NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Rural Telehealth and Healthcare System Readiness Web Meeting 1

The National Quality Forum (NQF) convened a public web meeting for the Rural Telehealth and Healthcare System Readiness on January 5, 2021.

Welcome and Introductions

Nicolette Mehas, NQF senior director, welcomed participants to the web meeting and introduced the NQF project team. Dr. Marcia Ward and Dr. William Melms, the Committee co-chairs, also provided welcoming remarks. Maha Taylor, NQF managing director, facilitated roll call and verbal disclosure of interests. Ms. Mehas reviewed the following meeting objectives:

- Orient the Telehealth Committee to the goals of the project.
- Provide an overview of the background for the project approach and results of the measurement frameworks developed by the 2017 Telehealth Committee and the 2019 Healthcare System Readiness Committee.
- Begin discussion on the role of measurement in assessing quality during pandemics and other disasters and when delivering care in rural areas via telehealth.

Disclosures of Interest and Review of Meeting Objectives

Maha Taylor facilitated introductions of the Committee members and conducted disclosures of interest (DOIs). Ms. Mehas also facilitated brief introductions of the federal liaisons on the project.

Project Purpose

Ms. Mehas highlighted the purpose of the project, which is to create a conceptual measurement framework that guides quality and performance improvement for care delivered via telehealth in rural areas in responses to disasters.

The Committee was informed that upon completion of its work, key stakeholders will be able to identify which measure are available for current use; encourage the development of new measures that address gaps; and promote the use of such measures to assess the impact of telehealth on healthcare system readiness and health outcomes in rural areas affected by disasters like pandemics, natural disasters, mass violence, and other public health events.

Background and Context

Ms. Mehas reviewed the project background and the Committee charge. She emphasized that the project builds on prior work, namely NQF's Telehealth Framework (2017) and Healthcare System Readiness Framework (2019).

Previous work identified various domains and subdomains that need to be addressed when assessing the quality of care delivered via telehealth. These are the four domains:

- **Access to care**, which examines whether telehealth services allow individuals to obtain clinical services effectively and whether remote practices can provide specialized services.
- **Financial impact or cost**, which examines the burden that may be placed on patients/family/caregivers.
- **Experience**, which examines the usability and the effect of telehealth on patients, care team members, and the community to determine if the use of telehealth is to patients and providers comparable to services rendered in person.
- **Effectiveness**, which represents the system, clinical, operational, and technical aspects of telehealth.

The Committee identified six priority areas for telehealth measurement: travel, timeliness of care, actionable information, added value of telehealth to provide evidence-based best practices, patient empowerment, care coordination. Each of these areas is connected to multiple domains/subdomains of the framework.

Ms. Mehas presented the Healthcare System Readiness Framework, which is an actionable all-hazards framework to assess readiness of healthcare systems to respond to and recover from disasters and emergencies. The project identified four domains based on the four S's of surge capacity throughout the four phases of emergency management. It was noted that there were no NQF-endorsed healthcare readiness measures available, however the Committee noted some existing measures from the Centers for Disease Control and Prevention (CDC) and the National Institute for Occupational Safety and Health (NIOSH) and also put forward measure concepts that align with the framework domains.

Several points from the Healthcare System Readiness report were identified as being directly related to telehealth and rural areas. For example, telehealth was identified as a possible tool for increasing ability of healthcare systems to ensure availability of staff capable of performing disaster response tasks. Telehealth was also identified as a nonhospital-based element of healthcare systems that can help provide surge capacity in emergencies. It was also recognized that rural providers may prioritize investments in disaster planning differently than those in urban areas.

In addition to the previously discussed frameworks, NQF staff will reference recommendations and guidance outside of NQF as well as measures and measurement tools (e.g., Consumer Assessment of Healthcare Providers and Systems, Healthcare Effectiveness Data and Information Set measures) that have been adapted for telehealth use as part of an environmental scan to guide the Committee's work.

Project Overview

Ms. Mehas shared the Committee charge, which is to discuss the following:

- Changes in telehealth technology, policy, and practice
- Changes to measures and measure concepts in telehealth since 2017 Telehealth report
- Priority measures and measure concepts that link telehealth, rural healthcare system readiness, and health outcomes
- Gaps in telehealth measurement
- Potential unintended consequences related to the use of telehealth for enhancing system readiness in rural areas.

Committee input will be used to create an updated framework that will link quality of care provided by telehealth, healthcare system readiness, and rural health outcomes in a disaster.

A high-level timeline of the key milestones and web meetings was reviewed. The Committee will participate in six web meetings from January through October 2021. Committee members will also provide input on the environmental scan, which will be finalized by July 20, as well as the final recommendations report, which will be finalized by December 13.

A Committee member asked for additional information from the federal partners on how they intend to use the outcomes from this year's Committee's work. CMS shared that the agency has been interested in expanding the number of telehealth appropriate measures they use, especially given the current situation with COVID-19, as well as exploring whether telehealth appointments can replace in-office appointments or be used as part of an adaptive healthcare system. Another Committee member shared that it is important to consider improving preparedness on an everyday basis so that providers are ready to scale up telehealth resources quickly in the event of an emergency.

Role of Quality Measurement in Relation to Disasters and Telehealth Discussion

Ms. Mehas started the discussion by recognizing that the Committee will be adapting the 2017 Telehealth Framework for quality measurement to focus on rural areas during disasters. Ms. Mehas summarized previous discussion on the role of measurement in supporting telehealth:

- Measurement can provide data to understand if telehealth is comparable (or is an improvement over) in-person care.
- Measuring readiness can prompt planning, communication, and maintenance activities, driving health systems to become more person-centered and improve capacity/capabilities, accessibility, etc.
- Consistent definitions and widely accepted/impactful quality measures need to be developed and used in order to achieve high-quality outcomes.

Co-chair Dr. Melms facilitated discussion of how COVID-19 has changed telehealth delivery in rural areas. Committee members shared their experiences, and the following themes emerged:

- Providers experienced a huge initial surge in telehealth appointments when public health agencies advised that in-person non-emergent care would be shut down.
- Many providers had telehealth systems in place, but they were usually designed for office-to-office specialty consultations. Waivers for site designation allowed providers to reach patients via telehealth in new areas (e.g., patients in remote areas that were not designated 'rural', patients that could not travel to a site in person), but systems needed to develop and adopt new platforms that had the capability to reach patients in their homes, which took weeks to months.
- Providers faced challenges in the pivot to telehealth delivery:
    - Infrastructure challenges. Video visits were impossible in some areas because of limited broadband; telephone visits were possible in more situations, but still posed a challenge in areas with limited cell phone service. Multiple Committee members noted that the audio-only visit waiver was extremely helpful. One Committee member noted that the emergency COVID-19 waivers actually complicated use of their existing telehealth system, which was set up to require detailed documentation on licensing, consent, etc. for auditing purposes.
    - Difficulty training a large number of providers on the new telehealth platforms in a short period of time and "scaling up."
    - Patients could be uncomfortable using new telehealth platforms or devices, especially vulnerable populations (e.g., undocumented immigrants).

- Committee members were unclear about the future of telehealth provision after the COVID-19 emergency ends:
    - Patients may have had substandard experiences with telehealth given the fast pivot during the emergency, which might affect their willingness to use telehealth services later on.
    - Health information exchanges do not have a structure in place to track changes in telehealth use.
    - The role of non-traditional health system infrastructure (e.g., direct-to-consumer care models) in telehealth and measurement is unclear.

Co-chair Dr. Ward opened discussion on unique measurement considerations that apply to telehealth in rural areas during disasters. Dr. Ward noted that the original Telehealth Framework and the Healthcare System Readiness frameworks each covered broad topics, and in this year's work, the Committee will need to find a balance to combine elements of both frameworks and make them easily applicable to rural areas. The Committee discussed the following measurement considerations:

- It is unclear if the goal of measuring telehealth quality is to compare in-person care to telehealth care or to compare telehealth care to no care.
- Multiple Committee members agreed that quality measures for telehealth delivery should not be entirely different than those used for in-person care, as telehealth is just an alternative delivery method. However, supplemental questions (e.g., questions on satisfaction and ease-of-use; access to broadband and cellular capability) can be useful metrics specific to care provided via telehealth.
- A Committee member shared that collecting information on different modalities of care (e.g., real-time vs. asynchronous; video vs. phone visits; use of home monitoring devices) could help quantify geographic and socioeconomic disparities in quality of telehealth care.
- A Committee member noted that measurement around efficiency of care (increasing capacity during disasters) could be a helpful addition to the framework. This concept is related to access to care.
- A Committee member commented that a time-to-scale metric could be helpful.

Public and Member Comment

Ms. Mehas opened the web meeting to allow for public and member comment. One comment was shared from a federal liaison who noted that as part of patient experience, it is important for local providers to be engaged with rural care and build trust with patients. The liaison noted this was especially important during the COVID-19 emergency.

Next Steps

Ms. Mehas notified the Committee of upcoming activities. NQF will use the Committee's input as part of the environmental scan, and themes from the meeting will be used to start building the draft rural telehealth and healthcare system readiness framework. The next Committee web meeting is February 1, 2021 from 3:00 to 5:00 p.m. ET.