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, MPHM, 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

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

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

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

(Laughter.)

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

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

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

(Laughter.)

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

well as with the transcription.

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

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

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

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

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

Senior Director.

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

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

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

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

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

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

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

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

MEMBER HALL-BARROW: Hi, Julie Hall-

Barrow, Children's Health in Dallas.

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

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

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

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

MEMBER HARRIS: Yael Harris, Mathematica Policy Research.

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

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

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

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

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

MEMBER SPIEGEL: Good morning, Daniel Spiegel, DaVita.

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

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

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

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

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

MEMBER GRAF: Don Graf, National

Telehealth Director, UnitedHealthcare.

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

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

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

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

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

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

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

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

future.

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

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

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

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

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

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

DR. BURSTIN: It's a great diagram.

MR. GOLDWATER: Thank you.

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

So again, it's a way of organizing our

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

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

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

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

(Laughter.)

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

(Laughter.)

MR. GOLDWATER: Yes, go ahead. Sure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Henry?

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

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

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

of the care that everybody gives today.

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

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

MEMBER DEPHILLIPS: Exactly.

CO-CHAIR HOLLANDER: Okay. Steve?

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

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

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

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

CO-CHAIR HOLLANDER: Marcia?

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

So I think we have to keep that in

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

CO-CHAIR HOLLANDER: Angela?

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

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

CO-CHAIR HOLLANDER: Angela?

MEMBER WALKER: Yes. I think, getting

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

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

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

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

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

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

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

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

opinion. Yes, Sarah?

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

CO-CHAIR HOLLANDER: Yes, we will.

MEMBER SOSSONG: Okay.

CO-CHAIR HOLLANDER: Yes. Yael?

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

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

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

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

CO-CHAIR HOLLANDER: Yes. Yael?

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

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

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

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

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

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

telemedicine undermines the evolving nature of this technology.

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

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

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

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

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

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

(Laughter.)

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

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

definition, recognizing it evolves over time.

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

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

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

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

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

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

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

The last bullet I just wanted to

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

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

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

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

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

MEMBER MOEWE: Just one comment on the

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

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

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

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

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

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

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

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

that helps us rank and prioritize these.

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

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

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

CO-CHAIR HOLLANDER: Stewart?

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

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

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

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

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

MEMBER HARRIS: So one thing I wanted

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

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

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

CO-CHAIR HOLLANDER: Thank you. Paul?

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

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

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

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

CO-CHAIR HOLLANDER: Chuck?

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: So is it worth --

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Dale?

MEMBER ALVERSON: I just wanted to

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

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

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

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

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

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

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

consultation.

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

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

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

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

it, says it's great.

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

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

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

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

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

CO-CHAIR HOLLANDER: Yael?

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

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

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

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

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

MEMBER HARRIS: Right. And that's --

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

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

CO-CHAIR HOLLANDER: Right.

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

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

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

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

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

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

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

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

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

Should concordance between primary and specialty providers sharing images be prioritized

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

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

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

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

CO-CHAIR HOLLANDER: Go ahead, Jason.

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

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

CO-CHAIR HOLLANDER: Angela?

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

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

CO-CHAIR HOLLANDER: Sarah?

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

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

CO-CHAIR HOLLANDER: Okay. Peter?

MEMBER RASMUSSEN: I think when you're

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

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

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

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

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

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

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

MEMBER MOEWE: I'm not really sure this

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

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

MEMBER MOEWE: -- for any medicine?

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

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

MEMBER MOEWE: Right.

CO-CHAIR HOLLANDER: -- and doing

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

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

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

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

So, I think that's one of the things

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Good point. Stewart?

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

(Laughter.)

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

MEMBER FERGUSON: Yes, on the previous presentation.

(Laughter.)

CO-CHAIR HOLLANDER: From the last meeting.

MEMBER FERGUSON: What's this thing

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

(Laughter.)

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: No? Okay. There

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

CO-CHAIR WARD: There are --

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

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

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

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

CO-CHAIR HOLLANDER: Okay.

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

MR. GOLDWATER: No, not really.

CO-CHAIR WARD: Okay.

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

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

CO-CHAIR HOLLANDER: Okay.

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

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

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

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

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

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

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

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

What to include when discussing the

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

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

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

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

So, it seems to me, the logic is use

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay.

MEMBER DARKINS: So, it's comity.

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

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

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

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

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

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

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

So, if it's not being used by a

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

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

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

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

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

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

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

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

framework.

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

CO-CHAIR HOLLANDER: Oh, okay.

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

(Laughter.)

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

(Laughter.)

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

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

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

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

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

technologies.

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

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

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

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

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

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

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

Next slide.

How to develop clear measures that capture the cost and resource use of implementing and maintaining telehealth systems accurately. This is actually the first time we've seen this bullet point today. Facility fees exist on other sides, they don't necessarily with telemedicine.

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

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

MEMBER GIBONEY: On the first bullet,

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

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

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

CO-CHAIR HOLLANDER: Don?

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

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

CO-CHAIR HOLLANDER: Other comments? I thought Marybeth was going, but she's just getting coffee.

(Laughter.)

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

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

preexisting measures and other measures that will be developed?

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Paul?

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

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

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

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

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

potentially examine articles on telehealth to administer antimicrobial stewardship programs.

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

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

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

CO-CHAIR HOLLANDER: Okay.

MR. GOLDWATER: -- this slide.

CO-CHAIR HOLLANDER: Okay.

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

mean, this is more --

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

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

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

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

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

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

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

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

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

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

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

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

that would have expanded the document significantly.

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Then, next

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

(Laughter.)

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

CO-CHAIR WARD: Yes.

(Laughter.)

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

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

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

MS. STREETER: I do.

MR. GOLDWATER: All right.

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

MR. GOLDWATER: That way.

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

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

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

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

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

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

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

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

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

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

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

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

definitions.

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

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

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

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

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

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

a main domain, which is clinical quality measures.

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

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

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

see our patients.

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Marybeth?

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

CO-CHAIR HOLLANDER: Daniel?

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

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

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

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

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

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

have a different view.

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

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

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

And I think that the longer the

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

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

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

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

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

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

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

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

CO-CHAIR WARD: They have definitions.

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

I would actually say, under

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

MEMBER HARRIS: Adam?

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Yael, and then Julie.

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

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

(Laughter.)

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

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

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

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

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

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

CO-CHAIR WARD: That's okay.

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

MEMBER HARRIS: Cost and resource use.

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

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

CO-CHAIR WARD: Which aye?

MR. GOLDWATER: Cost.

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

MR. GOLDWATER: Okay.

MEMBER SOSSONG: So, I want to go back

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

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

CO-CHAIR HOLLANDER: Adam?

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

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

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

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

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

some kind of framework for reimbursement.

CO-CHAIR HOLLANDER: Right.

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

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

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

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

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

CO-CHAIR HOLLANDER: No more.

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

CO-CHAIR HOLLANDER: Lunch.

(Laughter.)

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

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

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

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

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

CO-CHAIR HOLLANDER: Angela?

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

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

CO-CHAIR HOLLANDER: Angela?

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay.

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

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

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

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

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

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

(Laughter.)

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

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

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

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

CO-CHAIR HOLLANDER: Peter?

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

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

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

CO-CHAIR HOLLANDER: Adam?

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

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

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

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

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

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

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

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

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

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

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

It may be a system thing or it may be

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

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

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

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

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

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

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

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

(Laughter.)

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

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

experience.

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

CO-CHAIR HOLLANDER: Stewart?

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

(Laughter.)

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

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

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

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

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

CO-CHAIR HOLLANDER: Angela?

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

CO-CHAIR HOLLANDER: I would agree.

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

CO-CHAIR HOLLANDER: What are those four?

MR. GOLDWATER: Five.

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

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

effectiveness, clinical effectiveness. Is that accurately representing?

CO-CHAIR WARD: Angela wants you to repeat.

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

(Laughter.)

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

MEMBER ALVERSON: To this point.

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

(Laughter.)

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

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

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

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

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

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

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

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

MEMBER DOARN: Can you pull up the other document?

CO-CHAIR WARD: The AHRQ one?

(Laughter.)

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

CO-CHAIR WARD: I know.

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

MEMBER DOARN: Technology. So these

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

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

MR. GOLDWATER: So can I interject, Marcia?

CO-CHAIR WARD: I guess.

MR. GOLDWATER: Okay, all right.

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Angela --

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

CO-CHAIR HOLLANDER: Okay. Angela,

Sarah, Dale.

(Laughter.)

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

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

CO-CHAIR HOLLANDER: Sarah?

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Dale?

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

MEMBER SOSSONG: What about the system delivery?

MEMBER ALVERSON: I think it can fit under effectiveness.

CO-CHAIR HOLLANDER: So I want to

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

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

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

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

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

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

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

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

four?

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

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

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

then the measure could be in the effectiveness domain --

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

CO-CHAIR HOLLANDER: Okay.

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

MEMBER GIBONEY: Violent agreement.

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

(Laughter.)

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

MR. GOLDWATER: Then --

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

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

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

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: No, just that one

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

CO-CHAIR HOLLANDER: I should use my microphone.

MR. GOLDWATER: Oh, right.

(Laughter.)

MR. GOLDWATER: Okay. So --

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

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

(Laughter.)

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

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

MR. GOLDWATER: Okay.

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

this exercise with the big group and going through --

MR. GOLDWATER: Sure.

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

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

CO-CHAIR WARD: I like that idea.

CO-CHAIR HOLLANDER: Okay.

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

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

(Laughter.)

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Daniel?

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

CO-CHAIR HOLLANDER: Okay. David?

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

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

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

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

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

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

MEMBER GIBONEY: So I think David

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

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

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

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

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

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

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

the use of these, of telehealth/telemedicine.

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

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

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

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

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

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

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

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

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

MEMBER DOARN: Well, I mean, I guess.

It could be probably across both.

CO-CHAIR HOLLANDER: Okay.

MEMBER GIBONEY: Yes, I --

CO-CHAIR HOLLANDER: Stewart?

MEMBER GIBONEY: Oh, sorry.

CO-CHAIR HOLLANDER: Stewart, then Paul.

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

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

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

need? What am I paying for it?

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

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

CO-CHAIR HOLLANDER: Eve-Lynn?

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

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

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

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

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

MEMBER NELSON: No, it --

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

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

CO-CHAIR HOLLANDER: So I guess --

MEMBER NELSON: It's more the local --

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

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

CO-CHAIR HOLLANDER: Okay.

MEMBER NELSON: -- delivering the service.

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

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

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

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

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

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

MEMBER WALKER: Exactly, as an example.

CO-CHAIR HOLLANDER: So I'm going to

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

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

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

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

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

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

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

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

It has to be something that is measurable.

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

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

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

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

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

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

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

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

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

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

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

MEMBER NELSON: Yes.

CO-CHAIR HOLLANDER: Yes? Okay.

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

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

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

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

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

MEMBER NELSON: I just wanted to

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

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

CO-CHAIR HOLLANDER: Okay. Sarah?

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

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

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

MR. GOLDWATER: Absolutely.

CO-CHAIR HOLLANDER: Okay.

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

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

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

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

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

would be too difficult to do.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Angela?

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

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

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

MEMBER GIBONEY: This may be a question

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

(Laughter.)

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Don?

MEMBER GRAF: I wanted to loop back to

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

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

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

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

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

CO-CHAIR HOLLANDER: Stewart?

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay.

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

CO-CHAIR HOLLANDER: Okay.

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

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

slope.

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

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

(Laughter.)

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

CO-CHAIR HOLLANDER: Oh, Adam?

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

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

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

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

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

CO-CHAIR HOLLANDER: Fair enough.

MEMBER WALKER: Would that fall into system?

CO-CHAIR HOLLANDER: Yes. Is that

system effectiveness? Yes. Oh, Yael?

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

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

CO-CHAIR HOLLANDER: So I'm going to go with Angela's comment, but despite the fact I'm generally a lumper, I personally want to lobby for splitting patient from family and caregiver.

Because I can imagine there's patients you can't assess their experience, right, in long-term care facilities and things, and then it

really becomes more about the family and caregiver experience. And I think I want to be really clear that the family and caregiver experience is hugely important and never risk it getting lost under the category of patient experience.

So, I'll offer the friendly amendment with splitting that into a fifth category and see how others feel. Adam, left over? Anybody disagree/agree with that? Or everybody's ready for lunch?

(Laughter.)

CO-CHAIR HOLLANDER: Okay. So quick show of hands. That's a fifth category, raise your hand, or keep it down if you want it to just be in the patient category. Okay. Just leaving it in the patient category, show your hands. Okay. So it looks like it's a lumper. So now, before we break for lunch -- oh, go ahead, Marcia.

CO-CHAIR WARD: So in my world, which is public health, provider has a very specific

meaning, which is physicians, APPs, those that can prescribe. That may not be the word choice of people around the table, so I just want to make sure that we're real clear whether we use provider or whether we use clinician for that label.

CO-CHAIR HOLLANDER: Go ahead, Steve. And then Peter.

MEMBER RASMUSSEN: We're collectively whispering over here clinician to broaden it. We agree.

CO-CHAIR HOLLANDER: Okay.

MEMBER RASMUSSEN: And we're actually moving more toward the concept of just team member.

CO-CHAIR HOLLANDER: Care team?

MEMBER RASMUSSEN: Care team member, yes.

CO-CHAIR HOLLANDER: Is that better than clinical professional? Care team member, okay.

MEMBER DARKINS: Well, one of the

things around operationalizing is, sometimes you do have the capacity to create new entities. So for example, if you're doing -- your telepresenter at the distal end may well -- you've developed a whole new category. So if you end up being exclusive to start off with, you can't create those changes. So if you make team member, it's broad --

CO-CHAIR HOLLANDER: Yes.

MEMBER DARKINS: -- and will encompass change.

CO-CHAIR HOLLANDER: I love that. Don?

MEMBER GRAF: Recognize the team, but from a payer perspective, the clinical professional, that is really more who can bill and get paid. And so I would just be careful that we're not making it too vanilla.

CO-CHAIR HOLLANDER: So I think, the way I see it, and NQF can correct me if I'm wrong, is that, you can still -- so care team member could be our sub-domain, but the measure could still be around physicians doing this or

APPs doing this or, now, ancillary staff doing this. Yes. So I think -- oh, we have other -- oh, Julie?

MEMBER HALL-BARROW: I just want to go back and root for you, Judd, for the fifth. Just because, working in the pediatric field, the parents and families make all the decisions. I don't care how the patient feels about it.

So I really want to garner that we look at that, and even as we look to broader opportunities, like you were talking about, what we're doing today, but for mobile apps, if they're 13 and under, they can't actually provide me any data about their healthcare via the app; their parents or family has to do that. It's not only until they're over 13, can we actually get data straight from them.

So patient experience for them, they're not making any of the decisions. So I think it would be hard for us to do that. So I really would like to push for the fifth, please.

CO-CHAIR HOLLANDER: Henry?

MEMBER DEPHILLIPS: I'm wondering if we can use, just thinking out loud, Julie, similar approach. So care team, broadly those sort of helping render care, versus recipient team, all of those involved with receiving care, whether it's a child, a parent on behalf of a child, a caregiver on behalf of a patient, blah, blah, blah.

CO-CHAIR HOLLANDER: So, then, maybe we could just change an and to an or: patient, family, or caregiver, and then it's sort of the care team or the recipient team. Don?

MEMBER GRAF: And I'm not arguing against it, okay? But the role of the parent or the role of the caregiver, aren't they really an extension of the patient, a representative of the patient, as opposed to a separate entity? I guess I would --

MEMBER HALL-BARROW: I don't know.

MEMBER GRAF: -- through my own eyes --

MEMBER HALL-BARROW: We have a very large foster care program, and that is a brand

new parent to this family is now making decisions. And so the patients, still, we want to know how they're feeling. So I don't know if always that is the case. They're extensions, but do they have the same experience that the child is having? I think, no, not always.

CO-CHAIR HOLLANDER: Okay. So we're going to do Angela, Henry, and Yael, and then we're going to call the question and eat lunch. Henry went away? Okay.

MEMBER WALKER: I like the and/or. I think the framework just identifies that there is some place for things to fit and that they exist, so I don't think it necessarily needs its own category.

CO-CHAIR HOLLANDER: Okay. Last comments from Yael.

MEMBER HARRIS: And I'm going to advocate for the and/or, too, not to pick a fight. But I think, first of all, the caregiver is the advocate on behalf of the patient, since they're under 13. If they're over 13, hopefully

the patient can speak for themselves, but the parents are part of it.

And I want to bring in the whole point of tele-behavioral health, which is, if you're providing CBT to an adolescent, the adolescent may have a different experience than the parent in terms of how it's impacting them, but that doesn't negate.

So you can still capture that in a single category versus creating separate categories, because suddenly you're undermining, did the intervention work or not? If they have different perspectives, those are both valid, but I think if you put them together, you can get a better picture.

CO-CHAIR HOLLANDER: Okay. So we're going to have public comment after this, but just sort of head nod, my take-home points, although the words may tweak a little is, we've come up with four categories now: patient, family, or caregiver; care team member, and I would add, including the clinical provider, so that's clear;

the community; and the telepresenter. And those are our four categories to go forward with.

I would like to, and I'll, Dan, get to your comment in a minute, I would like to ask the question, do we need more discussion of this after lunch? Did this work? Is this category resolved? We're never going to get perfection, but is it good enough to move on to the next stage?

We'll take Dan's comment, and then if somebody's dying to make another one, they can. And then we'll do the -- Dan and Sarah -- and then we'll do the public comment period afterwards.

MEMBER SPIEGEL: I guess, I would just ask, for those who suggested the telepresenter as a separate category, is that part of the care team today, or will it be just a natural part of the care team in the future?

CO-CHAIR HOLLANDER: Okay. Sarah?

MEMBER SOSSONG: I see that as part of the care team.

CO-CHAIR HOLLANDER: So you think, now that we've broadened care team, we could do away with telepresenter? I see a lot of head nodding. Anybody object to that? Wow, we're really good at lumping.

(Laughter.)

CO-CHAIR HOLLANDER: Okay.

MEMBER WALKER: I'd like --

CO-CHAIR HOLLANDER: No, can't talk anymore.

MEMBER WALKER: I might suggest just defining that, so it's made clear that that's where that particular piece fits, so the individuals creating --

CO-CHAIR HOLLANDER: Okay. So, I think in the text of each of these sub-domains --

MEMBER WALKER: Exactly.

CO-CHAIR HOLLANDER: -- we have to be really careful to include what we're talking about. But Jason has captured all of that in his notes. So this --

MR. GOLDWATER: Word for word.

(Laughter.)

CO-CHAIR HOLLANDER: Okay. Public comment period?

MR. GOLDWATER: Yes.

CO-CHAIR HOLLANDER: Okay, we're open for public comments.

MR. GOLDWATER: All right. So we'll start with the phone, and then we'll start with the back. On the phone, Operator, can you open it up for public comment, please?

OPERATOR: Okay. At this time, if you would like to make a comment, please press * and then the number 1. And there are no public comments at this time.

MR. GOLDWATER: Okay. Anyone that is in-person? Yes, microphone is right there.

MR. QUINN: Hello. I'm Matt Quinn. I'm the Senior Advisor for Health Technology at HRSA. And I just wanted to echo, no pun intended, some of the comments, as well as to add something, I think, that's significant.

I couldn't agree more that using the

measures to advance things like access, care coordination or teamwork, as Dr. Darkins said, patient experience, and other areas that are not well developed in broader healthcare is a really good opportunity with this, and to leverage, to the extent possible, the measures that we already have for healthcare in this domain, so that it's not duplicative.

To pick up on one of Chuck's points, and Yael said this morning, she quoted, Are Virtual Doctor Visits Really Cost-Effective?, that's the top of the news. And really, we could throw the baby out with the bathwater if we really didn't get specific and understand what the intervention involved in, quote, virtual doctor visits. It could mean a million things to a million different people.

And as we measure here, as Chuck described, I think it's very important that we have a taxonomy here to describe the actual telehealth interventions and the characteristics of them.

So things like modalities, things like who the participants are, is it part of a model like ECHO or store-and-forward or something else? What are the components? What is the security? What are the adjacent technologies or care models? These things are going to be very important in teasing out what works and what doesn't work, what should be reimbursed and what should not be reimbursed, et cetera.

And then there are also characteristics of the technology itself. And I'll just -- recently passed by Congress was something called the 21st Century Cures Act. And no comment on that, but to quote Section 422, within one year, the Secretary will convene stakeholders to develop reporting criteria related to usability, security, interoperability, and other performance measures of EHRs.

I could see that 21st-and-a-Half Century Cures might involve the same stuff for telehealth. So we should think ahead about those measures, because those will be the criteria by

which we can evaluate these systems, both for purchasing, for evaluation and other things, but also to start looking ahead to another really important and confounding topic in health IT, which is unintended consequences.

So I would just say, I don't know if that's another domain, something that we can pick up, but that taxonomy to be very specific is going to be very important when assessing both structural, process, and outcome measures.

MR. GOLDWATER: Thank you. Any others? Right.

MS. TRUJILLO: Good afternoon, my name is Sylvia Trujillo with the American Medical Association. First of all, thank you for convening this gathering of exceedingly knowledgeable individuals who are really, I think, elucidating and expanding what we can do in this space. I'd like to echo a couple of points -- exactly -- that Matt Quinn made.

And we, of course, are trying to figure out how to validate and integrate into

clinical practice those modalities that have been validated into the practice of medicine. So telemedicine or telehealth shouldn't be any different than medical practice. And that's really a goal that we're striving to realize through various activities.

So we would strongly urge, to the extent that you can utilize existing frameworks, paradigms, and measures, so that you do not add an extra layer of burden onto those who elect to integrate telehealth tools and practices into their system of delivery, you should do so.

And to the extent that there are gaps where you are not able to identify and capture based on those existing measures and activities based on modalities, flag those, and work through those as priority areas, as well.

Just a reminder, the CPT Editorial Panel is working on what is essentially a parallel process on thinking about how you use descriptors to describe services and procedures and whether our existing services and procedures

descriptors are adequate or they need to be modified, and doing a gap analysis for the very same reason, that we streamline the ways in which individuals both identify those services and integrate those into practice. So thank you very much for your service.

CO-CHAIR HOLLANDER: Thank you.

MR. GOLDWATER: Anyone else? Okay. Thank you very much. We'll take lunch for an hour. Oh, one more. Oh, wow.

DR. ALEMU: My name's Girma, I'm with HRSA. I have just a couple of comments. This phase, when we look at reports and meetings discussing quality issues, quality measures, one of the most important items which is always mentioned is outcome.

That's, why do we invest if we don't measure the outcomes? What we are doing should show in the outcome, which is the main goal of our work. So I see adding outcome in the domain part as an important fact.

And the second one was -- by the way,

the discussion was very engaging. I'm really happy to see that everybody's into it. And one thing which we need to see here during the measurement issue is, we have to be able to characterize what can be measured.

There are a lot of ideas which can be really researched, which can be worked on, but we have to look at those facts that can be measured. For example, one issue was mentioned when we talk about subdomains, I agree with really what you say. I see two important points.

The first one, patient experience. It can be said patient and/or caregiver or family experience, you know, sometimes patients cannot provide their experiences. They can be children, or for some other reasons they cannot provide their experiences, but there are families or caregivers who can talk about the experience which they saw. So, that's one of the subdomains.

The next one, from the provider's perspective. When we say providers, it can be

nurses, it can be doctors, and so on. But going further, community, it's very important to know how the community responds or sees that kind of services. But how can we measure that? How can we get data on that? That is the main problem.

And what, for me, is important is, what are the priorities and what can be done and measured? But those, I'm not saying that those issues are not important, but I think we have to focus on those two points. So, thank you, that was my comment.

CO-CHAIR HOLLANDER: Thank you.

MR. GOLDWATER: Thank you. All right. Anyone else? No? Okay, we'll take an hour for lunch. Thank you all.

(Whereupon, the above-entitled matter went off the record at 12:34 p.m. and resumed at 1:37 p.m.)

MR. GOLDWATER: So, we do need everybody back so we can continue. So, I'll give everybody another couple of minutes.

I think initially what we were

planning on doing was diving you all into groups and having you discuss subdomains for the remaining three. But after some discussion with the co-chairs and realizing the trauma if Dale and Stewart are split apart, we've opted to --- I'm kidding. I'm just saying that because Dale's not here.

(Laughter.)

MR. GOLDWATER: I think what we're going to do is just keep you all together. Because, again, I think when we were in the planning stages of this with Judd and Marcia, we envisioned there being more domains subsequently than being more subdomains. But you've done such an excellent job of consolidating to just really high level and getting to the essential elements that I think it would be probably more productive to just stay in the large group and discuss this.

When we get to actually building out measure concepts, we'll see if we want to split up then. But I think for the measure subdomains we can probably all stay together.

So, what we're going to do now is turn to the effectiveness domain. And we're going to have Dr. Hollander lead this discussion while we diligently take notes.

So, go ahead, Judd.

CO-CHAIR HOLLANDER: So, we have, you know, about an hour and 35 minutes to get through three things. It was sort of our best guess that effectiveness was going to be the bigger discussion item rather than cost, which I think we're going to recommend be done in dollars.

But, so, we thought we would begin with effectiveness and that way we could use a little more time for that if we actually need it, and then roll over to access and cost to get that done.

So, we have divided -- or we have spoken about two subdomains in the effectiveness area a bunch, which is system and clinical effectiveness. And we'll start there and open the discussion as to whether we want more subdomains or we could just move on to access at

this point. No, I'm just kidding.

(Laughter.)

MR. GOLDWATER: Nice try, Judd.

CO-CHAIR HOLLANDER: And go home after dinner. But, you know, so system/clinical effectiveness. And then we'll have the lumper-splitter things and say, you know, how much goes in system effectiveness, how much goes in clinical effectiveness, and what other categories may be specifically called out as other subdomains.

So, the floor is open for incredibly intelligent, thoughtful comments or anything else anybody wants to say.

MEMBER DOARN: It's like a game show.

So, when you talk about systems, you know, as a quasi-engineer/program manager, I always think of the actual infrastructure of a hospital, a clinic; not the actual healthcare delivery system itself, but the individuals or the people involved.

So, when you talk about systems, are

we separating into those two, the operations part and then you have the actual clinical part? I mean, in the sense of, you know, a system, I mean, there's a clinical button, but I'm just thinking of the systems themselves. Is it the EHR? Is it the billing system? Is it the IT support? I mean, when you say "systems," I'm not sure what you mean.

CO-CHAIR HOLLANDER: I'd say I don't really define what I mean. You guys define what we mean. So let's go ahead and define what we want it to mean.

Adam.

MEMBER DARKINS: So, I'd just say one of the things around effectiveness, I think, is really usability.

So if you're going to end up investing infrastructure to do this and you've got a system where the connectivity goes down, the physician can't do consultations, you've got about one or two goes at it and then all faith is going to disappear out of it.

So I think it's just a very basic thing, which is around for both clinician and patient, how you make sure the things, however you're connecting, happens, functions, and is seamless.

Because if you don't do that, no matter what you try and do elsewhere you're going to find --- so, I mean, it's very basic and starting with something very mundane, but I think that's a really big discriminator in success.

MEMBER GIBONEY: Well, along with usability, I think availability or accessibility. You can come up with an outstanding telehealth solution, but if it's only available to five percent of your providers or in particular geographies or particular settings, then it's not going to be very effective.

So, maybe this goes to spread or, you know, other concepts, but just availability/accessibility.

CO-CHAIR HOLLANDER: Alright. Daniel.

MEMBER SPIEGEL: So, I wonder if

usability falls better under the experience-of-care domain for either clinicians or family and patients. I agree it's very important, but I just wonder if it would fall better under a different domain.

CO-CHAIR HOLLANDER: Don.

MEMBER GRAF: I just wanted to comment, Chuck, on when you said "systems," I can't help thinking sort of end-to-end process and that everything that fits in, you know, from this end to this end could be all the different sort of systems and processes that go into that encounter. So, I mean, just conceptually, that's what I was thinking.

MEMBER DOARN: If you have a system of, like, let's say, personnel, and you have to have a certain kind of surgical team or pediatric team, whatever it is, then the employment system, the actual personnel system, I mean, I know that's way down in the weeds, but the way you measure that is different than you measure the IT, you know, whether the computers are working

or whether the monitoring systems in the operating room are working correctly.

So, to me, there's different kinds of systems, but I don't know if we'd put them all under that same banner if we're missing something, or maybe I'm over-engineering it.

CO-CHAIR HOLLANDER: Well, so, I guess I would just say I do remember some of the comments on availability that we do have a category called "access," right? So, it may be availability fits better there.

And I guess as we're going through --- maybe not, but as we're going through, do we want specific carve-outs --- and I'm just asking the question --- for specific things? Is it system, and one component of the system is the technical aspects of the system?

And I think last time we talked about workforce we talked about technical components and we broke some category down, you know, into those two things.

So, is "system" too broad, or do we

want to subdivide some system components?

MEMBER GIBONEY: Well, just in terms of availability, when I think of access, I'm thinking access to care: how does telehealth actually get you to care?

And when I was thinking of availability, I'm saying, is the telehealth solution deployed in a system?

CO-CHAIR HOLLANDER: Okay. Henry.

MEMBER DePHILLIPS: So, just a little bit big picture. When I think of the word "system effectiveness," "system," almost by definition, to me, anyway, has a lot of moving parts. And "effectiveness" basically means, does it accomplish the intended goal?

I'll use the system I'm the most familiar with, Teladoc system, as an example. So, the goal is to provide subscribers the ability to get access to care faster, sooner, quicker than whatever the other choices were without it, right? So, that's the goal.

The system that we have in place is

multifactorial, right? We have a network of docs, we've got a variety of ways you can request a visit, we've got a platform that does all the algorithmic matching between the providers and the patients.

And then the effectiveness is how many are we doing, how fast do we connect after the request goes out, and is it being used for its intended purpose?

So, when I think of the subdomains in effectiveness, clinical effectiveness is one. I think system effectiveness is a lot of moving parts. And for that one --- I'm usually a lumper, but for that one I may be a little bit of a splitter, because I think there are a number of components under system effectiveness that contribute to that particular subdomain.

CO-CHAIR HOLLANDER: So what would you split it into?

MEMBER DePHILLIPS: Well, you've got systems of people. You've got systems of technology, which is also broad and maybe needs

to be subdivided some. You've got systems of program design.

I'm sure among the group there's probably a couple more, but those are the types of areas under "systems" that I think about.

CO-CHAIR HOLLANDER: So, do people think philosophically that's the right way to think about systems and we should be thinking of the different components? And then as we're talking about what the subdomains may be now we should be thinking of it as technology, people, program design and other things and focus on the system effectiveness?

Or, you know, so, right now we have system effectiveness, subcategories, or, you know, dotted lines, clinical effectiveness. Is there another big subdomain? Or should we be splitting the system effectiveness and thinking of how can we better define that as multiple subdomains? And then are the subdomains proposed the right ones?

MEMBER GIBONEY: I don't know if this

helps, but when I think about what the measures of system effectiveness might be -- I'll share some of those with you and maybe that will help us decide if we need another category, but when I'm thinking about, you know, capability to do what we intend to do, what is our goal, right?

And I think about things like, you know, what is our responsiveness? How well does the telehealth help with responding to some sort of identified need? What is the rates of use? Is it being used by the people and the percentage of the people that we want it to be used for? If you're deploying in a particular setting and you need 85 percent of the people to use it, you know, what is that.

Does it facilitate the appropriate sharing of information? You know, whatever it is, is the information that you're able to share -- if you need pictures, does it do pictures? You know, if you need access to an electronic health record, does it accomplish that? You know, is it routing the request to the right

person on the other end? Is it connecting whoever needs the service to the right person?

And so, to me, those are elements of system effectiveness. They actually --- is it accomplishing what we want it to accomplish? Those are some of those elements.

And so maybe they all fall under system effectiveness. I don't know if we would want to split them out further, but those are some of the elements that describe a quality telehealth implementation, to me.

CO-CHAIR HOLLANDER: Kristi.

MEMBER HENDERSON: So, I think I like them split: operations, clinical and technical, potentially.

And to the point around measuring those, "use" doesn't mean effective when you think of it in clinical terms, but "use" may be effective in the operation side. If your goal in operations is to get adoption, great. You've met that measure, but that doesn't necessarily mean you have an effective clinical operation, because

you may still have, you know, whatever, disease progression or whatever. So, I like splitting it.

CO-CHAIR HOLLANDER: So, are you proposing that operations, clinical, and technical are under the system effectiveness, or in the whole effectiveness category? We had system effectiveness and clinical --

MEMBER HENDERSON: System effectiveness and breaking that down.

CO-CHAIR HOLLANDER: Okay.

MEMBER HENDERSON: Just an idea.

CO-CHAIR HOLLANDER: Okay. Angela.

MEMBER WALKER: I would agree largely with what's said. I think the system effectiveness is kind of the process measure, whereas the clinical effectiveness is the outcomes piece that was talked about before.

I like technology, I like operations, design for some of the systems things, and then thinking about the population health component for clinical, or the efficiency component for the

clinical.

CO-CHAIR HOLLANDER: Go ahead.

CO-CHAIR WARD: When Yael and I did a review of tele-ED, 90 percent of the measures out there for the emergency department were process measures. And they were clinical, but they were process measures, because that's the way that the world has gone with CMS first tackling the process.

We all want to get to outcomes, but I'm concerned about compartmentalizing, that the process goes into systems and -- I think that's probably not the best way to split it.

CO-CHAIR HOLLANDER: Adam.

MEMBER DARKINS: In creating a framework, it seems to me how much we can create a framework that's going to enable other people to then use it and how much we need to tell you what it looks like. Because some of the questions that have been sort of raised about system effectiveness are really, you know, important to do.

But do we create a framework where a policymaker at a local level then can get the data and he or she or the team can then make that assessment? Or are we going to try and take on that role and say we're creating a framework where -- does that -- because it just seems to be some of this we're answering really sort of, you know, world hunger problems as we get into some of the aspects of it.

And, again, I'm not saying it shouldn't be done, but as the first stab at this and should we be saying, as we write this, thinking of the final report, we're creating a framework that means that if you're a payer at a local level providing care in this community, this framework will provide the infrastructure where you can then use your data and your assets and you can do supplemental research and you can answer some of these big policy questions which are relevant to you versus saying, you know, we're actually going to create a framework that's going to do this for you.

MR. GOLDWATER: So, the answer is -- so, there's two answers to that. The first is, the primary purpose of a framework is to provide a foundation upon which measures can be developed, because they don't exist currently.

So, whether a payer at a local level wants to develop those measures, or whether URAC, for example, wants to develop those, is entirely up to those organizations.

But the foundation basically says, here's what -- again, a framework is to organize information. So here are the domains in telehealth this committee feels are important, the most relevant, the most significant. Here are the subdomains under those topics that the committee feels are the most applicable, most relevant, most important, most significant. And from that, here are the measure concepts that you can take and build measures from.

Could you then look at that and say, is there research to be done on some of this that would potentially lead to the development of that

measure, particularly if the data to build a measure is unavailable right now or there are other topics related to that concept that should be explored? Absolutely, but the primary purpose is to be a foundation for development.

Because if you -- and, you know, Judd and Marcia and others will know this: when you open up a topic and say "build measures," it's sort of a Tower of Babel, right? Everybody starts building things. They are duplicative of one another. There is limited variation between two different sets of --- I mean, that's how it used to be done.

You know, back in the days, Marybeth and I and others can remember in the mid-'90s when we were figuring out how to do this, that everybody was developing measures. And people were duplicating measures and creating measures of limited variance and there was no guiding framework about what to develop for cardiovascular disease or COPD or mental health.

So what was learned is, if you create

a framework upon what really becomes important to develop, then you sort of remove that problem. And you don't, as you said, create something that collapses under its own weight. It doesn't become so big, so onerous that, you know, there's 600 concepts and people are going to be building a thousand measures which no one will ever use.

I mean, that's why we have 2500 measures at the moment. Who's going to use 2500 quality measures? Not very many people, you know.

And it gets back to people will use quality measures if they're going to be reimbursed or if they're going to get certified or if it's going to be an extra value that they can mark up and say we have reached X quality threshold because we met these measures.

So, that's what the framework is for, to help guide the development of measures. But it certainly can be used to pursue research if there's a concept area that should be explored in more detail.

CO-CHAIR HOLLANDER: Don.

MEMBER GRAF: In the context of what you just said, and to the extent that clinical effectiveness and cost effectiveness have already sort of been carved out, the system effectiveness, which almost sounds like it's above both, really becomes sort of operational effectiveness. Or maybe it's just the word "system" that is getting in the way.

CO-CHAIR HOLLANDER: Kristi, you look like you're leaning, about to say something.

MEMBER HENDERSON: I think that's kind of where I was going with creating an operations category underneath it. And without having another three buckets, keeping this system effectiveness and then having the sub-units gives some clarity, I guess, to it. But operations means a lot more to me, as well. Systems is big and scary.

CO-CHAIR HOLLANDER: So, I'm wondering --- sort of a friendly amendment to your proposal and the concept -- well, clearly we have a

clinical effectiveness. We either keep or don't keep the systems effectiveness, but we add to that operations and technical effectiveness.

And so I'd actually propose four subdomains: system, operations, technical and clinical. And everything should fit into one of those. And the only advantage of systems is it sort of spans the others. And in some measures, if you're measuring how an ACO provides telemedicine, there's a whole system involved. But if you're measuring how telemedicine flows in, you know, one provider's office, there's probably not a whole system, it's probably the individual buckets of operations, clinical, and technical.

So, in terms of a framework, every one may not fit within every category. But the idea of a framework there is I think, you know, within the limits of what we can think of, everything fits into one of those buckets.

MR. GOLDWATER: Just to add on something which I think might be important, so,

you know, let's say you come up with four subdomains under effectiveness, and then we start deciding or brainstorming measure concepts, and we get to system effectiveness, and you're brainstorming these concepts and you all come to the conclusion of, we just can't get something here that would be usable. They fall under other categories or this is not going to be measurable or this is really not going to provide any value.

There's no rule that says whatever you decide right now we have to carry through with. I mean, we can remove that concept, that subdomain, if you're unable to come up with any existing measures or any measure concepts that you think would be valuable.

It may sound great right now and then you may flesh it out and find out that there's nothing. It's okay. I mean, we're not going to go back over the transcript and say, "Well, Don said we had to do this." And so, I mean, that's not how it's going to work. You can eliminate in the process of this.

MEMBER GRAF: I want to endorse what you said, but I want to better understand where cost effectiveness would have fit into --

CO-CHAIR HOLLANDER: Well, cost is its own category.

MEMBER GRAF: Right. As is clinical, but I thought I heard you organizing --

CO-CHAIR HOLLANDER: Clinical is not its own category. Clinical effectiveness is under effectiveness.

MEMBER GRAF: Oh, sorry. I'm still looking at the ---

CO-CHAIR HOLLANDER: Yeah. But cost has its own category, yeah.

MEMBER GRAF: Must have been sleeping. Okay.

(Laughter.)

CO-CHAIR HOLLANDER: Mary.

MEMBER MOEWE: So, I'm thinking about getting the information back into the electronic health record. And probably this falls under operational effectiveness.

But, for the physicians, they've made such an investment in their EHRs and I think they feel like, you know, "I've put a lot of money into this, meaningful use has helped me, how do I then document this visit, this telemedicine visit, appropriately and effectively and keep it simple?"

So it's not, you know, do I record it, do I video --- I mean, video is a whole other, like, do you want to have those kinds of records, because it's a lot of data to store and they may not want to do that.

But, I mean, thinking about operational effectiveness, how do I want to store that visit in my electronic health record and keep that data? Because it may be -- there may be more data actually available from a telemedicine visit than there would be from a normal visit.

And it should be, you know -- because we were talking about this at lunch. It should be very similar. A visit's a visit. If it's

telemedicine or if it's a regular face-to-face just like this, we could be doing it remotely. It's the same thing. We're doing the same thing.

So, let's not reinvent the wheel, but we want to get that data into the record and make it simple.

CO-CHAIR HOLLANDER: Right. So, I think that that could fall under operations or technical. And I don't know if --- so, maybe I'm wrong here, but I'm not sure we need to answer that question.

MEMBER MOEWE: No.

CO-CHAIR HOLLANDER: We just need to create a bucket that the answer to that question, should someone want to measure it, would fit into the framework. And so I think that component does that.

I agree with your overall concept, you know, we need to document what we're doing. Depending on how it is, you know, if you're bringing a video and storing a video, well, it may be technically you need the ability to do it

or you may need the operational, you know, wherewithal ---

MEMBER MOEWE: Someone in the office to take care of it.

CO-CHAIR HOLLANDER: Right. And so, how we solve that -- so if the measure is capturing 98 percent of video visits and storing it, which I hope it never is, you know, I think this framework would enable that to do that. It would fit somewhere in there.

MEMBER MOEWE: Okay.

CO-CHAIR HOLLANDER: But I'm with you. I hope it's never there.

David.

MEMBER FLANNERY: I just want to follow up on Angela's comment about population health, because I think that comes under systems. It's not individual clinicians that are doing it, so it's a team, or the whole system has responsibility to a population. And so, I think that should be under system effectiveness.

MEMBER WALKER: I just have a

counterpoint to something that Jason had mentioned, which is ---

CO-CHAIR HOLLANDER: You can't argue with Jason, just so you know.

MEMBER WALKER: I'm going to do it. I'm going to argue with him.

(Laughter.)

MEMBER WALKER: Just because we create the bucket doesn't mean we have to keep it. And if it's something we identify at some point that there's no way to measure it, perhaps we shouldn't keep it.

And I would argue that if we're creating a document looking ahead towards the future, just because we're not measuring it now, it may be we're not measuring it yet.

So, this does give us a way to kind of conceptualize that ahead of time.

CO-CHAIR HOLLANDER: Jason stands down.

(Laughter.)

CO-CHAIR HOLLANDER: Okay. Other

comments?

So, throwing out the straw man at the moment, I think right now what we have is system effectiveness, operational effectiveness, clinical effectiveness, and technical effectiveness as four buckets under effectiveness.

Are we done? Do we have more? Did we nail it? This was supposed to be the hard one.

MEMBER GIBONEY: Well, are we going to talk about clinical effectiveness, as well? Are we just talking about system effectiveness right now?

CO-CHAIR HOLLANDER: Well, so, yes. I guess the question would be, do we want to add -- - so, in trying to frame this, I'm not sure at this point we have to determine what goes under clinical effectiveness, but, you know, which clearly is going to be some outcomes and some other things.

That may be the next step where we're talking about the --- what are we talking about

in the next step? The measure concepts. That may be a measure concept.

But I do think if there's something that we might think is in clinical effectiveness that rises to the importance of being its whole subdomain, then we should mention that now.

Angela is up. She's ready to go.

MEMBER WALKER: So, I would just mention, with the clinical effectiveness piece, I think this is probably the bucket where a lot of the measures previously developed will fit, because so many of them are that kind of outcomes piece. So, just thinking forward, to keep that in mind.

CO-CHAIR HOLLANDER: Yeah. Okay. So, can we really go on to the next category? Okay. Alright. I got head nods. Okay. So, we got those four. Good.

Marcia.

CO-CHAIR WARD: Okay. So, we have two left. We have cost and we have access. Got a preference which is going to be easiest to be ---

access? Okay. So, nominations. The floor is open for nominations for subdomains for access. Are there any?

MEMBER GIBONEY: So, I really like what was said just a minute ago, and I'm trying to think of how we put this into either a subdomain or something. But the fact that telehealth is access; telehealth is not just getting someone access to a face-to-face visit, you know, it is, in and of itself, providing whatever that expertise is or whatever that provider is on the other end.

And so, for us, as a provider of care, as the county, we're constantly in this conversation with the state trying to convince them that the work we're doing with telehealth is, indeed, meeting their access standards.

But they are, you know, saying, "Well, the only thing that meets the access standards is that face-to-face visit." And we keep saying, "No, no, we've got something that's actually better."

And so, you know -- and so I'm just kind of wondering is there a subdomain within access that is required to articulate that very clearly? Because I think that that conversation with payers or with, you know, regulatory entities is so pervasive and so prevalent.

Do we want to call it out in its own specific line somewhere in this report, that statement that we believe that the access to care provided by telehealth is, indeed, care? Does that make sense?

CO-CHAIR HOLLANDER: Let's go to Dale.

MEMBER ALVERSON: Two major subdomains that I see, really, is access for the patient. So, that's one. It's a different type of thing, and that might even go to direct-to-patient care services, what have you. But also providers who want access to that, say, specialty services.

So, I sort of see those as two general categories under access. And there may be more, but those are two that I see as subdivisions.

CO-CHAIR HOLLANDER: Okay. Yael.

MEMBER HARRIS: So, I totally agree. I don't know how low we want to go, but there's the five As of access that we all learned in grad school. And then, of course, timeliness.

So, if we want to go lower, there's, you know, availability, there's timeliness -- I'm trying to think -- affordability, there's all the --- he's just nodding, because he went to grad school, too.

(Laughter.)

MEMBER HARRIS: Obviously, the same instructor.

Anyways, it depends on how low we want to go. But when we're thinking about access, do we want to just group those altogether, which is fine, or are we putting out a call for new measures? In which case we might want more granular, because then we look at what we have and identify where there's gaps.

CO-CHAIR HOLLANDER: So, do you recall what the rest of the As are?

MEMBER HARRIS: I'm looking it up

right now. Who remembers? Oh, Henry remembers. Go ahead, Henry.

MEMBER DePHILLIPS: Are you trying to get me in trouble?

CO-CHAIR HOLLANDER: Yes. Do you know what they are? Go ahead.

MEMBER DePHILLIPS: I just did a Google search. So, affordability, availability, accessibility, accommodation, and acceptability.

CO-CHAIR HOLLANDER: Okay. Don is next.

MEMBER GRAF: I was thinking in terms of the same thing. I didn't have the same words, but in the telehealth construct was the word before the access: "timely access," "rural access," I mean, the things that are specific to telehealth and how that word is used.

CO-CHAIR HOLLANDER: Okay. Now Henry and then Adam.

MEMBER DePHILLIPS: Thanks. On this particular domain, I actually am doing in my head point/counterpoint like the old Saturday Night

Live routine.

And so the lumping category, my personal definition of "telemedicine" is the use of technology to export medical information form where it is to where it's needed. That's what goes on up here when I think about telemedicine.

So, from that standpoint, access could be one thing. And everything about access could fit in that, whether it's doctor to patient, doctor to doctor, whatever.

On the other side of the coin, I know there are several folks from HRSA here, and I know that the HRSA folks are very focused on rural access, right? Access to care when you live geographically away from care.

But a lot of folks also understand that in the middle of Washington, D.C. there's an access issue. It is still six months to get a dermatology visit in this town where there's a bunch of dermatologists.

So, I'm kind of on the fence about whether to lump access or whether to split it out

into rural or urban or specialty or demographic or socioeconomic, you know what I'm saying?

So, I'm throwing those out to sort of prompt people to think where do you fall in that spectrum. I'm not answering the question. I'm asking the question.

CO-CHAIR HOLLANDER: Okay. Go ahead, Adam.

MEMBER DARKINS: I know we've kind of all got the Kool-Aid, otherwise we wouldn't be here. But it seems to me there is a piece around appropriateness. Just because you can do something at a distance, doesn't mean it's better.

So, the fact you can end up giving somebody instant access by video and they pay their co-pay, and it's cheaper for them to pay their co-pay rather than go into the clinic, doesn't mean they got more appropriate access.

So I think if we don't put that first, if we jump straight and say this has to be good because that's what we believe in. So, we ought

to have a gateway of appropriateness.

CO-CHAIR HOLLANDER: Okay. I think Peter.

MEMBER RASMUSSEN: I guess I'm against the concept of splitting rural versus urban, because it really just depends upon availability of a appropriate provider geographically, as well as the time that --- the acuteness of the clinical situation.

In a large healthcare system, you know, the neuro-stroke neurologist might be five blocks away. To get to the ED that's an access problem in a timeliness fashion. So, to me, it doesn't matter if you live in rural Ohio or, you know, you're actually in the Cleveland Clinic.

And I guess also this concept of appropriateness, I think I understand what Adam is saying, but I think there's a misconception of what we're doing now is still the best level of care.

And I guess the appropriateness concept figures more into, is it going to be an

abused situation? Because you can do it, is it going to be abused by the system or the patient?

MEMBER DARKINS: No, I think, very straightforwardly, I mean, it may be somebody needs immediate and they shouldn't be --- I mean, maybe it would help triage to see me remotely, but it may be inappropriate. You're seen virtually without wanting to get into the weeds, that was all, just to presume that -- so the first-line access may be you have to wait to have a virtual care delivery.

CO-CHAIR HOLLANDER: Okay. I think Dale is next.

MEMBER ALVERSON: We didn't get any comments to the -- because I look at access as providers coming up saying -- and they could be providers at a variety of levels, not just physicians, "I need access to that service."

And then I look at access for patients independent of where they're located, whether it's urban, rural, whatever.

So, is that just not a good subdomain,

to divide it up between providers and patients?

CO-CHAIR HOLLANDER: Yeah, I have scribbled in my notes here as we're talking, I was just changing my whole thinking of this, and I have "access to patient," "access to provider," "access to medical records," "access to pharmacy," "access to imaging," "access to lab tests." It's really access to what the patient and providers need.

And I think we've been focusing on how easy is it to get access, but I'm not sure --- I mean, I think the measure is can you get the patient the care they need and do they have access to that?

And although I started thinking the way the conversation was, I think Peter's comments made me start thinking of it a little differently. So, I don't know.

Julie, you're up next.

MEMBER HALL-BARROW: Yeah. So, I just kind of reversed it in my head. So, we're talking about access, but what are the barriers,

right?

And so there's an article I read, and I just pulled it up, but it described them in three subs: financial, structural, and cognitive.

So, you talked about labs, all that. That's all the cognitive things. Structural could be everything from regulatory, the home's not a billable site -- I don't care where your home is, you're not going to get it.

And then if you look at it from financial, well, what is driving it is that because you're part of an ACO, and that's cheaper and that's the way you're going to go. And you're going to do that ten times before you finally realize, yeah, I better go somewhere.

So, I don't know if that works or not, but we could look at those.

CO-CHAIR HOLLANDER: And, Chuck, you're up next.

MEMBER DOARN: So, I was thinking why some people have access and some people don't. And I was thinking the word "bandwidth" and "last

mile." Although that's not quite as bad as it used to be, it's still a problem.

And then I said ZIP code and geography. You know, there are places in New York City that you can't hardly get to a healthcare facility, primarily down by the Mayor's Office by the Brooklyn Bridge. So, it's a long way to get to the hospital. So it doesn't have to be rural. It's probably all-encompassing.

And then I think the even more important part, when I first started doing this, you know, you had to go to a dedicated room. Now, it's on your phone, it's on your iPad, it's wherever you are, wherever the patient is.

So, I mean, access, you know, as long as you have the bandwidth and you have the device and there's someone on the other end, there's a system on the other end, you always have access. But if you don't have those components, then you can't have access and you have to go -- so the question is, is how far is definitive care? Is

it, you know, a mile away? Is it 240 miles in space? Is it on a boat, you know, in the ocean?

You got to have --- there's got to be a way of getting to care virtually. And then if you have to be transferred, like with the stroke, you know, how far away is it?

CO-CHAIR HOLLANDER: So, does that fall under structural, under Julie's?

MEMBER DOARN: The bandwidth, perhaps. But I think the location, I mean, I guess it's a change in mindset. It's sort of like you have, the device is in your hand, you know, or someone comes and says, "We're going to put these little robots in the nursing facility," versus, you now have your iPhone or your Android or whatever. It's right on your person. So you always have access because it's right there with you at all times versus going to a cart or going to a dedicated room or something like that.

CO-CHAIR HOLLANDER: Alright. Mary, I think.

MEMBER MOEWE: Across state boundaries

was a concern that I'm thinking about. And maybe it's because Tennessee has so many states surrounding it.

Like, we have issues regarding patients seeking care in other states and the interoperability of that data back and forth between, like, a city like Memphis and then surrounding Arkansas, Alabama, Mississippi.

How does this help that situation? How is the access improved by this? How does the reimbursement --- these are things I'm thinking of that are maybe not necessarily problems, but solutions.

This could potentially be a great solution to access to care across state boundaries. I don't know, but I'm looking to our United friend, because he seems to know a lot nationally about how reimbursement works across states.

But I think that's something that's a concern of mine is sharing of data, because I'm working with interoperability initiatives in the

State of Tennessee, so I think it's very important that we be able to share data across states. And we've run into constraints from security with sharing of data. So that's, in my mind, access to that data; then, sharing the data.

CO-CHAIR HOLLANDER: Okay. Nate.

MEMBER GLADWELL: Yeah, I just want to put a simple-minded vote into Dale's comment that what we're talking about is who's requiring the access. And I think that's probably where it should stay at this level, is the patient is requiring access, and then the referring or responsible provider is requiring access, and then all these subcategories could be fleshed out below those. That's my vote.

CO-CHAIR HOLLANDER: Okay. Who's next up?

MEMBER FERGUSON: So, just to kind of follow on, I think there's another part to that. I mean, we think of patients. We have providers that want it because they need to reach their

patients. Makes sense.

We also have systems that want to increase market share, penetrate other parts of another market. So, I think system might be another perspective.

Having said that, I actually did like the comments earlier about the five As. And I went to the wrong grad school, so I didn't study those five As.

(Laughter.)

MEMBER FERGUSON: Just for the record, I went to Case Western Reserve University and we studied other things, but doing a bottom-up thinking, right, when you think about access, you know, typically we think either patients are getting care, they're getting access to services they never got before, right? And that's kind of availability. Or they're getting access to services, but they're getting them faster. They were there, but now they're getting them faster. And so that's, to me, accessibility.

And I liked the suggestion from Adam

on appropriateness. I mean, those are three things -- that's a different way of slicing and dicing this. And I don't care which way we go, but I think they're both kind of valid approaches to this.

CO-CHAIR HOLLANDER: Chuck.

MEMBER DOARN: Well, the one thing I was thinking of is, you know, across state lines and I start thinking of language and culture.

So, you have people showing up at the emergency room, they, quote/unquote, "technically have access," but no one has any idea what they need because they speak the language or there's a cultural difference.

And this is not so much seen in every large city ---- I mean, certainly -- I mean, every city in the United States, but some of the larger cities we have immigrant population, you know, Hispanic population that don't necessarily speak the same dialogue.

I mean, we've got examples where a woman in this Mexican village went from one side

of the river to another side of the river and they had to take her to the hospital because she collapsed. They had no idea what was wrong. She had no idea what was going on.

They both speak, quote/unquote, "Spanish," but they couldn't communicate and it turned out the woman was pregnant. She had no idea how she got pregnant or that she was pregnant, and they couldn't really treat her, because they weren't sure. And so, you have that same kind of problem especially, you know, I think of people coming from other parts of the world that come here. Or maybe they won't come here anymore, I don't know, but there are clearly -- there's a challenge there, I think, as well.

CO-CHAIR HOLLANDER: Just to be different, I'm going to table hop and go Angela, Stewart, and then Daniel.

MEMBER WALKER: Okay. A couple clarifications before I interject. Julie, you had mentioned the three: structural, cognitive, and what was the third?

MEMBER HALL-BARROW: Financial.

MEMBER WALKER: Financial. And then Judd had also mentioned a list, but it sounded like it's more access to information, things like labs and prior history.

CO-CHAIR HOLLANDER: Yeah, it was access to patient. And now I'd say referring provider, medical record, pharmacy, imaging, lab tests. And medical record gets along some of the things Mary talked with across state lines. And I think at some point it's access not just to the patient, but the patient information.

MEMBER WALKER: Absolutely.

CO-CHAIR HOLLANDER: And maybe that's the right term. And then under patient information maybe it could be imaging, lab tests and other things, but I think that if we're doing visits with a patient devoid of any information, if you're doing neuro-stroke and Peter can't see the CAT scan, it's not really good care.

So, I do think -- I mean, that might fall under the clinical effectiveness, but I

think I would want to call out, as we're doing telemedicine, we want access to the other things that help us make a decision.

Clinical effectiveness might be can I see it well enough or interpret it well enough or get it back in a timely manner.

MEMBER WALKER: I agree.

CO-CHAIR HOLLANDER: At least that's the way I thought about it.

MEMBER WALKER: That's the way I thought about it. You know, access is becoming for me a term like "quality." It's just so broad. You know, what do you mean by that?

And I love the five As. I love the sixth A with appropriateness, because I think it defines there may be certain disease states or certain patient populations or cohorts for which clinical medicine is the ideal. And there may be populations that fit the same -- that tele or virtual services is more suited for that disease process or that patient population.

If we went with the five As, plus the

sixth of appropriateness, it would just be important to make sure that we're capturing these other things like patient information in some of our other domains, either system effectiveness or clinical effectiveness.

CO-CHAIR HOLLANDER: I think Dan was next.

MEMBER SPIEGEL: I guess I have two comments. One, with regards to the discussion around language barriers or across state lines, one of the As, I think, was accommodation or something to that effect, which I think would actually cover language barriers and potentially other barriers, like if you're blind or deaf or something to that affect.

And then the other comment or question I have is should utilization of these services be captured somewhere and does that fall under access or some other domain?

CO-CHAIR WARD: Okay. I'm hearing --- so, we're talking about subdomains and a classification/categorization system for

subdomains, and I'm hearing us comment this a couple different ways.

And so, one thing I heard was three possible subdomains, access for the patient, access for the provider, access for the system. So that would be one structure for subdomains.

I'm hearing another one, which is technical access, financial access, structural access, cognitive access, regulatory access. Those could be subdomains.

I'm also hearing the five As, which could be subdomains. I think of them as definitions for access, maybe, but that could also be another subdomain system.

So I feel like we've got three buckets here and we kind of have to pick one.

CO-CHAIR HOLLANDER: Kristi.

MEMBER HENDERSON: Can I clarify, the three that you had when you said patient, care team, and system, what is system access? What does that include?

MEMBER FERGUSON: I was thinking more

at the healthcare system. So, a healthcare system may be expanding into a new market, may be expanding their reach. It's more than just a provider reaching out at that point. So you would measure it differently. There would be different measures associated with it.

Can I just do an add-on? I thought I heard a --- I didn't consider data as being an access issue, but clearly it is, right? It was brought up.

Does that deserve its own subdomain as well, then? I mean, it's so clear in interoperability and some other issues. It takes care of the EHR in-and-out view.

CO-CHAIR HOLLANDER: Henry.

MEMBER DePHILLIPS: So, in the category of "if there's more than three subdomains I get a headache," it strikes me that a way to simplify and maybe capture all of this is access for patients, access for providers, and access to information.

MEMBER HENDERSON: And we forgot the

system.

CO-CHAIR HOLLANDER: Okay. And Marybeth.

MEMBER DePHILLIPS: So, sorry, a quick comment. I may get thrown out of the room for saying this, but I'll risk it. A hospital expanding to offer new services in a new area, to me, that's a provider. A hospital system is a provider system. It's a -- I lump it with the broad category of providers/provider. I don't look at it as just an individual person.

CO-CHAIR HOLLANDER: Kristi, are you up? I'm sorry, Marybeth is up.

MEMBER FARQUHAR: I was just trying to get my head around network adequacy and that term that's being used.

A lot of folks, you know, CMS has not decided not to use it, because they couldn't really measure it very well, but I think it speaks to access here, particularly with patient and provider and data. All that kind of stuff comes into that whole category of adequacy.

CO-CHAIR HOLLANDER: Paul.

MEMBER GIBONEY: When I think about what Henry and Dale both said about access for patients, access for providers, ultimately if a provider needs access, they're actually needing access on behalf of the patient. They're not just like, "oh, I wonder, you know, what the latest treatment is for this."

Well, no, they're saying, "Given this patient, I wonder what the latest treatment is for this."

And so, I wonder if you could even lump that further like access to expertise or access to care. I mean, sometimes telehealth can help you get access to primary care, too. So, it's not just specialty expertise. But it's almost like you have access to some sort of thing in the medical setting that's represented by someone, usually, whether it's clinical care or whatever, I think access to information is really key.

And then, you know, one of the other

things that Judd brought up very early on in this conversation was access to other medical stuff: meds, labs, diagnostic tests, you know, things like that that help the providers make decisions.

So, I don't know if --- I almost want to think about lumping, you know, access to some sort of clinical care or expertise, access to information, and access to, like, diagnostics or ancillary labs or meds or, you know, I don't know. I guess I'm thinking of a different way to lump these things, because I'm not sure I'm incredibly comfortable with access for providers, access for patients.

Even though those are measures, they're both seeking the same thing in the end.

CO-CHAIR HOLLANDER: Don.

MEMBER GRAF: So, I wanted to add to the network adequacy. As we're responding to, like, Medicaid contracts, oftentimes network adequacy is on the table and it defines timely access to appropriate care through the use of telemedicine and close those service delivery

gaps defined by gebspecialty, you know, so many miles away from a physician, as all sort of measures of whether we're being in compliance or not. So, the network adequacy, I think, is important.

CO-CHAIR HOLLANDER: So, I would just comment that I think network adequacy may fall under, you know, the operational effectiveness or the technical effectiveness, you know, if you're talking about the IT components or you're talking about the workforce components. And so it's already captured in the framework.

I mean, I guess you can argue whether it goes in access, too, but if you can't actually get the access, well, then you would fail in the access measure and the effectiveness measure might tell you why.

MEMBER GRAF: It's provider network adequacy.

CO-CHAIR HOLLANDER: Oh. You mean, do you have enough providers available --

(Simultaneous speaking.)

CO-CHAIR HOLLANDER: So, that would fit into a system thing, right? So, if you have a system thing and you have no providers either geographically local or remote, then you might miss on the network adequacy.

MEMBER GRAF: Right. And all of that fits into access.

CO-CHAIR HOLLANDER: Yeah. I see that.

Jason.

MR. GOLDWATER: So, I just wanted to break in here because --- I mean, it goes back just a little ways about access to data and can the data get into the system, do we examine interoperability?

So, one, we're undertaking a project already to develop a measure framework around interoperability. And since I'm the senior director on that, which I can assure you is nothing like this, unfortunately, that, you know, I think there will probably be a lot of cross-application between what comes out of that that

will apply here.

So, I don't think that's something we need to discuss at this meeting to be incorporated into that framework.

I think when the interoperability framework is completed, there is certainly reason to align some of those measure concepts or measures with this one without having to delve into that.

Because I think as we start getting into the areas of interoperability and data access, that is --- that's a whole other topic. I mean, there's a number of different issues that have to be raised with that that I don't think we really need to cover here.

MEMBER RASMUSSEN: That doesn't mean you're excluding the access to data from this --

MR. GOLDWATER: No.

MEMBER RASMUSSEN: Okay.

CO-CHAIR HOLLANDER: Okay. Angela.

MEMBER WALKER: Going or building off what's been said, I think most of the As would

meet the patient.

Network adequacy kind of falls into the provider system. And I really like the idea of maintaining access to information, because it's so integral to doing virtual services outside the patient's medical records.

So, if we defined "patient accessibility" with the five As just in written terms, not subdomains, would those be agreeable subdomains of patient, provider/network adequacy and access to information?

CO-CHAIR HOLLANDER: Okay. Megan.

MS. MEACHAM: Thank you. I'm just going to put on the rural hat for a second. I agree. I don't think that we need to do a separate subdomain that's saying, like, are you rural or urban.

But in thinking about just like we want to be able to say, is the quality of care provided through telehealth the same as through in-person or any other modality, when we're doing research, we also need to be able to say, are

there differences between rural and urban? So, is telehealth improving access more in urban or more in rural?

So, if there's still a way to build that geography in or --- and also thinking about the barrier side. Someone mentioned barriers. So, like, maybe it's an issue for access for people no matter where you live.

I live in Rockville, Maryland. And it took me a month to get an appointment. And it will probably take me an hour to drive there.

So, you know, access --- all those issues still remain, but, you know, what --- we need to be able to also be able to research and say what are the differences between rural and urban.

So, just try to keep that in mind as we're thinking about this as well.

CO-CHAIR HOLLANDER: Steve.

MEMBER HANDLER: Just one quick point of clarification. When you were saying about access to the provider, sometimes, of course,

this also hits on the rural aspect and other low-resource settings, if there is an appropriate IT access in the facility or in, perhaps, a patient's home.

I just want to make sure that that's captured. I don't know that that would be the responsibility of the provider having access to the IT resources. So, I don't know if we could put that in there or not.

CO-CHAIR HOLLANDER: All right. Don, are you up or --- Steve.

CO-CHAIR WARD: Angela, will you repeat? Because you were reconceptualizing and, I think, doing three buckets.

MEMBER WALKER: Oh. So, the three buckets would maybe be the patient thinking about the six As, the provider/network adequacy, and access to information.

CO-CHAIR HOLLANDER: Nate.

MEMBER WALKER: But it doesn't take into account the point just made by Steve with the technical component.

CO-CHAIR HOLLANDER: Nate.

MEMBER GLADWELL: I got the flashing green light of death down here. Sorry.

Just wanted to maybe edit Don's comments and not use the word "network" -- because in telehealth that's, you know, very confusing --- and potentially use "panel" -- "provider panel," you know, some other language that keeps the network, from a technology perspective, far from what we're talking about here.

CO-CHAIR WARD: Kristi.

MEMBER HENDERSON: Do we want to be consistent and use "care team"?

CO-CHAIR HOLLANDER: Yeah. I like that.

CO-CHAIR WARD: Okay. So, some friendly amendments is what I'm hearing to Angela's --- are people comfortable with that?

And so, patient access, which included the five or six As; care team network adequacy --

MR. GOLDWATER: Care team adequacy and

then --

CO-CHAIR WARD: Okay. Care team.

CO-CHAIR HOLLANDER: Yeah. Here's the way I have it worded here taking down these things that at least one person likes, it's just me; access for patients, access for care team and network adequacy --- it's not actually two, it's actually for the care team that's providing the care for the patients, because the access for patients is to the care team --- and then access to information and data.

(Off mic comment)

MR. GOLDWATER: So, I would --- so, I think it was access to the care team --- or access for the care team, access for the patient and/or family.

Access to information, I would probably not go into data. I would just say "information."

CO-CHAIR WARD: Okay.

MR. GOLDWATER: One thing about the five As, which actually is not a grad school

term. So, the late, great John Eisenberg from AHRQ is the one that originally came up with that and it was put into grad school curriculums.

So, I don't know where Yael is getting her information, but --

(Laughter.)

MR. GOLDWATER: I'm kidding. Yeah. So, affordability is one of those five As, which really is, are you able to afford the care?

Do you think that's one of those that should be included? I mean, is that relevant to telehealth; do you know?

CO-CHAIR HOLLANDER: I would --- yeah.

MR. GOLDWATER: I mean, I'm just asking.

MEMBER DePHILLIPS: So, yeah. Yes.

MR. GOLDWATER: Okay.

MEMBER DePHILLIPS: I mean, that's the whole socioeconomic discussion. It's great to have access to a specialist a hundred miles away through a smartphone. But if the access is a $500 swipe on your credit card before you get

connected, that's a barrier.

MR. GOLDWATER: Again, it was just is it something we could --- that we --- it could be measured that would be relevant to us all.

MEMBER RASMUSSEN: And is it a higher standard for telemedicine than for in-person, bricks-and-mortar visits?

CO-CHAIR HOLLANDER: I don't think so --

MEMBER RASMUSSEN: Is that currently being measured?

CO-CHAIR HOLLANDER: -- because I think it depends on the measure. And I think this gets to Megan's comment on the rural versus not rural things as well.

You can do the research. It depends on the measure. We're not defining what people can do. But if I'm discharging someone from the ED and they need to see an electrophysiologist because I'm sending them home still with a condition and I can't provide that care, I sort of fail on that measure, right, because I'm not

continuing the care.

And they may not make the care, because their payer --- maybe this is at the payer level for attribution and United won't cover that care. So, then, they should get dinged for not covering that care. And there are measures that actually require sort of more wrap-around care.

And then just because it's on the framework again doesn't mean that anybody gets dinged, because someone has to submit a measure that fits within the framework.

And it may turn out when NQF looks at that, they say "That's not really a feasible measure, because it's not covered by any payer, and it's not going to move the needle or change it." But one could --- I don't know, maybe one can't imagine --- one could theorize a day where people need to pay for everything, whatever people need covered or needs to be covered, without discussing how realistic or not that is that you might actually want a measure that can

accommodate that.

But, again, because we're doing this and we're being right now for the moment blind to geography, doesn't mean you can't do research and say, "does this work better in rural environments than urban environments?"

It may turn out if the measure gets out there and it fails in rural environments, it forces people to fix it in rural environments. So, I think it gets, you know, HRSA what they want.

And the same way here. If you send someone home and don't provide them rehab after their stroke, because they don't have care, well, that's something Cleveland Clinic gets dinged on or the payer gets dinged on depending on the level of attribution if that measure is approved, but we're not approving measures right now. We're just saying what might come down the road.

So, I think it's fair to have it in the framework. It may or may not get used.

CO-CHAIR WARD: Okay. So, if people

are --

CO-CHAIR HOLLANDER: Oh, wait.

CO-CHAIR WARD: Sorry.

MEMBER SOSSONG: Just a clarifying question. Within the subdomains, we haven't created sub-subdomains for any of the other subdomains.

So, while the five or six access points are nice, I think we purposely didn't go into the detail on those others. So, I'm just curious whether or not that should be written into the narrative or whatever you just described, or whether it's a sub-subdomain.

CO-CHAIR WARD: And whether it's subdomains, whether it's definitions, what that means.

Jason says "definitions."

MEMBER SOSSONG: Definitions. Great.

CO-CHAIR WARD: Okay. So, folks are comfortable with that for access.

Our last one, cost. So, what sort of subdomains under cost?

CO-CHAIR HOLLANDER: I recommend dollars.

(Laughter.)

CO-CHAIR HOLLANDER: Henry.

MEMBER DePHILLIPS: So, just building off where we were earlier today, if I recall correctly, we had --- we rolled up cost, cost effectiveness. And then I don't know whether we want to include value or whether -- really, cost effectiveness covers value, but at least initially that's kind of how I would envision the subdomains.

CO-CHAIR HOLLANDER: Other comments?

MEMBER GRAF: Where does opportunity cost fit into this?

CO-CHAIR HOLLANDER: Interesting.

Daniel.

MEMBER SPIEGEL: Sorry. Just a quick clarification. I don't know if I missed this.

Did we already cover experience?

CO-CHAIR WARD: Yeah.

MEMBER SPIEGEL: Okay.

CO-CHAIR WARD: Before lunch.

MEMBER SPIEGEL: All right.

(Laughter.)

MR. GOLDWATER: Daniel, the coffee is right over there. That's fine.

(Laughter.)

CO-CHAIR HOLLANDER: Sarah.

MEMBER SOSSONG: I think it definitely makes it easier to the extent that we have similar definitions across these different areas.

So, just looking back at what we just decided on for access, I think that patient and/or family is a nice category. Care teams and systems encompasses a lot of things underneath it as well.

I like the idea of opportunity cost as well, because that's often something that we're trying to communicate to payers. Yeah, just throwing it out there to keep consistent definitions.

CO-CHAIR HOLLANDER: Okay. I think it's Stewart and then Don.

MEMBER FERGUSON: So, I just wanted to be clear. So, when we say "cost," we're actually including --- I heard opportunity cost. We're also including the cost of no care, and cost avoidance. So, all that belongs in this cost domain, just so we're not talking about --

CO-CHAIR HOLLANDER: Can you just list all that so we make sure we're capturing --- so, the opportunity cost, cost avoidance --

MEMBER FERGUSON: Cost of no care and --- yeah, and then --- yeah.

CO-CHAIR HOLLANDER: Okay.

MEMBER GRAF: And I'm just going to tag onto that maybe moving cost --- a higher elevation to cost could be revenue. Because, I mean, that's the opportunity piece that I think he's talking about.

So, new revenue in terms that could be driven by clinical efficiencies and expanding provider capacity. So, it's the opposite of cost, but still financial.

CO-CHAIR HOLLANDER: Okay. So, should

--- so, then now --- so, that raises the issue should cost not be the domain, should financial impact be the domain?

MEMBER GRAF: That's where I was going. Because you can't fit these others in if you just say "cost."

CO-CHAIR HOLLANDER: Oh, my god, you're revisiting the morning. So, just proving Jason's point, we could go backwards, too.

So, is that the consensus? We should change that to financial --

MS. MEACHAM: Does productivity fit under financial? Because I think productivity is actually one thing that we would really like you guys to get at, the productivity cost.

CO-CHAIR HOLLANDER: It could.

CO-CHAIR WARD: Say that again? What, Megan?

MS. MEACHAM: Productivity cost, absenteeism, miles traveled/saved, et cetera.

CO-CHAIR HOLLANDER: Henry.

MEMBER DePHILLIPS: I'm going to go

back to being a lumper on this one. Maybe I'm an idealist, but when I think about cost effectiveness, I've --- in my mind, I've included all of those things.

I've included the opportunity cost. I've included the productivity savings, you know. If we --- again, our world if we offer telemedicine benefit to a large employer and their employees now don't have to leave work to go get it, the cost effectiveness of the offering not only is the medical cost savings, but it's the productivity improvement as well.

So, in my mind, cost effectiveness does encompass a lot of these other things. So, I don't know that we need to split them out. I'm going to come down on that side.

CO-CHAIR HOLLANDER: Okay. Steve.

MEMBER HANDLER: Also, I might get tomatoes thrown at me, but there also could be incremental cost increase, right? So that services --- telemedicine can increase cost. We should capture that.

So, you could do telemedicine and still need to go to the emergency department, et cetera. So, we should make sure that we capture the upside.

CO-CHAIR HOLLANDER: Well, that's where I think financial impact is --

MEMBER HANDLER: The bottom line, it has to go in both directions.

MEMBER GRAF: And while I agree conceptually with what you're saying, financial impact to an audience of accountants and bean counters is going to not play the same way. They'll think cost.

CO-CHAIR HOLLANDER: So, I'm starting to wonder whether the subdomains here should actually be financial impact to who rather than what.

The paragraph is the what, and the opportunity cost and the efficiencies, but the financial impact is to the patient, right? Do you save parking? Do you save gas? Do you have --- save time? Do you have more days of work?

To the provider, it might actually be --- it might be more expensive to buy a telemedicine license and do it from your facility that you're paying for anyway, you know.

So, there may be different costs to the patient and their family members and caregivers, to the provider and their whatever, to the health system, and to the payer.

And so, maybe it's about who experiences the cost and not what are the incremental costs.

MEMBER GRAF: And I would argue those are the subcategories.

CO-CHAIR HOLLANDER: Yeah.

MEMBER GRAF: And then you build below those, because every one of those is somebody who's got skin in the game.

CO-CHAIR HOLLANDER: Right. Henry, you seem like you're going to have a heart attack soon, so --

MEMBER DEPHILLIPS: Sorry. Chest pain is a terrible thing.

I don't disagree with anything Don said about the impact to the patient, impact --- but I want to make sure we don't lose sight of the overarching concept that certain applications of telemedicine reduce cost to the system. The system being accommodation of people that are paying for medical care, and I want to make sure we don't lose sight of that.

We can subdivide it into who in the system is saving what, but I want to make sure that the cost savings to the system is really the overarching concept.

CO-CHAIR HOLLANDER: So, under the financial impact, then, you're proposing there's an overall cost to everybody, right?

It's not even necessarily the system, per se, because it's the patient, you know, and their out-of-pocket costs, which Don may not consider part of his system, and then each of the incremental components.

MEMBER DEPHILLIPS: Yeah. Let me just --- I'll give you just a real concrete example.

So, in our world, we took $440 million out of the cost of medical care for the people we served last year.

Each of our different clients wax up that savings between the client and the member, right? The copay could be five or 40, right? So, it varies --- who saved what, varies, but the bottom line is we took $440 million of unnecessary cost out of the medical system for our clients last year.

That's the notion I want to make sure we don't lose sight of.

CO-CHAIR HOLLANDER: Yael.

MEMBER HARRIS: So, building on that, I think the cost --- I'm not comfortable with the cost to the patient versus the cost --- basically, saying what Henry said.

First of all, patients may be willing to pay more. The couple times I've used telehealth, it's not covered by my insurance, but I've paid for it because it was so much more convenient. And I didn't sit there counting out

how many miles I was putting on my car and how much gas mileage, it was the convenience -- I could have put off how much time I took off from leave from work. It's so hard to calculate. I think it's the cost overall because had I not gotten that care, what would have been the downside?

And then as far as cost to the provider, I keep thinking back to that study Marcia referenced that we were working on.

One of the measures we didn't --- we kind of recommended, but really doesn't exist, was cost of avoidable care, but avoidable care to whom?

And the issue was, we were measuring it by would the patient be transported by car, like nonemergent; would the patient be transported by ambulance, kind of emergent, but not crisis; or would the patient be transported by ambulance, crisis, emergency?

And so, the cost, then, who does it go to in terms of, you know, the --- if it was ---

it's a judgment call, first of all, whether it's emergent or not. But, second of all, if it's not emergent, it's to the patient, because it's their car.

So, I think it gets to this point of if I were developing that measure and drafting that measure, which subdomain would I even put it in?

CO-CHAIR HOLLANDER: Eve-Lynn.

MEMBER NELSON: I think just thinking about the cost to the distant site as well I know, you know, I've brought up presenters before, but sometimes they're giving their time. So, it may not be --- it may be harder to quantify, but just the space, the time, the community cost associated with helping support the provider-to-patient encounters.

CO-CHAIR HOLLANDER: Chuck.

MEMBER DOARN: I was thinking of small hospitals that if a telestroke network always advises, you know, they need to be transported to the bigger hospital, the smaller hospital suffers

because they don't keep their beds hot.

So, there could be a loss --- I mean, there could be a downside to this whole thing is that you could actually close smaller hospitals. I mean, we already see that anyway.

The other one is a return on investment. I mean, a lot of times when you talk to a business person and say, "Well, I want to put in, you know, $200,000 of direct and indirect cost or fixed and variable cost to build this telemedicine system, and it's going to cost me so much for people and so much for hardware," the person is always going, "Well, how long is it going to take me to recoup money back?"

They don't ever ask you about how you going to --- you know, that's the opportunity cost I mentioned earlier. How you going to, you know, how's it going to benefit the overall system?

And one clinical department in the university may be all about doing this, another one is like there's no way we're going to do

this, but they actually would benefit from that, you know.

You see these --- the telestroke carts in the emergency room, they --- I have a surgeon who wants to actually use it for something completely different and no one even thought about that when they bought it.

So, I think sometimes the business side of the telemedicine, or at least within an academic health center, they always look at what's the return on investment and they never really think about these other things.

CO-CHAIR HOLLANDER: Okay. Don, then Paul, then Dale.

MEMBER GRAF: And add to opportunity cost to opportunity loss, so when we talk about the originating site being a presenting site and getting little, or, if anything, and not using that exam room to generate, you know, new revenue.

The other being, you know, FQHC resistance to wanting their providers to

participate in an echo clinic, because how many patients could they be seeing.

So, there's always that sort of business model and the opportunity lost associated with how they're kind of constructing and, you know, engaging in telehealth.

CO-CHAIR HOLLANDER: Paul.

MEMBER GIBONEY: I agree that some of these things, kind of like Yael was saying, that it's hard to measure, there's so many different factors, but I don't think that's a reason to leave it out. Because just because we can't measure it well today, doesn't mean it's not important to flag.

I mean, there are true costs to the patient or cost savings to the patient with this. Even though we got a hard time quantifying that, I think it's still important to put it in the framework to acknowledge it so that if there are measures that can be developed in the future that can capture at least pieces of that, just their transportation costs, or just their time off of

work costs, or just, you know, it may just be looking at a very small piece of that, but it's critical to leave it in the framework, because it is a real cost.

CO-CHAIR HOLLANDER: Dale.

MEMBER ALVERSON: Another part of the subdomains, because this comes up a lot and some of the efforts actually has to do with community economic development, it's an indirect benefit.

In other words, they talk about if we had telehealth, get better --- we have --- get better access to that service, we have a healthier community, we can build our economic base in that community by having telehealth services.

So, some of that has to be captured in this, is this --- and I don't know what you'd call it, but it certainly is the indirect impact of --- for economic development in a community.

CO-CHAIR WARD: So, I'm hearing a lot of different components to cost or financial impact here.

I am also hearing something that I think is maybe pretty parallel to the way we ended up structuring access.

And since I work with a whole bunch of health economists, I know a common approach that they take is cost to the patient, cost to the provider, cost to the health system, cost to society and they often figure out how you take something and you divide it into those buckets.

So, I know that if we do that, it will resonate with at least some group and it seems parallel to what we did with access.

Angela.

CO-CHAIR HOLLANDER: Okay. So, Don was first and then --

CO-CHAIR WARD: Angela was up before. That's why I --

CO-CHAIR HOLLANDER: Oh, okay. All right. We'll do Angela, Don and Kristi.

MEMBER WALKER: I do like the parallel way to look at things, but here's another way to consider it: Cost of care; opportunity lost or

opportunity cost; downstream cost, which would be things like the hospitals closing; and cost savings.

CO-CHAIR HOLLANDER: Would that be the paragraph that frames this, or would that be the subdomains?

MEMBER WALKER: Potential subdomains.

CO-CHAIR HOLLANDER: Okay. Don, I think, was --

MEMBER GRAF: And I'm thinking sort of backwards or bottom up or however we talked about it before and I think about the transportation cost savings to the systems, I think of lost wages from a member perspective, a time out of school and its impact on grade performance, you know.

And so, I can't help thinking this is --- when we start plugging in the actual dollars and cents that I use in pitching any telehealth program and put it -- can I put it in a P&L, I can't help thinking that maybe that's where we need to start and that the rest of it will sort

of percolate.

And it might percolate to the very things you just mentioned, but --

MEMBER WALKER: I was thinking it would.

MEMBER GRAF: Yeah.

CO-CHAIR HOLLANDER: So, I mean, is it important to overall change the word "cost" to "financial impact" and not have "cost" anywhere in it, it's just "financial impact"?

And that allows you if it's financial impact to the patient, to take into account these opportunity costs and travel savings and work stuff right there because they're not just money spent, it's financial impact.

Kristi.

MEMBER HENDERSON: Yes. So, I definitely like the financial impact, but, Marcia, to your categories, I have written down the same and societal was one of them, but then I did --- layered it with direct or indirect costs.

So, I think we're all kind of going to

the same direction with those four different categories.

CO-CHAIR WARD: So, cost to patient, which in our language would be the family; cost to the provider, which broadly would be whoever the provider is, so it could be ambulatory, inpatient, could be the hospital, whatever --

CO-CHAIR HOLLANDER: Or the care team.

CO-CHAIR WARD: Care team. Financial impact to the health system, and then financial impact to society.

MEMBER DARKINS: I just --

CO-CHAIR HOLLANDER: Adam.

MEMBER DARKINS: I was going to ask Jason in terms of creating a framework, are there existing ways to look at this from NQF? Because one of the advantages of creating a framework is it has comparators.

If we end up creating something which is really loose, all over the place, and we just sort of say, well, here's a recommendation, what then is used as that framework to then put some

kind of systematization discipline in it?

MR. GOLDWATER: All right. So, we can look at other frameworks that we've developed in the past. You know, there's ones that have already been completed. So, we have one on health IT and patient safety, which we completed last year, which had many more subdomains and far more concepts than I think we're probably going to get here, but that's a much broader, you know, there are a number of different moving parts.

There's also a foundation from which to begin, because there was already research on a sociotechnical model of how to base that, plus ONC already funded a health IT and patient safety center.

So, I think, Adam, there's nothing that I'm hearing now or looking at that would not be effective if it was fleshed out more.

I think changing cost to financial impact makes a tremendous amount of sense. I think where I was, you know, personally getting a little wary is when we start sort of getting into

the fine tuning of financial impact like opportunity cost or productivity loss or things of that nature, you know, those are too refined to be a subdomain. Those are measure concepts.

And I think, you know, the four that Marcia laid out; impact to patients, to provider or, I guess, to care team, the health system and society, I think all of those other things can fit into these, which is really the way you want to go.

So, I think your point is well-made, but there's nothing in here I'm looking at that would prevent this framework from unfolding and being implemented.

MEMBER DARKINS: The reason I just quickly ask is, one of the things which has beset this whole field has been inability to release systematic look at costs.

So, if there was a way to make it more systematic that means comparators could be made, I think it would be a great help.

MR. GOLDWATER: Right.

MEMBER DARKINS: That was all.

MR. GOLDWATER: Well, one of the things I would probably tell you all is if you look at that slide, the very last bullet, you know, those were gaps that you all mentioned and that were referenced in the literature that don't exist at the moment in terms of measurement.

So, how do we look at family-centered care in telemedicine? What's the standard of care versus the standard of care plus telemedicine? What would a patient do in the absence of telemedicine?

I think all the subdomains you have put forth cover those areas. And I think the concepts that will come from that, will cover those areas.

MEMBER DARKINS: So, I don't want to belabor this, but, Chuck, didn't Rashid do a publication on looking at cost?

(Off mic comment)

MEMBER DARKINS: I think it was something in the last ten days.

MEMBER DOARN: There was a report. He did write a manuscript recently on a couple of different --- and the empirical evidence ones for sure have been recent, but there wasn't --- I don't remember exactly when --

MEMBER DARKINS: Well, I didn't want to take us back into sort of, you know, past history --

MEMBER DOARN: No.

MEMBER DARKINS: -- but I did think having looked systematically, somebody trying to make a systematic approach to looking at costs, maybe that would be something we could share as a framework that sort of fits in, if that makes any sense.

MEMBER DOARN: Yeah, and I think if you --- that's why I was saying in the very beginning if we went back -- in this particular area and went back, you know, maybe back into 1995-2000 time period, there are probably, you know, half a dozen articles that might add value to this discussion versus all eight articles that

were --

MR. GOLDWATER: So, Dr. Bashshur is on this committee. But because of his health, can't physically travel to be here.

So, he seems like a wonderful human being from his email contacts and we send him our documents and he writes back.

And they're long emails, but he referenced his own work regarding cost and said essentially the same thing that if you need a foundation, we've written this and this and this and this.

So, I think, again, to get back to when we started this, when we start unfolding these measure concepts and start fleshing them out, you know, some of the additional literature that we will probably include will provide a foundation for that, an evidence base.

So, that's not to say, Chuck, we're going to limit --- I'm not going back to 1972, I'm sorry. That's --

(Off mic comment)

MR. GOLDWATER: But I will, you know, certainly if --- we'll look at Dr. Bashshur's citations with respect to cost. Because even though we, you know, had a limit as to what we were going to look at again because of time constraints, I think that we can, you know, find an article that sort of justified these domains and subdomains and really provide an evidence base for cost.

CO-CHAIR HOLLANDER: So, four more now and then we're taking a break. If you put you thing up, we're ignoring you after this. So, we'll run from Eve-Lyn on down this way.

MEMBER NELSON: Sure. Make me follow Chuck.

I think the financial impact to society is especially helpful for the echo measures especially looking at, you know, workforce or tension, those kinds of things. So, thanks for including that.

CO-CHAIR HOLLANDER: Henry.

MEMBER DEPHILLIPS: Just to help me

connect the dots, the four domains, again, were; cost to patient --

CO-CHAIR HOLLANDER: Financial impact.

MEMBER DEPHILLIPS: -- financial impact. I'm fine with that.

CO-CHAIR WARD: Financial impact to patient/family, financial impact to the care team --

MEMBER DEPHILLIPS: Care team.

CO-CHAIR WARD: -- financial impact to the health system --

MEMBER DEPHILLIPS: Health system.

CO-CHAIR WARD: -- financial impact to society.

MEMBER DEPHILLIPS: Okay. Help me connect the dots.

Harvard Medical School researcher studies one of --- a client of ours. It's a 50-state home improvement retailer whose logo color is orange, but I can't mention the name. They save $21.30 PMPM after --- 18 months after implementing.

The cost of the self-insured employer, the cost of care that that company pays for its employees and dependents, $21.30 PMPM, which is some number of millions of dollars.

How does that get captured in this framework?

(Simultaneous speaking)

CO-CHAIR HOLLANDER: So, I'm pretty sure there's never going to be a measure asking does Home Depot save money?

MEMBER DEPHILLIPS: I didn't say Home Depot.

CO-CHAIR HOLLANDER: So, but whatever. So, it's really, you know, what are the measures --- so, you know, what are the measures designed for? And they're designed for care providers.

So, as a company that sells to employers, the measures may not be designed to does a single employer save money, but it probably could fit under the system.

So, by saying what system, what payer, the payer might be United or it might be a --

MEMBER DEPHILLIPS: Fair enough. The fact that several people went right to health system gives me great comfort. Thank you.

MEMBER GRAF: And my question is also a connect-the-dot question, but it's more specific to societal measures.

Any examples that I can wrap my head around? None are coming to mind right off the top.

CO-CHAIR WARD: So, in my listening to health economists and having tried to write some things on this, they actually talk about societal including both the patient and the provider, in this case, the health system. All three would capture --- societal would bundle all those three, because it's the biggest.

And so, when you do a financial analysis, you pick a perspective that you're going to take to do your financial analysis.

And so, if you're an insurer, that's your perspective. If you're a hospital, that's your perspective. If you're an academician, you

might be looking at, you know, patient opportunity costs or avoided, you know, travel times and saving on sick leave and stuff like that.

So, you pick your perspective and that's --- that was what I was thinking of when I suggested breaking it this way, because that's a common way to do it.

MEMBER GRAF: So, I get that from a perspective standpoint, that it really is sort of a societal --- more of an overarching. But in this context, we have it separate from those.

And so, are there separate --- or is it really societal and then provider, patient, and system fall under that?

CO-CHAIR WARD: So, like Chuck was talking about, a hospital closure. And a hospital closure in a community if it's an independent hospital, it ---

MEMBER GRAF: Okay.

CO-CHAIR WARD: -- you may not think just the --- it may not specifically be a health

system, but it's what's the impact on that in the community, their economic development? All those sorts of things might come into the societal perspective.

MEMBER GRAF: Thanks. That helps. I had forgotten about that.

MEMBER GIBONEY: And I just want to throw in like cost to jail systems, you know. Like if you're doing a substance abuse telemedicine intervention or behavioral health, the societal cost to keeping people out of the jails or other, you know, kind of societal --- I mean, there's any number of societal costs you can think of after a telehealth intervention.

CO-CHAIR WARD: Okay. So, the question is, are people comfortable with those four buckets for --- then you get to have a break.

MR. GOLDWATER: Wait. So sorry. I'm not, actually, but I just want to run through the domains --- the subdomains to make sure that we've adequately represented them.

(Off mic comment)

MR. GOLDWATER: Well, I just want to make sure right now we've got it adequately worded, represented so that when we get back and we talk about the concepts, we all know where we're starting from.

CO-CHAIR HOLLANDER: I think I have the exact ---

MR. GOLDWATER: We'll type them during the break.

CO-CHAIR HOLLANDER: Okay. So, I think I have the exact wording we came up with. So, under access, there was access for patients or families ---

MR. GOLDWATER: Uh-huh.

CO-CHAIR HOLLANDER: -- and the As in parentheses. Access for care team, and we changed it from "network adequacy" to what?

MR. GOLDWATER: To information.

CO-CHAIR HOLLANDER: No. No. No. It was care team and --

(Simultaneous speaking)

CO-CHAIR HOLLANDER: Okay. So, access for care team.

MR. GOLDWATER: Uh-huh.

CO-CHAIR HOLLANDER: And then network adequacy, as it used to be defined, is included in the definition.

(Off mic comment)

CO-CHAIR HOLLANDER: I know. We're going to change the word. Right. Access to information is the third.

MR. GOLDWATER: Right.

CO-CHAIR HOLLANDER: And financial impact, we just read those. Financial impact to patient, family or caregiver, to care team, to health system or payer, to society --

MR. GOLDWATER: Uh-huh.

CO-CHAIR HOLLANDER: -- an experienced patient, family or caregiver, care team member, community. For effectiveness, they all end with effectiveness, system, clinical, operational, technical.

MR. GOLDWATER: That's what I have.

CO-CHAIR WARD: We are good.

MR. GOLDWATER: You guys are incredible, really.

CO-CHAIR HOLLANDER: Everybody take an extra minute.

(Whereupon, the above-entitled matter went off the record at 3:07 p.m. and resumed at 3:35 p.m.)

MR. GOLDWATER: All right. the point of the meeting now where we are going to -- we're at the last phase here, so we have brilliantly gotten domains and subdomains in a much faster and more consolidated way than I -- we ever envisioned possible. We were rehearsing every conceivable scenario, and this was not one of them.

We thought oh, there will be 16 or 18 of these. We're going to have to get them into groups and take notes, and then we're going to have to go back and we're going to have to argue, and really, I mean, if I could put you all in my pocket and take you to every meeting I have, I

would do it in a minute. Not you, Angela --

MEMBER DePHILLIPS: If you prefer --

MR. GOLDWATER: -- but everyone else.

(Laughter.)

MEMBER DePHILLIPS: If you prefer, we can start throwing chairs, you know, Geraldo --

MR. GOLDWATER: Well the thing is that May and Irvin have not -- I don't think they have been in a meeting, and I am like this is not always how it goes. This is the -- this is the ideal, but this is not always how it goes, so --

CO-CHAIR HOLLANDER: Unless you want to do a lot of other committee meetings, stop --

(Laughter.)

MR. GOLDWATER: No, so we -- I mean, in all seriousness, we do really want to thank you. This has been incredibly productive, and I think we feel really good where we are and where we are going and what this is going to be.

But now we start getting into the point where we're going to develop measure concepts, so what I want to do, I -- we were

going to break into groups, but I don't think there is a point in doing that now. Because you all are working so well in a large group, I don't see why we would break you all up, unless the fighting begins and Judd starts throwing chairs and cursing at people, which he is apt to do. Kidding.

So what I want to do is sort of talk about what a measure concept is. I know, you know, some people like Marybeth and Yael who have -- and certainly Marcia who have developed measures understand this, but for the rest of you, just so we're all on sort of the same basis, a measure concept is not actually a quality measure. So a quality measure has very steep components. It has a numerator, it has a denominator, it has exceptions, it has exemptions, and then ultimately it produces a percentile which lets you know how far you are moving towards quality.

A concept is not a measure. A concept is an idea for a measure that at the moment does

not exist. It is important as we sort of go through this that the concept does have to relate to the -- one of the subdomains. It can't be something that is somewhat kind of related to the subdomain, but not really. It has to directly relate to that, because envision yourself as the user of this. You would be looking at basically a map, and it would be saying here is a subdomain of access, here's some measure concepts that could be developed into measures. You want it to flow very sequentially, very logically.

The concept does need to specifically, as much as possible, be related to telehealth. It goes back to Adam's comment at the beginning. We are not trying to solve the problems of healthcare. It will fall and collapse under its own weight. We are specifically talking about telehealth.

The concept also cannot be incredibly broad, like we want to -- you know, the measured concept is opportunity cost due to telehealth. That is a little broad. You have to make it a

little bit more specific so that somebody can look at that and say, oh, I could take this and make a numerator, make a denominator, and create a measure.

Next slide. So when you are developing and evaluating measure concepts, so this really sort of came up in our last meeting that we talked about sort of the different dimensions. Now, we are not -- you are not beholden to these, but as you develop concepts related to those subdomains, some things that you all talked about should be in part of these measures are the infrastructure capacity; the appropriateness of the measure, it does relate to telehealth now and in the future; potentially therapeutic outcomes, including diagnosis, and that would be specific to certain subdomains; looking at patient outcomes; and also that the -- most importantly, the measure concept has to be actionable so people could look at it and create the measure, and that preferably, you know, you have the capacity, it is appropriate, it deals

when necessary with therapeutic outcomes or patient outcomes.

And so the prioritization of these concepts, and again, going back to our last meeting, it is, you know, what are the most critical elements or dimensions of that measure concept as you're building -- thinking through that? What really becomes the critical area you are looking eventually to measure? What would -- what is its potential to drive improvements? How easy would it be to implement? And then, as I said earlier, if this became a measure, is there data available to populate the measure? Because if that data is impossible to get, the measure would not be useful.

And again, going back to Angela's comment, if the data is not available now, do you think the data will be available in the future? Reference that because we will include that in the report. And then, again, think because of your experience, we have gone over these subdomains, so as we look at things like, you

know, financial impact to the care team, what gaps currently exist, you know? Where is there not a measure? Where do you think that would be -- where would that be -- how could that be filled in a way that would be effective and important and really have significance?

We don't want to be duplicating measures. We don't want to be piggybacking on measures that already exist. We don't want to be copying anything. Now, as you come up with measure concepts, if the NQF team identifies measures that actually map to that, which I don't think we're going to find, but in the event we do, we will tell you that tomorrow. Like oh, there's a concept? Well here is a measure. What do you think?

I don't think that is going to happen because really what you have covered so far are very specific to telehealth, and there are significant gaps in measures, but again, you want a measure that is going to fill a gap because that makes the framework actionable and very

significant.

So with that in mind, I will turn it back to our cruise directors, who will lead the discussion on measure concepts. Do you want to go to the slide that we -- previous to this? Again, going back to Judd's comment, we are always on the slide that we're not on. Right, okay, good. So I guess we could start with access to care.

MEMBER SPIEGEL: Is it possible to send this slide out?

(Pause.)

CO-CHAIR HOLLANDER: So -- so I actually -- because, you know, we were so excited we were so efficient, we actually forgot to discuss how we were approaching this session. But -- but -- you know, at the break, but one of the things that I just asked Katie to pull up is I thought it would be good for the people in the room that -- that have not seen the measure evaluation process to get a quick look at what the tool is and the flow chart as to what items

measures are evaluated on, so we're just trying to pull up that slide quickly.

It is just a couple items, and I think it will, you know, basically make it a little more concrete how we're going. And I apologize I hadn't thought about that in advance, but --

MR. GOLDWATER: You are forgiven.

CO-CHAIR HOLLANDER: Oh, okay. All right. So -- and Marcia suggests we sort of begin with experience as the easiest thing to do, to begin with, again, and I will ask the question of Jason, and I will throw it out as a strawman thing I could get right or wrong, that I am not sure the measure needs to fit into one or only one of these domains. It could span other ones, and so it may not be important to say oh, is that access or system effectiveness? It is just that the measure fits within overall the things we think are important to look at.

MR. GOLDWATER: Yes.

CO-CHAIR HOLLANDER: And so it looks like this is a slide taken from another group

that is reviewing measures --

MR. GOLDWATER: Yes.

CO-CHAIR HOLLANDER: -- and I am sorry. This one, Daniel, it looks like is just going to be on the central monitors, but we will be on and off this, you know, pretty quick.

So these are the items that show up. So the first is, you know, does anybody care? Is it important to measure and report? So if everybody decides that it is not important and it fails this, nothing else on the slide matters, so people need to believe it is important.

And -- and I think -- I am doing this off the top of my head -- at some point, within the importance category, you assess is there a gap? Like if we are 99 percent effective in this, it might be important, but it does not really need to be measured because you're not going to get improvement, and so you really look for some variability that suggests you can do it better, but other people are doing it not -- not as well. And so this is, you know, sort of a

little bit of, you know, just is it important.

Then there is a -- a sort of structured assessment where the measure developer submits data that shows the measure as they propose is reliable and valid, and so, you know, it is the same concepts of reliability and validity you learned at, you know, all through school: are you able to measure what you want to measure, and does it represent what you want to measure?

Then -- then it gets to feasibility, and this is an area where some of the discussion we had already we say, well, you can't really measure that, so no one is going to propose a measure that can't be measured because if it is not feasible, the measure, it is not actually going to get through that portion of it. It does not mean the framework can't be broader. It just means until it becomes feasible, nobody is actually going to be able to get a measure.

Usability and use is really can you get the measure and use it? And then -- then

there is a comparison or -- or harmonization with competing measures so that it is -- is it different enough that it is worth measuring again? And somehow, 2500 measures got approved that are different enough it is worth doing a little different, so sometimes, there's little shades of gray, and sometimes there's not. But is this -- it is only this slide, right? Is there a next slide, or is there not?

Yeah, so -- so this is the basic concept. So really, it has got to be important, and you've got to be able to do it reliable -- in a reliable and valid measure, and you have to be able to do it. Those are the three big buckets, and so as we are now looking at measure concepts, we -- we want to make sure to come up with ideas that, you know, have some degree of importance and that everybody could agree or we can test for reliability and validity, because unless you show testing for reliability and validity, the measure is never going to get to the stage that it passes.

Is this -- people think this is helpful, or did I just confuse everybody? Okay. All right. So then we can go back to now discussing the measure concepts within the experience category, which while the slides are going up, was -- oh, they are up. Okay. So I don't know. I mean, Jason, maybe it would be a good idea for you to throw out the first -- you know, a theoretical measure concept on this?

MR. GOLDWATER: A theoretical one?

CO-CHAIR HOLLANDER: So just to start the discussion.

MR. GOLDWATER: So I guess we can talk about access of -- to care --

CO-CHAIR WARD: Experience.

MR. GOLDWATER: You want to do experience first?

CO-CHAIR WARD: Yes.

MR. GOLDWATER: Okay. Well you're really putting me on the spot to think of a concept. That is what you're supposed to do, not me. What? Communication? Okay. Right, so --

right, so a concept -- right, that is -- thank you, Marybeth. You are now my favorite committee member. So a concept could be that the use of telehealth facilitates greater communication between a patient and a provider.

That is very hypothetical. Don't use that. That is just -- that -- but again, it is not -- it is specific, but broad enough that it can be fine-tuned into a measure.

MEMBER GIBONEY: What about a measure of confidence in my plan of care as a -- as a measure? Like some sort of, I don't know -- I don't know if you want to get into details like a Likert scale, 1 to 5, or something like that, of like, you know, because of whatever this health measure, I feel confident that --

CO-CHAIR HOLLANDER: So I am going to think in a way now of, you know, a little different, having someone that has sat through some of these measurement things, and say, well, that is probably not measurable because we don't -- we can, but then we would have to ask

everybody their confidence, and so it is not likely to hit the feasibility points.

Now, on the other hand, you -- you could actually take that and say something about are patients more likely to carry out their plan of care? And you could measure that in terms did they get their prescriptions filled, so are their prescriptions filled within 24 hours of a visit, you know? And then maybe you could get a different experience between an office visit and a telehealth visit, or show it is just as good.

But now, as we are coming up with these concepts, I would say think in terms of something that you might be able to measure from -- you know, Jason I think also does the eMeasures. It is easier if it is something we can measure electronically by merging databases from places to do that, but if you know of surveys like a Press Ganey survey --

MEMBER GIBONEY: Well, that's what I was thinking --

CO-CHAIR HOLLANDER: -- that goes out

--

MEMBER GIBONEY: -- they -- they ask questions just like that on Press Ganey surveys.

CO-CHAIR HOLLANDER: So then you may be able to be doing that.

MEMBER GIBONEY: Yes.

CO-CHAIR HOLLANDER: Chuck?

MEMBER DARKINS: That was what I was thinking, you know, a survey, you know, you get back from a Delta Airlines flight, they send you a thing, you get back from a Ford dealer, they send you a thing, you leave the doctor's office, and they send you a thing: how was your experience at UC Health? And so you -- you know, you sort of fill in the blanks, you know. They ask you five or six questions, you know, how was the doctor, how was the office visit, you know, was the temperature just right, you know, do they serve you espresso -- just kidding. But I mean it is -- that is -- you get that data very quickly.

MR. GOLDWATER: Let me just interject

for just a second, I am sorry, only because I think some people think of measuring quality as you're measuring the activity or the action of a provider to a patient, and typically -- I mean, there's plenty of measures that do that, but there's also the ability for a patient to look at measurement from a patient perspective. So patient-reported outcome measures is really a very big topic in quality measurement because it gets to the patient's point of view and really looks at outcomes and their effect on patients, and the ability to collect that data for these types of measures typically come through some sort of standardized instrumentation, whether it is a survey or some other mechanism to gain -- so for depression, for example, they use the PHQ-9, and that way they are able to evaluate a patient's perspective on depression and then make the proper treatment protocols as a result.

So don't -- when you are thinking of concepts, it can be a provider action or a patient action as well.

CO-CHAIR HOLLANDER: Okay. Don and then Henry?

MEMBER GRAF: So I am going to use a Medicaid mandate example. I am going to pick on New Mexico and suggest to you that part of the requirements in that state -- I am probably not going to get them all, but it is duplicated, unduplicated count of services by county, Native versus non-Native-American populations, behavioral versus non-behavioral, urban versus rural versus frontier counties.

So -- and those are just like reporting requirements today that mostly come from utilization -- or, you know, claim databases and things like that, but those are just examples of what came to mind. Thought I would share.

MEMBER DePHILLIPS: Just throwing this out since you started on experience, patient, one -- a couple concepts that stem from the earlier discussion, Jason, comparing current standard of care to standard of care plus telemedicine. Patient demonstrates a greater understanding --

is able to demonstrate a greater understanding of their care plan, that is probably something that is measurable, and patients have greater compliance with their care plan. In other words, they complete their care plan a greater percentage of that time. That is probably also measurable.

CO-CHAIR HOLLANDER: Daniel?

MEMBER SPIEGEL: I actually had those two exact concepts written down, so I second that. I don't know if this falls under patient experience or under maybe system or technical effectiveness, but something around privacy might be important as well, and you can measure that in terms of whether a patient feels that their privacy is protected, in a Press Ganey survey, for example, or you can measure that in some maybe more systematic way.

CO-CHAIR HOLLANDER: Peter, is that a hand almost going up? No? Okay. Yes?

CO-CHAIR WARD: I think with experience, as Jason said, there's a lot of

existing measures out there, but I think specifically to telehealth, because it has got technology, something about the technology working, the experience of the technology working in a satisfactory fashion for the clinician to do their job for the patients to feel comfortable with it would be a new concept.

MEMBER RASMUSSEN: Yes, I would, you know, echo that one, as we do a lot of scheduled telemedicine visits with patients, and there is -- that is a frequent concerns I hear from providers is that there is some technical glitch. That would be a -- that would be a great one to add on.

CO-CHAIR HOLLANDER: Yes, Sarah?

MEMBER SOSSONG: So I am just looking at the patient survey that we have done, and so we have things like, you know, did you have a technical problem? And then we have a breakdown of areas. So are we trying to just describe this at a high level? Or I think to the kind of -- we do ask also CG-CAHPS questions, like, you know,

did you see your provider within 15 minutes? Did the clinician explain things in a way to understand?

Do we not want to repeat if it is something that exists elsewhere, or is this supposed to almost be a comprehensive list of all -- is this supposed to be a comprehensive list of all the potential things that could be included there? I am just confused on ultimately what the end product should be.

CO-CHAIR WARD: I think both. I think where there's existing measures that they apply, we should think about those, and then when there are not existing measures that are specific to telehealth that need to be developed, that is another area, so I think it is both.

CO-CHAIR HOLLANDER: I think what -- you know, what I am hearing on the experience side is actually ease of use and ability -- and to me, a very measurable thing from my past experience is whether the patient, we call it self-sustaining, but whether the patient and the

provider could hop on without having a person sitting next to them or calling them and telling them how to download an app and use it is really a huge experiential thing that might actually even overlap, you know, cost and cost-effectiveness and some other areas because it is really costly to have somebody run around and handhold the provider and have somebody call each patient that wants to do a scheduled visit and make sure they can download it and do test visits, which, you know, we have done stuff like that over time.

So I -- I think maybe it is -- I don't know the right way to turn it into a measure, but, you know, how many resources are needed for the patient to satisfactorily conduct the visit on their own, or can they do it with no additional help, which is sort of a binary yes/no decision, and in fact, that probably would be something that could be done electronically because there are -- within the telehealth platforms that I am familiar with, if they are

doing a test visit, there is a no-charge visit the day before, then there's a charge visit the next day, we probably could pull out how often is there a no-charge visit within 48 hours prior to a charge visit and see how much work and practice is involved. Or how often are there two or three visits with the same provider on the same day, meaning there was a technical glitch in the first or second call with the same provider?

So we might be able to dig out some of those experiential things from the telehealth platform, or at least some of the direct-to-consumer ones.

MEMBER MOEWE: I was thinking too about -- thank you. I was thinking more around like the connectivity issues. Is somebody calling in at the right time? Like if you are meeting with your provider, you could actually measure that with whatever system you're using.

Like one of the things that is frustrating when you are on conference calls is people don't all call in at the same time, so

they are not there, so it is important that if you have an appointment with your provider at 11 o'clock, that he is on the phone at 11 in the -- I mean, these are measurable things, and that the connectivity is clear, you know, the conversation is easy to understand, and these are things that I think could be measured pretty simply.

CO-CHAIR HOLLANDER: Maybe it is as simple as duration of the visit, which could be measured from when you show up in the office for an in-person visit to when you get your discharge instructions for an in-patient visit, as to when you get on the video for a telehealth visit and get off the video with a --

MEMBER MOEWE: Right.

CO-CHAIR HOLLANDER: -- telehealth visit --

MEMBER MOEWE: And --

CO-CHAIR HOLLANDER: -- so --

MEMBER MOEWE: -- and were the instructions clear to you? Because I think that is something many patients, even from a face-to-

face visit, don't take away, their clear directive as to what are my meds, when do I take them, do I understand when I am going to see you next, you know, all those things are measurable things that you could ask a patient.

CO-CHAIR HOLLANDER: Oh, and down at the end, Adam?

MEMBER DARKINS: I was just going to say, I mean, it seems a bit complicated. Again, I am maybe not -- just whether or not it was completed satisfactorily would be the way into this because, I mean, what would you do with all the information you have just described? You've got a plethora of different telehealth interventions that would take place in a plethora of different places, and so you would -- unless you've got the structure and process, if you just start off by saying let's -- first cut at it, was it completed as intended?

CO-CHAIR HOLLANDER: Right. So it gets to the measure concepts that we had before for the dimensions of evaluation, I think, like

did you have the infrastructure capacity to get it done, and did it result in actionable information, right? That is -- that is effectively were you able to do the call to the satisfaction of the patient and provider and then have both of them be able to act on the information, would be part of clinical experience, as well as some of the others.

I guess Jason are we supposed to drill down on specific things here, or, you know, still a -- a little clarity around, you know, what we're talking about is can you get discharge instructions, which could probably run across every disease specialty, and can you complete the meaning of the call with every disease specialty? But it is not saying -- you know, do we want to say oh, you had a heart failure, revisit within seven days?

MR. GOLDWATER: You don't want to get that specific.

CO-CHAIR HOLLANDER: Okay.

MR. GOLDWATER: Broad -- I mean,

broad, but the parameters around it are enough to where you can conceptually look or think of a measure. So, you know, like Mary Lou was saying, you know, you can measure things like the accessibility or the availability, were they on the call, did the call last long enough for the visit to be completed? You know, those are broad, but you can measure those. There's ways of building a measure from that, and you don't need to get specific like you need to give discharge instructions seven days after a telehealth visit.

CO-CHAIR HOLLANDER: Okay.

MR. GOLDWATER: That is -- that would eventually be a measure --

CO-CHAIR HOLLANDER: Okay.

MR. GOLDWATER: -- not a measure concept.

CO-CHAIR HOLLANDER: So I would add a concept too, does it increase the likelihood of the patient showing up for the visit, right? I mean, maybe it is easier to get on a telehealth

visit than an in-person visit. Maybe they ignore it because they think it is not important. So there is some equipoise in that. What?

MEMBER SOSSONG: Does that fall under access? And that's a -- I think that is where we often --

CO-CHAIR HOLLANDER: Oh, yes --

MEMBER SOSSONG: -- group that --

CO-CHAIR HOLLANDER: -- I -- well --

MEMBER SOSSONG: -- we look at no-show rates under --

CO-CHAIR HOLLANDER: Yes.

MEMBER SOSSONG: -- the --

CO-CHAIR HOLLANDER: Paul?

MEMBER SOSSONG: -- access piece. I want to --

MEMBER GIBONEY: One of the -- oh, go ahead, Susan --

MEMBER SOSSONG: No no.

MEMBER GIBONEY: -- Sarah. One of the -- one of the big advantages of telehealth is the ability to coordinate care and improve

transitions of care from one provider to another to share that information, and the way -- a measurement of that would be asking for the patient how well coordinated was your care? You know, when you saw the specialist, did they know why you were there, and did they have your information?

Or, you know, for -- how well -- you know, because there are measures out there right now, you know, a patient sees a specialist and we only know -- we know that 50 percent of the time, PCP never finds out what happened with the specialist visit, but in terms of experience, you know, from the patient's perspective, did you know -- did -- did your providers know what was going on with your care? Or something like that, some sort of care coordination measure.

CO-CHAIR HOLLANDER: Don.

MEMBER GRAF: To your comment earlier Judd about do you know that the patient is actually going to show, we have done studies where we see a direct correlation between the

distance someone travels to an appointment and the no-show rate associated with that appointment are direct, and so that is one measure.

CO-CHAIR HOLLANDER: Yes. Sarah, Stewart, and then Adam.

MEMBER SOSSONG: So I guess going back to one comment you made, Judd, about the number of minutes, I think the one concern with that sort of measure is just the fact that it would create perverse incentives for clinicians to have very quick visits. So if it is -- so I don't know if that would be broken down by specialty, but I just want to think about the unintended consequences.

So I think to one of Adam's points about what the modality is I think would be a really important question in this point because that then really drives what are we comparing? I also think asking where the patient is is important, so are they in the home -- are they in the home, are they in their office?

We have just asked generally: did you

have any technical problems? I think there is -- you know, if we ask that question on every single visit, we get a yes 50 percent of the time because then it comes into billing, it comes into, well, my home, you know, internet connection had issues, so their audio -- so I think when we have really broken it down by something that is purely the technology, it has gotten to be very low, but we have had to be careful about how we ask that question, so I think just asking did you have technical problems, and then, to your point, did you need someone's help in order to get it, yes/no, would be enough.

But I think ultimately, just rolling them all up, you know, going back to the CG-CAHPS question around, you know, your overall ranking of the visit from a -- on a scale of 1 to 10, ends up being something that captures many of these -- these elements, but ultimately, I wonder too just if -- this is such a huge list. Is there value in, you know, all combining, what are

-- what are all of the measures that we look at in terms of these areas and cross-referencing those?

CO-CHAIR HOLLANDER: Well, we get a little bit of that tomorrow --

MEMBER SOSSONG: Okay.

CO-CHAIR HOLLANDER: -- just looking at --

MEMBER SOSSONG: Okay.

CO-CHAIR HOLLANDER: -- some measures. Stewart?

MEMBER FERGUSON: So I -- one question I had is are we just looking for lots of ideas under each of these? We are not -- this is not like the domains where you have three to four ideas, right? Okay. All right.

So one of the things, following through, we -- we do track click time from one -- certain store-and-forward you can collect from one case until they dispose of it, return it, they archive it, whatever, and we don't use it as a way to try to incentivize people to do it fast,

we just use it as a measure of how fast we are seeing patients. And it gives us a sense of efficiency. It also gives us a measure of, as we improve the technology, does that time get shorter, and will we be able to see it drop over time? So I think that's a good measure.

We did a survey a few years ago. We had hundreds and hundreds of users that had done hundreds and hundreds of cases, and we looked at people that had done 100, 500, or over 500 cases, and we asked them what was the most important thing in telehealth. And the interesting thing is for the -- for the people that create cases, the people out in the rural areas, the most important thing to them for the people that have done hundreds of cases is the response time.

So I think that is something that you really want to measure. I think people don't think about it. I think -- and again, a store-and-forward issue, but for video, it would be time to schedule, so those would be pretty critical issues.

CO-CHAIR HOLLANDER: So Dan -- Dan?

MEMBER SPIEGEL: I don't know, maybe this is a measure itself instead of a concept, but I was wondering if there is a way to get at a proxy for patient or family experience by looking at repeat use, so people who come back and use the service again. So I don't know if that is too specific, but just a thought of a proxy way to get at experience.

MR. GOLDWATER: No, that is not too specific because you could then build a measure from that on a specific condition. So --

CO-CHAIR HOLLANDER: So it could be patient retention or follow-up -- or degree of follow-up. Steve?

DR. HANDLER: So we ask a number of -- excuse me -- questions. We have a post-consult survey, and I can read it, or I can make it available, but we always ask did you discuss or review the goals of care? So we want to make sure that we're aligning. And then we ask about what peripherals or devices are used, just

generic, and that could be depending upon whatever service is being used.

Then we have ten questions that we ask about the encounter itself that asks about the audio; the video; did the resident or the patient seem comfortable; did the nurse, or, in the context of the telepresenter, seem comfortable; and then were they able to -- excuse me -- obtain adequate history, present illness, past medical history in view of systems; then a physical exam; and then other questions, satisfaction question, and then for us, the primary outcome is did this avoid an ED or hospitalization?

So we ask all those questions in line. I don't know if that is useful or not, but I think that from our experience in our CMS Innovation Ward and in other areas, it has been very useful for us.

CO-CHAIR HOLLANDER: So I think what we -- we have done is we have evolved a little bit to recognizing that, you know, what we have in domains and subdomains are not clearly a

bucket to address in these measure concepts one at a time because we're spanning things that happen, so we started with let's focus on experience, and everything we have discussed has some tie to experience, but -- but maybe since we really have public comments in about 10, 15 minutes, we should just open it up broadly to measure concepts overall, you know, pretending at least for the moment that they will span multiple categories and that is okay.

We don't have to have a measure concept that only fits in one bucket, and it may lead to more robust -- well, looking at the things going up, it's going to lead to more robust conversation right away. So Marybeth and then Paul?

MEMBER FARQUHAR: Before you leave patient experience, you know, what I am hearing is a lot of measures that will come out of the composites that are already established by CAHPS, you know, provider communication, did I get the care that I wanted to as much as I wanted to, did

I get the information, was I discharged appropriately, did I get the information I needed in order to maintain my care? And then a rating of a provider. So some of these things are already established. I think that you are talking about those in the sub-sub-sub-level versus the upper level, but that is just me.

CO-CHAIR HOLLANDER: Paul?

MEMBER GIBONEY: The response time and time to schedule would fit definitely into access as well, and then kind of going along the scheduling time, if there is identified a -- a right time for scheduling or a recommended time for scheduling, how closely did the system deliver the appointment at whatever that intended time was?

CO-CHAIR HOLLANDER: Adam?

MEMBER DARKINS: It seems to me there is a case to be somewhat strategic in this and say what are we really trying to achieve? So if we were saying what we would really like to achieve let's say is access to care between

specialty care and primary care, we ought to think kind of what is doable for a busy primary care clinic to end up doing measures?

In other words, keeping the patient in primary care, some of the things we might be adding might be very difficult. So I think what are we -- if we were to think strategically, so we've got not a very big penetration of telehealth generally, and what we are trying to see is how this would gradually expand.

There are ways in which what we could end up doing is creating a framework very much acute hospital-based which might help around the acute hospital, but might not sort of -- does that -- it seems to me, you know, we ought to be a little more sensitive to location when we think about time because if someone was traveling to primary care, hanging around for an extra 10, 15 minutes is not as easy as one might think.

CO-CHAIR HOLLANDER: Right. I think that this gets back to Henry's big concept earlier on: does usual care plus telehealth offer

benefits over usual care alone? And it could be for, you know, every disease entity known to mankind, and span these domains. It is really what is the incremental value of adding telehealth to the care of somebody with COPD or a skin lesion, a this, a that? And do that, and probably -- and it would span a lot of this. Don and then Chuck.

MEMBER GRAF: So we conduct surveys as well, and some of the questions that were asked are ones that we have as well: overall rating; average travel time and cost if you were to have seen that provider face-to-face; average work hours lost, so letting them define that; probability of repeating, coming back for a second time, and if not, why; your reason for choosing telehealth, or, you know, or, if not, face-to-face; preferences; and then delineating between new and -- and established. And by the way, do this in several languages.

CO-CHAIR HOLLANDER: Okay. Peter I -- oh, Chuck and then Peter and then Angela.

MEMBER DOARN: So I think I am on Alaska Time. It seems to me that when you look at the literature for the last ten years for sure that there are questionnaires that people have used to ask every one of these questions, so I am curious, are we supposed to develop a new questionnaire, or are you going to use existing questionnaires? I am lost at exactly what --

CO-CHAIR HOLLANDER: Yes --

MEMBER DOARN: -- you --

CO-CHAIR HOLLANDER: -- so --

MEMBER DOARN: -- said.

CO-CHAIR HOLLANDER: -- that, I can answer that. That is so the measure developer can figure out how to get it, we are just talking about some of these experience --

MEMBER DOARN: But it has already -- I mean, but it has already been captured --

CO-CHAIR HOLLANDER: But we -- we don't -- so somebody will propose a measure, and they will say this is the data we're going to access to compare, you know, Alaska to New Mexico

to wherever. Then it has to meet the criteria of domains and subdomains that we have laid out. We don't have to develop any of that. That is how the measures --

MEMBER DOARN: Okay.

CO-CHAIR HOLLANDER: -- will be developed.

MEMBER DOARN: I am back in D.C. now. Okay.

CO-CHAIR HOLLANDER: So that gets much easier. Okay, Peter?

MEMBER RASMUSSEN: Yes, I think on the access end of things, in terms of both patient and care team, addressing things like availability, accessibility, and appropriateness is, you know, very much like a telestroke program. You know, if you are running a telestroke program, what is the percentage of patients who have access to that telestroke neurologist, you know, something like that would be very helpful.

CO-CHAIR HOLLANDER: Who do we got

next? Angela is next. Don, are you up or not up?

(No audible response.)

CO-CHAIR HOLLANDER: Okay. Angela, Kristi, Dan.

MEMBER WALKER: Sure. So just jumping back to the patient experience for a second, I think as part of the Institute for Healthcare Improvement, patient experience is one of the components of their triple aim, and as part of that, they identified six features: safety, effective, patient-centered, timely, efficient, and equitable care, and I think we have addressed many of those with ideas already thrown out, but just making sure that each of those is on the record. But there would be ways to measure many of those and develop measures from it.

CO-CHAIR HOLLANDER: Kristi?

MEMBER HENDERSON: I just wanted to add the avoided ED transfer, so unnecessary emergency room transfers, and then you mentioned this, but I think you used different terms, but

around no-show rates, decreasing those.

CO-CHAIR HOLLANDER: So I would rather say, rather than unnecessary ED transfers, as the ER guy here, it is, you know, able to provide care without transferring to a higher level, because, you know, to me, and, you know, I don't want to go too much on a tangent, but if nobody else is going to take care of the patient, it's a necessary transfer. It might be avoidable, but so I try and avoid that language. Dan is up next, actually.

MEMBER RASMUSSEN: I mean, I guess sort of a follow-up comment on what Kristi said though, but sometimes, it is -- because of a telemedicine program, you are going to generate more transfers than you would otherwise. Specifically, the telestroke program, it is going to be better to get that patient out of rural ED who needs a stroke neurologist or an endovascular person, so you're, you know, going to -- so you have to be careful what that measure looks like based on the disease process that you're talking

about.

CO-CHAIR HOLLANDER: Yes, so, you know, and I don't know the trauma measures. I don't know if, you know, any NQF staff works on trauma stuff, but -- but sometimes, at least, I know they are evaluated as if you transfer someone for less than 24 hours and they live, that is a bad transfer, right? You didn't really need that patient there because you didn't do a procedure, and they went home the next day, and now you incurred a helicopter cost and made their family not see them, and there was no reason to do that. So maybe measures can be developed around appropriateness of transfer.

And again, to Chuck's point, we don't need to figure out what that is. Somebody else would have to do it, and if they didn't get it right, the measure would not be approved, but if somehow they got it right and the people who are content experts in that area approved it, then it can get approved. So Dan and then Eve-Lynn?

MEMBER SPIEGEL: So I think this --

this concept might fall under access to care for patient, but we talked earlier about accommodation, and -- and linguistic accommodation, so perhaps access to providers or to a translator, or providers who speak the native language of the patient.

CO-CHAIR HOLLANDER: Eve-Lynn?

MEMBER NELSON: Related to patient experience, the question we continue to get with behavioral health all the time is around relationship or therapeutic alliance.

CO-CHAIR HOLLANDER: Peter -- now Don, you are up for real? Yes.

MEMBER GRAF: So I wanted to add a couple to the list from down there: ED utilization, readmission reduction, NICU day reductions, all, you know, as -- as quantitative elements.

I also wanted to ask -- and I am not going to get this exactly straight -- but NCQA I think is -- is taking a look at accepting -- potentially accepting more telehealth in terms of

HEDIS measures, and so I wonder if -- if some of our discussion about these measures ought to be kind of dovetailing in with what they already have in place.

MR. GOLDWATER: I can answer that a little bit. So NCQA is sort of -- is taking the existing HEDIS measures and -- some of the existing measures and adding telehealth as another means of delivery of care, modality of care. So what we're doing here is sort of creating brand new concepts. I think that once we are done with this exercise is to see where there is an intersection between what you all have conceptualized and what they may be doing, so you're right.

And I should, you know, also say that tomorrow, we are going to look at existing measures and see if you think any of those are applicable to the framework, and if so, how do you suggest those are modified or adapted so that telehealth is included as a means of care delivery, or do they have to be adapted?

CO-CHAIR HOLLANDER: Oh, Kristi?

MEMBER HENDERSON: So should we consider with remote monitoring the impact it could have on length of stay to get people out of the hospital sooner and continue and extend that care in the home?

CO-CHAIR HOLLANDER: That is a great one. Stewart? So actually, for remote monitoring and everything, everything related to, you know, mobile health and eMedicine, can we get people out of the hospital faster? That is a really important one.

MEMBER FERGUSON: It may have been said, but new services offered. A lot of times, you don't have services. And the other thing on business days or days lost, we actually track days lost in school as well. We have a lot of children in school-based programs.

CO-CHAIR HOLLANDER: Okay. Paul, I think, Paul, are you up?

MEMBER GIBONEY: Pivoting to clinical effectiveness, you know, that could go into any

disease process anywhere, and I want to just throw out the concept, do we -- when we are thinking about all those different diseases that we could be talking about in clinical, do we want to come up with a measure that says, you know, like instead of just saying, you know, percentage of people with hemoglobin A1c under 9, for, you know, because of telehealth, but just kind of saying telehealth -- taking existing stuff that is already out there for all those clinical areas and saying telehealth delivers either the same outcome or a better outcome with an existing measure for clinical quality?

CO-CHAIR HOLLANDER: Who is that? Sarah, you're up over there.

MEMBER SOSSONG: This has been alluded to, but I think just to put it on the record too, also, whether or not an in-person visit was required within a certain time period, I think that would really vary. For derm, I think we were looking at like a -- within three weeks, did you still need a dermatology appointment for

primary care? Like urgent care visits, it might be within 72 hours, did you still need, but that follow-up rate.

CO-CHAIR HOLLANDER: Okay. And you know, I don't think there has been a lot of mention of transitions of care, but, you know, can telehealth facilitate transitions of care, prevent 30-day readmissions, prevent bounce-backs, include medication compliance? You know, I think there is a whole host of things. You could probably take every transition to care measure and say can telehealth improve that? So I think that that is probably a critically important thing to do that -- that people speak towards.

And then is that Peter? Are you up?

MEMBER RASMUSSEN: I don't know if we have talked about virtual chronic disease management, but I think we need some kind of measure around, you know, percentage of hypertension control in a population, or, you know, something like this.

CO-CHAIR HOLLANDER: Okay. So right, can telehealth keep people out of the hospital? Yes, you know, or --

MEMBER RASMUSSEN: Or --

CO-CHAIR HOLLANDER: -- usual care plus --

MEMBER RASMUSSEN: -- or --

CO-CHAIR HOLLANDER: -- telehealth?

MEMBER RASMUSSEN: Yes. I mean, I guess I am just -- I am just thinking about on an ACO population, you know, we're not that great at getting people under control, and the whole visit we add on, you know, some remote devices that will increase that percentage that are now under control --

CO-CHAIR HOLLANDER: So --

(Simultaneous speaking.)

MEMBER RASMUSSEN: -- somewhat --

CO-CHAIR HOLLANDER: -- keep people out of the hospital and improve measures of control of various diseases?

MEMBER RASMUSSEN: Yes.

MR. GOLDWATER: Just -- just to interject for a moment, so things such as reduction in hospitalization, avoidable hospitalizations, reduction in visits to the emergency room, reduction in hospital readmissions, those are -- are well-documented quality measures that are ready. I mean, those have been around for a long time, so all, you know, we would be doing is adding telehealth as a delivery mechanism, which I think is fine.

I would probably ask at the moment to not think of measure concepts that are comparing telehealth to regular or care delivered in another way, but thinking of telehealth on its own, you know, what would be the benefit or what would be a measure of that? Because tomorrow, again, we are going to start looking at measures that already exist and see how telehealth could fit into those, because I think the way it is going, every quality measure that is in existence could be adapted in some way to say is telehealth better, which is not really adding to a framework

that is -- it's just basically comparing telehealth to other modes of delivery, which many of you have written studies on that we examined, not, you know, from 1972, but from, you know, a more current relevant time period.

MEMBER RASMUSSEN: Well, you know, I hear you to that end. Then I think we should still put something around longitudinal virtual health, so maybe then it is percentage of patients who -- who are -- you know, who are still enrolled in the program three months later, or success of technology in capturing the desired variable, you know, something -- something around this, yeah.

MEMBER GRAF: Could clearing ED beds be considered another example of, you know, for like a psych patient that, you know, you don't have somebody on staff, and just so it's more like clinical efficiency, or would that be included?

CO-CHAIR HOLLANDER: Yes, you can get people out of my beds, I am happy. But -- but

again, that is sort of a -- it might come back to Jason's concept of that is, you know, a delivery mechanism, and, you know, our state is interesting because they used to come into the hospitals in Pennsylvania, and if you layered on telehealth, to do telederm in the hospital, you needed a separate Department of Health approval, and they have actually since passed an -- I don't want to say a law, some guidance document or regulatory document that says if you're just adding telehealth as the delivery mechanism to provide care, you're already licensed to provide care, don't tell us. It is fine. It is your doctor doing what your doctor does in a different way, which was really cool, you know, in our state.

So -- so coming back to things that are, you know, telehealth-specific -- oh. I am not going to repeat what I just said. Okay. So we had Stewart.

MEMBER SOSSONG: I think just one of the biggest ones I thinking about what is tele-

specific that we have always really tried to probe patients and clinicians on is what is the personal connection you feel with your clinician, and that is something that I don't think we are generally asking with in-person visits, but we were very interested in how does that change when it is virtual, so I would suggest that personal connection is a category for telehealth.

CO-CHAIR HOLLANDER: Yes. Stewart?

MEMBER FERGUSON: So -- so we talk about telehealth letting a provider operate at the top of their license, and one way to measure that is the complexity of cases they see. So we, the dermatologist, does not seem the simple cases. We triage that with a PA or whatever and let them do the procedures. But some measure along those lines.

CO-CHAIR HOLLANDER: Okay. Peter?

(No audible response.)

CO-CHAIR HOLLANDER: No, mistake? Yes. So I think we will turn it over to Jason for public comment period. I would like to

summarize what we said, but I am not sure I am capable of doing that, so hopefully somebody from the public can do that very well.

MR. GOLDWATER: Operator, can you turn the phones and see if anyone has a public comment, please?

THE OPERATOR: Certainly. To make a public comment, please press star 1.

(No audible response.)

THE OPERATOR: And there are no public comments.

MR. GOLDWATER: And anybody from the audience?

(No audible response.)

MR. GOLDWATER: Well, that is unusual. Okay.

To summarize what we have done -- thank you, Chuck -- is I think we have a solid list of domains and subdomains. I have approximately, by my notes, I would say maybe 16 or 17 generalized concepts. I did not write down the ones that correlated to an already-existing

measure because I think that is what we will start doing tomorrow. So that is a lot to get done. It's a lot, so thank you all very much.

I think tomorrow, we will review what we have gone over. We will type this up, what we have so far, and we will continue our measure concept discussion, and then we will start moving into prioritization, which is -- you know, the best way to do this exercise is brainstorm all the concepts you can think of that you think would be relevant, and then the prioritization is picking which ones you think are really the most impactful, most relevant, and those will be included in the reports initially as, you know, how to start with a framework, and then all of the other concepts will be listed, but in -- more than likely, in an appendix of other concepts to consider.

And we will also then have a discussion about what we need to include in the framework in addition to the concepts, and we will have a discussion by our public policy

director about MIPS and alternate payments models and how telehealth will be impacting that, and Meg, who is going to be speaking with us, and I went to the Hill to talk about this as they were drafting 21st Century Cures, so she is going to have a great perspective about, you know, what is going to happen down the line with this.

So with that in mind, thank you all very much. Have a wonderful dinner. I wish we could join you, but our son is turning nine, so Cheesecake Factory it is. Yay.

(Laughter.)

MR. GOLDWATER: All right. At least it is not Golden Corral.

(Whereupon, the meeting went off the record at 4:25 p.m.)

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C E R T I F I C A T E

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

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter