NATIONAL QUALITY FORUM
Driving measurable health improvements together

Meeting Summary

Rural Telehealth and Healthcare System Readiness Web Meeting 5

The National Quality Forum (NQF) convened a public web meeting for the Rural Telehealth and Healthcare System Readiness Committee on July 27, 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 provided opening remarks for the meeting. Amy Guo, NQF Senior Analyst, facilitated roll call of the Committee members and federal liaisons.

Ms. Guo reviewed the meeting objectives, which were to finalize discussion on potential changes to the measurement framework, finalize discussion and prioritize measures and measurement concepts relevant to rural telehealth and readiness, discuss gap areas and potential unintended consequences relevant to the measurement framework, and discuss draft recommendations.

Ms. Guo also reminded Committee members of the project purpose. The goal of this project is 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 project is complete, key stakeholders will be able to identify measures available for use, encourage development of new measures in gap areas, and promote the use of measures to assess the impact of telehealth in rural areas during disasters.

Finalization of Measurement Framework

Yvonne Kalumo-Banda, NQF Manager, provided an update on the content of the Rural Telehealth and Healthcare System Readiness measurement framework.

Updated Framework Content

The Committee was notified that NQF updated the framework content in the domains of Cost, business models and logistics; Experience; Effectiveness; and Equity using feedback from Web Meeting 2.

The Cost, business models and logistics domain was updated to include adaptability and system readiness. The Experience domain was refined by adding clinician experience with telehealth (e.g., comfort with platforms, ability to get assistance and advice from trustworthy sources during an emergency), patient choice (e.g., option to receive remote vs. in-person services), and patient trust of health system and telehealth technology. The Effectiveness domain was updated to include considerations related to planning for clinical issues not addressable through telehealth, and the Equity domain was expanded to include social determinants of health (SDOH) (e.g., access to primary care, transportation, food insecurity) and the impact on telehealth on existing inequities. The Committee agreed with the updates and did not have additional feedback.

Updated Rural Specific Measurement Considerations

NQF notified the Committee that they updated the language related to rural measurement considerations to better convey some of the points as opportunities rather than challenges and to provide additional examples. Digital literacy was removed because it is a challenge that is not only specific to rural areas but across populations.

The description section of the low patient volume item was updated to include an example of how to address the challenge – measuring at a broader level such as state. Content included under the limited broadband access challenge description was updated from 'not many' to 'fewer' residents being able to receive telehealth in their homes. Under paucity of local in-person resources, an update was made to include 'attracting and retaining talent' (e.g., healthcare providers and telehealth technology professionals). The challenge of informal provider networks was refined to include 'informal communication among provider networks.' The Committee expressed that the updates were reflective of previous discussion and did not have any additional recommendations.

Measurement Framework

Ms. Kalumo-Banda shared two draft options of visual representations of the measurement framework (i.e., Figure 1 and Figure 2) for Committee feedback.

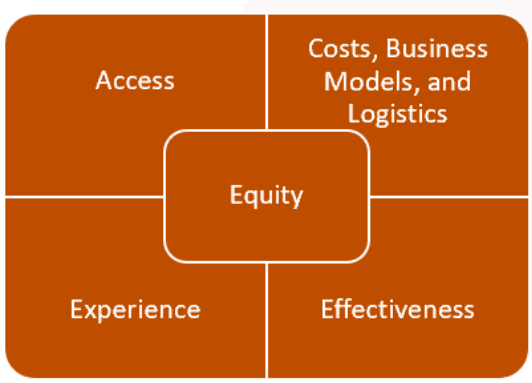

Figure 1

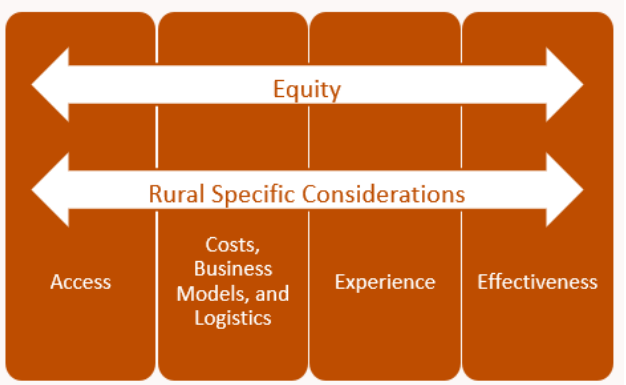

Figure 2

NQF staff noted that Figure 1 depicts equity in the center touching all other domains and that rural-specific considerations is not shown but would be included as spanning all domains. Figure 2 depicts the domains with equity and rural-specific considerations cutting across all of them.

A Committee member voiced support for Figure 2, noting that it has all the domains and cross-cutting aspects of equity and rural-specific considerations. Another member agreed and stated that they would recommend moving the names of the domains up, in between the equity and rural-specific considerations arrows.

A Committee member who expressed their preference for Figure 1, suggested moving equity from inside the diagram to the outer section or coupling equity and rural-specific considerations together with the domains inside. The member noted that representation of domains in Figure 2 is siloed and does not reflect the interaction that takes place across them. Another member voiced support for Figure 1 with the updates suggested by fellow Committee members and expressed that reflecting the domains as a Venn diagram may better reflect the interaction that takes place between equity and the other domains. A member voiced support for all the updates recommended to Figure 1 and asked the

Committee to consider adding an indication of the relationship between rural-specific considerations and equity.

Dr. Mehas thanked the Committee for their feedback and shared that the recommendations (e.g., considering a Venn diagram with equity and rural-specific considerations in the outer section and all four-domains interacting inside) would be relayed to the NQF design team to update the graphic.

Finalization of Measures and Measure Concepts

Prioritized Measures

Dr. Mehas shared that NQF staff updated the list of relevant measures based on Committee feedback from Web Meeting 4, removing eight measures from the shortlist that Committee members noted were less important and adding 15 new measures based on suggestions to diversify the topics represented in the list. The updated list includes 32 measures that address access to care and specialists, acute care, admissions/readmissions, behavioral health, care coordination, and patient experience. Dr. Mehas emphasized that this list is still not final and encouraged the Committee to provide additional feedback to help iterate on the shortlist and add or remove measures if appropriate. The Committee discussed the list of measures grouped by topic area.

Access Measures

Committee members discussed two Agency for Healthcare Research and Quality (AHRQ) measures, N/A: Access to Care and N/A: Access to Specialists. The Committee was in consensus that these measures were appropriate to include in the list of prioritized measures and did not express any concerns related to unintended consequences.

Acute Care Measures

Committee members provided comments on the following measures related to acute care:

- 0163: Primary PCI Received Within 90 Minutes of Hospital Arrival
- 0495: Median time from ED arrival to ED departure for admitted ED patients
- 0496: Median time from ED arrival to ED departure for discharged ED patients
- 0497: Admit decision time to ED departure time for admitted patients
- N/A: Door to Puncture Time for Endovascular Stroke Treatment
- N/A: Emergency Medicine: Emergency Department Utilization of CT for Minor Blunt Head Trauma for Patients Aged 2 Through 17 Years
- N/A: Emergent care for improper medication administration, medication side effects
- N/A: Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke
- N/A: Median Admit Decision Time to ED Departure Time for Admitted Patients (eCQM)
- N/A: Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the hospital

A Committee member commented that many of these measures are related to emergency department throughput and processes, but they may not be appropriate for rural emergency departments. The member suggested that more appropriate measures might focus on the period of time between entering the door and being directed to appropriate care. Another member agreed, adding that it could be helpful to include measures related to both higher-acuity conditions (e.g., stroke care, myocardial infarction) that could require transfer to another facility as well as lower-acuity conditions.

A Committee member noted that many of these measures assume that there is a nearby emergency department (ED), or that beds are available in the ED. The member flagged that this may not be true during an emergency, so measures of whether the ED is operating/available or whether there are ED beds available would be a helpful supplement. Another member elaborated that in order to understand the total time needed to access care, it would be necessary to measure availability of different types of services in the patient's vicinity, time to travel to these facilities, time to be triaged and start treatment or start a transfer to the appropriate facility, etc. Committee members shared that if there are versions of these measures that specifies "time to transfer or admission", "time to being on camera/call with a person who can provide care" instead of "time to admission", "time to treatment", etc., this would be more appropriate for rural areas.

The Committee discussed that many rural facilities may not have the expertise available on-site to treat specific conditions and may be able to mitigate this through the use of telehealth (e.g., having a specialist consult call in). A member noted that not all admissions to rural hospitals require specialist care, so measure denominators should be adjusted to reflect only patients that require specialist care. If this adjustment is not made, measurement may not be able to detect the benefit of telehealth. At least three Committee members agreed with this point.

A Committee member noted that many of the measures related to acute care focus on individual health emergencies, but may not capture common injuries that could occur in rural areas or during natural disasters. The member suggested that additional types of injuries – e.g., severe abrasions, loss of limbs, burns – be represented in the acute care measures. Committee members discussed that the specific injuries would vary depending on emergency, so if a more general trauma treatment measure exists (e.g., "time of presentation in ED to treatment of any trauma" or "time of presentation… to disposition plan"), it would be a helpful inclusion. A Committee member and a federal liaison also flagged that with trauma care, telehealth is not frequently used yet; however, another member shared that telehealth still has the potential to help reduce time to receive trauma care, even if it is currently untested/uncommon.

A Committee member expressed concerns with the suitability of 0163: Primary PCI Received Within 90 Minutes of Hospital Arrival and N/A: Door to Puncture Time for Endovascular Stroke Treatment in rural areas. The member shared that some rural hospitals may have the capability to transfer patients within this time, but others may have intermittent capability to transfer. Another member agreed, sharing that from their location in Kodiak, Alaska, transports are by flight only; it takes 60 to 90 minutes to fly to Anchorage assuming the flight team is already on island, so a 90-minute window would be near impossible during an emergency situation. A member shared that it would be difficult to standardize a recommended "minimum timing" for transfer to another facility, since this would differ by rural facility depending on proximity to the nearest city. A member asked whether 0163 is expected to be the standard for hospitals who are unable to perform PCI in-facility; Committee members were unsure but discussed that in some particularly remote locations, patients are administered thrombolytics before transfer. A member shared that EMS protocols often divert these patients away from the emergency department at critical access hospitals and push them directly to tertiary care centers, so this measure may not make sense for most rural facilities.

A member flagged that the condition-specific measures in this list may be susceptible to low case-volume, and they prefer using some of the more general measures to avoid this problem. Another member agreed that these measures will all be affected by low case-volume.

Admissions/Readmissions Measures

Committee members provided comments on the following measures related to admissions and readmissions:

- 0275: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)
- 0277: Heart Failure Admission Rate (PQI08-AD)
- 1768: Plan All-Cause Readmissions
- 1789: Risk-Standardized, All Condition Readmission
- 2888: All-Cause Unplanned Admissions for Patients with Multiple Chronic Conditions
- 3490: Admissions and Emergency Department (ED) Visits for Patients Receiving Outpatient Chemotherapy
- N/A: Potentially Preventable 30-Day Post-Discharge Readmission Measure (Claims based)

A Committee member shared that most readmissions happen through the emergency department, so including measures related to emergency department use seems appropriate. The member shared that readmissions measures act as a proxy for failures of outpatient care, but being placed under observation also reflects a failure of outpatient care without being classified as a readmission. The member acknowledged that the Committee is not adjusting existing measures or creating new measures, but suggested that this point could be acknowledged in the report. Another member agreed and noted that readmissions measures also act as a proxy for poor discharge planning, which can be handled in part via telehealth even outside of emergency situations.

A member shared that they like the mix of all-cause and condition-specific readmissions measures in the list, and suggested that it could be helpful to include readmissions measures related to diabetes control. A Committee member suggested that the AHRQ's list of ambulatory care sensitive condition measures could be helpful to consider for the list of prioritized measures. The member shared a link to AHRQ measures and flagged the section of PQI measures related to ambulatory sensitive conditions. The member shared that in a rural area with good healthcare, they would expect to see a low and stable rate of preventable admissions; in a disaster, they would expect admissions to increase, but the rise would be mitigated by a health system's use of telehealth services.

Another member disagreed that condition-specific measures should be included, noting that the condition-specific readmissions could be triggered during emergencies even if previously well-managed at home (e.g., having a heart attack during a high-stress situation). The member shared that in order to interpret changes in performance, there would need to be a way to separate increases in admissions resulting from the emergency vs. increases resulting from poor care. Another member noted that this discussion highlights the difference between primary effects (disaster directly affects condition) vs. secondary effects of emergencies (disaster interrupts care for a chronic condition); the member noted that they are not aware of any measures that distinguish between these two types of effects, but it would be useful to include measures related to this if they exist. At least two Committee members agreed that they would prefer to use more general readmissions measures instead of condition-specific measures, with one member noting that more general measures could also mitigate low case-volume concerns in rural areas.

A member reiterated that while all-cause readmissions is a valid measure, condition-specific readmissions measures may be helpful for purposes of understanding the impact of telehealth on care. For example, heart failure and chronic obstructive pulmonary disease (COPD) can be addressed with telehealth, so readmissions measures specific to these conditions would be more likely to capture any significant effects on access or quality of care facilitated by access to telehealth. Another member

expressed a preference to include both a broad "all cause" measure as well as key condition-specific admissions measures (suggested: heart failure, COPD/asthma, diabetes) measures.

A member noted that the timeline of the measures could be helpful in distinguishing between primary and secondary effects – e.g., spikes in admissions in the 24 hours following an emergency vs. admissions rates in a 30-day period after the emergency. Another member noted that in order to understand health systems' ability to scale up telehealth resources, it would be helpful for the timeline of measures to start before the time of the event/emergency.

A member asked for clarification on the intended use of the measures included in the report and asked whether it would be possible to provide a broader list of "Potentially Relevant Measures" and then allow users to decide which measures to use and how to interpret them during emergencies. NQF staff clarified that the measures are not intended to be used in any specific programs at this time but are meant to be a list that informs quality improvement efforts; while the recommendations report could include some wording about the strength of the recommendations, NQF staff are concerned that labelling the list "potentially relevant" could weaken the strength of any recommendations from the report.

In terms of unintended consequences, a member shared that admissions and readmissions performance could also be unexpectedly reduced during an emergency (e.g., avoiding healthcare system due to fear of infection). While readmissions measure performance would be improved, the lower rates of readmission would be indicative of lapses in care instead of good care. However, they acknowledged that these measures could be helpful for understanding overall outcomes during an emergency alongside other measures. Another Committee member added that during a localized disaster, overflow from nearby hospitals could have unexpected increases in admissions (e.g., a dialysis center is closed down, so the next-nearest hospital has increased patients), and healthcare facilities should not be penalized for these increased admissions.

Behavioral Health Measures

Committee members provided comments on the following measures related to behavioral health:

- 0004: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
- 0418/0418e: Preventive Care and Screening: Screening for Depression and Follow-Up Plan
- 0576: Follow-Up After Hospitalization for Mental Illness
- 2152: Preventive Care and Screening: Unhealthy Alcohol Use: Screening & Brief Counseling
- 3175: Continuity of Pharmacotherapy for Opioid Use Disorder (OUD)

Multiple Committee members expressed support for inclusion of behavioral health measures. A Committee member noted that the COVID-19 pandemic demonstrated the importance of mental health care, and another member noted that behavioral health interventions are well-suited to telehealth.

A Committee member flagged that, as with the admissions and readmissions measures, the timeline for each of the measures would be important when interpreting performance (e.g., anxiety symptoms likely to be elevated 24 hours after the time of an emergency). The member also noted that it is important to measure whether behavioral health interventions are available before, during, and after the emergency. The member suggested that a measure on immediate access to psychological care should be noted as a gap during emergencies.

A Committee member noted that states, counties, and regions often support access to care during emergencies, and population-level measures of mortality, overdoses, suicide rates, etc. could help support stakeholders in identifying disparities in care across larger geographic regions.

A Committee member shared that in terms of prioritization, 3175: Continuity of Pharmacotherapy for Opioid Use Disorder (OUD) is a high priority for them. The member shared that screening and follow-up measures are important, especially during ongoing disasters, but during a shorter, acute disaster, they would prioritize immediate care for conditions that have already been identified.

Care Coordination Measures

Committee members provided comments on the following measures related to care coordination:

- 0006: Care Coordination (Centers for Medicare and Medicaid Services)
- 0097: Medication Reconciliation Post-Discharge
- 0326: Advance Care Plan
- N/A: Closing the Referral Loop: Receipt of Specialist Report
- N/A: Drug Regimen Review Conducted with Follow-Up for Identified Issues PAC IRF QRP
- N/A: Transfer of Health Information to the Patient Post-Acute Care (PAC)
- N/A: Transfer of Health Information to the Provider Post-Acute Care (PAC)

A Committee member asked for the rationale behind including the measure N/A: Closing the Referral Loop: Receipt of Specialist Report. Another member shared that since telehealth has the potential to accidentally disrupt regular care processes, they are supportive of including this measure and incentivizing providers to connect back to a patient's regular care team. The original Committee member acknowledged that this is important, but expressed concern that this measure was not appropriate to prioritize during a disaster. Another member shared that they think this measure is actually more important during emergencies since patients are more likely to be receiving care from temporary volunteers working in the area; if the volunteers do not share information back with the regular care team, any information on care is lost once they leave the area.

A Committee member shared that closing the referral loop is important both in terms of receipt of the specialist report as well as receiving the referral itself. The member shared that during COVID-19, it was difficult to understand what services patients had received because patients were not showing up for regular visits and none of the telehealth platforms were sharing information about referrals with each other. Committee members discussed that ideally, systems would be tracking receipt of specialist reports and referrals prior to emergencies. While performance would likely be worse during emergencies, telehealth could mitigate the overall impact.

A Committee member asked whether this metric would be affected by behavioral health services (i.e., whether behavioral health specialists would not be able to share back a detailed report due to privacy concerns). Another member suggested that a relevant measure concept may not be the initial report, but engagement between the specialist and primary care provider over time.

Two members flagged that the metric on closing the referral loop could be problematic if the disaster affects broadband access or reliability. A member noted that even if providers are unable to connect via broadband, they can adapt and use the next best available technology (e.g., audio calls) to maintain some level of communication and coordination.

Experience Measures

Committee members discussed the inclusion of the CAHPS Health Information Technology Item set. NQF staff noted that in response to the large-scale adoption of telehealth as a result of COVID-19, a new version of the Clinician/Group CAHPS survey is being developed that would ask questions related to the most recent visit, but this is still being tested and is not available for use yet.

A Committee member shared that for their telehealth platform, every encounter includes a follow-up with the CAHPS questionnaire specific to that visit. In their experience, the "time" indicator (did your doctor spend enough time with you?) has been more helpful for understanding patient satisfaction than the CAHPS composite indicator for communication. The member shared that on digital platforms, it may be easier to understand and track patterns related to how long providers spend with their patients.

Another member highlighted that patient experience is a vital part of measuring the impact of telehealth, sharing that they often get comments from patients about how helpful telehealth visits are for them.

Prioritized Measure Concepts

Dr. Mehas shared an update on the prioritized list of measure concepts relevant to rural telehealth for system readiness. In early July, NQF staff solicited additional feedback on the ranking of most important measure concepts to highlight in the final report. Overall, NQF received responses from 15 Committee members; some of the measure concepts that Committee members most frequently flagged as important included concepts around increasing access to specialty providers, eliminating travel, providing care without using the emergency department, measuring availability of broadband to facilitate telehealth visits, etc. Dr. Mehas asked the Committee whether there are additional details that should be captured in the report related to these measure concepts, as well as whether any of the most important concepts are missing from the list.

Committee members provided the following feedback on the measure concepts:

- Overall Comments and Organization
    - For increased clarity in the final recommendations report, present the measure concept first and then list all relevant domains in the following column.
    - Since there are not many existing measures specific to rural areas, telehealth services, and emergencies, Committee members would prefer that the report emphasize the measure concepts as the most important part of the report (rather than the list of existing measures).
    - The list of measure concepts to date represent a good mix of logistical and clinical quality concepts.
- Concept: Availability of broadband for patients and providers to participate in telehealth visits
    - Consider rewording to read "availability of reliable broadband."
    - Committee members were not sure whether broadband would be defined according to the FCC definition or if a different minimum would need to be defined for purposes of healthcare and video visits.
- Concept: Was travel eliminated for a specific patient encounter because of telehealth services?
    - Consider rewording to read "was travel eliminated or reduced."
- Concept: The system was able to effectively provide the care that was recommended
    - Consider rewording to make measure concept more specific to telehealth and/or disasters and clarify the gaps that need to be filled in measurement – e.g. "The system was able to effectively provide the care that was recommended after a disaster because of telehealth"

    - Clarify whether "the system" refers to the telehealth component of system or the entire healthcare system.
    - The phrasing "care that was recommended" may not capture the best possible care for patients who did not have access to specialists prior to the emergency and thus did not have a recommended care plan in place. Consider rewording or supplementing with a measure or measure concept related to access to specialists.

- Concept: Identification of mechanisms to identify and respond to uniquely stressed care capabilities within the system (e.g., overwhelmed EDs, ICUs, mental/behavioral health practices, long-term care facilities, health centers, etc.)
    - Consider rewording to read "deployment of mechanisms."

Gap Areas

Dr. Mehas shared that in past discussion and surveys, Committee members identified gap areas in measurement including measures addressing the digital divide, SDOH including health literacy, quality of processes and outcomes associated with telehealth delivery, time taken from request to physician visit, patient experience, volume of services, and adaptability and system readiness. Dr. Mehas asked the group whether there are additional gap areas that should be reflected in the report, as well as whether the Committee has any specific suggestions for measures, measure concepts, or measurement approaches related to SDOH that should be included.

A Committee member noted that one of the previously identified gaps on the digital divide is related to SDOH, as it could measure whether people have the resources (e.g., internet-enabled devices, broadband) to be able to access telehealth. Another member added that access to confidential space for telehealth visits should also be included when assessing available resources. A member of the public also shared via the chat that form factor for internet-enabled devices (e.g., mobile devices vs. computers) should also be considered as an access or equity measure, as different types of devices may be shared among individuals, making symptom monitoring and access less reliable.

Another member asked for clarification on whether the group is limited to existing measures or whether the group is interested in discussing or highlighting emerging measures. NQF clarified that the priority list included in the report would be focused on fully developed measures, but emerging measures can be included as part of discussion on measure concepts or tools that can be useful in the future. The member shared that CyncHealth is creating a transportation measure around social determinants of health that could be useful to consider.

A federal liaison shared that measures on language preference would be helpful to consider in order to address SDOH. Committee members suggested that measures on health literacy, ability to provide care in patient's language, and accessibility for patients with visual and hearing impairments would be useful. A member also noted that the new United States Core Data for Interoperability (USCDI) standards include SDOH data.

A member shared that it could be helpful to measure whether providers are using screening tools for SDOH, but acknowledged there may not be measures that exist in this area yet.

A member also highlighted the importance of interoperability/data exchange and the concept that information should be able to travel freely between primary care providers and specialists, as well as the need for telehealth providers to be able to access the patient's native electronic medical record for purposes of care coordination. Multiple Committee members agreed with this comment, and one

member noted that this is referred to as “interoperable technology” in the recommendations report but should be expanded past technology to data and information.

Additional Report Content

Dr. Mehas shared that due to time constraints, the Committee would not be able to discuss the final recommendations in the report during Web Meeting 5. However, Committee members were strongly encouraged to review the content in the full recommendations report and provide comments via email.

Public Comment

Dr. Mehas opened the web meeting to allow for public comment. No additional comments were offered by members of the public or federal liaisons.

Next Steps

Ms. Guo shared that a summary of Web Meeting 5 would be circulated in the following weeks. Ms. Guo also thanked the Committee for comments received on the draft recommendations report to date and welcomed any additional written feedback Committee members are able to provide by August 1. Written feedback, as well as discussion from the meeting, will be used to update the draft recommendations report before it is posted online for public comment in September. Ms. Guo also shared that the next web meeting is scheduled for October 25 from 3:00 – 5:00 pm ET. Dr. Mehas, Dr. Ward, and Dr. Melms closed the meeting by thanking Committee members for their participation.