NATIONAL QUALITY FORUM

Moderator: TeleHealth Project
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OPERATOR: This is Conference #: 84271085.

Operator: Welcome everyone. The webcast is about to begin. Please note today's call is being recorded. Please standby.

Jason Goldwater: And good afternoon everyone. Thank you for joining the call this afternoon. Happy Valentines Day to everyone. I'm sorry that we were unable to make things and summon to you. It was a little busy for us over the past couple of weeks but Happy Valentines nonetheless, I hope you're going to enjoy your day in some way shape or form.

Regrettably, Chuck Doarn is not making the meeting because he's on a plane. That to me is incredibly lame excuse for getting out of the (sonnet) that he was suppose open up the meeting with. However, that being the case, we will continue to move forward.

Next slide.

So, I just – brief welcoming introduction. I'm Jason Goldwater. I think as you know the senior director for this project. In the room with me is Katie Streeter, who is the senior P.M., Tracy Lustig who is the other senior director and subject matter expert. And we do have two new people who you all we'll have a pleasure of meeting in just couple of weeks, May – pronounce your name?

May Nacion: Nacion.

Jason Goldwater: Nacion, who is our new project manager and Irvin Singh who is our project analyst.

Next slide.

So now we're going to up to roll call and I will turn this over this to Katie.

Katie Streeter: Thank you. Judd Hollander?

Judd Hollander: I am here. Welcome everybody.

Katie Streeter: Marcia Ward?

Marcia Ward: I'm here and welcome also.

Katie Streeter: Dale Alverson? Rashid Bashshur? Adam Darkins? Henry DePhillips? No – Chuck is not available. Marybeth Farquhar?

Marybeth Farquhar: Here.

Katie Streeter: Stewart Ferguson?

Stewart Ferguson: Here.

Katie Streeter: David Flannery?

David Flannery: Present.

Katie Streeter: Paul Giboney?

Paul Giboney: I'm here.

Katie Streeter: Don Graf? Julie Hall-Barrow? Steven Handler? Yael Harris? Kristi Henderson?

Kristi Henderson: Here.

Katie Streeter: Mary Lou Moewe? Eve-lynn Nelson?

Eve-lynn Nelson: Here.

Katie Streeter: Stephen North?

Stephen North: I'm here.

Katie Streeter: Peter Rasmussen? Sarah Sossong?

Sarah Sossong: Present.

Katie Streeter: Daniel Spiegel?

Daniel Spiegel: Present. By the way, I didn't notice that there are several folks whose names you called out who are logged in to the WebEx and so I don't know if they're just on the phone or on mute or something.

Katie Streeter: Thank you. Jean Turcotte?

Jean Turcotte: Here.

Katie Streeter: Dennis Truong? Angela Walker?

Angela Walker: Here.

Jason Goldwater: Henry is on the phone.

Katie Streeter: Thanks. Henry, we see your hands raised. Yes, several people are logged in on the webinar and just a reminder if you would like to speak during today's call, you will also have to dial in. Do I miss anybody else? Jason?

Jason Goldwater: All right. Next slide.

So our agenda for this afternoon, part from the welcoming introduction, so we will – just to a very quick review of the meeting objectives and then I'm going to turn the call over to Judd and Marcia, our co-chairs, and they will be facilitating the discussion on your initial thoughts on the Environmental Scan Report.

The final comments to us are not due until the end of the month. So for those of you that may have read some if not all and have some initial thoughts, we certainly like to hear them so that we can begin preparing for the next draft ahead of time. After that, we'll have an opportunity for public comment and then we will talk about next steps.

So feedback on the draft of environmental scan reports, so at this point in that, I'm going to turn it over to Judd and Marcia, and they're going to lead the discussion on the report itself and specifically to get what feedback you all might have on particular sections of the report itself, namely the structure of the environmental scan report, the domains of information that we highlighted, the clinical focus areas, the initial measure selection, and current gaps.

So with that in mind, Judd, Marcia, I'll turn it over to you. The floor is yours.

Judd Hollander: Marcia would you prefer I begin or would you like to take the lead?

Marcia Ward: Go for it.

Judd Hollander: I knew you're going to say that. So, I think the most important thing is that, you know, we received some comments back but I think it's only from about four people that had, you know, either bulleted comments or comments within the text of the report and (we're) tracking features.

And I think that there's a couple of themes that I found in the incredibly small and so far which is people tended to focus on typographical errors, should we define telehealth and telemedicine, and then adding in some references that there are others, you know, may have written.

And I think I would rather do is take, you know, may not be 20,000 foot view because the report is very, very complete and very thorough, but really have us address going through these areas where we're talking about methodology and the results in the clinical areas, what a big picture items that the report maybe could benefit from being more complete with or is it actually totally perfect as it is. I don't know that it's worth awhile on this conference call to

say, hey should include reference so and so by doctor so and so. That we could deal with by e-mail.

I know that when we have the face-to-face meeting it took, I don't now, somewhere between 20 and 30 seconds for all (shiners) to be removed from the room, but often on conference calls people tend to remain silent. I think if we're going to be really productive in a couple of meetings in the face-to-face meeting. This is really great forum for us to, you know, drill down deeper than 10,000 feet but not show in the weeds that we need to be writing sentences.

And so I think, you know, we probably can begin …

Male: Thank you.

Judd Hollander: … with a discussion of the methodology and say, how did people think that was covered in the report. Obviously, the report is done and we discussed the methodology when we were at the face-to-face meeting, but is there something that's not clear in the report or some big oops, we should have done A and we didn't, and nobody is going to like this data because we didn't, or people happy with the methodology and the way it is described and then we can move more into discussing the results that were found in the presentation of the results.

So, I'll open the floor for discussion on that and let people go wherever they would like.

Henry DePhillips: Hey, Judd, it's Henry. I've got a comment if the time is right.

Judd Hollander: Time is perfect.

Henry DePhillips: Thanks. So, I'm just kicking off myself and it occurred to me when we were there for the in-person visit. First of all, the report was incredibly well done, incredibly well written, incredibly well research. I was blown away by the quality of the report so my hat offs to you guys. Just unbelievable stuff.

The only the thing that occur to me as I read through the report was – on look – comparing the use of telemedicine to, you know, other sort of pre-telemedicine forms of care obviously put a lot of attention to that. What was interesting was on the study design or the studies that were studied, if you will, was that many times sort of traditional care was compared to pure telemedicine care.

But in 2017, you know, telemedicine and obviously a bunch of different flavors becomes another option for people, so right. So I'm wondering if the comparison – if we shouldn't sort of attempt to find a comparison or maybe there are some there that I missed where its all of the sort the – the traditional modalities and compared to all the traditional modalities plus telemedicine being another option for modality.

Is that makes sense?

Jason Goldwater: It does. Yes, this is Jason. That does makes sense on us. And I think we do actually have some of those articles, or certainly we can find them in certain area.

Henry DePhillips: OK. Thanks.

Judd Hollander: Are there thoughts and comments?

Dale Alverson: This is Dale Alverson. You know, quick question. Should we be prepared to address, you know, Appendix A, you know, in-person meeting to listen initial measures that could be applied because I understand we really want to look at measures that would be – that we consider evidence-based, that could be applied by others in the telemedicine realm?

Jason Goldwater: The answer is yes. That's going to be part of our in-person meeting is to review the measures that exist to determine which ones would be applicable to the framework and why. I think for this discussion it's – just more cursory. You know, was there – do we look at the right measures, you know, do we choose from the right selection. We obviously looked all the NQF and endorsed measures as well as the measures that are kept in the AHRQ

database which is I think every measure. And then we looked at the ones that we're in MIPS and in other programs.

So, I think that discussion is there anywhere else we should be looking besides where we look. But as for what measure to include, that's not the focus of today.

Judd Hollander: Yes, I think, you know, one of the hard things, one of the difficulties I had as I was reading the report and reflecting back on the in-person meeting is I kept thinking at points, well, this doesn't reflect the decisions we made in the in-person meeting. And then I, you know, sort of reset my thought process and said, "Well, that's the goal of this report." This report is about the environmental scan and what was the original ask.

So in areas where we talked about the domains, for example, the domains that I mentioned in this report are the domains that the environmental scan was based on but the domains that after we discussed, you know, what we knew about the environmental scan, we settled on at the first face-to-face meeting.

And so I think it's difficult because in many ways we're a step ahead of the report in our discussions, but we haven't taken the report into account. But I think really the goal of today is to provide feedback on this report and keep a focus to this report alone.

Jason Goldwater: That's correct, Judd.

Don Graf: Sorry, this is Don Graf. I got my audio screwed up but I'm now on. And I wanted to comment when it's open.

Judd Hollander: Go ahead.

Don Graf: Sure. So, speaking to the overall approach, it struck me that – and a couple of different places in the report where it referenced expansion but low utilization. I couldn't help thinking that adoption engagement, sorry, messaging to promote adoption engagement wasn't in of itself considered as a – an indicator of quality.

I don't know if anybody else is kind of getting that feeling as they read it.

Judd Hollander: Can you elaborate on that. I'm not sure I understand 100 percent what you mean.

Don Graf: So, you know, just like for example in the executive summary it says, you know, Medicare program is growing rapidly in recent years. Its overall utilization in Medicare provider space remains relatively low. And then later on in the report it talks about low utilization in the – in this environment of, you know, expanding growth and technology and connectivity and everything else that utilization still is low.

And I, you know – so part of my life in terms of getting, you know, got the horse to water but we got to get up to drink somehow. But that by itself is becoming more and more measure of success and quality then – and we didn't see it represented in the document.

Judd Hollander: So are you suggesting that the incorporated as a, you know, part of the measure framework or you suggesting that there be a paragraph to explain the reasons why there might be low utilization that follows those sentences?

Don Graf: Maybe the latter. I just know that putting up there and saying that there are – that there's low utilization and then not commenting at all about, you know, just seems open-ended somehow.

Judd Hollander: Other people thoughts on that topic?

David Flannery: This is David Flannery. I think that's correct is like the whole area of the limitation science kind of things because there are ways to be successful in implementation and that is actually should be a metric of some sort of, you know, how you do best practices to do implementation the proper way to be successful. So I think that's a valid point to look at.

Judd Hollander: So I'm just trying to pressure test the comments not that I disagree. But if there was a measure that said telemedicine should be used for A, and the telemedicine, you know, X percent of the time, well then it would be up to people locally to decide how to implement but it might actually still be a

measure. Would that tie in to the framework that we talked about before such as patient and provider experience, so maybe down the frame – down the road our framework is actually capturing that or – because I guess what I'm thinking is saying that there should be a metric or measure that said you should implement assume there's proven benefit that is better than alternatives.

And I guess that could exist in some areas but roll and deciding a measure framework, do you think we can – can we put the paragraph that Don was talking about and then capture that by other items that maybe are going to be in our framework now that are not really in the environmental scan report, which again is not our final document, it's a starting document.

David Flannery: Right. This is David again. I want to put a pitch for my concept about system effectiveness. And I would I think then implementation comes under system effectiveness as a potential area.

Judd Hollander: Right. And I think we have that, right, retained.

Female: We talked somewhat at the in-person meeting last time to about infrastructure and I wonder if some of the recent remarks are being regards to that and where's that capture in the current domain?

Judd Hollander: What Jason – and so I'm going to ask a question because what I don't see on these slides is what did we, you know, as the list of what we settled on the exact wording of the domains. And it might be worth based on the conversation, is just repeating, you know, what we had agreed on in the last meeting because it might help frame some of these concerns.

Jason Goldwater: I don't – we don't have them in the slides, so the focus of this was how the environmental scan report was initially framed. But when we went through and develop the report many of the concepts that were discussed in the in-person meeting were presenting themselves in the studies, under the domains we already have. Now that doesn't mean as we progress along with this we won't separate those out independently.

And then, in addition to that, do conduct additional research on articles that might fill into that. But the initial – the initial (crux) of this was just to go over those original domains of the environmental scan and to discuss the issues that were important to HRSA and the government as well as what was being initially setup for the measure framework. And then when we met and discussed this, we would then go back over what had been discussed, see what studies pulled that out that information into that, and from that continue to refine and develop measure concepts and measures.

Judd Hollander: Right. And, you know, David, I believe system effectiveness is one of the measure concepts that …

Jason Goldwater: That's correct. It was.

Judd Hollander: … surviving the first day. I actually just them up just to, you know, run through quickly but I think, you know, agreeing obviously with Jason that the concept is not revisit these at this point but to give people at least the level of comfort that these things fit into it. The measure concepts were access, cost and cost-effectiveness, system effectiveness, clinical effectiveness, patient and family, maybe slash caregiver experience and physician provider experience. And then the dimensions of care were actionable information, infrastructure capacity both in terms of workforce and bandwidth. Is it appropriate to perform via telemedicine, therapeutic outcome and patient outcome?

So I think a lot of the comments that have been made can tie back into least those preliminary concepts of what we were thinking. But again, the report, you know, aligns what the domains when the report got started, we subsequently have jumped ahead. But I think system effectiveness which was, you know, raised is clearly included.

Jason Goldwater: Right. And there are number of those articles that across all of the domains, there are several of them that touched on system effectiveness. So, if we, you know, as we progress further, if we recategorize somewhat and add that domain, you know, we have a basis of literature to include in that and then additional starting points to add more.

Judd Hollander: So, I think it just sort of focus to conversation in much through of things. I think, you know, step one on this slide in front of us is to focus on the methodology to those of you that have the report open. It's like pages 8, 9 and 10.

And so, you know, this basically the methodology was, you know, going through the literature and great literature and then rating using the NQF scoring matrix on five questions there were in the report adding up a total. And I believe it's seven or above then the article was selected for inclusion and then they are summarized within this.

And so, you know, that's the very short version of much more complex methodology, but it's started with 390 titles and abstract and 180 papers that had a score of seven or above are included in that if within the modalities and domains that was summarized here, they're included.

Is there anybody who feels there's a huge miss, not so much in terms of the domains that will focus on because that's one of the later agenda items, but in terms of the methodology that was followed? Or is everybody mostly OK with the methodology?

Stephen North: This is Stephen North. Do you think we missed any articles because tele-ICU was not in the list of terms that were searched?

Judd Hollander: So, Steve, I think that's a great point. I would put that on the clinical focus areas which is two agenda items down.

Stephen North: I'm sorry? I'll make my comment again in that.

Judd Hollander: I will remember it.

Jason Goldwater: So, Judd, if I could just say interject for a second to sort of anticipate Steve's comment and already know it because he sent a comments to us. When we send the report out, I think collectively has agree after we sort of debrief when it was done we realized that there were probably additional work that will need to be done in the areas of tele-ICU, telestroke and tele-ED. Some of those papers that we research do not make the cut or they did, but didn't

provide enough information of value in our opinion, but there are certainly additional research that could be done on those and should be, so we anticipate that.

Judd Hollander: OK, great.

Paul Giboney: Hey, Jason, this is Paul Giboney. As you guys were going through this, the executive summary and just throughout the document there is a very consistent reference to the value of telehealth in underserved settings and in rural settings. And this may sound like an odd comment coming from a guy who spends his entire career in the safety net.

I actually believe that telehealth is of high value in urban settings and even in settings where there is not a lack of access to care. I think in many ways telehealth is better access to care even in non-resource constraints settings. And I just didn't know if as you were looking at the studies and going through your methods, how much were you influenced in the perspective that the value of telehealth is in the rural setting or in the underserved setting, but not just in the broader clinical setting regardless of whether there's constraint access or not.

Jason Goldwater: Paul, thank you for the question. I'll quickly answer this and I'll let the rest of the committee sort of weigh in there. The preponderance of articles, a substantial number of them were all geared towards increasing access in rural and underserved communities. There were very, very few that talk about the utilization of telehealth modalities in urban areas or areas in which there was not a sort of positions or specialists.

So, that's the reason why the paper reflects that is because the literature pointed us in that direction. That's not say that there might not be additional literature that sort of validates or expands on what you were thinking is.

In addition to this, you know, the sponsor of this particular contract is HRSA who, of course, is very dedicated to improving the health and quality of those living in rural and underserved areas. So, those also, you know, we kept that in mind as we were looking at the articles as well.

Paul Giboney: Yes. I mean – and certainly knowing the audiences. And I fully agree that telehealth has been an incredible boon in all of those areas. Certainly, it has been in our area, you know, to help leverage specialty care and other things in resource constraint setting.

I just – I see the opportunities for the future in telehealth and I just didn't want to pigeon hole us in writing this report and sending maybe an unspoken massager or a meta message that, you know, telehealth is only valuable in resource constraints settings or rural settings.

Julie Hall-Barrow: Hey, this is Julie. Two things, one, I'm on. And the second is I echo that, you know, that this preponderance of the data, you know, if that's where the preponderance where the funding was coming from was the focus on rural health so that all the data from the money that was funded in from grants and research (terms), it's all the publication. So I think that the fact that there's been lack of funding to look at the urban area is probably why we don't see a deficit there in the publication.

But like my colleague, you know, I do think, you know, comparing the apples to apples, an eight-year-old does well accessing low acuity care in the school, really doesn't matter if it's in a urban or rural location. I think our outcomes will be very similar. So if there is a way that we could kind of, you know, make sure that we're not sending that subliminal message, this is only good for the rural, you know …

(Crosstalk)

Judd Hollander: So this Judd. I obviously agree with that and have raised that before. I can't say that I'm unaware of any society guidelines that say only treat this disease when they happen to be in this location. So, I think telemedicine is unique and that some people see, you know, it solve the problem in the rural areas, but I don't know that there's any publication that says it doesn't solve the problem in the urban areas. And every other guideline on how to treat every patient with every disease in the world, I don't believe there's a single guideline, I maybe off by one, but guidelines generally aren't written that say only treat people if they are in urban or rural or suburban location.

So I think we stand to be saying something really different if we're pausing that out. It does solve problems in both areas, but I like to say it's really about access, not geography. And if we focus on access, there are certainly access problems in rural areas and there are certainly access problems in urban areas and then maybe we can avoid the message that ties it to geographic location.

Julie Hall-Barrow: Perfect.

Angela Walker: This is Angela and I have a similar comment looking at kind of the natural bias in publications. I'm working on a talk that is discussing the pearls (and called) the teledermatology use and one thing I found is that there's a lot more pearls supported than pitfalls, and I think that's just natural in publication because we like to focus on the positive and many of the negative either aren't publish or aren't submitted for publication.

Is there someway we can just include the disclaimer at the start of this report making note of that natural in publication bias for both the rural, urban and kind of benefit and misuses of telehealth.

Jason Goldwater: I think that certainly something to consider. This is Jason. And I certainly understand the comment, Angela, and I think we would – those of us that spend a lot of time reading these articles would concur that most of them had a very positive slant.

There were some that indicated that there – there was no improvements over in-person health or in some cases there were some draw backs and I think we did include those in the report, that those were part in between, fairly. So, I think your points will noted and certainly something to discuss when we're all together about how to do it.

Daniel Spiegel: This is Daniel Spiegel. So I really appreciated the structure of the report. I thought, you know, breaking it down by modality and domain was helpful to make it more digestible. One thing that I did kind of struggle with and reading through the report though is, you know, some of the overlap among the modalities, so it's not really clear or clean lines a lot of times in some of the studies that were referenced. And I was wondering if there are some way

to kind of make that clear or when you went through the literature if you noted all of the various modality that were covered by particular study.

Jason Goldwater: Daniel, that's a great question and we wrestled with that for a long time because there were papers that we are reading that clearly can cut across to the three modalities. And I think the conclusion we came up with was the modality that was most dominant in the publication, the one that was most prevalently – prevalent, the one that was most often reference is where we went with that.

Even though we could understand that it could cross – it could cross a number of different modalities and certainly it could fit into a number of different domain areas, you know, that which we found to be the most prevalent, most reference is where we went because that just seem to be the easiest solution at the time.

But we figure as we move forward and talk to you all and go through these different domains and start finalizing those that might make that distinction a little bit more direct rather than having that be a little blurry. But I can – I think we all appreciate that it's a little fuzzy because it's cutting across, but just, you know, I guess given the time that we were under we had the sort of things what would be the best decision, the most expeditious when that was the one we came up with.

Judd Hollander: So I guess and just thinking it through this conversation I see too, you know, both relatively painless options. One is articulating in the body of the report that they take procedures classified to that predominant domain might be useful, but then many papers spend many domains.

The other are more complicated option and might not be worthy amount of work it would be, would be adding to the table of the papers, you know, what the predominant domain was, which is there and then what the other domains it may have crisscross with. I'm not sure if there's a lot of extra gain from going back in doing all of that work unless you guys have it on a table already. But maybe just clearly articulating in the methodology what you just said might be worthwhile.

Daniel Spiegel: OK.

Judd Hollander: So, are there any other concerns as it relates to methodology or should we start moving down the slide in discussing the way the result they presented? I think since 80 percent of the conversation has been more about the result, it's probably good to move through.

And so, obviously, they were classified by modality which is what we're talking about and then the domains. And so I guess at the first, you know, higher level, how did people find the flow and that it talk about them in terms of modality and then the domain. Does anybody have a recommendation? We do it differently.

Marcia Ward: If we go to the next slide that focuses on domains.

Male: I thought it was laid out well.

Judd Hollander: Anybody have something that they need to, you know, want to put out there that says it wasn't laid out well and you want to send NQF back to do a ton of work at your own risk realizing that you're going to see them in a couple of weeks.

Peter Rasmussen: You know, Judd, this is Peter. And, you know, I don't think there is a perfect way of laying out the information and no matter how it's put out there and articulated, there's going to be someone who's not going to be happy with that and I think this is good of categorization as I've seen and clearly the work through some of there makes it look excellent. I'm very happy with it.

Judd Hollander: Yes, I thought it was terrific. Anybody with any other suggestions that need to be captured in the layout? And then I guess, you know, marching again to the slide, you know, are there other domains that need to be capture? And I guess this is, you know, it would be helpful to have some insight as to the sequencing again because this is our starting point where we're discussing, you know, the measure concepts and dimensions of care.

Is it fine for the report to be if – with the five domains we began with in our recommendations? I don't know if it's going to be in this report or in a

subsequent report will be for different measure concepts and different dimensions of care. I'm assuming that that's OK the way it is, but I just wanted to ask the question so we know. And I think that's probably more a question for Jason and NQF on how this reports, you know, sequence.

Jason Goldwater: So I mean, the next one will be starting to build the measure framework. And so, as we start to put that report together, we'll be clearly identifying the domains of the framework which will be a lot of what, you know, you just – we've discussed to the last and in-person meeting and what was referenced here in addition to any additional research we may need to do.

And so these domains made very well or probably going to end up in the framework as well as the others that you talked about and then under that, you know, we would then reference the literature that talks about these domains. And then from that, you know, identify measure concepts as best as we are able that fit under each of this, as well as identifying measures that already exist that could be included. So, that will be the next report where we start laying out that out.

This, as you said is sort of how we started and this is right in the foundation of information on which to begin discussing how to – what the framework should look like and I know that we've already done a good portion of that work, which we were happy with, because it will make the meeting much easier when we're together. What it does mean is that when we go through and put that initial draft together, we'll be realigning some of the literature to fit under, you know, some of these new domains in addition to perhaps identifying new articles that would be reference in those areas and would have potential measure concepts on them.

Judd Hollander: Thanks. So with that background, then I think the question on the slide is – are there other domains that needs to be captured could be reworded or are there other domains that need to be captured over and above the things we discuss to the last face-to-face meeting.

What would – do we think this review here from a domain not from a clinical focus area, which is the next topic, do we think we, you know, done a good

job here and that's enough to move on and inform the measure framework and, in fact, inform the conversation we already had.

Angela Walker: This is Angela. Would it be possible to get an Appendix D which is the revision of the domains of information for the environmental scan? The things we discussed in-person.

Jason Goldwater: Sure. Or we can just send that to you directly.

Angela Walker: Either way.

Jason Goldwater: Right, but adding to the report, but sure.

Judd Hollander: OK. And then the next question is, will this domains provide a foundation on which the develop measure concepts to the framework? Is there something, you know, we've discussed the measure concepts again and, you know, and I'll read them out as I had in my notes, which was there were six access cost and cost-effectiveness, system effectiveness, clinical effectiveness, patient and family/caregiver experience and physician or provider experience.

And so the question is, do the domains in this report provide the foundation to develop the measure concept that I just read in anything else we might want to add as a result of seeing this report to the develop the framework? Or is there something missing?

Female: I thought it was good when – in the gaps session – when it talk about gaps in this report, it's kind of referenced some of the things we added in the in-person meeting. For example, under the gaps in this environmental scan, it talked about family-centered care. So just kind of alluding to what we're saying with the family experience. So it just – while it didn't scan for that, it did at least acknowledge in the gaps that that is something else we're interested in.

Judd Hollander: OK, good point. Other comments? OK. And the next question on the slide is – are those that NQF – are there domains that NQF should prioritize over others. Do we need to prioritize or, you know, at the stages putting everything out there without stating a priority just fine. And so that I made it a binary question someone has to answer.

Jason Goldwater: So, Judd, this is Jason. I mean, I will say that that will be another topic at the in-person …

Judd Hollander: OK.

Jason Goldwater: … as we get to the end of that meeting because it really is important that we hear from all of you about what we should be prioritizing. Because as we've said, you know, early and we kept repeating throughout this discussion, it's really crucial that this framework be actionable that people take it and start using it.

And telehealth is a very big field. As you all know, there's lots of different elements to it. I don't think a framework that tries to cover everything all at once is something that people will be able to use. So I think having a framework that covers a lot but then really prioritizes those issues that are really crucial and significant, and we demonstrate the utility and value of telehealth or those that we need to prioritize in.

I don't think, you know, this – it's something that we can discuss now as you want to but it is definitely going to be one of those topics we'll discuss when we're together in March.

Judd Hollander: OK. Guys, I think saving it to March make sense. So the next thing is the discussion that I think Steve started on clinical focus areas and on slide nine actually. The report as you all know has focused five big areas of mental health, dermatology, chronic disease, rehab, and care coordination.

You know, and to – they're sort of interesting because chronic disease is although it's a focus area is chronic disease, it's multiple different diseases similarly as can care coordination and some of the other entities be the same. So these are really big parts rather than, you know, just five clinical areas in the clinician's mind because they would be more disease specific for a clinician. And these were chosen, you know, not prospectively but after seeing where the studies are and the studies were done. And I think we started the conversation before by asking the question, are there other areas that NQF should focus in on and include in the environmental report. And we heard

from Jason that there's been discussion and, you know, reconsideration of EICU telestroke and tele-ED or urgent care. So, I guess it's by worth spending a couple minutes discussing the merits of diving into those areas as well as other areas that we have not yet mentioned on this call.

Adam Darkins: This is Adam Darkins. Can you hear me OK?

Judd Hollander: Absolutely.

Adam Darkins: What I was going to suggest, it seems there's some issue a little bit hear about slicing and dicing. So by that, what I mean is those are the priority areas you focused on, within those priority areas, often some of the studies are relatively small numbers. So, actually it's saying what are the – what's going to be the components of framework might be quite difficult. One other way to look at it is to say there's a piece around this which is sort of how this telehealth had value. And are there some generic ways cross everything whether it's certain parameters of value related to access, related to quality of care that might be generic that could be use to everything, perhaps with some to modification.

And then within that general framework, are there some specifics that might be added in as opposed to trying to sort of make it more – it seemed to be what I was hearing, somewhat was slightly siloed. Does that make sense to what I'm trying to say?

Judd Hollander: Yes, I mean I think I understand it. Others that want to add to that comment?

Peter Rasmussen: And I think that's a correct comment. This is Peter. And I – it feel like it's too narrow. Because in my mind the expanding – reinforcing what was just said is that it's really about telehealth in my mind is really about improving access and creating efficiencies in care delivery and projecting expertise where otherwise doesn't necessarily exist.

And, you know, I kind of categorize telemedicine in three buckets which is eICU, acute in-patient management and ambulatory settings. And I think telemedicine is applicable broadly and not really narrowing into these five things that are mentioned here or even expanded to eight with, you know,

telestroke in eICU added to it. So, I guess it would be nice if it was more broadly, it was unfocused as opposed to focus I guess.

(Crosstalk)

Steven Handler: This is Steve Handler. I don't know if you can hear me or not. But I agree, in fact, my comments I added the post-acute long-term care continuum. I also included two articles that look at very specific outcomes and it recently what I failed included n my e-mail was recently endorsed NQF measure about rehospitalization. And if we're also focusing on transitions of care in particular, then I think that we need to focus on the care continuum.

So, I almost feel like I set up for this maybe a discussion or an early description of the care continuum that might say which kind of future proofs this that although current studies have looked at individual silos or individual areas, we anticipate that in the future that additional applications and solutions across the care continuum will be developed would be ultimate goal that these technologies and solutions to also communicate across the care continuum to better improve care delivery across the health systems, plural.

Meaning, so we talk about the current state but we talk about the future state as well where we'd like it to go. But we have to base it at least on the current evidence which is available, which is on silos, which is the basis of our current data for the most part. So, it gives us the opportunity to – put a stake in the ground now. This is the current data but this look like we like to build towards.

And I think, as a group, we said over and over, we want transitions who care, we want to build towards that, so that would help I think this file level overview of what we'd like to see in the future despite of what we have right now. And it might mean that we create a map that list all the care settings and we might put a number of studies by care setting even. I think that would actually be a nice graphic.

Judd Hollander: So, listening to what people are saying in China developed consensus around it. I think the comment that, you know, we can in an environmental scan only

report things that exist in the environment is obviously important. But maybe there can be a brief discussion section somewhere upfront in this. And to some degree, what I'm trying to reword this in what might be NQF measure language and so – Jason correct me if just totally blew it.

But to some degree, if a health system or a payer has a comprehensive plan, what we're really talking about is attribution, right. It could be at the individual physician level for taking care of people with disease X and that might fit in to the way it's aligned. But if a health system is held responsible for driving down cost by including telemedicine an option for their patients across the care continuum, the attribution to decrease costs might actually be with the health system, and then telemedicine might be one but not all of the tools used to do that.

So, it might not be where as telemedicine proven to work on a disease but might be that systems that get attributed with lowering cost of providing better quality might be allowed to use telemedicine as one of the items within that.

And it might just be worth having that as a discussion somewhere in it because I think as we do measure concepts and dimensions of care, we probably at the end of the framework, you know, the way my understanding is the way NQF works is one of these measures are attributed to somebody or some institution.

Jason Goldwater: That's correct, Judd. That's exactly how I think we would probably write them.

Judd Hollander: Right. So I think then it would take care of the issue being raised in that we can look (to questions). Since we are just standing the environment, yet, you know, several of us probably have papers out there with cute little diagrams describing our continuum of care. I think if there's stuff that's published there, I mean, I don't know whether that something we want to include as a paragraph or an appendix or not at all. But we might want to have some comments just highlighting the points that were made. But again, that's our thoughts and our personal recommendations and I agree with all of them but

I'm not sure we could find that in the environment, to put in an environmental scan. Is that makes sense?

Paul Giboney: This is Paul Giboney. You know, one of the things I'm thinking about is since we know we're, you know, we're looking in the environment to help us begin the process of developing a framework. One of the things that we want to include in that environmental scan is that – because we want the measure framework to be more generalizable and more usable and more practical. And so, we don't want to leave out in the environmental scan large types of applications of telehealth that we might want to see in our measure framework down the way.

So like, for example, you know, like the chronic disease one. You know, the studies that we looked at were, you know, around asthma or COPD or diabetes. But because those are in the chronic disease thing, and some point of the future, if someone who wanted to apply those towards, you know, in stage liver disease or chronic kidney disease, they could because they're generalizable because it's a similar disease.

The benefit of putting something like a tele-ICU or a telestroke in our environmental scan and looking specifically for those areas is that is a type of use of telehealth that's not easily represented in the five clinical areas that we currently have. It occupies another space.

And so, if we were going to develop a measure framework that was going to be practical and usable, there's this whole type of use of telehealth in the ICU and stoke areas that's not well represented in the first five that we have. And so, I would think there's some value in including those in the environmental scan because of that.

Sarah Sossong: And this is Sarah Sossong. And just to piggyback on all of the comments. I really like the suggestion of the care setting and I think the point that's being made right now – made right now or telestroke, tele-ICU, one of the things that we have really tried to hone in on is what is the acuity of the service. So, I think – and I think part what's getting me hang up on this is at that Derm is represented there but not other clinically specific.

So I think if we had like a acute and non-acute as categories and just even adding acute, I would say that telestroke, tele-emergency medicine, tele-critical care and a number of other things we haven't even thought of or haven't even happened yet in the acute care arena can fall into there in the future.

And I'm sorry, we probably talked about this on a prior call but the one thing I also see missing it's just the mention of the modality. You know, people get really caught up on what's video and what's – so what's synchronous and what's asynchronous. So, again, whether it's within this part or another part, I think it should just be acknowledged that we're looking in both modalities.

Jean Turcotte: Jean Turcotte here. I just wanted to comment that I echo completely what was just said. I came from the very acute care background and, you know, I think we need to include acute care, the ICU definitely programs like stroke and neurology that are out there. And, you know, and I had the same question and I forget when we were together how we came up with something specific as dermatology where in the sense depending on the environment, we could consider, you know, acute in that aspect.

But I think we need to have the category and we complement the chronic disease, we have so many diagnosis and met modes that we used under the chronic disease topic or category. I think we would need the same thing with acute care. So, I very much support and think we really need to look at that.

Judd Hollander: So I'm, you know, going to throw in some comments here that I think represent what NQF did and thought of the dilemma with this, is I think they scanned the broad environment and found the areas that were selected as the areas where there was the most outcome based literature. And that was the basis for the judgment rather than leaving anything out.

But I agree with all the sentiments and in fact in the comments that I sent in that the areas that it discussed should be included. And maybe what we need to do and I throw this out just for people' thoughts, is effectively make the comments that would just made that these are high used areas and if it – and so now, I'm making up the next thought.

If in fact the literature that was there didn't score a seven on the NQF scale and did – and wasn't one of the five prioritized areas, maybe the group as a whole could decide and I think we might have that these are important enough going forward that they need to addressed. And we could have a statement that says the current state of the literature didn't get over above but because we know these are widely deployed used cases we feel like we need to address them and then we could summarize the literature with the deficits that exist.

But as we look at the measures and want to begin to pressure test measure and see if they applied then we can pressure test the framework we developed in those areas as well. And that way, we can preserve sort of the scientific selection by methodologic rigor that's already been done. And if in fact these other areas were not included because of a little lower level of rigor. We could still decide they should be included and therefore make sure we include them in the framework and have mention of them.

Adam Darkins: So one of things I was going to say around that is that makes great sense. The other just piece as I'm hearing it is an aspect to this in some ways which is looking in the rear-view mirror and that we're working an area – we're talking about an area which is quite dynamic. So if one looks at things like tele-ICU and critical care and stroke, they're really morphing in some ways in programs which are advanced towards specialty care consultation.

So, it seems to me there's a way and yes, look at the past and look at what's – but also sort of map out what the future might be. So (for instance), focusing and saying let's set stones around critical care, that maybe where the rear-view and the literature is in tele-ICU. But isn't this in fact morphing towards specialty care in the future?

And one other comment I'd say, it seems to me an important piece of this is going to be helping to change management. That if you are a physician or in other clinician who is reticent about telehealth, then one of the things you want to encourage just the development of outcome measures that people can look at, they can reassure themselves and say, "Hey, this should be introduced in my organization. Here are some quality data that makes me feel reassured that I'm going to come on board and do with it," use it.

So those are my two pieces around, A, perhaps we ought to just think about where this is morphing to rather be, you know, totally just what's been in the past. And secondly, make it by practical so that those who are going to use it can gain the evidence so this is going to help with change management.

Judd Hollander: I think that's the whole purpose of the framework so we can go forward. I think everybody would agree.

Jean Turcotte: I want to – it's Jean here again. I would add one more comment and that is, you know, I would probably agree with the literature and knowing how this was, you know, what was included was based on that, it's very confusing because of – it's just the way the programs are developed. There's not a loss. What is out there is very common and very similar and is put out by almost the same people all the time.

But I think when we look forward to the framework and the fact that we want to be able to establish the measures, including acute care, all programs cost a lot but there's an incredible amount of resources that go into these programs like the ICUs and the strokes, and I think there is going to be a need for clear measure. And so, again, I think that's why it's important that somehow we make sure to consider all that as we develop the framework.

Judd Hollander: Does anybody object to that concept I guess? OK. So, I think, you know, we – I think we've given good feedback where what kind of congruent for most people on the committee. The next topic is looking at initial measure selection. And this is a bit more complicated. It's a, you know, long list in the report of the measures, the slide summarizes them.

Are there things that are missing, are there problems that crop up outside of talking about the different clinical focus areas because if we're now going to expand into the acute care space, obviously, we'll need to do and look through for those measures, but what were people's thoughts on the measures that were listed at the end of the report.

Paul Giboney: This is Paul Giboney. I thought the measures were great. I really enjoyed actually the way they were arranged and categorized and then summarized. So, thank you Jason and team for that.

You know, clearly, I think that if, you know, this is what we're seeing so far but if we're going to develop a framework, kind of like a referenced earlier, I would love us to see us, you know, come up with a measure framework that allows folks to take a particular framework and apply it to a disease that maybe hasn't yet been studied in the literature but is so similar that a similar measure or outcome can be applied. So like, let's say the measure is about management of hypertension or something like that.

There's a certain goal and that's the construct to the measure does, you know, telehealth help moved move that goal. I would love to be able to design something that says, "Yes," you know, also would it be applicable if telehealth can move the goal on kidney disease or something like that. I don't know if that make sense.

Judd Hollander: Yes.

(Crosstalk)

Steven Handler: So this is Steve Handler. Are you looking for additional measures to include very specifically?

Paul Giboney: No, is that question for me? No, I'm not asking for additional measures for …

Steven Handler: No, I'm sorry. No. So no, this question is for the NQF and for sort of the governing people, Jason, et cetera, are you – in this part of this discussion, are you looking for additional measures that may have been missed or we should consider, I guess?

Jason Goldwater: So there's two questions. The first is, you know, we chose the measures from, again, those that were NQF endorsed, those that were found in the AHRQ National Measures Clearinghouse which I think unless I'm wrong takes every measure and categorizes it.

And then, the measures under the MIPS Program, because that's where the measures could be most impact for giving unless something changes or next year, you know, MIPS will be here and people will be reporting on those measures as part of either alternate payment model or it's a value-based purchasing program.

So, are those sources OK, or there are other sources that we said, we looking at? And then, you know, I think that there certainly an awful lot of merit to looking that areas that the literature may not have uncovered or areas in which you all, again, with all of your collected experience feel – there is certainly a need for measure concepts because of the clinical area which telehealth would be advantageous. And it's not in the literature then that's when identify gap which really – is what the framework is intended to fill is to not just look at what's there but fill the gaps that are currently existing.

Judd Hollander: Some people's comment?

Eve-lynn Nelson: This is Eve-lynn. From a behavioral health perspective, I thought the measures were good, it's just there weren't in any pediatric measures and the measures we're mostly focus on depression. So if there could be a broader range or maybe a look across the lifespan.

Jason Goldwater: All right, we noticed that too, Eve-lynn.

Eve-lynn Nelson: Thanks.

Jason Goldwater: Points well made.

Julie Hall-Barrow: Hi, it's Julie. I think we've brought that up I think when we were face to face (inaudible) we're going to try to go back and we review that.

Jason Goldwater: OK.

Judd Hollander: So I think we're going to spend a lot of time on the face to face, you know, talking about the framework and the measures and pressure testing things. So we'll spend a bit more time on this.

I think, you know, the comment that I'll throw out there is – and I think the framework will accomplish this, is in my mind, there's two really broad buckets. There's measures that might be about telemedicine and then some measures that telemedicine might actually be useful to help achieve the measures.

And so, one of our challenges is going to be ways to, you know, make suggestions or incorporate telemedicine within preexisting measures that may not require telemedicine but telemedicine maybe useful. You know, one is in the care coordination where you need to set up an appointment for people discharges with heart failure within seven days. Well, one is an appointment. Right now, telemedicine would not be reimbursable by Medicare for that, you know, unless it's done in the certain side of service or you're in a rural area. So it might be hard to achieve that goal.

And so, there maybe some recommendations that we make that this could be used in the setting. And then they'll obviously be some telemedicine specific things that maybe tied to diseases.

So I think as I look over the list, you know, I'm trying to think of it some both of those head sets, there's probably a bunch more different ways to think about. But I guess my suggestion is, it is worth spending a bit of time on this list before we get together face to face and thinking about what are common themes and how telemedicine might be used to help meet these measures in a better way.

Paul Giboney: Now you bring up, this is Paul, again, you bring up an interesting point Judd in that, you know, there is expectations out there from different organizations that are looking at us. You know, I know that, you know, in California we've got our specialty care folks that want us to, you know, provide a face to face visit within 15 days of the request.

And if we had a measures that was saying that, you know, telehealth specialty care has been delivered within, you know, certain number of days or whatever, then we could possibly look to that and say, hey, to our local state and say, hey, are we – here's a measure. We're meeting that measure of

providing telehealth access to specialty care within, you know, X number of days.

And that's – you know, the way the measures are list out here right now, they're in their different clinical categories, but they're not in an overarching category that says access like, you know, here's the measure of access, you know, a lie response or going forward respond within X period of time be a telehealth.

It just seems like there's an opportunity there to create measures that are applicable in multiple – across multiple specialties not just in specific clinical category.

Judd Hollander: I agree with you.

Marcia Ward: Yes. This is Marcia, I agree completely. I think the top line there the existing measures drawn from AHRQ, NQF and MIPS, those are exactly the right sources to go for, or go to. But I think going back to the previous slide when we were talking about clinical areas and things and talk about the importance of – including some clinical areas. I really hate the idea of sending Jason and his whole team back to pulling a whole bunch more literature and going through all the work of scoring it and describing it.

But I think we could expand on the list of measures and, as was just said, not restricted to these five clinical areas, but maybe categorize it by the expanded set of domains that we talked about.

And I think that AHRQ and NQF already do that categorized measures by domains that are similar to what we've talked about in terms of clinical effectiveness and access and cost and cost-effectiveness.

Judd Hollander: So, Jason, when you did the original scan and grading of articles to decide what buckets there were articles in, did you pull in grade, neuro-stroke, eICU and, you know, urgent care or emergency medicine and they just didn't get over the bar, is a lot of that work actually done already?

Jason Goldwater: So, let me first start off by saying, Marcia, you are and will always be our favorite committee member.

Marcia Ward: Happy Valentines Day for me.

Jason Goldwater: Secondly, so Judd, yes. A number of those articles that appear and since there were 390 of them are off the top of my head I can't recollect which ones they were. Some of them did not score out and then knows that did as we were going through and putting the report together, you know, we made an objective assessment of some of these articles while they may have scored well when we were writing them. In the course of the report, they were not adding the value we initially thought they were. Or they were not providing enough to – raise an impact on or to look at a measure concept or to feed into a decision tree about what measures to be choosing in (inaudible). So, ultimately, they were excluded, which is why we were left with the number of articles that we had.

And so, while jokingly, we certainly appreciate Marcia's comment. I mean I think we fully expect that there'll be some additional research we're going to have to do. You know, certainly, I don't think any other thought that the environmental report would stay static as this as it would require some realignment and readjustment especially given how far we got in our discussions with the in-person meeting.

So, you know, I think there's a lot of articles we still have that we could look at and we take a look at if we're going to reformat this in the way that has been suggested.

Probably, what will more than likely to happen is we'll take everybody's comments and we, you know, edit the report based on those comments. And then I think when we meet and start laying out the ground work for the framework and have to then realign parts of the scan and the literature to help feed in to that so that there's an evidence based for it, that's probably one that will take effect and we fully expect to be doing that.

And add the articles like I said in the telestroke, tele-ICU, tele-ED. And we …

Judd Hollander: You know, and I, Jason, I got to tell you. I interpreted Marcia's comment is slightly different than you did. I interpreted her as volunteering to do all the work so you would …

Marcia Ward: I'm not laughing.

Jason Goldwater: You're welcome to do that. Judd, I do want to point out that we did get a comment on the webinar from the Infectious Disease Society of America to – are suggesting that other domains to be considering might be hepatitis C, HIV, more other a chronic infectious diseases as well. But the comment unless those are being captured under care coordination and chronic disease, and the answer is we did find one example of HIV under Care Coordination. But as for the others, hep C, we found under Project ECHO, obviously, for in terms of education but we could continue to look at that. That's certainly something to consider.

Judd Hollander: Yes. And that could fit depending on the category into chronic disease or if it's acute care, you know, I don't know. I guess it depends on how we're going to focus on the three things we talked about today, to say all go and one bucket of acute care and get split out, then I think we become more broad-based than as we, you know, do the dermatology equivalent and make it eICU and neuro-stroke.

You know, in my mind, neuro-stroke is a provider to provider thing, right. And so, the hepatitis C could be provider to provider or it could be patient to provider. So, I don't know. I guess that's discussion that we'll need to have down probably face to face.

But I think it's probably the good time to change. And I think that discussion and comments from the (I.D.) society lead nicely into slide 11 which is the, you know, the current gaps. And so, I think we spend a bit of time discussing some of the gaps already but I think this is the opportunity to run though these questions and – since we don't really go and question by question order, you know, let's just take a moment and I'll read the five questions first for those that may not have slide in front of them.

What current gaps in telehealth measurement, either through a clinical area or telehealth in general, need to be considered?

Are there measure concepts that can be developed that assesses concordance between a primary care provider and a specialty provider sharing images?

What measure concepts are important in relation to the involvement of family members or other caregivers in the management of care for care coordination? And I think we've included that in our original framework discussion.

How can telehealth facilitate family-centered care? And what are the most important gaps to consider in terms of impact and how can those be prioritized?

And I think I'll take the chair prerogative, or co-chair prerogative to just throw out one thought that hasn't come up yet, and that I'm kind of surprise about, which is mostly the literature is one would expect compares, you know, outcome of in-person visit to outcome with telemedicine visit. But for many patients, particularly in the acute care setting, the option is no visit.

And so, I think one of the gaps we have across all measures is we don't – like if you're doing a clinical trial, you do standard of care and standard of care plus telemedicine.

Well, for a third of people who come to office-based practices, that's actually cancelling their appointment because they can't make it there that day or rescheduling. And so telemedicine is, hopefully, better option than not seeing anybody. And none – I guess the Care Coordination staff could take this into account a little bit, because if you don't get the appointment and don't see the provider and it's coordinated, you sort to fail as it is.

But I just think that one of the gaps I would throw out there is telemedicine sometimes needs to be compared to what the patient would do in the absence of telemedicine and in the rural hospital, clinical care access hospital, it might be, you know, a family practitioner are managing stroke without a neurovascular specialist. In office business setting, it might be missing the

office visit. And the urgent care setting it might not be getting the therapy of condition on Saturday night.

And I don't think the measures do terribly well at assessing that. I don't know a way around that, but it probably is where – somewhere in the report, I personally think making mention that it should be compared to the care to patient would otherwise receive or not as compare to another in-person visit.

And I'll open it up for discussion on all five questions and my comment.

Adam Darkins: So I got a couple of comments, one of my comments is I think the things should be based on the clear hypothesis. So, if something is put in it doesn't necessarily follow. I mean, family-centered care, yes, but what's the hypothesis that it's based on rather than just (motherhood) and (inaudible).

On the second thing, just to build up on what you just said around no care. The other issue is going to be bias. There going to be certain patients who are going to end up having telehealth, you know, give you a good example, the somebody who's very, very obese. It might well be, there would preferentially get telehealth because it becomes very difficult for somebody who's usually obese sometimes to travel, travel and otherwise.

So, I think that just speak comparison both using the intervention of telehealth against not using it. And the reasons that you said around no care but also bias. I think there should be some qualifications. So this just not crudely seen, use this, it's the only intervention. There should be some kind of just allowance made for bias.

Judd Hollander: Other comments? No one identified any gaps?

All right, I think maybe we just consider that we've mentioned them over the last, you know, hour and change.

Jason Goldwater: And also some have been sent through comments as well.

Judd Hollander: Right. So I think if no one has other things to add, we're actually, you know, 10 minutes ahead of schedule which is nice. And it's time to turn it over to May to discuss next steps.

Jason Goldwater: Right. So, actually, before we get to that we will open up that for public comments. So again, we appreciate everybody participating today as always. Thank you very much for the insightful comments. And we realize that your comments are not doing until the end of February but we really appreciate the robust discussion. And so just lead to really a very solid framework. And I think we're all very pleased and excited about that because the impact that it could have could be significant.

So, at this time, we'll open it up for public comment. Operator, can you please do that.

Operator: Yes. This time if you want to make a comment please press star then the number one.

At this time, there were no public comments.

Jason Goldwater: OK, there was also a – there was a comment made me as a web, again, by IDSA on potentially examining articles on using telehealth to administer antimicrobial stewardship programs. So, that might be something that may look into.

Judd Hollander: And that's actually interesting because there's probably a lot of measures related to that. And anecdotally, although it's unpublished – it's not actually anecdotally. We have the data but it's not yet published.

So without divulging too much of the numbers, we've actually compared adherence to antibiotics stewardship numbers following the choosing wisely campaigns with the same set of providers who function in the E.D. and urgent care and telehealth land. And they actually the best in telehealth land.

And our hypothesis, it's because the patient have invested less time so they actually don't mind not getting antibiotics but have to wait four or five hours

in the E.D., hell, you ain't going home without antibiotic so you're throwing food at somebody.

So, it turns out that – it probably, I'm sure there's lot of measures on antibiotic stewardship. And so, I think that's actually, probably, an important comment that we didn't get at, but might actually fall into measures in the acute care space.

Jason Goldwater: So, as Judd as you may and as others of the committee as you may or may not know that NQF just finished antibiotic stewardship playbook that was grant funded and that IDSA and others were heavily active in. So, we could certainly go to that for some source materials. And we – the principle investigators are just down the hall from Katie, so we can go talk to them.

Judd Hollander: Great.

Jason Goldwater: All right. So now I will turn it over to May for next steps. So, go ahead.

(Off-Mic)

May Nucion: ... next one. This is again are just an overview slide of our timeline. And as you know we are – we have completed our draft environmental scan progress. We are in our committee web meeting and then our next in-person meeting will be on March 7-8, and now, go back ...

(Off-Mic)

May Nucion: (Key) dates, our in-person meeting March 7-8. We will start at 8:30 end at 4:30. For the second day, we will end at 2:30. We will then have two more web meetings that we will continue to discuss and advice our measurement by next report.

If you haven't succeeded your travel arrangements from the NQF Meetings Department, please do let us know, especially if you are having any troubles or anything like that. And we would prepare you to RSVP by March 1st.

Judd Hollander: So, I think we have now finished 37 minutes early which should give everybody time to go buy flowers and cards, because there's no coming home with a Valentines day gift.

Jason Goldwater: Judd, you're man after my own heart so, yes. Everybody has plenty of time to go take care of their last minute procrastinating on Valentines Day gifts.

So, I wish everybody a very – not me, I think we all here at NQF wish you all a very Happy Valentines Day. I hope that you do something special today, one way or the other. And we are really looking forward to seeing you all on March.

I should let you know that May describes herself as an introvert. So, I told her that will not work with our committee. So, we'll have to work on that when we all meet her. She and Irvin are both (inaudible), we're very fortunate to have them. And I know you'll like them as well.

So, we look forward to seeing you all. Have a great, great day. And we'll talk to you all soon.

Female: Thank you.

Male: Thank you.

Judd Hollander: Bye-bye.

Male: Bye.

Male: Thanks everybody.

Jason Goldwater: Bye-bye.

END