NATIONAL QUALITY FORUM
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Meeting Summary

Rural Telehealth and Healthcare System Readiness Web Meeting 2

The National Quality Forum (NQF) convened a public web meeting for the Rural Telehealth and Healthcare System Readiness Committee on February 1, 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. Amy Guo, NQF Senior Analyst, facilitated roll call.

Dr. Mehas reviewed the meeting objectives, which were to review the changes in telehealth policies and practices since the release of the 2017 Telehealth Measurement Framework as well as how the referenced policies and practices impact current care and system readiness in rural areas. Dr. Mehas then reminded the group that the purpose of the project is to create a conceptual framework that guides quality and performance improvement for care that is delivered via telehealth in rural areas in response to disasters. Dr. Mehas also informed the committee that at the end of this work, key stakeholders shall be able to identify which measures 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 health system readiness and health outcomes in rural areas that are affected by disasters.

Background and Context of Telehealth Policies and Practices

Yvonne Kalumo-Banda, NQF Manager, discussed background and context as it relates to telehealth policies and practices. Ms. Kalumo-Banda discussed how telehealth has grown steadily since its inception by the U.S. Department of Defense in the early 90s. However, the greatest shift in telehealth policies and practices happened last year in response to the coronavirus (COVID-19) public health emergency. Prior to the 1135 waivers issued in response to COVID-19, the Centers for Medicare & Medicaid, would only pay for telehealth on a limited basis, when the person receiving the services is in a designated rural area and when that individual was physically present at eligible clinics, hospitals, or certain other types of medical facilities for the service.

Under the current waivers, the Centers for Medicare & Medicaid is now paying for office, hospital and other visits furnished via telehealth across the country, including in patient places of residence. The Department of Health and Human Services (HHS) Office of the Inspector General is also providing flexibility for healthcare providers to reduce or waive cost-sharing services that are paid by federal health programs. The Centers for Medicare & Medicaid Services (CMS) is also waiving requirements that patients, physicians and non-physician practitioners perform in-person visits for nursing home residents, and is allowing these visits to be conducted via telehealth where appropriate. Finally, pre-COVID-19 frequency limitations set on subsequent inpatient visits (once every three days), skilled nursing facilities (once every 30 days), and critical care consultant patients (once per day) have been removed.

Ms. Kalumo-Banda shared that while many of these telehealth-related waivers are only guaranteed during the COVID-19 public health emergency, several states are considering legislation to make some of

these temporary changes permanent, allowing providers to invest in telehealth services. For example, on January 10, 2021, Governor Cuomo announced a plan to expand to telehealth access for New York State residents in underserved and rural communities, eliminate location requirements, and develop interstate licensing with states in the northeast region for specialist providers. In California, Assembly Bill 32 aims to indefinitely extend telehealth flexibilities in Medi-Cal programs. Finally, in Massachusetts, bill S.2984 aims to remove financial and insurance barriers to telehealth services by extending payment parity for in-person and telehealth services.

Policies and Practices Discussion

Co-chairs Dr. Ward and Dr. Melms opened the discussion on telehealth-relevant policies and practices. The Committee first discussed whether there were additional recent changes to telehealth policies and practices that are relevant to rural providers that should be considered while developing the framework. The Committee suggested looking at the changes that were made with the Consolidated Appropriations Act that was passed in December 2020. The Act added another type of originating site, the rural emergency hospital, to be eligible for reimbursement of telehealth services under Medicare. The changes also increased access to mental health services for diagnosis, treatment or evaluation by eliminating geographical restrictions and allowing the home to be an eligible site for care delivery; however, patients are still required to have one in-person visit with the telehealth provider within the six-month period prior to the telehealth encounter in order for telehealth services to be eligible for reimbursement. The Committee also discussed that the slow hospital credentialing system (no unified credentialing platform) can prevent telehealth providers from practicing and discussed whether it can addressed through a regulatory or legislative fix. A Committee member noted that delegated credentialing is sometimes proposed as a solution to credentialing issues within the healthcare system, but the process is still very time consuming and has heavy administrative burden. Several Committee members shared that it might be helpful to consider changes in practices by insurance and private payers as they may be creating innovative solutions to encourage telehealth use. Finally, Committee members noted that policies around e-prescribing should be considered.

The Committee also discussed how the currently proposed post-emergency changes may affect the industry, especially rural providers. The Committee discussed that providers are reluctant to invest in infrastructure and training for telehealth programs without reassurance that the regulatory environment will support telehealth in the long term; this is particularly salient for rural providers, who often have extremely limited capital and resources. Another area of discussion was infrastructure and limited broadband access in rural areas despite availability of funding. Committee members shared that other options (e.g., satellite) should be considered alongside broadband, and broadband also needs to be supplemented by increasing digital literacy of patients and providers.

Lastly, the Committee discussed how the potential benefits and any unintended consequences of the new telehealth policies can be captured as part of the measurement framework. A Committee member noted that the framework should capture both regional and national level policies and emergencies. The Committee also provided more general feedback on considerations for the framework, including that measures should be disease-specific and telehealth should be considered a modality of providing care (e.g., “days at home for last six months of life” could be compared between in-person and telehealth visits and correlated with other outcomes such as readmissions and cost). The Committee also discussed that any metrics on cost may need to be based on episodes of care, and that timeliness and access to information may need to be redefined for an emergency context where incomplete information is available to providers. Finally, the Committee identified unintended consequences: increased telehealth

use could either worsen or improve coordination of care, and could pose new opportunities to understand wait times, face-to-face time with providers, and other metrics of effectiveness of care.

Draft Rural Telehealth Framework

Dr. Mehas introduced an initial draft of the Rural Telehealth and Healthcare System Readiness measurement framework to the Committee. Dr. Mehas shared that this draft framework is based on the content and structure of the 2017 Telehealth Framework but pulls in additional information from the 2019 Healthcare System Readiness Framework and the past Rural Health work on low case-volume and challenges in rural quality measurement. The draft framework includes four domains (Access to Care & Technology; Costs, Business Models, & Logistics; Experience; Effectiveness) that roughly map to the four domains included in the 2017 Telehealth Framework (Access to Care; Financial Impact/Cost; Experience; Effectiveness). However, the draft framework also includes a fifth domain, Rural-Specific Measurement Issues.

Relevant Domains	**Rural / Disaster-Specific Issue / Measurement Consideration**
Access to care & technology	• Broadband issues (phone v. video) • Telehealth technology / capacity for communication • Geographic distance / travel • Clinical use cases: Disaster-specific care, time-sensitive emergencies (e.g. stroke), access to primary / specialty care, system-wide coordination
Costs, business models, and logistics	• Cost to patients, caregivers, and insurers • Business sustainability, spillover effects of telehealth (i.e. transfers, staffing) • Technology costs, Logistics of launch, existing partnerships
Experience	• Patient experience with telehealth • Caregiver experience with telehealth
Effectiveness	• Quality of care for clinical issues addressable through telehealth, other emergencies, and gaps in care that telehealth can address • Time to care delivery, receipt of specific care • Specific care needs of rural patients
Rural-Specific Measurement Issues	• Low volumes of patients (i.e. reliability), risk adjustment, Critical Access Hospital issues

Rural Telehealth Framework Discussion

Co-chairs Dr. Ward and Dr. Melms opened the discussion by asking the Committee to share feedback on any other domains that might be important to consider for the telehealth framework. The Committee offered the following suggestions:

- The “Access” domain should include basic computer literacy and training.
- The “Cost” domain should address wider financial impact to the community (What jobs, testing, etc. stay in the community by providing care locally? Are there workforce ramifications or reduced risk for employers in rural areas associated with reduced travel times to get care?)
- The framework should capture these additional concepts:
    - Consistency of platforms and effect on patient experience (e.g., does one patient need to learn how to use multiple online platforms to visit with different providers?)

- Ability to connect patients to local resources or services when providing care via telehealth (e.g., does the provider have information on patient's ability to access emergency services?)
- Role of the "champion" in promoting telehealth implementation and the added challenge of recruiting and retaining a champion in rural areas with high turnover
- Regulatory support or flexibility during emergencies (e.g., the temporary relaxation on enforcing the Health Insurance Portability and Accountability Act during COVID-19)
- Acceptability and trust of technology
- Additional concepts representing healthcare system readiness and preparedness

The Committee also discussed the role of equity (reducing disparities, considering cultural competency, language barriers, computer literacy, etc.) within the structure of the framework. The Committee agreed that equity should be represented in the framework but were not sure whether it should be included as its own domain. Several Committee members shared that if equity-related items are placed in their own domain, it may be ignored. However, another member felt that calling equity out as its own domain was important instead of trying to spread these items out across the entire framework.

Next, the Committee discussed additional measurement issues relevant to rural telehealth that should be considered in the framework. A Committee member shared that it might be relevant to consider informal provider networks and communication within rural hospital systems, especially in tight-knit rural communities. A Federal liaison also shared that additional stakeholders outside the traditional 'medical system' (volunteer fire departments, churches, volunteers providing phones, etc.) should also be considered. A Committee member also shared that interoperability is a major issue that should be considered, and that having common technologies could make it easier and less expensive for rural providers to adopt and maintain health information technology (HIT) that can support telehealth visits. A national HIT strategy for emergencies (e.g., an e-reporting system ready to scale) could also save time and money during an emergency like COVID-19. The Committee discussed that the final framework should not require providers to take on any additional costs or adopt special reporting systems in order to align their quality reporting with the framework.

Finally, the Committee discussed the organization of the framework. The Committee was generally comfortable with the first four domains presented but raised the possibility of spreading the content from the Rural-Specific Measurement Issues domain across the first four domains. A Committee member noted that it is unclear how some measurement issues should be categorized (e.g., is access to video visits categorized as access, experience, or something else?), but the Committee will need to help describe how these issues fit in the domains as part of the final recommendations report. Finally, a Committee member shared his experience with telehealth as a rural caregiver, emphasizing the isolation from hospital resources and the role of local organizations such churches, libraries, etc.

Public Comment

Ms. Guo opened the web meeting to allow for public and member comment. No public comments were offered.

Next Steps

Ms. Guo notified the Committee of upcoming activities. NQF will incorporate the Committee's discussion from Web Meeting 2 as part of the environmental scan and will continue to update and iterate on the framework of the project. Ms. Guo also mentioned that the project team will be sharing

the initial results of the environmental scan to date during the next web meeting, which is scheduled for February 22 from 3:00 to 5:00 pm Eastern time.