NATIONAL QUALITY FORUM

Moderator: Rural Health
July 29, 2015
1:00 p.m. ET

OPERATOR: This is Conference #: 42994770.

Good day and welcome the Rural Health committee web meeting. Please note today's call is being recorded and all public lines will muted during our meeting. Committee members please note your lines will be open for the duration of today's call. So please be sure to use your mute button when you're not speaker or presenting.

Please keep you computer speakers tuned off if you joined us by phone and please do not place the call on hold at any time. If you need assistance at any time today please press star, zero and an operator will assist you. For technical support with the web portion of our meeting today, you can send an e-mail to NQF@commpartners.com.

Today's meeting will include specific question and comment period. However you can submit your questions at any time by using the web conference window. To do so simply type your question in the chat box on the lower left corner of your screen. Please be sure to click the send button located next to the box to send your questions in.

During the designated public comment period, you will also have the opportunity to ask live questions over the phone by pressing star one. These instructions will be repeated later in our meeting.

I'd like to draw your attention to the links area located to the side of the slide window. You'll find presentation materials and resource information relative

to today's meeting located there. Simply click on the link of your choice and it will open it in a separate web browser window from which you can print or save the file. It will not interrupt your viewing of the meeting as it will open it in a separate web browser window.

And now it is my pleasure to welcome Mitra Ghazinour, Mitra let's get started.

Mitra Ghazinour: Thank you, (Shawn). Good afternoon everyone, thank you for joining today's call. This is a post-comment call for the Rural Health committee members. And – so first I would like to start with introducing the project team.

Karen Johnson is the Senior Director leading this project. And myself, I'm the Project Manager who's supporting the committee. And also I'm joined with my colleagues Severa Chavez, who is the Project Analyst. Now I would like to do a roll call of the committee members before we start reviewing the meeting objective. Kelly Court?

Kelly Court: I'm here.

Mitra Ghazinour: Thank you. Bruce Landon?

Bruce Landon: I'm here.

Mitra Ghazinour: OK. Ira was not able to join us today. Jonathan Merrell?

(Off-mike)

Mitra Ghazinour: Ann Abdella?

Ann Abdella: I'm here.

Mitra Ghazinour: Thank you. Guy Nuki?

Guy Nuki: I'm here.

Mitra Ghazinour: Thanks. Michael Baer? Kimberly Rask?

Kimberly Rask: I am here.

Mitra Ghazinour: Thank you. Tonya Bartholomew?

Tonya Bartholomew: Hi, I'm here.

Mitra Ghazinour: Thank you. Robert Rauner?

Robert Rauner: Here.

Mitra Ghazinour: Thank you. John Gale?

John Gale: Yes I'm here.

Mitra Ghazinour: Thank you. Sheila Roman? Aaron Garman?

Aaron Garman: Here.

Mitra Ghazinour: Thank you. Susan Saunders? Gregory Irvine?

(Off-mike)

Mitra Ghazinour: Stephen Schmaltz?

Stephen Schmaltz: Here.

Mitra Ghazinour: Thank you. Jason Kessler?

Jason Kessler: Good afternoon, I'm here.

Mitra Ghazinour: Thank you. Tim Size?

Tim Size: Here.

Mitra Ghazinour: Thank you. Jason Landers?

Jason Landers: I'm here.

Mitra Ghazinour: Thanks. Brock Slabach? OK, thank you everyone. Now I would like to turn this over to Karen.

Sheila Roman: Hi, this is Sheila Roman. I just got on the line.

Mitra Ghazinour: Thank you, Sheila.

Karen Johnson: Hi, thank you, Mitra. Before we go any further, let me see if there's any of our HRSA colleagues on the line as well that would like to say hello? Anybody from HRSA?

OK, so thank you guys so much for joining our call today. We appreciate your time very much. I am dialing in. I'm on vacation today so I'm dialing in from beautiful Southwestern Virginia. My internet connection is a little iffy now so hopefully I won't lose you, but if I do I will dial back in.

So, our objectives for today's call, this is what we call our post-comment call. So just to remind you of what we've done, after our hour in-person meeting back in February we drafted a couple little version of the recommendations (and put) a report around it and we put that out for public comments, for 30-day public comments period.

And that ended at the end of June. I think that's right. And we – as soon as – taking a look at these comments and, we are going to provide responses to the comments and we wanted to have this call in order to give you the committee an opportunity to a considerable comment and also to just think back on your work today in your report and recommendations are today.

And, giving you a chance to discuss the comments and other things that you would like to discuss, which will be the last time that we will convene you as a committee. So, we want you to just to give us any feedback that you would like to give. Again, concerning the comments that we received, anything that you think we need for your clarity in the report.

So, those are the objectives of the meeting to talk about the public comments and discuss any potential revisions that you would like to make. And, we also are hoping that we have a little time at the end to discuss some potential next steps for Rural Health performance measurement. We'll see if we have time to do that, but hopefully we will be able to do that.

And the way this is going to work just so you know what we're going to do, we have drafted some responses to the comments and some we haven't really addressed yet because we – those were things that we need to talk about and we have different slides, we're going to pose some questions to you for discussion.

And, Kelly is going to help facilitate that for us to kind of – Kelly and I, we will walk through several slides, we won't have time clearly to walkthrough all of the comments. So, what we'll ask you to do is if there's things that we don't pull off specifically but yet we would like to discuss, just let us know toward the end of the call and we would do that.

We will finish drafting responses to those comments and we will put both the comments and the final responses from the committee, those will become part of the report, (inaudible) of the report. So that's what we will be doing in the next couple hours and then over the next few weeks.

So Kelly would you like to say something to get started and then we'll stop for minute, we'll hand it back over to Mitra again, it's kind of an introduction to the comments received and then we'll get into the meat of the call. OK? Anything you would to say to the committee?

Kelly Court: Thank you, Karen. Good afternoon, everybody. So Karen and Mitra have done a really nice job getting us organized today. I think our challenge will be to keep our comments concise and see kind of on track of what Karen has prepared in the slides that we – make sure that we get through everything that – and her team has what they need to prepare, responses to the comments and any modifications to our report.

I think the next thing we're going to do here is – Mitra is going to review kind of some high level kind of theme and summary of the comments that we received.

Mitra Ghazinour: Sure, thank you. So the draft report of committee's recommendations about process for NQF member on public comment from June 1st to June 30th. During the comment period, NQF received over 30 comments from 16

organizations, including 6 NQF members, member organizations and 10 additional organizations.

Although all comments are subject to discussion as Karen mentioned earlier, we will not discuss each and every comment instead we will spend the majority of time considering the major topics and the most significant issues that rose to the top.

The majority of the comments were supportive of the committee's recommendations especially the committee recommendation regarding testing continued alignment of measurement efforts for rural providers, using the core set of majors along on the main view of optional measures. Creating the map of what (inaudible) CMS on the selection rural relevant measures, using measures for rural providers and address lower case volume.

Making participation in CMS quality improvement programs mandatory for all rural providers but allowing a phase approach. And creating payment programs that include incentives but not penalties for rural providers. And, how the several commenters also raised concerns with some of the recommendations for making participation mandatory and also requiring rural providers to report on a required core set of measures.

And so this is a good segue to the next agenda item which Kelly and Karen are going to discuss and address the comments in more detail.

Kelly Court: Thanks, Mitra. And so we got – like I said we got 10 slides here to go through. So we'll – between Karen and myself we'll kind of review the points and then we'll open it up for the group for discussion. And I think we – especially concerned about, do we need to make some changes to the recommendations that we made?

If we go to the next slide. So the first area – so there was support by many of the commenters about moving towards the mandatory program for rural providers. There were several comments that didn't necessarily (inaudible) supported. Hopefully you all have the PDF that was sent out that have the

comments by number. So, there was concern by one commenter about having a negative impact on patient access to services.

I think the intent of this one was that many rural providers are overworked and this could take away from patient care. Comment number 11 was really quite long, and talks about a mandatory program not being a good fit. I mean there's discussion in there about whether this needs Congressional approval, how it fits with the movement towards alternative payment models that we see coming in the environment.

And then there's two comments about a mandate being premature. So, specifically the technical challenges for low-volume providers. And then comment number 22 was meeting a reasonable starting point. So, hopefully you had a chance to review this comment. And I think – Karen, if you have anything to add?

Karen Johnson: No, I don't think so. I think – I put that slide there because I think that really is a good prequel if you will to the next slide which was probably some of the suggestions that came on some of these concerns because of mandatory participation, recommendation in particular.

Kelly Court: Does it make sense to discuss this slide alone or should we move to the next slide and discuss them as a group?

Karen Johnson: Let's go ahead and – it looks like they moved to the next slide. So, yes – several folks suggested, particularly in light of the discomfort for some, supported mandatory participation which is kind of listed there. Go back to the next slide please, Severa.

People wondered if whether our recommendations should be either prioritized in some way, sequence in some way and/or some kind of a timeline be given to that – folks with – which things need to converse or should these all happen in the next six months or the next year, in the next five years that sort of thing. So, kind of three different suggestions and I think – either of those might help to dislodge a little bit some of the discomfort that was voiced on a mandatory participation part.

And what I tried it here and I'll hand it back to Kelly to lead the committee through this. Bt I try to think of some pros and potential cons about doing either of these three things particularly the sequence thing. But we should even discuss, you know, prioritization, different than sequencing, is it possible to even do any of that, is it wise to do that. Are these things potential next steps that would be, you know, the bailiwick of some other rural health committee.

So, let me stop there and give it back to you Kelly.

Kelly Court: Thanks, Karen. And so you can see the questions on the slide there that Karen proposed for us to think about. So we really kind of need to open it up now, get some input on whether we should consider reorganizing the reports so that's kind of first thing happen first. Or, if that's difficult and creates more confusion, so I'm going to open it up for comment within the group. So if you're on mute, you'll need to unmute yourself and we'll take it from there.

Robert Rauner: OK. Well this is Bob Rauner, I'll start off. And, one issue that I see is in multiple comments is that they're different based on where you are. So like a primary care clinic, most of these measures are not relevant equally in urban and rural. But, I can tell you that ACO of 14 clinics, we prioritize even within, you know, the 33 quality measures that Medicare gives us, that you can't do 33 at once, I think people are worried about the numbers of comment.

The quality measure can get too cumbersome unless we're prioritizing focus on the high-impact things first. So, I would agree with some prioritization.

Tim Size: This is Tim, it certainly makes good sense to me, I think what was clearly explicit that we weren't supporting mandatory participation in the assumption system we have. And that, you know, our recommendation is in the context of the total report, but it could be more explicit about some milestones have to be reached before we would support a mandatory participation.

Kelly Court: Yes, this is Kelly. Karen and I had talked about this one. This is one that I think makes sense. Because we have – we have recommendations about the funding development of new measures, you know, making sure measures are relevant. And having paper reporting come first and then eventually moving

into public reporting in there and then pay for performance. So, to me it makes sense that we would organize the report in the order that many of these tasks would occur.

And then where possible state that some of these task would happen parallel. Other comments on this?

John Gale: This is John Gale. I would agree that, as we think about the report, meaning to look at the different types of providers, inpatient, long-term care. You know the more ambulatory services, physician practices (RAC) and (FQAC).

We need to think about sort of parsing out the measures differently because they're different issues. I'll be inclined to keep a strong commitment to making the measure mandatory with a phased implementation to move folks along. I think we got be – I believe explicit that that is ultimately the expectation, but they won't be forced on providers and that there will be a period to get – to adopt and change. I think we need to clear that this really has to happen.

Karen Johnson: So this is Karen. Sorry, let me just make sure that everybody is aware of the wording that we used. So, for this recommendation, we said, the recommendation is – participation is CMS quality improvement programs is mandatory for all rural providers but allow a phased approach for full participation across program type.

And then a little further on in bold text, we say this recommendation for mandatory participation for all rural providers is however contingent on uptake of several of the other committee recommendation particularly in those related to measure selection and use, payment incentive option and alignment.

So we put a little bit of guard around that, so I, you know, part of what we would try to get is how much more specific do you guys want to be on that.

Guy Nuki: So this is Guy Nuki. And I appreciate you're reading that up because I thought that we had put some of that in. But it sounds as if being even more specific, say before we can move from step A to step B, certain things need, you know, needs to be met.

Because one of the things is that – I really believe that expectations need to work both ways. One expectation the providers are eventually have mandatory participation but the other expectation is that on the, you know, regulatory body that certain things are met prior to both expectations hold out to the providers then we do need to (inaudible) about that.

Kelly Court: Karen, I think that – from my perspective that is a great place to start. But when I look at the other recommendations, they don't feel like they come in the order that they would have to occur. So after the recommendation you just read, then we have used a core step. And then we have composite measures, and then we jump into payments. And then offer reward and then we have funds work to consider peer groups. And then we have used measure to rural providers that are explicitly address low-case volume and guiding principles.

So I'm wondering if we just – the other recommendations in order they would chronologically occur. But it may clarify some of the – and we could say after the first one that you just read, steps to consider to move into this steps – phased approach would include, you know, the following things.

Karen Johnson: OK.

Tim Size: This is Tim …

Kelly Court: Fund development of rural relevant measures is, you know, getting closed to the end of the report. You know and that really should be maybe closer to the beginning. Because we agreed that we really don't always have the measure we need. So until we have measure that we need we probably shouldn't be talking about payment issues.

Tim Size: Yes. This is Tim, I agree with what Kelly just said. I want to make (another) comment. Because I think it's worth making – maybe it's about libertarian tendencies that I'm not like a big fan mandatory anything, but that's not what I supporting of having that language.

What I'm really very, very strong about is that, I think it's the death knell for rural health is if we continue down this path of telling whole country that it's

OK to expect to less from rural. Since the nation through CMS for, you know, the huge, huge overwhelming number of providers has already spoken that if you're a real provider you will participate.

And so, it's not so much that I'm a big fan of mandatory, I just think we need to find a way for contextually relevant metrics so that we're seeing on the mainstream otherwise we're in big trouble. So, if there's anyway of adding words to that effect – it's nice – it wasn't so much for the mandatory aspect it was the discontinuing quickly and as soon as we can responsibly do so, this carve out of rural because I think it's a backwater engine.

Karen Johnson: Yes, and Tim to your point, actually the sentence that I read that I said was bold and mandatory – bold and italicized in the report, up above that is the last sentence of the paragraph that basically try to get to your point. You know, being held back and that sort of thing. So, maybe we can look at that paragraph afterwards to make sure that that paragraph is getting to the point that you really want to make.

And, you know, decide if we need to add anything else to that. I don't know if you had a copy of that report but it's the first full paragraph on page 12, it's where we tried to get to that piece, you know, to get to the point you're talking about.

Tim Size: Yes, and, you know, not everything gets read, sometimes we why use bold print or sometimes you just have to say it over or …

Karen Johnson: Yes.

Tim Size: … you decide a million times and some people still wrong here. So.

Karen Johnson: Yes, yes. Well, and, you know, maybe it is something like that we have to be very clear. And to be honest with you, I don't remember if I was adamant about that in the executive summary and that be another place that we could make that point as well.

Kelly Court: Other comments about – so, does anyone feel that we should back away from the recommendation that it's mandatory?

OK, hopefully everybody was able to get off mute if you had – if you feel strongly about that. Strong feelings about trying to get this kind of just not changing the recommendations but putting them in a different order.

Tim Size: I think it's a great idea.

Kelly Court: Karen, do you have what you need for this set of slides?

Karen Johnson: Well, let's talk a little bit more about what that order might be. I think I know if you say Kelly, development of the rural relevant measure might be sort of the first things on the list. And I'm not sure if we can really get a consensus with – on the phone that maybe we can get a little start. And then as post work from this call, we will send out something to have you link them and then we'll finalize. If that works for everybody.

Kelly Court: Yes, so I think – I mean just kind of broadly, I think the recommendation that we have about developing measures, the criteria for selecting measure only to go towards the fund.

Karen Johnson: OK.

Kelly Court: Things related to – then how measures would be adjusted and benchmarks would probably go somewhere in the middle. And then things related to payment and incentives would go more towards.

Karen Johnson: OK.

Kelly Court: And I'd be to happy to, you know, work with you or a couple of other people to kind of work through that in more detail.

Karen Johnson: OK.

Robert Rauner: Robert Rauner, I would encourage to start to – there are some comments in the report about starting with broad community health, crosscutting measures as the first step before you go to the others things and broad things like blood pressure control immunization, cancer screening that – are going to have high numbers, even rural areas to start there.

And I don't know if we even mentioned that (Stephen), I think some data need to go (inaudible) health needs assessment but …

Kelly Court: Yes, we're going to – and we got a slide coming up, that will talk about that in a little more detail.

Robert Rauner: OK.

Kelly Court: Other thoughts on this, these two slides? OK, I think Mitra, then we could go to the next slide.

OK, so, one of our recommendations was that we would be supportive of core set. And there was a comment about – assuming the core set was the same measures for all providers. So I think we have to – we'll talk about that, and that core set might be irrelevant to some providers.

And Karen, do you want to say a little bit more about that?

Karen Johnson: Yes, I think it might be just the way that we load it. I think we did write it that we would have a core set for a rural providers. I think – and it's my fault since I drafted that language I think that – let me make sure that the committee at least agrees and if they won't then we'll figure out what you do agree to that – and make sure that there would be a core set for hospitals and core set for, you know, either the ambulatory side or for clinician, that sort of thing.

So, we're not saying that hospital would necessarily use the same measure as a clinician, you know, but each setting might have a core set. So, but let's make sure that I understand at least that understanding. And if not then let me find out exactly what we're thinking in terms of the core set. And then, I'm not sure if we'll need to do much more after that.

Kelly Court: And then maybe, so Mitra, if you could go to the next slide. This kind of repeat what Karen just said.

Karen Johnson: Yes, thank you.

Kelly Court: Then we'll talk about cost-cutting versus disease specific. So is there anyone that thought that we would have this one core set versus multiple core sets based on the kind of provider?

Stephen Schmaltz: This is Stephen Schmaltz, I would agree with having a separate core set for ambulatory and a separate one for in-patient.

Bruce Landon: This is Bruce Landon and I concur that, you know, not everything applies to every institution and we ought to talk about for instance the capabilities of certain rural and critical access hospitals. So for instance if your hospital doesn't provide surgical services then that shouldn't be included in your core set.

Robert Rauner: This is Bob Rauner. I'll be the dissenting opinion and say there are some measure that do apply a cross settings and that if they were aligned, it would help some of our problems that we have right now. So medication reconciliation is a cross setting – breast cancer screening is a big problem we have, we have people that do the mammogram and don't bother to send it to the person who needs it.

If there were some alignment for at least some big measures like that, I think it would help the community quite a bit.

Kelly Court: OK.

Bruce Landon: Yes, I'd agree with that, to the extent that we can some – because those measure that extend the cross settings and then, you know, at some point is really driven by what's the service setting is like. And, you know, I don't know if have to be too complicated about that but, it's clear that at least with as the measure sets, have developed they would be addressed specifically to different types of providers.

Bruce Landon: This is Bruce again, just to be clear like – so for instance a measure like mammography screening, that doesn't seem like it's appropriate measure for the in-patient setting, for, you know, if it's only doing in-patient hospital here. So, obviously the alignment is always good but we, you know, should acknowledge that we can't always fit square peg into a round hole.

Robert Rauner: I agree with that however in most rural (hot) places, the same hospital, that the in-patient care also doing mammography screening. And so – although it's a different setting within the building, it's still the hospital doing that.

Bruce Landon: Right, but it's not – it's the hospital that's responsible for ordering and making sure that's done however is providing the ambulatory care.

Robert Rauner: Yes but when they do it, it's their responsibility to get to the person who ordered it.

(Crosstalk)

Kelly Court: ... transferring the result not mammography screening. So, perhaps we could – perhaps we could recommend that there'll be alignment of themes across the ambulatory or hospital setting such as transitions of care, patient safety. However I think it would be difficult to have the same measure in both settings, you know, with – maybe there's a few exceptions. But …

Guy Nuki: I think that what we should say is state that it's obviously very difficult, it would be desirable if possible but that should not compromise the measure by trying to make it fit into the – try to make it cost – scenarios and that would just compromise the measure. It would be nice if one existed but for instance the mammogram one is – and a good example is, the measure for the hospital to get the reading back is a completely different measure from the rural health clinic that's ordering the mammogram. So.

Kelly Court: Right.

Jason Landers: This is Jason Landers. A small – a very small set that crosses all provider types might make sense but then maybe some breakout among the specific things that would more relevant in the outpatient setting, you know, versus the hospital setting and clinic setting.

Sheila Roman: This is Sheila Roman. I thought that this issue was probably the most common issue in the public comment. So, you know, I think it's something that we really need to address carefully. And, I would agree that there are

different measures between different settings, but there is also crossover measures. And I think we need to get, you know, both of those in the core set.

Kelly Court: So could you give an example Sheila?

Sheila Roman: Well, you know, I think medication are reconciliation, clearly goes, you know, across settings. But, you know, some hospital specific treatments or, you know, hospital care for instance, hospital cap for instance. You know is the type of care is very specific to the setting. And, you know, I wonder where some of the chronic disease, conditions like diabetes, hearth failure, the usual suspects, COPD, fit in relevant, you know, related to core set versus measures that can be chosen. Because I have the sense that at least some of the commenters are, you know, felt that the measures are – really should be the same as for non-rural settings. And, you know, that we needed to recognize that.

Kelly Court: And we're going to – I'm coming from that in a little bit here and we'll talk about that. What if we use – and I think, the problem now is if we try to do too much with chronic disease, we get to the small numbers so quickly and that's what we have not. What if we use words like the core set should complement each other?

You know, be aligned and complement. But I think, there maybe a few measures that apply to both settings but I think it's going to be very difficult to come up with more than just a couple.

Guy Nuki: I like that wording but I would also be very worried that something would try to create a measure that they can put across all settings.

Female: Yes.

Guy Nuki: And try to make it fit. And, you'd basically be trying to force hospitals to do something that they really shouldn't be doing or they're not very – or they shouldn't be responsible for but, because someone decided that this measure that goes across or likewise in the clinic.

So, it's – I think we should include wording that it would be nice that they should complement each other, it would be nice if there was one – you should not sacrifice the measure's integrity just to try to get across service sites.

Robert Rauner: I think the same approach make sense so, you know, what the hospital discharge transfer, there's a seen side and the receive side so the interest number are going to be different but they should have similar themes though.

Kelly Court: Other thoughts on this? Karen, do you know what to do?

Karen Johnson: Yes, I think I can work with this. Let me get just a little bit more clarity about the question of the highest – the conditions of highest occurrence. So, Sheila's diabetes, heart failure, COPD. I think, earlier the way we wrote it is, we would probably see more cross cutting kinds of measure in core set and raise the disease specific for the optional set.

But a lot of people question that, so do you want to leave a little bit open for potential high-frequency diseases in the core set or continue to have them in the optional set potentially?

Kelly Court: This is Kelly. I think on the ambulatory side, it makes sense to consider them, you know, some of them being in the core set.

Karen Johnson: OK.

Kelly Court: But when you go to the hospital side, that's the same situation we have now. And so I think …

Karen Johnson: OK.

Kelly Court: … then they have to be in the optional side.

Jason Kessler: This is Jason Kessler here. I think that – any measures that would be around a specific condition should probably be limited to things like screening for them. And there's a couple of reasons for that that, you know, obviously the low volume is really significant. And, you also start – when you start looking at measures around specific conditions, you're targeting a specific population. For example if you're looking at hypertension or diabetes, you're looking at

adults and you're not even considered to the effort care, which obviously people of all ages are excited to be cared for in the rural settings.

So I would tend to – tend to lean towards – just, you know, if you're going keep and use specific measures in the core set, just keeping things like screening. You know, are you screening for diabetes, are you screening for hypertension, that sort of thing.

Kelly Court: OK, I'm hearing no disagreement with Jason. So, let's go with that.

(Crosstalk)

Karen Johnson: Go ahead, Kelly.

(Off-mike)

Kelly Court: I was just going to ask Severa to go to the next slide. OK, so then, we had discussed in our recommendation, how to incorporate community providers. And there were a couple of suggestions. And so, Karen I'm going to let you describe – take this one. This one is a little more complicated.

Karen Johnson: Yes. I think the different commenters – actually it's two different commenters, number 30 and 31. Because just in case you're wondering why we had comments split across groups, it's kind of the functionality is the way our commenting system works. So it's really long, it got chopped into pieces basically.

But, the idea there is – there seem to be quite a few people who were know that if you did talk about the population health and wellness of the community. And, they were supportive of that, but they noticed that the discussion pretty much was around the medical providers, not so much bringing in the various community providers. So, it's really a question of – is there any additional text that you would want to do to discuss potentially the contribution of community providers. Or even, do we even want to go further. So, clearly one could, you know, in measurement, if you're measuring – if you're doing a population health measurement, you know, by definition you

are a technology – contribution it's not just a medical "care" but other types of care.

It's kind of in there but I don't think we were explicit about it in the report. So, let me stop there and see if that makes sense to you guys and if not I can try again.

Tim Size: This is Tim, I'm not sure it makes, it doesn't quite yet. I think part of the conundrum and complexity here is that we have more in the language that we're all kind of using. We're using population happening two quite distinct ways, one in medicalized version for our a panel of patients. And the other is …

Karen Johnson: Yes.

Tim Size: … broader community. My experience has been more often than not, and I think it would be true of our – some of our commenters. People use those terms interchangeably without being clear about it. That's one comment.

The second comment would be – I guess my initial bias would be – this would put in a very specific narrow context of providers who might be eligible for taking performance and/or some degree of accountability to the Medicare program. So I guess I would like to keep that focused and to the degree that we're bringing a community definition of population health which I'm a big fan of, it would be in the context of what we providers are contributing to that. As oppose to saying, OK what are metrics or other non-medical providers that support community.

Because that's a very, very large bucket, you know, I just – it would quickly spiral to become meaningless. So, I think we should kind of keep our focus.

Robert Rauner: This is Bob Rauner. I actually know that (Keith Muller), he used to teach at our School of Public Health so that's kind of why he's so public health focused. He has a lot of great comments for the – for almost I'd say the next stages of this report rather than this report. Although I am also biased (inaudible), I think we do need to keep an eye toward the community health but it might be beyond the scope of this report. You know, I'm a big fan

putting into the community hospital needs assessment and all those sort of things, that might be beyond the scope of this report though.

Karen Johnson: OK, so I'm hearing from a couple of these – doing the – continuing to keep it more narrow if it's OK with you.

Kelly Court: Yes, and again, for me it's not issue of personal preference, it's an issue of the scope of the report.

Karen Johnson: OK.

Kelly Court: Other thoughts or comments on this one?

Sheila Roman: And I think we might leave some segue into the future. Because I think that these types of measures are really not developed for, you know, any side of care.

Robert Rauner: Could you acknowledge the comment to say that there should be a follow up to this or – and I think you did in your comment. You said something about the committee action guide or whatever the – you kind of point to another area in that – I think these comments are very good, it just – it needs to go to the next stage of the report possibly.

Karen Johnson: OK.

Kelly Court: OK, let's move on then to the next one. So, question here is related to different standards for rural providers. So adjusting measurement benchmarks and less reporting of measures. I'll admit I didn't really understand that comment. So, Karen do you have anything to add there?

Karen Johnson: Sure. Well I think I was in the same boat. This is what I thought that comment was saying, especially the first one. It did sound like that the comments were suggesting that perhaps there should be different benchmarks for rural providers. I'm not going to put words in your mouth but I kind of assuming that that's not where he wants to do. But then another commenter suggested maybe rural providers, just because of resource constrains perhaps shouldn't have to report on as many measures as other providers.

Guy Nuki: Well, I'm looking at the comment of eight at the moment. And it says, preferred the separate sets of measures not be developed and the second paragraph says, keeping with the philosophies of aligning and streamlining measure, rural providers could have a different or stratified measurement target. So maybe what they're saying is, is that, measure should be the same and target should be the same.

Karen Johnson: Right, right. So does that – if you were just, you know, I guess I was thinking like if you were thinking about, you know, glucose control as one of your measures. It sounded like they were saying you might have expect a different percentage of – that these patient can control, for rural providers to compare to the other providers. Does that sound like …

Tim Size: Yes. Well this is Tim, and I guess that would be pretty antithetical to what I think we've been saying. This might be a good time – reinforce the messaging I think in the report and some of the commentators mentioning that it is possible in communities that have more socioeconomic challenges, performances is going to be lower and if we're – if the purpose of a particular metric is to compare provider performance alike, alike, requires some considerations of socioeconomic differences and but I thought we kind of already touched on that on the report. But beyond that, it doesn't make a lot of sense to me.

Robert Rauner: This is Bob.

Kelly Court: Go ahead, Bob.

Robert Rauner: On the (AST) specific, I think that is what we kind of talk about even during our meeting in D.C. about the sociodemographic factors are, becoming more and more recognized. And I think he just want or she just want to point out, and just like your risk adjust infections for diabetics, you may want risk adjust role if you came from a very poor community or very obese community, you're going to have more diabetics.

So I think, you know, the insurance status, you know, marital status, you know, is becoming more noticed and this is throwing a lot of quality

measures, I think he's just trying to make a point there. That needs to be taken into account.

Karen Johnson: OK.

Sheila Roman: Yes, I would agree with that. Going back to your last slide, I know the community resources, you know, we want to have equivalent to the next report. But, I think community resources do reflect the benchmarks that rural providers can meet because, for instance in community I have to do telehealth if I need to do diabetic education. Or to get us – or I mean to get like a nutrition consultation, it has to be through telehealth.

So, again, maybe risk stratifying that's based on community resource available. OK?

Kelly Court: I think – I mean we do think that there might be a need for a separate set of measures, don't we? Because every single hospital setting, the current – acute care hospital measures don't work for rural. You know, but depending on the setting, there may need to be a different set.

Guy Nuki: Correct. I think that we talked about that as well. I think it's – I think that we definitely need to – because of the statistical issues and the locations, I thought – I was in the understanding that were saying you, you know, we'd like to have some that are common, that clearly we're going to need to come up with different sets of measures.

Stephen Schmaltz: Yes, I think this is more the benchmarking of the measure though is what they're trying to point out here. Is that the measure maybe the same but the benchmark they have to slightly different. And not necessarily worse in rural areas but I think that's a common misperception, we have many cases where the care actually is better in rural areas but it's just people don't really understand it or realize it, or hasn't been measured yet.

Kelly Court: Jason, do you have thoughts in your perspective and Jason Kessler, or Jason Landers?

Jason Kessler: I guess my – in a very general sense, it doesn't make a lot of sense to me to have different – different benchmarks. If you've chosen the appropriate measures you shouldn't need them, does that makes sense. I think it's more a measure – (a met) of measure selections and tweaking benchmarks.

Jason Landers: This is Jason Landers, actually I think tweaking benchmarked is actually dangerous.

Kelly Court: Well maybe what we say is – because treating benchmarks imply the different level of care, maybe what we say is that the measures have to be appropriately adjusted for risk and socioeconomic …

Karen Johnson: Sounds good.

(Steve): Don't you just want to do that for outcome measures? You don't want to do it for all measures do you?

Kelly Court: I would say no just for the outcome measures, not process measures, you know.

Sheila Roman: This is Sheila Roman. I do think that commenters were suggesting that it should be done for process measures as well. I think that they were suggesting that there are, you know, a lot of differences for field demographics between the populations that do not get filtered in to any kind of measure.

Robert Rauner: This is Bob. Maybe another way to look at it is where you're using the measure. If you're using it to set quality, I don't think there should be differences between rural and urban. But when it comes down to dinging people from and auditing standpoint or paying them different types of money, then you probably do need to bring in the adjustments. So maybe it depends – for folks getting quality, the measure should be the same.

Kelly Court: Yes, and this should …

Robert Rauner: But if you're going to start dinging providers, then they need to be different.

Kelly Court: I think the suggestion in comment number two that the Academy of Family Physicians made is actually quite good. They support risk adjustment for rural relevant and demographic factors, consideration of risk adjustments for rural relevant socioeconomic – socioeconomic factor is important to help achieve like to like comparisons. And that – and they talk about that in relationship to pay-for-performance.

Male: Yes, I like the language as well.

Kelly Court: OK.

Sheila Roman: And this is Sheila Roman again. And I wonder if the issue will – get in this sequence to pay-for-performance is really one of paying for improvement rather than paying for achievement in the setting of pay-for-performance, or paying for the one where the score is best.

Kelly Court: But can you say a little bit more about that, Sheila?

Sheila Roman: Sure. In the hospital value based pay-for-performance program, there, the hospitals are benchmarked both for achievement and for improvement. And in counting toward their score, their total performance score, I believe that the – where they performed best has more of an impact on their performance score. So this will be something that would become activated in the setting of pay-for-performance where we would be including improvements, as well as achievements.

Kelly Court: And I think Karen didn't – I think we recommended that – did we Karen when we talked about pay-for-performance that would be based on both improvement and achievements?

Karen Johnson: Yes, yes. So you actually do have that recommendation made already. And I don't remember the details that they – (CDP) program, but I think – my thinking is, so it sounds like we agree here. I think what they do is they look at both and they give you whichever is better. I mean, clearly – yes, OK. Yes, because if you're already doing great, then it's really hard to improve. So yes, OK.

I think I have enough here to respond to this comment, and we thought that section just a little bit to make sure that we're being very clear that adjustment – the appropriate adjustment is needed.

And to tell you the truth, just in terms of process measures first than outcome measures. The jury is still out, some people do think that process measures should be adjusted for patient demographic types of variable, but not everybody agrees with that. So that's – you know, it's certainly not – it's not something that everybody aggress with across the board.

Kelly Court: Good to know. OK, so then the next one is – has to do with …

(Off-mike)

Kelly Court: So there's a comment – two comments in number 12 about alignment without standardization, and then more alignment with private payers. I didn't really understand the comments about alignment without standardization.

Karen Johnson: You know, I think some of your discussion already today is requesting this idea of alignment without standardization, the idea that you can align on concepts or trying to measure the same thing but maybe you don't need exactly the same measure in different settings or what have you for different levels of analysis to achieve that. So I think that's what they were getting at in that comment.

And as written, the report is – pretty much we just talked about alignment. We talked about different types of alignment that we talked about alignment of measures. So I think that implicitly we're saying, you know, it'd be nice to use the same measures whenever you can.

So given the discussion you've already had, (I'd give) pretty easily – maybe add a little bit of an explanatory piece to that or a little kind of better goals to that too. So I suggest that maybe it's always appropriate to have the exact same measure, but you still might want to be measuring the same concept.

Robert Rauner: This is Bob. As an example from our Blue Cross meeting this morning, actually because the insurance plan is very HEDIS focused, what they're

measuring was in the clinic side, we're looking at it from a slightly different level, so the NQF diabetes control measure we're looking at is not exactly what they're using, but it's close, and maybe that's what they're getting at.

Karen Johnson: It could be, yes.

Kelly Court: Yes, so it's important. I mean, so Bob, when see that, you don't get into a situation where the HEDIS measure has great performance and your other measure has low performance. I mean, do they pretty much travel together?

Robert Rauner: I think they're pretty close, the problem comes when they – if they say – they actually aren't – they're giving us a looser connection between quality and payment (inaudible) by trusting us, so that work's OK. But if they're going to ding us specifically on the HEDIS measure, they're numbers won't exactly match ours because they're seeing often partial snippets of the information because their claims are incomplete.

So it gets to the problem depending on the relationship you have with them, right now, our Blue Cross relationship is pretty good and trustworthy. I know they're taking our measures at the face value and not like going into every chart and auditing. But that relationship between payers and providers isn't there across the country and of course is not even in all of our providers locally.

So I think that's part of the problem, is that if you're doing for quality improvement, it's not so important to (inaudible). But when they start – like I said earlier, when you get to dinging people, and paying them different money, then they kind of do have to depending how that relationship is, again it’s more complicated.

I think that’s why I like the Medicare Shared Savings Program even thought they’re not perfect. They're a blend of the claims and quality, and is the NQF number, you know, 0034. That does help from that standpoint.

But a lot of the commercial payers, you know, they're all doing their own thing and now they'll use their own HEDIS measures, almost all – I think everybody is looking at diabetes. They're basing it on blood pressure control,

if they're looking at it from slightly different reasons, and that often goes back to alignment between public and commercial, and Medicaid – you know, Medicaid commercial and Medicare aligning which is a big problem from the clinic level because we have to work all three but they don't seem to get that (inaudible).

Guy Nuki: Correct. I mean – and I think that we also need to stress the (inaudible) component, because if you have to measure something in three ways, that means you have to do three times the amount of work. And many of those rural providers don't have the large systems in place, and they – individuals should do all of that work. It's just adding work to people with limited resources. I think that's a really critical piece of this.

Kelly Court: Are there comments for Karen on this one before we move on?

OK. We'll go to the next slide. And these are some additionals that didn't really fit in some of those other categories. So if you think about low case volumes, there was one comment that suggested – that's able to aggregate data for several facilities if they belong to the same corporate system. So we see that comments in number 23. Is that something we think is a good idea?

Guy Nuki: I think we addressed that when we recommended that systems join together, three larger systems.

Kelly Court: That there's voluntary ability to do that? What about formations of a method work through to address the low case volume problem? So Karen, how would you see that as different from the MAP?

Karen Johnson: Well the MAP, their responsibility really is to help to provide input on the selection of measures. I think this was just a suggestion to actually bring some methodologists together to really tackle the low case volume problems and much more of the methodological discussion, and probably high level stats to try to tackle the problem.

Kelly Court: So that one would be more applicable in our comment about funding development of additional role measures?

Karen Johnson: It can really (inaudible) there, yes.

Kelly Court: Any comments …

Bruce Landon: This is Bruce. I'm not sure if Steve agrees with me, but I feel like part of what this committee did was at least to address that issue and suggest several potential, you know, ways to mitigate that problem. And it's not fair to me that there are, you know, that many additional options.

Karen Johnson: So it may not – I mean, that's really it, Steve, which I wasn't actually sure.

(Crosstalk)

Karen Johnson: Yes. I'm sorry, go ahead.

Bruce Landon: I said I don't know if Steve Schmaltz is still or not, and has …

Stephen Schmaltz: Yes, I'm on. I would agree with you Bruce that options are limited for that.

Karen Johnson: I'm sorry, Bruce. I was thinking it was Steve who was speaking. OK, so doing it, our methods that work, Bruce, may not be that truthful perhaps. Is that what I'm hearing?

Bruce Landon: Yes. And I think we sort of outlined a bunch of it. Yes, but relatively limited number of options that we have, which is, yes, similar to what some of us have written out of that before, and that was one of the reasons we sort of suggested as, you know, one possible direction was, you know, encouraging groups or small providers to aggregate together for the purposes of recording and potentially for purposes of improvement. But I do recall we (inaudible) a very voluntary sort of thing.

Karen Johnson: Right.

Sheila Roman: This is Sheila Roman. I think what this brings up is it's certainly not clear to me of the options that we have for dealing with small numbers, which option mitigates the problem best. And maybe rather than a method work group, some kind of work group to address the low case volume problem and make a recommendation as to how it should be approached in the rural setting.

And that may be as basic as – in the prioritization that we spoke about earlier – as which are – you know, which measures.

Kelly Court: This is Kelly. I think part of the problem is we don't have good measures. There aren't very many crosscutting measures. But I don't know if that's the same as what we're talking about for methods, or is that different?

All of the hospital measures are specific to a disease. You know, there's no crosscutting measures, things that would apply to every inpatient, and I think that that's the problem, maybe not so much in the ambulatory side.

Sheila Roman: Right. I would agree with you. You know, I don't think that – I think that is problem. But I also think that we haven't solved the problem of how we handle small numbers. And maybe that's something that, you know, we need to evaluate. I don't know what does Steve or Bruce think?

Bruce Landon: Well some of things do apply to every (inaudible) like med reconciliation vaccination status and appropriate follow up upon discharge. There are some things that apply to every patient that it (inaudible).

Kelly Court: Those things are not currently measures on the hospital side.

Bruce Landon: (Inaudible) to me (inaudible) for some of the core conditions like pneumonia and MI, CHF, et cetera.

Kelly Court: Influenza is still there. The other measures have been retired.

Bruce Landon: Can someone repeat the question that was asked toward us again?

Kelly Court: I think what we're trying to – go ahead, go ahead.

Karen Johnson: Sorry, please go ahead.

Kelly Court: I think we're trying to address whether we want to put something in the recommendation related to the suggestion about a methods work group.

Bruce Landon: Yes. So again, my feeling is that a lot of that is in here, and I'm not sure – still, like it's – it will be somewhat redundant. And you know, one of the comments is – a couple minutes ago, is that, you know, I fully understand the best approach, and I actually don't think that – the issue there is that there is no – I think the best approach is more of a political and opinion question than methodological question, because all of them involve tradeoffs that will differ according to where you leave things and what your vantage point of the world is.

You know, clearly – you know, from a physical point of view, you consider very well. You know, if we put together multiple years of data, we'll have more data, but then, obviously things change overtime, where you consider we could – you know, if you don't have adequate sample sizes, then you have to get together with other providers. And we certainly heard a lot of pushback on the committee from mandating something like that. I feel like these are more sort of political and judgment questions rather than methodological issues that are standing in the way there that require a different solution.

Kelly Court: And does anybody feel strongly that we should include the methods, it sounds like we have – gaining consensus on leaving that out?

OK. Then the next set of questions or recommendations, we have two specifically to the use of CAHPS surveys, that there was one suggestion that we include the ability to allow alternatives to the CAHPS survey. And there was another one very similar, number 27, that says we recommend to relax – or require that these CAHPS surveys do the time expense and literacy levels in come rural areas.

I'll talk about that. I can say at least in Wisconsin that we have 56 critical access hospitals. They really are not struggling with the CAHPS survey. So I'm not sure if that's similar in all geographic locations, and if there are differences between the use of HCAHPS in the hospital versus the clinic based CG CAHPS tools.

Guy Nuki: You know, I still remember where I ended up in the report, but we talked about when we were in D.C. about the difficulty with using these large

commercial vendors and the – I don't know where that discussion ended up, somewhere in our report or not.

Karen Johnson: Yes, it did. This is Karen. It is on page 27. And we phrased it like this, "Relax requirements for use of vendors in administrating CAHPS surveys and/or off our alternative data collection mechanisms." So in both cases, I think we were – it's written as if the CAHPS surveys would be used to collect data differently somehow. So these comments which suggest, you know, potentially using something other than CAHPS, or perhaps making CAHPS not required for some rural providers, or something like that, so it definitely – both of these suggestions to go beyond what you had – what we had originally written out as your recommendation.

Tonya Bartholomew: This is Tonya. I like the emphasis to be put more on allowing alternatives better than relaxing the requirements, because going back to Tim's comment about the clinical measurements, I think that falls with the patient experience as well, and that quality is so – needs to be expected from rural providers. But allowing alternatives to measure that patient experience that come, I think might be a little bit more feasible for rural providers.

Guy Nuki: I guess the question is that, is it the – are we looking for an alternative to a CAHPS, or looking for an alternative vendor.

Kelly Court: I think we're looking for an alternative way to administer the CAHPS, the standardized CAHPS instruments.

Tim Size: This is Tim, and I have to say that I guess a conflict of interest, because I'm the director of a coop of 40 rural hospitals, and we actually do have shared service that we do mostly for our hospitals, but also for others. It's very – and very much less than in some of the large national firms. So I think we're one example, and my guess is there are other examples on the country where smaller hospitals have come together and have found economical ways to do HCAHPS, so I think that flexibility is already in the system, and it – people want to come together to make use of.

Ann Abdella: Hi. This is Ann. I would agree with what Tim just said. I don't think that cost is necessarily an issue. And I think the people who are deploying this

survey have provided multiple opportunities for literacy and language to be able to overcome that opportunity to get feedback and input. I don't think there's anybody on the phone here would argue that the size of the tools maybe onerous. But it is what it is, and that's what's being offered everywhere.

So I'm not – when we say might be as if you were having an issue, and I think it might've been the person number 27 who referenced that shear volume, being able to get a relevant, and again, that low volume question, might be the issue. And so is there an opportunity or a way to use the tool but somehow score it differently based on the number of responses you're able to …

(Off-mike)

Guy Nuki: I agree with what she said. I don't agree with the cost question. I have more than one hospital I work with that is not willing to spend more money if it's quite expensive to some of the vendors' charge just by the number they mail out. And the cost prohibits getting enough data even though there's enough patients they've seen.

Kelly Court: They need to talk to Tim.

Ann Abdella: Shop it around.

Kelly Court: So I think that the point Ann made though is a good one. So that the requirements for the minimum sample size may be difficult, so you know, if you don't have a lot of patients, you're not going to get a lot of surveys back, and then – so that the sample size needs to be considered.

Tim Size: Yes, I know – this is Tim, and I'm not – I'll quickly go beyond my competence. My understanding is that CMS took out of the end of people discharged from their hospitals and nursing homes, which is not a small number. And I know that's made it challenging for a number of hospitals. So I guess our recommendation might be the alternatives of ask for reconsideration of that.

Karen Johnson: This is Karen. I know that came up in our meeting. I don't recall right off the top of my head. I think we talked about that case or point as a potential solution to the low volume problem is to, so we consider or at least, you know, pay attention when you're thinking about its exclusions to measures. We should be thinking about the impact on those low case volumes. So I think we did include that within a different section of our report under a different thrust, if you will.

Kelly Court: Yes. Karen, I'm going to do a time check here. So I have 20 after 1:00 here in Wisconsin. We've got a number of – we've got two slides yet to go, are we still in good shape for time?

Karen Johnson: I think we're doing really good. So I didn't hear a lot of feeling that we should say much more about CAHPS. We didn't say a couple things about CAHPS. I can use your discussion to maybe fill out that a little bit more. But if nobody has some (reverting) additions to that, then we can just leave that and go on to the next slide.

Kelly Court: OK, so if we go to the next slide, the first comment related to swing beds, swing beds or outpatients. Well technically, an outpatient often finds in a bed in the same area or next to an inpatient. So they're typically excluded in full inpatient measures. This suggestion was that swing beds should be included. And I think we addressed that in what Karen just talked about, is that the definition of measures should be – the exclusions should be considered that would allow rural providers, especially hospitals to increase their sample sizes.

Any other thoughts about swing beds?

OK, how about the suggestion to include housing security, food security as potential sociodemographic adjusters?

Tim Size: I think that's beyond scope.

Kelly Court: It is, so I don't know how you would even do that. Tonya, do you have a thought about that?

Tonya Bartholomew: I think we – I think that's beyond the scope too.

Kelly Court: OK, the next one is – oh, we're going to go quick now – additional principal for selection is measured across the continuum of …

Bruce Landon: Actually – this is Bruce. Can I just jump in one second. So when I looked at that comment, I initially thought absolutely the same, it's beyond scope. But I'm just curious, are there any county level measures of those sorts of variables that we should take advantage, or ZIP code level, and I have no idea what the answer to that question could be.

Karen Johnson: This is Karen. I think – my guess is, right now, the data aren't there. So it might be there in some small portions. And NQF is working on a – as you probably know, because we've mentioned it before the – a trial of how different SCS factors might be included in measures that they come to us for potential endorsement. So the next couple of years are really going to be (inaudible) opportunities for us. And we'll learn more about what might be out there.

I don't remember that food security came up in the SCS panel's deliberations. There was some discussion about housing security. But I think those kind of variables, for the most part, you know, the data, the chart, they usually aren't there, and might not be easily available …

(Crosstalk)

Karen Johnson: Yes.

Bruce Landon: I guess you could – if there's somewhere in our report where we could sort of refer that ongoing work, enable that that it should inform decisions made about, you know, risk adjustments for – in this context.

Karen Johnson: Yes, there was a recommendation to EMA, let's say. Let me find it. I'm not putting much finger on it. There's – a couple that really came out …

Bruce Landon: Yes, yes, yes.

Karen Johnson: … consider rural relevant sociodemographic factors and risk adjustment, and you guys did talk about that. And a couple that definitely came to mind that we have putted in the report was – just the help shortage area was one that you've mentioned. Distance to referral hospital, time of travel, frontier area designation, so those were a couple that you guys specifically pointed out that might be relevant.

Ann Abdella: This is Ann. And probably you might be able to add food security to that list, because they're a designated food (desert). To your point, I think, Bruce, you might be the one that asked it, but they have that information down to the census block level.

Karen Johnson: So I think it really is matter of, you know, you did mention a list, distance, time of travel, help shortage areas, that you just want to add these two more as a couple more potential things to your going-to-do list is just really the question for you.

Ann Abdella: This is Ann, and I would vote yes.

Bruce Landon: I guess, I wouldn't put it as a requirement. And again, I would sort of – you know, to the extent of this – what we would – that this is informed by whatever happens from the experimentation that's going on. I think it's sort of a more overriding issue.

Karen Johnson: OK.

Kelly Court: Yes, I would agree with that.

Sheila Roman: This is Sheila, and I do think that housing security and food security are two potential factors that do predict risking poor outcomes. So while I agree it's out of scope for what we've been doing, you know, I do think that we have to pay, you know, some kind of – you know, we put some kind of comment as to the slides that they would be useful.

Kelly Court: Yes. I mean, if you don't have – if you're supposed to be being measured on your patient population's ability to manage their diabetes, and they don't have access to good food, that does have an impact on the outcome.

So if you're going to be measured on an outcome that has so many variables beyond your control, I think that paying lip service to it at least to put it in there as a placeholder to make people think about it. I know that we are looking at a more holistic way about the environment that people live in and have to be healthier or sick in rural communities is really important, because that's the future for all of us.

(Crosstalk)

Tim Size: Yes, I agree. You know, I spoke to being out of scope, because we haven't really studied it. And so I think we need to be very cautious when we speak to the issue even though I'm one that's particularly sensitive to. But since we already have language in there that gave a number of examples, I think adding these two with additional examples is not inconsistent with my thinking. So I just – let's add it to a list of examples and move on.

Kelly Court: OK, I'm going to keep us moving here. So the next on was an additional principal to getting – no, go back to slide – here we go. Should we add a principal in our measure selection that is measured go across the continuum?

Robert Rauner: I think those are kind of also already discussed in the alignment comments …

(Off-mike)

Ann Abdella: I would agree. And I think if you put that in, and the measure doesn't go across the continuum, would that exclude it? So I think it's – to me, it seems to narrow.

Karen Johnson: Well, I don't – this is Karen. I don't that it would necessarily mean that a measure would have to go across the continuum of care, but perhaps you need measures that measure across the continuum of care.

Kelly Court: Agreed, and that are complementary to one another.

Karen Johnson: So in other words, it's not enough just to measure in the hospital. You need to measure in different settings. I don't think anybody disagrees with it. It's just

a question of whether you want to actually include that in your principals for selection.

Robert Rauner: Well, it sounds to me like we're setting another buzz worth that the alignment is encompasses this.

Karen Johnson: OK, we can do that.

Kelly Court: And we talked about complementary, so I think if we address it in the section we already talked about, we've kind of got it covered.

Karen Johnson: OK.

Kelly Court: What about the suggestion that we address measurements for the health care exchanges and/or Medicaid managed care?

Robert Rauner: I would say out of the scope. And frankly, from the clinic level, we're going to treat them the same anyway for the most part, so.

Ann Abdella: Yes, to me, it seems out of scope.

Jason Kessler: Jason Kessler here. I agree with it that it's out of scope, and it's also too widely varied from state to state to probably have anything that's going to be of significance, nationwide along rural health settings.

Kelly Court: OK. I think we can go to the next slide.

Karen, I'm going to let you take this one.

Karen Johnson: Yes, so what I wanted to do is just make sure that we are aware or make sure that you're aware that we are aware that some folks, when they read in that report, did have agreed basic understandings. And I listed a few of these here. The idea that all rural practices, there are low volume that you've recommended a separate way of measures for rural providers that all rural providers are in (inaudible).

There are things – misunderstandings by folks who read the report, so we are going to just treat the text a little bit. Try to make those misconceptions go

away. So this is really just to inform you that we are – we will be tweaking a rural that – just try to fix those misconceptions.

Kelly Court: OK. Then as we go to the next slide, I'm wondering if we've already answered that first one.

Karen Johnson: I think you have, yes.

Kelly Court: Are there thoughts then about things we have not talked about already that we need to improve as a modification in the report?

OK, then I think, Karen, we're ready to go to potential next steps.

Karen Johnson: Yes, that's great. And I'm glad we have just a couple minutes to talk about this. This is really just to give you guys a chance to give us a little feedback. You know, we're coming to the closing of this project. We have really thought of this project as is pretty much foundational work to try to get performance measurement for rural providers on a national stage, you know, in a different way through working with NQF. And we just wanted to get any ideas for news that you might have that may suggest avenues for further work in some future projects from future times that you think NQF might be helpful in doing.

So for example, we've already opined about a methods workshop, so it sounds like that you don't think that would be a fruitful next step. But just curios, and maybe you do have any ideas or maybe you have any right this second, but if anybody has any ideas of what you think might be a good next step move, move us forward along that NQF could make, say, contribution, we'd be curios to hear that.

Gregory Irvine: This is Greg Irvine in Idaho. I think one of the things that I've learned from this process has been how incredibly heterogenous our group is, and how different our practices are. As – those of us that the practice in the frontier have very different concerns and needs I have know as practice in more highly more populated areas.

And I think for the future, it's important that NQF includes, you know, at least as it pertains to rural medicine as widely dispersed group of people to get together to express the fact that we don't all have the same concern, or have the needs, and that be validated by future activities.

I think when we look a the public comments, one of them that came through for me loud and clear was that my concerns about allowing us to have the flexibility to choose measures that measure quality that are relevant to our community is absolutely critical. And what works in Idaho not necessarily work in Wisconsin, and vice versa.

And with our flexibility, we're basically creating a busy work that does no one any good. We need to be able to customize, especially in a rural setting what we're doing. And I'll make that plea one last time.

Karen Johnson: Thank you, Greg. Do you see a separate project at some point that would focus only on frontier providers? Do you think that's something that – you know, we don't have funding for this kind of thing, but we could potentially seek funding from different folks, if we're – or is it premature, I mean, and that (spare) for this?

Gregory Irvine: Well I mean, it's good that the frontier providers were – a couple of this at least we are included in this committee. I think that was hopefully helpful. Also providing – you know, we tend to be very primary care centric in these kinds of efforts, but even in rural medicine, there are – there's specialty care that's being provided. And I think the specialists need to have a voice at the table also. And I know I was a bit of an experiment bringing in orthopedics on the committee, a brave point at that. And I think it's important that we not think that everything the sun rises and sets with primary care. There are other concerns and other needs that come not only from the frontier, but also from the specialists.

Karen Johnson: OK. Others? Ideas of potential next steps for NQF and measurement of rural providers?

Robert Rauner: This is Bob Rauner. I really agree with Greg on that, that this panel is very, very good, because of its heterogeneity and representativeness, and (inaudible) panel that (inaudible) on because of that, I think.

I hope there is another stage to this report where we talk about, you know, what the stages and the development might be as far as, you know, development reporting, and eventually, maybe getting the payment how we walk through that potential, hopefully there's some follow up to this based on lessons learned over the next couple of years.

And I hope also that there's a pursuing that community health angle, and I need to read your population health guide to see if you're (inaudible), does it any way, but how that aligns the community level, quality improvement, maybe even the community health improvement plans and hospital needs assessments.

Tim Size: This it Tim. To go back to your question. And we actually I think gave an answer, at least a number of us did at our first meeting. And I think we have greatly (inaudible) important recommendations to CMS. But there are only worth the paper, if CMS takes it seriously and really does a deep dive to struggle with the implementation. So to the degree that NQF can help by transparency around that process, you know, and a light on to what degree CMS follows through or doesn't follow through because they have so many other irons in the fire. And that to me, would be fundamentally the most important next step.

Karen Johnson: OK.

Guy Nuki: Maybe I'm misunderstood when we were in Washington. I though that there was going to be a MAP process that would be developed around this and take these recommendations. And that was almost predesigned as the next step is …

(Off-mike)

Karen Johnson: Yes, I think that was definitely your recommendation. And you know, we will give it back to CMS to see what they – where they land with it. Right

now, I see – and the commentaries were correct. Right now, any kind of MAP process like that would pertain just to the small hospitals and the providers – with small providers. They're already included in the current CMS program.

You know, at some point, if (CEH) and (RHCs), et cetera, come into the fold in some way, whether in the current programs or in some other kind of program get to be developed, that might be even more pertinent. But yes, it did come through as a recommendation.

Kelly Court: I think – Karen, this is Kelly. I think it seems like both of these won't get any traction unless some new measures get developed. And I'm really thinking more for the hospital side, because there aren't crosscutting measures. And so you know, I would love to see funding, you know, for development of measures that are really relevant to rural hospitals, because right now, they aren't there.

Karen Johnson: OK.

Ann Abdella: And Karen, this is Ann. There's just this – everybody there is probably seeing as much more clearly than I am. But I have a worry about the facts that, you know, in our executive summary and everything else, we talk about pay-for-performance programs. And CMS is already moving down the road of value based payments, and leaning it in a different way I think in just pay-for-performance.

And you know, we're moving to the value modifier and all of those different things, and we might be well served if we want CMS to take that report seriously if we thrown in some of their language into this, and how this positions rural communities to keep pace to be able to turn that corner with the rest of the country, because things are moving so quickly that I worry about how we're even going to help the providers in our community do this, and they're a little bit more advanced than other, and they're still getting their head wrapped around simple pay-for-performance, and that may not be option for them a few years down the road.

Karen Johnson: OK.

Ann Abdella: And that we're going to – people are just rocketing to these partial or capitated rates to pay providers. And they've got to know what their numbers are and what their quality is in order to be able to survive that.

Karen Johnson: OK.

Ann Abdella: So for whatever is worth.

Karen Johnson: Thank you, Ann. Quick question for you. It's like me, when I remember that horrendous spreadsheet that, you know, we found a thousand measures, lots of duplicates, but a thousand potential measures for hospitals and clinicians. But it was way too big to be a projects try to actually look in detail at some of those – at those measures and actually turn up with some kind of a core set or some kind of an optional set.

Is that something that you think is a potential next step for NQF to try to work on, or is that premature at this point, or maybe even not that useful?

Guy Nuki: You know, it's actually an interesting idea, but I think if we're going to do that, we should – I would imagine that many of those things that we would come up with would have contingencies. In other words, they couldn't be placed until – you know, until something else happens such as technical abilities and things like that.

And if NQF had the same approach to developing that and putting those – including those recommendations that go along with each measure, it might preclude somebody else from making those measures and then just mandating them prior to making sure that the ability to do it properly was created.

Tim Size: Yes, this is Tim. I don't mean to be cheeky, but I think the NQF has done a lot more time on rural without being over committed to it, so that would be good.

Karen Johnson: OK. So potentially do some further work on that or – and will get premature at this point?

Tim Size: Actually, I don't think anything's premature. I go back to some of those that we spoke a couple of minutes ago, things are moving extremely quickly.

Karen Johnson: OK. OK, I don't want to belabor this and I'm definitely paying attention to our cause, but this was very helpful for us just to think about in our planning and our thinking what we want to do, you know, going forward perhaps.

If you have other ideas that come to mind, shoot some e-mail, we'd really appreciate it.

So for now, let's go ahead. Mitra, can you set us up to open our lines for any public comments? Again, this is NQF and all our names are open to the public. So we also want to give the public an opportunity to respond if they would like. So Mitra, can we walk us through that?

Mitra Ghazinour: Sure. (Bridgette), would you please open the lines for public comments?

Operator: At this time, if you would like to make a public comment, please press star, then the number one on your telephone keypad.

And there are no public comments at this time.

Karen Johnson: Great, thanks so much.

And we are going to tell you what our project – next steps are. I think I alluded to a couple of these already. Severa, were you going to walk us through our next step.

Severa Chavez: Thanks, Karen. So we have just a couple of things to look forward to. September 9, the NQF team will be doing – will be presenting our recommendations, the committee's recommendations to CMS, with the report due out on September 14. We will be sending a copy of that final report to all the committee members, and the copy will also be posted on the project web page on the NQF site.

Severa Chavez: And once again, thank you to everyone's dedication to this important work.

Unless we have more questions or comments, I think we're adjourned.

Karen, do you have a final request for Kelly?

Karen Johnson: Yes, let me just make sure that everybody understands we're going to take all of these discussions today, and (I'll make) the report in the ways that we've talked about. If other things occur to you in the next few days, we will be working on this probably next weekend and possibly the week after that. But there is still a little bit more time, if you have ideas that you want us to try to incorporate, we still can do that, so just let us know.

And from the project team and myself especially, thank you so much for all of the effort. I've really enjoyed getting to know you guys and working with you, and I hope our paths cross again in the future.

Kelly, would you like to do some final goodbye, before we let everybody go?

Kelly Court: Yes, I just want to echo what Karen said. And also, Karen, thank you, and Mitra and Severa for the great job you've gotten us through a tough this task. And I think we've hopefully got something of substance that CMS will be able to take and use.

Karen Johnson: Thanks so much. Anybody else who has any parting words before we close the call?

Tim Size: This is Tim. I like to really thank the staff. I've been in a lot of committees and you guys are really professional and much appreciated.

Karen Johnson: Thank you, Tim. OK, with that, we're going to give you 14 minutes of your day back. Thank you so much. We appreciate your time, and have a great rest of you day.

Operator: Thank you for joining us. This concludes today's call. You may now disconnect.

END