NATIONAL QUALITY FORUM
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Meeting Summary

Rural Telehealth and Healthcare System Readiness Web Meeting 4

The National Quality Forum (NQF) convened a public web meeting for the Rural Telehealth and Healthcare System Readiness Committee on June 8, 2021.

Welcome, Introductions, and Review of Web Meeting Objectives

Nicolette Mehas, NQF Senior Director, welcomed participants to the web meeting and introduced the NQF project team, CMS supporting staff, and Committee co-chairs Dr. Marcia Ward and Dr. William Melms. Dr. Ward and Dr. Melms thanked participants for joining and provided opening remarks. Dr. Mehas facilitated roll call of the Committee members and federal liaisons.

Dr. Mehas reviewed the meeting objectives, which were to review public comments on the environmental scan, begin discussion on the updated measurement framework and draft recommendations report content, and begin discussing the measures and measurement concepts most relevant to the measurement framework.

Dr. Mehas also reminded Committee members of the project purpose, to create a conceptual measurement framework that guides quality and performance improvement for care delivered via telehealth in rural areas in response to disasters. After the completion of the project, key stakeholders will be able to identify which measures are available for 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.

Public Comments on Environmental Scan

Dr. Mehas provided an overview of the public commenting process. The environmental scan was available for public comment from April 9, 2021 through May 7, 2021, and seven organizations submitted a total of 15 comments on the scan. Dr. Mehas shared that the comments were categorized as Framework Topics and Organization, Challenges of Telehealth Provision, Additional Policies and Practices, and Other Comments. Dr. Mehas shared that NQF would summarize the comments and proposed responses, and the Committee should provide input on the proposed responses and determine whether additional changes should be made to the scan.

Framework Topics and Organization

Dr. Mehas shared feedback on framework topics and organization and proposed responses from NQF:

Comment	Proposed Response
A commenter suggested that NQF align wording and categorization between the rural- and telehealth-relevant topics in the measure scan (e.g., “behavioral/mental health” category vs. “mental health/substance use” category).	NQF will align the wording and grouping for these categories for additional clarity.
A commenter suggested that NQF expand telehealth-appropriate topics considered in the	NQF will discuss the appropriate scope of topics with the Committee.

scan (e.g., preventive care, surgical care, advance directives, perinatal, obesity, other specialty).	
Commenters provided thoughts on preferred characteristics of measures used with the framework, including the need to consider non-NQF-endorsed measures and provide information on reasons for loss of endorsement for measures in the list. Commenters also shared that structural measures are difficult to control for physicians, and patient-reported outcome-based performance measures (PRO-PMs) are difficult to collect. Performance gap data considered for the measures should specifically reflect rural and telehealth care.	NQF will acknowledge the difficulty of collecting structural measures and PRO-PMs but will ultimately plan to include a mix of different measure types in the final framework to drive quality improvement. The Committee will also consider measures that are not NQF-endorsed that are fully specified, scientifically acceptable, and feasible. NQF and the Committee will also consider publicly available data on measure performance.

A Committee member agreed that aligning the wording and categorization of the rural- and telehealth-relevant topics would make sense.

A Committee member shared that the scope of the project should not be expanded and the focus should remain on care during emergency, but it would be valuable to acknowledge the importance of chronic care during extended emergencies in the final report. Another Committee member agreed that the topics in the scan should remain the same but the report should acknowledge the elements of telemedicine during emergencies that impact chronic conditions. Another Committee member noted that this could fit in with the final recommendations report alongside discussion of future Committee work.

A Committee member shared additional comments related to NQF endorsement, noting that while NQF endorsement serves as a shorthand for scientifically acceptable and feasible measures, NQF endorsement is helpful because NQF-endorsed measures have publicly available specifications. The Committee member shared that the measures considered for use with the framework should not be proprietary or expensive/difficult to use.

A federal liaison asked whether the organizations that provided comments were representative of all the stakeholders that might have an interest in the environmental scan, due to concerns about perpetuating inequity. NQF shared that the call for public comments was shared widely among NQF membership, CMS listservs, and other contacts. NQF also invited Committee members and federal liaisons to share any additional contacts that might be interested in reviewing the scan and report and offered to incorporate additional feedback if desired.

Challenges of Telehealth Provision

Dr. Mehas shared feedback on challenges of telehealth provision and proposed responses from NQF:

Comment	Proposed Response
Commenters reaffirmed topics covered in the scan, including the need to expand reimbursement and flexibilities from payers after the COVID-19 pandemic; the importance of audio-only visits; the role of patient education and technological literacy in establishing	While no specific changes are recommended to the environmental scan, NQF and the Committee thank the commenters for sharing feedback to inform the final report.

telehealth services; the role of medical liability policies and cross-state licensing; and the need to expand patient and provider access to broadband.	
Commenters noted that extended emergencies (such as the COVID-19 pandemic) may necessitate long-term care for chronic conditions and felt this should be addressed in the scan.	NQF will discuss the how the framework should account for patients' chronic care needs during extended emergencies with the Committee.

A Committee member commented again that they feel that the scope of topics covered in the framework should remain focused on emergency care, but expressed that many emergency care organizations (such as the National Disaster Medical System) provide care related to chronic conditions (e.g., diabetes wound care, triaging renal failure) during physical disasters such as hurricanes and that response should be reflected in part of the framework.

A Committee member asked whether the topic of chronic diseases could be sufficiently covered by including access measures for chronic care needs in the list of relevant measures to use with the framework. Another Committee member agreed that access measures would be a helpful way to integrate chronic diseases into the report. A Committee member added that for pediatric care, children often receive some of their chronic care assistance through schools; any discussion of telehealth for chronic care needs should consider the different systems that interact in providing chronic care and how telehealth is handled by each of these systems. Another Committee member noted that when considering definitions for access, the group should also consider which providers are allowed to conduct services via telehealth (e.g., physician assistants, community navigators).

A Committee member commented that in extended emergencies, immediate needs for chronic diseases such as diabetes, cancer, chronic pain, and chronic obstructive pulmonary disease (COPD) are typically triaged but at some point during the extended emergency, missed wellness visits and long-term prevention start to become a concern. When patients begin missing annual wellness visits, they may lose checkpoints to identify worsening chronic conditions. Another Committee member agreed but noted that the impact is dependent on both the health condition and the scope of the emergency. Another Committee member also agreed that chronic care is affected during emergencies, but reminded the group that the Committee needs to find a balance to ensure the highest-priority topics (e.g., access, system readiness) are covered in the framework, instead of including every condition possible.

Committee members discussed the importance of measuring both adaptability (ability to change and scale up delivery of services during an emergency, including provider attitudes and openness to using telehealth) and readiness (availability of equipment, telehealth systems, training, etc. prior to emergency) during extended emergencies. The Committee did not have any immediate suggestions for measures related to adaptability, but NQF staff shared that they can bring forward additional measures related to chronic disease, access to care, adaptability, and healthcare system readiness for the Committee's consideration.

Additional Policies and Practices

Dr. Mehas shared feedback on policies and practices and proposed responses from NQF:

Comment	Proposed Response
A commenter suggested that NQF include detail on the expansion of the U.S. Office of Personnel	NQF will include this additional information in the scan.

Management's Federal Employees Health Benefits (FEHB) to include mental health services via telehealth.	
A commenter suggested that NQF provide additional detail on state-level approaches to telehealth services.	NQF is unable to provide in-depth analysis of state-level policies related to telehealth, but can provide links to external resources such as the American Telemedicine Association or the Center for Connected Health Policy.
A commenter noted that the Office for the Advancement of Telehealth (OAT) is slated to be elevated out of HRSA's Federal Office of Rural Health Policy.	NQF will include this additional information in the scan.
A commenter suggested that NQF review comment letters responding to the November 2020 U.S. Department of Health and Human Services request for information regarding waiver extensions after the public health emergency.	NQF will review these comment letters and will revise the scan to reflect any additional content as appropriate and/or share information with the Committee to inform the measurement framework.
A commenter thanked NQF for the description of the VA's Digital Divide Consult.	While no specific changes are recommended to the environmental scan, NQF and the Committee thank the commenter for sharing feedback.

A Committee member commented that since telehealth is changing so rapidly, the content of the environmental scan will inevitably be dated as soon as it is released. The member suggested that in addition to linking to external resources for state-level analyses of telehealth, NQF should also note that these external resources also serve as a helpful resource for federal policies and private-sector policies. The group agreed that the American Telemedicine Association and Center for Connected Health Policy were useful resources to include, and suggested including additional resources including the Center for Telehealth and E-Health Law, the Federation of State Medical Boards, ProviderBridge, and the Multi-Discipline Licensure Resource Project.

Other Comments

Dr. Mehas shared feedback on the remaining comments and proposed responses from NQF:

Comment	Proposed Response
A commenter highlighted the importance of health equity in the report and noted that intersection of disparities should be addressed.	Health equity will be reflected as a domain in the final framework and recommendations report.
A commenter provided additional survey data from their organization describing participants' use, preferences, and experience with telehealth for child neurology services.	While no specific changes are recommended to the environmental scan, NQF and the Committee thank the commenter for sharing feedback.

Committee members provided additional suggestions for topics that should be reflected in the health equity domain in the final framework. Suggestions included language and communication barriers (including visual and hearing impairments, and English as a second language), digital literacy, trust in the health system (which can be measured with certain indices), developmental disabilities, intellectual disabilities, etc. A Committee member suggested that equity could be reflected in a measure or overall phased score capturing providers' availability to accommodate certain high-priority areas (e.g., "This

provider has the ability to provide services with American Sign Language, but is unable to address these other 9 areas"). This score could be used to inform recommendations for providers (e.g., "In order to provide more equitable care, you need to hire additional bilingual staff.")

NQF thanked the commenters who provided feedback on the report and noted that the team will add an appendix of all comments received, as well as making updates to the body of the scan and incorporating additional details in the recommendations report and final framework.

Updated Measurement Framework

Yvonne Kalumo-Banda, NQF Manager, provided an update on the Rural Telehealth and Healthcare System Readiness framework. Ms. Kalumo-Banda shared that based on feedback from Web Meeting 2 in February 2021, NQF updated the framework to include one additional domain (Equity), as well as adding additional considerations under existing considerations (Basic computer literacy and training; ability to connect to local resources following telehealth visits; interoperability; wider financial impacts of telehealth on the community). Ms. Kalumo-Banda also shared that rural-specific measurement considerations had been pulled into a separate table from the measurement framework, as Committee members had shared that these measurement considerations spanned all existing domains.

The updated draft measurement framework presented was as follows:

Domain	Considerations
Access to care & technology	• Broadband issues (phone vs 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, • Systemwide coordination • Basic computer literacy and training • Ability to connect to local resources following a telehealth visit • Interoperability of health information technology
Costs, business models, and logistics	• Cost to patients, caregivers, and insurers • Business sustainability, spillover effects of telehealth (e.g., transfers, staffing) • Technology costs, logistics of launch, existing partnerships • Wider financial impacts on the community (e.g., jobs, absenteeism)
Experience	• Patient experience with telehealth (e.g., need to learn multiple platforms, acceptability and trust of technology) • 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
Equity	• How quality of care and outcomes differ by age, racial, and socio-economic factors

Committee members and federal liaisons provided the following feedback on the framework (sorted by domain below):

- Access to care & technology
    - The "telehealth technology" phrase should be clarified – e.g. listing examples of devices, both video-enabled and audio-enabled.
- Costs, business models, and logistics
    - The concepts of adaptability and readiness (discussed earlier during the public comments) could be integrated in this section and/or under "Systemwide coordination" in the Access domain.
- Experience
    - The clinician experience should also be captured in the Experience domain (e.g., comfort with learning to use new telehealth systems, ability to get assistance and advice from trustworthy sources during an emergency).
    - Patient choice (option to receive remote vs. in-person services) should be included as a consideration for patient experience.
    - Expand wording around "trust" to reflect trust of health system, not just technology (e.g., "Do you have a comfortable relationship with your doctor?" vs. "Are you comfortable using telehealth services?")
- Effectiveness
    - The framework should acknowledge that there are certain aspects of care that telehealth cannot address, and that these should be accounted for in system planning.
- Equity
    - Additional examples (e.g., gender identity, language barriers, food insecurity) should be included.
    - Additional aspects (e.g., social determinants of health [SDOH], access) should be explicitly mentioned as part of this domain.
    - Consider whether telehealth has mitigated existing inequities or is exacerbating them.
    - Telehealth services have the potential to reduce stigma (e.g., receiving behavioral health counseling from someone outside the community).

The draft rural-specific measurement considerations presented were as follows:

Issue	Description
Low patient volumes	Reduces measurement reliability and ability to risk adjust
Economic strain limits investment	Ability of rural providers to invest in telehealth is limited, particularly without guarantees of long-term ROI given policy uncertainty
Limited broadband access	Limited rural coverage does not allow for many residents to receive telehealth in their homes
Digital literacy of rural residents	Lower literacy of rural residents in digital health limits ability to connect
Telehealth may reduce in-person access	An unintended consequence of increased telehealth access may be to reduce access to in-person care in rural areas as providers centralize and shift to telehealth
Paucity of local in-person resources	If in-person care is recommended following a telehealth visit, availability may be limited
Lower technological sophistication	Rural communities and facilities may have harder times recruiting talent to implement and maintain telehealth
Rural readiness issues	Rural areas have fewer resources for both healthcare and non-healthcare readiness (i.e., equipment and human capital) required to respond to a public health emergency

Informal provider networks	Rural areas may have more informal networks, making it difficult to implement uniform telehealth programs
Role of local organizations	Local organizations (e.g., churches, libraries) may have an outsized impact on healthcare delivery in some rural communities

Committee members and federal liaisons provided the following feedback on the rural-specific measurement considerations (sorted by issue below):

- Low patient volumes
    - Consider including additional detail around level of measurement (e.g. "reduces ability to measure performance at the clinician level… may need to measure at the state or other level for sufficient reliability")
- Economic strain limits investment
- Limited broadband access
    - Reword "does not allow for many residents" to "allows for fewer residents… to receive telehealth in their homes."
    - Note that the lack of broadband also affects other services (e.g., EMS services).
- Digital literacy of rural residents
    - This category is already covered in other areas of the framework (Access domain) and could be interpreted as falsely blaming rural residents. The group would rather emphasize the availability of technology rather than the digital literacy of residents. This issue can probably be removed from the list of rural-specific considerations.
- Telehealth may reduce in-person access
- Paucity of local in-person resources
    - It could be helpful to acknowledge the lack of primary care providers/"medical homes" for many rural areas.
- Lower technological sophistication
    - This category should be reworded and/or could be combined with the "Paucity of local in-person resources" category, as it seems to be describing another workforce issue.
- Rural readiness issues
- Informal provider networks
    - "Informal networks" should be clearly defined.
- Role of local organizations
    - "Outsized impact" (negative connotations) should be reworded to "important impact" (more positive connotations).

Committee members also suggested that the list of rural-specific considerations could be reframed to be more solution-oriented rather than problem-oriented (e.g., "telehealth has potential advantages in rural areas"). A Committee member also suggested that rural strengths – e.g., the presence of champions that can help encourage uptake of telehealth delivery – could be acknowledged in the framework.

Updated List of Relevant Measures and Measure Concepts

Dr. Mehas provided a brief update on the list of relevant measures and measure concepts being considered for use with the framework. NQF initially identified 324 rural-relevant, telehealth-relevant, and readiness-relevant measures as part of the draft environmental scan; based on findings from the literature review and prior Committee input, NQF shared a new shortlist of 25 measures that staff deemed most directly related to telehealth in rural areas during emergencies as a starting point for discussion. NQF asked Committee members to provide input on the importance and feasibility of these

25 measures in early-mid May, as well as share additional measures, measure concepts, and gaps that should be considered in the creation of the framework. NQF received ratings on importance and feasibility from seven Committee members via survey form, as well as receiving written feedback via email from additional Committee members.

Dr. Mehas shared that from the group's feedback, substance use and mental health measures were important to keep on the list, but the initial list needed to be diversified to include additional measures on access to chronic disease treatment, acute care measures (e.g., emergency conditions that can be treated via telehealth), additional cross-cutting measures, and additional outcome measures. Committee members also commented that the measures in the shortlist should be evaluated for whether they have a rural-specific performance gap, whether they are relevant to emergencies, and whether they can specifically be addressed with telehealth.

Dr. Mehas also shared that N/A Access to Care, NQF #2152 Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling, N/A Access to Specialists, and NQF #0576 Follow-Up After Hospitalization for Mental Illness were rated the most important and feasible measures from the shortlist; NQF #0004 Initiation and Engagement of Alcohol and Other Drug Dependence Treatment, NQF #0097 Medication Reconciliation Post-Discharge, NQF #0006 Care Coordination, and N/A Comprehensive Assessment for Patients With Complex Needs were also rated highly important, but less feasible. NQF shared that these eight measures will remain on the shortlist for now.

Dr. Mehas also shared a list of the measures that were rated less important, including NQF #0005 CAHPS Clinician/Group Survey, measures on assessments for heart failure and weight, and measures on appropriate treatment of upper respiratory infection and avoidance of antibiotic overuse, and asked the Committee for feedback on whether any of these measures should remain in consideration for use with the framework. Jesse Pines, NQF Consultant, also noted that the antibiotic and overuse measures are currently used as some of the few metrics to compare telehealth vs. in-person care at this time. Committee members agreed that they were comfortable with rating these measures as less important and did not have strong feelings about keeping these measures in the shortlist.

Dr. Mehas provided a brief overview of the additional measures that Committee members suggested considering for the framework – these were most commonly mental health and depression measures, unplanned admissions and readmissions, medication measures, and measures addressing transfer of information and care plans. Dr. Mehas also reviewed the additional measure concepts and gaps identified by the Committee (described in more detail in the Web Meeting 4 slide deck) and shared that NQF will use this feedback to update and expand the list of relevant measures and will share an updated version with the Committee for further input.

Dr. Mehas noted that if Committee members were unable to provide feedback via email or survey on the initial list of relevant measures and measure concepts, NQF welcomes any additional feedback via email. NQF will also use the comments from today to update the list and will bring the refined list of measures back to the Committee for additional input.

Public Comment

Dr. Mehas opened the web meeting to allow for public comment. A member of the public thanked the Committee for their work on this project, sharing that the concepts are difficult to articulate and define but they hope to use this work to inform their telehealth research at their hospital system.

Next Steps

Dr. Mehas notified the Committee of upcoming activities and next steps for the project. NQF will continue to incorporate feedback from public comments and the web meeting into the environmental scan. NQF will also continue working on the first draft of the recommendations report, informed by comments on the scan, framework, and measures. Dr. Mehas also shared that the next web meeting is scheduled for July 27, 2021 from 2:00 pm – 4:00 pm ET.