NATIONAL QUALITY FORUM
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Meeting Summary

Rural Telehealth and Healthcare System Readiness Web Meeting 6

The National Quality Forum (NQF) convened a public web meeting for the Rural Telehealth and Healthcare System Readiness Committee on October 25, 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. Noting that this was the last web meeting, Dr. Ward and Dr. Melms thanked the Committee for their participation throughout the project and for joining the meeting.

Amy Guo, NQF Manager, facilitated roll call of the Committee members and federal liaisons and reviewed the meeting objectives, which were to review public comments on the draft report, and for the Committee to discuss any outstanding issues from their review of the draft report. Ms. Guo 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 the Draft Report

Dr. Mehas provided an overview of the public commenting process. The environmental scan was available for public comment from September 15, 2021, through October 8, 2021, and eight organizations submitted a total of 31 comments on the draft report. Dr. Mehas shared that the comments were categorized as Framework Topics and Organization, Relevant Measures, Gaps Areas and Measure Concepts, Recommendations, 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 draft report before it is finalized.

Framework Topics and Organization

Dr. Mehas and Yvonne Kalumo-Banda, NQF Manager, shared feedback on framework topics and organization and proposed responses from NQF:

No.	Comment	Proposed Response
1.	Recommendation to highlight the effectiveness of using telehealth to provide coordination of care/services between providers and healthcare members for the patient. (page 9)	NQF acknowledges the importance of care coordination in providing effective care, and this concept is currently represented as System-Wide Coordination in the Access to Care Domain. (page 8)

Comment 1: Dr. Mehas shared the proposed response and asked the Committee if the response was adequate or if the recommended edit should be made to the Effectiveness domain.

A Committee member shared that when referencing "system wide coordination" most people think of health systems and not all healthcare entities that treat and/or support patients. The member recommended a language change to indicate that coordination of care services goes beyond health systems and encourages collaboration between different entities (e.g., health departments, communities). Another member concurred and suggested the language be updated to "system wide care coordination." Dr. Mehas noted the Committee's recommendation and shared that NQF will update the public comment response and add content to the report to emphasize that coordination should span beyond the limits of a single health system (e.g., community wide coordination).

No.	Comment	Proposed Response
2.	Recommendation to mention the importance of information marketing on the value of telehealth that engages both providers and patients. (page 13)	The importance of providing information and guidance on telehealth to providers and patients has been described in more detail within the Experience domain, under the Trust of Technology and Clinician and Care Team Experience subdomains. (page 12)

Comment 2: Dr. Mehas shared the proposed response, noting that the draft report highlights the importance of providing information and guidance on telehealth use for providers and patients under the Experience domain. Dr. Mehas asked the Committee if the proposed response was adequate or if the Committee suggests the inclusion of additional strategies for engaging patients and providers. A member shared that the proposed response was adequate, noting that the entire framework is providing information on the importance of assessing the value of telehealth, to which a co-chair agreed. The Committee did not suggest the inclusion of additional content related to this comment.

No.	Comment	Proposed Response
3.	Recommendation to highlight the need to plan for clinical issues not addressable via telehealth and specify that telehealth is not intended to replace in-person care. (page 13)	NQF has tried to emphasize that telehealth cannot entirely replace in-person care. However, for certain clinical areas (e.g., behavioral health treatment and diagnosis), telehealth can be a helpful supplement to provide care where it would otherwise be unavailable in emergency situations. (page 12)

Comment 3: Ms. Kalumo-Banda shared the proposed response, noting that in several sections of the draft report it is emphasized that telehealth should not replace in-person care. NQF proposed highlighting this point earlier in the report. A co-chair agreed that this point had been highlighted in different parts throughout the report and asked the Committee whether NQF's recommendation to state this earlier in the report would be helpful. A Committee member recommended also highlighting the importance of patient choice early in the report. A co-chair noted that the Experience section of the

report references patient choice and patient trust of the health system. A member asked the Committee whether the intent of the commentor was for the report to address the need for a backup plan for treatments where telehealth would be inappropriate (e.g., having a warm hand-off to in-person resources). In response, a member shared that their understanding of the comment was that not everything can be treated via telehealth, which has already been addressed in the draft report. Several Committee members supported the idea of highlighting that telehealth is meant to replace in-person care at the beginning of the framework section. Ms. Kalumo-Banda noted that NQF will update the report by adding additional language related to telehealth not replacing in-person care to the beginning on the report (i.e., page 7). The language will state that the report is not intended to imply that telehealth should replace all in-person care; telehealth does not function independently of the rest of the healthcare system; and patients who do not benefit from telehealth in a certain situation are recommended to receive in-person care.

No.	Comment	Proposed Response
4.	Recommendation to recognize an overlap in telehealth use during emergency and non-emergency situations (e.g., COVID-19 has helped inform the appropriate and effective use of telehealth, priority uses during emergencies that apply to standby or active capacity when not in emergencies)	The Committee will discuss whether additional content should be included in the report related to telehealth applications outside emergencies or readiness, or if the current report content is adequate. (page 10-17)

Comment 4: Ms. Kalumo-Banda asked Committee members to provide input on whether additional content should be included in the report related to telehealth applications outside emergencies or readiness, or if the current report content is adequate. A co-chair shared that this recommendation could be addressed alongside the proposed update highlighting that telehealth is not intended to replace in-person care. The update could include language stating that telehealth is also useful in non-emergency situations. Two Committee members agreed with this suggestion to include language at the beginning of the framework section. Another member agreed with the suggestion and added that since telehealth is an evolving field, the Committee should consider adding a statement at the beginning of the framework section clarifying that telehealth is not appropriate for every situation. A co-chair voiced support for the recommendation and asked the Committee how to address the readiness piece of the comment. The co-chair shared that in preparation for emergencies, health systems should plan how they will use telehealth to support an effective transition to its use during an emergency.

No.	Comment	Proposed Response
5.	Recommendation to acknowledge that public investment in telehealth should be “sustained” vs. “one-off” (e.g., sustainable reimbursement models) and that telehealth alone should not be sufficient when rating network adequacy standards.	The Committee will discuss potential solutions for sustained investment and review the suggested solution related to network adequacy standards. (page 14)

Comment 5: Ms. Kalumo-Banda asked the Committee for input on whether the language on public investment in Table 2: Rural-Specific Considerations Affecting Measurement of Telehealth and System Readiness (in section “Economic strain limits investment”) should be adjusted. A member shared that

sustained commitment, training, and education should also be referenced in addition to sustained investment. A co-chair highlighted that the comment also emphasizes the need for sustainable financial models related to telehealth. Next, the Committee discussed the portion of the comment related to telehealth and network adequacy standards. A co-chair noted that the comment is related to reimbursement and coverage decisions and outside of the project's scope. A member asked if the Committee would consider including a statement that if a provider is in-network for in-person care, they should also be in-network for telehealth. A co-chair stated that comment is a policy decision and depends on the landscape after COVID-19 waivers end. The Committee discussed that the report focuses on measurement and assessing telehealth quality and agreed that making a statement on network adequacy standards would be out of scope. Ms. Kalumo-Banda noted that NQF would include additional language to note that "sustained investment" considers not only funding but also commitment, infrastructure, education, and training.

Relevant Measures

Ms. Kalumo-Banda shared feedback on the list of relevant measures and proposed responses from NQF:

No.	Comment	Proposed Response
6.	Recommendation to reword Potential solution to "Informal communication among provider networks" to "Ensure and/or require that rural telehealth services and programs are made available to local providers and community members" (page 15)	NQF can update the language if the Committee agrees with the recommendation.

Comment 6: Ms. Kalumo-Banda shared the suggested change in wording and asked for the Committee's feedback. Two Committee members shared that they are comfortable with the change. Another Committee member asked who had submitted this comment and whether the wording change would be supporting a specific agenda; a member noted that this comment was submitted by the Radiation Injury Treatment Network. A member suggested that the comment could be related to concerns about complying with telehealth requirements and developing a network that undermines in-person services but noted this would be related to unintended consequences instead of the actual framework. Another member suggested that the wording change may be related to encouraging states to include telehealth options in the regulatory landscape.

A Committee member expressed concerns with the use of "require" in the suggested revision. Another member agreed, sharing that the original solution was intended to involve local providers and the updated wording may make it possible for large organizations outside the local community to provide telehealth services and shut out local providers, as long as telehealth is still technically made available to local providers. At least three members agreed with this point; one member suggested the alternative wording "Ensure and encourage that local providers and community members be included in services..." Another member noted that this change should also be incorporated on page 14 of the draft report ("Ensure and encourage that providers and community members be included in plans…"). Ms. Kalumo-Banda confirmed that NQF would adjust this wording in both areas of the report accordingly.

No.	Comment	Proposed Response
7.	Recommendation for measurement tools to include specificity regarding user experiences related to accessibility and/or accessible design criteria (e.g., screen reader accessibility, video-conferencing for ASL, plain language, non-text-based interfaces)	NQF included Equity as a domain in the measurement framework, with the recommendation to consider factors including disability (including physical, developmental, and intellectual disabilities), socioeconomic status, language, and communication barriers (including visual and hearing impairments as well as first language), geographical location and literacy. (page 13)

Comment 7: Ms. Kalumo-Banda shared the comment and proposed response with the Committee. A Committee member asked for clarification on whether the comment is related to the framework description, or if it is referencing the Gaps section of the report; Ms. Kalumo-Banda shared that the comment did not specify, but if the Committee would like to include additional information on the need for additional measurement tools, this could be included in the Gaps section of the report. At least three Committee members shared that the proposed response was sufficient and appropriate as-is.

Gap Areas and Measure Concepts

Ms. Kalumo-Banda and Dr. Mehas shared feedback on gap areas and measure concepts and proposed responses from NQF:

No.	Comment	Proposed Response
8.	A commentor noted that the framework acknowledges health disparities and technology literacy, as well as other dimensions of user experiences but highlighted that the report does not capture those who lack technology and would likely not be served in an emergency. Also highlighted by the commentor is a possible overestimation of residential internet service coverage by Federal Communications Commission due to the entire census block defining service coverage if at least one has household has coverage.	The challenges exacerbated by the digital divide were highlighted in the environmental scan and noted under the experience domain of the draft report. Table 2 (Rural-Specific Considerations) recognizes the challenge of limited broadband access and included a potential solution, creating incentives for broadband providers to develop networks in rural areas. This section also highlights the role of local organizations (e.g., churches, libraries), which can be used as hotspots for people to access broadband services/internet. (page 14)

Comment 8: Ms. Kalumo-Banda shared the comment and proposed comment with the Committee. A federal liaison commented that even though local organizations may be able to provide internet

hotspots in rural communities, these do not always offer privacy. Committee members agreed and further noted that these public areas may be closed during a state of emergency (e.g., libraries closed during COVID-19). A Committee member also shared that the response should acknowledge solutions other than broadband, such as phone-based telehealth, which was frequently used with low-income populations in rural areas. Finally, a federal liaison noted that even when broadband is provided in an area, residents may be uncomfortable using it or may not have interest in setting up. Ms. Kalumo-Banda and Dr. Mehas noted that NQF will refine language in the response to acknowledge phone-based care, privacy concerns for hotspots, discomfort with internet and devices, etc. and will check throughout the report to ensure these points are emphasized.

No.	Comment	Proposed Response
9.	Recommendation to consider measurement of user capacity to use specific telehealth technologies as a measure of access. The user could be either the patient or the provider.	The Committee will discuss the potential inclusion of user capacity as a separate consideration in the list of gaps to highlight this consideration outside of providing initial training. (page 22)

Comment 9: Dr. Mehas asked the Committee for feedback on whether the report should incorporate additional language related to user capacity to use telehealth technologies in the Gaps area of the report. A Committee member shared that if the comment is about accessibility for users with intellectual and other disabilities, they agree this is an opportunity to highlight a user group that may require additional assistance. Several Committee members noted that the full comment refers to page 10 of the report and may be intended to address technological capacity. A federal liaison highlighted again that some patients may be uncomfortable adapting to new technology.

Committee members discussed that the group should broaden terminology used throughout the report to broader “technical literacy” or “digital literacy,” as smartphone use is higher than computer use in rural areas. A Committee member noted that even though the original intent of the comment was likely not related to disabilities, they still agree that it would be valuable to acknowledge the impact of disabilities on ability to use different telehealth technologies and the experience across a broad range of users. NQF shared that they can make these updates to the report accordingly.

Recommendations

Dr. Mehas shared feedback on the recommendation’s comments and proposed responses from NQF:

No.	Comment	Proposed Response
10.	Suggestion to include risks of telehealth adoption and use, which may include lost community capacity which would adversely affect people with high-level needs who rely on in-person care.	The report acknowledges that telehealth is not a substitute to in-person care but can be used to enhance access to care in an emergency and/or disaster where care would otherwise not be available. The Committee recognized that local providers could experience reduced in-person volumes as an unintended consequence of increased telehealth, so NQF has highlighted this in Table 2 as a potential challenge and have provided potential solutions for mitigation. (page 14-15)

Comment 10: Dr. Mehas shared the comment and proposed response with the Committee, noting that this comment is related to the prior discussion of in-person vs. telehealth care. Dr. Mehas asked whether the Committee would prefer to include additional detail related to the potential for reducing local in-person capacity and its effect on rural communities (loss of built trust with community members, local knowledge of resources to leverage during emergencies, effect on complex populations). A Committee member expressed that they were uncertain whether additional detail on risks of telehealth use were within scope of the project; another Committee member agreed, noting that the charge of this group was to promote and discuss measurement related to telehealth, not discuss the overall risks of telehealth. NQF shared that this point will not be highlighted in the report but asked for further clarification on whether additional detail should be added in the table of potential unintended consequences. At least five Committee members shared that the report content was appropriate as-is.

No.	Comment	Proposed Response
11.	A commentor noted that under Recommendation 9, Health Equity/Social Determinants of Health (SDOH) recommendations may not be feasible (e.g., individuals without access to broadband/lacking technological knowledge will not use telehealth). (page 26)	The Committee will discuss whether the recommendations relating to SDOH should be adjusted, and whether the current suggestion is a feasible way to understand disparities in telehealth experience and use.

Comment 11: Dr. Mehas shared the comment and proposed response with the Committee and provided additional context from the full comment (SDOH factors are not included on CMS-mandated surveys, commenter expressed concerns that questions on telehealth use would only be asked to populations that are already using telehealth). A Committee member shared that the report should have an equity recommendation, and they do not support removal of Recommendation 9; the member also shared that surveys can and do ask for perspective from patients who do not use telehealth. Another member agreed with this comment and added that telehealth does not have to be conducted from a patient's home; even if a patient needs to travel to a secondary location to use telehealth services, they may still be cutting down travel time. The member emphasized the importance of measuring why some patients do not use telehealth to understand opportunities for improvement and increased reach. At least three Committee members agreed with this comment; one member added that this viewpoint fits in with the concept of equity by design. Another member shared that equity is not limited to a measure of who is using telehealth vs. not using telehealth; there may also be differences in experience among people who use telehealth. A Committee member also noted that patients without access to broadband could still use audio-only telehealth. The co-chairs summarized that the Committee was in strong consensus to maintain the original wording of Recommendation 9.

Other Comments

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

No.	Comment	Proposed Response
12.	A commentor recommended that the report includes a fulsome list of conditions that are not telehealth sensitive and should not be treated via telehealth (e.g., Tardive Dyskinesia [TD])	NQF recognizes that not all conditions are appropriate for telehealth care. (page 13)

Comment 12: Dr. Mehas shared the comment and proposed response with the Committee and asked whether the proposed response was appropriate or if the report should include more details on conditions that should not be treated using telehealth. A member shared they do not think this type of list should be included and noted that aspects of Parkinson's disease, one of the conditions noted by the commenter, can be identified and treated via telehealth. Another member concurred and shared that endometriosis and uterine fibroids can also be treated via telehealth (e.g., evaluation and developing of a treatment plan). A member voiced support for the other members' responses and suggested including a statement that not all conditions are ideal for telehealth. Another member stated that there may be situations where the is no other alternative method of care available, which would render telehealth appropriate. The member recommended including in the report that even if telehealth is not ideal for a scenario, it may be reasonable to use if alternatives do not exist (e.g., during a disaster). The member shared concern that the report may be used to inform payment models; therefore, listing conditions may result in payers not reimbursing providers for care delivered via telehealth. A member agreed with the concern and recommended that the report not specify "telehealth sensitive" or "non-telehealth sensitive" conditions, noting that telehealth is evolving rapidly and listing specific conditions may outdate the report. Another member agreed with this comment, giving an example of how Parkinson's disease can now be detected based on gait data collected from mobile phones. Committee members discussed that the appropriateness of treating a patient via telehealth is highly context-specific and is dependent on patient needs as well as the provider's best judgment, capabilities, and comfort with addressing certain conditions over telehealth; these can also change rapidly based on emergency context and developments in technology.

A Committee member shared that the language used in the report should not be specific to medical conditions and should more broadly state that not all care is ideally provided via telehealth; a Committee member expressed agreement with staying diagnosis-agnostic, and other Committee members suggested alternative language including "scenarios," "circumstances," and "cases." Another Committee member noted that additional language in page 13 of the report should also be amended to reflect current discussion – i.e., correct "telehealth is an alternative method of delivering healthcare" to read "telehealth is a modality of care delivery" and focus the subdomain description on language related to providing the standard of care. At least two Committee members agreed with these suggestions. Dr. Mehas shared that NQF will not provide a specific list of telehealth-appropriate conditions in the report, revise language in the report to reflect "scenarios" rather than "conditions," and reflect that telehealth is a modality of delivery. Dr. Mehas asked for additional guidance on whether the remainder of the sentence should be amended to "...can be treated optimally using telehealth." A Committee member suggested "Care should be delivered to patients in the optimal manner for the given patient, condition, and time," with additional language noting that this may be in-person or telehealth care, and optimal delivery may be different based on timing (i.e., during a disaster).

No.	Comment	Proposed Response
13.	A commentor recommended improved specificity in defining broadband access and additional detail on the potential unintended consequences for complex populations due to lowered in-person volumes and increased telehealth use.	The Committee will discuss additional detail on improved specificity in defining broadband access, and additional detail on the potential unintended consequences for complex populations due to lowered in-person volumes and increased telehealth use. (page 14-15, page 22)

Comment 13: Dr. Mehas shared the comment and noted that there were several similar comments that the Committee had previously discussed. The Committee did not offer additional feedback on this comment.

No.	Comment	Proposed Response
14.	A commentor recommended the use of scientifically rigorous measures (e.g., NQF endorsed, measures used in CMS quality programs and/or measures that are part of the NCQA chart abstraction process), noting that other measures will cause implementation and administrative challenges. (page 18-21)	NQF acknowledges the importance of using scientifically rigorous measures to support the framework. During previous Committee discussions (web meeting 5), some members expressed a preference for NQF-endorsed measures, however the group ultimately agreed to consider any measures that were determined to be scientifically sound based on publicly available information.

Comment 14: Dr. Mehas introduced the comment and reminded the Committee of prior discussion on whether the list of relevant measures should be limited to certain characteristics (e.g., NQF endorsed); in previous meetings, the Committee had come to consensus that the group should consider scientifically sound measures and had discussed that existing measures are limited and development of new measures in this area is important for the future. A Committee member reiterated this point and shared that they still agree with the decision to consider scientifically sound measures. Another Committee member also shared that since virtual care continues to evolve, it is important to encourage continued development of measures which can eventually be submitted for NQF endorsement.

Additional Committee Discussion on the Draft Report

Dr. Mehas acknowledged that the group has discussed the draft report in detail during preceding web meetings and invited Committee members to provide any final comments on the report, including the recommended list of measures, measurement gaps and measure concepts, final recommendations, and general content and organization of the report.

A federal liaison asked whether the group should consider adding further detail related to equity in the report. A Committee member shared that Equity is highlighted as a domain in the framework; while the Committee had difficulty identifying relevant existing measures, it was noted as a gap in the Gaps and Measure Concepts section and was included as one of the final recommendations in the report. The liaison asked whether any new measures (e.g., food insecurity measures) were available and relevant; a Committee member noted that the group had tried to focus on more telehealth-specific equity measures (e.g., access to broadband and technology) but had not identified any currently under development.

A Committee member noted that as part of the description of the equity domain, the report mentions the possibility of stratifying outcomes by aspects of identity but does not provide specific recommendations for which factors to measure; the member shared that this is reasonable for the purposes of the report but noted that the field will likely need to agree on a more standardized set of equity-related factors that are measured in the future.

A Committee member also noted that it may be helpful to include additional detail related to the roles of different providers in facilitating use of telehealth (e.g., potential role of community health workers in supporting use of telehealth and identifying and following up on SDOH needs).

NQF shared that they will review the report for additional opportunities to include detail on roles, as well as reviewing one more time for relevant equity-related measures.

Public Comment

Ms. Guo opened the web meeting to allow for public comment. There were no comments received from the public.

Next Steps

Ms. Guo notified the Committee of the next steps for the project. NQF will continue to incorporate feedback from public comments into the final report and will post the final report online by November 30, 2021. Dr. Mehas thanked the Committee for their discussion and perspectives throughout the project, as well as the co-chairs for their leadership. The co-chairs also thanked the Committee as well as NQF staff before adjourning.