

NATIONAL QUALITY FORUM

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TELEHEALTH MULTISTAKEHOLDER COMMITTEE

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CREATING A FRAMEWORK TO SUPPORT MEASURE

DEVELOPMENT FOR TELEHEALTH

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TUESDAY,
MARCH 7, 2017

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The Telehealth Multistakeholder Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, NW, Washington, DC, at 9:00 a.m., Judd Hollander and Marcia Ward, Co-Chairs, presiding.

PRESENT:

JUDD HOLLANDER, MD, Co-Chair; Associate Dean for Strategic Health Initiatives; Vice Chair, Finance and Healthcare Enterprises, Sidney Kimmel Medical College, Department of Emergency Medicine, Thomas Jefferson University

MARCIA WARD, PhD, Co-Chair; Director, Rural Telehealth Research Center, University of Iowa

DALE ALVERSON, MD, Medical Director, Center for Telehealth, University of New Mexico Health Sciences Center

ADAM DARKINS, MB, ChB, MPH, MD, FRCS, Vice
President for Innovation and Strategic
Partnerships, Americas Region, Medtronic
Plc., Medtronic

HENRY DePHILLIPS, MD, Chief Medical Officer,
Teladoc, Inc.

CHARLES DOARN, MBA, Professor, Family and
Community Medicine, University of
Cincinnati

MARYBETH FARQUHAR, PhD, MSN, RN, Vice President,
Quality, Research & Measurement, URAC

ARCHIBALD (STEWART) FERGUSON, PhD, Chief
Technology Officer, Alaska Native Tribal
Health Consortium

DAVID FLANNERY, MD, Medical Director, American
College of Medical Genetics and Genomics

PAUL GIBONEY, MD, Director of Specialty Care,
Los Angeles County Department of Health
Services

NATE GLADWELL, RN, MHA, Director of Telehealth
and Telemedicine, University of Utah
Health Care

DON GRAF, National Telehealth Director,
UnitedHealthcare

JULIE HALL-BARROW, EdD, Vice President, Virtual
Health and Innovation, Children's Health,
Children's Medical Center

STEVEN HANDLER, MD, PhD, CMD, Associate
Professor, Chief Medical Informatics
Officer, University of Pittsburgh Medical
Center

Yael HARRIS, PhD, MHS, Senior Health Researcher,
Mathematica Policy Research

KRISTI HENDERSON, DNP, NP-C, FAAN, FAEN, Vice
President, Virtual Care & Innovation,
Seton Healthcare

MARY LOU MOEWE, MT (ASCP), PMP, ACP, FACHE,
CPHIMS, Director of e-Health Initiatives,
State of Tennessee, Department of Health
Care Finances and Administration (HCFA),
Medicaid, State of Tennessee

EVE-LYNN NELSON, PhD, Director & Professor, KU
Center for Telemedicine & Telehealth,

University of Kansas Medical Center
 PETER RASMUSSEN, MD, Medical Director, Distance
 Health, Cleveland Clinic
 SARAH SOSSONG, MPH, Director of Telehealth,
 Massachusetts General Hospital
 DANIEL SPIEGEL, National Director of Home
 Hemodialysis, DaVita Healthcare Partners
 Inc.
 DENNIS TRUONG, MD, Director of
 Telemedicine/Mobility and Assistant
 Physician-In-Chief, Kaiser Permanente Mid-
 Atlantic States
 ANGELA WALKER, MD, FAAD, Direct Dermatology,
 Science 37

NQF STAFF:

SHANTANU AGRAWAL, MD, President and CEO
 HELEN BURSTIN, MD, MPH, Chief Scientific Officer
 JASON GOLDWATER, MA, MPA, Senior Director,
 Quality Measurement
 TRACY LUSTIG, DPM, MPH, Senior Director
 ELISA MUNTHALI, MPH, Vice President, Quality
 Measurement
 MAY NACION, MPH, Project Manager
 IRVIN SINGH, MPH, Project Analyst
 KATHRYN STREETER, MS, Senior Project Manager
 MARCIA WILSON, PhD, MBA, Senior Vice President,
 Quality Measurement

ALSO PRESENT:

GIRMA ALEMU, MD, MPH, Office of Health
 Information Technology and Quality, Health
 Services Administration
 MEGAN MEACHAM, MPH, Public Health Analyst,
 Federal Office of Rural Health Policy,
 Health Resources and Services
 Administration
 SYLVIA TRUJILLO, MPP, JD, Senior Attorney,
 Legislative Counsel Division, American
 Medical Association
 MATTHEW QUINN, MBA, Senior Advisor for Health
 Information Technology, Health Resources
 and Services Administration

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P-R-O-C-E-E-D-I-N-G-S

9:04 a.m.

MR. GOLDWATER: I am sincerely, and I honestly mean this, sometimes I have to fake that, the sentiment at meetings, but I'm honestly thrilled to see all of you. We have eagerly been waiting this -- Dale, I'm serious, really.

I have been -- we've been eagerly waiting and anticipating this meeting. I think the last time we all got together, there were three of us: Tracy, Katie, and myself. We've added two new team members who will introduce themselves later.

And I think we've hyped you up so much, I don't see how you're ever going to meet the expectations that we've set. We've said, this is probably the most lively, entertaining, intelligent, passionate group we have at NQF. And I don't know -- I, honestly, I'm serious. So we're really happy to see you all.

We have a lot to do in the next couple of days, but we're incredibly confident we're

1 going to get it done. Also, as you will notice,
2 our new CEO is here, Shantanu is here. Helen
3 Burstin is here, our Chief Medical Officer --
4 Scientific Officer, sorry. And also, resident
5 MD, besides Shantanu. Marcia and Elisa are there
6 in the back, and myself. So let the fun begin,
7 with all of us being here in one place.

8 So what we're going to do is spend
9 just a couple of minutes, I think Shantanu has
10 some opening remarks, and then we'll do some
11 welcome and introductions. And then, Irvin
12 Singh, who is one of our newest, and I will go
13 over the project and purpose, and we'll talk
14 about a measure framework and what we need to do
15 for this next couple of days. So Shantanu, I'll
16 turn it over to you.

17 DR. AGRAWAL: Awesome, thank you. That
18 is a lot of hype. I'm very excited about the
19 meeting. I will tell you that pitching you as
20 the smartest, most excited is going to offend the
21 pediatricians who were here last week.

22 (Laughter.)

1 DR. AGRAWAL: I'm going to tell them
2 about that because they were pretty excited to do
3 their work as well. This is a great topic. I'm
4 really glad that you all are here; the amount of
5 expertise around this table is just incredible.

6 Telehealth is, I would say it's the
7 future, but it's really the current that will
8 lead into the future. It's important, far
9 beyond, I think we often think of it as a rural
10 health issue. It is not just a rural health
11 issue, and I think it fundamentally is one of the
12 ways in which we want to interact with our
13 physicians and other providers going forward.

14 It's sort of, when you think about
15 building practices around the patient, telehealth
16 and real-time communication with your doctor is
17 just really central to that. So great topic. I
18 want to thank deeply our two co-chairs, Marcia
19 Ward and Judd Hollander. I just got to meet
20 Marcia today. I've, unfortunately, known Judd
21 for a while.

22 (Laughter.)

1 DR. AGRAWAL: Judd was my attending
2 when I was a trainee at Penn. He was one of our
3 legendary attendings. I truly enjoyed working
4 with him, very smart guy. We always loved
5 working with Judd because he would sit in the
6 back and let you take care of the patient your
7 way.

8 The only time he would intervene is if
9 you were doing something stupid. It was what I
10 call my first experience in telehealth, because
11 I'd have to go all the way to the back of the ER
12 to talk to the doctor and let him know what I was
13 doing and then all the way back to the patient.

14 (Laughter.)

15 DR. AGRAWAL: But I'm deeply
16 appreciative of their leadership. And without
17 further ado, we'll get this started.

18 MR. GOLDWATER: Well, I don't know
19 about anybody else, but NQF definitely wants to
20 hear those stories, Judd. So let me turn it over
21 to our two co-chairs, who we've been
22 communicating with rather frequently over the

1 last couple of months in preparation for this
2 meeting. Judd and Marcia, do you have a few
3 words?

4 CO-CHAIR HOLLANDER: Welcome back,
5 thank you for all your hard work and this is the
6 long day and a half. So I think our challenge, I
7 was, actually I wasn't joking: when Jason laid
8 out what we were going to do, I said I don't know
9 how we're going to kill a day and a half doing
10 that. Then he sent us the draft of the slides,
11 and I said, is it four days?

12 So I apologize in advance when we cut
13 people off, but we're going to try and get
14 everybody engaged and get to the bottom line
15 here, but we really have a pretty robust amount
16 of work to get done in a short period of time.
17 So Marcia will be the heavy, and I'll be the nice
18 person, as I'm sure you expected.

19 CO-CHAIR WARD: Seriously, I want to
20 welcome everybody. And given the tone of the
21 meeting and the productivity of the meeting that
22 we had in the fall, I'm really optimistic that

1 we'll be able to build on that and get something
2 done today.

3 MR. GOLDWATER: Okay. So just a few
4 logistics. I know it's been a little while since
5 we've seen each other. The restrooms, for those
6 who will need them, you exit the main conference
7 area; they're past the elevators on your right.

8 We will be taking breaks throughout
9 the day. First one will be at 10:30, and then
10 we'll have lunch, which will be provided. And
11 then another break at 3:00 p.m.

12 At the end of every meeting and at
13 various points in between, we will be opening
14 this up for public comment. As you all know,
15 there are people in the back, and there are
16 people that will be listening in that will surely
17 be having comments, especially now that we are
18 building the framework.

19 The wifi network, the user name and
20 password are in front of you. Please mute your
21 cell phone at all points during the meeting;
22 otherwise, it will interfere with the meeting, as

1 well as with the transcription.

2 When you are speaking, as you all
3 know, please hit the speak button on your mic;
4 otherwise, the transcriber will not be able to
5 hear you, even if the rest of us do.

6 And as it was last time, if at some
7 point you have a question or discussion point,
8 just put your tent card up like this. I will
9 probably be organizing the questions so Marcia
10 and Judd can run the meeting effectively, but
11 please put your tent card up so I know when to
12 call on you.

13 The purpose and objectives and what
14 we're going to do we're going to get into a
15 little bit later, but for now, I'd like the NQF
16 team and staff to be introducing themselves, and
17 then we'll have everybody else follow through
18 with introductions, apart from Shantanu, who has
19 already done this. So we'll start with Helen.

20 DR. BURSTIN: Good morning, everybody.
21 Helen Burstin, Chief Scientific Officer here.

22 DR. LUSTIG: Hi, I'm Tracy Lustig, a

1 Senior Director.

2 MS. STREETER: Hi, I'm Katie Streeter,
3 Senior Project Manager.

4 MR. SINGH: Good morning, everybody.
5 My name is Irvin Singh, and I am the Project
6 Analyst for NQF.

7 MS. NACION: Hello, and I'm May Nacion.
8 I'm the Project Manager.

9 MS. MUNTHALI: Good morning, Elisa
10 Munthali, Vice President for Quality Measurement.

11 DR. WILSON: Good morning, Marcia
12 Wilson, Senior Vice President, Quality
13 Measurement.

14 MR. GOLDWATER: Okay. Thank you very
15 much. And now we'll start with the rest,
16 starting with you, Megan.

17 MS. MEACHAM: Hi, I'm Megan Meacham.
18 I'm with the Federal Office of Rural Health
19 Policy.

20 MEMBER DOARN: My name is Chuck Doarn,
21 a Professor at the University of Cincinnati.

22 MEMBER HALL-BARROW: Hi, Julie Hall-

1 Barrow, Children's Health in Dallas.

2 MEMBER SOSSONG: Sarah Sossong, Mass
3 General Hospital in Boston.

4 MEMBER ALVERSON: Good morning, Dale
5 Alverson, Medical Director, Center for
6 Telehealth, University of New Mexico.

7 MEMBER FERGUSON: Good morning, Stewart
8 Ferguson, Alaska Native Tribal Health Consortium.

9 MEMBER FLANNERY: I'm David Flannery.
10 I'm Medical Director with American College of
11 Medical Genetics and Genomics. But prior to
12 that, I did telemedicine since 1995 in Georgia
13 and served on many boards. And by way of
14 disclosure, I'm on the board of Salus Telehealth,
15 which is a start-up in telemedicine.

16 MEMBER HARRIS: Yael Harris,
17 Mathematica Policy Research.

18 MEMBER TRUONG: Good morning, Dennis
19 Truong, Telemedicine Director at Kaiser
20 Permanente.

21 MEMBER HANDLER: Good morning, Steve
22 Handler, University of Pittsburgh MC.

1 MEMBER GLADWELL: Good morning, Nate
2 Gladwell, Telehealth and Outreach, University of
3 Utah Health Care.

4 MEMBER NELSON: Good morning, Eve-Lynn
5 Nelson, University of Kansas Medical Center.

6 MEMBER DARKINS: Good morning, Adam
7 Darkins, Vice President of Innovation and
8 Strategic Partnerships, Medtronic.

9 MEMBER SPIEGEL: Good morning, Daniel
10 Spiegel, DaVita.

11 MEMBER HENDERSON: Kristi Henderson,
12 Ascension Texas and UT Dell Medical School.

13 MEMBER FARQUHAR: Good morning. I'm
14 Marybeth Farquhar. I'm from URAC in Washington,
15 DC.

16 MEMBER DEPHILLIPS: Good morning, Henry
17 DePhillips, Chief Medical Officer at Teledoc.

18 MEMBER WALKER: Angela Walker from the
19 American Academy of Dermatology.

20 MEMBER MOEWE: Good morning, Mary Moewe
21 from the State of Tennessee e-Health Department.

22 MEMBER GRAF: Don Graf, National

1 Telehealth Director, UnitedHealthcare.

2 MEMBER GIBONEY: Good morning, Paul
3 Giboney, Los Angeles County Department of Health
4 Services.

5 MR. GOLDWATER: All right. I think
6 that does it for everyone around the table. So,
7 what we're going to do now is just go over the
8 project purpose and objectives. Irvin is going
9 to lead that discussion. And then we'll talk
10 about what is a measure framework and what our
11 tasks are in front of us for the next day and a
12 half. So Irvin, take it away.

13 MR. SINGH: Thank you, Jason. So I
14 just want to go over the four goals that we want
15 to achieve in the telehealth project and to sort
16 of guide the discussions on how we're going to
17 move forward for the next couple of days for our
18 in-person meeting.

19 So the first objective that we have is
20 to identify the most optimum way to attach the
21 pertinent clinical measures to telehealth
22 encounters and how we can leverage those

1 experiences as we guide the development of the
2 telehealth measurement framework.

3 And then, going further, we would like
4 to do a thorough review of the telehealth
5 measures that are currently in existence and
6 assess the direction of where we should take
7 things from here with regards to the future
8 telehealth measurement development.

9 And the third objective that we'd like
10 to achieve is to discuss any telehealth
11 measurement gaps that are currently in existence
12 and find ways to develop the framework that could
13 potentially address gaps that could arise in the
14 future and how the framework can accommodate
15 them.

16 And then, finally, our fourth central
17 aim for the telehealth project is to find how
18 existing measures can fit the telehealth
19 measurement framework that we're going to
20 develop, as well as future-proof it as much as
21 possible so that we can make it applicable to the
22 telehealth measures that can be produced in the

1 future.

2 And just sort of one of the central
3 themes that we want to keep in mind is to find
4 ways to make the telehealth measurement framework
5 actionable and have immediate impact, as soon as
6 we discuss how we can implement it. So this
7 diagram here sort of represents where we -- how
8 we've been carrying the project forward, as well
9 as how we're going to see it as it progresses
10 forward.

11 And I just want to take the time to
12 just thank everybody for their high level of
13 participation throughout the project as we were
14 able to get a lot of valuable insight through
15 reviewing the environmental scan, through our
16 webinars that we've been having, and in providing
17 those test use cases. They've all provided a lot
18 of valuable intel on how we can further refine
19 the measurement framework.

20 So we, as you all know, we sent out
21 the environmental scan that had all the criteria
22 of what we were looking for, in at least

1 establishing that baseline of what the
2 measurement framework would look like. And then
3 we aggregated all of the comments as of February
4 28th and produced another iteration of the
5 environmental scan framework, which you all
6 should have received.

7 And then we're going to take all of
8 the discussion points that we're going to gain in
9 the next couple of days in the telehealth in-
10 person meeting and then come up with a second
11 official iteration of the draft March 31st. And
12 then Jason's going to take it from here to
13 discuss the actual structure, core structure of
14 the measurement framework.

15 MR. GOLDWATER: Okay. So I'm really
16 happy that I was able to meet with Helen last
17 week.

18 DR. BURSTIN: It's a great diagram.

19 MR. GOLDWATER: Thank you.

20 (Laughter.)

21 MR. GOLDWATER: I basically took your
22 scribbles on the board and made it into a diagram

1 about what a measure framework is. So the last
2 time we all go together, what we really did was
3 sort of set the course for what this meeting was
4 going to be and what the end product of it was
5 going to be and to help inform the environmental
6 scan. So we finished the environmental scan, at
7 least the most current iteration, which you all
8 received yesterday.

9 I understand that we got some comments
10 just a couple of days ago, and other articles
11 have now been published, so I want to let you all
12 know, we haven't just ignored you. We are going
13 to be looking at those and potentially
14 incorporating them, but we wanted to go through
15 the first iteration of this, which incorporated
16 all of the articles we initially scored. And we
17 finished with the comments that we received from
18 all of you, thank you very much, as well as from
19 the government, thank you, Megan, and your team.

20 And now we're going to spend the next
21 day and a half really focused on developing a
22 measure framework. And a framework -- and,

1 Helen, if I get this wrong, just tell me -- is a
2 real way of organizing concepts, ideas, and
3 thoughts around the ways of measuring telehealth
4 and to be able to identify existing gaps and
5 develop concepts to hopefully fill those gaps.

6 So the framework begins by identifying
7 domains that are highly relevant and applicable
8 to telehealth. And some of those, we've already
9 done. In fact, we've already listed domains that
10 you all thought were important the last time we
11 met, which included access to care, cost and
12 cost-effectiveness, patient and clinician
13 experience, and so forth.

14 So we had actually done the first part
15 of this, where we have the domains. And what we
16 need from all of you is to really try to work
17 with us to identify, out of all of those domains,
18 which ones are really the most important.

19 I realize we all think they're all
20 important, and I don't want to ignore them, but
21 we need a framework that's actionable, and if we
22 have something that's as big as the Titanic, it's

1 not -- it's going to sink eventually. So we want
2 something that is highly actionable, highly
3 relevant, and highly usable.

4 And out of each one of those domains,
5 so access to care, if that's a domain, then we're
6 going to work to identify subdomains. So, what
7 categories would fit under access to care? What
8 are relevant issues that really pertain to that?

9 And once those subdomains are
10 identified, then identifying measures and measure
11 concepts. So what measure concepts could we talk
12 about around access to care? And a concept is a
13 representation of a measure that may not exist
14 yet or an idea that we need to create.

15 And so, where or how could we develop
16 concepts around different domains under access to
17 care that would provide a way of measuring it?
18 And then we'll turn our attention to the measures
19 that we've already identified to see which one of
20 those measures do you think would fit within this
21 framework?

22 So again, it's a way of organizing our

1 thoughts so that when the report is released, it
2 will then provide sort of a blueprint or a
3 template of sorts for people to look at and say,
4 we can develop measures around access to care or
5 patient and clinician experience; here are the
6 relevant domains, sub-domains, and concepts; how
7 do we take those concepts and build them into
8 measures; and what measures already exist that we
9 could already use?

10 So the last time around, I did most of
11 the facilitating, which I'm apt to do. And that
12 was really because we needed to sort of set the
13 foundation. We needed to sort of -- how we were
14 going to build the house, so to speak. But now
15 we're getting to the point where we're building
16 the framework, and that really needs to come from
17 all of you.

18 The reason you were all chosen, the
19 reason you all are here, is to build this for us.
20 And so it really needs to be a representation of
21 the Committee. So this time around, Judd and
22 Marcia have graciously agreed to facilitate the

1 meeting and be your cruise directors for the next
2 two days. Which, since Chuck is here, is going
3 to be incredibly difficult to do. But --

4 (Laughter.)

5 MR. GOLDWATER: You didn't think you
6 were going to get away with this scot-free, did
7 you, Chuck?

8 (Laughter.)

9 MR. GOLDWATER: Yes, go ahead. Sure.

10 DR. BURSTIN: So that was perfect, what
11 Jason described. I want to put it in a little
12 more terms that are a bit more action-oriented.
13 People always think the concept of measurement
14 framework sort of falls flat. So we'll have a
15 framework at the end of this; how is this useful?

16 And tie it to a comment Judd made to
17 us when we were saying hello earlier, which is, I
18 can tell you what three measures I want, but I'm
19 not sure what the framework is. Again, the idea
20 would just be, what's sort of the balanced
21 scorecard of how you're going to evaluate the
22 access to and quality of telehealth.

1 If you want to work backwards and say,
2 I have a sense of what the most important
3 measures would be and then think about how to
4 categorize them, that's fine. It's really just a
5 way of figuring out what you want to ultimately
6 measure telehealth on.

7 If it's easier for you to think about
8 it in terms of, hey, I would like to think of the
9 following measures, we could then help you figure
10 out what the actual picture looks like in terms
11 of the domains and the subdomains, but we want to
12 make sure that at the end of the day, we're not
13 having telehealth measured, for example only on
14 cost or only on access.

15 But you want to get more of that
16 balanced perspective of what are the key things
17 you want to always measure about the quality of
18 telehealth and access to telehealth, such that
19 you feel like you have a good sense overall of
20 how it's adding value to the healthcare system.

21 And again, I think that balance
22 concept is really important for a framework, that

1 we're not just focusing on one domain; we really
2 want to make sure we're getting that full picture
3 of the overall quality of how it's contributing.

4 MR. GOLDWATER: Thank you, Helen,
5 that's great. So, we'll have Judd and Marcia
6 sort of lead it from this point on. The NQF team
7 will be here to answer questions, facilitate in
8 terms of identifying when people want to talk or
9 make comments.

10 Really, what we need by the time this
11 meeting ends tomorrow is we need a very solid
12 understanding of what this framework needs to
13 look like so that we can then go and write it,
14 and that there's no ambiguity; there's no
15 confusion; there's nothing that is not clear.
16 That we have a very clear understanding of what
17 it is you all want to see, what you think is
18 going to work, and what you think is needed.

19 And then we will then take all of
20 those thoughts and ideas, outline them, and write
21 the report and give you something else to read.
22 Because clearly, what would we be doing if we

1 weren't giving you something to read? And then,
2 continuing to work through that, through a couple
3 of additional webinars and some edits before it
4 goes out to the public for their comment, and
5 then it is finally released.

6 So really, this is all about you,
7 which I know you love, Henry, and it's all about
8 really your feedback and your insight and all of
9 your expertise helping to build this. So we're
10 really looking forward to this; everything that
11 we've been doing has really led up to this point
12 right now.

13 So with that in mind, I will turn it
14 over to our fabulous co-chairs to lead the rest
15 of the way. And we will stay back. If we have
16 any questions, we'll be sure to interject to ask
17 them, to make sure we're getting something very
18 clear.

19 And there's going to be points in the
20 meeting we're going to break you all out into
21 smaller groups, because that will be more
22 effective than having everyone debate 15

1 subdomains under access to care, which I'm not
2 saying we're going to have that many, but it's
3 more effective when we work in smaller groups and
4 report out. All right.

5 CO-CHAIR HOLLANDER: All right. So
6 Marcia and I agreed to sort of alternate by
7 sections. I'm relieved we're ahead of schedule,
8 but I'm actually doing some simple math. We have
9 13 slides with five to seven bullet points on
10 them each; we were allotted a half an hour for
11 discussion of them. We now have an hour.

12 But these are a summary of the
13 environmental scan reports, so if you're just
14 reinforcing a comment that's on the slide, keep
15 it quiet. If you vehemently disagree with a
16 suggestion, then, obviously, voice it. And
17 otherwise, we're just going to run through the 13
18 slides and make sure we have consensus.

19 There are some of the things that I
20 think are worthy of, just my own opinion, worthy
21 of a little more discussion. Since it requires
22 extra work that's not in the current report, we

1 should make sure we think it's worthwhile or not.
2 But let's look at this as ways to give the
3 insiders at NQF feedback on what needs to be
4 changed in the report; let's not concentrate on
5 typos and extra references and things like that.

6 So basically, I'm going to look at the
7 slides in front of us and go through them line-
8 by-line. So there was some discussion about
9 broadening the definition of telehealth. I think
10 there was a decent bit of discussion about the
11 implications of telehealth, as Shantanu said to
12 begin, extending beyond rural areas, and so I
13 think that's important.

14 I don't know how much, but it doesn't
15 really hurt to differentiate between telehealth
16 and telemedicine. I'm kind of a lumper rather
17 than a splitter, but whatever people do there
18 seems okay.

19 Here's a really additional work item
20 for staff, is expanding it beyond areas that the
21 report focused on and the suggested areas here
22 are eICU, acute care, neuro-stroke, urgent care,

1 on-demand care, et cetera. We probably have to
2 define et cetera, because that's not really good
3 guidance, saying do et cetera.

4 But I think this is probably a place
5 we should pause and, as I look at this, there's
6 two pathways that could evolve. They left this
7 out, presumably, because there wasn't a ton of
8 evidence that made it get included.

9 So what do we do in an area that we
10 think is really important, but might not have the
11 same number or quality of evidence as some of the
12 areas that were included in the report? And I
13 think this is an area worth a couple minutes of
14 discussion to give guidance, because it obviously
15 impacts how the framework gets developed and
16 whether or not it would be easily applied to
17 these areas. So go.

18 MEMBER DOARN: So would the report
19 actually have a narrative in there about defining
20 telehealth/telemedicine?

21 CO-CHAIR HOLLANDER: Yes, I think we've
22 suggested that.

1 MEMBER DOARN: So, is it going to be
2 the NQF definition? HHS? DoD? There are six
3 different definitions within HHS, so how do you
4 kind of circle the wagons around a definitive
5 definition, because telemedicine and telehealth
6 are not exactly the same thing?

7 MR. GOLDWATER: Correct. So the
8 definition that we used was the HHS definition
9 that came from the Department and HRSA in a
10 report to Congress that I believe was 2001. And
11 that was the definition we used.

12 MEMBER DOARN: So I think when you --
13 in the narrative, then, because it will go out
14 for public consumption, I think it's probably
15 wise to at least reference the fact that there
16 are multiple different definitions across the
17 federal space, and even companies have their own
18 as well. I mean, the ATA has one, Institute of
19 Medicine, and so forth.

20 So I think it's very important to at
21 least -- if you're citing that you're using HHS,
22 and that's the one Congress likes, that's fine,

1 but a lot of the other agencies, and that's the
2 paper we wrote a couple years ago, is that by
3 legislative intent, the definitions are different
4 in a couple of key agencies or departments.

5 CO-CHAIR HOLLANDER: Okay. Henry?

6 MEMBER DEPHILLIPS: Just a couple of
7 quick comments, not going to pile on. With
8 respect to the et cetera reference, probably
9 every specialty in healthcare could have a
10 component delivered by telemedicine, so it might
11 be a bit of a comprehensive list. Behavioral
12 health should probably be named; that's a huge
13 gap in our country.

14 The second to last bullet, I think the
15 question mark can go away. I think the
16 quantification of cost is a very important part
17 of being able to measure its success.

18 And the last bullet actually gets to
19 the question I was trying to ask on the last
20 phone conference among us, and that is, the cost
21 of telehealth versus a face-to-face visit, I kind
22 of see telemedicine or telehealth as an extension

1 of the care that everybody gives today.

2 And so I'm wondering if we could frame
3 that also to include the cost of healthcare
4 delivered without the benefit of telemedicine
5 versus the comprehensive healthcare delivered
6 with telemedicine?

7 CO-CHAIR HOLLANDER: So usual care
8 versus usual care plus telemedicine?

9 MEMBER DEPHILLIPS: Exactly.

10 CO-CHAIR HOLLANDER: Okay. Steve?

11 MEMBER HANDLER: So I mentioned in my
12 comments that we should consider post-acute and
13 long-term care and provided some evidence for
14 that in my comments. So with regard to that
15 bullet point third from the bottom, with the i.e.
16 additional sites of care, that's what I was
17 suggesting.

18 I also mentioned the framework, just
19 in thinking about this in the terms of the
20 transitions of care, we could think about
21 settings of care, because we talked about that in
22 terms of the transitional care concept or

1 construct. And I agree, you could list every
2 specialty, right, so we kind of keep on circling
3 around this issue.

4 We could do it by specialty; we could
5 do it by location, physical location, et cetera,
6 but I think we probably need to really figure
7 this out as a group how we're going to do that.
8 It's going to keep on coming at us until we do
9 that.

10 CO-CHAIR HOLLANDER: Marcia?

11 CO-CHAIR WARD: Getting back to Jason's
12 comment about evidence, so people that have been
13 involved in systematic reviews, meta-analyses,
14 you go out and you gather all the studies that
15 have been published, and if you're doing it on a
16 disease category and a treatment, a drug
17 treatment, what you find is the old drugs have
18 lots and lots and lots of studies on them,
19 because they've been available for 20 years, and
20 the newer, maybe fabulous, drugs only have a
21 handful of studies.

22 So I think we have to keep that in

1 mind. We don't want to get too locked into how
2 much evidence is there supporting something,
3 because it's going to be supporting older
4 technology. So we just, I think, need to keep
5 that in mind and not get locked into the evidence
6 or the amount of evidence has to drive our
7 framework going forward.

8 CO-CHAIR HOLLANDER: Angela?

9 DR. BURSTIN: And maybe just a quick
10 response to Marcia, because she's absolutely
11 right. I think, in some ways, it's not so much
12 what you have now, but again, the framework is
13 all about how you're going to be able to build
14 this for the future.

15 So you may not have data right now or
16 evidence that reflects this split, but you want
17 to be able to ensure that the framework and the
18 concepts you put forward identify it as an issue,
19 so that the work does happen. So I couldn't
20 agree more.

21 CO-CHAIR HOLLANDER: Angela?

22 MEMBER WALKER: Yes. I think, getting

1 back to what Steve had said and then also
2 considering the future of this, the organization
3 that we create right now in identifying the
4 framework is going to be of great importance.

5 If we can be very transparent about
6 that and include a narrative on how we did it and
7 think about where these might fit, they're
8 probably similar to some already with evidence in
9 our framework, and the ones that aren't, if we at
10 least have the organizational structure in mind,
11 we can, at that point, figure out where they fit
12 in.

13 CO-CHAIR HOLLANDER: Right. And to
14 that end, I think, and you put together a nice
15 graphic or table. I don't know if that's on a
16 subsequent slide. We can send that around at
17 some point later, trying to summarize it.

18 One of the dilemmas is, as you're
19 mapping out a framework, how much of a framework
20 is broad and how much is specific? And I think a
21 lot of us have gotten down to, oh, it's
22 telestroke, teledermatology, telepsych, and it's

1 really not teleCOPD and teleasthma and
2 telepulmonary and telecardiology, it's actually a
3 scheduled visit with your provider from a
4 location somewhere.

5 And I think it would behoove us if we
6 got over the fact that a use case is a disease,
7 but it's communication between Person A and
8 Person B and maybe a site of service to be
9 included as well, and looked at it more broadly.

10 Of course, the evidence isn't
11 provider-to-provider, the evidence is neuro-
12 stroke or eICU, but the data for neuro-stroke or
13 eICU may fit, in my mind, within a provider-to-
14 provider framework. The evidence for an
15 asthmatic or pediatrics or dermatology may be
16 synchronous or asynchronous, but fit within a
17 consumer-to-provider framework.

18 And so it's hard to balance how
19 specific we get, but I think the more we can
20 apply the disease-specific things to a broader
21 use case, the better off we're going to be at
22 creating a framework. And, again, just one man's

1 opinion. Yes, Sarah?

2 MEMBER SOSSONG: And I think this is
3 getting to your point. On the last call, we
4 talked about a framework that would break down
5 into four areas: the clinical settings, so we
6 talked about the ED; post-acute; I think to some
7 of the comments here, the acuity, and that gets
8 to telestroke, so acute/non-acute; and then the
9 modality, the synchronous/asynchronous. And so,
10 are we going to have separate session where we
11 spend more time on the framework?

12 CO-CHAIR HOLLANDER: Yes, we will.

13 MEMBER SOSSONG: Okay.

14 CO-CHAIR HOLLANDER: Yes. Yael?

15 MEMBER DARKINS: I was just going to
16 say, the issue of evidence, I think, is difficult
17 in this sense. Are we intending to create a
18 framework which is prescriptive, or are we -- a
19 frame that's permissive?

20 If we end up saying this is around
21 evidence, and piecemeal, every single area is
22 going to have to develop evidence, this thing is

1 going to die in its tracks. If what we say is,
2 the evidence shows that delivery of healthcare in
3 different settings across the continuum, using
4 this technology, is -- there is evidence for it,
5 and we use that to create the framework, surely,
6 I think what we want to do is to help access.

7 So if somebody is a provider, let's
8 say in a small rural area or in an inner city
9 area where there's an access problem, we want to
10 create a framework. They can then modify
11 services and develop them according to the
12 framework, not the fact that they end up saying,
13 we'd love to do this, but there's this
14 prescriptive thing which is now telling us,
15 unless all this applies. Do I make sense there?
16 So I think --

17 CO-CHAIR HOLLANDER: Yes. Yael?

18 MEMBER HARRIS: So, I just wanted to
19 focus on the first couple of locations. When we
20 talk about broadening the definition of
21 telehealth, I don't know if we necessarily need
22 to define telehealth. There's been so many

1 efforts to do so, we could spend the entire day
2 just doing that.

3 And I don't know if the framework
4 needs that level of clarity, because telehealth
5 is constantly evolving, as we mentioned. So
6 defining it means we're limiting what this
7 framework is capable of doing.

8 And then that feeds into the issues of
9 telehealth versus telemedicine. I think we
10 should pick a term like e-care, because
11 telehealth and telemedicine assumes you're
12 providing care to a patient. Remote monitoring
13 is care to a patient, but it's not directly
14 providing.

15 And then, mobile health is an
16 increasingly growing area, and mobile health is
17 not necessarily face-to-face or sending your
18 vitals to someone else. There's also Project
19 ECHO, which is -- is that telehealth?

20 So I think, I don't want to undermine
21 the report, but I think spending time defining
22 telehealth or separating telehealth and

1 telemedicine undermines the evolving nature of
2 this technology.

3 And then, I wanted to address the
4 second bullet, which is beyond the rural setting.
5 And I wanted to say, beyond a specific, any
6 setting. So you talk rural, urban, but you also
7 talk home, on-the-go.

8 So I just wanted to put that out
9 there, which I know with rural, we're talking
10 about Medicare reimbursement, but I really think
11 -- Medicare reimbursement is the slowest part of
12 this; we're looking at how the private sector is
13 reimbursing this. And presently, Medicaid is
14 reimbursing this, and they're not limited by
15 rural versus non-rural.

16 CO-CHAIR HOLLANDER: Good points.
17 Adam, are you up to talk again? So Don?

18 MEMBER GRAF: I just wanted to comment
19 to something that you'd said earlier. That one
20 of the litmus tests to the successful framework
21 is really, to the extent that we can replicate
22 that in-person and not concentrate on the service

1 delivery model and that the quality metrics that
2 already exist shouldn't be disregarded. So
3 rather than trying to create something new, let's
4 keep our eye on the target here.

5 CO-CHAIR HOLLANDER: Okay. So I think
6 we're going to move on to the next slide, and
7 we're probably going to have the same discussions
8 on each of the next 13 slides. But I think, if I
9 could --

10 (Laughter.)

11 CO-CHAIR HOLLANDER: But I think I
12 could summarize what I think I'm hearing, which
13 is, despite Chuck actually starting out by
14 saying, let's pick a definition and define it and
15 acknowledge other ones, I think I'm hearing more
16 consensus to the broader we get and the less
17 specific we get across all these things, the
18 better.

19 So maybe taking the definitions as an
20 example, we should acknowledge there's multiple
21 definitions, and by the very nature of this
22 report, we don't want to pin ourselves to any one

1 definition, recognizing it evolves over time.

2 And that's probably the philosophical
3 direction we want to give to NQF for most things,
4 based on the last discussion I heard. People
5 sort of -- raise your hand if you object to that
6 concept. Okay. All right. So next slide.

7 And rather than me read them and waste
8 four minutes reading them, let's look over the
9 comments. And really, I guess I can't do it with
10 -- because there's people on the phone.

11 But remarks about bias in
12 publications, so I think just a more balanced
13 presentation of the data or what the data may
14 reflect is worth it. Differentiating cost for
15 providers versus cost effect on patients.

16 I'm not 100 percent sure what do
17 telehealth measure capture. I think we're going
18 to go through the measures later, so we can avoid
19 comment on that. What should the primary focus
20 points of telehealth measurement framework be?
21 We're going to spend a lot of time discussing
22 that.

1 And then I think we had several hours
2 of conversation at the last meeting on diagnostic
3 accuracy until I believe it was Kristi came up
4 with the concept of actionable information,
5 resolving that discussion. And I think we all
6 sort of agreed on that as a concept before. But
7 I'll open up these points for more discussion
8 now. Anything to add? Okay. Henry?

9 MEMBER DEPHILLIPS: Just really
10 quickly. This is the first time I've been
11 through this exercise. And really, understanding
12 the difference between creating a framework from
13 which measures are developed and understanding
14 what measures are out there has been hugely
15 helpful.

16 So obviously -- and Marcia, taking
17 your last comment, if you look at the past,
18 there's some evidence; if you look forward, we
19 need way more evidence in many different areas.
20 So the framework, I think, will help us guide
21 that.

22 The last bullet I just wanted to

1 comment on. I think that, going back to the
2 domains, obviously quality of care is arguably
3 the single most important domain we will put
4 structure around.

5 And I think that, when you start
6 getting into things like diagnostic accuracy,
7 appropriateness of interventions, that kind of
8 stuff, it really falls under the umbrella of
9 quality of care, and patient outcomes studies
10 will capture all of that.

11 If accuracy is degraded, then quality,
12 the outcomes will be degraded, and so forth. So
13 I think the focus on quality and the focus on
14 patient-oriented outcomes, which is standard in
15 the medical industry is a good way to go.

16 CO-CHAIR WARD: And following up on
17 that, I think that might be an example of quality
18 of care as a domain and then diagnostic accuracy
19 as a sub.

20 CO-CHAIR HOLLANDER: Yes. Yael, are
21 you up for a comment? No? Okay. Mary?

22 MEMBER MOEWE: Just one comment on the

1 cost. I would really rather it say, value to the
2 patient, value of the telehealth to providers,
3 rather than cost, because I think we're so
4 focused on cost and not what value it's bringing,
5 when it's truly value.

6 CO-CHAIR HOLLANDER: Yes. So, to that
7 point, let me throw a concept out there that I
8 wrestle with. If I'm not the payer, and I'm not
9 the payer, then I like to compare value, and
10 there may be more value from a visit that costs
11 more than from a patient not having a visit.

12 And one of the things that's implicit
13 in all the comments that came back, as I looked
14 through them, and the concerns of payers and CBO
15 and others, is that now there will be excess
16 visits where there wouldn't have been a visit,
17 and the cost will go up.

18 And although, frankly, running a
19 telemedicine program that's direct-to-consumer,
20 that's not what we're seeing, and our models
21 suggests it saves money. It's not published, so
22 we can't use it.

1 But I think that the value concept
2 might be more important than cost, and there
3 probably does need to be some language that doing
4 an extra visit might actually have higher value,
5 rather than just comparing, oops, there's an
6 extra visit, to no visit.

7 And I don't know how we could sell
8 that concept; I can't prove that right now. I
9 don't know if anybody else knows of anything that
10 can, but I think it's important that we at least
11 discuss that. Other comments? Am I missing --
12 okay, let's move on to the next slide while we
13 can.

14 So next slide is how to define
15 telehealth measures. And I think this gets to
16 some of the definitional concepts we had before.
17 What additional domains? I think we'll come back
18 to that later, so we don't need to do that right
19 now.

20 How to define ranking parameters and
21 acceptability regarding the strength of evidence.
22 And we're going to go through an exercise later

1 that helps us rank and prioritize these.

2 Should there be further research in
3 the cost/cost-effectiveness area? And I guess
4 the comment here reflects, maybe there's more
5 information out there than was included in the
6 report, or at least whoever wrote these comments
7 believed that to be the case.

8 MR. GOLDWATER: So just a clarification
9 on that last point. So the comment was is that
10 there's not an overabundance of evidence related
11 to cost and cost-effectiveness with telehealth.

12 There are studies; there are reports.
13 But as compared to things such as access and
14 analysis of different modalities, there was not
15 as much evidence. So given that, how do we
16 handle that issue within the framework?

17 CO-CHAIR HOLLANDER: Stewart?

18 MEMBER FERGUSON: Would part of the
19 framework or part of the outcome from this group
20 be to try to drive research in a certain
21 direction, where we have gaps? So for instance,
22 this is a very good example. We might lay out a

1 framework for research for some areas that would
2 actually help the field.

3 CO-CHAIR HOLLANDER: So I think, and
4 I'll just answer from conversations with Jason
5 before, I think you're exactly right on that.
6 And right now, we're sort of talking about the
7 environmental scan report, so it's a little bit
8 what's out there.

9 The framework can actually do that in
10 the framework report and highlight that.
11 Obviously, cost and cost-effectiveness is a large
12 part of the framework, but if there's nothing in
13 the environmental scan, all we can comment, is
14 say that there's a lack of evidence there within
15 that report.

16 And sometimes, I personally get
17 confused, because we're looking at a 100-page
18 report, and we tend to think it's our final work
19 product, and it's not. It's actually our
20 beginning work product. But I think what you're
21 saying is right. Yael?

22 MEMBER HARRIS: So one thing I wanted

1 to bring up, and this is from my days working on
2 Medicare, is, and I don't like to think about
3 this, but is what's called the woodwork
4 phenomenon. So, it gets into the cost-
5 effectiveness along with the accuracy or
6 necessity of care.

7 And CMS is always worried, yes, is it
8 appropriate care, but is this building up care?
9 In other words, is this making -- increasing the
10 level of need of care that wouldn't have been
11 there? On my mind, that's, yes, because there
12 was an unmet need in access, but that's a concern
13 that they always have when they expand benefits.

14 So I just wanted to put that on the
15 table for consideration. Again, no one in the
16 room wants to think about that, but I think if
17 we're thinking about changing the reimbursement
18 structure, it's something to consider.

19 CO-CHAIR HOLLANDER: Thank you. Paul?

20 MEMBER GIBONEY: So I've been thinking
21 about both the cost-effectiveness, but also about
22 the value conversation. Because value is so hard

1 to define. It's kind of, in some ways, in the
2 eye of the beholder.

3 But when I think about, at least from
4 specialty care through telehealth, I think of
5 what we kind of call in L.A. County, the five
6 rights of healthcare. The right care delivered
7 by the right provider in the right location with
8 the right information in the right time frame.

9 And if you're able to deliver those
10 five, and telehealth adds to that, then you're
11 getting a lot of value, right? It's all these
12 correct things are happening in care. And it's
13 regardless of whether or not it's been delivered
14 as a face-to-face visit or face-to-face plus
15 telehealth or telehealth solely. If you're
16 accomplishing all five of those things, then you
17 are delivering value into the patient scenario.

18 CO-CHAIR HOLLANDER: Chuck?

19 MEMBER DOARN: Well, and I may have
20 made this comment before, but when you say the
21 very last thing, it's based on the last ten
22 years, because that's the literature you looked

1 at. But there are papers that go back 20, 30
2 years.

3 Now, granted, the dollar changed
4 during that period of time, but some of the
5 lessons learned, I think, are there. And if
6 we're not looking at it, then this is not a very
7 accurate statement. And that's the concern I
8 have about the entire report. It's based on the
9 last ten years.

10 Technology, of course, is -- it'll
11 change by tomorrow, for sure. But looking back,
12 I think, at the last, maybe -- you go back to the
13 1990s, we've had several meetings, we've talked
14 about research, what the platforms should be, how
15 we should do the research, funded by various
16 organizations, some sitting at the table.

17 But clearly, I think that maybe we
18 should actually go back and look at some of that,
19 maybe in key areas, certainly cost. If we went
20 back to, say, 1990, as an example, there might be
21 salient information there that would be of value
22 to this report.

1 CO-CHAIR HOLLANDER: Peter? Yes, just
2 --

3 MEMBER RASMUSSEN: Thank you. The
4 comment that was just made a little bit -- a
5 moment ago about, is telehealth better or cost-
6 effective? I mean, I guess, somehow, I have a
7 little bit of a problem with the thinking that
8 current status quo is the best care and it's the
9 right care. It's just the care that we have
10 right now.

11 So I don't want to lose perspective of
12 the fact that in many, many situations,
13 telemedicine is better than what we're doing now,
14 just inherently. And I don't know how to flesh
15 that out.

16 Like, Judd, if I operate on you and
17 you're doing fine, there's no reason for you to
18 come back to see me. We just do a quick
19 telemedicine encounter. I don't know how to
20 prove that that's actually better than -- to me,
21 it's just common sense, a lot of this stuff.

22 CO-CHAIR HOLLANDER: So is it worth --

1 MEMBER RASMUSSEN: But it's different
2 from, like, running pediatric dental outreach
3 into rural Georgia. That probably needs
4 something else. You know what I mean? So we
5 need to have some flexibility in how we assess
6 that. I don't think we need cost-effectiveness
7 analysis on me seeing you post-op, but we do in
8 probably some of these other things.

9 CO-CHAIR HOLLANDER: Right. Well, as
10 we get into different domains, then I think that
11 may be in the patient-provider experience and
12 where you went on that. But I think trying to
13 broaden out the concept you're making is, if we
14 consider current state the gold standard, it's
15 pretty hard to prove you beat the gold standard,
16 right?

17 And so, maybe there is worth some
18 comment in the report that nobody thinks medical
19 care is perfect the way it is, and so we need to
20 move ahead. It's not are we as good as we're
21 doing now; it's are we doing something different
22 that meets one of the domains that may improve

1 patient-provider experience or access or cost-
2 effectiveness? Don I think was next.

3 MEMBER GRAF: Yes. From a payer
4 perspective, one cost consideration often not
5 considered enough is the transportation-related
6 cost that, in the Medicaid, for example, a lot of
7 health plans are at risk for it.

8 And just simple algorithms that we've
9 developed to determine how many miles are being
10 saved and the costs associated with those
11 transportation costs, lost wages, I mean,
12 everything that kind of goes into what you save
13 when you conduct that visit virtually, I think
14 would warrant additional.

15 CO-CHAIR HOLLANDER: Are there any
16 measures that actually take into account cost to
17 patient rather than cost to payers?

18 DR. BURSTIN: There are very, very few.
19 They have been listed as concepts, out-of-pocket
20 costs. We've not seen any directly come through.

21 CO-CHAIR HOLLANDER: Okay. Dale?

22 MEMBER ALVERSON: I just wanted to

1 underscore a couple things. When I look at it
2 from a practical standpoint, when we look at
3 implementing a telehealth program, whatever the
4 domain might be, it's based on a defined need,
5 and can telehealth meet that need?

6 So for instance, let's take
7 dermatology, why would we use any form of
8 telehealth for dermatology? Well, right now, it
9 takes six months from the time of a referral to a
10 consult.

11 So somehow, I sort of look at it that
12 way, that these outcome measures that are
13 evidence-based are usually driven by a need in
14 which we believe these technologies, however you
15 want to define them, telehealth, telemedicine,
16 eHealth, are going to meet that need. So, I
17 think, hopefully we can keep that in mind.

18 I mean, we've heard part of it is, can
19 we decrease costs of transportation, could
20 telehealth meet that need? Could we decrease the
21 time from consult to the actual consultation? So
22 those are the kind of things that I'm looking at.

1 And I sort of look to Helen, how do --
2 you kind of mentioned that, maybe we need to --
3 for some of us, we got to work backwards, because
4 we see a need; I think tele can meet that need.
5 What's the hypothesis? What's the measure? So
6 I'm sort of working backwards, and I don't know
7 if that's part of the dilemma that we face,
8 because I'm sort of looking at it from a much
9 more direct, practical standpoint.

10 DR. BURSTIN: I think that's absolutely
11 right, Dale. And I think, in some ways, what
12 you're saying is it's really an efficiency,
13 access domain, and then you would really hone in
14 on it.

15 It also, going back to the earlier
16 comment, I do think there's a series of use cases
17 here that are probably not domains and
18 subdomains, that probably need to get thought
19 about almost as a third dimension, whether it's
20 patient-to-provider, and then the access issues,
21 the experience issues come in, whether it's
22 provider-to-provider care, provider-to-provider

1 consultation.

2 Those may have very different
3 expectations in terms of the measurement than you
4 would, just as a broad -- because telehealth is
5 so big, and the way you're all talking about it
6 slightly differently, might be just another way
7 to hone in on what's most important.

8 CO-CHAIR HOLLANDER: Okay. I think we
9 have Paul, Angela, and then Yael. And then,
10 we'll go to the next slide.

11 MEMBER GIBONEY: It's kind of been
12 referenced, and Helen, your comment about, we
13 just don't have a lot of studies or documents on
14 patient experience, but so much of this stuff
15 just makes so much sense. I think it would be a
16 shame on us to leave it out.

17 We've got a lot of local providers in
18 the L.A. area that are doing, they've created
19 apps and they're doing all their post-op wound
20 checks by phone. Patient takes a picture with
21 the phone, sends it via a HIPAA-secure app to the
22 surgeon or the dermatology who takes a look at

1 it, says it's great.

2 Patient just saved a day off of work,
3 they saved all the transportation costs, the
4 parking, the cost for the institution to check
5 them in and to register them and to do all of
6 that. And there may not be a randomized
7 controlled trial on that, but some of it just
8 makes sense.

9 And it's what I think our patients are
10 going to be expecting from us more and more and
11 more is to be able to say, look, I've got this
12 phone and I just made my plane reservations and
13 I've ordered my dinner and I've done all this.
14 Can't I just send you a picture of my basal cell
15 wound that got excised, and wouldn't that be
16 enough?

17 MEMBER WALKER: Something else to think
18 about when we're trying to identify measures, and
19 I love the idea about working backwards, because
20 I think if you think about the measure first,
21 you're essentially instructing somebody who wants
22 to or would consider to do the study what to look

1 at, what to look for, is the use of the EHR for
2 some of this. Because more and more, that is the
3 method by which we're getting our data, and it's
4 reducing the time required to do some of these
5 studies.

6 So if you think about the cost
7 component, how would you collect information from
8 an electronic health record or some other source
9 where we already have the data present, in order
10 to look at that, and then working backwards from
11 the measure into the subdomain and domain makes a
12 lot of sense.

13 CO-CHAIR HOLLANDER: Yael?

14 MEMBER HARRIS: So this just fits right
15 into this slide, before we move on. I just a got
16 an alert from Kaiser News, article published, top
17 story today, Are Virtual Doctor Visits Really
18 Cost-Effective? Not So Much, Study Says.

19 So, just want to emphasize again that,
20 this is what I got to before, which everyone's
21 like, oh my god, what are you talking about?
22 Access, we're going to have to demonstrate with

1 this framework that, yes, access for things that
2 people wouldn't have gone to the doctor for, like
3 sinusitis, et cetera, that now they're going for,
4 so it costs more money, are offset by access to
5 things that might have been put off and are going
6 to result in more complications.

7 And that's something we have to think
8 about going forward. So it's, Medicare
9 reimbursement and the woodwork phenomenon, it's
10 more than that. The media is all over this
11 saying, is this actually saving money? And they
12 don't care, are the patients happier? Until
13 they're sick.

14 CO-CHAIR HOLLANDER: Yes. I've
15 actually seen that study. It's like every other
16 study that's out of a database. It only knows
17 what claims data is. It doesn't know who showed
18 up in the ER that would not have been in the ER
19 for telemedicine. I mean, it's a horrible study
20 to get --

21 MEMBER HARRIS: Right. And that's --

22 CO-CHAIR HOLLANDER: -- the kind of --

1 MEMBER HARRIS: -- why our framework
2 really needs to --

3 CO-CHAIR HOLLANDER: Right.

4 MEMBER HARRIS: -- get at more than
5 just cost-effectiveness.

6 CO-CHAIR HOLLANDER: Right. We have,
7 I think -- oh, okay, Nate, I'm sorry, I didn't
8 see you. You're up, then.

9 MEMBER GLADWELL: Yes. Just kind of a
10 combination comment, I don't know how it fits in
11 the framework. But as I'm listening to the
12 discussion, I think focusing on quality and the
13 common quality metrics that already exist in that
14 specialty is the focus.

15 I mean, if you think about, you don't
16 do a randomized trial on where patients wait in
17 the waiting room when you change up the logistics
18 of the waiting room. You just wonder about
19 quality, and you track quality metrics.

20 In my mind, telehealth is synonymous
21 with the waiting room. You're just treating
22 patients in a different location, different way,

1 different mechanism, but the focus is still on
2 the quality and the outcome.

3 CO-CHAIR HOLLANDER: Okay. Next slide,
4 please. Okay. So, this gets to the points that
5 were raised, how to have a telehealth measure be
6 compatible with MIPS and then, Alternative
7 Payment Models over time.

8 And should the number of telehealth
9 measures be expanded from what it is currently?
10 Well, obviously, it's sort of none, so I think we
11 would agree it's, yes, but maybe we can discuss
12 how to do that. And the framework is one thing.

13 And then, tomorrow, we have a whole
14 discussion on MIPS and MACRA, but I guess we can
15 hear some of the top-line comments that people
16 have right now. Any comments? Okay, we'll defer
17 that discussion until tomorrow, then. We'll go
18 to the -- oh, yes, we can go to the next slide.
19 Okay. So, this actually gets to some of the,
20 maybe, quality issues.

21 Should concordance between primary and
22 specialty providers sharing images be prioritized

1 in addressing gaps? Would it improve patient
2 safety, reduce cost, et cetera? And then,
3 there's the question of involving family members
4 and caregivers and how to put them into measures.
5 So, two totally different concepts here.

6 MEMBER RASMUSSEN: I don't understand
7 the first point.

8 CO-CHAIR HOLLANDER: So, I think the
9 first one is, I guess asking the question is,
10 would a measure be, okay, I take a CT scan and
11 the ER doc looks at it and a neurosurgeon looks
12 at it remotely and we agree there's a bleed on
13 the CT scan, or we agree it's melanoma? Is that
14 enough to be a measure saying there's concordance
15 between images?

16 MEMBER FLANNERY: I was sort of puzzled
17 by that. Since the primary care physician should
18 not have the expertise of the specialist and
19 they're actually seeking the specialist's input,
20 why would we want to look at concordance between
21 the PCP and the specialist?

22 CO-CHAIR HOLLANDER: Go ahead, Jason.

1 MR. GOLDWATER: I'll just do this as
2 clarification. So, a large number of studies
3 that we pulled out talked about concordance.
4 They were studies that were randomized controlled
5 trials or they were general studies with another
6 methodology, but I would probably roughly say
7 about 50 percent of these were concordance-based
8 studies, which we wrote, I mean, we just
9 basically described what the studies were.

10 And that was what led to that comment.
11 So, I think that the genesis of that was just the
12 preponderance of literature that we found that
13 discussed this. Particularly in the dermatology
14 area, where it was very significant.

15 CO-CHAIR HOLLANDER: Angela?

16 MEMBER WALKER: Yes. And that is,
17 actually, a great point to make, and is a
18 problem, I think, for those studies. If you're
19 looking at the concordance between a primary care
20 physician looking at a skin lesion and a
21 dermatologist looking at a skin lesion in a tele-
22 setting, it's not a comparison to make.

1 It's really, what's the comparison
2 between the dermatologist seeing that image
3 versus the dermatologist in clinic? Because then
4 you've got the same level of expertise.

5 CO-CHAIR HOLLANDER: Sarah?

6 MEMBER SOSSONG: And all I would add
7 is, I think we have talked about this in previous
8 sections, that UCSF has a really rigorous consult
9 program. We've done over 6,000 -- Mass General
10 has done over 6,000 e-consults across 30
11 different specialty areas. So, I think that's
12 getting to this.

13 I think that the concept is more also,
14 how do we account for provider-to-provider
15 interactions? I think, to date, generally the
16 payers have not been interested in this type of
17 telehealth for us, because they figure this is
18 what we should be doing as part of an ACO. But I
19 think that was part of the intent of this
20 particular comment as well.

21 CO-CHAIR HOLLANDER: Okay. Peter?

22 MEMBER RASMUSSEN: I think when you're

1 talking about images, we might be better off
2 defining some kind of technological quality. I
3 think a lot of the concordance stuff that you
4 might have found, Jason, was because the
5 technology was rudimentary and can you actually
6 transmit the images? And, obviously, that's
7 getting better and better every day.

8 The issue around dermatology is not
9 necessarily, can a dermatologist read and picture
10 remotely? Yes, they can, but is the resolution
11 sufficient to make a diagnosis? So, I think,
12 that's probably a better metric around images, is
13 some kind of minimum technological requirement.

14 CO-CHAIR HOLLANDER: So, I think, in
15 trying to summarize some guidance here, because
16 this is a lot of the literature that's out there,
17 so NQF can have direction, I think what I'm
18 hearing a little bit is a comparison between
19 Specialty A and Specialty B doesn't make sense.

20 That, again, maybe this is covered in
21 the larger domains of quality, actionable
22 information, and is covered other places and so,

1 we don't need anything specific about concordance
2 here. If you're getting the right information,
3 you should be able to act on it, if you're
4 getting the right information that's high
5 quality.

6 So, it probably can be covered
7 elsewhere. And it's nice, because it makes it,
8 at least in my mind, the framework we came up
9 with last time deals with this in a broad sense,
10 and we don't have to do anything specific for it.
11 Is that sort of the group consensus around this?
12 Okay.

13 And then, the other issue, there was
14 a lot of discussion last -- or there was very
15 little discussion, but I think a lot of
16 consensus, that the measures should include
17 family members and caregivers, as appropriate,
18 and take that into account. There's probably a
19 shortage of that in some other measure areas.
20 But I -- anybody want to add any comments related
21 to that?

22 MEMBER MOEWE: I'm not really sure this

1 is truly unique to telemedicine, though. I mean,
2 I think these concepts are across-board concepts.
3 So, are we trying to focus on what is unique to
4 telemedicine and telehealth, or can it be across
5 the board --

6 CO-CHAIR HOLLANDER: I think it can be
7 --

8 MEMBER MOEWE: -- for any medicine?

9 CO-CHAIR HOLLANDER: -- across the
10 board. So, what I'm thinking, and, again, this
11 is just one person's thoughts, is, as we talk
12 about the patient experience, it could be
13 patient, family, and caregiver experience.

14 And it may turn out -- I mean, one of
15 the things in the practical sense, everybody
16 says, oh, the 94-year-old can't do telemedicine.
17 No, but the 94-year-old's son or daughter who
18 would have to drive them and might be much
19 happier walking downstairs when mom and dad live
20 with them --

21 MEMBER MOEWE: Right.

22 CO-CHAIR HOLLANDER: -- and doing

1 telemedicine. That might not enhance the 92-
2 year-old with Alzheimer's experience, they can't
3 do the survey, but it might certainly enhance the
4 caregiver's experience.

5 And so, I think if we build that in
6 and explicitly say that's part of it, I think
7 you're 100 percent right, it should be with
8 everything, but maybe we're the first group to
9 outline it.

10 MEMBER DARKINS: I just want to follow
11 up on that. I mean, I think that there's the
12 kind of theoretical issues, academic issues,
13 policy issues, and then, there's the practical
14 issue of how I would implement this.

15 So, if we're suggesting that if you do
16 telehealth measures, in addition to any other
17 quality measures that might be done for the
18 caregiver and for the patient, telehealth would
19 have another separate set, we're going to create
20 a nightmare for whoever is implementing a quality
21 initiative.

22 So, I think that's one of the things

1 around this, to end up saying, are we going to
2 recreate the whole of the measures which are done
3 in healthcare for everything else that's then
4 done for telehealth?

5 Or are we end up going to say, there
6 are specific aspects of healthcare delivery that
7 relate to telehealth that have certain specific
8 indices and we would expect that in the normal
9 course of the delivery of healthcare?

10 Where the caregiver issues and where
11 the patient issues are captured, if there is
12 something of particular significance, you might
13 do it. But I think, otherwise, I don't know
14 about you, I think we're going to create a
15 nightmare.

16 CO-CHAIR HOLLANDER: Yes. I think
17 watching the NQF heads out of the corner of my
18 eyes, they were like bobbleheads, saying, yes,
19 yes, yes, to your second one. So, I think
20 there's broad agreement.

21 DR. BURSTIN: Just one quick, it's a
22 really interesting thought. I think, generally,

1 the hope would be that you could use existing
2 measures and say, telehealth is now part of those
3 measures and how does telehealth do on those
4 measures? I will say, though, we don't have very
5 many good measures of access.

6 So, I think this Committee could help
7 drive us towards better measures overall, that
8 get at access, that get at issues like caregiver
9 experience, that are gaps for the whole
10 healthcare system, aren't unique to telehealth,
11 but would actually be useful to us in terms of
12 driving towards the measures we need globally for
13 all of healthcare.

14 MEMBER DARKINS: And I would just
15 endorse it. I entirely agree, I think there are
16 specific things we can really help for healthcare
17 in general, exactly as just described, rather
18 than reproducing.

19 CO-CHAIR HOLLANDER: Okay. Peter?
20 Okay. Eve-Lynn?

21 MEMBER NELSON: I think, related to the
22 family and caregiver context is also the

1 community context. I just think about our
2 school-based telemedicine clinics. So,
3 understanding the provider, the specialist, the
4 family caregiver, but also the school community
5 context, it really impacts the outcome. So, I'm
6 not quite sure where that fits within the
7 framework, but I think it needs to fit somewhere.

8 CO-CHAIR HOLLANDER: Good point.
9 Stewart?

10 MEMBER FERGUSON: I'm going to use the
11 fact that it's 6:00 in the morning in Alaska as
12 an excuse to go back to the first bullet.

13 (Laughter.)

14 CO-CHAIR HOLLANDER: The first bullet
15 on the first slide or the first bullet on this
16 slide?

17 MEMBER FERGUSON: Yes, on the previous
18 presentation.

19 (Laughter.)

20 CO-CHAIR HOLLANDER: From the last
21 meeting.

22 MEMBER FERGUSON: What's this thing

1 called? A framework? I don't get it.

2 (Laughter.)

3 MEMBER FERGUSON: No, on the
4 concordance issue. So, I mean, we've published a
5 number of concordance studies and, generally, our
6 driver for doing them is to try to validate and
7 convince yourselves whether it's as good or
8 better than in person, right? And we look at
9 provider differences.

10 But I think the thing that might be
11 important for this group is, when we do
12 concordance studies, what you usually do is
13 develop a best practice for us. And this is true
14 of most concordance studies.

15 So, you find that you can't really
16 compare a 100 pixel by 100 pixel derm image to an
17 in-person, but you can compare a 1,000 pixel by
18 1,000 pixel. So, they tend to set standards, you
19 put scales in, there's all these things that you
20 do in derm imagining and other things. If you're
21 doing ear imaging, you remove was before you do
22 it, and so forth.

1 So, the concordance studies usually
2 lead to best practices, which I think is the
3 value of them in many cases. So, I don't know if
4 that has anything to do with the framework, but I
5 think that's kind of an important --

6 CO-CHAIR HOLLANDER: That's a good
7 point.

8 MEMBER FERGUSON: -- part in terms of
9 developing that.

10 CO-CHAIR HOLLANDER: Great point.
11 Okay. Let's move to the next slide. Okay. So,
12 what are the immediate next steps to identify
13 issues of consideration for development of the
14 telehealth measure framework? And let's -- how
15 to define each measure in the framework?

16 And, here, we're talking about
17 specific things, drilling down, such as mileage,
18 distance saved, absenteeism, et cetera. And any
19 additional points to discuss? We can't really be
20 at the end of this already, are we?

21 CO-CHAIR WARD: No. There's --

22 CO-CHAIR HOLLANDER: No? Okay. There

1 must be, like, ten more. Oh, okay.

2 CO-CHAIR WARD: There are --

3 CO-CHAIR HOLLANDER: Okay. So, oh, no,
4 we've got six more slides after this. Okay.
5 Somebody --

6 CO-CHAIR WARD: So, to clarify, there
7 --

8 CO-CHAIR HOLLANDER: Oh, because it's
9 the webinar.

10 CO-CHAIR WARD: There's two headings to
11 this.

12 CO-CHAIR HOLLANDER: Okay.

13 CO-CHAIR WARD: So, there was feedback
14 from the Standing Committee and then, there's
15 feedback -- what's the two different sets? Do
16 they have any importance to us?

17 MR. GOLDWATER: No, not really.

18 CO-CHAIR WARD: Okay.

19 MR. GOLDWATER: So, there was -- the
20 feedback on the environmental scan, we got
21 feedback from several of you and then, we got
22 feedback from the government, which included

1 several people from HRSA and HHS. And we
2 consolidated those comments --

3 CO-CHAIR HOLLANDER: Okay.

4 MR. GOLDWATER: -- into one. And where
5 we could make changes on the report based on the
6 comment, we made the changes. So, someone said,
7 add this citation to this argument, it
8 strengthens it overall, and we would simply add
9 the citation. Or, this sentence is ambiguous,
10 can you clarify this? Then, we would do that.

11 When there were questions, such as,
12 how do you evaluate concordance studies, that's
13 not exact something, or, how do you, there's a
14 lack of cost/cost-effectiveness studies, how do
15 you develop that into a framework?

16 That's not really something that we
17 can edit into the report, without getting your
18 feedback from. Otherwise, we would be
19 interjecting our own thoughts, which is really
20 not what we do and not what we want to be doing.

21 In terms of the webinar, which is now
22 what we're turning to, this is a lot of questions

1 that you asked or questions that we got from the
2 public later. And, again, rather than spending
3 time on the webinar, which was only roughly an
4 hour long and 25 minutes of that was dedicated to
5 a presentation, we brought those questions here,
6 so we could have a more robust discussion.

7 CO-CHAIR HOLLANDER: All right. So,
8 we've got about six slides and about 15 or 20
9 questions, which, I guess, we actually posed,
10 that we need to get through in the next 20
11 minutes.

12 So, running through these, how do we
13 compare traditional modalities versus traditional
14 modalities plus telemedicine? This was a comment
15 that I think Henry raised earlier, is something.

16 How do we select appropriate
17 telehealth measures when it comes to developing
18 the framework? I think this is an activity for
19 later in this meeting, look at preexisting
20 measures and do that, which came out of this
21 webinar.

22 What to include when discussing the

1 low utilization of telehealth, despite the
2 expansion of technology and connectivity. And
3 this was because, I think, at two places in the
4 report, there was a comment that, although
5 telehealth is growing, adoption is still very
6 low. And so, this was this group's feedback.

7 And then, refine and further integrate
8 system effectiveness in the report, which I think
9 is in the report, so we can leave that one.
10 That's one of our domains or measure concepts.
11 Adam?

12 MEMBER DARKINS: In relation to the
13 first one, I mean, I think we've touched on it
14 before, it seems to be what's really important is
15 how you code for activity. And, particularly,
16 code for activity across the continuum.

17 Now, that's going to be an evolving
18 process, but if you can code for the activity
19 taking place, then, A, you can look at cohorts
20 before and afterwards and you can make
21 comparisons.

22 So, it seems to me, the logic is use

1 routine data systems and have an identifier that
2 you can code for that means you can do that. So,
3 I think there's an IT piece in the report. I
4 would suggest we put in something along those
5 lines.

6 CO-CHAIR HOLLANDER: I actually think
7 that's a great idea. We're wrestling with, how
8 do we bill for it on an enterprise-wide level,
9 and it's almost impossible to figure out what the
10 right codes to use are, because CMS has different
11 guidance than every payer and every payer wants
12 it differently.

13 And although most of the payers in our
14 neck of the woods won't reimburse for it, trying
15 to get on top of writing the right scripts to
16 figure it out and who has a GT modifier and who
17 doesn't and who wants you to use the 99444 code,
18 which is really for an established patient, even
19 though there's no code for a new patient.

20 It would be really good if somewhere
21 within this, and I think it is part of a measure
22 framework, to be able to do eMeasures out of

1 claims data. And right now, that's actually not
2 really facilitated based on billing.

3 So, it may not be a problem we could
4 solve, but getting it so that the payers have
5 sort of a unified way of accepting billing codes
6 would actually get us closer to the point you're
7 raising, I think.

8 MEMBER DARKINS: Could I make a
9 suggestion? That, rather than taking it from the
10 billing side, because I think one of the great
11 problems with healthcare is everything is stemmed
12 from billing, why don't we take it -- it should
13 be done much more from the patient quality and
14 then, you take the billing from that, as opposed
15 to trying to create a billing code and then, end
16 up saying, how do we then modify a billing code
17 to be used for quality?

18 CO-CHAIR HOLLANDER: So, I mean, my
19 short answer to you is, I would agree with you,
20 but I just don't think it's likely to happen.
21 And so, it's sort of, in the good, better, best
22 scenario, you're giving the best scenario, but I

1 think rechanging the whole billing structure is
2 something that, no matter how strongly we write
3 or recommend, probably isn't going to happen.

4 So, if we could find a recommendation
5 to leverage and get what we want to develop
6 measures, which is actually our goal, using the
7 preexisting constructs that everybody uses,
8 that's probably the best win we could get out of
9 this. Not that I disagree with you.

10 MEMBER DARKINS: I wasn't suggesting,
11 change the billing codes, I was suggesting
12 finding a means to sort of do both.

13 CO-CHAIR HOLLANDER: Okay.

14 MEMBER DARKINS: So, it's comity.

15 CO-CHAIR HOLLANDER: Okay. From the
16 payer side?

17 MEMBER GRAF: If we're locked in,
18 we're trying to define quality and assess it
19 through things like Project ECHO, for example,
20 which is not reimbursable.

21 And layering in quantifiable benefits
22 to that, creating mechanisms that, under

1 Alternative Payment Models, reimbursement for
2 those kinds of services, where the benefits are
3 sort of self-evident or could be attached,
4 becomes so much more easy, and shouldn't be
5 ignored. Because that is the way that we're all
6 moving.

7 CO-CHAIR HOLLANDER: Great point. Oh,
8 yes, Dale? Yes?

9 MEMBER ALVERSON: Just on the third
10 bullet, about should telehealth adoption be an
11 indicator of quality, I just want to make sure we
12 refer back to, I think, really a sentinel book
13 called Diffusion of Innovations by Everett
14 Rogers. And it really talks about, what are the
15 criteria for successful adoption?

16 And that can be for any innovation,
17 including telehealth. And I would reflect back
18 on that, because one of the issues, then, for
19 instance, you look at the five criteria for
20 successful adoption, one is perceived benefit by
21 the user.

22 So, if it's not being used by a

1 multitude of different potential users, why
2 aren't they perceiving a benefit? Or will they
3 perceive a benefit, as more literature comes out?
4 The other talks about complexity. If telehealth
5 is too complex, not easy to use, it won't be
6 adopted.

7 The other is what's called
8 compatibility, how well does it fit into workflow
9 and the way we do things? And, of course, this
10 is disruptive, so it takes time. And the others,
11 I think, are probably apropos for telehealth and
12 that's called trialability. If you can try it
13 without overturning the whole method in which you
14 deliver care, then it's more likely to be
15 adopted. And then, the fifth one is visibility.

16 But just on that third bullet, I would
17 really, somehow in the report, if that's going to
18 be part of it, when we try to reflect upon low
19 utilization, how might that change and what are
20 we going to do to change it?

21 CO-CHAIR HOLLANDER: Yes. And this,
22 when I read this sentence, it's true to me, but I

1 think it's a little, I don't want to say
2 disingenuous, I'm not sure what the right word
3 is, but if you don't pay for it or you create so
4 many hurdles to use on the payer side, it's a
5 little different than pure innovation.

6 You could decide to go buy your iPhone
7 when it comes out the first time and pay your
8 \$600. Here, you have to ask mom to buy your
9 iPhone and if mom, as CMS, says no, you're not
10 going to use it.

11 So, it's not really a surprise if no
12 one's going to buy you your toy, that you can't
13 use your toy. And so, I think the low adoption
14 is, there's all the things you point out that are
15 clearly true, but if nobody wants to pay for it,
16 then of course adoption is going to be low.

17 So, I think if we're going to talk
18 about low adoption, I think we need to have
19 comments about, because it's not embraced by the
20 people who would pay for it. Or maybe we just
21 decide we want to remove these lines, because
22 it's not germane, really, to creating a measure

1 framework.

2 MR. GOLDWATER: I just was going to
3 say, I'm going to steal that analogy for future
4 speeches.

5 CO-CHAIR HOLLANDER: Oh, okay.

6 MR. GOLDWATER: That was terrific,
7 about CMS being the mom, restricting you from
8 your iPhone is a -- I can't think of -- there's
9 nothing better I can think of myself.

10 (Laughter.)

11 CO-CHAIR HOLLANDER: So, as you know,
12 I'll be in trouble, because it's branded, iPhones
13 or Androids. But --

14 (Laughter.)

15 CO-CHAIR HOLLANDER: Okay. Next slide.
16 So, I think these are the things we're tasked
17 with doing in this two-day meeting, clearly
18 define the modalities, build the measure
19 framework, prioritize the domains, how to make it
20 actionable, how to broaden the realm of
21 telehealth, and I think that was the first slide
22 that we discussed that, and how to incorporate

1 the care continuum, I think this was related to I
2 think it was largely Henry's points about value
3 early on.

4 So, in my mind, I think we've covered
5 this slide or we'll spend the next day covering
6 this slide. I don't know if there's anybody who
7 feels compelled to add something right now to
8 this. Dan?

9 MEMBER SPIEGEL: So, the first bullet,
10 I think, on there was actually my comment during
11 the webinar. I guess, I'm not sure that the
12 bullet totally captures where I was going with
13 it, but with any sort of framework, my
14 perspective is, it should be sort of mutually --
15 as mutually exclusive and collectively exhaustive
16 as possible.

17 And so, I was reading through the
18 draft report and the first example under mobile
19 health and access to care, it talked about taking
20 pictures and storing them and sending them to a
21 provider for review later, which is exactly what
22 we talk about with sort of store-and-forward

1 technologies.

2 And so, I don't think you can
3 necessarily distinguish between all of the
4 different modalities. But my point in kind of
5 bringing this out, with regards to the draft
6 report, is that, we should at least acknowledge
7 that there is overlap in a lot of these studies,
8 where one technology may be using multiple -- or
9 one example or study may be using multiple
10 modalities.

11 CO-CHAIR HOLLANDER: And I think,
12 following on that, do we want to be clear, and
13 maybe it's in there, I don't remember the
14 specifics already, but do we want to be clear
15 that this report is not intended to be
16 restrictive based on where current evidence
17 exists now, but is intended to create a framework
18 for things that have as yet not even been
19 invented?

20 And we probably need to be clearer on
21 that point or people will say, oops, didn't say
22 COPD in this report, we're not doing it.

1 Although, it does say COPD. Okay. Next slide.

2 I think, actually, we've spent a bit
3 of time talking about bullet item number one,
4 categorization. And I don't know that we need to
5 do this, in a couple of the framework discussions
6 later on, we do separate out acute.

7 There's a lot of language in the
8 report about chronic care, this might have
9 actually even been my comment, is that, I like to
10 say, although it's not strictly speaking true,
11 people don't actually die of chronic diseases,
12 they die of acute exacerbations of chronic
13 diseases, and it's important that we don't limit
14 the framework to only chronic diseases. And so,
15 we should have a way to do that.

16 Adding discussion on attribution. And
17 I know there's a whole NQF report on attribution,
18 which is fun reading if you have trouble getting
19 to sleep one night. And then, how to -- and
20 we've talked a lot about the last line, but I
21 think these are things that are sort of mom and
22 apple pie in doing this. Other comments here?

1 Next slide.

2 How to develop clear measures that
3 capture the cost and resource use of implementing
4 and maintaining telehealth systems accurately.

5 This is actually the first time we've seen this
6 bullet point today. Facility fees exist on other
7 sides, they don't necessarily with telemedicine.

8 How to make the framework applicable
9 in situations that have not yet arisen. We've
10 discussed that. Are there other sources to
11 consider when evaluating current telehealth
12 measures? I think this more specifically should
13 be current measures that might have telehealth
14 built into it, besides the ones that were in the
15 report.

16 Should we be adding specifically any
17 pediatric-based measures to the report? And
18 then, the last one, which I think overlaps, how
19 to incorporate telemedicine within preexisting
20 measures where it's not required, but may be
21 useful. Paul?

22 MEMBER GIBONEY: On the first bullet,

1 telehealth is always becoming more and more
2 efficient. The first one just, capture the cost
3 and resource use of implementing and maintaining
4 telehealth systems.

5 If you're hosting a telehealth
6 solution on your own servers and you're investing
7 a lot of that, then your cost is going to be
8 \$1,000. But if you've actually done it as a
9 subscription to a service, someone else, who is
10 running a server farm and deploying this
11 telehealth solution to over 50 systems, the cost
12 and resource use might be \$200.

13 This one just -- the measures -- how
14 far down that road do we want to go? Because
15 this is such a moving landscape, what costs you
16 \$1,000 one year, next year may really only cost
17 you \$150. That one just struck me as very hard
18 for this group to tackle, it's such a moving
19 thing, unless we come up with key categories.

20 CO-CHAIR HOLLANDER: Don?

21 MEMBER GRAF: Another component to
22 bullet number one is the ability of the provider,

1 in your case, just to use it. What not to wear,
2 lighting, just sort of the basic things. You can
3 have all the great tech in the world -- we do an
4 attestation program, part of our contracts with
5 providers wanting to do virtual visits, to speak
6 to issues like that, so that we have a sense
7 that, even with all the tech, they know how to
8 use it.

9 CO-CHAIR HOLLANDER: Other comments?

10 I thought Marybeth was going, but she's just
11 getting coffee.

12 (Laughter.)

13 CO-CHAIR HOLLANDER: Fake out. Okay,
14 next slide. Actually, let me go back to the last
15 one again, because this is just sort of -- since
16 I'm the chair and I get to speak to the point,
17 could we go back? Yes.

18 So, I think it's really important, and
19 somebody made this point early on and I think
20 Adam made it then as well, that it's not just all
21 about telemedicine, it's about how is
22 telemedicine leveraged to get built into

1 preexisting measures and other measures that will
2 be developed?

3 But, yet, the majority of the day, we
4 tend to function as though we're building a new
5 framework just around telemedicine. And so, I
6 think this is the point that, as we look over
7 other preexisting measures, where can
8 telemedicine play a role?

9 There are multiple measures that
10 require a visit, well, what is a visit? Right
11 now, I assume a visit is an in-person visit or
12 somebody going to somebody's home. And so, is
13 there a way to do word search on every measure,
14 look for visit, and define telemedicine meets
15 visit in some of them, maybe all of them, to do
16 that?

17 But I just don't want to lose the
18 concept that, I don't think it is terribly well
19 addressed in the report directly, nor do I know
20 that it needed to be in the environmental scan,
21 but should be in the measure framework, that
22 telemedicine is a way to do a visit or provide

1 care that may be mandated by other things in
2 other measures. Dale?

3 MEMBER ALVERSON: Not to necessarily
4 belabor the first point, but there are a lot of
5 other confounders that impact on that, this
6 implementing and maintaining tele-systems. And
7 that has to do with access to affordable
8 broadband. And I can tell you that that's a
9 global issue, that's certainly an issue in a
10 large rural state like New Mexico.

11 So, I don't know if we want to really
12 go there, but, I mean, that's one of the barriers
13 of using a lot of these systems is that access to
14 affordable infrastructure and, particularly,
15 broadband, to support these approaches and
16 applications.

17 CO-CHAIR HOLLANDER: Paul?

18 MEMBER GIBONEY: Yes. On the
19 pediatric-based telehealth measures, Judd, I
20 think you already answered that question. I
21 think the answer is, of course we do, but we
22 don't have to call them just pediatric measures.

1 Just like you said, if we're using it
2 here, but it doesn't specifically mention COPD,
3 but it's, the use case is the same, well, then of
4 course it includes COPD. I would argue the same
5 for our pediatric measures.

6 If it doesn't actually specifically
7 call out pediatric asthma, but we're applying a
8 solution to the monitoring of a kid with asthma
9 during flu season, well, then of course our
10 framework should apply to that.

11 CO-CHAIR HOLLANDER: Right. Okay, next
12 slide. How to create telehealth measures across
13 multiple clinical specialties. We've sort of
14 done that. And then, we talked about broader
15 categories, such as provider-to-provider or
16 patient-to-provider and I guess we'll get into a
17 discussion in the framework how we want to do
18 that.

19 I think we've discussed the third one
20 already, comparison of an outcome of an in-person
21 visit versus telemedicine visit versus no visit,
22 in the value-based concept. And then,

1 potentially examine articles on telehealth to
2 administer antimicrobial stewardship programs.

3 I think we're getting a little in the
4 weeds on that and it probably should fit. Any
5 comments on any of this? Okay. I think we're
6 one or two slides away from break, let's try and
7 get there.

8 So, this goes back to where we got the
9 definition from and I think we've discussed the
10 definition already. We added some additional
11 references. The report references an AHRQ
12 evidence map of systematic reviews that was
13 developed last year that assessed impact of
14 telehealth on clinical outcomes. I don't know
15 what's actionable on that. And maybe it's just
16 something we should be including.

17 MR. GOLDWATER: So, I mean, I could
18 speak to --

19 CO-CHAIR HOLLANDER: Okay.

20 MR. GOLDWATER: -- this slide.

21 CO-CHAIR HOLLANDER: Okay.

22 MR. GOLDWATER: So, these are the -- I

1 mean, this is more --

2 CO-CHAIR HOLLANDER: Oh, these are
3 revisions? Okay.

4 MR. GOLDWATER: These are more high
5 level, so these are just the revisions that were
6 made, that we could take action on. So, the
7 first was to use the 2001 definition. And,
8 again, that doesn't mean that that's the final,
9 but that's for this next iteration, that's where
10 that came from.

11 A number of you pointed out additional
12 literature sources to use that would strengthen a
13 number of points made in the study, which those
14 were included. There has been a lot of work in
15 HHS on telehealth, I think a lot of you know
16 that.

17 And the discussion with the government
18 was, we should be inclusive of some of that work,
19 namely the AHRQ evidence map from last year,
20 because that was more directly relevant to the
21 work that we're doing now. We really looked at
22 systematic reviews within that evidence map that

1 focused on the intersection of telehealth on
2 outcomes, utilization, and costs.

3 We offered a little bit more
4 clarification on the methodology, on how articles
5 were chosen and synthesized, which a number of
6 you pointed out. And then, we compared that to
7 the AHRQ evidence map and how they went about
8 doing their selection and scoring of articles.

9 And then, there were a number of other
10 edits and comments that were made with respect to
11 clarifying some ambiguity, making a few things a
12 little clearer, adding summaries at the end of
13 every modality to sort of summarize what had been
14 discussed, and so forth.

15 CO-CHAIR HOLLANDER: Okay. So,
16 somehow, we are done with this, five minutes --
17 oh, no, we're not.

18 MEMBER DOARN: So, I was sitting here
19 thinking and I remember talking to Dena and then
20 Sherilyn and, of course, now Bill England, OAT
21 has funded a tremendous amount of telemedicine,
22 as has the VA, NASA, DoD, and so on.

1 And I'm wondering if, a lot of things
2 never see a manuscript, they never get published,
3 but there are reports that are deliverables on
4 the contract or the grant, and I'm wondering if
5 it's possible, or maybe you've done this, gone
6 back and looked at, what did the DoD or the VA or
7 some of these OAT projects in the middle of
8 nowhere, what did they come up with as some of
9 the challenges that we're not necessarily
10 addressing? Is there something in that report
11 that would be of value to us?

12 MR. GOLDWATER: So, that's a good
13 point, Chuck. We did look at the VA work. A lot
14 of that work, there were a number of articles, as
15 Adam is aware, that were published from that that
16 we were able to use. We have looked at the DoD
17 and we'll determine, I think, based upon what we
18 sort of discuss here today about what to pull
19 from that particular study.

20 There is an awful lot that the
21 government has done throughout the years with
22 respect to telehealth. To incorporate all of

1 that would have expanded the document
2 significantly.

3 And I think we were, in working with
4 the government, we really focused on very
5 specific literature that we could quote and
6 reference that would at least set the stage for
7 the future discussions. As we move further down,
8 we may then find ourselves incorporating
9 information from those reports.

10 MEMBER DOARN: But it would expand the
11 report or would it change the report? I think
12 that's a more important -- because before it goes
13 from 100 pages to 300 pages, but it's going in
14 that direction when it really needs to be going
15 in that direction, is a big difference.

16 MR. GOLDWATER: I agree. So, and I'll
17 again state that I think it's probably to see
18 what you all -- it really comes down to, Chuck,
19 where you all want to take the framework. What
20 do you want the framework to look like? And
21 then, what information can we pull additionally
22 that would support that?

1 The literature review and the time
2 that we had to do it, it was really just
3 identifying a set of articles, coming up with a
4 scoring rubric, and using that, focusing only on
5 a ten year period. And I'm well aware that there
6 have been articles from 1990 all the way up until
7 now, but, again, we had time and page constraints
8 with what we could add.

9 And, really, the whole point of the
10 literature review is to facilitate this
11 discussion and to sort of add in information to
12 get you all thinking about what we need to do,
13 how we need to shape this, what should be
14 included, what should not.

15 To say, we shouldn't be adding every
16 conceivable measure, we should be narrowing the
17 focus, here are the things that are happening
18 with our state or our region with respect to
19 access and cost, that's what the literature
20 review really is to do, is to facilitate this
21 discussion so we know how to move forward.

22 CO-CHAIR HOLLANDER: Okay. Then, next

1 slide, which is my favorite, actually, I believe.
2 Okay.

3 (Laughter.)

4 CO-CHAIR HOLLANDER: So, 15 minutes,
5 we'll come back at 10:45. And then, we will have
6 a challenge of an hour and 45 minutes to move
7 through one slide.

8 CO-CHAIR WARD: Yes.

9 (Laughter.)

10 CO-CHAIR HOLLANDER: Marcia selected
11 that section to chair.

12 (Whereupon, the above-entitled matter
13 went off the record at 10:29 a.m. and resumed at
14 10:55 a.m.)

15 MR. GOLDWATER: All right. If
16 everybody could start working their way back.
17 So, I've already got -- before we turn this over,
18 back to Judd and Marcia, to start working with
19 domains. So, I've gotten a few questions about
20 the dinner this evening. So, Katie, do you have
21 details on that?

22 MS. STREETER: I do.

1 MR. GOLDWATER: All right.

2 MS. STREETER: Yes. A dinner
3 reservation has been made at P.J. Clarke's, which
4 is --

5 MR. GOLDWATER: That way.

6 MS. STREETER: Yes. I'll make sure we
7 all have the address. It's just within a couple
8 of blocks. It's for 5:30, that time is flexible,
9 we can adjust that if we decide we'd like to this
10 afternoon, I just need to call them.

11 MR. GOLDWATER: It's a great place,
12 good food, very casual. Your kind of place,
13 Chuck. Because we always have you in mind as
14 we're -- no, we didn't, I'm just kidding. All
15 right. So, Judd, I'll turn it back to you.

16 CO-CHAIR HOLLANDER: Marcia, I'll turn
17 it to you.

18 CO-CHAIR WARD: So, we have, I think,
19 an hour and 15 minutes for this next agenda item,
20 which is listed as Prioritization of Domains for
21 the Measure Framework. And, as Judd said,
22 there's one slide for this, which is the domains

1 that we talked about last fall and then, have
2 talked about again on our webinars.

3 And my understanding is that we are
4 going to be voting, and I see we've got devices,
5 and we're going -- the goal from what I
6 understand, is that we will go through a series
7 of votes and prioritize our lists of domains.

8 But I want to take a co-chair's
9 prerogative and go to the last bullet of, are
10 there any other domains that should be added?
11 And to maybe rephrase a little bit, summarize
12 this morning, we talked all about the
13 environmental scan and a lot of the questions in
14 the environmental scan, I think we have to
15 remember that the NQF staff had a limited amount
16 of time and resources and absolutely could not
17 capture the world of telehealth in their
18 environmental scan.

19 They took a slice, I think they made
20 a very prudent decision of last ten years. They
21 looked at the research that was out there, the
22 studies that were published that were out there,

1 looked at where they had the biggest body of
2 evidence, meaning the number of studies in
3 particular areas, and focused on those.

4 And I think they made very prudent
5 decisions. I think, as a Committee, we have to
6 understand that, when we get to domains, we can
7 now think outside the box. That was a great
8 starting point, got us on the same language, got
9 us some understanding about the research that's
10 out there, but it doesn't lock us in.

11 And for a framework for measures,
12 domains is really where that work begins. And
13 so, there was an initial set that we talked about
14 in the fall, we talked quite a bit at the fall
15 meeting about some other concepts, I'll call
16 them, for adding some domains. And so, the list
17 has gotten expanded here to reflect that
18 conversation that we had.

19 So, I said the co-chairs prerogative,
20 when we talked about the definition of telehealth
21 and telemedicine, there are a lot of
22 organizations out there that have come up with

1 definitions.

2 And I envision, for this group, I'm
3 assuming for this group, and given that it's HRSA
4 funded and NQF name all over this work, that you
5 don't want somebody to read this report and go,
6 well, did you consider this main body that has
7 obviously put domains forward?

8 And NQF has a set of domains. And so,
9 I wanted to make sure that we at least were aware
10 of domains NQF, Katie and I were looking at
11 these, I think they call them measure types, and
12 they're basic categories.

13 And so, if we look at -- our slides
14 are moving -- if we look at what NQF has done in
15 terms of categorizing a set of measures, I just
16 want us to be aware, that doesn't have to lock us
17 in, but going to that last bullet of, are there
18 any other, I want to make sure that if somebody
19 reads this report down the road and goes, well,
20 duh, it's an NQF thing, why didn't you include
21 the NQF categorization of blah, blah, blah, that
22 at least we processed through that.

1 The other big entity that has done a
2 lot of work in this area is AHRQ. And so, AHRQ
3 has the Measures Clearinghouse and they have a
4 set of categories and their categories, likewise,
5 are very similar to NQF's. I think maybe they
6 worked together, like borrowed from each other or
7 something.

8 What's on the screen right now is the
9 National Quality Measure Clearinghouse. This is
10 AHRQ's National Quality Measure Clearinghouse
11 Domain Framework. And the top set that you can
12 see here is healthcare delivery, they've got a
13 bottom set that has all to do with population
14 health.

15 And so, just to look at these and how
16 they have structured their domains, and so, this
17 morning, I heard people talk about quality,
18 within healthcare delivery, they have clinical
19 quality measures, they use, I call it the
20 Donabedian process outcome structure, they've got
21 those in there along with patient experience and
22 access. So, they lump those as sub-domains under

1 a main domain, which is clinical quality
2 measures.

3 They also have what they call related
4 healthcare delivery measures, and this is where
5 you have cost and utilization. And then, they
6 have clinical efficiency measures. So, they
7 actually look at efficiency separate from cost,
8 the way that they structure it.

9 And so, I want people to know that
10 these things are out there and I think it would
11 behoove us to at least have considered. So, I
12 wish we had multiple screens here so we could
13 cross whatever, but --

14 MEMBER DOARN: The one question, I
15 guess, when we talk about domains, I'm wondering
16 -- when you think about advancing technology,
17 what's here today is going to change tomorrow, I
18 mean, that wasn't -- used to not be the model,
19 but that's clearly what's happening now, I'm
20 thinking of things like artificial intelligence
21 and virtual reality, things that actually change
22 the paradigm of the way we teach and the way we

1 see our patients.

2 So, I don't know if a domain should be
3 under technology itself or if that's an
4 underlying part of the foundation of what we're
5 doing.

6 And then, the other one is
7 informatics. How -- the data sets coming out of
8 these electronic health records and populations
9 statistics and so forth, from multiple libraries
10 around the country, or, not libraries, excuse me,
11 databases, that have this information in it that
12 we can utilize to either predict things or make
13 changes.

14 And then, the other one is the whole
15 concept of, maybe it's under management, workflow
16 process, how the physician's interactions with
17 the patients change. They come into the office
18 and they're going to see a patient in ten minutes
19 and then they're going to go to the next patient.

20 But now, it's like, you're going to go
21 sit in this room and you're going to see these
22 patients virtually. And maybe that takes less

1 than ten minutes, maybe it takes longer, I don't
2 know, depending on the case.

3 But the whole workflow as a domain,
4 and, again, it may be under management, but in
5 your original presentation, I don't think the
6 word management appeared there. It's not? Okay.
7 Yes, so, I mean -- so, those were some of the
8 things I think are perhaps missing.

9 CO-CHAIR HOLLANDER: Okay. Marybeth?

10 MEMBER FARQUHAR: Yes. I was going to
11 say that, I was thinking, one, in terms of -- oh,
12 I'm sorry -- the informatics and to build on
13 that, but also the security of the system itself,
14 and having it under a management domain, I think,
15 as Charles had said over there.

16 CO-CHAIR HOLLANDER: Daniel?

17 MEMBER SPIEGEL: So, I know the
18 question is, are there other domains that should
19 be added, I'm actually a fan of consolidation.
20 And there were two opportunities that I saw. So,
21 one was, cost and cost-effectiveness, I don't
22 think you can get -- you can't get to cost-

1 effectiveness without measuring cost, so I don't
2 know that we necessarily need both.

3 And then, the other opportunity, I
4 wasn't clear on the difference between clinician
5 experience and experience of the clinical team, I
6 think those could be consolidated as well. And
7 then, I guess I hadn't -- well, I'll just leave
8 it at that.

9 CO-CHAIR WARD: Okay. So, taking off
10 Daniel's, I agree, and the consolidation may be a
11 good place to start before we think about adding
12 to it.

13 So, if we can focus on places here
14 where folks are comfortable combining,
15 consolidating, grouping. And Daniel suggested
16 the clinician experience, experience of the
17 clinical team, is somebody seeing those as very
18 distinct or can we combine those?

19 MEMBER DOARN: Well, I mean, is there
20 a difference between what a physician, what a PA
21 might see versus a lab tech? I mean, they're all
22 part of that clinical team, but they may each

1 have a different view.

2 And maybe what they have to say -- it
3 ultimately comes down to whatever the physician
4 has to say, but, I mean, those other people have
5 some kind of input, so their experience might be
6 different.

7 CO-CHAIR HOLLANDER: I was going to
8 say, getting back to our broad versus specific
9 conversation before, the fewer categories and the
10 better that more things could fit within each
11 category, the better it is. So, yes, I think we
12 want to be inclusive, but I think we want to be
13 inclusive in preferably no more than five major
14 categories.

15 But, again, it's a framework and
16 making sure, like I think that, Chuck, is great
17 as a pressure test, like if we have something so
18 it doesn't take into account advanced practice
19 providers, that's a problem, but the clinical
20 team being anybody who works clinically, that
21 sort of fits to me, rather than being specific.

22 And I think that the longer the

1 laundry list is, the harder it is. And I thought
2 that what we just saw from AHRQ was sort of a
3 really nice way to lay some of that out and even
4 maybe a little more consolidation may be useful,
5 but they sort of had a nice little roadmap for us
6 to think about.

7 CO-CHAIR WARD: And following up on
8 Chuck's, we're talking domains now, later on this
9 afternoon, we're going to go to sub-domains. So,
10 those may be sub-domains off of -- so, think of
11 broad categories here.

12 MEMBER HALL-BARROW: Yes. So, I would
13 just add to that, then, so, experience, why don't
14 we use the domain of experience and then as we
15 get to the subs, it could be clinician, it could
16 be patient, it could be X. So, that's my first
17 one that I think we should put on there.

18 CO-CHAIR WARD: How do people feel
19 about that, a big domain of experience or
20 perceptions? Okay. And I hear we can edit on
21 the fly, so if we can combine those two bullets
22 into one large domain.

1 And then, Daniel also suggested
2 combining cost and cost-effectiveness. So, cost-
3 effectiveness could be a sub-domain or we can
4 tease it out further. Does that make sense to
5 people to combine those into one large category?

6 MEMBER DOARN: But wouldn't cost-
7 effectiveness and cost be part of, quote/unquote,
8 management or business processes? So, now, you
9 bring it up to a higher level where cost is a
10 subset of how you run your business.

11 CO-CHAIR WARD: How do people feel
12 about that?

13 MEMBER SOSSONG: I guess, just looking
14 at the AHRQ -- and it would be helpful to know
15 how to find that link, I'm searching and can't
16 find it --

17 CO-CHAIR WARD: They have definitions.

18 MEMBER SOSSONG: -- but the cost and
19 resource use is the terminology they use. I
20 think that would be a nice term to use. And
21 then, cost-effectiveness is a subset of that.

22 I would actually say, under

1 effectiveness and efficiency, which is also the
2 term they use, that's where the clinical
3 effectiveness, clinician, system effectiveness,
4 and other things could fall. Which seems to
5 overlap a bit with access.

6 MEMBER HARRIS: Adam?

7 MEMBER DARKINS: I was going to say,
8 one of the sort of things around this is going to
9 be how it gets paid for. So, looking forwards, I
10 mean, there's one thing about, we can do all this
11 work, but if there isn't going to be some form of
12 payment for it, it's going to be difficult to go
13 forwards.

14 And it seems to me there are kind of
15 two alternative ways it could go. One would be,
16 is it going to be reimbursed directly? Given the
17 current environment, with changes in ACA, I guess
18 one would have to say, the likelihood of a whole
19 new entitlement isn't high.

20 So, the other piece around this would
21 be, fitting into a value-based care framework,
22 which is probably going to persist. So, there's

1 a way in which, if you slice and dice this, you
2 could argue that access to care is an element of
3 value, rather than cost and cost-effectiveness
4 and some of these things.

5 It seems to me, it would be, broadly,
6 to end up saying there's an element of value-
7 based care, seems to me -- I think would be
8 useful to be able to focus on, so that if it came
9 to, what framework will be introduced at the end
10 of it, you could think how it fits into both
11 those alternatives.

12 CO-CHAIR HOLLANDER: Okay. I think
13 Peter is next.

14 MEMBER RASMUSSEN: Yes. I mean, I
15 think I fundamentally agree with what Adam is
16 trying to say and I really liked, I think you
17 were alluding to it Judd, is I really liked what
18 was, the framework that was shown here for a few
19 moments, where they lumped together a lot of the
20 clinical stuff together, because to me that makes
21 a lot of sense. And that access and experience
22 and outcomes really reflect clinical behavior.

1 I liked how they had split out that
2 efficiency, specifically, and sort of elevated
3 the importance of efficiency, because a lot of
4 what we do around telemedicine is to improve
5 efficiency as well. I think, to me, this makes a
6 lot of sense, just looking at it without having
7 much opportunity to think about it, but I kind of
8 like the way they lump things together here.

9 CO-CHAIR HOLLANDER: Yael, and then
10 Julie.

11 MEMBER HARRIS: I also like Adam's
12 approach, but then I would say that a lot of it
13 fits under value-based care. So, experience of
14 care is part of the value-based care, when you
15 look at how CMS is defining it. And I worry that
16 then we're just getting too large. So, I might -
17 - can we go back to the other slide?

18 CO-CHAIR HOLLANDER: We're just trying
19 to be on whatever slide we're not on.

20 (Laughter.)

21 MEMBER HARRIS: That one, yes. I have
22 it on my computer, but -- all right, I've got it.

1 So, I'm thinking we -- with these groups, I think
2 access is a domain of itself. And some of these,
3 as we mentioned, it's a Venn diagram, so kind of
4 care coordination fits with access.

5 But then, I'm thinking cost and we
6 break down cost into effectiveness, actual cost
7 of care, we might be able to fit value-based care
8 in there, cost relative to quality or something.
9 Then, I think experience. And then, the sub-
10 domains are patient/family experience, clinician
11 experience, clinical care team experience. And
12 then, I think the whole effectiveness, and you
13 can break effectiveness down into the sub-domains
14 we've talked about.

15 So, I'm not saying all of these are
16 not essentially important, but I think if you go
17 forward with a laundry list, you're less likely
18 to get buy-in than if you go forward with, like,
19 four clear domains and then sub-domains within
20 them.

21 CO-CHAIR WARD: Thank you. I like
22 that.

1 MR. GOLDWATER: I just need a point of
2 clarification before we get to Julie, sorry.

3 CO-CHAIR WARD: That's okay.

4 MR. GOLDWATER: Which is, so, if we're
5 going to consolidate costs into a singular
6 domain, just to clarify, should it be cost or
7 should it follow what Sarah just suggested, which
8 is cost and resource use?

9 MEMBER HARRIS: Cost and resource use.

10 MR. GOLDWATER: Cost and resource use?
11 Do you think it should be cost and resource use,
12 show of hands if it should be cost and resource
13 use. And then, it should just be cost. It
14 should just be cost? Okay. The ayes have it.

15 MEMBER SOSSONG: Okay. Well, I want to
16 --

17 CO-CHAIR WARD: Which aye?

18 MR. GOLDWATER: Cost.

19 MEMBER SOSSONG: Yes, but I want to
20 stop that.

21 MR. GOLDWATER: Okay.

22 MEMBER SOSSONG: So, I want to go back

1 to what Adam said. So, I think when we look at
2 value, I mean, I know it seems very broad, but
3 under value, we could really have some definitive
4 subcategories. Value? Value to who? Value to
5 the patient, improved outcomes. Value to the
6 provider, ability to do continuity of care.
7 Value, meaning what's the cost of this, what's
8 the cost-effectiveness?

9 I'm not so sure that that value
10 grouping would be too broad if we were definitive
11 in what we said. But I did agree with Yael in
12 terms of the pieces with the cost-effectiveness
13 and the access to care being its own domain,
14 access to care.

15 CO-CHAIR HOLLANDER: Adam?

16 MEMBER DARKINS: So, I was just quickly
17 going to say to that point, cost-effectiveness is
18 a very specific entity. So, we're putting cost-
19 effectiveness, are we suggesting that in order to
20 be able to meet quality criteria, you've had to
21 have done a cost-effectiveness study? Which, I
22 would guess, that's not the case. Presumably,

1 you'd want something slightly soften, which is
2 allowing people to end up using this and then, to
3 meet those domains of quality.

4 CO-CHAIR HOLLANDER: So, two comments.
5 One is, I think your last comment asks an
6 important question, but one is, to be included in
7 the environmental scan, there would need to be a
8 study. There doesn't need to be a study to be
9 included in the measure framework or any evidence
10 related to it, which is really the end product.

11 The second thing, and this is just,
12 again, one person's thoughts, I think value is
13 obviously important, but it's the whole thing.
14 Like, I don't think value's a measurement domain,
15 I think the whole thing creates value. And so, I
16 just wonder whether everything we're doing is a
17 domain within value, because if there's no value,
18 it shouldn't be part of a measure.

19 MEMBER DARKINS: So, I wasn't trying to
20 be philosophical about it, what I was suggesting
21 was very practical. And by that, what I mean is,
22 in the end, this is going to have to tie into

1 some kind of framework for reimbursement.

2 CO-CHAIR HOLLANDER: Right.

3 MEMBER DARKINS: So, I'm just saying
4 that one of those frameworks relates to value
5 and, therefore, if you're saying that, one wants
6 to encourage the growth of this, it's going to
7 happen in a value-based framework.

8 How would you provide something that
9 would fit into that framework? Now, whether you
10 call it as such, it was really more, the end
11 results of making sure it was applicable and
12 useful, not necessarily getting philosophical.

13 CO-CHAIR HOLLANDER: Right. So, maybe
14 it's sort of the preamble to the whole measure
15 framework and in the conclusion, that we think
16 this framework, if adopted, will develop measures
17 that will create value, rather than making value
18 a domain within the framework.

19 MEMBER MOEWE: And that goes back to,
20 I think, what Dale said earlier, adoption, it
21 will not be adopted if there is not reimbursement
22 and payment for it. And that really has to be

1 first and foremost in our minds. So, I think
2 both Adam and Dale said that, I just reinforce
3 that, it's very important that we focus on that.

4 CO-CHAIR HOLLANDER: No more.

5 CO-CHAIR WARD: Okay. So, I'll admit,
6 I'm a little confused where we are.

7 CO-CHAIR HOLLANDER: Lunch.

8 (Laughter.)

9 MEMBER GIBONEY: Well, I -- just to try
10 to, because I also am trying to, kind of trying
11 to keep up, I'm hearing domains of access, cost,
12 experience. And then, I heard someone suggest
13 that maybe we lump effectiveness, system
14 effectiveness and clinical effectiveness into one
15 effectiveness category with those two sub-
16 domains. I think there's value in that, although
17 they are quite different.

18 Even though they both use the term
19 effectiveness, which is a term I really like, one
20 is saying, how does this work? Like, what are
21 the logistics, how does this improve the way we
22 do our business, the way we coordinate, the way

1 we do transitions, the way we communicate? And
2 then, the other one, clinical effectiveness is,
3 what is that outcome? Like, how well does it get
4 us to a particular better health outcome?

5 And so, I mean, you could lump those
6 into effectiveness with the sub-domains, but I
7 thought maybe it would be good to think a little
8 bit more about what those two categories are
9 trying to describe. One seems to be a little bit
10 more operational and one seems to be a little bit
11 more end result.

12 CO-CHAIR WARD: Thoughts on that? I
13 hear you. How do people feel about lumping all
14 the effectivenesses together versus having
15 distinct domains for clinical and system
16 effectiveness?

17 CO-CHAIR HOLLANDER: Angela?

18 MEMBER SOSSONG: I think just looking
19 at, again, the NQMC Domain Framework and, like
20 Peter said, not having had a lot of time to think
21 about this, I think it's just about how the group
22 wants to organize it.

1 So, I think, looking back at the way
2 they organized it, I think it's, to the point
3 that you're making Paul, they've looked at health
4 delivery system measures and clinical quality
5 measures, so that, then, breaks it out
6 differently. So, I think it's just a decision
7 point one way or the other, so I don't know if
8 that's a voting point, but I think either makes
9 sense as long as people are clear on which way it
10 goes.

11 CO-CHAIR HOLLANDER: Angela?

12 MEMBER WALKER: This is maybe more a
13 question for the group, but I wonder if quality
14 falls under clinical effectiveness? I think we
15 had talked about that at a prior meeting. And,
16 if so, is there any distinction made from domain
17 versus sub-domain and would that, in any way,
18 indicate that we're de-emphasizing it from others
19 that we've labeled as domains?

20 CO-CHAIR HOLLANDER: I'm going to ask
21 a question to your question, because it now
22 confuses me. So, I'm not sure that quality would

1 only fit in the effectiveness category. I could
2 see it fitting -- maybe it doesn't really fit in
3 the cost, but maybe it fits in the cost-
4 effectiveness category.

5 It certainly should fit in the access
6 category and you could probably argue both ways
7 whether it fits in the experience category. So,
8 quality may, again, be a higher level than what
9 we're discussing now. I'm not sure how to
10 incorporate that. Henry?

11 MEMBER DEPHILLIPS: So, just to finish
12 that out, quality is -- when I first sat back
13 down, and I apologize for being out of the room -
14 - quality is not explicitly indicated as a domain
15 here. And that's, to me, a little bit troubling.

16 So, I guess, based on what you just
17 said, Judd, is quality like value, it just goes
18 across all of these things? Are we going to have
19 it as an overarching, integral feature? Will it
20 be called out that way? Or do we have a domain
21 called quality of care, quality of outcomes?

22 MR. GOLDWATER: So, as the, one of the

1 NQF staff, so quality of care -- here's what I
2 have so far, let me just make sure I'm getting
3 this clear, for all of our benefit.

4 So, the domains that I've been able to
5 compile, now we've gone from those to essentially
6 four, which are access to care, value-based care,
7 which would be encompassing cost and presumably
8 quality, experience, and effectiveness, unless we
9 decide to split effectiveness out into two very
10 distinct domains, which I don't think we've
11 concluded yet.

12 Quality of care is a pretty broad
13 term. And so, the danger of that, and for those
14 who develop measures, please speak up, is there's
15 different types of quality of care measures,
16 they're not just all focused on the outcome.

17 So, if you say quality of care, then
18 you're looking at things like structure and
19 process and experience, which we then would be
20 sort of duplicating ourselves, and outcome. So,
21 I think that I -- I think the intent was quality
22 is sort of infused in all of this, because there

1 will always be process and structure and outcomes
2 that will be involved in all of them.

3 CO-CHAIR WARD: Okay. You just
4 confused me, because I thought we were -- it
5 wasn't value, was the name of that domain, but it
6 was cost was the name of a domain and that value
7 encompasses a whole bunch of -- is assumed in a
8 bunch of these.

9 MR. GOLDWATER: Okay.

10 CO-CHAIR WARD: So, I need
11 clarification from the group on, when we talked
12 about lumping cost and cost-effectiveness, what
13 are we calling that? Are we calling that cost or
14 are we calling that value-based care?

15 CO-CHAIR HOLLANDER: So, Paul's up, but
16 let me say something first.

17 MEMBER GIBONEY: Yes, I'm not answering
18 that exact one.

19 CO-CHAIR HOLLANDER: Okay. So, let me
20 just, trying to think on the fly, maybe value's
21 not up top, maybe quality is up top, because then
22 cost, right, then you have quality divided by

1 cost or cost divided by quality or the
2 relationship between them is then value, and the
3 other things all fall related to quality
4 underneath.

5 So, maybe value is implicit, because
6 you have quality and then the other domains. I
7 don't know, I'm just trying to think in a logical
8 way to present it. So, value becomes inferred,
9 based on the quality relationship with the
10 domains. New topic, Paul.

11 (Laughter.)

12 MEMBER GIBONEY: All right. I was
13 thinking back to the effectiveness thing, as
14 Jason was doing his summary. Access, cost,
15 experience, and then, if we -- what if we say
16 system effectiveness, the way we do -- the way
17 telehealth helps us do business, accomplish all
18 of our various functions, and then, instead of
19 clinical effectiveness, clinical outcome?

20 So, it's a little bit more targeted
21 as, are we actually, Angela and I were talking
22 earlier, are we catching the melanomas earlier?

1 What is the outcome of melanoma because of what
2 we're doing?

3 Anyway, that would lead us to five
4 domains instead of four, but I think for people
5 that are actually trying to do telehealth,
6 calling out how we go about doing what we're
7 doing and what the clinical outcome at the end
8 is, would be an important distinction for people
9 that are looking from the outside and saying, how
10 do I implement this at the County of Los Angeles?

11 CO-CHAIR HOLLANDER: Peter?

12 MEMBER RASMUSSEN: I just want to go
13 back to your comments about quality a minute ago,
14 Judd. I think, I can't say I agree with your
15 concept that quality is sort of pulled out and is
16 overarching, because I think to the day-to-day
17 caregiver, quality is me giving antibiotics 30
18 minutes prior to skin incision. It's a different
19 meaning.

20 I think you were trying to get at
21 quality is great care, but I think it confuses --
22 there's a big Q and a bigger Q, I guess, to

1 quality. So, I'm just a little bit worried about
2 how, if you use quality, it's going to be
3 confused.

4 CO-CHAIR HOLLANDER: Adam?

5 MEMBER DARKINS: I was going to say, it
6 may sound a bit trite, but I find in these
7 situations, it's helpful to think of who the
8 customer for this is. And so, if one thinks
9 about it, when you implement telemedicine
10 programs or telehealth programs or whatever you
11 want to call them, e-health programs, one of the
12 customers for a quality program of what we're
13 doing is the everyday clinician, who's providing
14 services in a setting.

15 They need persuasion that what they're
16 going to do is going to be safe and it's not
17 going to end up putting patients at risk. So,
18 there's a piece around it where they need to be
19 able to use it.

20 There's a piece around it where, if
21 you're a hospital provider, you have to be able
22 to ensure, as you're moving into this new area,

1 you've got the ability to do it safely and
2 effectively. And you can look at payers.

3 So, I think there are ways in which we
4 should broadly categories things and we can slice
5 and dice it, but how we eventually slice and dice
6 it should be really, in part, around who's going
7 to use it, rather than us thinking about it from
8 a kind of more theoretical level.

9 Does that -- so, I think, we could
10 spend forever arguing one way or another what
11 some of this should look like, but if we can
12 broadly categorize it, we can then come back.
13 But it seems rather than worry about the domain
14 at the top and then work down, let's worry a
15 little more about how it's going to be used and
16 how it's going to make sense at the bottom, and
17 then end up reshaping those -- does that sound
18 acceptable?

19 CO-CHAIR HOLLANDER: So, I'm going to
20 sort of ask a question on that of Jason and
21 staff. I think that's about attribution, and you
22 correct me if I'm wrong. When a measure gets

1 developed, for those of you that haven't been on
2 measure committees, it gets attributed
3 effectively to a responsible party.

4 I'm probably using all the wrong NQF
5 words here. But it might be attributed to the
6 ACO to provide care for patients with heart
7 failure, how do they do it system-wide? It might
8 be attributed to the primary care provider and it
9 may still be about heart failure.

10 Or it might be attributed to the
11 cardiologist who takes care of them in the
12 outpatient setting. Or post-surgery, be
13 attributed to the surgeon over the next year,
14 even though the surgeon has little to do with
15 what happens over the next year afterwards.

16 So, I think, and, again, correct me if
17 I'm wrong, that the attribution takes care of
18 Peter's case, who's the quality and how is it,
19 like you probably wouldn't be in charge of
20 quality for a whole year on a timed antibiotics
21 thing.

22 It may be a system thing or it may be

1 a surgeon thing or it may be an anesthesiologist
2 thing, who it's attributed to, and then, it would
3 drill down to that level. And so, the quality
4 would impact that measure for that provider, as
5 compared to a different measure may impact
6 quality for all of United in how they administer
7 things. Is that somewhat accurate?

8 MR. GOLDWATER: So yes, that's
9 accurate. So whenever a measure -- now, keep in
10 mind, not a measure concept, an actual quality
11 measure that will be used in a program --
12 whenever a committee decides to endorse that
13 measure or whenever that measure is put forward,
14 actually, there is an attribution of who is that
15 applying to? Most of the time, it's the
16 clinician. The clinician takes an action that
17 leads to a result, and as a result, based on
18 evidence, that indicates high quality of care.

19 Over time, however, as we have moved
20 more into care teams providing comprehensive care
21 to patients for a variety of reasons, or we
22 watch, particularly in the post-acute/long-term

1 care area, where there are transitions between
2 care, attributions become a little bit more
3 muddled. Because the measure itself may be
4 attributed to a singular provider, even though
5 that singular provider is not solely responsible
6 for the care of that patient.

7 So I think, to get to Adam's point,
8 which I think is a good one, is, as we start
9 building, and this is further down the line, when
10 those measure concepts start to get developed, it
11 becomes important to think about how that would
12 be attributed and how that would be affecting
13 ultimately the clinician or the patient or the
14 care team.

15 How would that be developed in a way
16 where the attribution is appropriate? Because
17 then that addresses, I think, that very
18 legitimate concern, which is, who is ultimately
19 going to be using this? Because if you look at
20 these concepts and see how they're being
21 attributed, then it shows how those would be
22 implemented in a way that would be beneficial.

1 CO-CHAIR HOLLANDER: Okay. Angela, are
2 you up, down?

3 MEMBER WALKER: Kind of undecided, I'm
4 still thinking through the thought.

5 (Laughter.)

6 MEMBER WALKER: So having brought up
7 the question and then heard some discussion about
8 it, I think I would advocate for the removal of
9 quality and not have it be an overarching thing
10 either. Because I do think, now, in retrospect,
11 that maybe it is too vague a term, and it
12 probably does relate to each of these in some
13 small piece or way.

14 And then I started to think back, from
15 kind of a use case scenario, if I'm a
16 dermatologist and I want to catch melanoma
17 earlier, as Paul and I had talked about, my
18 measure might be that 80 percent of melanomas I
19 detect are thin-stage, and how do I achieve that?
20 That might fit under a subdomain of clinical
21 accuracy, which is kind of quality of care. And
22 that might fit under the domain of the physician

1 experience.

2 So I can kind of track back of, what's
3 my goal for something I can measure that provides
4 or increases good care from a measure to a
5 subdomain to a domain, and make it fit into kind
6 of the algorithm we have? So it may be that
7 we've caught what we need to catch with the four.
8 And I'll leave it to the group to define what
9 those four are.

10 CO-CHAIR HOLLANDER: Stewart?

11 MEMBER FERGUSON: So it's 7:30 in
12 Alaska, so I have two thoughts now.

13 (Laughter.)

14 MEMBER FERGUSON: But I guess I'm
15 challenged by this thing, is quality the overall
16 one, or is value the overall one? I think when
17 you do telehealth, you don't even start doing it
18 unless you meet a quality standard, and you don't
19 keep doing it unless you meet a value standard.
20 So I think they're both -- one gets you in the
21 door, one keeps it going, to some extent, in a
22 very crude way of looking at it.

1 So I don't know if -- I guess I'm not
2 particularly interested in arguing if quality is
3 the overall one or value is the overall one. I
4 think they both need to be there for telehealth
5 to even happen.

6 But I want to kind of put a vote in
7 for what Paul was talking about. I like the idea
8 of having a system effectiveness domain. I think
9 that's missed a lot of times. I think we talk
10 about more the micro level with telehealth, its
11 value, it costs less; we have better access, et
12 cetera, but really what happens when you embrace
13 it in an organization is the system becomes much
14 more effective. And that's really important that
15 we keep that -- I vote very strongly for that
16 being one of our top-level domains.

17 CO-CHAIR WARD: Okay. I want to circle
18 back. In the very beginning, a few people
19 mentioned some other items. And the ones that I
20 jotted down were workflow, management. Do people
21 feel like those are encompassed, going to be
22 subdomains, fit within one of our existing ones?

1 The other new ones I heard were
2 informatics, technology, and security. Adoption,
3 reimbursement. Okay. Going back to informatics,
4 technology, and security, which my brain kind of
5 bundles together, are they going to fit in here,
6 do they belong as a separate domain, or will they
7 be encompassed with what we've got?

8 CO-CHAIR HOLLANDER: Angela?

9 MEMBER WALKER: Depending on how
10 broadly we're willing to look at system
11 effectiveness, I think they're here.

12 CO-CHAIR HOLLANDER: I would agree.

13 CO-CHAIR WARD: Okay. So what I'm
14 hearing is we've kind of boiled this down to
15 four.

16 CO-CHAIR HOLLANDER: What are those
17 four?

18 MR. GOLDWATER: Five.

19 MEMBER GIBONEY: Clinical outcomes is
20 not part of system effectiveness, I propose.

21 MR. GOLDWATER: So the five that I
22 have, all right, access, cost, experience, system

1 effectiveness, clinical effectiveness. Is that
2 accurately representing?

3 CO-CHAIR WARD: Angela wants you to
4 repeat.

5 MR. GOLDWATER: Yes, Angela, I'll go
6 slower.

7 (Laughter.)

8 MR. GOLDWATER: You West Coasters,
9 seriously, really? Access to care, or I guess
10 just access; cost; experience; and then, system
11 effectiveness, which would relate to how business
12 is being done or how you do business; and
13 clinical effectiveness, which would deal
14 specifically with a clinical outcome. Is that
15 correct, Paul? So is that accurate?

16 MEMBER ALVERSON: To this point.

17 MR. GOLDWATER: Okay, Dale says yes.
18 We're done. That's it.

19 (Laughter.)

20 CO-CHAIR HOLLANDER: So I want to argue
21 to combine the two effectiveness categories. And
22 this is my rationale. There's things that will

1 be hard to define which one they're in, and
2 there's probably things that will fall through
3 the cracks in the middle right now.

4 So system effectiveness, I think we
5 could think some of the technology clearly fits
6 in that. But the clinical effectiveness, there's
7 areas where maybe that's system effectiveness;
8 maybe that's clinical effectiveness, if there's
9 multiple providers.

10 I mean, I don't know. I guess we're
11 trying to develop something broad and if
12 effectiveness is -- so what's the disadvantage of
13 just effectiveness with the subdomain being
14 system, clinical, other? It's still highlighted.
15 And I guess I'm asking the question if giving us
16 broader effectiveness makes it more adaptable as
17 new things evolve in the future, rather than
18 pinning it to two categories.

19 CO-CHAIR WARD: Now you've done it.

20 Yael?

21 MEMBER HARRIS: So, I'm going, I know
22 you're looking for dissenters, but I'm going to

1 agree with that and I think I'm going to point
2 out specifically care coordination and
3 transitions. Because it's a system
4 effectiveness, but it's also, quality and
5 outcomes are clearly related to that.

6 And so I think when we put these as
7 two separate domains, when we get to the sub-
8 domain of care coordination, which I think
9 everyone in the room is going to agree, where
10 does it go, and does that undermine if someone is
11 trying to develop measures in the other category
12 where we didn't list it?

13 MEMBER DOARN: Can you pull up the
14 other document?

15 CO-CHAIR WARD: The AHRQ one?

16 (Laughter.)

17 MEMBER DOARN: It would be nice if they
18 were split-screen.

19 CO-CHAIR WARD: I know.

20 MR. GOLDWATER: You're so high
21 maintenance, Chuck.

22 MEMBER DOARN: Technology. So these

1 domains have been approved by a similar committee
2 to this, many years ago perhaps, I don't know.
3 Telemedicine and telehealth are tools to practice
4 medicine. These are for medicine. Why not just
5 use these? And these things we just mentioned
6 fit into every one of those categories.

7 In other words, why reinvent the
8 wheel? The wheel is here. It's different, I
9 mean, it's a different wheel, maybe it's taking
10 us to a different place, but a lot of the things,
11 as I read them, process, access, outcome,
12 structure, patient experience, I mean, the things
13 we mentioned here are basically the same as
14 these. We're just using different tools to get
15 there.

16 MR. GOLDWATER: So can I interject,
17 Marcia?

18 CO-CHAIR WARD: I guess.

19 MR. GOLDWATER: Okay, all right.

20 (Laughter.)

21 MR. GOLDWATER: So you're correct that
22 there was a committee a long time ago that built

1 sort of this framework. Where I would disagree,
2 respectfully, Chuck, is that this is really
3 focused very heavily on measurement. Like these
4 are talking about measures that already exist and
5 how they're classified.

6 What we're talking about now are
7 measures that, at this point -- we listed
8 measures that we identified because of what the
9 literature was leading us towards, but there
10 still hasn't been a conclusion by this group as
11 to whether those measures actually apply. So
12 what we're really talking about is measures that
13 have not been developed yet, that would
14 effectively examine telehealth.

15 And the point of the project is for a
16 framework to be developed that allows those who
17 are implementing and running telehealth programs,
18 those that develop measures, and those that are
19 involved with quality of care to be able to
20 develop measures specifically around telehealth.

21 So while you're correct in that there
22 are some overlaps between the NQMC and what we're

1 doing, in some cases they're not, because we
2 don't really -- there are no process measures
3 related to telehealth at this point. There are
4 no structural measures to telehealth at this
5 point.

6 And we don't even know if -- I think
7 we have to sort of go through the concept
8 exercise to see what falls out of that and how it
9 specifically relates to telehealth. This is, to
10 me, this is extremely broad to cover the entire
11 universe of quality measurement.

12 MEMBER DOARN: So I'll just use it as
13 an example. In healthcare we decided at some
14 point in the last 20-30 years, I suppose, to do
15 laparoscopic surgery, rather than open. I mean,
16 we still do open surgery. And laparoscopic
17 surgery was developed back in the 20s, but it
18 didn't really -- you still had to have huge hole
19 in the abdomen to do it.

20 You now have this being approached in
21 1992-1993 and you fit this in this model, right?
22 Now, you come up and say, well, I'm going to use

1 this laptop, and I'm going to put a camera on it,
2 and I'm going to talk to the patient from a
3 distant site. Why doesn't it fit in this model?

4 MR. GOLDWATER: So the difference here,
5 Chuck, is the idea that you moved to laparoscopic
6 surgery would not fit into that. You'd have to
7 build measure concepts around laparoscopic
8 surgery to evaluate it. Once those measures are
9 built, the measures would fall under this. So we
10 are -- what you're looking at is a step further
11 from where we are.

12 CO-CHAIR HOLLANDER: Okay. Angela --

13 MEMBER DARKINS: One point to just add
14 to that, Chuck, is, essentially, laparoscopic
15 surgery takes place normally in one institution,
16 in an operating suite. What we're developing as
17 measures are going to help develop a network,
18 which is going to link several different
19 facilities together. Therefore, I think that
20 this needs to be able to do that function, which
21 would make it slightly different.

22 CO-CHAIR HOLLANDER: Okay. Angela,

1 Sarah, Dale.

2 (Laughter.)

3 MEMBER WALKER: I can certainly see the
4 point to use what's already in existence,
5 especially if it's looking at clinical care, and
6 we're thinking five years in the future, when we
7 no longer refer to telecare as telecare but just
8 care.

9 But while we may not use this at the
10 onset to kind of develop the structure for how we
11 should look at telemedicine and telehealth, it
12 might be important or prudent to make sure that
13 we've encompassed each of these into the
14 structure that we build or into the framework
15 that we build.

16 CO-CHAIR HOLLANDER: Sarah?

17 MEMBER SOSSONG: I think, going back to
18 the original question around, is it the five or
19 four? So access, cost, experience, and then,
20 effectiveness, does that get broken down?

21 I mean, personally, I'd be supportive
22 of it being effectiveness as a single category,

1 but I'd say that system delivery would be an
2 important other metric, because I think if system
3 delivery is a subcategory of effectiveness, it
4 would be easy for that to get lost.

5 So I think I would suggest the access,
6 cost, experience, system delivery, and
7 effectiveness, only because there are things,
8 adoption, management, utilization, so there are a
9 lot of things that fall under how the system
10 manages telehealth that I think are important to
11 have at the highest domain level, personally.

12 CO-CHAIR HOLLANDER: Okay. Dale?

13 MEMBER ALVERSON: I totally agree with
14 Sarah, four domains. I took, I just looked at
15 the common words: access, cost, experience,
16 effectiveness. And then, you have the sub-
17 domains that Marcia is talking about.

18 MEMBER SOSSONG: What about the system
19 delivery?

20 MEMBER ALVERSON: I think it can fit
21 under effectiveness.

22 CO-CHAIR HOLLANDER: So I want to

1 follow up on Yael's comment on the care
2 coordination piece, with a little bit of an ER
3 story. So anybody who's been to an ER or ever
4 worked in ER management, right, people don't want
5 readmissions and people don't want ER boarders.
6 And one of our CMS Star Ratings for ER flow is
7 door-to-bed upstairs or door-to-admission.

8 I don't control upstairs. I control
9 when I decide to admit the patient, but I can't
10 move them upstairs if all the beds are filled.
11 And hence, that's like a major care coordination
12 thing that I actually, personally get dinged on,
13 but it's really a system effectiveness thing.

14 So I don't know in what bucket, if I
15 have to split clinical effectiveness and what I
16 do from system effectiveness, and so I love them
17 being tied together, because a lot of what we do
18 as an individual, we can't possibly do unless the
19 system is built.

20 And when we split it, we'll have
21 measures that penalize providers or help
22 providers when they don't actually control it.

1 Whereas if it's all together in one effectiveness
2 pot, it makes the administrators who control our
3 destiny at the hospital level play nice, or we
4 can't possibly win, and it puts them with some
5 skin in the game.

6 So as I sit here thinking about it, I
7 think, wow, what if you didn't blame me for your
8 problems? How much easier would it be to fix?
9 And the reality is, that's what happens.

10 Every avoidable ER admission, which is
11 a term that kills me, but is really important, is
12 because somebody sent that patient to the ER when
13 they shouldn't be there, and now the poor ER doc
14 is stuck with, what do I do with this patient
15 that the system has already failed, and they get
16 yelled at for admitting the patient, when
17 effectively their primary care provider decided,
18 oops, I can't take care of them. So I love tying
19 the clinical/provider level and system
20 effectiveness together for that reason.

21 CO-CHAIR WARD: Okay. I'm seeing nods.
22 I'm hearing four. Do we have dissenters against

1 four?

2 MEMBER DARKINS: I don't want to waste
3 time on it, because I think we should just go
4 forward. All I will just say, the converse of
5 what you describe is you've got two different
6 tribes, and so it can sometimes be less
7 functional.

8 If you have an overall quality
9 framework with four subcommittees, you end up
10 resolving those problems at that level. If you
11 have two -- I mean, if you've got people involved
12 in IT and people involved in system
13 effectiveness, which is very technical, and you
14 get physicians trying to get themselves all
15 caught up in the weeds of stuff they don't know,
16 you find yourself with a dysfunctional -- so I
17 can play it either way, but I just put to you the
18 fact that your n of 1 and your frustration is
19 equally well seen on the other side.

20 CO-CHAIR HOLLANDER: I guess my counter
21 is, it can still be dealt with at the subdomain
22 level. So it could still be effectiveness, and

1 then the measure could be in the effectiveness
2 domain --

3 MEMBER DARKINS: I don't want to argue
4 --

5 CO-CHAIR HOLLANDER: Okay.

6 MR. GOLDWATER: Okay. So, we're all in
7 agreement for four?

8 MEMBER GIBONEY: Violent agreement.

9 MR. GOLDWATER: Violent agreement?
10 I'll tweet about that.

11 (Laughter.)

12 MR. GOLDWATER: No I'm kidding, just
13 joking. So now that we have four -- what's that?
14 Yes, I'll wait until this weekend at 6:00 a.m.
15 and then I'll start tweeting. So now that we
16 have four domains, I'm not sure we need to engage
17 in a prioritization exercise. Do you think we
18 do?

19 Because I mean, when we anticipated
20 this originally, we thought, oh, there will be 16
21 to 18 domains and then -- well, Stewart, it's not
22 like you all are shy about your ideas, which is

1 why you're here -- and so, we thought, if there's
2 16 -- and I know it's 8:00 in Alaska, thanks, I
3 get it.

4 (Laughter.)

5 MR. GOLDWATER: So now that it's -- we
6 thought if there were 18 domains, we can't do all
7 of that. That would be too overwhelming, so we
8 probably need to prioritize the four or five, but
9 you all have done this for us.

10 So I'm not sure that we need to engage
11 in this. I don't -- I just want to say, I wish I
12 could take you all to every freaking committee
13 meeting I have. I mean, my life would be a lot
14 easier if -- so, what are you all doing in two
15 weeks? I'm kidding. All right. Okay. So I
16 think at this point --

17 CO-CHAIR WARD: I suggest giving us a
18 preview of what comes next.

19 MR. GOLDWATER: So what comes next is
20 we have four domains. So we were going to break
21 you all into groups and have you start
22 identifying subdomains, so those areas that are

1 relevant to each one of these sort of overarching
2 domain categories. And then after some time,
3 report out about what you have come up with.

4 And then we'll have a discussion about
5 what people think about those domains,
6 subdomains, rather. We'll narrow those down, and
7 then we'll come up with a list of subdomains
8 under each one of the domains.

9 And then, we'll start talking about
10 either what measures you already have in mind
11 that you would like to apply to those or what
12 measure concepts. So either it can be very
13 specific measures or it could just be sort of
14 overarching concepts. So I think, I mean,
15 ideally, we were going to think about how to
16 break you up during lunch, which we now can't do.
17 So we're going to just sort of wing this about
18 how to break people up.

19 MEMBER HARRIS: Just a quick question.
20 What if two of the breakout groups come up with a
21 similar concept?

22 MR. GOLDWATER: Then --

1 MEMBER HARRIS: I know we were trying
2 to be as black and white as possible, but it's
3 not possible, so I was wondering how that will be
4 resolved?

5 MR. GOLDWATER: So I think when we have
6 the discussion, that will facilitate, if we have
7 two identical concepts, then you all will have to
8 decide, if that's a relevant concept, where does
9 it fall? And a majority of the group will
10 dictate where that ends up. Does that sound
11 reasonable?

12 I'm going to take that as a yes.
13 Okay. So I guess we'll break up. Maybe we
14 should break up into four groups, since we have
15 four domains. Do you want to do that?

16 CO-CHAIR HOLLANDER: So do we want to
17 have a group with each domain just do that domain
18 --

19 MR. GOLDWATER: Yes.

20 CO-CHAIR HOLLANDER: -- or each group
21 does all four domains?

22 MR. GOLDWATER: No, just that one

1 domain, that would probably be easier. What was
2 that supposed to mean?

3 CO-CHAIR HOLLANDER: I should use my
4 microphone.

5 MR. GOLDWATER: Oh, right.

6 (Laughter.)

7 MR. GOLDWATER: Okay. So --

8 CO-CHAIR WARD: I'm guessing that maybe
9 there's some folks that really want to be in a
10 particular domain. They love that concept.

11 MR. GOLDWATER: Okay. Does anybody --
12 what's that?

13 (Laughter.)

14 MR. GOLDWATER: You guys, sometimes
15 Chuck has really good ideas. This was one.

16 CO-CHAIR HOLLANDER: So, I'm going to
17 pose a process measure here.

18 MR. GOLDWATER: Okay.

19 CO-CHAIR HOLLANDER: Because a lot of
20 our discussions initially are, like, what the
21 hell is a domain, and what are we trying to do?
22 And I wonder if we're not better off beginning

1 this exercise with the big group and going
2 through --

3 MR. GOLDWATER: Sure.

4 CO-CHAIR HOLLANDER: -- one of them and
5 at least sort of clarifying what we're trying to
6 accomplish.

7 MR. GOLDWATER: Go ahead. It's your
8 meeting, go ahead.

9 CO-CHAIR WARD: I like that idea.

10 CO-CHAIR HOLLANDER: Okay.

11 MR. GOLDWATER: Okay. You're up, Judd.

12 CO-CHAIR HOLLANDER: Marcia's going to
13 lead this part of the meeting now.

14 (Laughter.)

15 CO-CHAIR HOLLANDER: So, of the four,
16 I guess, is there anybody that prefers doing,
17 probably the -- maybe I'm just going to totally
18 screw this up, but probably the one that might be
19 simplest in my mind is the experience one.

20 And if we can work through and drill
21 down in sub-domains there, it may give us an
22 idea. Like, we might be able to resolve that

1 one, potentially, around the table. I imagine
2 the effectiveness one is going to go on forever.

3 But maybe we could try discussing what
4 would be a subdomain in the experience space as a
5 group and use that as an example, and then if we
6 get lucky and can reach resolution on that in the
7 next little bit, then we can just split into
8 three groups probably to finish up the other
9 three. Does that seem reasonable? Okay, I got
10 two head nods; I'm going with it. Okay. So what
11 do people think would be sub-domains in the
12 experience group? Chuck?

13 MEMBER DOARN: Maybe I shouldn't speak.
14 Okay, there you go. I was thinking, you have
15 more than -- I mean, you have the patient, and
16 you have the physician. Those are two, but you
17 also have IT support. You have business
18 processing, the people who are doing billing, the
19 people who are involved in the infrastructure of
20 the clinic or the hospital.

21 So it's not just the patient
22 experience. And then, you have the family as

1 well, so you have multiple different levels of
2 people looking at this experience. And you
3 pointed out, Judd, about the 94-year-old doesn't
4 really want to do anything, but the family
5 members obviously want to do the telehealth, is
6 an example.

7 CO-CHAIR HOLLANDER: Daniel?

8 MEMBER SPIEGEL: So given we've gone
9 from two experience domains to one, I think the
10 original two are pretty good subdomains, being
11 patient and family experience as one subdomain
12 and then clinician or clinical team experience as
13 a second subdomain.

14 CO-CHAIR HOLLANDER: Okay. David?

15 MEMBER FLANNERY: I don't know how
16 granular you want to get for subdomains, but I
17 would think, for the referring physician to a
18 specialist, that might be another scenario, like
19 how they're pleased with it, how effective it is,
20 that kind of stuff.

21 CO-CHAIR HOLLANDER: Daniel, you back
22 up or are you still -- so do we want to lump, and

1 I'm not sure how many sub-sub-subdomains we have,
2 is provider good enough, or is it physician, PA,
3 blah, blah, blah, referring, receiving, or is it
4 just provider experience is the subdomain?

5 That, in my mind, doesn't mean you
6 can't have a measure that assesses the experience
7 of the referring physician, but again, within the
8 subdomain, I don't know that we need to drill
9 down to every person.

10 And then, when I think, some of the
11 tortures of my shop are actually billing, I don't
12 think there's going to be a measure that assesses
13 billers' experience. So I think it's what is
14 there likely to be measures that come out of?
15 And maybe the way to deal with all the other
16 things is to have an other.

17 So it may be patient and family, and
18 then do we want the patient and family/caregiver
19 together? Or do we want one for patient, and is
20 the family and caregiver totally different?
21 Because it is a different experience. Paul?

22 MEMBER GIBONEY: So I think David

1 brings up a really good point, and maybe it's
2 more of a question. So yes, we have two
3 providers. We have one that is requesting
4 expertise and then one that is providing the
5 expertise, and they're interacting via
6 telehealth. Both are providers, so you could
7 talk about the provider experience. But when
8 we're really getting down to measures, you're
9 going to have different measures.

10 You're going to have, what is the
11 PCP's experience of this thing, because that's
12 one very large, significant stakeholder in any
13 telehealth solution. Then you've got the expert,
14 the specialist or whatever on the other end, what
15 is their experience?

16 And so I guess my question is, if we
17 leave the subdomain of provider experience or
18 clinical team experience, does that still give us
19 the freedom to, with the measures, to break it
20 down into all the possible providers? Or do we
21 want to, in the subdomain, kind of say, requester
22 of the service, the provider of the service?

1 Maybe that's more of like, where is this going
2 from the subdomain?

3 CO-CHAIR HOLLANDER: Right. So, maybe
4 it's actually the text around the framework that
5 says -- because then you get to, well, is it the
6 cardiologist? Well, what if it's an
7 electrophysiologist? What if it's a heart
8 failure guy or gal? Let's come this way,
9 starting with Dale.

10 MEMBER ALVERSON: Not to initially
11 muddy the water, but I think about this from a
12 lot of standpoints, and I'd surely invite
13 comments from someone who may represent the
14 payers, because we're talking about
15 reimbursements. So what is the payer's
16 experience related to the use of
17 telemedicine/telehealth?

18 So we've talked about the patient
19 being the ultimate, and the family, the
20 providers, and you mentioned both the requester
21 and the consultant, but I'm curious about the
22 payers and how we relate to their experience with

1 the use of these, of telehealth/telemedicine.

2 CO-CHAIR HOLLANDER: Sarah? Oh, you
3 went down? Okay, Chuck?

4 MEMBER ALVERSON: Yes, I'm looking at
5 Don, but --

6 MEMBER GRAF: Well, from a payer
7 perspective, at least from mine, ours is really a
8 compilation of representing the patient and the
9 provider experience, because they are our
10 constituents. And so I don't really have a sense
11 of having an individual separate payer
12 experience; our experience is defined by theirs.
13 And family and --

14 CO-CHAIR HOLLANDER: Right. Okay.
15 Sarah, are you still down? You're down? Okay.
16 Chuck?

17 MEMBER DOARN: So, the reason why I
18 bring up the business thing is, I'll use a da
19 Vinci robot as an example. So the physicians
20 want to use the robot to do surgery.
21 Administration decides to do the capital
22 investment and buy the robot.

1 And everybody's on team, except one
2 group, and that's the OR nurses. They're like, I
3 won't use the language, but they were like, so
4 you made this decision to do this, and now we can
5 only do seven operations today instead of twelve.
6 That impacts the business model.

7 So they never really -- you never --
8 and if you're going to introduce a new
9 technological approach, you have to get everybody
10 on the same team or everybody on the team on the
11 same page.

12 And if you can measure that, you can
13 say, okay, well, it's great, because the doctors
14 like it; the PAs like it; the patients like it.
15 But the business process hates it for a variety
16 of reasons: they're not getting reimbursed; it's
17 too difficult; the guidelines and regulations
18 from the payers are -- so that's why I added that
19 as one.

20 CO-CHAIR HOLLANDER: Is that system
21 effectiveness rather than experience?

22 MEMBER DOARN: Well, I mean, I guess.

1 It could be probably across both.

2 CO-CHAIR HOLLANDER: Okay.

3 MEMBER GIBONEY: Yes, I --

4 CO-CHAIR HOLLANDER: Stewart?

5 MEMBER GIBONEY: Oh, sorry.

6 CO-CHAIR HOLLANDER: Stewart, then
7 Paul.

8 MEMBER FERGUSON: So in small rural
9 communities, oftentimes we look at the community
10 experience as well. A little bit different from
11 patient, family. I mean, you look at the impact
12 of sexual abuse, drug and alcohol abuse, crime,
13 depression, there's so many other factors that we
14 can look at from a community perspective that
15 don't fall under family or patient.

16 CO-CHAIR HOLLANDER: Okay. Paul? And
17 then Eve-Lynn. Paul and then Eve-Lynn.

18 MEMBER GIBONEY: Okay. Yes. So,
19 something that both you guys just said is, I
20 don't think he's concerned about his experience.
21 I think he's more concerned about, what is the
22 business proposition here? How is it meeting a

1 need? What am I paying for it?

2 When I think of experience with
3 technology, I'm thinking about how easy it is to
4 use, how comfortable am I with it, how much it
5 makes my day go better. I mean, experience is
6 more of this, what -- the something new has
7 happened. How is that making me feel? How is
8 that going along?

9 There's other metrics that can deal
10 with, how am I going to bill for it? And how --
11 that's not experience. I think the way we're
12 talking about it, my experience with my iPhone
13 is, how does it help me do what I want to do?
14 It's not, what is my plan like? What is Verizon
15 charging me? How much data do I have? Maybe
16 that feeds into experience a little bit, but
17 it's, how does this thing work?

18 CO-CHAIR HOLLANDER: Eve-Lynn?

19 MEMBER NELSON: This is similar to
20 Stewart's example, but I think there's also the
21 presenter. Especially with kids, we have this
22 school on the other side who may or may not be

1 the referrer, but the person who's facilitating
2 that on the other end, and their experience.

3 CO-CHAIR HOLLANDER: So how would you
4 sort of encapsulate that in a heading as a sub-
5 domain?

6 MEMBER NELSON: I guess for us, it's
7 the presenter. That's what we would title that
8 person. You could call it a champion or --

9 CO-CHAIR HOLLANDER: Is that sort of
10 the patient/family caregiver? Would that count
11 as a caregiver. It's not the way we think of it
12 as the person who --

13 MEMBER NELSON: No, it --

14 CO-CHAIR HOLLANDER: -- goes in the
15 home --

16 MEMBER NELSON: It would be more -- for
17 example, in the school, it could be a school
18 nurse or the teacher, the person on the other
19 side that's helping the family connect with
20 telehealth.

21 CO-CHAIR HOLLANDER: So I guess --

22 MEMBER NELSON: It's more the local --

1 CO-CHAIR HOLLANDER: -- what I'm
2 asking, in trying to stay broad is, could we
3 consider that a caregiver in the word, but in the
4 paragraph around that, talk about school-based
5 programs where the school nurse may be part of
6 the caregiver team? So that we're not carving
7 out things that are separate by where you are.
8 Or do you not think that works for you?

9 MEMBER NELSON: I guess, I think of the
10 family and the patient as a unit, the distant
11 site, where it -- I think that could fit under
12 community, whoever's with that, and then, the
13 provider or specialist --

14 CO-CHAIR HOLLANDER: Okay.

15 MEMBER NELSON: -- delivering the
16 service.

17 CO-CHAIR HOLLANDER: Okay. Angela's
18 next, and then who is it? I saw something -- oh,
19 it's -- okay. So, Angela's first and then, Steve
20 second.

21 MEMBER WALKER: Yes. So, to address
22 Eve-Lynn's particular situation and to comment

1 somewhat, too, on what Stewart suggested, I like
2 the community piece. I think it's an important
3 one. But maybe facilitator of telehealth?
4 Because it's not really someone directly involved
5 in either giving the care or receiving the care,
6 but it's the someone who's in charge of kind of
7 operationalizing it.

8 And then, my next plug would be, for
9 the subdomains that we propose, initially, I
10 didn't really see kind of how the community piece
11 would be measured, until I heard the school-based
12 example.

13 So when we think about the subdomains,
14 just to make sure that we're exhaustive and
15 exclusive, maybe also giving one of those use
16 case scenarios, so that we know, how would the
17 end user be utilizing this subdomain, and how do
18 we think about measures there moving forward?

19 CO-CHAIR HOLLANDER: So you're saying,
20 as one example, not as in every way?

21 MEMBER WALKER: Exactly, as an example.

22 CO-CHAIR HOLLANDER: So I'm going to

1 ask Stewart for a clarification, because I
2 understood the community thing to be a little
3 different. I kind of understand your facilitator
4 thing may work for the school-based program, but
5 my understanding of Stewart was, the impact on a
6 whole rural community where there's no providers.
7 Is that -- that's what you meant?

8 MEMBER FERGUSON: Right. Yes, exactly.
9 So for instance, gosh, pick your issue. Sexual
10 abuse is a big issue in rural, remote areas, and
11 the lack of access to sexual abuse response teams
12 is a big challenge.

13 Once a community knows they have that
14 access and we can make it available, there's a
15 change in the community, right? We treat alcohol
16 and drug abuse. We do a lot of things, suicide
17 prevention, you name it, that has a community
18 impact. I would just say, I like what Eve-Lynn
19 was talking about.

20 I guess I was thinking, people that at
21 the other end, we actually have school nurses and
22 sometimes not even nurses, I kind of thought that

1 fell a little bit under what you said about
2 providers, because you were kind of lumping
3 everybody at both ends of a telehealth case under
4 the provider. But if not, then it would -- it's
5 not community, so it's something different.

6 CO-CHAIR HOLLANDER: That might be
7 facilitator. Jason wanted to say a word.

8 MR. GOLDWATER: Right, I just want to
9 interject something before we get to Steve. And
10 that is, looking at this slide about how you
11 develop subdomains, but also, I want to just sort
12 of get you all to start thinking ahead of this,
13 which is, again, the ultimate goal here is to
14 create a framework that has measure concepts or
15 measures.

16 When it comes to a measure concept,
17 the idea around a concept is to be able to
18 develop a measure that would effectively and
19 objectively assess quality in some way. So where
20 that becomes important here is, you have to
21 remember as you're developing subdomains and
22 concepts, you have to be able to measure that.

1 It has to be something that is measurable.

2 Which means you have to be able to get
3 data at some point and be able to use that in a
4 measure that will then give you a metric that you
5 can say, we're meeting this threshold or we're
6 not.

7 So, to get to sort of what Stewart was
8 saying, and to some extent, what Eve-Lynn was
9 saying, I think social determinants of health are
10 extremely important and really give a more
11 comprehensive picture of quality than a lot of
12 just basic encounter data.

13 The problem is that social determinant
14 data is difficult to obtain, especially at that
15 point during an encounter or at some point
16 thereof. I mean, we're still exploring ideas,
17 and we're doing that here, about how we
18 incorporate social determinants of health.

19 So I think all of these ideas are
20 great, and we should certainly continue the
21 discussion and see how to flesh these out
22 further, but just to keep in mind, ultimately,

1 you want to build measures from this. And in
2 order to build an effective measure, you have to
3 have the data to populate the measure. So if the
4 data is impossible to get or difficult to get, it
5 sort of renders the measure itself ineffective
6 and unusable.

7 MEMBER HANDLER: So what we use, and I
8 think this is an important distinction, is we --
9 so in the nursing home, post-acute, there could
10 be a requester. Doesn't have to be a physician,
11 first of all; it could be a nurse.

12 And the second thing is, I think that
13 we're really talking about a telepresenter. The
14 telepresenter is a well-known, definable person
15 who actually just operates the equipment and can
16 have certification to do so. So those could be
17 EMTs. They could be nurses, et cetera.

18 So those are the people that don't
19 have to be family members, but also they can be
20 trained to the point of doing that and getting
21 data on them. So that should, I hope, bring some
22 clarity to this, perhaps.

1 MEMBER HALL-BARROW: So I just want to
2 echo that. So telepresenter is kind of the word,
3 and I think there's two parts of it. There is a
4 clinical telepresenter, and then there's non-
5 clinical, because in many locations, when it is
6 very rural, there will not be a nurse in any
7 school in any located county.

8 So it may be a teacher, a secretary.
9 So their confidence level, if you compare that to
10 an LVN or an LPN, will look very differently. So
11 I think you've got to have both those measures.
12 So telepresenter, clinical, and non-clinical.

13 CO-CHAIR HOLLANDER: Adam, and then,
14 Eve-Lynn, are you up again?

15 MEMBER NELSON: Yes.

16 CO-CHAIR HOLLANDER: Yes? Okay.

17 MEMBER DARKINS: So I was also
18 interested in kind of the focus of this. Because
19 again, realizing it's tremendously important,
20 some of the soft things that are difficult to get
21 the data, how do we think about prioritizing
22 things around patient safety?

1 So you're starting a new program,
2 you're in tele-mental health, suicidality and how
3 you deal with suicidality at the distal end is
4 really important, having a process in place to be
5 able to do it. So I think there's also a
6 hierarchy of saying there's quite an overhead to
7 putting this stuff in place.

8 So as we start off, we can end up
9 really doing mother and apple pie and doing
10 something which, yes, will change the world, but
11 will it be possible to implement? Or will it
12 obfuscate what's being done?

13 So I'm not saying one focuses on
14 suicidality, but I think we need some kind of
15 grid to be able to say how we don't go off into
16 abstraction, which may be really important if
17 you're doing an academic study, but it may not
18 really be relevant to a healthcare provider
19 implementing it.

20 CO-CHAIR HOLLANDER: Okay. Eve-Lynn?
21 And then we'll come around to Sarah.

22 MEMBER NELSON: I just wanted to

1 reiterate Julie's comment. When I'm talking
2 about facilitator, it is more thinking about the
3 person who is not just flipping on the machine,
4 but kind of before, during, and after, although
5 you could certainly have the experience of both.

6 And then I was going to use
7 telehospice as another example where we use the
8 facilitator. So it's not just schools, which I
9 think others have said, but it's just that person
10 on the other side who's helping a family who
11 might not otherwise be able to connect.

12 CO-CHAIR HOLLANDER: Okay. Sarah?

13 MEMBER SOSSONG: I know this is a
14 repeat, but I think just again, thinking about
15 what is telehealth or digital health going to
16 look like in ten years. I think some of these
17 subdomains that we're talking about are very
18 useful based on how we're doing this work today,
19 but I just wouldn't want those to limit the
20 measurements that people may come up with in the
21 future. In the future, it could be machine
22 learning.

1 So I think telepresenter, for example,
2 fits really well under care team. So again, I
3 think to just lump these into patient and family,
4 maybe community as a category, clinician and care
5 team. And then with the text giving some
6 explanation of what those things could be, but
7 would keep it broad in a way that would be useful
8 as this changes.

9 CO-CHAIR HOLLANDER: All right. Julie,
10 are you residual or no? Okay. So Jason, are we
11 actually having the right discussion?

12 MR. GOLDWATER: Absolutely.

13 CO-CHAIR HOLLANDER: Okay.

14 MR. GOLDWATER: Absolutely. I don't --
15 yes. Nobody's going off track, nobody is --
16 you're not, I mean, Stewart maybe, but -- I'm
17 kidding. I mean, really, I think everybody's
18 very much on the right track.

19 I just -- I was hearing the discussion
20 of social determinants, and that just sort of was
21 like, it's a terrific discussion, and it's
22 incredibly important. Just make sure as you're

1 going forward, you have a concept in your idea
2 that you can measure.

3 That it's something like, if we get
4 into suicidality, or we get into the lack of an
5 appropriate response from the sexual abuse team,
6 or you're looking at sort of factors like genetic
7 history or smoking or obesity and how it affects
8 other elements that may be causing a poor
9 outcomes and what telehealth could do to
10 intervene in that, just make sure it's something
11 that, as the framework gets put forward, it can
12 be implemented into a measure in which data is
13 available to actually assess it.

14 Because if we -- either the data is
15 available right now, or the data will be
16 available, you believe, in the future, and where
17 that data would be coming from. Because if it's
18 a measure that it would be impossible to get the
19 data or it would take work well beyond the
20 telehealth encounter, the measure itself that
21 eventually comes from the framework would not be
22 utilized. It would not be actionable because it

1 would be too difficult to do.

2 CO-CHAIR HOLLANDER: Okay. Henry,
3 Angela, Paul.

4 MEMBER DEPHILLIPS: A couple things.
5 Thanks, Jason, for reminding me that it needs to
6 be measurable to be an output from the framework.
7 My question is, this stems from my newness to
8 this type of exercise, for other framework
9 domain-related exercises that you've done --
10 here's another great example of I'm a very
11 concrete thinker. It strikes me that this whole
12 conversation boils down to we have splitters, and
13 we have lumpers.

14 And so my questions for you is, those
15 of you that have a lot of experience with this,
16 when you're putting a framework together and
17 determining subdomains, are you better served
18 lumping, or are you better served splitting?

19 Does extraordinary detail with
20 subdomains give you a better work product, or
21 does keeping it somewhat general and not quite as
22 well-defined give you more latitude, to Sarah's

1 point, and not restrict you in the future, with
2 the framework?

3 CO-CHAIR HOLLANDER: Do you want to
4 answer that?

5 MR. GOLDWATER: I'm trying to think of
6 the best way to answer this. So I mean, I think,
7 right now, I'm not sure that's an overriding
8 concern. Because, again, we're not developing
9 measures, right? You're developing concepts,
10 things that don't exist.

11 Overarching ideas of things where
12 measures can be developed from. And those
13 measures that you want to include are ones that
14 already exist. Or those that have been involved
15 in this for a very long time may have a very
16 definitive idea of a measure.

17 And then it's sort of, are we sure
18 that we can actually measure that? But I will
19 tell you that I don't think we need to spend too
20 much of our energy on that. I would rather -- I
21 think NQF would benefit from having you spend the
22 energy on concepts.

1 And the only thing that we would
2 interject in is if it's like, this concept is
3 involving elements that, if we were to actually
4 specify this into a measure, I'm not sure it
5 would be captured.

6 I don't really think that that's going
7 to happen, because the reason there are measure
8 developers around this Committee is so that, I
9 would hope, they would interject and go, wait a
10 minute, that's not going to work. Or, that's not
11 going to work today, but it might work in the
12 future. We might have that data.

13 And again, it was just, social
14 determinant data is incredibly important. It's
15 widely available, but it's not widely available
16 at the point of an encounter.

17 So you can ask somebody if they're
18 smoking or not, and then you could do the
19 analysis to factor that in, but whether somebody
20 has a history of sexual abuse, god forbid, or a
21 number of other mitigating circumstances, unless
22 you're going to ask them a questionnaire at the

1 beginning of the encounter and incorporate that,
2 that's not data you're going to get.

3 CO-CHAIR HOLLANDER: Okay. Angela?

4 MEMBER WALKER: So I was actually going
5 to speak a little bit towards that. I actually
6 do want to put in a plug for Stewart's remarks,
7 because I think the community piece is really
8 important, especially in the rural setting where
9 community is small.

10 And it may not be the best science,
11 but I think qualitative studies do offer
12 something, and so even though we can't capture it
13 in the encounter, offering surveys to the
14 community and what their perception is, and how
15 telehealth has changed the social determinants of
16 health and people's response to alcoholism or
17 incidences of child abuse could be something
18 really important that's very valuable to give
19 back.

20 CO-CHAIR HOLLANDER: Okay. Paul and
21 then Don.

22 MEMBER GIBONEY: This may be a question

1 for Jason. It goes off of Henry's comment a lot,
2 and maybe we're thinking alike; we both have such
3 great hair.

4 (Laughter.)

5 MEMBER GIBONEY: Is there a precedent
6 for proposing subdomains that overlap, but they
7 intentionally try to capture different
8 approaches? So like, you have patient, family,
9 and community and clinical team experience, but
10 then you also say, I also have the experience of
11 the initiator of the telehealth and the responder
12 to the telehealth.

13 And even though, recognizing that
14 there is possibly some overlap there, the
15 measures that might fall out of those subdomains
16 might look different. So is there a precedent
17 for saying, yes, in these subdomains, we've got
18 these areas, and we understand that there's some
19 overlap there, but we're doing that
20 intentionally?

21 MR. GOLDWATER: So there is precedent
22 for doing that. I think where -- and I

1 understand that could be a reality here, because
2 so much of this overlaps with one another. I
3 mean, there's, as I think somebody said, the
4 mobile health, some of the examples we were
5 giving were store-and-forward technology, and
6 you're correct, it is.

7 I think, if we're going to -- if
8 you're going to go down that route, which is
9 fine, we just have to be clear how we're defining
10 that within the different overarching domains.
11 So if you're going to use patient experience in
12 two, for example, in two domains, how are you
13 defining that so people can understand the
14 difference?

15 Because when the report is written, we
16 have to be very clear about how we're defining
17 that, because the first question we'll get from
18 the public will be, why did you include this
19 twice? And then we have to point that out. It
20 has to be explicit about why that is.

21 CO-CHAIR HOLLANDER: Okay. Don?

22 MEMBER GRAF: I wanted to loop back to

1 a comment on Stew and relate it to something
2 Helen said earlier. The community experience is
3 really kind of where the puck is going to be.
4 And so as we're developing programs, really
5 valuing highly the social determinants of health,
6 it is something that, if not having empirical
7 evidence to support benefits today, it is
8 absolutely the direction that we're going.
9 Whole-person care, it is interwoven in a lot of
10 places.

11 CO-CHAIR HOLLANDER: Okay. Daniel and
12 then Stewart.

13 MEMBER SPIEGEL: To the point about
14 splitting versus consolidating or lumping, I
15 guess the way I kind of see it is, you can write
16 a whole paragraph about a domain or a subdomain,
17 but the domain ultimately will be defined by the
18 subdomains that are included in it. And the
19 subdomains will then be defined by the
20 measurement concepts that are included within
21 that.

22 So I think, and that's kind of the way

1 that I think about it. And so ultimately, as
2 long as the measurements that fit within the
3 measurement concepts can only fit within one
4 measurement concept, then I think we're okay.

5 CO-CHAIR HOLLANDER: Stewart?

6 MEMBER FERGUSON: So there's another
7 group that's important to us in terms of an
8 experience, but I don't think they belong on this
9 list, but I just thought I would throw it out
10 there, and that's administrators and executives.

11 It's indirect, but we can't function
12 and provide telehealth unless administrators and
13 executives support it. But they're -- what they
14 know kind of comes from the providers, and it
15 comes from the revenue side, so it's not
16 necessarily belonging on here, but they are
17 important, I think.

18 CO-CHAIR HOLLANDER: So I guess I'm
19 going to ask the question to the group, should
20 there just be a category that's other, speaking
21 with the concept that's broad, so that no one
22 will ever read this report and say, oops, you're

1 not a patient or a provider or a blah, blah,
2 blah; you don't count? Or no?

3 MR. GOLDWATER: So, I would recommend
4 against that.

5 CO-CHAIR HOLLANDER: Okay.

6 MR. GOLDWATER: Because then, it
7 becomes all-encompassing. So where does other
8 begin, and where does other stop?

9 CO-CHAIR HOLLANDER: Okay.

10 MR. GOLDWATER: Again, as is the case
11 with so many of these types of reports and
12 frameworks, we're not going to cover everything.
13 I mean, I think we're going to get to the most
14 important things, because you all have enough
15 expertise to know what's really important.

16 And as Stewart mentioned, I think the
17 community aspect is incredibly important and
18 should absolutely be measured. I just want to
19 make sure we can measure it so that it's
20 effectively leading to some way of evaluating it.
21 But I think, Judd, I understand what you're
22 saying, but I think that's kind of a slippery

1 slope.

2 CO-CHAIR HOLLANDER: Okay. So I think
3 -- oh, Angela?

4 MEMBER WALKER: Yes, just look at my
5 diagnosis NOS codes to know that I use other more
6 often than I should.

7 (Laughter.)

8 MEMBER WALKER: But I do have a plug
9 for four. I do have a plug for four. So I'm
10 thinking provider, making it broad, general,
11 inclusive of any provider; community;
12 telepresenter; and then patient and family. So
13 that's my plug for four, and I welcome comments.

14 CO-CHAIR HOLLANDER: Oh, Adam?

15 MEMBER DARKINS: Again, I think we're
16 going to come up against the fact a lot of this
17 is going to be measured anyway, so we're going to
18 be duplicating measures that take place.

19 So I'm not saying we wouldn't do it,
20 but if one were to distill out and say, what's
21 one of the really unique things around
22 telehealth, telemedicine, whatever we're talking

1 about, around delivering this, I would have
2 thought one of the really key things is around
3 teamworking. Because what you're essentially
4 doing is creating virtual teams and how you
5 interface.

6 That would plug into things like the
7 medical home as well. So I think -- and there
8 would be existing ways to do that that would make
9 sense. So yes, have all those things, but I do
10 think one of the overarching things that really
11 is important, if you're an eICU, it's almost all
12 around a virtual team creation.

13 If you're doing specialty advice into
14 primary care, it's almost all around teamworking.
15 So I would just plug that one of the overarching
16 things that I think we should push is around a
17 measure of teamworking, because it's not
18 successful if you don't do it.

19 CO-CHAIR HOLLANDER: Fair enough.

20 MEMBER WALKER: Would that fall into
21 system?

22 CO-CHAIR HOLLANDER: Yes. Is that

1 system effectiveness? Yes. Oh, Yael?

2 MEMBER HARRIS: I was just going to say
3 that's a perfect example of what I brought up
4 earlier, which is, there's overlap between these
5 categories. And so that's where I think the --
6 we don't -- you can have measure concepts, but I
7 think we need an example within each, probably
8 not the traditional.

9 Like in the provider satisfaction, we
10 don't need to say, the presenting physician,
11 because that's understood. But some of these
12 other features that we want to include in these
13 categories should be there so someone who wasn't
14 part of this discussion knows that their measure
15 does fit into one of these subdomains.

16 CO-CHAIR HOLLANDER: So I'm going to go
17 with Angela's comment, but despite the fact I'm
18 generally a lumper, I personally want to lobby
19 for splitting patient from family and caregiver.

20 Because I can imagine there's patients
21 you can't assess their experience, right, in
22 long-term care facilities and things, and then it

1 really becomes more about the family and
2 caregiver experience. And I think I want to be
3 really clear that the family and caregiver
4 experience is hugely important and never risk it
5 getting lost under the category of patient
6 experience.

7 So, I'll offer the friendly amendment
8 with splitting that into a fifth category and see
9 how others feel. Adam, left over? Anybody
10 disagree/agree with that? Or everybody's ready
11 for lunch?

12 (Laughter.)

13 CO-CHAIR HOLLANDER: Okay. So quick
14 show of hands. That's a fifth category, raise
15 your hand, or keep it down if you want it to just
16 be in the patient category. Okay. Just leaving
17 it in the patient category, show your hands.
18 Okay. So it looks like it's a lumper. So now,
19 before we break for lunch -- oh, go ahead,
20 Marcia.

21 CO-CHAIR WARD: So in my world, which
22 is public health, provider has a very specific

1 meaning, which is physicians, APPs, those that
2 can prescribe. That may not be the word choice
3 of people around the table, so I just want to
4 make sure that we're real clear whether we use
5 provider or whether we use clinician for that
6 label.

7 CO-CHAIR HOLLANDER: Go ahead, Steve.
8 And then Peter.

9 MEMBER RASMUSSEN: We're collectively
10 whispering over here clinician to broaden it. We
11 agree.

12 CO-CHAIR HOLLANDER: Okay.

13 MEMBER RASMUSSEN: And we're actually
14 moving more toward the concept of just team
15 member.

16 CO-CHAIR HOLLANDER: Care team?

17 MEMBER RASMUSSEN: Care team member,
18 yes.

19 CO-CHAIR HOLLANDER: Is that better
20 than clinical professional? Care team member,
21 okay.

22 MEMBER DARKINS: Well, one of the

1 things around operationalizing is, sometimes you
2 do have the capacity to create new entities. So
3 for example, if you're doing -- your
4 telepresenter at the distal end may well --
5 you've developed a whole new category. So if you
6 end up being exclusive to start off with, you
7 can't create those changes. So if you make team
8 member, it's broad --

9 CO-CHAIR HOLLANDER: Yes.

10 MEMBER DARKINS: -- and will encompass
11 change.

12 CO-CHAIR HOLLANDER: I love that. Don?

13 MEMBER GRAF: Recognize the team, but
14 from a payer perspective, the clinical
15 professional, that is really more who can bill
16 and get paid. And so I would just be careful
17 that we're not making it too vanilla.

18 CO-CHAIR HOLLANDER: So I think, the
19 way I see it, and NQF can correct me if I'm
20 wrong, is that, you can still -- so care team
21 member could be our sub-domain, but the measure
22 could still be around physicians doing this or

1 APPs doing this or, now, ancillary staff doing
2 this. Yes. So I think -- oh, we have other --
3 oh, Julie?

4 MEMBER HALL-BARROW: I just want to go
5 back and root for you, Judd, for the fifth. Just
6 because, working in the pediatric field, the
7 parents and families make all the decisions. I
8 don't care how the patient feels about it.

9 So I really want to garner that we
10 look at that, and even as we look to broader
11 opportunities, like you were talking about, what
12 we're doing today, but for mobile apps, if
13 they're 13 and under, they can't actually provide
14 me any data about their healthcare via the app;
15 their parents or family has to do that. It's not
16 only until they're over 13, can we actually get
17 data straight from them.

18 So patient experience for them,
19 they're not making any of the decisions. So I
20 think it would be hard for us to do that. So I
21 really would like to push for the fifth, please.

22 CO-CHAIR HOLLANDER: Henry?

1 MEMBER DEPHILLIPS: I'm wondering if we
2 can use, just thinking out loud, Julie, similar
3 approach. So care team, broadly those sort of
4 helping render care, versus recipient team, all
5 of those involved with receiving care, whether
6 it's a child, a parent on behalf of a child, a
7 caregiver on behalf of a patient, blah, blah,
8 blah.

9 CO-CHAIR HOLLANDER: So, then, maybe we
10 could just change an and to an or: patient,
11 family, or caregiver, and then it's sort of the
12 care team or the recipient team. Don?

13 MEMBER GRAF: And I'm not arguing
14 against it, okay? But the role of the parent or
15 the role of the caregiver, aren't they really an
16 extension of the patient, a representative of the
17 patient, as opposed to a separate entity? I
18 guess I would --

19 MEMBER HALL-BARROW: I don't know.

20 MEMBER GRAF: -- through my own eyes --

21 MEMBER HALL-BARROW: We have a very
22 large foster care program, and that is a brand

1 new parent to this family is now making
2 decisions. And so the patients, still, we want
3 to know how they're feeling. So I don't know if
4 always that is the case. They're extensions, but
5 do they have the same experience that the child
6 is having? I think, no, not always.

7 CO-CHAIR HOLLANDER: Okay. So we're
8 going to do Angela, Henry, and Yael, and then
9 we're going to call the question and eat lunch.
10 Henry went away? Okay.

11 MEMBER WALKER: I like the and/or. I
12 think the framework just identifies that there is
13 some place for things to fit and that they exist,
14 so I don't think it necessarily needs its own
15 category.

16 CO-CHAIR HOLLANDER: Okay. Last
17 comments from Yael.

18 MEMBER HARRIS: And I'm going to
19 advocate for the and/or, too, not to pick a
20 fight. But I think, first of all, the caregiver
21 is the advocate on behalf of the patient, since
22 they're under 13. If they're over 13, hopefully

1 the patient can speak for themselves, but the
2 parents are part of it.

3 And I want to bring in the whole point
4 of tele-behavioral health, which is, if you're
5 providing CBT to an adolescent, the adolescent
6 may have a different experience than the parent
7 in terms of how it's impacting them, but that
8 doesn't negate.

9 So you can still capture that in a
10 single category versus creating separate
11 categories, because suddenly you're undermining,
12 did the intervention work or not? If they have
13 different perspectives, those are both valid, but
14 I think if you put them together, you can get a
15 better picture.

16 CO-CHAIR HOLLANDER: Okay. So we're
17 going to have public comment after this, but just
18 sort of head nod, my take-home points, although
19 the words may tweak a little is, we've come up
20 with four categories now: patient, family, or
21 caregiver; care team member, and I would add,
22 including the clinical provider, so that's clear;

1 the community; and the telepresenter. And those
2 are our four categories to go forward with.

3 I would like to, and I'll, Dan, get to
4 your comment in a minute, I would like to ask the
5 question, do we need more discussion of this
6 after lunch? Did this work? Is this category
7 resolved? We're never going to get perfection,
8 but is it good enough to move on to the next
9 stage?

10 We'll take Dan's comment, and then if
11 somebody's dying to make another one, they can.
12 And then we'll do the -- Dan and Sarah -- and
13 then we'll do the public comment period
14 afterwards.

15 MEMBER SPIEGEL: I guess, I would just
16 ask, for those who suggested the telepresenter as
17 a separate category, is that part of the care
18 team today, or will it be just a natural part of
19 the care team in the future?

20 CO-CHAIR HOLLANDER: Okay. Sarah?

21 MEMBER SOSSONG: I see that as part of
22 the care team.

1 CO-CHAIR HOLLANDER: So you think, now
2 that we've broadened care team, we could do away
3 with telepresenter? I see a lot of head nodding.
4 Anybody object to that? Wow, we're really good
5 at lumping.

6 (Laughter.)

7 CO-CHAIR HOLLANDER: Okay.

8 MEMBER WALKER: I'd like --

9 CO-CHAIR HOLLANDER: No, can't talk
10 anymore.

11 MEMBER WALKER: I might suggest just
12 defining that, so it's made clear that that's
13 where that particular piece fits, so the
14 individuals creating --

15 CO-CHAIR HOLLANDER: Okay. So, I think
16 in the text of each of these sub-domains --

17 MEMBER WALKER: Exactly.

18 CO-CHAIR HOLLANDER: -- we have to be
19 really careful to include what we're talking
20 about. But Jason has captured all of that in his
21 notes. So this --

22 MR. GOLDWATER: Word for word.

1 (Laughter.)

2 CO-CHAIR HOLLANDER: Okay. Public
3 comment period?

4 MR. GOLDWATER: Yes.

5 CO-CHAIR HOLLANDER: Okay, we're open
6 for public comments.

7 MR. GOLDWATER: All right. So we'll
8 start with the phone, and then we'll start with
9 the back. On the phone, Operator, can you open
10 it up for public comment, please?

11 OPERATOR: Okay. At this time, if you
12 would like to make a comment, please press * and
13 then the number 1. And there are no public
14 comments at this time.

15 MR. GOLDWATER: Okay. Anyone that is
16 in-person? Yes, microphone is right there.

17 MR. QUINN: Hello. I'm Matt Quinn.
18 I'm the Senior Advisor for Health Technology at
19 HRSA. And I just wanted to echo, no pun
20 intended, some of the comments, as well as to add
21 something, I think, that's significant.

22 I couldn't agree more that using the

1 measures to advance things like access, care
2 coordination or teamwork, as Dr. Darkins said,
3 patient experience, and other areas that are not
4 well developed in broader healthcare is a really
5 good opportunity with this, and to leverage, to
6 the extent possible, the measures that we already
7 have for healthcare in this domain, so that it's
8 not duplicative.

9 To pick up on one of Chuck's points,
10 and Yael said this morning, she quoted, Are
11 Virtual Doctor Visits Really Cost-Effective?,
12 that's the top of the news. And really, we could
13 throw the baby out with the bathwater if we
14 really didn't get specific and understand what
15 the intervention involved in, quote, virtual
16 doctor visits. It could mean a million things to
17 a million different people.

18 And as we measure here, as Chuck
19 described, I think it's very important that we
20 have a taxonomy here to describe the actual
21 telehealth interventions and the characteristics
22 of them.

1 So things like modalities, things like
2 who the participants are, is it part of a model
3 like ECHO or store-and-forward or something else?
4 What are the components? What is the security?
5 What are the adjacent technologies or care
6 models? These things are going to be very
7 important in teasing out what works and what
8 doesn't work, what should be reimbursed and what
9 should not be reimbursed, et cetera.

10 And then there are also
11 characteristics of the technology itself. And
12 I'll just -- recently passed by Congress was
13 something called the 21st Century Cures Act. And
14 no comment on that, but to quote Section 422,
15 within one year, the Secretary will convene
16 stakeholders to develop reporting criteria
17 related to usability, security, interoperability,
18 and other performance measures of EHRs.

19 I could see that 21st-and-a-Half
20 Century Cures might involve the same stuff for
21 telehealth. So we should think ahead about those
22 measures, because those will be the criteria by

1 which we can evaluate these systems, both for
2 purchasing, for evaluation and other things, but
3 also to start looking ahead to another really
4 important and confounding topic in health IT,
5 which is unintended consequences.

6 So I would just say, I don't know if
7 that's another domain, something that we can pick
8 up, but that taxonomy to be very specific is
9 going to be very important when assessing both
10 structural, process, and outcome measures.

11 MR. GOLDWATER: Thank you. Any others?
12 Right.

13 MS. TRUJILLO: Good afternoon, my name
14 is Sylvia Trujillo with the American Medical
15 Association. First of all, thank you for
16 convening this gathering of exceedingly
17 knowledgeable individuals who are really, I
18 think, elucidating and expanding what we can do
19 in this space. I'd like to echo a couple of
20 points -- exactly -- that Matt Quinn made.

21 And we, of course, are trying to
22 figure out how to validate and integrate into

1 clinical practice those modalities that have been
2 validated into the practice of medicine. So
3 telemedicine or telehealth shouldn't be any
4 different than medical practice. And that's
5 really a goal that we're striving to realize
6 through various activities.

7 So we would strongly urge, to the
8 extent that you can utilize existing frameworks,
9 paradigms, and measures, so that you do not add
10 an extra layer of burden onto those who elect to
11 integrate telehealth tools and practices into
12 their system of delivery, you should do so.

13 And to the extent that there are gaps
14 where you are not able to identify and capture
15 based on those existing measures and activities
16 based on modalities, flag those, and work through
17 those as priority areas, as well.

18 Just a reminder, the CPT Editorial
19 Panel is working on what is essentially a
20 parallel process on thinking about how you use
21 descriptors to describe services and procedures
22 and whether our existing services and procedures

1 descriptors are adequate or they need to be
2 modified, and doing a gap analysis for the very
3 same reason, that we streamline the ways in which
4 individuals both identify those services and
5 integrate those into practice. So thank you very
6 much for your service.

7 CO-CHAIR HOLLANDER: Thank you.

8 MR. GOLDWATER: Anyone else? Okay.
9 Thank you very much. We'll take lunch for an
10 hour. Oh, one more. Oh, wow.

11 DR. ALEMU: My name's Girma, I'm with
12 HRSA. I have just a couple of comments. This
13 phase, when we look at reports and meetings
14 discussing quality issues, quality measures, one
15 of the most important items which is always
16 mentioned is outcome.

17 That's, why do we invest if we don't
18 measure the outcomes? What we are doing should
19 show in the outcome, which is the main goal of
20 our work. So I see adding outcome in the domain
21 part as an important fact.

22 And the second one was -- by the way,

1 the discussion was very engaging. I'm really
2 happy to see that everybody's into it. And one
3 thing which we need to see here during the
4 measurement issue is, we have to be able to
5 characterize what can be measured.

6 There are a lot of ideas which can be
7 really researched, which can be worked on, but we
8 have to look at those facts that can be measured.
9 For example, one issue was mentioned when we talk
10 about subdomains, I agree with really what you
11 say. I see two important points.

12 The first one, patient experience. It
13 can be said patient and/or caregiver or family
14 experience, you know, sometimes patients cannot
15 provide their experiences. They can be children,
16 or for some other reasons they cannot provide
17 their experiences, but there are families or
18 caregivers who can talk about the experience
19 which they saw. So, that's one of the
20 subdomains.

21 The next one, from the provider's
22 perspective. When we say providers, it can be

1 nurses, it can be doctors, and so on. But going
2 further, community, it's very important to know
3 how the community responds or sees that kind of
4 services. But how can we measure that? How can
5 we get data on that? That is the main problem.

6 And what, for me, is important is,
7 what are the priorities and what can be done and
8 measured? But those, I'm not saying that those
9 issues are not important, but I think we have to
10 focus on those two points. So, thank you, that
11 was my comment.

12 CO-CHAIR HOLLANDER: Thank you.

13 MR. GOLDWATER: Thank you. All right.
14 Anyone else? No? Okay, we'll take an hour for
15 lunch. Thank you all.

16 (Whereupon, the above-entitled matter
17 went off the record at 12:34 p.m. and resumed at
18 1:37 p.m.)

19 MR. GOLDWATER: So, we do need
20 everybody back so we can continue. So, I'll give
21 everybody another couple of minutes.

22 I think initially what we were

1 planning on doing was diving you all into groups
2 and having you discuss subdomains for the
3 remaining three. But after some discussion with
4 the co-chairs and realizing the trauma if Dale
5 and Stewart are split apart, we've opted to ---
6 I'm kidding. I'm just saying that because Dale's
7 not here.

8 (Laughter.)

9 MR. GOLDWATER: I think what we're
10 going to do is just keep you all together.
11 Because, again, I think when we were in the
12 planning stages of this with Judd and Marcia, we
13 envisioned there being more domains subsequently
14 than being more subdomains. But you've done such
15 an excellent job of consolidating to just really
16 high level and getting to the essential elements
17 that I think it would be probably more productive
18 to just stay in the large group and discuss this.

19 When we get to actually building out
20 measure concepts, we'll see if we want to split
21 up then. But I think for the measure subdomains
22 we can probably all stay together.

1 So, what we're going to do now is turn
2 to the effectiveness domain. And we're going to
3 have Dr. Hollander lead this discussion while we
4 diligently take notes.

5 So, go ahead, Judd.

6 CO-CHAIR HOLLANDER: So, we have, you
7 know, about an hour and 35 minutes to get through
8 three things. It was sort of our best guess that
9 effectiveness was going to be the bigger
10 discussion item rather than cost, which I think
11 we're going to recommend be done in dollars.

12 But, so, we thought we would begin
13 with effectiveness and that way we could use a
14 little more time for that if we actually need it,
15 and then roll over to access and cost to get that
16 done.

17 So, we have divided -- or we have
18 spoken about two subdomains in the effectiveness
19 area a bunch, which is system and clinical
20 effectiveness. And we'll start there and open
21 the discussion as to whether we want more
22 subdomains or we could just move on to access at

1 this point. No, I'm just kidding.

2 (Laughter.)

3 MR. GOLDWATER: Nice try, Judd.

4 CO-CHAIR HOLLANDER: And go home after
5 dinner. But, you know, so system/clinical
6 effectiveness. And then we'll have the lump-
7 splitter things and say, you know, how much goes
8 in system effectiveness, how much goes in
9 clinical effectiveness, and what other categories
10 may be specifically called out as other
11 subdomains.

12 So, the floor is open for incredibly
13 intelligent, thoughtful comments or anything else
14 anybody wants to say.

15 MEMBER DOARN: It's like a game show.

16 So, when you talk about systems, you
17 know, as a quasi-engineer/program manager, I
18 always think of the actual infrastructure of a
19 hospital, a clinic; not the actual healthcare
20 delivery system itself, but the individuals or
21 the people involved.

22 So, when you talk about systems, are

1 we separating into those two, the operations part
2 and then you have the actual clinical part? I
3 mean, in the sense of, you know, a system, I
4 mean, there's a clinical button, but I'm just
5 thinking of the systems themselves. Is it the
6 EHR? Is it the billing system? Is it the IT
7 support? I mean, when you say "systems," I'm not
8 sure what you mean.

9 CO-CHAIR HOLLANDER: I'd say I don't
10 really define what I mean. You guys define what
11 we mean. So let's go ahead and define what we
12 want it to mean.

13 Adam.

14 MEMBER DARKINS: So, I'd just say one
15 of the things around effectiveness, I think, is
16 really usability.

17 So if you're going to end up investing
18 infrastructure to do this and you've got a system
19 where the connectivity goes down, the physician
20 can't do consultations, you've got about one or
21 two goes at it and then all faith is going to
22 disappear out of it.

1 So I think it's just a very basic
2 thing, which is around for both clinician and
3 patient, how you make sure the things, however
4 you're connecting, happens, functions, and is
5 seamless.

6 Because if you don't do that, no
7 matter what you try and do elsewhere you're going
8 to find --- so, I mean, it's very basic and
9 starting with something very mundane, but I think
10 that's a really big discriminator in success.

11 MEMBER GIBONEY: Well, along with
12 usability, I think availability or accessibility.
13 You can come up with an outstanding telehealth
14 solution, but if it's only available to five
15 percent of your providers or in particular
16 geographies or particular settings, then it's not
17 going to be very effective.

18 So, maybe this goes to spread or, you
19 know, other concepts, but just
20 availability/accessibility.

21 CO-CHAIR HOLLANDER: Alright. Daniel.

22 MEMBER SPIEGEL: So, I wonder if

1 usability falls better under the experience-of-
2 care domain for either clinicians or family and
3 patients. I agree it's very important, but I
4 just wonder if it would fall better under a
5 different domain.

6 CO-CHAIR HOLLANDER: Don.

7 MEMBER GRAF: I just wanted to
8 comment, Chuck, on when you said "systems," I
9 can't help thinking sort of end-to-end process
10 and that everything that fits in, you know, from
11 this end to this end could be all the different
12 sort of systems and processes that go into that
13 encounter. So, I mean, just conceptually, that's
14 what I was thinking.

15 MEMBER DOARN: If you have a system
16 of, like, let's say, personnel, and you have to
17 have a certain kind of surgical team or pediatric
18 team, whatever it is, then the employment system,
19 the actual personnel system, I mean, I know
20 that's way down in the weeds, but the way you
21 measure that is different than you measure the
22 IT, you know, whether the computers are working

1 or whether the monitoring systems in the
2 operating room are working correctly.

3 So, to me, there's different kinds of
4 systems, but I don't know if we'd put them all
5 under that same banner if we're missing
6 something, or maybe I'm over-engineering it.

7 CO-CHAIR HOLLANDER: Well, so, I guess
8 I would just say I do remember some of the
9 comments on availability that we do have a
10 category called "access," right? So, it may be
11 availability fits better there.

12 And I guess as we're going through ---
13 maybe not, but as we're going through, do we want
14 specific carve-outs --- and I'm just asking the
15 question --- for specific things? Is it system,
16 and one component of the system is the technical
17 aspects of the system?

18 And I think last time we talked about
19 workforce we talked about technical components
20 and we broke some category down, you know, into
21 those two things.

22 So, is "system" too broad, or do we

1 want to subdivide some system components?

2 MEMBER GIBONEY: Well, just in terms
3 of availability, when I think of access, I'm
4 thinking access to care: how does telehealth
5 actually get you to care?

6 And when I was thinking of
7 availability, I'm saying, is the telehealth
8 solution deployed in a system?

9 CO-CHAIR HOLLANDER: Okay. Henry.

10 MEMBER DePHILLIPS: So, just a little
11 bit big picture. When I think of the word
12 "system effectiveness," "system," almost by
13 definition, to me, anyway, has a lot of moving
14 parts. And "effectiveness" basically means, does
15 it accomplish the intended goal?

16 I'll use the system I'm the most
17 familiar with, Teladoc system, as an example.
18 So, the goal is to provide subscribers the
19 ability to get access to care faster, sooner,
20 quicker than whatever the other choices were
21 without it, right? So, that's the goal.

22 The system that we have in place is

1 multifactorial, right? We have a network of
2 docs, we've got a variety of ways you can request
3 a visit, we've got a platform that does all the
4 algorithmic matching between the providers and
5 the patients.

6 And then the effectiveness is how many
7 are we doing, how fast do we connect after the
8 request goes out, and is it being used for its
9 intended purpose?

10 So, when I think of the subdomains in
11 effectiveness, clinical effectiveness is one. I
12 think system effectiveness is a lot of moving
13 parts. And for that one --- I'm usually a
14 lumpner, but for that one I may be a little bit of
15 a splitter, because I think there are a number of
16 components under system effectiveness that
17 contribute to that particular subdomain.

18 CO-CHAIR HOLLANDER: So what would you
19 split it into?

20 MEMBER DePHILLIPS: Well, you've got
21 systems of people. You've got systems of
22 technology, which is also broad and maybe needs

1 to be subdivided some. You've got systems of
2 program design.

3 I'm sure among the group there's
4 probably a couple more, but those are the types
5 of areas under "systems" that I think about.

6 CO-CHAIR HOLLANDER: So, do people
7 think philosophically that's the right way to
8 think about systems and we should be thinking of
9 the different components? And then as we're
10 talking about what the subdomains may be now we
11 should be thinking of it as technology, people,
12 program design and other things and focus on the
13 system effectiveness?

14 Or, you know, so, right now we have
15 system effectiveness, subcategories, or, you
16 know, dotted lines, clinical effectiveness. Is
17 there another big subdomain? Or should we be
18 splitting the system effectiveness and thinking
19 of how can we better define that as multiple
20 subdomains? And then are the subdomains proposed
21 the right ones?

22 MEMBER GIBONEY: I don't know if this

1 helps, but when I think about what the measures
2 of system effectiveness might be -- I'll share
3 some of those with you and maybe that will help
4 us decide if we need another category, but when
5 I'm thinking about, you know, capability to do
6 what we intend to do, what is our goal, right?

7 And I think about things like, you
8 know, what is our responsiveness? How well does
9 the telehealth help with responding to some sort
10 of identified need? What is the rates of use?
11 Is it being used by the people and the percentage
12 of the people that we want it to be used for? If
13 you're deploying in a particular setting and you
14 need 85 percent of the people to use it, you
15 know, what is that.

16 Does it facilitate the appropriate
17 sharing of information? You know, whatever it
18 is, is the information that you're able to share
19 -- if you need pictures, does it do pictures?
20 You know, if you need access to an electronic
21 health record, does it accomplish that? You
22 know, is it routing the request to the right

1 person on the other end? Is it connecting
2 whoever needs the service to the right person?

3 And so, to me, those are elements of
4 system effectiveness. They actually --- is it
5 accomplishing what we want it to accomplish?
6 Those are some of those elements.

7 And so maybe they all fall under
8 system effectiveness. I don't know if we would
9 want to split them out further, but those are
10 some of the elements that describe a quality
11 telehealth implementation, to me.

12 CO-CHAIR HOLLANDER: Kristi.

13 MEMBER HENDERSON: So, I think I like
14 them split: operations, clinical and technical,
15 potentially.

16 And to the point around measuring
17 those, "use" doesn't mean effective when you
18 think of it in clinical terms, but "use" may be
19 effective in the operation side. If your goal in
20 operations is to get adoption, great. You've met
21 that measure, but that doesn't necessarily mean
22 you have an effective clinical operation, because

1 you may still have, you know, whatever, disease
2 progression or whatever. So, I like splitting
3 it.

4 CO-CHAIR HOLLANDER: So, are you
5 proposing that operations, clinical, and
6 technical are under the system effectiveness, or
7 in the whole effectiveness category? We had
8 system effectiveness and clinical --

9 MEMBER HENDERSON: System
10 effectiveness and breaking that down.

11 CO-CHAIR HOLLANDER: Okay.

12 MEMBER HENDERSON: Just an idea.

13 CO-CHAIR HOLLANDER: Okay. Angela.

14 MEMBER WALKER: I would agree largely
15 with what's said. I think the system
16 effectiveness is kind of the process measure,
17 whereas the clinical effectiveness is the
18 outcomes piece that was talked about before.

19 I like technology, I like operations,
20 design for some of the systems things, and then
21 thinking about the population health component
22 for clinical, or the efficiency component for the

1 clinical.

2 CO-CHAIR HOLLANDER: Go ahead.

3 CO-CHAIR WARD: When Yael and I did a
4 review of tele-ED, 90 percent of the measures out
5 there for the emergency department were process
6 measures. And they were clinical, but they were
7 process measures, because that's the way that the
8 world has gone with CMS first tackling the
9 process.

10 We all want to get to outcomes, but
11 I'm concerned about compartmentalizing, that the
12 process goes into systems and -- I think that's
13 probably not the best way to split it.

14 CO-CHAIR HOLLANDER: Adam.

15 MEMBER DARKINS: In creating a
16 framework, it seems to me how much we can create
17 a framework that's going to enable other people
18 to then use it and how much we need to tell you
19 what it looks like. Because some of the
20 questions that have been sort of raised about
21 system effectiveness are really, you know,
22 important to do.

1 But do we create a framework where a
2 policymaker at a local level then can get the
3 data and he or she or the team can then make that
4 assessment? Or are we going to try and take on
5 that role and say we're creating a framework
6 where -- does that -- because it just seems to be
7 some of this we're answering really sort of, you
8 know, world hunger problems as we get into some
9 of the aspects of it.

10 And, again, I'm not saying it
11 shouldn't be done, but as the first stab at this
12 and should we be saying, as we write this,
13 thinking of the final report, we're creating a
14 framework that means that if you're a payer at a
15 local level providing care in this community,
16 this framework will provide the infrastructure
17 where you can then use your data and your assets
18 and you can do supplemental research and you can
19 answer some of these big policy questions which
20 are relevant to you versus saying, you know,
21 we're actually going to create a framework that's
22 going to do this for you.

1 MR. GOLDWATER: So, the answer is --
2 so, there's two answers to that. The first is,
3 the primary purpose of a framework is to provide
4 a foundation upon which measures can be
5 developed, because they don't exist currently.

6 So, whether a payer at a local level
7 wants to develop those measures, or whether URAC,
8 for example, wants to develop those, is entirely
9 up to those organizations.

10 But the foundation basically says,
11 here's what -- again, a framework is to organize
12 information. So here are the domains in
13 telehealth this committee feels are important,
14 the most relevant, the most significant. Here
15 are the subdomains under those topics that the
16 committee feels are the most applicable, most
17 relevant, most important, most significant. And
18 from that, here are the measure concepts that you
19 can take and build measures from.

20 Could you then look at that and say,
21 is there research to be done on some of this that
22 would potentially lead to the development of that

1 measure, particularly if the data to build a
2 measure is unavailable right now or there are
3 other topics related to that concept that should
4 be explored? Absolutely, but the primary purpose
5 is to be a foundation for development.

6 Because if you -- and, you know, Judd
7 and Marcia and others will know this: when you
8 open up a topic and say "build measures," it's
9 sort of a Tower of Babel, right? Everybody
10 starts building things. They are duplicative of
11 one another. There is limited variation between
12 two different sets of --- I mean, that's how it
13 used to be done.

14 You know, back in the days, Marybeth
15 and I and others can remember in the mid-'90s
16 when we were figuring out how to do this, that
17 everybody was developing measures. And people
18 were duplicating measures and creating measures
19 of limited variance and there was no guiding
20 framework about what to develop for
21 cardiovascular disease or COPD or mental health.

22 So what was learned is, if you create

1 a framework upon what really becomes important to
2 develop, then you sort of remove that problem.
3 And you don't, as you said, create something that
4 collapses under its own weight. It doesn't
5 become so big, so onerous that, you know, there's
6 600 concepts and people are going to be building
7 a thousand measures which no one will ever use.

8 I mean, that's why we have 2500
9 measures at the moment. Who's going to use 2500
10 quality measures? Not very many people, you
11 know.

12 And it gets back to people will use
13 quality measures if they're going to be
14 reimbursed or if they're going to get certified
15 or if it's going to be an extra value that they
16 can mark up and say we have reached X quality
17 threshold because we met these measures.

18 So, that's what the framework is for,
19 to help guide the development of measures. But
20 it certainly can be used to pursue research if
21 there's a concept area that should be explored in
22 more detail.

1 CO-CHAIR HOLLANDER: Don.

2 MEMBER GRAF: In the context of what
3 you just said, and to the extent that clinical
4 effectiveness and cost effectiveness have already
5 sort of been carved out, the system
6 effectiveness, which almost sounds like it's
7 above both, really becomes sort of operational
8 effectiveness. Or maybe it's just the word
9 "system" that is getting in the way.

10 CO-CHAIR HOLLANDER: Kristi, you look
11 like you're leaning, about to say something.

12 MEMBER HENDERSON: I think that's kind
13 of where I was going with creating an operations
14 category underneath it. And without having
15 another three buckets, keeping this system
16 effectiveness and then having the sub-units gives
17 some clarity, I guess, to it. But operations
18 means a lot more to me, as well. Systems is big
19 and scary.

20 CO-CHAIR HOLLANDER: So, I'm wondering
21 --- sort of a friendly amendment to your proposal
22 and the concept -- well, clearly we have a

1 clinical effectiveness. We either keep or don't
2 keep the systems effectiveness, but we add to
3 that operations and technical effectiveness.

4 And so I'd actually propose four
5 subdomains: system, operations, technical and
6 clinical. And everything should fit into one of
7 those. And the only advantage of systems is it
8 sort of spans the others. And in some measures,
9 if you're measuring how an ACO provides
10 telemedicine, there's a whole system involved.
11 But if you're measuring how telemedicine flows
12 in, you know, one provider's office, there's
13 probably not a whole system, it's probably the
14 individual buckets of operations, clinical, and
15 technical.

16 So, in terms of a framework, every one
17 may not fit within every category. But the idea
18 of a framework there is I think, you know, within
19 the limits of what we can think of, everything
20 fits into one of those buckets.

21 MR. GOLDWATER: Just to add on
22 something which I think might be important, so,

1 you know, let's say you come up with four
2 subdomains under effectiveness, and then we start
3 deciding or brainstorming measure concepts, and
4 we get to system effectiveness, and you're
5 brainstorming these concepts and you all come to
6 the conclusion of, we just can't get something
7 here that would be usable. They fall under other
8 categories or this is not going to be measurable
9 or this is really not going to provide any value.

10 There's no rule that says whatever you
11 decide right now we have to carry through with.
12 I mean, we can remove that concept, that
13 subdomain, if you're unable to come up with any
14 existing measures or any measure concepts that
15 you think would be valuable.

16 It may sound great right now and then
17 you may flesh it out and find out that there's
18 nothing. It's okay. I mean, we're not going to
19 go back over the transcript and say, "Well, Don
20 said we had to do this." And so, I mean, that's
21 not how it's going to work. You can eliminate in
22 the process of this.

1 MEMBER GRAF: I want to endorse what
2 you said, but I want to better understand where
3 cost effectiveness would have fit into --

4 CO-CHAIR HOLLANDER: Well, cost is its
5 own category.

6 MEMBER GRAF: Right. As is clinical,
7 but I thought I heard you organizing --

8 CO-CHAIR HOLLANDER: Clinical is not
9 its own category. Clinical effectiveness is
10 under effectiveness.

11 MEMBER GRAF: Oh, sorry. I'm still
12 looking at the ---

13 CO-CHAIR HOLLANDER: Yeah. But cost
14 has its own category, yeah.

15 MEMBER GRAF: Must have been sleeping.
16 Okay.

17 (Laughter.)

18 CO-CHAIR HOLLANDER: Mary.

19 MEMBER MOEWE: So, I'm thinking about
20 getting the information back into the electronic
21 health record. And probably this falls under
22 operational effectiveness.

1 But, for the physicians, they've made
2 such an investment in their EHRs and I think they
3 feel like, you know, "I've put a lot of money
4 into this, meaningful use has helped me, how do I
5 then document this visit, this telemedicine
6 visit, appropriately and effectively and keep it
7 simple?"

8 So it's not, you know, do I record it,
9 do I video --- I mean, video is a whole other,
10 like, do you want to have those kinds of records,
11 because it's a lot of data to store and they may
12 not want to do that.

13 But, I mean, thinking about
14 operational effectiveness, how do I want to store
15 that visit in my electronic health record and
16 keep that data? Because it may be -- there may
17 be more data actually available from a
18 telemedicine visit than there would be from a
19 normal visit.

20 And it should be, you know -- because
21 we were talking about this at lunch. It should
22 be very similar. A visit's a visit. If it's

1 telemedicine or if it's a regular face-to-face
2 just like this, we could be doing it remotely.
3 It's the same thing. We're doing the same thing.

4 So, let's not reinvent the wheel, but
5 we want to get that data into the record and make
6 it simple.

7 CO-CHAIR HOLLANDER: Right. So, I
8 think that that could fall under operations or
9 technical. And I don't know if --- so, maybe I'm
10 wrong here, but I'm not sure we need to answer
11 that question.

12 MEMBER MOEWE: No.

13 CO-CHAIR HOLLANDER: We just need to
14 create a bucket that the answer to that question,
15 should someone want to measure it, would fit into
16 the framework. And so I think that component
17 does that.

18 I agree with your overall concept, you
19 know, we need to document what we're doing.
20 Depending on how it is, you know, if you're
21 bringing a video and storing a video, well, it
22 may be technically you need the ability to do it

1 or you may need the operational, you know,
2 wherewithal ---

3 MEMBER MOEWE: Someone in the office
4 to take care of it.

5 CO-CHAIR HOLLANDER: Right. And so,
6 how we solve that -- so if the measure is
7 capturing 98 percent of video visits and storing
8 it, which I hope it never is, you know, I think
9 this framework would enable that to do that. It
10 would fit somewhere in there.

11 MEMBER MOEWE: Okay.

12 CO-CHAIR HOLLANDER: But I'm with you.
13 I hope it's never there.

14 David.

15 MEMBER FLANNERY: I just want to
16 follow up on Angela's comment about population
17 health, because I think that comes under systems.
18 It's not individual clinicians that are doing it,
19 so it's a team, or the whole system has
20 responsibility to a population. And so, I think
21 that should be under system effectiveness.

22 MEMBER WALKER: I just have a

1 counterpoint to something that Jason had
2 mentioned, which is ---

3 CO-CHAIR HOLLANDER: You can't argue
4 with Jason, just so you know.

5 MEMBER WALKER: I'm going to do it.
6 I'm going to argue with him.

7 (Laughter.)

8 MEMBER WALKER: Just because we create
9 the bucket doesn't mean we have to keep it. And
10 if it's something we identify at some point that
11 there's no way to measure it, perhaps we
12 shouldn't keep it.

13 And I would argue that if we're
14 creating a document looking ahead towards the
15 future, just because we're not measuring it now,
16 it may be we're not measuring it yet.

17 So, this does give us a way to kind of
18 conceptualize that ahead of time.

19 CO-CHAIR HOLLANDER: Jason stands
20 down.

21 (Laughter.)

22 CO-CHAIR HOLLANDER: Okay. Other

1 comments?

2 So, throwing out the straw man at the
3 moment, I think right now what we have is system
4 effectiveness, operational effectiveness,
5 clinical effectiveness, and technical
6 effectiveness as four buckets under
7 effectiveness.

8 Are we done? Do we have more? Did we
9 nail it? This was supposed to be the hard one.

10 MEMBER GIBONEY: Well, are we going to
11 talk about clinical effectiveness, as well? Are
12 we just talking about system effectiveness right
13 now?

14 CO-CHAIR HOLLANDER: Well, so, yes. I
15 guess the question would be, do we want to add --
16 - so, in trying to frame this, I'm not sure at
17 this point we have to determine what goes under
18 clinical effectiveness, but, you know, which
19 clearly is going to be some outcomes and some
20 other things.

21 That may be the next step where we're
22 talking about the --- what are we talking about

1 in the next step? The measure concepts. That
2 may be a measure concept.

3 But I do think if there's something
4 that we might think is in clinical effectiveness
5 that rises to the importance of being its whole
6 subdomain, then we should mention that now.

7 Angela is up. She's ready to go.

8 MEMBER WALKER: So, I would just
9 mention, with the clinical effectiveness piece, I
10 think this is probably the bucket where a lot of
11 the measures previously developed will fit,
12 because so many of them are that kind of outcomes
13 piece. So, just thinking forward, to keep that
14 in mind.

15 CO-CHAIR HOLLANDER: Yeah. Okay. So,
16 can we really go on to the next category? Okay.
17 Alright. I got head nods. Okay. So, we got
18 those four. Good.

19 Marcia.

20 CO-CHAIR WARD: Okay. So, we have two
21 left. We have cost and we have access. Got a
22 preference which is going to be easiest to be ---

1 access? Okay. So, nominations. The floor is
2 open for nominations for subdomains for access.
3 Are there any?

4 MEMBER GIBONEY: So, I really like
5 what was said just a minute ago, and I'm trying
6 to think of how we put this into either a
7 subdomain or something. But the fact that
8 telehealth is access; telehealth is not just
9 getting someone access to a face-to-face visit,
10 you know, it is, in and of itself, providing
11 whatever that expertise is or whatever that
12 provider is on the other end.

13 And so, for us, as a provider of care,
14 as the county, we're constantly in this
15 conversation with the state trying to convince
16 them that the work we're doing with telehealth
17 is, indeed, meeting their access standards.

18 But they are, you know, saying, "Well,
19 the only thing that meets the access standards is
20 that face-to-face visit." And we keep saying,
21 "No, no, we've got something that's actually
22 better."

1 And so, you know -- and so I'm just
2 kind of wondering is there a subdomain within
3 access that is required to articulate that very
4 clearly? Because I think that that conversation
5 with payers or with, you know, regulatory
6 entities is so pervasive and so prevalent.

7 Do we want to call it out in its own
8 specific line somewhere in this report, that
9 statement that we believe that the access to care
10 provided by telehealth is, indeed, care? Does
11 that make sense?

12 CO-CHAIR HOLLANDER: Let's go to Dale.

13 MEMBER ALVERSON: Two major subdomains
14 that I see, really, is access for the patient.
15 So, that's one. It's a different type of thing,
16 and that might even go to direct-to-patient care
17 services, what have you. But also providers who
18 want access to that, say, specialty services.

19 So, I sort of see those as two general
20 categories under access. And there may be more,
21 but those are two that I see as subdivisions.

22 CO-CHAIR HOLLANDER: Okay. Yael.

1 MEMBER HARRIS: So, I totally agree.
2 I don't know how low we want to go, but there's
3 the five As of access that we all learned in grad
4 school. And then, of course, timeliness.

5 So, if we want to go lower, there's,
6 you know, availability, there's timeliness -- I'm
7 trying to think -- affordability, there's all the
8 --- he's just nodding, because he went to grad
9 school, too.

10 (Laughter.)

11 MEMBER HARRIS: Obviously, the same
12 instructor.

13 Anyways, it depends on how low we want
14 to go. But when we're thinking about access, do
15 we want to just group those altogether, which is
16 fine, or are we putting out a call for new
17 measures? In which case we might want more
18 granular, because then we look at what we have
19 and identify where there's gaps.

20 CO-CHAIR HOLLANDER: So, do you recall
21 what the rest of the As are?

22 MEMBER HARRIS: I'm looking it up

1 right now. Who remembers? Oh, Henry remembers.
2 Go ahead, Henry.

3 MEMBER DePHILLIPS: Are you trying to
4 get me in trouble?

5 CO-CHAIR HOLLANDER: Yes. Do you know
6 what they are? Go ahead.

7 MEMBER DePHILLIPS: I just did a
8 Google search. So, affordability, availability,
9 accessibility, accommodation, and acceptability.

10 CO-CHAIR HOLLANDER: Okay. Don is
11 next.

12 MEMBER GRAF: I was thinking in terms
13 of the same thing. I didn't have the same words,
14 but in the telehealth construct was the word
15 before the access: "timely access," "rural
16 access," I mean, the things that are specific to
17 telehealth and how that word is used.

18 CO-CHAIR HOLLANDER: Okay. Now Henry
19 and then Adam.

20 MEMBER DePHILLIPS: Thanks. On this
21 particular domain, I actually am doing in my head
22 point/counterpoint like the old Saturday Night

1 Live routine.

2 And so the lumping category, my
3 personal definition of "telemedicine" is the use
4 of technology to export medical information form
5 where it is to where it's needed. That's what
6 goes on up here when I think about telemedicine.

7 So, from that standpoint, access could
8 be one thing. And everything about access could
9 fit in that, whether it's doctor to patient,
10 doctor to doctor, whatever.

11 On the other side of the coin, I know
12 there are several folks from HRSA here, and I
13 know that the HRSA folks are very focused on
14 rural access, right? Access to care when you
15 live geographically away from care.

16 But a lot of folks also understand
17 that in the middle of Washington, D.C. there's an
18 access issue. It is still six months to get a
19 dermatology visit in this town where there's a
20 bunch of dermatologists.

21 So, I'm kind of on the fence about
22 whether to lump access or whether to split it out

1 into rural or urban or specialty or demographic
2 or socioeconomic, you know what I'm saying?

3 So, I'm throwing those out to sort of
4 prompt people to think where do you fall in that
5 spectrum. I'm not answering the question. I'm
6 asking the question.

7 CO-CHAIR HOLLANDER: Okay. Go ahead,
8 Adam.

9 MEMBER DARKINS: I know we've kind of
10 all got the Kool-Aid, otherwise we wouldn't be
11 here. But it seems to me there is a piece around
12 appropriateness. Just because you can do
13 something at a distance, doesn't mean it's
14 better.

15 So, the fact you can end up giving
16 somebody instant access by video and they pay
17 their co-pay, and it's cheaper for them to pay
18 their co-pay rather than go into the clinic,
19 doesn't mean they got more appropriate access.

20 So I think if we don't put that first,
21 if we jump straight and say this has to be good
22 because that's what we believe in. So, we ought

1 to have a gateway of appropriateness.

2 CO-CHAIR HOLLANDER: Okay. I think
3 Peter.

4 MEMBER RASMUSSEN: I guess I'm against
5 the concept of splitting rural versus urban,
6 because it really just depends upon availability
7 of a appropriate provider geographically, as well
8 as the time that --- the acuteness of the
9 clinical situation.

10 In a large healthcare system, you
11 know, the neuro-stroke neurologist might be five
12 blocks away. To get to the ED that's an access
13 problem in a timeliness fashion. So, to me, it
14 doesn't matter if you live in rural Ohio or, you
15 know, you're actually in the Cleveland Clinic.

16 And I guess also this concept of
17 appropriateness, I think I understand what Adam
18 is saying, but I think there's a misconception of
19 what we're doing now is still the best level of
20 care.

21 And I guess the appropriateness
22 concept figures more into, is it going to be an

1 abused situation? Because you can do it, is it
2 going to be abused by the system or the patient?

3 MEMBER DARKINS: No, I think, very
4 straightforwardly, I mean, it may be somebody
5 needs immediate and they shouldn't be --- I mean,
6 maybe it would help triage to see me remotely,
7 but it may be inappropriate. You're seen
8 virtually without wanting to get into the weeds,
9 that was all, just to presume that -- so the
10 first-line access may be you have to wait to have
11 a virtual care delivery.

12 CO-CHAIR HOLLANDER: Okay. I think
13 Dale is next.

14 MEMBER ALVERSON: We didn't get any
15 comments to the -- because I look at access as
16 providers coming up saying -- and they could be
17 providers at a variety of levels, not just
18 physicians, "I need access to that service."

19 And then I look at access for patients
20 independent of where they're located, whether
21 it's urban, rural, whatever.

22 So, is that just not a good subdomain,

1 to divide it up between providers and patients?

2 CO-CHAIR HOLLANDER: Yeah, I have
3 scribbled in my notes here as we're talking, I
4 was just changing my whole thinking of this, and
5 I have "access to patient," "access to provider,"
6 "access to medical records," "access to
7 pharmacy," "access to imaging," "access to lab
8 tests." It's really access to what the patient
9 and providers need.

10 And I think we've been focusing on how
11 easy is it to get access, but I'm not sure --- I
12 mean, I think the measure is can you get the
13 patient the care they need and do they have
14 access to that?

15 And although I started thinking the
16 way the conversation was, I think Peter's
17 comments made me start thinking of it a little
18 differently. So, I don't know.

19 Julie, you're up next.

20 MEMBER HALL-BARROW: Yeah. So, I just
21 kind of reversed it in my head. So, we're
22 talking about access, but what are the barriers,

1 right?

2 And so there's an article I read, and
3 I just pulled it up, but it described them in
4 three subs: financial, structural, and cognitive.

5 So, you talked about labs, all that.
6 That's all the cognitive things. Structural
7 could be everything from regulatory, the home's
8 not a billable site -- I don't care where your
9 home is, you're not going to get it.

10 And then if you look at it from
11 financial, well, what is driving it is that
12 because you're part of an ACO, and that's cheaper
13 and that's the way you're going to go. And
14 you're going to do that ten times before you
15 finally realize, yeah, I better go somewhere.

16 So, I don't know if that works or not,
17 but we could look at those.

18 CO-CHAIR HOLLANDER: And, Chuck,
19 you're up next.

20 MEMBER DOARN: So, I was thinking why
21 some people have access and some people don't.
22 And I was thinking the word "bandwidth" and "last

1 mile." Although that's not quite as bad as it
2 used to be, it's still a problem.

3 And then I said ZIP code and
4 geography. You know, there are places in New
5 York City that you can't hardly get to a
6 healthcare facility, primarily down by the
7 Mayor's Office by the Brooklyn Bridge. So, it's
8 a long way to get to the hospital. So it doesn't
9 have to be rural. It's probably all-
10 encompassing.

11 And then I think the even more
12 important part, when I first started doing this,
13 you know, you had to go to a dedicated room.
14 Now, it's on your phone, it's on your iPad, it's
15 wherever you are, wherever the patient is.

16 So, I mean, access, you know, as long
17 as you have the bandwidth and you have the device
18 and there's someone on the other end, there's a
19 system on the other end, you always have access.
20 But if you don't have those components, then you
21 can't have access and you have to go -- so the
22 question is, is how far is definitive care? Is

1 it, you know, a mile away? Is it 240 miles in
2 space? Is it on a boat, you know, in the ocean?

3 You got to have --- there's got to be
4 a way of getting to care virtually. And then if
5 you have to be transferred, like with the stroke,
6 you know, how far away is it?

7 CO-CHAIR HOLLANDER: So, does that
8 fall under structural, under Julie's?

9 MEMBER DOARN: The bandwidth, perhaps.
10 But I think the location, I mean, I guess it's a
11 change in mindset. It's sort of like you have,
12 the device is in your hand, you know, or someone
13 comes and says, "We're going to put these little
14 robots in the nursing facility," versus, you now
15 have your iPhone or your Android or whatever.
16 It's right on your person. So you always have
17 access because it's right there with you at all
18 times versus going to a cart or going to a
19 dedicated room or something like that.

20 CO-CHAIR HOLLANDER: Alright. Mary,
21 I think.

22 MEMBER MOEWE: Across state boundaries

1 was a concern that I'm thinking about. And maybe
2 it's because Tennessee has so many states
3 surrounding it.

4 Like, we have issues regarding
5 patients seeking care in other states and the
6 interoperability of that data back and forth
7 between, like, a city like Memphis and then
8 surrounding Arkansas, Alabama, Mississippi.

9 How does this help that situation?
10 How is the access improved by this? How does the
11 reimbursement --- these are things I'm thinking
12 of that are maybe not necessarily problems, but
13 solutions.

14 This could potentially be a great
15 solution to access to care across state
16 boundaries. I don't know, but I'm looking to our
17 United friend, because he seems to know a lot
18 nationally about how reimbursement works across
19 states.

20 But I think that's something that's a
21 concern of mine is sharing of data, because I'm
22 working with interoperability initiatives in the

1 State of Tennessee, so I think it's very
2 important that we be able to share data across
3 states. And we've run into constraints from
4 security with sharing of data. So that's, in my
5 mind, access to that data; then, sharing the
6 data.

7 CO-CHAIR HOLLANDER: Okay. Nate.

8 MEMBER GLADWELL: Yeah, I just want to
9 put a simple-minded vote into Dale's comment that
10 what we're talking about is who's requiring the
11 access. And I think that's probably where it
12 should stay at this level, is the patient is
13 requiring access, and then the referring or
14 responsible provider is requiring access, and
15 then all these subcategories could be fleshed out
16 below those. That's my vote.

17 CO-CHAIR HOLLANDER: Okay. Who's next
18 up?

19 MEMBER FERGUSON: So, just to kind of
20 follow on, I think there's another part to that.
21 I mean, we think of patients. We have providers
22 that want it because they need to reach their

1 patients. Makes sense.

2 We also have systems that want to
3 increase market share, penetrate other parts of
4 another market. So, I think system might be
5 another perspective.

6 Having said that, I actually did like
7 the comments earlier about the five As. And I
8 went to the wrong grad school, so I didn't study
9 those five As.

10 (Laughter.)

11 MEMBER FERGUSON: Just for the record,
12 I went to Case Western Reserve University and we
13 studied other things, but doing a bottom-up
14 thinking, right, when you think about access, you
15 know, typically we think either patients are
16 getting care, they're getting access to services
17 they never got before, right? And that's kind of
18 availability. Or they're getting access to
19 services, but they're getting them faster. They
20 were there, but now they're getting them faster.
21 And so that's, to me, accessibility.

22 And I liked the suggestion from Adam

1 on appropriateness. I mean, those are three
2 things -- that's a different way of slicing and
3 dicing this. And I don't care which way we go,
4 but I think they're both kind of valid approaches
5 to this.

6 CO-CHAIR HOLLANDER: Chuck.

7 MEMBER DOARN: Well, the one thing I
8 was thinking of is, you know, across state lines
9 and I start thinking of language and culture.

10 So, you have people showing up at the
11 emergency room, they, quote/unquote, "technically
12 have access," but no one has any idea what they
13 need because they speak the language or there's a
14 cultural difference.

15 And this is not so much seen in every
16 large city ---- I mean, certainly -- I mean,
17 every city in the United States, but some of the
18 larger cities we have immigrant population, you
19 know, Hispanic population that don't necessarily
20 speak the same dialogue.

21 I mean, we've got examples where a
22 woman in this Mexican village went from one side

1 of the river to another side of the river and
2 they had to take her to the hospital because she
3 collapsed. They had no idea what was wrong. She
4 had no idea what was going on.

5 They both speak, quote/unquote,
6 "Spanish," but they couldn't communicate and it
7 turned out the woman was pregnant. She had no
8 idea how she got pregnant or that she was
9 pregnant, and they couldn't really treat her,
10 because they weren't sure. And so, you have
11 that same kind of problem especially, you know, I
12 think of people coming from other parts of the
13 world that come here. Or maybe they won't come
14 here anymore, I don't know, but there are clearly
15 -- there's a challenge there, I think, as well.

16 CO-CHAIR HOLLANDER: Just to be
17 different, I'm going to table hop and go Angela,
18 Stewart, and then Daniel.

19 MEMBER WALKER: Okay. A couple
20 clarifications before I interject. Julie, you
21 had mentioned the three: structural, cognitive,
22 and what was the third?

1 MEMBER HALL-BARROW: Financial.

2 MEMBER WALKER: Financial. And then
3 Judd had also mentioned a list, but it sounded
4 like it's more access to information, things like
5 labs and prior history.

6 CO-CHAIR HOLLANDER: Yeah, it was
7 access to patient. And now I'd say referring
8 provider, medical record, pharmacy, imaging, lab
9 tests. And medical record gets along some of the
10 things Mary talked with across state lines.
11 And I think at some point it's access not just to
12 the patient, but the patient information.

13 MEMBER WALKER: Absolutely.

14 CO-CHAIR HOLLANDER: And maybe that's
15 the right term. And then under patient
16 information maybe it could be imaging, lab tests
17 and other things, but I think that if we're doing
18 visits with a patient devoid of any information,
19 if you're doing neuro-stroke and Peter can't see
20 the CAT scan, it's not really good care.

21 So, I do think -- I mean, that might
22 fall under the clinical effectiveness, but I

1 think I would want to call out, as we're doing
2 telemedicine, we want access to the other things
3 that help us make a decision.

4 Clinical effectiveness might be can I
5 see it well enough or interpret it well enough or
6 get it back in a timely manner.

7 MEMBER WALKER: I agree.

8 CO-CHAIR HOLLANDER: At least that's
9 the way I thought about it.

10 MEMBER WALKER: That's the way I
11 thought about it. You know, access is becoming
12 for me a term like "quality." It's just so
13 broad. You know, what do you mean by that?

14 And I love the five As. I love the
15 sixth A with appropriateness, because I think it
16 defines there may be certain disease states or
17 certain patient populations or cohorts for which
18 clinical medicine is the ideal. And there may be
19 populations that fit the same -- that tele or
20 virtual services is more suited for that disease
21 process or that patient population.

22 If we went with the five As, plus the

1 sixth of appropriateness, it would just be
2 important to make sure that we're capturing these
3 other things like patient information in some of
4 our other domains, either system effectiveness or
5 clinical effectiveness.

6 CO-CHAIR HOLLANDER: I think Dan was
7 next.

8 MEMBER SPIEGEL: I guess I have two
9 comments. One, with regards to the discussion
10 around language barriers or across state lines,
11 one of the As, I think, was accommodation or
12 something to that effect, which I think would
13 actually cover language barriers and potentially
14 other barriers, like if you're blind or deaf or
15 something to that affect.

16 And then the other comment or question
17 I have is should utilization of these services be
18 captured somewhere and does that fall under
19 access or some other domain?

20 CO-CHAIR WARD: Okay. I'm hearing ---
21 so, we're talking about subdomains and a
22 classification/categorization system for

1 subdomains, and I'm hearing us comment this a
2 couple different ways.

3 And so, one thing I heard was three
4 possible subdomains, access for the patient,
5 access for the provider, access for the system.
6 So that would be one structure for subdomains.

7 I'm hearing another one, which is
8 technical access, financial access, structural
9 access, cognitive access, regulatory access.
10 Those could be subdomains.

11 I'm also hearing the five As, which
12 could be subdomains. I think of them as
13 definitions for access, maybe, but that could
14 also be another subdomain system.

15 So I feel like we've got three buckets
16 here and we kind of have to pick one.

17 CO-CHAIR HOLLANDER: Kristi.

18 MEMBER HENDERSON: Can I clarify, the
19 three that you had when you said patient, care
20 team, and system, what is system access? What
21 does that include?

22 MEMBER FERGUSON: I was thinking more

1 at the healthcare system. So, a healthcare
2 system may be expanding into a new market, may be
3 expanding their reach. It's more than just a
4 provider reaching out at that point. So you
5 would measure it differently. There would be
6 different measures associated with it.

7 Can I just do an add-on? I thought I
8 heard a --- I didn't consider data as being an
9 access issue, but clearly it is, right? It was
10 brought up.

11 Does that deserve its own subdomain as
12 well, then? I mean, it's so clear in
13 interoperability and some other issues. It takes
14 care of the EHR in-and-out view.

15 CO-CHAIR HOLLANDER: Henry.

16 MEMBER DePHILLIPS: So, in the
17 category of "if there's more than three
18 subdomains I get a headache," it strikes me that
19 a way to simplify and maybe capture all of this
20 is access for patients, access for providers, and
21 access to information.

22 MEMBER HENDERSON: And we forgot the

1 system.

2 CO-CHAIR HOLLANDER: Okay. And
3 Marybeth.

4 MEMBER DePHILLIPS: So, sorry, a quick
5 comment. I may get thrown out of the room for
6 saying this, but I'll risk it. A hospital
7 expanding to offer new services in a new area, to
8 me, that's a provider. A hospital system is a
9 provider system. It's a -- I lump it with the
10 broad category of providers/provider. I don't
11 look at it as just an individual person.

12 CO-CHAIR HOLLANDER: Kristi, are you
13 up? I'm sorry, Marybeth is up.

14 MEMBER FARQUHAR: I was just trying to
15 get my head around network adequacy and that term
16 that's being used.

17 A lot of folks, you know, CMS has not
18 decided not to use it, because they couldn't
19 really measure it very well, but I think it
20 speaks to access here, particularly with patient
21 and provider and data. All that kind of stuff
22 comes into that whole category of adequacy.

1 CO-CHAIR HOLLANDER: Paul.

2 MEMBER GIBONEY: When I think about
3 what Henry and Dale both said about access for
4 patients, access for providers, ultimately if a
5 provider needs access, they're actually needing
6 access on behalf of the patient. They're not
7 just like, "oh, I wonder, you know, what the
8 latest treatment is for this."

9 Well, no, they're saying, "Given this
10 patient, I wonder what the latest treatment is
11 for this."

12 And so, I wonder if you could even
13 lump that further like access to expertise or
14 access to care. I mean, sometimes telehealth can
15 help you get access to primary care, too. So,
16 it's not just specialty expertise. But it's
17 almost like you have access to some sort of thing
18 in the medical setting that's represented by
19 someone, usually, whether it's clinical care or
20 whatever, I think access to information is really
21 key.

22 And then, you know, one of the other

1 things that Judd brought up very early on in this
2 conversation was access to other medical stuff:
3 meds, labs, diagnostic tests, you know, things
4 like that that help the providers make decisions.

5 So, I don't know if --- I almost want
6 to think about lumping, you know, access to some
7 sort of clinical care or expertise, access to
8 information, and access to, like, diagnostics or
9 ancillary labs or meds or, you know, I don't
10 know. I guess I'm thinking of a different way to
11 lump these things, because I'm not sure I'm
12 incredibly comfortable with access for providers,
13 access for patients.

14 Even though those are measures,
15 they're both seeking the same thing in the end.

16 CO-CHAIR HOLLANDER: Don.

17 MEMBER GRAF: So, I wanted to add to
18 the network adequacy. As we're responding to,
19 like, Medicaid contracts, oftentimes network
20 adequacy is on the table and it defines timely
21 access to appropriate care through the use of
22 telemedicine and close those service delivery

1 gaps defined by gebspecialty, you know, so many
2 miles away from a physician, as all sort of
3 measures of whether we're being in compliance or
4 not. So, the network adequacy, I think, is
5 important.

6 CO-CHAIR HOLLANDER: So, I would just
7 comment that I think network adequacy may fall
8 under, you know, the operational effectiveness or
9 the technical effectiveness, you know, if you're
10 talking about the IT components or you're talking
11 about the workforce components. And so it's
12 already captured in the framework.

13 I mean, I guess you can argue whether
14 it goes in access, too, but if you can't actually
15 get the access, well, then you would fail in the
16 access measure and the effectiveness measure
17 might tell you why.

18 MEMBER GRAF: It's provider network
19 adequacy.

20 CO-CHAIR HOLLANDER: Oh. You mean, do
21 you have enough providers available --

22 (Simultaneous speaking.)

1 CO-CHAIR HOLLANDER: So, that would
2 fit into a system thing, right? So, if you have
3 a system thing and you have no providers either
4 geographically local or remote, then you might
5 miss on the network adequacy.

6 MEMBER GRAF: Right. And all of that
7 fits into access.

8 CO-CHAIR HOLLANDER: Yeah. I see
9 that.

10 Jason.

11 MR. GOLDWATER: So, I just wanted to
12 break in here because --- I mean, it goes back
13 just a little ways about access to data and can
14 the data get into the system, do we examine
15 interoperability?

16 So, one, we're undertaking a project
17 already to develop a measure framework around
18 interoperability. And since I'm the senior
19 director on that, which I can assure you is
20 nothing like this, unfortunately, that, you know,
21 I think there will probably be a lot of cross-
22 application between what comes out of that that

1 will apply here.

2 So, I don't think that's something we
3 need to discuss at this meeting to be
4 incorporated into that framework.

5 I think when the interoperability
6 framework is completed, there is certainly reason
7 to align some of those measure concepts or
8 measures with this one without having to delve
9 into that.

10 Because I think as we start getting
11 into the areas of interoperability and data
12 access, that is --- that's a whole other topic.
13 I mean, there's a number of different issues that
14 have to be raised with that that I don't think we
15 really need to cover here.

16 MEMBER RASMUSSEN: That doesn't mean
17 you're excluding the access to data from this --

18 MR. GOLDWATER: No.

19 MEMBER RASMUSSEN: Okay.

20 CO-CHAIR HOLLANDER: Okay. Angela.

21 MEMBER WALKER: Going or building off
22 what's been said, I think most of the As would

1 meet the patient.

2 Network adequacy kind of falls into
3 the provider system. And I really like the idea
4 of maintaining access to information, because
5 it's so integral to doing virtual services
6 outside the patient's medical records.

7 So, if we defined "patient
8 accessibility" with the five As just in written
9 terms, not subdomains, would those be agreeable
10 subdomains of patient, provider/network adequacy
11 and access to information?

12 CO-CHAIR HOLLANDER: Okay. Megan.

13 MS. MEACHAM: Thank you. I'm just
14 going to put on the rural hat for a second. I
15 agree. I don't think that we need to do a
16 separate subdomain that's saying, like, are you
17 rural or urban.

18 But in thinking about just like we
19 want to be able to say, is the quality of care
20 provided through telehealth the same as through
21 in-person or any other modality, when we're doing
22 research, we also need to be able to say, are

1 there differences between rural and urban? So,
2 is telehealth improving access more in urban or
3 more in rural?

4 So, if there's still a way to build
5 that geography in or --- and also thinking about
6 the barrier side. Someone mentioned barriers.
7 So, like, maybe it's an issue for access for
8 people no matter where you live.

9 I live in Rockville, Maryland. And it
10 took me a month to get an appointment. And it
11 will probably take me an hour to drive there.

12 So, you know, access --- all those
13 issues still remain, but, you know, what --- we
14 need to be able to also be able to research and
15 say what are the differences between rural and
16 urban.

17 So, just try to keep that in mind as
18 we're thinking about this as well.

19 CO-CHAIR HOLLANDER: Steve.

20 MEMBER HANDLER: Just one quick point
21 of clarification. When you were saying about
22 access to the provider, sometimes, of course,

1 this also hits on the rural aspect and other low-
2 resource settings, if there is an appropriate IT
3 access in the facility or in, perhaps, a
4 patient's home.

5 I just want to make sure that that's
6 captured. I don't know that that would be the
7 responsibility of the provider having access to
8 the IT resources. So, I don't know if we could
9 put that in there or not.

10 CO-CHAIR HOLLANDER: All right. Don,
11 are you up or --- Steve.

12 CO-CHAIR WARD: Angela, will you
13 repeat? Because you were reconceptualizing and,
14 I think, doing three buckets.

15 MEMBER WALKER: Oh. So, the three
16 buckets would maybe be the patient thinking about
17 the six As, the provider/network adequacy, and
18 access to information.

19 CO-CHAIR HOLLANDER: Nate.

20 MEMBER WALKER: But it doesn't take
21 into account the point just made by Steve with
22 the technical component.

1 CO-CHAIR HOLLANDER: Nate.

2 MEMBER GLADWELL: I got the flashing
3 green light of death down here. Sorry.

4 Just wanted to maybe edit Don's
5 comments and not use the word "network" --
6 because in telehealth that's, you know, very
7 confusing --- and potentially use "panel" --
8 "provider panel," you know, some other language
9 that keeps the network, from a technology
10 perspective, far from what we're talking about
11 here.

12 CO-CHAIR WARD: Kristi.

13 MEMBER HENDERSON: Do we want to be
14 consistent and use "care team"?

15 CO-CHAIR HOLLANDER: Yeah. I like
16 that.

17 CO-CHAIR WARD: Okay. So, some
18 friendly amendments is what I'm hearing to
19 Angela's --- are people comfortable with that?

20 And so, patient access, which included
21 the five or six As; care team network adequacy --

22 MR. GOLDWATER: Care team adequacy and

1 then --

2 CO-CHAIR WARD: Okay. Care team.

3 CO-CHAIR HOLLANDER: Yeah. Here's the
4 way I have it worded here taking down these
5 things that at least one person likes, it's just
6 me; access for patients, access for care team and
7 network adequacy --- it's not actually two, it's
8 actually for the care team that's providing the
9 care for the patients, because the access for
10 patients is to the care team --- and then access
11 to information and data.

12 (Off mic comment)

13 MR. GOLDWATER: So, I would --- so, I
14 think it was access to the care team --- or
15 access for the care team, access for the patient
16 and/or family.

17 Access to information, I would
18 probably not go into data. I would just say
19 "information."

20 CO-CHAIR WARD: Okay.

21 MR. GOLDWATER: One thing about the
22 five As, which actually is not a grad school

1 term. So, the late, great John Eisenberg from
2 AHRQ is the one that originally came up with that
3 and it was put into grad school curriculums.

4 So, I don't know where Yael is getting
5 her information, but --

6 (Laughter.)

7 MR. GOLDWATER: I'm kidding. Yeah.
8 So, affordability is one of those five As, which
9 really is, are you able to afford the care?

10 Do you think that's one of those that
11 should be included? I mean, is that relevant to
12 telehealth; do you know?

13 CO-CHAIR HOLLANDER: I would --- yeah.

14 MR. GOLDWATER: I mean, I'm just
15 asking.

16 MEMBER DePHILLIPS: So, yeah. Yes.

17 MR. GOLDWATER: Okay.

18 MEMBER DePHILLIPS: I mean, that's the
19 whole socioeconomic discussion. It's great to
20 have access to a specialist a hundred miles away
21 through a smartphone. But if the access is a
22 \$500 swipe on your credit card before you get

1 connected, that's a barrier.

2 MR. GOLDWATER: Again, it was just is
3 it something we could --- that we --- it could be
4 measured that would be relevant to us all.

5 MEMBER RASMUSSEN: And is it a higher
6 standard for telemedicine than for in-person,
7 bricks-and-mortar visits?

8 CO-CHAIR HOLLANDER: I don't think so
9 --

10 MEMBER RASMUSSEN: Is that currently
11 being measured?

12 CO-CHAIR HOLLANDER: -- because I
13 think it depends on the measure. And I think
14 this gets to Megan's comment on the rural versus
15 not rural things as well.

16 You can do the research. It depends
17 on the measure. We're not defining what people
18 can do. But if I'm discharging someone from the
19 ED and they need to see an electrophysiologist
20 because I'm sending them home still with a
21 condition and I can't provide that care, I sort
22 of fail on that measure, right, because I'm not

1 continuing the care.

2 And they may not make the care,
3 because their payer --- maybe this is at the
4 payer level for attribution and United won't
5 cover that care. So, then, they should get
6 dinged for not covering that care. And there are
7 measures that actually require sort of more wrap-
8 around care.

9 And then just because it's on the
10 framework again doesn't mean that anybody gets
11 dinged, because someone has to submit a measure
12 that fits within the framework.

13 And it may turn out when NQF looks at
14 that, they say "That's not really a feasible
15 measure, because it's not covered by any payer,
16 and it's not going to move the needle or change
17 it." But one could --- I don't know, maybe one
18 can't imagine --- one could theorize a day where
19 people need to pay for everything, whatever
20 people need covered or needs to be covered,
21 without discussing how realistic or not that is
22 that you might actually want a measure that can

1 accommodate that.

2 But, again, because we're doing this
3 and we're being right now for the moment blind to
4 geography, doesn't mean you can't do research and
5 say, "does this work better in rural environments
6 than urban environments?"

7 It may turn out if the measure gets
8 out there and it fails in rural environments, it
9 forces people to fix it in rural environments.
10 So, I think it gets, you know, HRSA what they
11 want.

12 And the same way here. If you send
13 someone home and don't provide them rehab after
14 their stroke, because they don't have care, well,
15 that's something Cleveland Clinic gets dinged on
16 or the payer gets dinged on depending on the
17 level of attribution if that measure is approved,
18 but we're not approving measures right now.
19 We're just saying what might come down the road.

20 So, I think it's fair to have it in
21 the framework. It may or may not get used.

22 CO-CHAIR WARD: Okay. So, if people

1 are --

2 CO-CHAIR HOLLANDER: Oh, wait.

3 CO-CHAIR WARD: Sorry.

4 MEMBER SOSSONG: Just a clarifying
5 question. Within the subdomains, we haven't
6 created sub-subdomains for any of the other
7 subdomains.

8 So, while the five or six access
9 points are nice, I think we purposely didn't go
10 into the detail on those others. So, I'm just
11 curious whether or not that should be written
12 into the narrative or whatever you just
13 described, or whether it's a sub-subdomain.

14 CO-CHAIR WARD: And whether it's
15 subdomains, whether it's definitions, what that
16 means.

17 Jason says "definitions."

18 MEMBER SOSSONG: Definitions. Great.

19 CO-CHAIR WARD: Okay. So, folks are
20 comfortable with that for access.

21 Our last one, cost. So, what sort of
22 subdomains under cost?

1 CO-CHAIR HOLLANDER: I recommend
2 dollars.

3 (Laughter.)

4 CO-CHAIR HOLLANDER: Henry.

5 MEMBER DePHILLIPS: So, just building
6 off where we were earlier today, if I recall
7 correctly, we had --- we rolled up cost, cost
8 effectiveness. And then I don't know whether we
9 want to include value or whether -- really, cost
10 effectiveness covers value, but at least
11 initially that's kind of how I would envision the
12 subdomains.

13 CO-CHAIR HOLLANDER: Other comments?

14 MEMBER GRAF: Where does opportunity
15 cost fit into this?

16 CO-CHAIR HOLLANDER: Interesting.
17 Daniel.

18 MEMBER SPIEGEL: Sorry. Just a quick
19 clarification. I don't know if I missed this.

20 Did we already cover experience?

21 CO-CHAIR WARD: Yeah.

22 MEMBER SPIEGEL: Okay.

1 CO-CHAIR WARD: Before lunch.

2 MEMBER SPIEGEL: All right.

3 (Laughter.)

4 MR. GOLDWATER: Daniel, the coffee is
5 right over there. That's fine.

6 (Laughter.)

7 CO-CHAIR HOLLANDER: Sarah.

8 MEMBER SOSSONG: I think it definitely
9 makes it easier to the extent that we have
10 similar definitions across these different areas.

11 So, just looking back at what we just
12 decided on for access, I think that patient
13 and/or family is a nice category. Care teams and
14 systems encompasses a lot of things underneath it
15 as well.

16 I like the idea of opportunity cost as
17 well, because that's often something that we're
18 trying to communicate to payers. Yeah, just
19 throwing it out there to keep consistent
20 definitions.

21 CO-CHAIR HOLLANDER: Okay. I think
22 it's Stewart and then Don.

1 MEMBER FERGUSON: So, I just wanted to
2 be clear. So, when we say "cost," we're actually
3 including --- I heard opportunity cost. We're
4 also including the cost of no care, and cost
5 avoidance. So, all that belongs in this cost
6 domain, just so we're not talking about --

7 CO-CHAIR HOLLANDER: Can you just list
8 all that so we make sure we're capturing --- so,
9 the opportunity cost, cost avoidance --

10 MEMBER FERGUSON: Cost of no care and
11 --- yeah, and then --- yeah.

12 CO-CHAIR HOLLANDER: Okay.

13 MEMBER GRAF: And I'm just going to
14 tag onto that maybe moving cost --- a higher
15 elevation to cost could be revenue. Because, I
16 mean, that's the opportunity piece that I think
17 he's talking about.

18 So, new revenue in terms that could be
19 driven by clinical efficiencies and expanding
20 provider capacity. So, it's the opposite of
21 cost, but still financial.

22 CO-CHAIR HOLLANDER: Okay. So, should

1 --- so, then now --- so, that raises the issue
2 should cost not be the domain, should financial
3 impact be the domain?

4 MEMBER GRAF: That's where I was
5 going. Because you can't fit these others in if
6 you just say "cost."

7 CO-CHAIR HOLLANDER: Oh, my god,
8 you're revisiting the morning. So, just proving
9 Jason's point, we could go backwards, too.

10 So, is that the consensus? We should
11 change that to financial --

12 MS. MEACHAM: Does productivity fit
13 under financial? Because I think productivity is
14 actually one thing that we would really like you
15 guys to get at, the productivity cost.

16 CO-CHAIR HOLLANDER: It could.

17 CO-CHAIR WARD: Say that again? What,
18 Megan?

19 MS. MEACHAM: Productivity cost,
20 absenteeism, miles traveled/saved, et cetera.

21 CO-CHAIR HOLLANDER: Henry.

22 MEMBER DePHILLIPS: I'm going to go

1 back to being a lumper on this one. Maybe I'm an
2 idealist, but when I think about cost
3 effectiveness, I've --- in my mind, I've included
4 all of those things.

5 I've included the opportunity cost.
6 I've included the productivity savings, you know.
7 If we --- again, our world if we offer
8 telemedicine benefit to a large employer and
9 their employees now don't have to leave work to
10 go get it, the cost effectiveness of the offering
11 not only is the medical cost savings, but it's
12 the productivity improvement as well.

13 So, in my mind, cost effectiveness
14 does encompass a lot of these other things. So,
15 I don't know that we need to split them out. I'm
16 going to come down on that side.

17 CO-CHAIR HOLLANDER: Okay. Steve.

18 MEMBER HANDLER: Also, I might get
19 tomatoes thrown at me, but there also could be
20 incremental cost increase, right? So that
21 services --- telemedicine can increase cost. We
22 should capture that.

1 So, you could do telemedicine and
2 still need to go to the emergency department, et
3 cetera. So, we should make sure that we capture
4 the upside.

5 CO-CHAIR HOLLANDER: Well, that's
6 where I think financial impact is --

7 MEMBER HANDLER: The bottom line, it
8 has to go in both directions.

9 MEMBER GRAF: And while I agree
10 conceptually with what you're saying, financial
11 impact to an audience of accountants and bean
12 counters is going to not play the same way.
13 They'll think cost.

14 CO-CHAIR HOLLANDER: So, I'm starting
15 to wonder whether the subdomains here should
16 actually be financial impact to who rather than
17 what.

18 The paragraph is the what, and the
19 opportunity cost and the efficiencies, but the
20 financial impact is to the patient, right? Do
21 you save parking? Do you save gas? Do you have
22 --- save time? Do you have more days of work?

1 To the provider, it might actually be
2 --- it might be more expensive to buy a
3 telemedicine license and do it from your facility
4 that you're paying for anyway, you know.

5 So, there may be different costs to
6 the patient and their family members and
7 caregivers, to the provider and their whatever,
8 to the health system, and to the payer.

9 And so, maybe it's about who
10 experiences the cost and not what are the
11 incremental costs.

12 MEMBER GRAF: And I would argue those
13 are the subcategories.

14 CO-CHAIR HOLLANDER: Yeah.

15 MEMBER GRAF: And then you build below
16 those, because every one of those is somebody
17 who's got skin in the game.

18 CO-CHAIR HOLLANDER: Right. Henry,
19 you seem like you're going to have a heart attack
20 soon, so --

21 MEMBER DEPHILLIPS: Sorry. Chest pain
22 is a terrible thing.

1 I don't disagree with anything Don
2 said about the impact to the patient, impact ---
3 but I want to make sure we don't lose sight of
4 the overarching concept that certain applications
5 of telemedicine reduce cost to the system. The
6 system being accommodation of people that are
7 paying for medical care, and I want to make sure
8 we don't lose sight of that.

9 We can subdivide it into who in the
10 system is saving what, but I want to make sure
11 that the cost savings to the system is really the
12 overarching concept.

13 CO-CHAIR HOLLANDER: So, under the
14 financial impact, then, you're proposing there's
15 an overall cost to everybody, right?

16 It's not even necessarily the system,
17 per se, because it's the patient, you know, and
18 their out-of-pocket costs, which Don may not
19 consider part of his system, and then each of the
20 incremental components.

21 MEMBER DEPHILLIPS: Yeah. Let me just
22 --- I'll give you just a real concrete example.

1 So, in our world, we took \$440 million out of the
2 cost of medical care for the people we served
3 last year.

4 Each of our different clients wax up
5 that savings between the client and the member,
6 right? The copay could be five or 40, right?
7 So, it varies --- who saved what, varies, but the
8 bottom line is we took \$440 million of
9 unnecessary cost out of the medical system for
10 our clients last year.

11 That's the notion I want to make sure
12 we don't lose sight of.

13 CO-CHAIR HOLLANDER: Yael.

14 MEMBER HARRIS: So, building on that,
15 I think the cost --- I'm not comfortable with the
16 cost to the patient versus the cost ---
17 basically, saying what Henry said.

18 First of all, patients may be willing
19 to pay more. The couple times I've used
20 telehealth, it's not covered by my insurance, but
21 I've paid for it because it was so much more
22 convenient. And I didn't sit there counting out

1 how many miles I was putting on my car and how
2 much gas mileage, it was the convenience -- I
3 could have put off how much time I took off from
4 leave from work. It's so hard to calculate. I
5 think it's the cost overall because had I not
6 gotten that care, what would have been the
7 downside?

8 And then as far as cost to the
9 provider, I keep thinking back to that study
10 Marcia referenced that we were working on.

11 One of the measures we didn't --- we
12 kind of recommended, but really doesn't exist,
13 was cost of avoidable care, but avoidable care to
14 whom?

15 And the issue was, we were measuring
16 it by would the patient be transported by car,
17 like nonemergent; would the patient be
18 transported by ambulance, kind of emergent, but
19 not crisis; or would the patient be transported
20 by ambulance, crisis, emergency?

21 And so, the cost, then, who does it go
22 to in terms of, you know, the --- if it was ---

1 it's a judgment call, first of all, whether it's
2 emergent or not. But, second of all, if it's not
3 emergent, it's to the patient, because it's their
4 car.

5 So, I think it gets to this point of
6 if I were developing that measure and drafting
7 that measure, which subdomain would I even put it
8 in?

9 CO-CHAIR HOLLANDER: Eve-Lynn.

10 MEMBER NELSON: I think just thinking
11 about the cost to the distant site as well I
12 know, you know, I've brought up presenters
13 before, but sometimes they're giving their time.
14 So, it may not be --- it may be harder to
15 quantify, but just the space, the time, the
16 community cost associated with helping support
17 the provider-to-patient encounters.

18 CO-CHAIR HOLLANDER: Chuck.

19 MEMBER DOARN: I was thinking of small
20 hospitals that if a telestroke network always
21 advises, you know, they need to be transported to
22 the bigger hospital, the smaller hospital suffers

1 because they don't keep their beds hot.

2 So, there could be a loss --- I mean,
3 there could be a downside to this whole thing is
4 that you could actually close smaller hospitals.
5 I mean, we already see that anyway.

6 The other one is a return on
7 investment. I mean, a lot of times when you talk
8 to a business person and say, "Well, I want to
9 put in, you know, \$200,000 of direct and indirect
10 cost or fixed and variable cost to build this
11 telemedicine system, and it's going to cost me so
12 much for people and so much for hardware," the
13 person is always going, "Well, how long is it
14 going to take me to recoup money back?"

15 They don't ever ask you about how you
16 going to --- you know, that's the opportunity
17 cost I mentioned earlier. How you going to, you
18 know, how's it going to benefit the overall
19 system?

20 And one clinical department in the
21 university may be all about doing this, another
22 one is like there's no way we're going to do

1 this, but they actually would benefit from that,
2 you know.

3 You see these --- the telestroke carts
4 in the emergency room, they --- I have a surgeon
5 who wants to actually use it for something
6 completely different and no one even thought
7 about that when they bought it.

8 So, I think sometimes the business
9 side of the telemedicine, or at least within an
10 academic health center, they always look at
11 what's the return on investment and they never
12 really think about these other things.

13 CO-CHAIR HOLLANDER: Okay. Don, then
14 Paul, then Dale.

15 MEMBER GRAF: And add to opportunity
16 cost to opportunity loss, so when we talk about
17 the originating site being a presenting site and
18 getting little, or, if anything, and not using
19 that exam room to generate, you know, new
20 revenue.

21 The other being, you know, FQHC
22 resistance to wanting their providers to

1 participate in an echo clinic, because how many
2 patients could they be seeing.

3 So, there's always that sort of
4 business model and the opportunity lost
5 associated with how they're kind of constructing
6 and, you know, engaging in telehealth.

7 CO-CHAIR HOLLANDER: Paul.

8 MEMBER GIBONEY: I agree that some of
9 these things, kind of like Yael was saying, that
10 it's hard to measure, there's so many different
11 factors, but I don't think that's a reason to
12 leave it out. Because just because we can't
13 measure it well today, doesn't mean it's not
14 important to flag.

15 I mean, there are true costs to the
16 patient or cost savings to the patient with this.
17 Even though we got a hard time quantifying that,
18 I think it's still important to put it in the
19 framework to acknowledge it so that if there are
20 measures that can be developed in the future that
21 can capture at least pieces of that, just their
22 transportation costs, or just their time off of

1 work costs, or just, you know, it may just be
2 looking at a very small piece of that, but it's
3 critical to leave it in the framework, because it
4 is a real cost.

5 CO-CHAIR HOLLANDER: Dale.

6 MEMBER ALVERSON: Another part of the
7 subdomains, because this comes up a lot and some
8 of the efforts actually has to do with community
9 economic development, it's an indirect benefit.

10 In other words, they talk about if we
11 had telehealth, get better --- we have --- get
12 better access to that service, we have a
13 healthier community, we can build our economic
14 base in that community by having telehealth
15 services.

16 So, some of that has to be captured in
17 this, is this --- and I don't know what you'd
18 call it, but it certainly is the indirect impact
19 of --- for economic development in a community.

20 CO-CHAIR WARD: So, I'm hearing a lot
21 of different components to cost or financial
22 impact here.

1 I am also hearing something that I
2 think is maybe pretty parallel to the way we
3 ended up structuring access.

4 And since I work with a whole bunch of
5 health economists, I know a common approach that
6 they take is cost to the patient, cost to the
7 provider, cost to the health system, cost to
8 society and they often figure out how you take
9 something and you divide it into those buckets.

10 So, I know that if we do that, it will
11 resonate with at least some group and it seems
12 parallel to what we did with access.

13 Angela.

14 CO-CHAIR HOLLANDER: Okay. So, Don
15 was first and then --

16 CO-CHAIR WARD: Angela was up before.
17 That's why I --

18 CO-CHAIR HOLLANDER: Oh, okay. All
19 right. We'll do Angela, Don and Kristi.

20 MEMBER WALKER: I do like the parallel
21 way to look at things, but here's another way to
22 consider it: Cost of care; opportunity lost or

1 opportunity cost; downstream cost, which would be
2 things like the hospitals closing; and cost
3 savings.

4 CO-CHAIR HOLLANDER: Would that be the
5 paragraph that frames this, or would that be the
6 subdomains?

7 MEMBER WALKER: Potential subdomains.

8 CO-CHAIR HOLLANDER: Okay. Don, I
9 think, was --

10 MEMBER GRAF: And I'm thinking sort of
11 backwards or bottom up or however we talked about
12 it before and I think about the transportation
13 cost savings to the systems, I think of lost
14 wages from a member perspective, a time out of
15 school and its impact on grade performance, you
16 know.

17 And so, I can't help thinking this is
18 --- when we start plugging in the actual dollars
19 and cents that I use in pitching any telehealth
20 program and put it -- can I put it in a P&L, I
21 can't help thinking that maybe that's where we
22 need to start and that the rest of it will sort

1 of percolate.

2 And it might percolate to the very
3 things you just mentioned, but --

4 MEMBER WALKER: I was thinking it
5 would.

6 MEMBER GRAF: Yeah.

7 CO-CHAIR HOLLANDER: So, I mean, is it
8 important to overall change the word "cost" to
9 "financial impact" and not have "cost" anywhere
10 in it, it's just "financial impact"?

11 And that allows you if it's financial
12 impact to the patient, to take into account these
13 opportunity costs and travel savings and work
14 stuff right there because they're not just money
15 spent, it's financial impact.

16 Kristi.

17 MEMBER HENDERSON: Yes. So, I
18 definitely like the financial impact, but,
19 Marcia, to your categories, I have written down
20 the same and societal was one of them, but then I
21 did --- layered it with direct or indirect costs.

22 So, I think we're all kind of going to

1 the same direction with those four different
2 categories.

3 CO-CHAIR WARD: So, cost to patient,
4 which in our language would be the family; cost
5 to the provider, which broadly would be whoever
6 the provider is, so it could be ambulatory,
7 inpatient, could be the hospital, whatever --

8 CO-CHAIR HOLLANDER: Or the care team.

9 CO-CHAIR WARD: Care team. Financial
10 impact to the health system, and then financial
11 impact to society.

12 MEMBER DARKINS: I just --

13 CO-CHAIR HOLLANDER: Adam.

14 MEMBER DARKINS: I was going to ask
15 Jason in terms of creating a framework, are there
16 existing ways to look at this from NQF? Because
17 one of the advantages of creating a framework is
18 it has comparators.

19 If we end up creating something which
20 is really loose, all over the place, and we just
21 sort of say, well, here's a recommendation, what
22 then is used as that framework to then put some

1 kind of systematization discipline in it?

2 MR. GOLDWATER: All right. So, we can
3 look at other frameworks that we've developed in
4 the past. You know, there's ones that have
5 already been completed. So, we have one on
6 health IT and patient safety, which we completed
7 last year, which had many more subdomains and far
8 more concepts than I think we're probably going
9 to get here, but that's a much broader, you know,
10 there are a number of different moving parts.

11 There's also a foundation from which
12 to begin, because there was already research on a
13 sociotechnical model of how to base that, plus
14 ONC already funded a health IT and patient safety
15 center.

16 So, I think, Adam, there's nothing
17 that I'm hearing now or looking at that would not
18 be effective if it was fleshed out more.

19 I think changing cost to financial
20 impact makes a tremendous amount of sense. I
21 think where I was, you know, personally getting a
22 little wary is when we start sort of getting into

1 the fine tuning of financial impact like
2 opportunity cost or productivity loss or things
3 of that nature, you know, those are too refined
4 to be a subdomain. Those are measure concepts.

5 And I think, you know, the four that
6 Marcia laid out; impact to patients, to provider
7 or, I guess, to care team, the health system and
8 society, I think all of those other things can
9 fit into these, which is really the way you want
10 to go.

11 So, I think your point is well-made,
12 but there's nothing in here I'm looking at that
13 would prevent this framework from unfolding and
14 being implemented.

15 MEMBER DARKINS: The reason I just
16 quickly ask is, one of the things which has beset
17 this whole field has been inability to release
18 systematic look at costs.

19 So, if there was a way to make it more
20 systematic that means comparators could be made,
21 I think it would be a great help.

22 MR. GOLDWATER: Right.

1 MEMBER DARKINS: That was all.

2 MR. GOLDWATER: Well, one of the
3 things I would probably tell you all is if you
4 look at that slide, the very last bullet, you
5 know, those were gaps that you all mentioned and
6 that were referenced in the literature that don't
7 exist at the moment in terms of measurement.

8 So, how do we look at family-centered
9 care in telemedicine? What's the standard of
10 care versus the standard of care plus
11 telemedicine? What would a patient do in the
12 absence of telemedicine?

13 I think all the subdomains you have
14 put forth cover those areas. And I think the
15 concepts that will come from that, will cover
16 those areas.

17 MEMBER DARKINS: So, I don't want to
18 belabor this, but, Chuck, didn't Rashid do a
19 publication on looking at cost?

20 (Off mic comment)

21 MEMBER DARKINS: I think it was
22 something in the last ten days.

1 MEMBER DOARN: There was a report. He
2 did write a manuscript recently on a couple of
3 different --- and the empirical evidence ones for
4 sure have been recent, but there wasn't --- I
5 don't remember exactly when --

6 MEMBER DARKINS: Well, I didn't want
7 to take us back into sort of, you know, past
8 history --

9 MEMBER DOARN: No.

10 MEMBER DARKINS: -- but I did think
11 having looked systematically, somebody trying to
12 make a systematic approach to looking at costs,
13 maybe that would be something we could share as a
14 framework that sort of fits in, if that makes any
15 sense.

16 MEMBER DOARN: Yeah, and I think if
17 you --- that's why I was saying in the very
18 beginning if we went back -- in this particular
19 area and went back, you know, maybe back into
20 1995-2000 time period, there are probably, you
21 know, half a dozen articles that might add value
22 to this discussion versus all eight articles that

1 were --

2 MR. GOLDWATER: So, Dr. Bashshur is on
3 this committee. But because of his health, can't
4 physically travel to be here.

5 So, he seems like a wonderful human
6 being from his email contacts and we send him our
7 documents and he writes back.

8 And they're long emails, but he
9 referenced his own work regarding cost and said
10 essentially the same thing that if you need a
11 foundation, we've written this and this and this
12 and this.

13 So, I think, again, to get back to
14 when we started this, when we start unfolding
15 these measure concepts and start fleshing them
16 out, you know, some of the additional literature
17 that we will probably include will provide a
18 foundation for that, an evidence base.

19 So, that's not to say, Chuck, we're
20 going to limit --- I'm not going back to 1972,
21 I'm sorry. That's --

22 (Off mic comment)

1 MR. GOLDWATER: But I will, you know,
2 certainly if --- we'll look at Dr. Bashshur's
3 citations with respect to cost. Because even
4 though we, you know, had a limit as to what we
5 were going to look at again because of time
6 constraints, I think that we can, you know, find
7 an article that sort of justified these domains
8 and subdomains and really provide an evidence
9 base for cost.

10 CO-CHAIR HOLLANDER: So, four more now
11 and then we're taking a break. If you put you
12 thing up, we're ignoring you after this. So,
13 we'll run from Eve-Lyn on down this way.

14 MEMBER NELSON: Sure. Make me follow
15 Chuck.

16 I think the financial impact to
17 society is especially helpful for the echo
18 measures especially looking at, you know,
19 workforce or tension, those kinds of things. So,
20 thanks for including that.

21 CO-CHAIR HOLLANDER: Henry.

22 MEMBER DEPHILLIPS: Just to help me

1 connect the dots, the four domains, again, were;
2 cost to patient --

3 CO-CHAIR HOLLANDER: Financial impact.

4 MEMBER DEPHILLIPS: -- financial
5 impact. I'm fine with that.

6 CO-CHAIR WARD: Financial impact to
7 patient/family, financial impact to the care team
8 --

9 MEMBER DEPHILLIPS: Care team.

10 CO-CHAIR WARD: -- financial impact to
11 the health system --

12 MEMBER DEPHILLIPS: Health system.

13 CO-CHAIR WARD: -- financial impact to
14 society.

15 MEMBER DEPHILLIPS: Okay. Help me
16 connect the dots.

17 Harvard Medical School researcher
18 studies one of --- a client of ours. It's a 50-
19 state home improvement retailer whose logo color
20 is orange, but I can't mention the name. They
21 save \$21.30 PMPM after --- 18 months after
22 implementing.

1 The cost of the self-insured employer,
2 the cost of care that that company pays for its
3 employees and dependents, \$21.30 PMPM, which is
4 some number of millions of dollars.

5 How does that get captured in this
6 framework?

7 (Simultaneous speaking)

8 CO-CHAIR HOLLANDER: So, I'm pretty
9 sure there's never going to be a measure asking
10 does Home Depot save money?

11 MEMBER DEPHILLIPS: I didn't say Home
12 Depot.

13 CO-CHAIR HOLLANDER: So, but whatever.
14 So, it's really, you know, what are the measures
15 --- so, you know, what are the measures designed
16 for? And they're designed for care providers.

17 So, as a company that sells to
18 employers, the measures may not be designed to
19 does a single employer save money, but it
20 probably could fit under the system.

21 So, by saying what system, what payer,
22 the payer might be United or it might be a --

1 MEMBER DEPHILLIPS: Fair enough. The
2 fact that several people went right to health
3 system gives me great comfort. Thank you.

4 MEMBER GRAF: And my question is also
5 a connect-the-dot question, but it's more
6 specific to societal measures.

7 Any examples that I can wrap my head
8 around? None are coming to mind right off the
9 top.

10 CO-CHAIR WARD: So, in my listening to
11 health economists and having tried to write some
12 things on this, they actually talk about societal
13 including both the patient and the provider, in
14 this case, the health system. All three would
15 capture --- societal would bundle all those
16 three, because it's the biggest.

17 And so, when you do a financial
18 analysis, you pick a perspective that you're
19 going to take to do your financial analysis.

20 And so, if you're an insurer, that's
21 your perspective. If you're a hospital, that's
22 your perspective. If you're an academician, you

1 might be looking at, you know, patient
2 opportunity costs or avoided, you know, travel
3 times and saving on sick leave and stuff like
4 that.

5 So, you pick your perspective and
6 that's --- that was what I was thinking of when I
7 suggested breaking it this way, because that's a
8 common way to do it.

9 MEMBER GRAF: So, I get that from a
10 perspective standpoint, that it really is sort of
11 a societal --- more of an overarching. But in
12 this context, we have it separate from those.

13 And so, are there separate --- or is
14 it really societal and then provider, patient,
15 and system fall under that?

16 CO-CHAIR WARD: So, like Chuck was
17 talking about, a hospital closure. And a
18 hospital closure in a community if it's an
19 independent hospital, it ---

20 MEMBER GRAF: Okay.

21 CO-CHAIR WARD: -- you may not think
22 just the --- it may not specifically be a health

1 system, but it's what's the impact on that in the
2 community, their economic development? All those
3 sorts of things might come into the societal
4 perspective.

5 MEMBER GRAF: Thanks. That helps. I
6 had forgotten about that.

7 MEMBER GIBONEY: And I just want to
8 throw in like cost to jail systems, you know.
9 Like if you're doing a substance abuse
10 telemedicine intervention or behavioral health,
11 the societal cost to keeping people out of the
12 jails or other, you know, kind of societal --- I
13 mean, there's any number of societal costs you
14 can think of after a telehealth intervention.

15 CO-CHAIR WARD: Okay. So, the
16 question is, are people comfortable with those
17 four buckets for --- then you get to have a
18 break.

19 MR. GOLDWATER: Wait. So sorry. I'm
20 not, actually, but I just want to run through the
21 domains --- the subdomains to make sure that
22 we've adequately represented them.

1 (Off mic comment)

2 MR. GOLDWATER: Well, I just want to
3 make sure right now we've got it adequately
4 worded, represented so that when we get back and
5 we talk about the concepts, we all know where
6 we're starting from.

7 CO-CHAIR HOLLANDER: I think I have
8 the exact ---

9 MR. GOLDWATER: We'll type them during
10 the break.

11 CO-CHAIR HOLLANDER: Okay. So, I
12 think I have the exact wording we came up with.
13 So, under access, there was access for patients
14 or families ---

15 MR. GOLDWATER: Uh-huh.

16 CO-CHAIR HOLLANDER: -- and the As in
17 parentheses. Access for care team, and we
18 changed it from "network adequacy" to what?

19 MR. GOLDWATER: To information.

20 CO-CHAIR HOLLANDER: No. No. No. It
21 was care team and --

22 (Simultaneous speaking)

1 CO-CHAIR HOLLANDER: Okay. So, access
2 for care team.

3 MR. GOLDWATER: Uh-huh.

4 CO-CHAIR HOLLANDER: And then network
5 adequacy, as it used to be defined, is included
6 in the definition.

7 (Off mic comment)

8 CO-CHAIR HOLLANDER: I know. We're
9 going to change the word. Right. Access to
10 information is the third.

11 MR. GOLDWATER: Right.

12 CO-CHAIR HOLLANDER: And financial
13 impact, we just read those. Financial impact to
14 patient, family or caregiver, to care team, to
15 health system or payer, to society --

16 MR. GOLDWATER: Uh-huh.

17 CO-CHAIR HOLLANDER: -- an experienced
18 patient, family or caregiver, care team member,
19 community. For effectiveness, they all end with
20 effectiveness, system, clinical, operational,
21 technical.

22 MR. GOLDWATER: That's what I have.

1 CO-CHAIR WARD: We are good.

2 MR. GOLDWATER: You guys are
3 incredible, really.

4 CO-CHAIR HOLLANDER: Everybody take an
5 extra minute.

6 (Whereupon, the above-entitled matter
7 went off the record at 3:07 p.m. and resumed at
8 3:35 p.m.)

9 MR. GOLDWATER: All right. the point
10 of the meeting now where we are going to -- we're
11 at the last phase here, so we have brilliantly
12 gotten domains and subdomains in a much faster
13 and more consolidated way than I -- we ever
14 envisioned possible. We were rehearsing every
15 conceivable scenario, and this was not one of
16 them.

17 We thought oh, there will be 16 or 18
18 of these. We're going to have to get them into
19 groups and take notes, and then we're going to
20 have to go back and we're going to have to argue,
21 and really, I mean, if I could put you all in my
22 pocket and take you to every meeting I have, I

1 would do it in a minute. Not you, Angela --

2 MEMBER DePHILLIPS: If you prefer --

3 MR. GOLDWATER: -- but everyone else.

4 (Laughter.)

5 MEMBER DePHILLIPS: If you prefer, we

6 can start throwing chairs, you know, Geraldo --

7 MR. GOLDWATER: Well the thing is that

8 May and Irvin have not -- I don't think they have

9 been in a meeting, and I am like this is not

10 always how it goes. This is the -- this is the

11 ideal, but this is not always how it goes, so --

12 CO-CHAIR HOLLANDER: Unless you want

13 to do a lot of other committee meetings, stop --

14 (Laughter.)

15 MR. GOLDWATER: No, so we -- I mean,

16 in all seriousness, we do really want to thank

17 you. This has been incredibly productive, and I

18 think we feel really good where we are and where

19 we are going and what this is going to be.

20 But now we start getting into the

21 point where we're going to develop measure

22 concepts, so what I want to do, I -- we were

1 going to break into groups, but I don't think
2 there is a point in doing that now. Because you
3 all are working so well in a large group, I don't
4 see why we would break you all up, unless the
5 fighting begins and Judd starts throwing chairs
6 and cursing at people, which he is apt to do.
7 Kidding.

8 So what I want to do is sort of talk
9 about what a measure concept is. I know, you
10 know, some people like Marybeth and Yael who have
11 -- and certainly Marcia who have developed
12 measures understand this, but for the rest of
13 you, just so we're all on sort of the same basis,
14 a measure concept is not actually a quality
15 measure. So a quality measure has very steep
16 components. It has a numerator, it has a
17 denominator, it has exceptions, it has
18 exemptions, and then ultimately it produces a
19 percentile which lets you know how far you are
20 moving towards quality.

21 A concept is not a measure. A concept
22 is an idea for a measure that at the moment does

1 not exist. It is important as we sort of go
2 through this that the concept does have to relate
3 to the -- one of the subdomains. It can't be
4 something that is somewhat kind of related to the
5 subdomain, but not really. It has to directly
6 relate to that, because envision yourself as the
7 user of this. You would be looking at basically
8 a map, and it would be saying here is a subdomain
9 of access, here's some measure concepts that
10 could be developed into measures. You want it to
11 flow very sequentially, very logically.

12 The concept does need to specifically,
13 as much as possible, be related to telehealth.
14 It goes back to Adam's comment at the beginning.
15 We are not trying to solve the problems of
16 healthcare. It will fall and collapse under its
17 own weight. We are specifically talking about
18 telehealth.

19 The concept also cannot be incredibly
20 broad, like we want to -- you know, the measured
21 concept is opportunity cost due to telehealth.
22 That is a little broad. You have to make it a

1 little bit more specific so that somebody can
2 look at that and say, oh, I could take this and
3 make a numerator, make a denominator, and create
4 a measure.

5 Next slide. So when you are
6 developing and evaluating measure concepts, so
7 this really sort of came up in our last meeting
8 that we talked about sort of the different
9 dimensions. Now, we are not -- you are not
10 beholden to these, but as you develop concepts
11 related to those subdomains, some things that you
12 all talked about should be in part of these
13 measures are the infrastructure capacity; the
14 appropriateness of the measure, it does relate to
15 telehealth now and in the future; potentially
16 therapeutic outcomes, including diagnosis, and
17 that would be specific to certain subdomains;
18 looking at patient outcomes; and also that the --
19 most importantly, the measure concept has to be
20 actionable so people could look at it and create
21 the measure, and that preferably, you know, you
22 have the capacity, it is appropriate, it deals

1 when necessary with therapeutic outcomes or
2 patient outcomes.

3 And so the prioritization of these
4 concepts, and again, going back to our last
5 meeting, it is, you know, what are the most
6 critical elements or dimensions of that measure
7 concept as you're building -- thinking through
8 that? What really becomes the critical area you
9 are looking eventually to measure? What would --
10 what is its potential to drive improvements? How
11 easy would it be to implement? And then, as I
12 said earlier, if this became a measure, is there
13 data available to populate the measure? Because
14 if that data is impossible to get, the measure
15 would not be useful.

16 And again, going back to Angela's
17 comment, if the data is not available now, do you
18 think the data will be available in the future?
19 Reference that because we will include that in
20 the report. And then, again, think because of
21 your experience, we have gone over these
22 subdomains, so as we look at things like, you

1 know, financial impact to the care team, what
2 gaps currently exist, you know? Where is there
3 not a measure? Where do you think that would be
4 -- where would that be -- how could that be
5 filled in a way that would be effective and
6 important and really have significance?

7 We don't want to be duplicating
8 measures. We don't want to be piggybacking on
9 measures that already exist. We don't want to be
10 copying anything. Now, as you come up with
11 measure concepts, if the NQF team identifies
12 measures that actually map to that, which I don't
13 think we're going to find, but in the event we
14 do, we will tell you that tomorrow. Like oh,
15 there's a concept? Well here is a measure. What
16 do you think?

17 I don't think that is going to happen
18 because really what you have covered so far are
19 very specific to telehealth, and there are
20 significant gaps in measures, but again, you want
21 a measure that is going to fill a gap because
22 that makes the framework actionable and very

1 significant.

2 So with that in mind, I will turn it
3 back to our cruise directors, who will lead the
4 discussion on measure concepts. Do you want to
5 go to the slide that we -- previous to this?
6 Again, going back to Judd's comment, we are
7 always on the slide that we're not on. Right,
8 okay, good. So I guess we could start with
9 access to care.

10 MEMBER SPIEGEL: Is it possible to
11 send this slide out?

12 (Pause.)

13 CO-CHAIR HOLLANDER: So -- so I
14 actually -- because, you know, we were so excited
15 we were so efficient, we actually forgot to
16 discuss how we were approaching this session.
17 But -- but -- you know, at the break, but one of
18 the things that I just asked Katie to pull up is
19 I thought it would be good for the people in the
20 room that -- that have not seen the measure
21 evaluation process to get a quick look at what
22 the tool is and the flow chart as to what items

1 measures are evaluated on, so we're just trying
2 to pull up that slide quickly.

3 It is just a couple items, and I think
4 it will, you know, basically make it a little
5 more concrete how we're going. And I apologize I
6 hadn't thought about that in advance, but --

7 MR. GOLDWATER: You are forgiven.

8 CO-CHAIR HOLLANDER: Oh, okay. All
9 right. So -- and Marcia suggests we sort of
10 begin with experience as the easiest thing to do,
11 to begin with, again, and I will ask the question
12 of Jason, and I will throw it out as a strawman
13 thing I could get right or wrong, that I am not
14 sure the measure needs to fit into one or only
15 one of these domains. It could span other ones,
16 and so it may not be important to say oh, is that
17 access or system effectiveness? It is just that
18 the measure fits within overall the things we
19 think are important to look at.

20 MR. GOLDWATER: Yes.

21 CO-CHAIR HOLLANDER: And so it looks
22 like this is a slide taken from another group

1 that is reviewing measures --

2 MR. GOLDWATER: Yes.

3 CO-CHAIR HOLLANDER: -- and I am
4 sorry. This one, Daniel, it looks like is just
5 going to be on the central monitors, but we will
6 be on and off this, you know, pretty quick.

7 So these are the items that show up.
8 So the first is, you know, does anybody care? Is
9 it important to measure and report? So if
10 everybody decides that it is not important and it
11 fails this, nothing else on the slide matters, so
12 people need to believe it is important.

13 And -- and I think -- I am doing this
14 off the top of my head -- at some point, within
15 the importance category, you assess is there a
16 gap? Like if we are 99 percent effective in
17 this, it might be important, but it does not
18 really need to be measured because you're not
19 going to get improvement, and so you really look
20 for some variability that suggests you can do it
21 better, but other people are doing it not -- not
22 as well. And so this is, you know, sort of a

1 little bit of, you know, just is it important.

2 Then there is a -- a sort of
3 structured assessment where the measure developer
4 submits data that shows the measure as they
5 propose is reliable and valid, and so, you know,
6 it is the same concepts of reliability and
7 validity you learned at, you know, all through
8 school: are you able to measure what you want to
9 measure, and does it represent what you want to
10 measure?

11 Then -- then it gets to feasibility,
12 and this is an area where some of the discussion
13 we had already we say, well, you can't really
14 measure that, so no one is going to propose a
15 measure that can't be measured because if it is
16 not feasible, the measure, it is not actually
17 going to get through that portion of it. It does
18 not mean the framework can't be broader. It just
19 means until it becomes feasible, nobody is
20 actually going to be able to get a measure.

21 Usability and use is really can you
22 get the measure and use it? And then -- then

1 there is a comparison or -- or harmonization with
2 competing measures so that it is -- is it
3 different enough that it is worth measuring
4 again? And somehow, 2500 measures got approved
5 that are different enough it is worth doing a
6 little different, so sometimes, there's little
7 shades of gray, and sometimes there's not. But
8 is this -- it is only this slide, right? Is
9 there a next slide, or is there not?

10 Yeah, so -- so this is the basic
11 concept. So really, it has got to be important,
12 and you've got to be able to do it reliable -- in
13 a reliable and valid measure, and you have to be
14 able to do it. Those are the three big buckets,
15 and so as we are now looking at measure concepts,
16 we -- we want to make sure to come up with ideas
17 that, you know, have some degree of importance
18 and that everybody could agree or we can test for
19 reliability and validity, because unless you show
20 testing for reliability and validity, the measure
21 is never going to get to the stage that it
22 passes.

1 Is this -- people think this is
2 helpful, or did I just confuse everybody? Okay.
3 All right. So then we can go back to now
4 discussing the measure concepts within the
5 experience category, which while the slides are
6 going up, was -- oh, they are up. Okay. So I
7 don't know. I mean, Jason, maybe it would be a
8 good idea for you to throw out the first -- you
9 know, a theoretical measure concept on this?

10 MR. GOLDWATER: A theoretical one?

11 CO-CHAIR HOLLANDER: So just to start
12 the discussion.

13 MR. GOLDWATER: So I guess we can talk
14 about access of -- to care --

15 CO-CHAIR WARD: Experience.

16 MR. GOLDWATER: You want to do
17 experience first?

18 CO-CHAIR WARD: Yes.

19 MR. GOLDWATER: Okay. Well you're
20 really putting me on the spot to think of a
21 concept. That is what you're supposed to do, not
22 me. What? Communication? Okay. Right, so --

1 right, so a concept -- right, that is -- thank
2 you, Marybeth. You are now my favorite committee
3 member. So a concept could be that the use of
4 telehealth facilitates greater communication
5 between a patient and a provider.

6 That is very hypothetical. Don't use
7 that. That is just -- that -- but again, it is
8 not -- it is specific, but broad enough that it
9 can be fine-tuned into a measure.

10 MEMBER GIBONEY: What about a measure
11 of confidence in my plan of care as a -- as a
12 measure? Like some sort of, I don't know -- I
13 don't know if you want to get into details like a
14 Likert scale, 1 to 5, or something like that, of
15 like, you know, because of whatever this health
16 measure, I feel confident that --

17 CO-CHAIR HOLLANDER: So I am going to
18 think in a way now of, you know, a little
19 different, having someone that has sat through
20 some of these measurement things, and say, well,
21 that is probably not measurable because we don't
22 -- we can, but then we would have to ask

1 everybody their confidence, and so it is not
2 likely to hit the feasibility points.

3 Now, on the other hand, you -- you
4 could actually take that and say something about
5 are patients more likely to carry out their plan
6 of care? And you could measure that in terms did
7 they get their prescriptions filled, so are their
8 prescriptions filled within 24 hours of a visit,
9 you know? And then maybe you could get a
10 different experience between an office visit and
11 a telehealth visit, or show it is just as good.

12 But now, as we are coming up with
13 these concepts, I would say think in terms of
14 something that you might be able to measure from
15 -- you know, Jason I think also does the
16 eMeasures. It is easier if it is something we
17 can measure electronically by merging databases
18 from places to do that, but if you know of
19 surveys like a Press Ganey survey --

20 MEMBER GIBONEY: Well, that's what I
21 was thinking --

22 CO-CHAIR HOLLANDER: -- that goes out

1 --

2 MEMBER GIBONEY: -- they -- they ask
3 questions just like that on Press Ganey surveys.

4 CO-CHAIR HOLLANDER: So then you may
5 be able to be doing that.

6 MEMBER GIBONEY: Yes.

7 CO-CHAIR HOLLANDER: Chuck?

8 MEMBER DARKINS: That was what I was
9 thinking, you know, a survey, you know, you get
10 back from a Delta Airlines flight, they send you
11 a thing, you get back from a Ford dealer, they
12 send you a thing, you leave the doctor's office,
13 and they send you a thing: how was your
14 experience at UC Health? And so you -- you know,
15 you sort of fill in the blanks, you know. They
16 ask you five or six questions, you know, how was
17 the doctor, how was the office visit, you know,
18 was the temperature just right, you know, do they
19 serve you espresso -- just kidding. But I mean
20 it is -- that is -- you get that data very
21 quickly.

22 MR. GOLDWATER: Let me just interject

1 for just a second, I am sorry, only because I
2 think some people think of measuring quality as
3 you're measuring the activity or the action of a
4 provider to a patient, and typically -- I mean,
5 there's plenty of measures that do that, but
6 there's also the ability for a patient to look at
7 measurement from a patient perspective. So
8 patient-reported outcome measures is really a
9 very big topic in quality measurement because it
10 gets to the patient's point of view and really
11 looks at outcomes and their effect on patients,
12 and the ability to collect that data for these
13 types of measures typically come through some
14 sort of standardized instrumentation, whether it
15 is a survey or some other mechanism to gain -- so
16 for depression, for example, they use the PHQ-9,
17 and that way they are able to evaluate a
18 patient's perspective on depression and then make
19 the proper treatment protocols as a result.

20 So don't -- when you are thinking of
21 concepts, it can be a provider action or a
22 patient action as well.

1 CO-CHAIR HOLLANDER: Okay. Don and
2 then Henry?

3 MEMBER GRAF: So I am going to use a
4 Medicaid mandate example. I am going to pick on
5 New Mexico and suggest to you that part of the
6 requirements in that state -- I am probably not
7 going to get them all, but it is duplicated,
8 unduplicated count of services by county, Native
9 versus non-Native-American populations,
10 behavioral versus non-behavioral, urban versus
11 rural versus frontier counties.

12 So -- and those are just like
13 reporting requirements today that mostly come
14 from utilization -- or, you know, claim databases
15 and things like that, but those are just examples
16 of what came to mind. Thought I would share.

17 MEMBER DePHILLIPS: Just throwing this
18 out since you started on experience, patient, one
19 -- a couple concepts that stem from the earlier
20 discussion, Jason, comparing current standard of
21 care to standard of care plus telemedicine.
22 Patient demonstrates a greater understanding --

1 is able to demonstrate a greater understanding of
2 their care plan, that is probably something that
3 is measurable, and patients have greater
4 compliance with their care plan. In other words,
5 they complete their care plan a greater
6 percentage of that time. That is probably also
7 measurable.

8 CO-CHAIR HOLLANDER: Daniel?

9 MEMBER SPIEGEL: I actually had those
10 two exact concepts written down, so I second
11 that. I don't know if this falls under patient
12 experience or under maybe system or technical
13 effectiveness, but something around privacy might
14 be important as well, and you can measure that in
15 terms of whether a patient feels that their
16 privacy is protected, in a Press Ganey survey,
17 for example, or you can measure that in some
18 maybe more systematic way.

19 CO-CHAIR HOLLANDER: Peter, is that a
20 hand almost going up? No? Okay. Yes?

21 CO-CHAIR WARD: I think with
22 experience, as Jason said, there's a lot of

1 existing measures out there, but I think
2 specifically to telehealth, because it has got
3 technology, something about the technology
4 working, the experience of the technology working
5 in a satisfactory fashion for the clinician to do
6 their job for the patients to feel comfortable
7 with it would be a new concept.

8 MEMBER RASMUSSEN: Yes, I would, you
9 know, echo that one, as we do a lot of scheduled
10 telemedicine visits with patients, and there is
11 -- that is a frequent concerns I hear from
12 providers is that there is some technical glitch.
13 That would be a -- that would be a great one to
14 add on.

15 CO-CHAIR HOLLANDER: Yes, Sarah?

16 MEMBER SOSSONG: So I am just looking
17 at the patient survey that we have done, and so
18 we have things like, you know, did you have a
19 technical problem? And then we have a breakdown
20 of areas. So are we trying to just describe this
21 at a high level? Or I think to the kind of -- we
22 do ask also CG-CAHPS questions, like, you know,

1 did you see your provider within 15 minutes? Did
2 the clinician explain things in a way to
3 understand?

4 Do we not want to repeat if it is
5 something that exists elsewhere, or is this
6 supposed to almost be a comprehensive list of all
7 -- is this supposed to be a comprehensive list of
8 all the potential things that could be included
9 there? I am just confused on ultimately what the
10 end product should be.

11 CO-CHAIR WARD: I think both. I think
12 where there's existing measures that they apply,
13 we should think about those, and then when there
14 are not existing measures that are specific to
15 telehealth that need to be developed, that is
16 another area, so I think it is both.

17 CO-CHAIR HOLLANDER: I think what --
18 you know, what I am hearing on the experience
19 side is actually ease of use and ability -- and
20 to me, a very measurable thing from my past
21 experience is whether the patient, we call it
22 self-sustaining, but whether the patient and the

1 provider could hop on without having a person
2 sitting next to them or calling them and telling
3 them how to download an app and use it is really
4 a huge experiential thing that might actually
5 even overlap, you know, cost and cost-
6 effectiveness and some other areas because it is
7 really costly to have somebody run around and
8 handhold the provider and have somebody call each
9 patient that wants to do a scheduled visit and
10 make sure they can download it and do test
11 visits, which, you know, we have done stuff like
12 that over time.

13 So I -- I think maybe it is -- I don't
14 know the right way to turn it into a measure,
15 but, you know, how many resources are needed for
16 the patient to satisfactorily conduct the visit
17 on their own, or can they do it with no
18 additional help, which is sort of a binary yes/no
19 decision, and in fact, that probably would be
20 something that could be done electronically
21 because there are -- within the telehealth
22 platforms that I am familiar with, if they are

1 doing a test visit, there is a no-charge visit
2 the day before, then there's a charge visit the
3 next day, we probably could pull out how often is
4 there a no-charge visit within 48 hours prior to
5 a charge visit and see how much work and practice
6 is involved. Or how often are there two or three
7 visits with the same provider on the same day,
8 meaning there was a technical glitch in the first
9 or second call with the same provider?

10 So we might be able to dig out some of
11 those experiential things from the telehealth
12 platform, or at least some of the direct-to-
13 consumer ones.

14 MEMBER MOEWE: I was thinking too
15 about -- thank you. I was thinking more around
16 like the connectivity issues. Is somebody
17 calling in at the right time? Like if you are
18 meeting with your provider, you could actually
19 measure that with whatever system you're using.

20 Like one of the things that is
21 frustrating when you are on conference calls is
22 people don't all call in at the same time, so

1 they are not there, so it is important that if
2 you have an appointment with your provider at 11
3 o'clock, that he is on the phone at 11 in the --
4 I mean, these are measurable things, and that the
5 connectivity is clear, you know, the conversation
6 is easy to understand, and these are things that
7 I think could be measured pretty simply.

8 CO-CHAIR HOLLANDER: Maybe it is as
9 simple as duration of the visit, which could be
10 measured from when you show up in the office for
11 an in-person visit to when you get your discharge
12 instructions for an in-patient visit, as to when
13 you get on the video for a telehealth visit and
14 get off the video with a --

15 MEMBER MOEWE: Right.

16 CO-CHAIR HOLLANDER: -- telehealth
17 visit --

18 MEMBER MOEWE: And --

19 CO-CHAIR HOLLANDER: -- so --

20 MEMBER MOEWE: -- and were the
21 instructions clear to you? Because I think that
22 is something many patients, even from a face-to-

1 face visit, don't take away, their clear
2 directive as to what are my meds, when do I take
3 them, do I understand when I am going to see you
4 next, you know, all those things are measurable
5 things that you could ask a patient.

6 CO-CHAIR HOLLANDER: Oh, and down at
7 the end, Adam?

8 MEMBER DARKINS: I was just going to
9 say, I mean, it seems a bit complicated. Again,
10 I am maybe not -- just whether or not it was
11 completed satisfactorily would be the way into
12 this because, I mean, what would you do with all
13 the information you have just described? You've
14 got a plethora of different telehealth
15 interventions that would take place in a plethora
16 of different places, and so you would -- unless
17 you've got the structure and process, if you just
18 start off by saying let's -- first cut at it, was
19 it completed as intended?

20 CO-CHAIR HOLLANDER: Right. So it
21 gets to the measure concepts that we had before
22 for the dimensions of evaluation, I think, like

1 did you have the infrastructure capacity to get
2 it done, and did it result in actionable
3 information, right? That is -- that is
4 effectively were you able to do the call to the
5 satisfaction of the patient and provider and then
6 have both of them be able to act on the
7 information, would be part of clinical
8 experience, as well as some of the others.

9 I guess Jason are we supposed to drill
10 down on specific things here, or, you know, still
11 a -- a little clarity around, you know, what
12 we're talking about is can you get discharge
13 instructions, which could probably run across
14 every disease specialty, and can you complete the
15 meaning of the call with every disease specialty?
16 But it is not saying -- you know, do we want to
17 say oh, you had a heart failure, revisit within
18 seven days?

19 MR. GOLDWATER: You don't want to get
20 that specific.

21 CO-CHAIR HOLLANDER: Okay.

22 MR. GOLDWATER: Broad -- I mean,

1 broad, but the parameters around it are enough to
2 where you can conceptually look or think of a
3 measure. So, you know, like Mary Lou was saying,
4 you know, you can measure things like the
5 accessibility or the availability, were they on
6 the call, did the call last long enough for the
7 visit to be completed? You know, those are
8 broad, but you can measure those. There's ways
9 of building a measure from that, and you don't
10 need to get specific like you need to give
11 discharge instructions seven days after a
12 telehealth visit.

13 CO-CHAIR HOLLANDER: Okay.

14 MR. GOLDWATER: That is -- that would
15 eventually be a measure --

16 CO-CHAIR HOLLANDER: Okay.

17 MR. GOLDWATER: -- not a measure
18 concept.

19 CO-CHAIR HOLLANDER: So I would add a
20 concept too, does it increase the likelihood of
21 the patient showing up for the visit, right? I
22 mean, maybe it is easier to get on a telehealth

1 visit than an in-person visit. Maybe they ignore
2 it because they think it is not important. So
3 there is some equipoise in that. What?

4 MEMBER SOSSONG: Does that fall under
5 access? And that's a -- I think that is where we
6 often --

7 CO-CHAIR HOLLANDER: Oh, yes --

8 MEMBER SOSSONG: -- group that --

9 CO-CHAIR HOLLANDER: -- I -- well --

10 MEMBER SOSSONG: -- we look at no-show
11 rates under --

12 CO-CHAIR HOLLANDER: Yes.

13 MEMBER SOSSONG: -- the --

14 CO-CHAIR HOLLANDER: Paul?

15 MEMBER SOSSONG: -- access piece. I
16 want to --

17 MEMBER GIBONEY: One of the -- oh, go
18 ahead, Susan --

19 MEMBER SOSSONG: No no.

20 MEMBER GIBONEY: -- Sarah. One of the
21 -- one of the big advantages of telehealth is the
22 ability to coordinate care and improve

1 transitions of care from one provider to another
2 to share that information, and the way -- a
3 measurement of that would be asking for the
4 patient how well coordinated was your care? You
5 know, when you saw the specialist, did they know
6 why you were there, and did they have your
7 information?

8 Or, you know, for -- how well -- you
9 know, because there are measures out there right
10 now, you know, a patient sees a specialist and we
11 only know -- we know that 50 percent of the time,
12 PCP never finds out what happened with the
13 specialist visit, but in terms of experience, you
14 know, from the patient's perspective, did you
15 know -- did -- did your providers know what was
16 going on with your care? Or something like that,
17 some sort of care coordination measure.

18 CO-CHAIR HOLLANDER: Don.

19 MEMBER GRAF: To your comment earlier
20 Judd about do you know that the patient is
21 actually going to show, we have done studies
22 where we see a direct correlation between the

1 distance someone travels to an appointment and
2 the no-show rate associated with that appointment
3 are direct, and so that is one measure.

4 CO-CHAIR HOLLANDER: Yes. Sarah,
5 Stewart, and then Adam.

6 MEMBER SOSSONG: So I guess going back
7 to one comment you made, Judd, about the number
8 of minutes, I think the one concern with that
9 sort of measure is just the fact that it would
10 create perverse incentives for clinicians to have
11 very quick visits. So if it is -- so I don't
12 know if that would be broken down by specialty,
13 but I just want to think about the unintended
14 consequences.

15 So I think to one of Adam's points
16 about what the modality is I think would be a
17 really important question in this point because
18 that then really drives what are we comparing? I
19 also think asking where the patient is is
20 important, so are they in the home -- are they in
21 the home, are they in their office?

22 We have just asked generally: did you

1 have any technical problems? I think there is --
2 you know, if we ask that question on every single
3 visit, we get a yes 50 percent of the time
4 because then it comes into billing, it comes
5 into, well, my home, you know, internet
6 connection had issues, so their audio -- so I
7 think when we have really broken it down by
8 something that is purely the technology, it has
9 gotten to be very low, but we have had to be
10 careful about how we ask that question, so I
11 think just asking did you have technical
12 problems, and then, to your point, did you need
13 someone's help in order to get it, yes/no, would
14 be enough.

15 But I think ultimately, just rolling
16 them all up, you know, going back to the CG-CAHPS
17 question around, you know, your overall ranking
18 of the visit from a -- on a scale of 1 to 10,
19 ends up being something that captures many of
20 these -- these elements, but ultimately, I wonder
21 too just if -- this is such a huge list. Is
22 there value in, you know, all combining, what are

1 -- what are all of the measures that we look at
2 in terms of these areas and cross-referencing
3 those?

4 CO-CHAIR HOLLANDER: Well, we get a
5 little bit of that tomorrow --

6 MEMBER SOSSONG: Okay.

7 CO-CHAIR HOLLANDER: -- just looking
8 at --

9 MEMBER SOSSONG: Okay.

10 CO-CHAIR HOLLANDER: -- some measures.
11 Stewart?

12 MEMBER FERGUSON: So I -- one question
13 I had is are we just looking for lots of ideas
14 under each of these? We are not -- this is not
15 like the domains where you have three to four
16 ideas, right? Okay. All right.

17 So one of the things, following
18 through, we -- we do track click time from one --
19 certain store-and-forward you can collect from
20 one case until they dispose of it, return it,
21 they archive it, whatever, and we don't use it as
22 a way to try to incentivize people to do it fast,

1 we just use it as a measure of how fast we are
2 seeing patients. And it gives us a sense of
3 efficiency. It also gives us a measure of, as we
4 improve the technology, does that time get
5 shorter, and will we be able to see it drop over
6 time? So I think that's a good measure.

7 We did a survey a few years ago. We
8 had hundreds and hundreds of users that had done
9 hundreds and hundreds of cases, and we looked at
10 people that had done 100, 500, or over 500 cases,
11 and we asked them what was the most important
12 thing in telehealth. And the interesting thing
13 is for the -- for the people that create cases,
14 the people out in the rural areas, the most
15 important thing to them for the people that have
16 done hundreds of cases is the response time.

17 So I think that is something that you
18 really want to measure. I think people don't
19 think about it. I think -- and again, a store-
20 and-forward issue, but for video, it would be
21 time to schedule, so those would be pretty
22 critical issues.

1 CO-CHAIR HOLLANDER: So Dan -- Dan?

2 MEMBER SPIEGEL: I don't know, maybe
3 this is a measure itself instead of a concept,
4 but I was wondering if there is a way to get at a
5 proxy for patient or family experience by looking
6 at repeat use, so people who come back and use
7 the service again. So I don't know if that is
8 too specific, but just a thought of a proxy way
9 to get at experience.

10 MR. GOLDWATER: No, that is not too
11 specific because you could then build a measure
12 from that on a specific condition. So --

13 CO-CHAIR HOLLANDER: So it could be
14 patient retention or follow-up -- or degree of
15 follow-up. Steve?

16 DR. HANDLER: So we ask a number of --
17 excuse me -- questions. We have a post-consult
18 survey, and I can read it, or I can make it
19 available, but we always ask did you discuss or
20 review the goals of care? So we want to make
21 sure that we're aligning. And then we ask about
22 what peripherals or devices are used, just

1 generic, and that could be depending upon
2 whatever service is being used.

3 Then we have ten questions that we ask
4 about the encounter itself that asks about the
5 audio; the video; did the resident or the patient
6 seem comfortable; did the nurse, or, in the
7 context of the telepresenter, seem comfortable;
8 and then were they able to -- excuse me -- obtain
9 adequate history, present illness, past medical
10 history in view of systems; then a physical exam;
11 and then other questions, satisfaction question,
12 and then for us, the primary outcome is did this
13 avoid an ED or hospitalization?

14 So we ask all those questions in line.
15 I don't know if that is useful or not, but I
16 think that from our experience in our CMS
17 Innovation Ward and in other areas, it has been
18 very useful for us.

19 CO-CHAIR HOLLANDER: So I think what
20 we -- we have done is we have evolved a little
21 bit to recognizing that, you know, what we have
22 in domains and subdomains are not clearly a

1 bucket to address in these measure concepts one
2 at a time because we're spanning things that
3 happen, so we started with let's focus on
4 experience, and everything we have discussed has
5 some tie to experience, but -- but maybe since we
6 really have public comments in about 10, 15
7 minutes, we should just open it up broadly to
8 measure concepts overall, you know, pretending at
9 least for the moment that they will span multiple
10 categories and that is okay.

11 We don't have to have a measure
12 concept that only fits in one bucket, and it may
13 lead to more robust -- well, looking at the
14 things going up, it's going to lead to more
15 robust conversation right away. So Marybeth and
16 then Paul?

17 MEMBER FARQUHAR: Before you leave
18 patient experience, you know, what I am hearing
19 is a lot of measures that will come out of the
20 composites that are already established by CAHPS,
21 you know, provider communication, did I get the
22 care that I wanted to as much as I wanted to, did

1 I get the information, was I discharged
2 appropriately, did I get the information I needed
3 in order to maintain my care? And then a rating
4 of a provider. So some of these things are
5 already established. I think that you are
6 talking about those in the sub-sub-sub-level
7 versus the upper level, but that is just me.

8 CO-CHAIR HOLLANDER: Paul?

9 MEMBER GIBONEY: The response time and
10 time to schedule would fit definitely into access
11 as well, and then kind of going along the
12 scheduling time, if there is identified a -- a
13 right time for scheduling or a recommended time
14 for scheduling, how closely did the system
15 deliver the appointment at whatever that intended
16 time was?

17 CO-CHAIR HOLLANDER: Adam?

18 MEMBER DARKINS: It seems to me there
19 is a case to be somewhat strategic in this and
20 say what are we really trying to achieve? So if
21 we were saying what we would really like to
22 achieve let's say is access to care between

1 specialty care and primary care, we ought to
2 think kind of what is doable for a busy primary
3 care clinic to end up doing measures?

4 In other words, keeping the patient in
5 primary care, some of the things we might be
6 adding might be very difficult. So I think what
7 are we -- if we were to think strategically, so
8 we've got not a very big penetration of
9 telehealth generally, and what we are trying to
10 see is how this would gradually expand.

11 There are ways in which what we could
12 end up doing is creating a framework very much
13 acute hospital-based which might help around the
14 acute hospital, but might not sort of -- does
15 that -- it seems to me, you know, we ought to be
16 a little more sensitive to location when we think
17 about time because if someone was traveling to
18 primary care, hanging around for an extra 10, 15
19 minutes is not as easy as one might think.

20 CO-CHAIR HOLLANDER: Right. I think
21 that this gets back to Henry's big concept
22 earlier on: does usual care plus telehealth offer

1 benefits over usual care alone? And it could be
2 for, you know, every disease entity known to
3 mankind, and span these domains. It is really
4 what is the incremental value of adding
5 telehealth to the care of somebody with COPD or a
6 skin lesion, a this, a that? And do that, and
7 probably -- and it would span a lot of this. Don
8 and then Chuck.

9 MEMBER GRAF: So we conduct surveys as
10 well, and some of the questions that were asked
11 are ones that we have as well: overall rating;
12 average travel time and cost if you were to have
13 seen that provider face-to-face; average work
14 hours lost, so letting them define that;
15 probability of repeating, coming back for a
16 second time, and if not, why; your reason for
17 choosing telehealth, or, you know, or, if not,
18 face-to-face; preferences; and then delineating
19 between new and -- and established. And by the
20 way, do this in several languages.

21 CO-CHAIR HOLLANDER: Okay. Peter I --
22 oh, Chuck and then Peter and then Angela.

1 MEMBER DOARN: So I think I am on
2 Alaska Time. It seems to me that when you look
3 at the literature for the last ten years for sure
4 that there are questionnaires that people have
5 used to ask every one of these questions, so I am
6 curious, are we supposed to develop a new
7 questionnaire, or are you going to use existing
8 questionnaires? I am lost at exactly what --

9 CO-CHAIR HOLLANDER: Yes --

10 MEMBER DOARN: -- you --

11 CO-CHAIR HOLLANDER: -- so --

12 MEMBER DOARN: -- said.

13 CO-CHAIR HOLLANDER: -- that, I can
14 answer that. That is so the measure developer
15 can figure out how to get it, we are just talking
16 about some of these experience --

17 MEMBER DOARN: But it has already --
18 I mean, but it has already been captured --

19 CO-CHAIR HOLLANDER: But we -- we
20 don't -- so somebody will propose a measure, and
21 they will say this is the data we're going to
22 access to compare, you know, Alaska to New Mexico

1 to wherever. Then it has to meet the criteria of
2 domains and subdomains that we have laid out. We
3 don't have to develop any of that. That is how
4 the measures --

5 MEMBER DOARN: Okay.

6 CO-CHAIR HOLLANDER: -- will be
7 developed.

8 MEMBER DOARN: I am back in D.C. now.
9 Okay.

10 CO-CHAIR HOLLANDER: So that gets much
11 easier. Okay, Peter?

12 MEMBER RASMUSSEN: Yes, I think on the
13 access end of things, in terms of both patient
14 and care team, addressing things like
15 availability, accessibility, and appropriateness
16 is, you know, very much like a telestroke
17 program. You know, if you are running a
18 telestroke program, what is the percentage of
19 patients who have access to that telestroke
20 neurologist, you know, something like that would
21 be very helpful.

22 CO-CHAIR HOLLANDER: Who do we got

1 next? Angela is next. Don, are you up or not
2 up?

3 (No audible response.)

4 CO-CHAIR HOLLANDER: Okay. Angela,
5 Kristi, Dan.

6 MEMBER WALKER: Sure. So just jumping
7 back to the patient experience for a second, I
8 think as part of the Institute for Healthcare
9 Improvement, patient experience is one of the
10 components of their triple aim, and as part of
11 that, they identified six features: safety,
12 effective, patient-centered, timely, efficient,
13 and equitable care, and I think we have addressed
14 many of those with ideas already thrown out, but
15 just making sure that each of those is on the
16 record. But there would be ways to measure many
17 of those and develop measures from it.

18 CO-CHAIR HOLLANDER: Kristi?

19 MEMBER HENDERSON: I just wanted to
20 add the avoided ED transfer, so unnecessary
21 emergency room transfers, and then you mentioned
22 this, but I think you used different terms, but

1 around no-show rates, decreasing those.

2 CO-CHAIR HOLLANDER: So I would rather
3 say, rather than unnecessary ED transfers, as the
4 ER guy here, it is, you know, able to provide
5 care without transferring to a higher level,
6 because, you know, to me, and, you know, I don't
7 want to go too much on a tangent, but if nobody
8 else is going to take care of the patient, it's a
9 necessary transfer. It might be avoidable, but
10 so I try and avoid that language. Dan is up
11 next, actually.

12 MEMBER RASMUSSEN: I mean, I guess
13 sort of a follow-up comment on what Kristi said
14 though, but sometimes, it is -- because of a
15 telemedicine program, you are going to generate
16 more transfers than you would otherwise.
17 Specifically, the telestroke program, it is going
18 to be better to get that patient out of rural ED
19 who needs a stroke neurologist or an endovascular
20 person, so you're, you know, going to -- so you
21 have to be careful what that measure looks like
22 based on the disease process that you're talking

1 about.

2 CO-CHAIR HOLLANDER: Yes, so, you
3 know, and I don't know the trauma measures. I
4 don't know if, you know, any NQF staff works on
5 trauma stuff, but -- but sometimes, at least, I
6 know they are evaluated as if you transfer
7 someone for less than 24 hours and they live,
8 that is a bad transfer, right? You didn't really
9 need that patient there because you didn't do a
10 procedure, and they went home the next day, and
11 now you incurred a helicopter cost and made their
12 family not see them, and there was no reason to
13 do that. So maybe measures can be developed
14 around appropriateness of transfer.

15 And again, to Chuck's point, we don't
16 need to figure out what that is. Somebody else
17 would have to do it, and if they didn't get it
18 right, the measure would not be approved, but if
19 somehow they got it right and the people who are
20 content experts in that area approved it, then it
21 can get approved. So Dan and then Eve-Lynn?

22 MEMBER SPIEGEL: So I think this --

1 this concept might fall under access to care for
2 patient, but we talked earlier about
3 accommodation, and -- and linguistic
4 accommodation, so perhaps access to providers or
5 to a translator, or providers who speak the
6 native language of the patient.

7 CO-CHAIR HOLLANDER: Eve-Lynn?

8 MEMBER NELSON: Related to patient
9 experience, the question we continue to get with
10 behavioral health all the time is around
11 relationship or therapeutic alliance.

12 CO-CHAIR HOLLANDER: Peter -- now Don,
13 you are up for real? Yes.

14 MEMBER GRAF: So I wanted to add a
15 couple to the list from down there: ED
16 utilization, readmission reduction, NICU day
17 reductions, all, you know, as -- as quantitative
18 elements.

19 I also wanted to ask -- and I am not
20 going to get this exactly straight -- but NCQA I
21 think is -- is taking a look at accepting --
22 potentially accepting more telehealth in terms of

1 HEDIS measures, and so I wonder if -- if some of
2 our discussion about these measures ought to be
3 kind of dovetailing in with what they already
4 have in place.

5 MR. GOLDWATER: I can answer that a
6 little bit. So NCQA is sort of -- is taking the
7 existing HEDIS measures and -- some of the
8 existing measures and adding telehealth as
9 another means of delivery of care, modality of
10 care. So what we're doing here is sort of
11 creating brand new concepts. I think that once
12 we are done with this exercise is to see where
13 there is an intersection between what you all
14 have conceptualized and what they may be doing,
15 so you're right.

16 And I should, you know, also say that
17 tomorrow, we are going to look at existing
18 measures and see if you think any of those are
19 applicable to the framework, and if so, how do
20 you suggest those are modified or adapted so that
21 telehealth is included as a means of care
22 delivery, or do they have to be adapted?

1 CO-CHAIR HOLLANDER: Oh, Kristi?

2 MEMBER HENDERSON: So should we
3 consider with remote monitoring the impact it
4 could have on length of stay to get people out of
5 the hospital sooner and continue and extend that
6 care in the home?

7 CO-CHAIR HOLLANDER: That is a great
8 one. Stewart? So actually, for remote
9 monitoring and everything, everything related to,
10 you know, mobile health and eMedicine, can we get
11 people out of the hospital faster? That is a
12 really important one.

13 MEMBER FERGUSON: It may have been
14 said, but new services offered. A lot of times,
15 you don't have services. And the other thing on
16 business days or days lost, we actually track
17 days lost in school as well. We have a lot of
18 children in school-based programs.

19 CO-CHAIR HOLLANDER: Okay. Paul, I
20 think, Paul, are you up?

21 MEMBER GIBONEY: Pivoting to clinical
22 effectiveness, you know, that could go into any

1 disease process anywhere, and I want to just
2 throw out the concept, do we -- when we are
3 thinking about all those different diseases that
4 we could be talking about in clinical, do we want
5 to come up with a measure that says, you know,
6 like instead of just saying, you know, percentage
7 of people with hemoglobin A1c under 9, for, you
8 know, because of telehealth, but just kind of
9 saying telehealth -- taking existing stuff that
10 is already out there for all those clinical areas
11 and saying telehealth delivers either the same
12 outcome or a better outcome with an existing
13 measure for clinical quality?

14 CO-CHAIR HOLLANDER: Who is that?

15 Sarah, you're up over there.

16 MEMBER SOSSONG: This has been alluded
17 to, but I think just to put it on the record too,
18 also, whether or not an in-person visit was
19 required within a certain time period, I think
20 that would really vary. For derm, I think we
21 were looking at like a -- within three weeks, did
22 you still need a dermatology appointment for

1 primary care? Like urgent care visits, it might
2 be within 72 hours, did you still need, but that
3 follow-up rate.

4 CO-CHAIR HOLLANDER: Okay. And you
5 know, I don't think there has been a lot of
6 mention of transitions of care, but, you know,
7 can telehealth facilitate transitions of care,
8 prevent 30-day readmissions, prevent bounce-
9 backs, include medication compliance? You know,
10 I think there is a whole host of things. You
11 could probably take every transition to care
12 measure and say can telehealth improve that? So
13 I think that that is probably a critically
14 important thing to do that -- that people speak
15 towards.

16 And then is that Peter? Are you up?

17 MEMBER RASMUSSEN: I don't know if we
18 have talked about virtual chronic disease
19 management, but I think we need some kind of
20 measure around, you know, percentage of
21 hypertension control in a population, or, you
22 know, something like this.

1 CO-CHAIR HOLLANDER: Okay. So right,
2 can telehealth keep people out of the hospital?

3 Yes, you know, or --

4 MEMBER RASMUSSEN: Or --

5 CO-CHAIR HOLLANDER: -- usual care
6 plus --

7 MEMBER RASMUSSEN: -- or --

8 CO-CHAIR HOLLANDER: -- telehealth?

9 MEMBER RASMUSSEN: Yes. I mean, I
10 guess I am just -- I am just thinking about on an
11 ACO population, you know, we're not that great at
12 getting people under control, and the whole visit
13 we add on, you know, some remote devices that
14 will increase that percentage that are now under
15 control --

16 CO-CHAIR HOLLANDER: So --

17 (Simultaneous speaking.)

18 MEMBER RASMUSSEN: -- somewhat --

19 CO-CHAIR HOLLANDER: -- keep people
20 out of the hospital and improve measures of
21 control of various diseases?

22 MEMBER RASMUSSEN: Yes.

1 MR. GOLDWATER: Just -- just to
2 interject for a moment, so things such as
3 reduction in hospitalization, avoidable
4 hospitalizations, reduction in visits to the
5 emergency room, reduction in hospital
6 readmissions, those are -- are well-documented
7 quality measures that are ready. I mean, those
8 have been around for a long time, so all, you
9 know, we would be doing is adding telehealth as a
10 delivery mechanism, which I think is fine.

11 I would probably ask at the moment to
12 not think of measure concepts that are comparing
13 telehealth to regular or care delivered in
14 another way, but thinking of telehealth on its
15 own, you know, what would be the benefit or what
16 would be a measure of that? Because tomorrow,
17 again, we are going to start looking at measures
18 that already exist and see how telehealth could
19 fit into those, because I think the way it is
20 going, every quality measure that is in existence
21 could be adapted in some way to say is telehealth
22 better, which is not really adding to a framework

1 that is -- it's just basically comparing
2 telehealth to other modes of delivery, which many
3 of you have written studies on that we examined,
4 not, you know, from 1972, but from, you know, a
5 more current relevant time period.

6 MEMBER RASMUSSEN: Well, you know, I
7 hear you to that end. Then I think we should
8 still put something around longitudinal virtual
9 health, so maybe then it is percentage of
10 patients who -- who are -- you know, who are
11 still enrolled in the program three months later,
12 or success of technology in capturing the desired
13 variable, you know, something -- something around
14 this, yeah.

15 MEMBER GRAF: Could clearing ED beds
16 be considered another example of, you know, for
17 like a psych patient that, you know, you don't
18 have somebody on staff, and just so it's more
19 like clinical efficiency, or would that be
20 included?

21 CO-CHAIR HOLLANDER: Yes, you can get
22 people out of my beds, I am happy. But -- but

1 again, that is sort of a -- it might come back to
2 Jason's concept of that is, you know, a delivery
3 mechanism, and, you know, our state is
4 interesting because they used to come into the
5 hospitals in Pennsylvania, and if you layered on
6 telehealth, to do telederm in the hospital, you
7 needed a separate Department of Health approval,
8 and they have actually since passed an -- I don't
9 want to say a law, some guidance document or
10 regulatory document that says if you're just
11 adding telehealth as the delivery mechanism to
12 provide care, you're already licensed to provide
13 care, don't tell us. It is fine. It is your
14 doctor doing what your doctor does in a different
15 way, which was really cool, you know, in our
16 state.

17 So -- so coming back to things that
18 are, you know, telehealth-specific -- oh. I am
19 not going to repeat what I just said. Okay. So
20 we had Stewart.

21 MEMBER SOSSONG: I think just one of
22 the biggest ones I thinking about what is tele-

1 specific that we have always really tried to
2 probe patients and clinicians on is what is the
3 personal connection you feel with your clinician,
4 and that is something that I don't think we are
5 generally asking with in-person visits, but we
6 were very interested in how does that change when
7 it is virtual, so I would suggest that personal
8 connection is a category for telehealth.

9 CO-CHAIR HOLLANDER: Yes. Stewart?

10 MEMBER FERGUSON: So -- so we talk
11 about telehealth letting a provider operate at
12 the top of their license, and one way to measure
13 that is the complexity of cases they see. So we,
14 the dermatologist, does not seem the simple
15 cases. We triage that with a PA or whatever and
16 let them do the procedures. But some measure
17 along those lines.

18 CO-CHAIR HOLLANDER: Okay. Peter?

19 (No audible response.)

20 CO-CHAIR HOLLANDER: No, mistake?

21 Yes. So I think we will turn it over to Jason
22 for public comment period. I would like to

1 summarize what we said, but I am not sure I am
2 capable of doing that, so hopefully somebody from
3 the public can do that very well.

4 MR. GOLDWATER: Operator, can you turn
5 the phones and see if anyone has a public
6 comment, please?

7 THE OPERATOR: Certainly. To make a
8 public comment, please press star 1.

9 (No audible response.)

10 THE OPERATOR: And there are no public
11 comments.

12 MR. GOLDWATER: And anybody from the
13 audience?

14 (No audible response.)

15 MR. GOLDWATER: Well, that is unusual.
16 Okay.

17 To summarize what we have done --
18 thank you, Chuck -- is I think we have a solid
19 list of domains and subdomains. I have
20 approximately, by my notes, I would say maybe 16
21 or 17 generalized concepts. I did not write down
22 the ones that correlated to an already-existing

1 measure because I think that is what we will
2 start doing tomorrow. So that is a lot to get
3 done. It's a lot, so thank you all very much.

4 I think tomorrow, we will review what
5 we have gone over. We will type this up, what we
6 have so far, and we will continue our measure
7 concept discussion, and then we will start moving
8 into prioritization, which is -- you know, the
9 best way to do this exercise is brainstorm all
10 the concepts you can think of that you think
11 would be relevant, and then the prioritization is
12 picking which ones you think are really the most
13 impactful, most relevant, and those will be
14 included in the reports initially as, you know,
15 how to start with a framework, and then all of
16 the other concepts will be listed, but in -- more
17 than likely, in an appendix of other concepts to
18 consider.

19 And we will also then have a
20 discussion about what we need to include in the
21 framework in addition to the concepts, and we
22 will have a discussion by our public policy

1 director about MIPS and alternate payments models
2 and how telehealth will be impacting that, and
3 Meg, who is going to be speaking with us, and I
4 went to the Hill to talk about this as they were
5 drafting 21st Century Cures, so she is going to
6 have a great perspective about, you know, what is
7 going to happen down the line with this.

8 So with that in mind, thank you all
9 very much. Have a wonderful dinner. I wish we
10 could join you, but our son is turning nine, so
11 Cheesecake Factory it is. Yay.

12 (Laughter.)

13 MR. GOLDWATER: All right. At least
14 it is not Golden Corral.

15 (Whereupon, the meeting went off the
16 record at 4:25 p.m.)
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This is to certify that the foregoing transcript

In the matter of: Creating a Framework to Support
Measure Development for Telehealth

Before: NQF Telehealth Multistakeholder Committee

Date: 03-07-17

Place: Washington, DC

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