in the Central Appalachian Region of the country, you have this independent streak. And going to the doctor, my father hasn't gone to the doctor in 25 years, probably. At least. He went when he had shingles and that's the only -- I mean, literally that's the only time in probably 50 years he's been to the doctor.

And that's probably not uncommon. Is there any data that gets to that level? It's a cultural kind of thing. It's probably pretty important, but I'm not aware of any. And I'm just curious if you guys know of any?

(Laughter)

CO-CHAIR COURT: It's a gender thing.

(Laughter)

DR. RAUNER: Okay. Well, we've been struggling with that actually. Because one of the things we decided to use is annual percentage of wellness visit. And some of our most rural places, the docs say, I said I just can't get

them to come in because it's not their mind set. It's that fatalistic, when it's my time, it's my time. So why would I come in to do this? Because you know, that's why they don't wear seatbelts. It's why they don't you know, and I grew up with that.

So I mean, so I kind of understand it. Although I used to throw it back, and it's like not changing the oil in your tractor because when it's your John Deere's time, it's your John Deere's time. You don't do that with your tractor, why would you do that for you? But there is that prevalent fatalistic, and it's really hard. And then on top of that, there's the economics, because the uninsurance rate, and high deductible rate is really high amongst independent, self-employed farmers for example.

And when it's $3,000.00 out of my pocket for that colonoscopy versus the $100.00 to change the oil in my tractor, guess what wins? And so it's -- so literally it's not an access issue for colonoscopy in Nebraska, but it's a

patient attitude, because of that fatalistic mind set. And it's an economic issue because of the under insurance and the high deductibles.

CO-CHAIR MOSCOVICE: So that's not going to be trivial to enter into any kind of SDS model, needless to say. All right Guy?

DR. NUKI: You know it's interesting, I think though that if you asked all of us, we all think that our community that we come from is the one that's the worst in that. And so I think that's an everywhere issue. I'm not so concerned about having to dig into that so that we can compare. Because it probably is more related to gender then socioeconomic status. I mean although the having to pay $100.00 to go to the doctor, or pay the entire bill because you have a you know, $8,000.00 deductible, that probably makes a difference.

But I don't think every -- I've worked in a lot of states. And every place -- it's a little bit like the people -- everybody in Maine thinks that people move to Maine because it's

easy to get Maine Medicaid. When I was in Washington, people thought that everybody moved to Washington just to get Washington Medicaid because I mean it -- I just don't think that -- it's just local lore.

CO-CHAIR MOSCOVICE: Greg?

DR. IRVINE: I don't have anything.

CO-CHAIR MOSCOVICE: Any other final comments on SDS before we move on?

DR. BAER: Just to support what Greg said. I thought that's why the built the Philadelphia International Airport.

CO-CHAIR MOSCOVICE: All right. I think it's time to move onto the -- to our discussion about what exactly is a MAP, and how it might fit into the future deliberations.

DR. BURSTIN: So we've talked a lot -- well, periodically about this elusive body called the MAP in the last couple of days. So we thought we'd just put a little more meat on the bones and perhaps talk about it a bit. So this is something funded by CMS to NQF where we

convene something called the Measures Application Partnership, which we affectionately refer to as the MAP. And the idea is to provide multistakeholder input to HHS specifically on which measures should be selected for which Federal programs.

It includes pay for reporting, it includes pay for performance as well. And currently, it's over 20 Federal programs. And I'll show that to you shortly.

And so what happens is MAP provides to NQF the measures under consideration across these 20 different Federal programs. We then bring it to these multistakeholder groups, and I'll go over that in a moment, and get their input about which measures they think are most appropriate, which measures they have concerns about.

It currently includes about 150 healthcare leaders and experts across -- a clinician workgroup, a hospital workgroup, and then a post-acute long term care workgroup. There are some other smaller workgroups as well.

And the one that to me seems most, sort of, analogous potentially for sort of an area that's kind of emerging is the dual eligibility workgroup. And Brock's smiling because he probably had the same thought. Where a lot of that work has really been about what are the measure gaps, what might you measure? As opposed to saying here's a set of measures, please select among them.

It does -- the other nice thing about this is it includes both private sector, but there are actually the Federal agencies sit at the table with us. So CMS sits at the table, HRSA, CDC, et cetera. Next.

So this is a list of the current Federal programs that we do. So for example, we've talked a lot about MSSP and PQRS and value-based purchasing. Those are all among the current measures that we review for CMS. And so these measures go to the MAP before CMS puts out their final rules, where they say which measures will be used. And we're an input to them, the

MAP workgroups and the final coordinating committee, are an input to those groups to then think about which measures would be most appropriate.

Interestingly when I was downstairs with the other meeting, I was talking to Kevin Larson who is head of Meaningful Use, the Medical Director of Meaningful Use for the Office of the National Coordinator, and I was mentioning critical access hospitals, and he said you know, the only program currently that includes critical access hospitals is Meaningful Use.

And he mentioned they actually have a full time analyst at ONC who could actually do any analysis we would like to be able to see some of the differences, for example of measures submitted by critical access hospitals, for the same measures against those of others. And I thought might be an interesting analytic piece we follow up on.

But it is remarkable that they are not generally included in any of these other

programs. So, something for us to think about. Next slide. And this is just an example. Part of what we really try to do as part of the MAP process is really focus on alignment. And so the idea is both to align within the Federal programs themselves, which is quite cacophonous still. But also then to take it to the private sector and see if we can get some alignments.

So just as an example there, I think there are about 30 -- I think there are about 40 hypertension measures that were used across the entire Federal Government. CDC, all the different Federal programs. And then they've ultimately gotten that down to I think two measures in use across all the Federal programs.

Similarly, the list that's listed up here, just a couple of other examples of risk associated conditions, HIV/AIDS, perinatal and obesity are some of their early focus areas. But that has been our goal.

If we can at least get the Federal Government to align internally, it then gives us

a better chance to work with the private payers as I mentioned yesterday, to say they've aligned. Now how do we get you guys to align as well? So it's been a really important input.

Yes, I'll just repeat the question. Yes, to those -- yes, so the white bars were literally the number of measures in use across the different Federal Programs. It is remarkable. So a lot of that to the credit of Kay Goodrich at AHRQ. And Nancy Wilson -- I'm sorry, Kay Goodrich at CMS and Nancy Wilson at AHRQ have done -- led this measurement council across HHS. So there really is a great deal of interest in alignment.

And so it is a good opportunity to think potentially about you know, the rule of measures. They may not always have the alignment perhaps. But it would be interesting at least to start from where they're beginning as a starting point. I think that is -- Mary, do I have anything else? I think that's it. Great.

So with that, questions? Thoughts?

And again, this is something we do under contract to CMS. We would need to, if this is an interest to this group, we'd be happy to certainly talk with both HRSA and CMS and see if perhaps we could ask them to consider for the future contract, the addition of a -- more of a -- along the lines of the dual eligibles workgroup, a rural providers workgroup. So, questions? Thoughts on that?

CO-CHAIR MOSCOVICE: I have Kelly and Brock.

CO-CHAIR COURT: So a question Helen, what obligation, if any, is CMS under to accept the recommendations of the MAP? I mean I'm familiar mostly with the hospital reporting, VBP, you know, those programs. And in the proposed and final rules, they often don't take into consideration that you know, the MAP has said this is not a recommended measure. So -- and do we run that same risk with rural?

DR. BURSTIN: So, it is a recommendation. It is not you know, it is not

certainly saying you must do this. For most of the hospital programs, home health, nursing homes, those kind of programs have very, very high rates that the recommendations from MAP match up quite closely.

There are certainly exceptions. But for the most part they line up quite closely. I mean if nothing else, they give them a pretty good sense of the big issues that are emerging that they hear from the stakeholders at the table. Even if it doesn't directly translate into a yes/no on particular measures. But we actually study the -- their adherence to the recommendations as well, is perhaps one way to think about it.

CO-CHAIR MOSCOVICE: Okay, Brock?

MR. SLABACH: So this may be a continuing education program for me as well today. Correct me if I'm wrong, but the CMS delivers to you all at NQF, the MUC list, the measures under consideration. And that's what then we deliberate upon at our workgroup

meetings.

What chance are there of outside insertions under measures under consideration, number one? And number two, how are measures developed? I guess you get those input from researchers around the country on various topics, and then NQF as a separate process evaluates those measures as well?

DR. BURSTIN: So there's only a couple of different ways this is done. And again, there's a pretty big difference between the physician programs and the other programs, to be honest. But as an example, for the PQRS program, for all the physician programs, there is actually a tool that they have open that anybody can submit a measure for consideration into this process. So it doesn't always require that CMS says we want to use this measure. Anybody can bring that measure forward. And that's a lot of what's on the MUC list.

In fact, increasingly -- and certainly Severa and Mitra could jump in, they've both been

very involved in the MAP process as well -- we are getting measures that are under development still. So it's actually interesting to see measures that are still at a pretty early conceptual level, where part of what they're asking for is this a reasonable direction to go? And any specific suggestions for how to move forward.

So, that might actually be a really interesting role for a rural group to look at some thoughts about what measures are under consideration or under development that might move forward.

But for some of the groups like for example, the duel eligible group, and correct me if I'm wrong Mitra or Severa, there's been less about looking at a list of measures for consideration and more about saying here are the gaps. Here's what we think a core list would look like for this group. Even in advance of measures necessarily put on a list by CMS for consideration.

So some of them are pretty early -- some of them are earlier in the process than others. And actually Ira sat on that, so Ira may have some thoughts on that too.

CO-CHAIR MOSCOVICE: Yes, the only thing I would say is so the dual eligibles are a subpopulation. But cause or if we wanted to look at it that way, or rural providers are subgroups of other provider groups. And so -- and from having sat on the MAP and from Brock being on it also, most of the measures there that get discussed are not very relevant for rural.

And so we need to think -- I think it's really important. I think that's really the next step after this group puts their report out. But it's really important to try to understand how those two different provider groups, with very different membership, would interact with each other. So they're not necessarily -- they may have different opinions about the value of some measures versus others.

Other comments about MAPs? And before

we said you know, that -- a couple of people said well, gee it would be you know, that is the logical next step for this group. That's what we said yesterday.

Now having heard from Helen, do you feel just as strongly about that? Are there other next steps? And I guess we'll be talking about that at the very end. But any other questions, really, relative to how MAPs fit into this? Or the value of them as the next step? Brock, is yours still up? Or are you down?

MR. SLABACH: Since the -- I'll take advantage of my raised card. Having been able to participate in the hospital workgroup and understand the process, I think that if we recommend mandatory reporting for these groups, and this is the process under which these rural relevant programs would be selected, I think it would be a very nice combination to be able to convince, or to satisfy, our colleagues that this is going to be done hopefully appropriately.

CO-CHAIR MOSCOVICE: Okay. Other

final comments for Helen? Okay.

DR. NUKI: I'll just word the same thing a little differently. It's terrifying to think that you would make these measures without a group like this at the table.

DR. BURSTIN: And I've just been -- the person who leads our dual workgroup wasn't available to come up. But part of what she pointed out as well as a lot of that group's actions have them thinking about how to generate measures that are more directly relevant to the population.

So I think that would be kind of building on some of the work we've done for the last couple of days. And then asking how existing measures could be modified or stratified to make sense to be perhaps more actionable to a given community.

So I think there are some nice analogies there. And we'd certainly be happy to follow up with CMS.

CO-CHAIR COURT: So question then,

Helen. How -- if NQF develops a rural MAP, how do you ensure that you have rural people and that it doesn't get sidetracked with non-rural people or people that don't understand the rural perspective?

DR. BURSTIN: Yes, again, this is pretty premature because we don't have one yet. But we would definitely do a call for nominees. We would make sure that it's appropriately populated.

We'd probably take a subsample of some folks. If it winds up being mainly critical access hospitals, it would be helpful to have some overlap. Because some folks already sit on a hospital workgroup for example. Just to understand the broader issues.

But you know, I think if you look at the Medicaid group we put together or the dual eligible group we put together, they really bring that expertise to the table.

CO-CHAIR MOSCOVICE: I'm not seeing any other comments. I'll turn it back maybe to

Karen to talk about lunch and that other.

MS. JOHNSON: About lunch, yes. Before we do that, I think do we have a public comment scheduled now or is that a little bit later?

MS. GHAZINOUR: No, that's at the end of the meeting.

MS. JOHNSON: Okay. I want to get a quick read of people around the table. I know at least one or two of you may need to leave early. And I'm not sure how early is early.

So the idea is we will have lunch and then come back and do a round robin, kind of your final say. How many of you need to leave before 12:30 to 1:30 when we're doing the round robin? Okay, three of you.

I'm wondering if we were scheduled to have lunch at noon I believe. Perhaps now would be a good time for you guys to give us your final round robin reflections. And I know you didn't have lunch to think about it. But we'd hate to miss yours just because of your travel plans.

So I guess the idea here is really, whatever you feel like you would like to go on the record for. If we've missed something. If you want to emphasize something. If you want to just comment on the process. Whatever you feel like sharing. And if you don't feel like sharing, that's fine too.

DR. KESSLER: I'd like to go first just because I really need to be leaving right about now. And it is difficult to try and you know, put a summarization of my thoughts through this, the whole couple days -- couple day process.

And I think we've done a whole lot here in terms of really getting out there what some of our major issues and thoughts are regarding quality measurement for rural medicine. At the same time, I don't think we've solved any problems.

I think that, you know, our friends from NQF have a lot of work to do in terms of synthesizing our thoughts. And we yet have some

work to do in terms of, you know, working with that information once it comes along.

Being part of a process like this kind of almost puts a whole new spin on measurement in general. Because I think there's just -- there's so many facets to it. And so many facets to any given population or any group that it really is difficult to, you know, to pick a limited set of measures and say yes, these are the important ones.

And these are the important ones in any setting. But these are the important ones for a rural setting. These are the important ones for an urban setting. You know, it's a difficult process.

And I think we've shed some light on it here today and yesterday. And I think it's an ongoing process. And I think no matter what happens coming out of this in terms of our recommendations, what we, you know, what gets passed on down and what gets accepted of our recommendations. I think you really have to look

at this in the same way I think that we have to look at the world of healthcare in general.

It is an evolving thing. It is going to change. And what we recommend now may not be what we would recommend in five years. So I guess that's a little bit kind of my perspective has been really in this whole process is just that we've accomplished a lot. There's a lot yet to come. But it's all -- it's all a work in progress and it always will be.

MS. JOHNSON: Thank you. Susan?

MS. SAUNDERS: I'm going to say much the same in a little different words. The last two days has been really incredible to hear the conversation and the dialogue. I think when you look to sum it you know, all up, this is the beginning of a long work in progress. Or the first step so to speak.

A couple of things that you know, I hope that we all walk away with is that the measures that come forth from this have got to be centered around the patient and the patient's

safety. They have to be something that is applicable to rural health, but to multiple types of providers. You know, the generalist, you know, there will be some specialists. The ones in patient-centered medical home, the rural health clinics. You know, it has to be something that can cross all of those lines.

And then also, I think that there has to be thought and consideration as to the burden of work. And how does that you know, distribute when they are implemented.

MS. JOHNSON: Thank you Susan. And Ann?

MS. ABDELLA: All right. A couple of thoughts. Number one, thank you all so very, very much for fighting the good fight and leading this to get it organized. I don't know who is -- who are the mouthpieces across the country who are advocating for this, but well done. And thank you to NQF for -- and HRSA for taking it on.

It's been an incredible opportunity to

-- and very comforting frankly, to know that the things that we are all facing, as much as there is heterogeneity, there is homogeneous issues and things that we're all facing. And I think there is a solution in all of this. There is an answer that we're going to be able to get to and find.

I think we have gained a little and pretty flexible and facile. I think that rural could take on a real important role in the future in the transition of care in the whole model of what happens in the country. We're like a great little Petri dish for you all to put stuff out and see if it's going to work as a pilot.

And you know, I think to the point of one of you gentlemen over there was saying about your network, your docs are all doing it all. You know, you are already locally integrated. You are doing all of the things that we are supposed to be doing. We lose it when we get outside of the hood.

And so I think there's a lot for everybody to learn from what it is we're doing

and how we're doing it and marry that to the bigger picture.

But thanks for the opportunity. It's been tremendous.

MS. JOHNSON: Great. Well, we don't need to belabor. Let's come back at 12:30. I believe, it looks like lunch is out. So, enjoy your lunch.

(Whereupon, the above-entitled matter went off the record at 11:50 a.m. and resumed at 12:28 p.m.)

MS. JOHNSON: Okay everybody, let's go ahead and reconvene. I hope you enjoyed your lunch. I hope you had a chance to talk with your neighbors and now your friends.

So the rest of our time really is going to be the round robin portion. So we've already got a start with Ann and Susan and Jason who had to leave already. But we are just going to ask you to give us your last final thoughts. Anything you want us to make sure that we get in the record and understand your feelings.

And then we will -- before we let you go, we'll have an opportunity for public comment and then Severa will tell us about next steps. So the things that we're going to be ask of you next. And then we'll leave.

We'll definitely be out of here by 2:00. We certainly won't keep you any later than that. We may even possibly get to go a little bit early. So, it's up to you in how this goes in the reflection section.

So with that, I'm going to start over here to my right with Stephen.

DR. SCHMALTZ: It's interesting to contrast this group with a group that met at the Joint Commission to consider measures for critical access hospitals, which I can talk about as well.

I think the task force really wanted to consider measures that were already being used in hospitals. So looking at this alignment issue. But I think at the end of it, what we got were measures that were used in the hospital that

were adjusted somewhat, but they weren't really different enough to be considered on their own. Plus you still had the small sample problem.

So I see this group looking broader and looking at maybe starting from scratch. And looking at a blank slate and considering other types of measures, other types of settings. And I think that's a good thing.

MS. JOHNSON: Thank you so much. And it looks like John is next.

Oh, okay. So this is your time for reflection. So, this could be your last word to the group, to us. Whatever you would like to say. If there's something that we missed that you want to make sure that you get on the table.

MR. GALE: Well, I am -- not that I can let lack of preparation get in my way.

My interest and my concern with this process, and I -- is that as we approach the report and we approach our recommendations, we begin to think about separating the types of providers that have been -- and the interests

that have been represented around the table. Because I do think we have some differences that if we discuss across all low volume rural providers, may get lost.

That we should probably look at hospitals separately from FQHCs, RACs, small volume providers. And then begin to think about sort of teasing out, if we can and probably through the editing and review process, some of the way that those two groups -- primary groups are different.

And then even within the medical practice side, clinical practice -- the clinics, you'll have the differences between physician -- different types of providers, specialists versus primary care. And think about how those differences play out. And I think to me that's an important point of what we need to do.

MS. JOHNSON: Thank you. And Tim?

MR. SIZE: Two thoughts. One just to follow up on John. I mean, I agree with what he said, except that the direction overall is for

integration at the local level, notwithstanding different payment types. And so a cautionary note.

As some of you know, I had the opportunity in public to have a little back and forth with Patrick Conway at the NRHA Conference. And the thought I wanted to leave us with, is I think this is incredibly, incredibly important work. And I think it's good that CMS hears from a cross section of rural. That they need to catch up and bring us into the fold.

And what I said to Conway, and I used the term and I think the audience with 700 people seemed to appreciate it. I think if we fail to do this work, we increasingly are consigning our provider colleagues, clinicians and communities to a backwater which they don't deserve.

So I think this is really important work.

MS. JOHNSON: Brock?

MR. SLABACH: Well, I've been reflecting I guess throughout the two days. And

so I don't want to repeat everything that's been said heretofore.

But I think that from our Association's point of view and from my personal point of view, I agree that this is very important work. And as we look ahead and see the trending in terms of hospital closures in rural communities, the concomitant economic decline that that presents in terms of community health, it is very important that we get this right because of the interface with potential pay-for-performance and making sure that these communities have the resources that they need in order to thrive in these environments.

So, I think that when I tie this together, I see this in the bigger picture. And at the same time, I am extremely concerned. And I think we need to be aware that we have to have quality facilities in these areas.

So it's not just one -- it's just not access or quality. I think it's access and quality. And I think that that's the message

that we need to send to those in our -- those who are going to be the recipients if you will, of these requirements if it ever gets to that point.

Secondly, I think that we need to be very sensitive to providers. Both hospitals, clinics and others that are going to be subject to these. And making sure that we follow through with our commitments in terms of technical assistance and process that will enable this to work.

And then lastly, making sure that we appreciate as I suppose, the differences. And we talked about that. And I think our discussion about SDS will help to alleviate possibly some of the concerns.

And I agree too that if you're comparing cohorts that are equivalent that could help, but then there's different populations within those cohorts for each of these facilities. So this is all very important as we move forward. Thank you.

MS. JOHNSON: Kim?

DR. RASK: One of my pet peeves when I go and work with physicians and hospitals about performance measurement and their data is, but we're different. The risk adjustment isn't the same.

So I just want you to know that my eyes are rolling too when I hear myself say this. I think as we talk about performance measurement for our rural providers, we really need to be careful. Because there are aspects of the measurement process that are going to be particularly problematic for these folks because of the low volume. And these folks also serve a different social mission in terms of being essential community providers. That we need to make sure it's captured or protected in the measurement process.

And so I think it behooves us to be particularly careful with the measures we choose and the way in which we apply them so that we don't have unintended consequences towards -- that will impact community rural health and

access to quality healthcare in rural communities.

MS. JOHNSON: Tonya?

MS. BARTHOLOMEW: Well first of all I hope I didn't scare you guys too much when I said that we don't have a psychiatrist in our State.

CO-CHAIR COURT: I think it explains a lot.

MS. BARTHOLOMEW: I really, really appreciate the privilege of being here. And I am kind of the elephant in the room I've noticed. Because I represent maybe frontier healthcare more than rural healthcare.

And so I do appreciate the opportunity to comment on my story and give you a perspective of what rural healthcare is in a rural state and how difficult that is.

I guess my two take away points or two main recommendations from my perspective are, can we please have alignment? Can we please have one reporting system, and the phase in? Those I think would be most successful in recruiting

practices in small hospitals to comply and participate.

MS. JOHNSON: Thank you. Jonathan?

MR. MERRELL: I'll just begin by saying thank you to everyone in the room for openly sharing, having professional dialogue. And I'll just say that I've learned a great deal just hearing the conversations and hearing from the different perspectives and the experiences in the room.

I think I just have a couple of highlights. I think the conversation that I believe Stephen led, and recommendations to move toward more continuous data collection. And maybe recognize the limitations of classification data. And the discussions on the social determinants. And I'm very excited to see what we learn from that type of data collection and use in the future.

And just thanks again for the invitation. Thanks.

MS. JOHNSON: Thank you. Jason?

MR. LANDERS: I'm the other Pennsylvania insurer. And we're a fairly big enterprise, covering Pennsylvania, West Virginia and Delaware.

And West Virginia, kind of our main leadership base is in Pittsburgh. By the way, as a Highmark employee, I feel that I'm uniquely qualified to say that it's the University of Pittsburgh Medical Center, but.

The -- I'm continually the what about West Virginia guy because there are such differences in rural measurement. Just that the delivery system in general than in urban areas and it's really nice to be in a room with a lot of people that have probably raised their hands at a lot of times and said this doesn't work for me.

So, that was a great pleasure. And I agree, the probably -- I don't think we said the word alignment enough and you know, I'm on both sides of this issue. I've been on the -- or practitioner's side and now the payer side. And

I can tell you that I sense everyone's concern when somebody says, why can't we just do the same way we do for this? And it makes no sense.

So, if we can underline that word alignment, I think that's probably one of the most important things that I think we could push forward to CMS. So, thank you guys.

MS. JOHNSON: Thank you. Sheila?

DR. ROMAN: First I'd like to thank everybody for a really rich discussion. I've learned a lot over these past two days.

I've been a clinician in under-served urban areas, but not in rural areas. And I think I've really come to appreciate the heterogeneity within the rural communities and their absolute necessity as a safety net for the care of people in those communities.

Having come from CMS, I think one of the things that's most important to me is the transitional aspect into pay-for-performance. I would remind people here that Hospital Compare started in 2003. HVBP did not come until 2010.

I believe that the PQRS program was an incentive program for probably seven years and is only now becoming a disincentive program.

So I think when you're dealing with a community of providers that has been eliminated from the programs that have been ongoing for such long periods of time that they can't just jump in at the top of the ladder and be expected to go. That there will be a lot of need for help with reporting and collecting.

And I would also echo -- I think Brock said this several times -- that unlike the physician value-based payment modifier, which is a budget neutral program, that I don't think this can be a budget neutral program. And that it really does need to reward the high efficiency, high quality providers for probably many years.

And there is some precedent in the VBPM program where for the second year in order to get the small groups in, they'll just be giving bonuses and not giving disincentives.

I would also echo the whole alignment

issue. I know with Hospital Compare that hospital reporting would have never moved from public reporting to pay-for-reporting to VBP without alignment of measures. And I think that's crucial. But I think we also need to understand the vast amount of work that actually goes into the alignment process.

And finally, I think that I would say that in order to make this work, that measures would need to be mandatory with the core set and flexible modules. And that you then have to have some evaluation along the way to see how it works. And I think CMS should build into their process some task force evaluation project along the way after they begin this process.

Thanks again for inviting me.

MS. JOHNSON: Thank you Sheila.

DR. BAER: I'll echo that thank you. And it also has been an eye opener for me.

While Jason says I'm the other payer in the state of Pennsylvania, there are lots of other managed care organization payers in

Pennsylvania. You have one, part of his company is a managed care, Medicaid company, but you know, a very large Medicare and commercial program they have.

So, one of my concerns you know, being a Medicaid only program, is that there -- and this is not just for me. This is just my personal opinion. When you've seen one program, you've seen them all. And when we talk about alignment, which I think is very important, I don't know how you translate something like this where I think it's easy to translate into a program in Medicare. But how do you get it out there in the 50 different Medicaid programs where there are carve outs and you know, mandatory managed care, and fee for service?

So is the program kind of administered at the state level? Or is it pushed out to whatever program is delivering the services? But I do think that we were talking a little bit about budget neutral. I think there needs to be additional dollars because the dollars that are

being used and pushed out to whatever delivery systems that are in the state right now, are severely stressed because of the ongoing comorbidities of our population.

But also the expansion of that population, whether it's in the -- under the ACA or some other waiver program that the states have developed in some kind of private coverage options that states may have. So I think alignment is so key.

And the other things that we really didn't talk about are alignments among other parts of the federal government. I think it's good to keep it at the HHS level, but what about the VA? The Indian Health Service? You know, there are folks over there too that would need to be aligned.

The other thing that I guess I struggled with a lot this whole meeting was, you know, what is the difference between a rural patient and a non-rural patient? I don't see much of a difference from a clinical standpoint

between the two. Boy, but the stuff that's around that patient, you know, the services, whether it's rural, whether it's a you know, a critical access hospital. How close to other services are they?

I think there's got to be some other way. I think from a clinical standpoint, you know, diabetes is diabetes. But how is that care delivered to that patient and how does that patient get to that care is very important.

And somehow that has to come into the equation in here in showing the difference between you know, the rural patients and the non-rural patients. So I think that's where I would somehow put a -- whether it's SDS or some other way to qualify what's different.

And again, thank you. It's been a pleasure.

MS. JOHNSON: Thank you Michael. Bob?

DR. RAUNER: Yes. I'd actually like to start first just by saying thanks. Because this is -- it's rare to have a representative

group with this breadth. Everything from the ruralist to the rural, with Greg and Tonya, to CMS, Johns Hopkins and Harvard. You don't see a panel like that very often.

And it's led to a discussion I think was worth it for me to come just to hear the discussion honestly. I of course had my things I wanted to say to you, but I think hearing this was enough of a reason of itself to come.

So for feedback, I'm a lumper and I'd like to lump in three buckets. So first I'm going to jump on the alignment bandwagon. And then alignment in terms of collaboration, like for example having a readmission measure that's good for both you know, hospital and physician, med rec in vaccinations.

These are things that will help us work together as to some things which have unfortunately driven a wedge. Our ACO metric frankly drove a wedge in our communities between us and some of our hospitals. And I'm still -- we're still trying to figure out how to fix the

unintended harm that that caused.

But also alignment in terms of what the CMS wants us to report on. I mean, obviously realize I don't like meaningful use at all. If they could make these things more streamline.

And I think you're hearing everybody complain about this. That I've got multiple things that I have to report on that don't align. Some are helpful for us, some are frankly more harm -- causing more harm than good. And I think if CMS could do no more harm on some of these issues.

The second issue which we talked earlier, but didn't -- I haven't heard yet, was that the Part A and B issues, and how those mess up a lot of incentives in the rural area. Whether it be the rural health centers totally be written out of meaningful use, and it took us two years to get the folks at CMS to understand the consequences of that, and they wouldn't listen. They were condescending. They would just say, oh you don't know what you're talking about.

Finally after two years they said, oh, wow, that is a problem. Yes.

The same thing with you know, the ACO program, Ann and I are dealing with. Literally that there's a structural flaw in the calculations because of critical access hospitals that might make us fail. Even if we really in effect win, we might still lose anyway because of a structural flaw.

And the third thing is, that to continue to garner that input from us, because in our perspective rurally, is that CMS drives things to us that fits for the 90 percent and doesn't fit for us. And they just don't listen to us. And they're the masters of ultimate lip service, but in the end, this is really a critical flaw and they need to listen to it so that we don't end up with three to four years of trying to get it fixed.

So I like the fact that we've had the opportunity to reply because most of us don't have time to read the Federal Register and write

long-winded explanations because we're too busy. And this is for me the best way to do it because I just don't have time.

So this interchange I hope will continue. Thank you.

MS. JOHNSON: Thank you Bob. Aaron?

DR. GARMAN: I want to thank you all. This has been very, very enlightening. And as a rural family practice plumber, I think that it shows tremendous support across the nation for rural healthcare.

I do --

CO-CHAIR MOSCOVICE: Can I ask you a question?

DR. GARMAN: Yes.

CO-CHAIR MOSCOVICE: Do you really do the plumbing?

DR. GARMAN: Some. Some. What I can manage I do. Yes, yes.

What's that? No, no, no. We actually do have one plumber in the area. So if he's available, he'll come over and do it. But

otherwise.

I do really appreciate the fact that we are starting to address some sociodemographic ideals around rural healthcare. And I do think that rural healthcare does provide excellent quality care. We just have to prove it.

And I think in -- if we can develop measures that are reasonable to be able to prove what we actually do, I think everybody is going to be happy. And so I just hope that CMS comes back and gives us a product that is reasonable and useful and helpful for everyone.

Thank you.

MS. JOHNSON: Thank you. Bruce?

DR. LANDON: I sound like a broken record a little bit. But I'll thank everybody as well, but I'm not going to go into as much detail because I think it's been very well said.

I guess I'll have a few things. So the first thing is you know, it was a little bit difficult at times figuring out what exactly the charge to this Committee was in the following

way. So I think we heard a lot of instances where current CMS policy and the way that they do things is -- which often is suboptimal, really doesn't work for particularly the tasks that we have at hand.

So for instance, you know, the way that the EHs are paid differently. The way that billing in rural health centers and community health centers is in the wrong place. And we can't really do claims-based measurement on them.

And this you know, actually even feeds back into the larger you know, issue at CMS. Which is you know, at some point or another, they're probably going to need to put together Part A and Part B and have a single insurance program. And you know, potentially as those efforts progress, this is something that can be addressed there.

However, I don't believe that it was the purpose of this Committee to rewrite laws and regulations. So it's kind of hard to do that as far as I can tell. So we have to work within

sort of a narrow confine.

So I think you know, clearly there are so many differences that have really been expressed very well by the people who are actually doing this type of medicine. And we've heard lots of important things.

My viewpoint is you know, we have a lot of challenges that we face for measuring performance in these small practice settings. And there's not a lot of answers. And you know, so I tried to sort of think about you know, so the issue now I think often is right now, you know, rural providers are basically excluded from a lot of these things.

So I think our job is to try to facilitate a way or to make recommendations that will at least give them a little bit of a runway to potentially sort of make it attractive for them to do certain things that will allow them to actually start participating. So I think it's really important that the recommendations really take that tone in terms of being sort of urging

and giving incentives as opposed to penalties and punishing them for not participating.

And I think if that's the tone that's adopted, then you can make more far out suggestions like you know, to the extent that some of you guys can aggregate or work together, that would be a good thing. But it has to be an option not a you have to do it.

You know, I think that was stated pretty clearly here. But certainly, if that is one option, then some people might choose to do it. And that could be a little bit of a runway.

Finally, I think the discussions related to SDS and other types of adjustment are really important. I think my -- I still believe that a lot of this should for this area should be the comparator groups and not necessarily incorporating them.

But I think I very much agree with the approach that NQF is taking, which is to tread carefully in this area and do it in an empirical data driven way. And with that I'll stop.

MS. JOHNSON: Thank you. Guy?

DR. NUKI: I think it's the last. It's all been said. But first, I'd just thank you very much. This is a very impressive group. I'm pretty pleased to have been part of it. And thanks for your listening and guidance and leadership.

So I'm going to try say things that weren't said. Because I just agreed you know, I agreed with pretty much -- I had to cross things off as you guys kept talking.

But, one is the MAP process and how important it is. And I meant it when I said that I'm terrified to think that the MAP will be put together with a bunch of people who work in Washington and you know, big cities, to come up with these measures. I mean, I think we need people that do that, as well involved, but you really need some of us that work in rural areas.

The other thing I wanted to stress was the technical assistance. That is so lacking in rural communities that expertise in that time and

that energy to you know, figure out you know, how are you going to manage the measures and how are you going to collect the data and all of that. I mean, just even the understanding of the system is difficult enough. I mean, it's very complicated. That's going to really be important.

I just wanted to stress the peer groups. I think one of the things hopefully you heard was that rural areas can be very different from one another and clumping them all together is not a good idea. And we can't break them up into a thousand different ones. But, trying to do that.

And then the last thing that we didn't -- I think that was maybe was just implied, we didn't talk a lot about it. But the purpose of these measures is not necessarily just to reward people for doing a good job, I think the purpose of these measures is to get people to change their behavior so that they do a better job taking care of patients.

And I think that that's going to be very important to keep in mind as we put together, as those measures are created and this process goes forward. Because we could all measure things that either A, we can't change or aren't really that important to patients. And none of that's going to be very useful.

Thank you.

MS. JOHNSON: Thanks. Greg?

DR. IRVINE: Am I last? You're going to talk, good. I didn't want to be last.

No, I want to thank also like everyone else has, the NQF for including us and bringing together a diverse and interesting panel to discuss these issues. It was a very brave for them to put an orthopod on the panel. Probably a mistake.

As the other frontier provider here and as the only surgeon on the panel, I -- it hopefully helped give a little bit different perspective. My message is that critical access hospitals at least in my world are critical to

their regions. That's why they're called that.

And my little hospital is absolutely critical to where I live. They're also on the edge. We struggle every day to keep the doors open. To stay financially viable to continue to give the care that we need to give. And we do that by being innovative and having -- being all on the same page to work.

And having the support of organizations like the NQF and CMS are critical to our ability to survive. Any measures that are developed as a result of this meeting, as I've said a hundred times, now a hundred and one, need to be flexible and they need to be aligned. They can't be one size fits all. We are so incredibly different from one another. It would have to be hopefully picked from a menu.

Pay-for-performance has to be revenue positive. If we start taking money away from critical access hospitals, we'll sink a whole bunch of them. And no care is not an option. And in frontier medicine, if our hospital goes

down, it means no care.

Quality sometimes means inventiveness. We are kings and queens of inventiveness in little hospitals because we have to be. You can't easily put what we do into box diagrams. We have to be nimble, we have to be quick, we have to be inventive. And that needs to be remembered in any quality measures that are undertaken.

Before coming here I asked a number of stakeholders in West Central Idaho what they want -- what message they want sent to Washington. Idaho's probably the most libertarian state in the country. Our reputation is well deserved. I'm probably the most moderate voice they could have possibly sent.

In fact I looked at my little poll that I took last night to remind myself what messages they want sent. And number one on the list was tell them back there to leave us the hell alone.

Actually we've opted out of Medicaid

expansion, so you're getting a lot of the money that we're not spending.

MS. JOHNSON: Okay. Ira or Kelly, I'm not sure.

CO-CHAIR COURT: I'll go next. So a couple of things. First ditto to everybody and you get a group this size and there's really a homogeneous group with a lot of diversity. And I think everyone was very respectful and learned. So, thank you for that. It made it easy to facilitate.

Now we all after two days together really understand rural and the challenges. But whoever receives this report and what they're going to do with it, need to understand it and have the same context that we do. Or we'll continue to do the same things we've always been doing. So, I think we need to spend time on making sure our recommendations are -- go forward with context or they won't be understood correctly.

I think we all want the same thing.

We want care in the rural setting because that's access, but we want it to be good. One of the things -- and our patients deserve that.

One of the things I get concerned about though is -- and I understand the need for pulling in other stakeholders and that is important, but they don't always want that access you know. Some of the solutions might be get rid of those rural providers. And so I think the multistakeholder process has to be done carefully so that they have the same fire in their belly that we have for let's do it, but let's do it right. So that's got to be done carefully.

And we have to do this in a way that we don't muck up, you know, that there continues to be that real safety net because it is important.

Also, I think we have to think about the current way to get voice in the things related to measures, getting on committees. Responding to public comments, I don't think work for rural providers. Because you got you know,

two docs and they're busy taking care of patients and going to the hospital and going to the nursing home. And there's not an administrative person in the critical access hospital reading the Federal Register.

So there might be an opportunity to work with other rural partners to make sure the voice -- just because there was public comment doesn't mean that it actually got to the people who need to comment. So, we might need to be creative about that.

And then the last -- the last point is an unfortunate part of my job is sometimes I get to talk to the media. And I think there's -- and it goes to the need for cross -- really good cross-cutting measures because these will eventually be used to perceive whether a practice, a physician, a hospital, is a good hospital, a good practitioner or a bad one. And what I always coach the media on is they are good at that measure. It doesn't mean they're a good or a bad hospital.

So, making sure we have cross-cutting measures that are a general reflection of the overall care provided I think is important. Because I can perceive these things are going to get pulled into a one/five star rating at some point. It will be used for tiered payment. You know, maybe not by Medicare or Medicaid, but by commercial insurers. So we need to make sure the measures really reflect you know, overall what we do.

CO-CHAIR MOSCOVICE: Well, I want to thank everybody. You never know -- it's been a pleasure working with Kelly, Karen and the other NQF staff on this --- and you never quite know when you're co-chairing a meeting like this if we're going to be looking at each other about half way into the meeting and going, oh, well we've got eight more hours to fill up, how are we going to do that?

And surprise, surprise, you weren't a shy group. Which was -- everybody in the room really had a chance and took advantage of that to

sort of say what was on their mind, which is the whole purpose of this. It's not for any one person to dominate this.

I've been doing work in this field for about a decade now. And as you can tell, it's -- you need patience and it's tough slogging along so to speak. And both of them in developing measures and working with states to use measures --- and with providers. And what I can honestly say is that I think this is the most important and best opportunity that we've had at the federal level to try to see if we can have an impact in this area.

And all I can say is it will be a high priority for me to work with NQF, CMS and others to make sure there really is a next step, that we really do move into the MAP arena and hopefully beyond that in terms of developing a set of measures that are going to be well accepted by everyone in terms of their relevance to rural and their importance in terms of measuring performance out there.

I do believe as I said earlier, that I think NQF and CMS are more willing to listen and -- to finally listen to folks out there in rural environments and have their input to these processes. So I'm impressed.

Helen's sincere in what she's doing. And the rest of NQF. And it may be a bit harder to feel that way about CMS, but I think they -- I think Patrick Conway is going to be real helpful in this process.

So I'm optimistic. I think we'll probably be certainly communicating with each other. I guess it's going to be at least verbally once and people get a chance to look at the report and provide their input and so forth.

And I just wanted to thank Karen and the NQF staff because they really -- some of us shared our thoughts with Karen last night and all of a sudden we had 15 slides that we almost look like we know what we're doing this morning. And that's not easy to do. Because we're all wondering what's going to happen this morning?

And she did a great job. So I really want to say thanks to that.

And I look forward to communicating with you. I also -- I got to say, I did wonder what the heck an orthopedic surgeon was going to do here? And you were great. And we had such variation in this group.

You know, we had -- as someone said, we had Harvard, we had psychiatrist-less Wyoming. We had just -- we had a couple of regulars, but it's been really refreshing and I learned a lot. So it was a really great two days for me.

DR. BURSTIN: Can I add my thanks particularly to Ira and Kelly for doing such a great job of managing this. And you should know, we actually intentionally picked this group to be as diverse as it was. So we intentionally picked an orthopedic surgeon.

So, thank you for applying Greg. Because we knew those perspectives would be incredibly different then the more usual perspectives that we would hear from this field.

I also want to just offer Curt an opportunity for any reflections. I mean the reason this project is actually here is because the Officer of Rural Health Policy went and asked that it to be funded as part of our CMS contract. So I wonder of Curt has any reflections?

DR. MUELLER: Three comments. Having missed two thirds of the meeting, it's hard to have gotten a whole perspective. But based on the issues that you raised today as sort of a summary and a wrap up from yesterday, I was very pleased. In the office we sort of identified issues that we'd like to see discussed. And they pretty much were on track. You guys met our expectations in that regard.

Secondly, I think I want to express some concern that's already been expressed. Ultimately what happens depends on whether CMS looks at this report or puts it on a shelf. And having seen some of the history that Sheila referred to, the development -- the PQRS and the work CMS has undertaken on the one hand, and

realizing that they have a fairly statutory requirements on the other. I just -- I hope that there is a transition for this that's sufficient to keep that ramp well-constructed. I worry about sometimes some of those things being out of even CMS's control.

And finally, you know, one of the reasons I'm glad Ira made the point about this being an opportunity to be heard on this issue. I think one of our standards of success for this project was making sure that CMS heard from the rural folks about the rural payment struggles.

You know, they've got a big job to do. And you know, they have -- they first focus on the urban areas. I understand that. They focus on the big practices.

But time is ticking away and we don't want to be left behind. We being rural stakeholders and so forth. And if we can achieve that with this report, we'll be quite happy. So, thank you. It's been very good.

MS. JOHNSON: Thank you Curt. And I

think Marty is still on the phone. Marty, would you like to say anything?

MR. RICE: Well thank you very much. The only thing I can really say is wow. This really turned out well. I agree with everything Curt had to say. I also wanted to thank some people that weren't mentioned that are kind of in the sidelines, really helped us out in this project.

One is Coretta Byrd from CMS, and she is the Contract Officer Representative for this contract. Jane Hammond with the Office of Clinical Standards and Quality, and now I think it's CCSQ. And Maria Durham.

They're the ones who approved this project. And they saw worth in it. And we really have to give a shout out to them too. And everybody from HRSA.

Thank you all again. And thank you for your time.

MS. JOHNSON: Thank you Marty. And I guess it's my turn to say thank you to the

Committee. You guys have made this fun and very much a learning experience for me as well.

As I told you before, it's dear to my heart because that's you know, my roots are in the rural area. So thank you for coming and for being so friendly to me, the introvert of the room. So, I do appreciate that very much.

So with that, I guess it's public comment. So, Mitra I'll let you take that over.

MS. GHAZINOUR: Operator, would you please open the lines for public comment.

OPERATOR: Yes ma'am. At this time if you'd like to make a comment, please press star then the number one.

There are no public comments at this time.

MS. JOHNSON: Thank you so much. And now we're going to end the day with Severa giving us just a run through of what you can expect from us from the next few days and months.

MS. CHAVEZ: Thanks Karen. So in about two weeks NQF will put together a short

document of just a summary of the key themes from the two-day meeting, along with the transcript, the web recording link and the summary will be posted on the NQF project page along their share point page.

But we'll send you an email to let you know that they are up there. Yes, a transcript, word for word.

I hope you all have our March 19 web meeting on your calendar. It's in the afternoon, 1:00 to 3:00 p.m. A few days before that we hope to send you the draft report so you have time to read it and we'll have a very robust discussion of it during the call.

And then between March 19 and April 15 we'll be revising, tweaking the report based on your comments. April 15 is when the draft is due to HHS.

And sometime between June and July we'll have the draft report open for public comment. A 30-day period. And these comments will be added to the final report that will be

submitted to HHS September 14. And again, of course, you'll get a copy of that.

So thank you all for coming and safe travels.

DR. BURSTIN: More a point to pick up on Kelly's comments. When this goes out for public comment, you should feel free to send it to your networks as well.

Again, they may not be people who would necessarily see it when we post it for comment. So, we would welcome you sharing it broadly and feel free to submit comments or have others submit comments from that wider breadth. Yes, Brock?

MR. SLABACH: A quick question on that. After today's meeting, is it okay to like blog or have a report on this in terms of public reference?

DR. BURSTIN: Everything NQF does is fully transparent, so absolutely. I mean, don't attribute a recommendation obviously of this group yet. I think you're still storming and

norming a bit. But you know, reflecting on it is perfectly fine.

MS. JOHNSON: Thanks so much and bye.

(Whereupon, the above-entitled matter went off the record at 1:13 p.m.)

M

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Performance Measurement for Rural Small-Practice Health Providers

Before: NQF

Date: 02-06-15

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter