

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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WEDNESDAY,
MARCH 8, 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

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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

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Center for Telemedicine & Telehealth,
University of Kansas Medical Center

STEPHEN NORTH, MD, MPH, Regional Clinical and IT
Director/Practicing Physician, Mission
Medical Associates and Mission Community
Primary Care

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
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NQF STAFF:

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Quality Measurement

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MARCIA WILSON, PhD, MBA, Senior Vice President,
Quality Measurement

ALSO PRESENT:

NATASSJA MANZANERO, MS, Telehealth Program
Coordinator and Rural Health IT Policy Lead,
Health Resources and Services Administration
MEGAN MEACHAM, MPH, Public Health Analyst,
Federal Office of Rural Health Policy,
Health Resources and Services Administration
MATTHEW QUINN, MBA, Senior Advisor for Health
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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:14 a.m.)

3 MR. GOLDWATER: My apologies for being
4 slightly late. I left my house at roughly 6:30
5 a.m. and just arrived. So, boy, do I love
6 Washington, DC. I tell you, this is when it is --
7 so, right.

8 DR. BURSTIN: I said you -- fifteen
9 minutes.

10 MR. GOLDWATER: Sorry, Steve. I
11 wasn't clear. So, I live in Laurel, Maryland,
12 which is sort of in between Baltimore and DC.
13 It's roughly 20 miles from the city. Normally,
14 it takes an hour. On a bad day, it takes an hour
15 and a half. On a day like today, I could have
16 probably driven to Houston from Dallas and back
17 and would not have been here.

18 So, anyway, so hello to everybody.
19 Good morning. It looked like the dinner was a
20 great success. I'm sorry we missed it, but I did
21 tweet all the pictures that you sent to me, which
22 Helen then liked and retweeted and NQF retweeted.

1 So now you're all over the social media universe.
2 So congratulations, and I hope you're happy with
3 that, and, if not, it's too late to do anything
4 about it, but anyway.

5 So, we did an awful lot yesterday. We
6 did get an incredible amount done, so I -- as
7 much as I'm sorry that I was a few minutes late,
8 I don't have any problem with knowing that we're
9 going to make up for the time and then some,
10 given how well the group has worked together.

11 So, I'll turn this back over to Judd
12 and Marcia. I know we were in the middle of
13 brainstorming measure concepts for experience, so
14 I believe we'll pick up from there.

15 CO-CHAIR HOLLANDER: So I think we're
16 supposed to start by reviewing yesterday. So it
17 -- we talked about these domains and subdomains.

18 So anyway, I think we can level-set
19 just by having this in front of us rather than
20 reading through them again. And then we got into
21 measure concepts, where I think we probably were
22 a little bit less directed and congealed and a

1 little bit more throwing ideas at the wall.

2 And I've evolved in my thinking really
3 in the last 15 minutes talking to Marcia, so it
4 was good that Jason was a little delayed, because
5 it gave us the chance to do that.

6 And I think based on what he was
7 saying at the end of the day, is -- and feel free
8 to correct me if I get any of this wrong, because
9 I'm still trying to evolve in how to direct my
10 own thinking, as well as maybe the group here, is
11 that what we want to do in measure concepts is we
12 want to come up with ideas for measures.

13 So it's not like domains and
14 subdomains, and we don't want them to be related
15 to measures that already exist. We will later on
16 today be going through measures that already
17 exist that can just layer on telehealth into
18 those measures. And so these are what kind of
19 telehealth non-disease-specific measures might we
20 actually want to put out there, without getting
21 down to it's a readmission for blah.

22 And so, Marcia and I, in sort of

1 brainstorming came up with a couple ideas.

2 Again, not necessarily any one of these is right.

3 But things that are specific to telemedicine
4 might include some measures about technical
5 issues, right?

6 There probably are no measures about
7 can you talk to your patient, and can they hear
8 what you're saying? But that would actually be an
9 important thing in telemedicine world. So, some
10 of the things that relate to technical issues,
11 maybe some of the things that relate to the
12 ability to deliver care when you're not with the
13 patient, right, that would be different than some
14 of the things we have.

15 There may be measures that relate to
16 timeliness of evaluation, but there may be
17 opportunities to have telemedicine-specific
18 measures that relate to timeliness of evaluation.
19 And then, the big picture item that we discussed
20 a lot yesterday in various forms, is the impact
21 of adding an additional care delivery mechanism,
22 i.e., telemedicine or mobile health, to standard

1 or traditional approaches across different areas,
2 are there measures that may be related to that?

3 And then, some of the comments that
4 Marcia had is well, this doesn't map into one
5 specific domain or subdomain. And in thinking
6 through, we said, okay, let's take the technical
7 issues component, and, well, that might actually
8 fit into access. So there could be a measure
9 regarding technical issues that fit into one of
10 the access subdomains or there might actually be
11 that measure that fits into operational or
12 technical effectiveness.

13 So this, again, is just meant to get
14 the conversation started, but it was at least
15 easier for me to think of it in terms of broad
16 perspectives. And then it turns out that
17 everything we thought of in broad perspectives,
18 we could then fit into one of the domains and one
19 of the subdomains.

20 And -- because yesterday we started by
21 saying, okay, let's focus on, I forget whether it
22 was experience or wherever we were talking, but

1 then the conversation got broader than
2 experience. And so, maybe today, it makes sense
3 to just acknowledge that we're not really good in
4 pinpointing into the micro-subdomain at the
5 beginning.

6 So let's start by taking broad measure
7 concepts or measure ideas, and then we could just
8 make sure they map to one of the domains or
9 subdomains, which if we come up with a great idea
10 for a measure concept, and we can't map it, well
11 then we've got a problem in defining the domains
12 and subdomains.

13 So this is, I think, the way everybody
14 might have preferred to approach it is what
15 things are really important, and then can it fit.
16 And so, I lot of today is going to be what's
17 important either in new measures now or in
18 preexisting measures in a couple hours. Does
19 that make sense to you guys? So, okay. Paul?

20 MEMBER GIBONEY: And just in terms of
21 measures that aren't out there in use, what we
22 found was store-and-forward technology,

1 electronic consultation is that the number of
2 exchanges matters. But what we found recently
3 was that the more exchanges that go back and
4 forth on a store-and-forward technology, the more
5 likely the two folks talking on it are likely to
6 arrive at a solution for the patient that does
7 not involve a face-to-face visit.

8 And so, in our system, we call that
9 intensity of touch. How many touches were back
10 and forth on the store-and-forward technology?
11 And that in and of itself was a metric, and then
12 we tied it to did it result in a face-to-face
13 visit with the specialist or did they come up
14 with a solution outside of that? So that's a new
15 measure that it doesn't relate to current ones.

16 CO-CHAIR HOLLANDER: Okay. Steve?

17 DR. HANDLER: Oh, is that per case,
18 the number of times you bounce the information
19 back and forth?

20 MEMBER GIBONEY: Yes. Exactly.

21 CO-CHAIR HOLLANDER: Adam?

22 MEMBER DARKINS: Talking to you last

1 night, it was very interesting to hear about what
2 you're about to get published. And it just
3 occurred to me it's slightly off-track what we're
4 talking about. One thing's occurred to me we
5 haven't covered, is how we encourage the most
6 low-cost and appropriate virtual care technology
7 to be used.

8 I think that that's something that
9 might come up -- might be something we should
10 include in what we do, because e-consults is
11 really a very powerful tool to use. So if you
12 can do something via e-consult, much better you
13 do that than end up with a video consultation.
14 So I don't know how we'd incorporate that, but it
15 just seemed to me a thought from last night.

16 CO-CHAIR HOLLANDER: Other ideas?

17 It's the second-day hangover. Yes, so, I mean, I
18 would just encourage people to just think of what
19 you do or what your predominant use case is at
20 your own institution, and say if somebody was
21 going to measure your effectiveness and your
22 ability to deliver care, how would they be able

1 to do it and --- because let's face it, we're in
2 a unique position.

3 We get to put some things out there
4 that people may want to develop, which, as people
5 that use this technology, it's nice if we're
6 directing people or throwing ideas out there that
7 we think are important, rather than letting
8 someone else who has no idea what we do come up
9 with ideas that they think is important.

10 So it's really, I think, if nobody has
11 ideas or at some point, we probably should just
12 spin the room and say well, what would be the
13 most important thing that would work in your shop
14 that you think is potentially doable that you
15 think would actually improve the care of the
16 patients you take care of. Angela?

17 MEMBER WALKER: We talked a little in
18 some of our early meetings about care
19 coordination, and making sure that we've got the
20 next step in place. I don't know where that
21 would fit in this necessarily, perhaps under
22 system effectiveness. But some type of measure

1 that looks at if an elevated level of care is
2 required, can that happen, and how is that
3 designed to happen?

4 CO-CHAIR HOLLANDER: Paul?

5 MEMBER GIBONEY: So kind of along with
6 what Angela is saying, if the telehealth
7 interaction has resulted in a desire for an
8 increased level of care, how good is a system at
9 delivering the care to that recommendation? What
10 we found in our system with e-consults is that
11 when the PCP and a specialist talk, sometimes the
12 patient does need to see the specialist, but
13 sometimes it doesn't need to be right away.

14 Our regulatory environment says you
15 have to get it, cram them in within 15 days or
16 else you're --- and every patient is exactly the
17 same. One size fits all. And what we found is
18 that when they talk, sometimes the specialist
19 says, yes, hey, I want to see that patient, but
20 start this treatment, I want to see them in two
21 months. Or the ophthalmologist looks at the
22 retinal scan and says, yes, I really need to see

1 that patient, but I want to see him in three
2 months to kind of see what the progression is
3 after you've got their sugar under control. Or
4 whatever it is.

5 And so we --- it kind of throws into
6 question this idea of patients always need to be
7 scheduled right away. And so I guess the metric
8 might be something like how well does the system
9 accommodate whatever that individualized care
10 plan is that emerges from telehealth, and how
11 well do they deliver on that particular care
12 plan?

13 CO-CHAIR HOLLANDER: Okay. Sarah?

14 MEMBER SOSSONG: So is now the time to
15 just throw out ---

16 CO-CHAIR HOLLANDER: Yes.

17 MEMBER SOSSONG: --- any of these
18 possible measures. So I think we've already
19 mentioned you have technical problems with the
20 visit, and then digging into is it sound --- I
21 think there are a lot of nuances that we've
22 thought about; joining the visit, the connection,

1 should logging into the software, ending the
2 visit, billing afterwards. I think something
3 that many of the D to C urgent care visits ask
4 patients is what would you have done if you
5 hadn't had your virtual visit?

6 So we ask that to patients, but we also ask
7 our providers what would you have done with the
8 patient if you hadn't had this visit? Would you
9 have asked them to come into the office? Would
10 you have had a phone call? Would you have not
11 done anything?

12 So I think we think that's important.
13 And also in terms of comfort with the technology,
14 we often ask people how many times did it take
15 them to get comfortable. We've been surprised
16 that the clinicians have generally said it takes
17 them three visits. We thought it might be more
18 than that, but I think just as a more of an
19 adoption metric. That's a helpful one.

20 CO-CHAIR HOLLANDER: Yes. And I'm
21 just going to add to the discussion, because I
22 think Angela raised this at the last face-to-face

1 meeting, and I don't think it's really been
2 discussed. Does taking care of patient A on
3 telemedicine make it easier to take care of
4 patients B, C and D?

5 And that's something that doesn't
6 really exist, I don't believe, in measures. But
7 if you can keep somebody out of the office,
8 because you could say they don't have melanoma, I
9 think, was the example, you could now see
10 patients who are more likely to have melanoma
11 faster and get them in and shorten it.

12 And I think that the idea of can you
13 use telemedicine to see a subset of patients and,
14 therefore, provide greater or more efficient
15 access to another subset would be great. Julie
16 and then Steve and then Adam.

17 DR. JULIE HALL-BARROW: Yes, so one of
18 the things from physician-to-physician consult we
19 tracked, you know, what was the requesting
20 physician's diagnosis and did that diagnosis
21 change and did transport change. If it's already
22 going to be a transport, did it move from a more

1 critical consult change or less or not at all?

2 CO-CHAIR HOLLANDER: Steve?

3 DR. HANDLER: Yes. It would
4 underscore a lot of the things that were said.
5 So we use an SBAR framework, and the initial S is
6 from the nursing perspective, and then, we'll
7 have the physician to have their own assert chief
8 complaint and see if they're same or different.

9 Second is underscore, also, the
10 comfort. The comfort from --- it's somewhat
11 subjective, but the distal site provider saying
12 their level of comfort of the resident or
13 patient, the comfort of the nurse, you also could
14 look at the comfort of using the technology, of
15 course, of the provider itself. And then you
16 could also look at how the technology itself
17 enabled, an enabling component in terms of
18 effectiveness of let's say each of the components
19 of the history and physical.

20 So does it -- is it effective in
21 giving you --- enable the history, physical exam,
22 review of systems. I mean if you wanted to go

1 down the list of a clinical traditional SOAP
2 note, and then what we also ask, once again,
3 high-level questions. Is it appropriate and
4 effective use of my skill set and time. And I'll
5 just stop at that for now.

6 CO-CHAIR HOLLANDER: I think Don --
7 oh, it was Adam and then Don. Okay.

8 MEMBER DARKINS: Asking a question if
9 I may do, not so much about what we've done
10 yesterday, but more about the principal of what
11 we're engaged in doing and how it's going to be
12 used. So, I mean I'm totally a hundred percent
13 with the importance about having processes,
14 making sure things are safe and effective.

15 I am struck a little bit by -- there's
16 a way in which a lot of what we said though is
17 very paternalistic. And one of the advantages of
18 this technology is it does make things more
19 accessible to patients.

20 Now, we don't have a direct patient or
21 consumer view on this, but I think there's a way
22 in which we could be heading, which is around the

1 fact that what we end up doing is make something
2 very onerous that ends up being something only a
3 very large healthcare provider or a very complex
4 organization could do.

5 So, in other words, if you can imagine
6 having to do the Joint Commission the whole
7 panoply of standards, what we could essentially
8 do is create a framework that will exclude the
9 kind of disrupters that might come into
10 healthcare.

11 So how do we obviate that very strong
12 paternalistic view? And how do we make sure we
13 complete that balance between being custodians
14 that make you something effective, but make sure
15 we don't end up, if you'd like, excluding the
16 ability for the patient to drive the system and
17 for other players to become involved, because
18 we've made the quality a barrier for any other
19 player to be involved?

20 MR. GOLDWATER: So, Adam, it's a great
21 question, and I think the answer is there's
22 always a tendency when you're developing

1 frameworks, or even when you're in our other
2 types of meetings, where we're actually reviewing
3 measures, that there is sort of the tendency to
4 be more paternalistic and to sort of rely on the
5 expertise of those that are sitting in the
6 Committee to develop process or outcome or
7 structural measures that will capture a
8 particular encounter and sort of dictate the
9 process or the outcome that you follow, if such
10 practices or evidence-based processes are
11 followed.

12 I think the way that we try to work
13 around that for this is all of you, in addition
14 to being experts in telehealth and certainly
15 looking at this from a provider standpoint, we do
16 have people here that can also look at this from
17 a patient standpoint.

18 And we really emphasize that when
19 we're looking at a framework, especially in these
20 types of domains that you have and subdomains, is
21 to consider not just the technology itself and
22 the use of that technology by a provider or a

1 care team, but also how the technology could be
2 leveraged by the patient, even if, at this moment
3 in time, that's not something that is possible,
4 but it's something that is possible if --

5 MEMBER DARKINS: Therefore, I'd like
6 to just ask -- maybe the rest of the group
7 doesn't have those issues, but I would like to
8 ask whether we can't actually formally include
9 some kind of mention of this within the report --

10 MR. GOLDWATER: Absolutely.

11 MEMBER DARKINS: It is essentially
12 like a fundamental principal that's part of what
13 we're doing. And we recognize that tension, and
14 we haven't got the answers, but we actually,
15 rather than sort of say, well, we'll just let it
16 be implicit and stuff, but we'll make it more
17 explicit. I think with others would agree.

18 MR. GOLDWATER: Right. I don't think
19 there's any issue with that. And certainly,
20 because we have certainly laid out and delineated
21 within the subdomains of patient experience as a
22 big part of this, and there's a number of areas

1 here where we're talking about access for
2 patients, impact on patients, certainly that's
3 going to be a very large part of the framework,
4 and we'll certainly get reference.

5 The hope is that we develop concepts
6 around that that can effectively be developed
7 into measures to be used that represent the
8 patient perspective. But, absolutely, that will
9 be a fundamental part of the report, and it was a
10 fundamental reason why you all are here, is to
11 not just bring the provider or technical
12 perspective but the patient one, as well.

13 CO-CHAIR HOLLANDER: Okay. Don?

14 MEMBER GRAF: So we've developed a
15 diagnosis-specific process flow. They're
16 templates but they are from the --- originating
17 in the distant-site perspective. They cover pre-
18 visit, during and then post-visit recommendations
19 that include making sure that the connectivity is
20 there, not only to the room, but to the PAC
21 systems or to the EMR systems to make sure that,
22 from a clinical perspective, what are the things

1 that needed to happen, a test needed to be done
2 or whatever, and really kind of flow all the way
3 to the end, up to and including scheduling of a
4 follow-up visit. So ---

5 CO-CHAIR HOLLANDER: Okay. I think
6 Stewart was next. No, David was.

7 MEMBER FERGUSON: Judd, just to your
8 point, you were talking about triaging patients,
9 et cetera. Just to let you know the CPT work
10 group for telehealth is actually discussing
11 developing a code for that, so you could actually
12 track it.

13 CO-CHAIR HOLLANDER: Cool. Great.
14 Okay. I think then, Daniel, and then Angela and
15 then back to this side was the order. I
16 apologize to anybody if I'm screwing up, but if
17 somebody has a comment that's specifically
18 germane to a comment that was just made, raise
19 your hand, too, and we'll cut you in the loop.

20 MEMBER SPIEGEL: So I want to actually
21 say again what Adam just said, and if we can
22 include something in the report about encouraging

1 the use of existing measures as much as possible,
2 because as a member of a very large healthcare
3 organization, we do measure a tremendous number
4 of metrics, and it is quite onerous, not to say
5 that it's not a good thing to do. So I want to
6 second that, Adam.

7 And then I did have --- as we're
8 rolling out sort of our --- at DaVita our remote
9 monitoring telehealth solution, we have a number
10 of metrics that we are looking to measure, and so
11 I'll just spout off a couple of them here.

12 So for us, missed visits or missed
13 encounters. So one of the things that we're
14 hoping to achieve is to reduce the no-show rate.
15 I think we probably talked about that yesterday.
16 We have a number of 24,000 or so patients who
17 treat at home. And so one of the things we're
18 hoping to do is reduce missed treatments, which I
19 guess would be sort of compliance with the care
20 plan or the prescribed therapy.

21 Avoid all hospitalizations, which I
22 think were touched on yesterday, and then we

1 actually measure direct patient care hours per
2 treatment. So that's folks who are directly
3 involved in the patient care -- the labor hours
4 that are required for each encounter.

5 CO-CHAIR HOLLANDER: Okay. Angela?

6 MEMBER WALKER: Yes, I hope this will
7 speak a little bit towards what Adam brought up,
8 as well. I think our professional society
9 struggles a little bit with the use of
10 teledermatology, because -- for many reasons.
11 But we've tried to emphasize that we really need
12 to think about the problem we're trying to solve.

13 And it may be that we've got two big
14 things we can fix -- either access in our very
15 resource- and provider-limited specialty or
16 quality. But if we sway too far toward one,
17 we're going to totally lose sight of the other.

18 And the best kind of use case of that
19 is for dermatology, it's a visual specialty.
20 Anybody can send me an image on a cell phone.
21 Right? If the access is made 100 percent, I'll
22 accept every image I receive. I don't care about

1 the history I get. I don't need any verification
2 that you are who you are or that you have any
3 additional history. And I can make a diagnosis -
4 - good, bad, ugly, otherwise.

5 If I make high quality, I may restrict
6 the type of image I receive, require higher
7 standards for how the photography is provided to
8 me, I have to have all this additional
9 information. And there's three logins or
10 firewalls to get past for security reasons.
11 Nobody's going to use it.

12 So we kind of have to think, what's
13 the problem we're trying to solve, and the
14 framework, as I see it, is a method to think
15 about those studies, think about those research
16 protocols, think about the metrics that we're
17 going to use in order to create the system to
18 solve the problem we're trying to solve.

19 CO-CHAIR HOLLANDER: I think it's
20 Stewart and then Dale on this side.

21 MEMBER FERGUSON: So I had kind of
22 three comments I just wanted to make. So one is

1 kind of following through on what you were
2 saying. So we actually try to measure data
3 quality in our system. And that can be image
4 quality. It can also be medical history. If you
5 get the relevant information.

6 And going forward, that becomes
7 incredibly important, because you don't have the
8 chance to have the person manipulate the camera,
9 and you get what you get. And it could be good
10 quality, but not sufficient. It could be bad
11 quality, but so forth. So that's an issue.

12 The second thing I was going to say is
13 that especially in a store-and-forward
14 environment, it's very important when you're
15 measuring, you sometimes have to separate the
16 measures for people that create cases and those
17 that actually consult on the cases, because the
18 data can be very different between the two. And
19 I'll give you one example.

20 We actually ask our providers are you
21 doing telemedicine? It's just a flat question
22 that we've asked them, and you find that people

1 that are actually at remote areas, you think it's
2 because it's convenient to the patient, it turns
3 out it's not.

4 Eighty-six percent of them say it
5 helps them communicate with the physician, and
6 only like five percent say it's convenient to the
7 patient. Whereas the consultants, over 50
8 percent say they do it because it's convenient to
9 the patient.

10 So the drivers are different. And I
11 think it's actually good if you understand those
12 drivers, because then you can build your system
13 to be more effective. And then the third thing I
14 see in terms of differentiating, I think it's
15 been mentioned, but I think it's really
16 important that we don't assume every telemedicine
17 case prevents travel. And that is an assumption
18 that's been made in the past by some studies.

19 We actually ask everybody that
20 consults in a telemedicine case, did it prevent,
21 cause or have no effect on travel, compared to
22 traditional models of care. And I think if you

1 start the study of the cases that cause travel,
2 we find that the majority of those are heart
3 patients with an EKG. But there are other
4 reasons, but you can start to differentiate the
5 effectiveness of your system.

6 CO-CHAIR HOLLANDER: Okay. Angela?

7 MEMBER WALKER: Is your group taking
8 the next step in saying maybe the heart patients
9 are ones that shouldn't be seen by telederm --
10 or, sorry, by telemethods?

11 MEMBER FERGUSON: No. It's actually
12 kind of the opposite. We didn't used to have
13 EKGs or stethoscopes in our village clinics.
14 When we introduced telehealth, it was a bit of a
15 perturbation to the system when we got some push-
16 back to even putting EKG in the village.

17 And now that we have it, we find that
18 eight percent of the time that you use that, the
19 actual cause is travel. And we're just catching
20 patients. And I think in the past when they
21 called with chest pain, they would MEDVAC them
22 immediately. And now we MEDVAC less, but we use

1 the EKG as a filter.

2 CO-CHAIR HOLLANDER: Okay. Dale?

3 MEMBER ALVERSON: One of the things I
4 want to make sure somehow gets translated into
5 the report is the important aspect of using
6 telemedicine for transitions of care. And when
7 one looks at, for example, just the data of
8 readmission rates, which could be one of the
9 metrics, it's pretty phenomenal to realize, in
10 fact, it would be the low-hanging fruit that in
11 the data of Medicare patients in New Mexico, a
12 high percentage of them are readmitted in the
13 first four days after discharge.

14 So that tells you there's not been a
15 good transition, and we've had some examples even
16 my area in neonatology, where discharge planning
17 includes the primary care pediatrician who will
18 be receiving the patient, they get engaged, are
19 you prepared for that patient and can better
20 communicate with the patient -- in this case, the
21 mom. So I just think it's an important aspect of
22 where telemedicine and telehealth can play a role

1 is in that transition of care.

2 So, and that's going to go back when
3 we get into the actual metrics and so on. We
4 talk about effective system, maybe even clinical
5 effectiveness in avoiding those kinds of
6 readmissions and better transitions. And I
7 think, going to what Stewart said, we've also
8 found that actually it expedites the transport,
9 because that patient needs to be transported and
10 can actually improve stabilization.

11 So if this patient's sicker than you
12 thought, they need to come here, and this is what
13 you need to do. And we studied that and
14 published that as well, that significant, almost
15 50 percent of the transports included advice that
16 change the management and stabilization of that
17 patient. So, again, it's sort of that transition
18 aspect that we have.

19 CO-CHAIR HOLLANDER: I'll say that,
20 you know, we wrestled with in our direct-to-
21 consumer thing, are there things that should pop-
22 up saying, oops, you have chest pain, don't do

1 this.

2 And we actually decided not to do
3 that, because we actually believe, and I can't
4 prove this, but that by seeing someone that
5 probably shouldn't have called me but should have
6 gone right to the ER, I get them to the ER
7 sooner. Because the -- sort of the activation
8 threshold to get in your car and go to the ER or
9 call an ambulance is way higher than calling
10 telemedicine. So I'm happy to see people who are
11 totally inappropriate for telemedicine and get
12 them to the right level of care faster.

13 And I wonder if --- and I say this in
14 part because many people in this room write
15 guidelines and sometimes guidelines say
16 telemedicine is inappropriate for this complaint.
17 I think we probably shouldn't do that.

18 But I wonder whether there's an
19 opportunity somewhere in this report to address
20 the concept that seeing people on telemedicine
21 that you can't treat might actually lead them to
22 get treated sooner, and is there a way to measure

1 people you can't treat, but you immediately refer
2 out.

3 Because I know, and I'm making up the
4 numbers a little bit, the average time for
5 somebody to show up in the ED with chest pain is
6 after three and a half hours of symptoms. It's
7 pretty close to that.

8 But the average time that they have
9 symptoms before they call telemedicine with that
10 is probably much less. Can I get them there
11 sooner? Again, is it good for the person even
12 though I can't treat? It's kind of weird.

13 MEMBER ALVERSON: And I would say that
14 it sort of fits, having been a medic in the
15 military, with triage. You know, some patients
16 that need immediate intervention and others can
17 be delayed or may be so severe that it's not even
18 worth trying to put a lot of effort in until
19 you've taken care of all the others. But I think
20 there's a triage aspect of telehealth that kind
21 of gets to what you're saying that ---

22 CO-CHAIR HOLLANDER: Yes.

1 MEMBER ALVESON: -- that you can make
2 better decisions about how to manage that
3 patient. Do they need to be transported? Do
4 they need immediate attention?

5 CO-CHAIR HOLLANDER: I think, Yael,
6 are you up? Is that yours?

7 MEMBER HARRIS: So I would concur with
8 everything that was said, and I just have two
9 suggestions. One is I think we focus on
10 outcomes. So the readmission measure that Dale
11 pointed out is a perfect example of an outcome
12 measure.

13 But then I want to take it a step
14 further, which is there's so many aspects of e-
15 care, whatever we're going to call it here, and
16 I'm worried that we're trying to put too many in
17 one bucket.

18 So as we think through measures, I'm
19 wondering if we want to think through what are
20 generic measures that might be more broadly
21 applied, but not necessarily applied to
22 everything, and what are measures that could be

1 applied to situations.

2 So, for example, readmissions refers
3 to a much more acute condition. However, if
4 we're talking about, for example, mobile health
5 to deal with chronic disease management, the
6 issue is not necessarily readmission, but it is
7 lower BMI, for example.

8 So thinking through some global
9 measures that outcomes, like cost, reduced time
10 to care, or something like that, but also
11 thinking through specific examples by different
12 types, telederm, et cetera, so that we can ---
13 we're trying to incite people to develop
14 measures, so we don't want to limit them to just
15 one type of telemedicine or telehealth approach,
16 and we also don't want to limit them to just to
17 also just one type, if they can think more
18 broadly.

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

20 MEMBER NELSON: I wanted to build on
21 what Daniel said about not using -- about trying
22 to use existing measures whenever we can, and I

1 think I've heard using existing outcome and
2 experience measures. I just wanted to include in
3 that also implementation measures, instead of 20
4 home-grown readiness measures and those kinds of
5 things, trying to use the D&I science we have to
6 also inform the process programmatic side.

7 And then building on what you all were
8 talking about with the value of when you can
9 connect and have that person come in on site,
10 that's really what needs to happen when you were
11 talking about the appropriateness question.

12 I think also with, for example, our
13 second-opinion clinics, just the value of
14 reassuring the distant site you've done
15 everything you can do, that person does not need
16 to come in, I think it's valuable.

17 CO-CHAIR HOLLANDER: Yes. We haven't
18 really haven't addressed the second-opinion thing
19 at all. So I think that's the first comment on
20 that the whole time. Henry?

21 MEMBER DEPHILLIPS: Thanks. A comment
22 and a concept. I work for a publicly held

1 company. I'd like to be able to speak freely
2 here. Can I have assurance that if I share
3 something it won't be quoted publicly?

4 CO-CHAIR HOLLANDER: Well, it's on a
5 public transcript.

6 MR. DEPHILLIPS: All right. I'll be
7 diplomatic.

8 DR. BURSTIN: I mean, we could ask the
9 transcriptionist to just stop for a moment if
10 it's big-business intelligence, but keep in mind
11 there are some people in the room, as well --

12 MR. DEPHILLIPS: All right.

13 DR. BURSTIN: -- so it's up to you.

14 MR. DEPHILLIPS: I'll phrase it in a
15 way that whatever happens is okay. So my comment
16 is it touches back to what David said earlier,
17 excuse me, Adam said earlier, and that is quality
18 not being overly restrictive.

19 I think that the task of the group in
20 putting this framework together is to ensure that
21 if any entity enters into the telemedicine world,
22 that there's a certain minimum-quality set of

1 standards that must be met before you can deploy
2 the program, yet the quality standards shouldn't
3 be overly onerous to where an effective, high-
4 quality program can't be implemented. Right?

5 So there's a balance in there
6 somewhere. I don't know exactly what the balance
7 is, but it's not too low and not too high, but
8 there's something in the middle. So --- and I
9 think we're getting at that, I think, with this
10 group incredibly well by the way.

11 My concept is this. There's one area
12 that occurred to me, now that the third cup of
13 coffee is kicking in, that crosses access for
14 patients, access for the care team to patients,
15 and where do we put community -- somewhere
16 between effectiveness and community experience,
17 and that is the notion of expanding network
18 capacity or capability. I don't need to use the
19 word network.

20 But there's a provider shortage in our
21 country. Nobody, I think, would argue that.
22 And, historically, the methods that have been

1 used to address that have been increasing the
2 number of medical school seats, forgiving loans
3 for docs who choose to practice in designated
4 rural areas. I could go on and on and on, but
5 think about the cost and the labor-intensiveness
6 and the non-scalability of all of that.

7 Back in 2002, when we put this HR perk
8 into the marketplace, which is really what it was
9 in 2002. There was no data supporting it. What
10 we did was we had a network of docs who were in
11 private practice, but if they had a cancellation
12 on their schedule and a no-show for a physical
13 and had an a hour free, they could log in and do
14 three or four visits and then log back out and
15 resume their schedule.

16 They would do it at lunch. They'll do
17 it on the weekends, when they're otherwise on
18 call and just available to receive phone calls
19 but not doing much else.

20 So if you think about how telemedicine
21 works in that realm, you're taking the existing
22 expertise and expanding capacity, both the volume

1 of patients that that provider of care can touch,
2 as well as removing the geographic limitations of
3 where the patients or consumers are of those
4 types of services.

5 And so from a measure of concept
6 standpoint, there's patient access, provider
7 access to patients and community goodness
8 associated with expanding the ability for the
9 existing system without spending any more money
10 other than on telemedicine stuff, to have a
11 broader and better ability to meet the medical
12 needs of the community service. So there's my
13 concept for the day.

14 CO-CHAIR HOLLANDER: If we do just
15 that, we're okay? Angela?

16 MEMBER WALKER: I'm going to put a
17 plug in for my clinical colleagues to have some
18 subdomain or concept in regards to physician
19 burnout as an unintended consequence of
20 telehealth or telemedicine.

21 Because, having seen firsthand if you
22 take a lot of the patients that can be managed

1 effectively and treat them in a tele setting,
2 that sometimes mean that the patients I see in
3 clinic are all my higher-level care patients.

4 And the way our clinics are
5 constructed, every visit's 15 minutes, and I rely
6 somewhat on the quick and easy, straightforward
7 cases that only take three to five minutes, in
8 order to have catchup throughout the day.

9 And as our days get longer with
10 electronic medical recordkeeping and everything
11 else that's been piling on, if I lose that three
12 to five-minute visit, and every visit is a 20 to
13 30-minute visit squeezed into 15 minutes, the
14 burnout potential of the clinical colleagues I
15 could see increasing.

16 CO-CHAIR HOLLANDER: Don?

17 MEMBER GRAF: I've got something
18 directly related to that. At San Francisco, they
19 published or presented --- they went to a store-
20 and-forward e-consult model there, and they
21 stopped essentially treating hypothyroidism
22 completely in their endocrinology clinic.

1 And then they talked --- and then they
2 quantified that indeed, their endocrinologists
3 were seeing much more complex cases in every
4 single visit and their -- kind of their case
5 index or whatever went up substantially. So I
6 just wanted to throw that in to validate Angela's
7 observations.

8 CO-CHAIR HOLLANDER: So this may link
9 to the comments earlier about something you're
10 doing on patient A and the impact on patients B,
11 C and D that may be unfavorable.

12 MEMBER WALKER: That's it.

13 CO-CHAIR HOLLANDER: Yes. Okay.
14 Dennis, you've been waiting a long time or you
15 just put it down? Gave up? We had you up too
16 long? Okay. Stewart?

17 MEMBER FERGUSON: So to follow through
18 on what Henry was talking about, we have a
19 department, for instance, that does three to four
20 thousand consults a year on telehealth, and they
21 do that with no drop in in-person visits.

22 And we actually find this is exactly

1 what you're talking about, especially in the
2 store-and-forward environment, where it's not
3 scheduled, we find most of our physicians can
4 squeeze in one to four consults a day with really
5 no impact on their actual patient load. And so
6 there's an efficiency that's gained from the
7 system.

8 The other thing that we find actually
9 is that we actually have patients that were
10 scheduled sometimes for the wrong department --
11 ophthalmology instead of otolaryngology. Those
12 things happen. And we actually find as we start
13 to triage those patients out and we get them to
14 the right department, and so there's some kind of
15 fat in the system.

16 The one thing I was going to add
17 though, is kind of going back to what Dale was
18 talking about earlier. There's standards of care
19 in almost all of our departments, and a couple
20 examples; our ENT department to do PE tube
21 placement, we have the highest rate of PE tube
22 placement. I think we're 10 or 20 times higher

1 than the lower 48, so we do a lot of tubes.

2 But the patients return to their
3 village, and there's no good economic model to
4 justify flying that patient back into Anchorage
5 for \$900 with an adult. And we used just not see
6 them. And then oftentimes those patients showed
7 --- presented in another year or two, they missed
8 school, they had challenges.

9 And so the standard of care is, of
10 course, is your post-surgical follow-up, so now
11 we do that with telehealth, so we meet our
12 standard of care. And that's a quality measure,
13 I think, that we could be thinking about.

14 There are plenty other examples. You
15 think about diabetic patients with the retinal
16 exam that has to happen on an annual basis, and
17 now we do that by telehealth. And then the other
18 thing that was learned when we do that is that we
19 actually find sometimes patients haven't been
20 seen for years.

21 And the last time we did the retinal
22 exams, a third of our patients, they got the

1 retinal exams through the Joslin Vision Network,
2 needed follow-up in treatment.

3 And so you actually prevent adverse
4 outcomes. And that might be another way ---
5 because these are patients that just wouldn't be
6 seen. And so standards of care and preventing
7 adverse outcomes seem to be two things that we
8 should really be focused on.

9 CO-CHAIR HOLLANDER: Okay, Steve and
10 then Don.

11 MEMBER NORTH: I have a feeling that,
12 talk about burnout, as a primary care doctor
13 who's having more and more patients who are going
14 to be needing and then building on that, talking
15 about taking away this level long --

16 I think that that's important to talk
17 about it, but I also think that we need to look
18 at how does that delivery interrupt the day if
19 it's built right into my workflow per week?

20 So if I'm expected to do any virtual
21 visits whether that be formal interactions with
22 my patients or free-standing platforms and also

1 leading them in. There interruptions, I don't
2 know if that's in the domains of that research
3 down the road. But that leads to the burnout.
4 And how is it -- what's creating it needs to be
5 sort of the conversation.

6 CO-CHAIR HOLLANDER: Okay, Don and
7 then Nate.

8 MEMEBER GRAF: So I want to kind of
9 piggyback on what you guys are talking about, but
10 from sort of a business perspective, by being
11 able to see more complex patients and then bill
12 for higher levels of care and get additional
13 reimbursement, the business model supports that
14 increase in revenue, and the practice management
15 should not be to just add more patients to ---
16 obviously, there's going to be some point where
17 you just can't add more patients, and that's
18 where the clinical efficiencies need to take
19 place.

20 If the clinic is generating more
21 money, maybe the blocks of time and how the
22 systems are set up for you to see patients' needs

1 to be adjusted or additional providers need to be
2 hired or whatever. So I'm not discounting at all
3 the burnout factor. Absolutely real. But I also
4 need to consider that clinical efficiency in
5 those revenues.

6 CO-CHAIR HOLLANDER: Yes. So I've
7 just been sort of taking notes and trying to find
8 things that fit between the cracks, as people
9 have been talking, and I have six things to state
10 that maybe fit into measure concepts that are
11 peripheral or around that people sort of tweak my
12 brain to put down and put on the record. Some
13 may be fine, some may not.

14 One is we talked yesterday a lot about
15 not having to miss work or school, and since the
16 whole goal of health is to keep people out of the
17 hospital and keep them well, can we talk about a
18 measure that looks at the number of productive
19 out of hospital days or number of days at work or
20 school within a period of time after a visit, I
21 think would be interesting.

22 And it may not really -- maybe that

1 shouldn't really be telehealth-specific, but I
2 don't know that it exists in other measures, so
3 it is a place to begin.

4 The other one that I think is actually
5 relevant for everything but is harder to do in
6 telehealth world, is does the provider have
7 access to the medical records? Like we talked
8 about the subdomain of information.

9 If you're a primary care doc taking a
10 phone call in a movie theater on Friday night,
11 that's not terribly useful. If you're sitting in
12 front of medical records and have access to it at
13 the time of the decision or know the patient,
14 that is useful.

15 I think that, at some point, we have
16 to face up to like some of us that are doing
17 direct-to-consumer may or may not have access to
18 medical records. As we get to more complexity,
19 it may or may not matter when it's somebody with
20 a cold and no past medical history.

21 But it might matter if it's somebody
22 on a whole bunch of immunosuppressive agents with

1 a couple different cancers. So I think access to
2 the information is something that we should be
3 measuring.

4 I think the need to travel at all ---
5 and I say this, and this is a little self-
6 serving, is that right now, there's a site of
7 service, right? So if we believe one of the
8 advantages of telemedicine is that patients can
9 do it from home, well, you might not need to go
10 to the dialysis center to have your stuff taken
11 care of, particularly if you don't need dialysis
12 that day.

13 But some of the ways things are paid
14 and restricted, you know, hurt. But if we're
15 trying to make telemedicine available or e-visits
16 available without travel, then it would be nice
17 if some of the policies didn't require travel.
18 So I, frankly, would like to measure the amount
19 of travel involved to get the care.

20 And then I think it's important that
21 we do care coordination on the other end. And so
22 I think it's important that we measure things

1 like the time from visit to obtaining
2 medications. Which, in theory, we might be
3 faster with in telemedicine, or slower.

4 If you are at a hospital that has a
5 pharmacy, and you go downstairs and get it in an
6 hour, as compared to you couldn't move, that's
7 why you did a telemedicine visit, and now you
8 need to find a pharmacy and get there, it might
9 be worse. So I think there's some equipoise in
10 that question, and we don't know which way it's
11 going to go, and that may be worth measuring.

12 And then I think feeding on some of
13 the comments Stewart made, and listening to my
14 providers complain about stuff, one of their
15 fears is that somebody can do a telemedicine
16 visit with a neurologist, but they actually have
17 a seizure disorder, and they just scheduled an
18 appointment with the ALS specialist, who doesn't
19 deal with seizures, and can we measure whether
20 the first visit is with the correct provider or a
21 provider that can deal with the problem, because
22 those are often issues that we see.

1 And if you go visit with the wrong
2 person, they just bounce you somewhere else or
3 send you to a visit tomorrow, it's not quite as
4 useful. So those are sort of the six things that
5 I just wanted to get in the record to think
6 about. Adam and then Paul.

7 MEMBER DARKINS: I just wanted to ask
8 you more about this avoidance of travel.
9 Implicit in what you're saying is essentially
10 that what you're suggesting is really you want to
11 push people towards having telehealth visits
12 rather than having face-to-face.

13 I would just caution you very, very
14 strongly that having grown programs, if you try
15 and make it that this is the standard of care,
16 and you don't make it patient choice, you will
17 find that you'll have problems.

18 I believe very strongly it should be
19 patient choice. In other words, if you offer
20 virtual services, you always give somebody the
21 option if they want a face-to-face service they
22 can have it. So I strongly object to personally

1 because I think that patient-choice piece is
2 really important.

3 Once you start saying this is the way
4 it has to be done and push it, I think you'll
5 have problems with the program, and I think it
6 will necessarily takes away that patient's
7 choice. So I would advocate very strongly not to
8 push a standard that tries to say this is the
9 preferential way to deliver care.

10 CO-CHAIR HOLLANDER: So I agree, and
11 I wouldn't push a standard. I didn't mean to do
12 that. I just thought it's something we could
13 measure that would provide some information.
14 And, again, some of the measurements are not
15 obtain a hundred percent. It's --- look for some
16 variability, and you may actually see -- so
17 let's, theoretically, agree 100 percent with what
18 you say.

19 If the average patient in your
20 community would travel -- I'm making up numbers -
21 - 50 percent of the time, but somebody is --
22 they're traveling 90 percent of the time or 5

1 percent of the time, both can be wrong. It's
2 like you don't have to get to 100 percent, but
3 you want to find sort of the right overall map
4 for a system.

5 And let's say you're doing this at
6 payer level. If one payer has 90 percent of
7 people never travel, and another payer has 5
8 percent of people never travel, you have to ask
9 the question why. It's probably not because of
10 patient choice. It's probably because the
11 patients weren't given the choice. But by having
12 a measure, it doesn't mean you have to move
13 everybody towards a hundred percent or zero
14 percent.

15 MEMBER DARKINS: I think we're in the
16 same place. All I would say is one of the things
17 about if you've worked with measures is you get
18 unintended consequences.

19 CO-CHAIR HOLLANDER: I agree.

20 MEMBER DARKINS: People end up obeying
21 what the measure is telling you. So whatever you
22 may think and I may think here, once it's there

1 or once it's out there, it can be a driver. So
2 if you want to find a way to qualify it, fine,
3 but just that was something I really think is,
4 will be detrimental to what we're trying to do.

5 CO-CHAIR HOLLANDER: Good question.

6 Well taken. Paul, Don, Angela, Peter.

7 MEMBER GIBONEY: Well, I had the same
8 response that he has.

9 CO-CHAIR HOLLANDER: Okay.

10 MEMBER GRAF: Actually, I was going to
11 comment to, Judd, your original statement and not
12 to just limit it to thinking about travel
13 specific to the patient, but providers traveling
14 as well, doing field clinics or even I'm at this
15 office on Monday, Wednesday and Friday, and I'm
16 at this office -- you know, they could be more
17 productive in measuring not having to travel.

18 CO-CHAIR HOLLANDER: Great point.

19 Okay. Cool.

20 MEMBER GIBONEY: Listening to the ones
21 you laid out, Judd, it makes me think of the
22 patient-centric ways of looking at some of these

1 metrics. One of the things we know about
2 telehealth and our system is that even if the
3 patient does end up with a face-to-face visit,
4 they're more prepared for a definitive first
5 visit. They've had some workup, they've had some
6 conversation, they've had some history.

7 I think a lot of people have had the
8 experience where they arrive at the specialist
9 for the first visit, and the specialist says why
10 are you here? This is why I'm here. Okay.

11 Let's get a bunch of tests and radiology studies
12 and stuff, and let's have you come back for a
13 second more definitive visit, and then we can
14 make our decision. And what we know now, is that
15 we can actually not waste that first visit, but
16 have a definitive first visit with the
17 specialist.

18 Now, you can look at that from a
19 system delivery standpoint, but you can also look
20 at it from a patient-centric standpoint. And
21 perhaps a patient-centric metric that goes along
22 with that is how much of the patient's time are

1 you using to arrive at some sort of definitive
2 action for conditions that we kind of, you know,
3 like an atypical chest pain workup on the
4 outpatient basis?

5 You know, how many -- in our current
6 model, how many visits to the cardiologist does
7 that take? In a telehealth model, how many --
8 how much of the patient's time does it take to
9 complete a workup for atypical chest pain or any
10 other kind of predictable things that we kind of
11 know what it takes and just comparing telehealth
12 to standard processes with respect to the
13 patient's time away from life?

14 CO-CHAIR HOLLANDER: Okay. Angela?

15 MEMBER WALKER: I really like that
16 time to diagnose this metric. I think that's an
17 interesting one. But one comment on Judd's
18 remarks that I think is important to note.

19 If we're thinking about patients'
20 assignment to the correct provider, specifically
21 with the seizure and A list remark, it would be
22 important to also look at that in a clinical

1 setting, because I think patients don't always
2 get to the right specialist in the clinical
3 setting. But having some type of disclaimer in
4 the report, that indicates any of these metrics
5 could be used specifically to look at telehealth,
6 but they should also be considered for the
7 clinical setting. And it's going to be really
8 important to try to do those studies alongside,
9 so that we know is one better than the other or
10 not.

11 CO-CHAIR HOLLANDER: Peter.

12 MEMBER RASMUSSEN: In respect to
13 Adam's comment about giving patient choice, we
14 believe in that as well, in terms of site of
15 service, whether it's telemedicine or in person.

16 But one of the ways that we're
17 evolving our program is that one of our pediatric
18 ENT doctors is only seeing children post-op using
19 telemedicine. And the way we're getting around
20 this patient choice is well then you don't have
21 surgery with Dr. X. You will see Dr. Y, if you
22 don't want to have a telemedicine follow up.

1 So I don't know how you account for
2 that kind of clinical practice behavior in a
3 metric when a physician's practice is only going
4 to be focused on telemedicine follow-ups in that
5 regard.

6 So also in the comment to your mention
7 about mileage and travel, I think that gets a
8 little complicated, as well. In my practice, I
9 can easily see you at home in a follow-up visit
10 or an outpatient visit, but you might have to
11 travel to the local imaging center to get the MRI
12 scan done.

13 And somehow you need to be thinking of
14 how we incorporate, or a lab test or something
15 like that. But I still can see you in your home.
16 So it just seems a little complicated in how you
17 measure that.

18 And then the final thing is, in terms
19 of remote patient monitoring, I don't know if
20 we've discussed any quality metrics around that,
21 but we probably need to be looking at something
22 about like frequency of remote vital sign input

1 or how often the blood pressure is being sent in,
2 how frequently are the daily weights or the
3 patient weights being sent in?

4 I think we need to be thinking about
5 that. There has to be some standard of, or
6 quality of how frequent that remote monitoring
7 behavior is happening.

8 CO-CHAIR HOLLANDER: Yes. Or actually
9 more importantly, how often it's reviewed, right?
10 I think that's probably it. Yes. That's
11 actually a great point. Stewart, Adam, Christie.

12 MEMBER FERGUSON: You know, I wonder
13 --- you mentioned care coordination. I wonder if
14 there's a kind of a higher level metric, and it's
15 more about a metric of integration of healthcare.
16 So care coordination works pretty well with
17 telehealth, but we do other things.

18 We actually did a pilot in one region
19 where every patient that was going to be referred
20 to a specialty department was involved in a
21 consultant with a health aide, a family physician
22 and a specialist, and we managed to decrease wait

1 times dramatically.

2 We used it for patients in our medical
3 home. We have a bunch of rural organizations,
4 certified PCMH, and they build us around
5 telehealth, and we're starting to integrate
6 behavior health into the primary care practice
7 through telehealth.

8 So there's a huge integration going on
9 here that's bigger than just care management.
10 And that's the beauty about this technology, you
11 can do joint sessions with three or four
12 different people in different locations rather
13 than point-to-point.

14 CO-CHAIR HOLLANDER: So should we be
15 measuring the percent of visits that are multi-
16 disciplinary visits, because maybe now the
17 providers don't need to travel and the patients
18 could have three or four people on a Webinar
19 effectively at the same time. Yes? Adam?

20 MEMBER DARKINS: Sure, I don't want to
21 sort of belabor things. One of the things that
22 struck me is I don't know what people's common

1 practice is informed consent in telehealth.

2 So in programs I've grown, we moved
3 that it was verbally-informed consent, that it
4 was included in the record, because there are
5 ways in which it's not directly comparable.
6 There are ways in which you can offer patient
7 choices, et cetera.

8 So we haven't actually, it seems to
9 me, if one's looking at one standard, one thing
10 we should decide is do we feel there should be
11 informed consent for it or not? I'm just sort of
12 interested in people's thoughts.

13 CO-CHAIR HOLLANDER: Thoughts on that
14 topic? Dan?

15 MEMBER DEPHILLIPS: I can give you
16 feedback from the regulatory front, and that is
17 just about every regulatory or legislative agency
18 that has taken up telemedicine regulation or
19 legislation, most of them have included a
20 provision for explicit informed consent. Just
21 what's out there.

22 CO-CHAIR HOLLANDER: Yes. And,

1 Daniel?

2 MEMBER SPIEGEL: Yes, and just to
3 clarify, do you mean informed consent for a
4 medical procedure or informed consent to be
5 treated via telehealth -- telemedicine?

6 MEMBER DARKINS: Informed consent for
7 the choice to be treated via telemedicine,
8 telehealth. Yeah.

9 MEMBER DEPHILLIPS: Which is the
10 intent of the regulation or legislation.

11 MEMBER SPIEGEL: Yes. And, so in my
12 experience when we've done it, we have informed
13 consent built into the process, and it's a paper
14 form that the patient signs during the first
15 visit to make sure that they want to participate
16 or receive care in that fashion.

17 CO-CHAIR HOLLANDER: Any other
18 comments on the informed consent issue by
19 anybody? Steve?

20 DR. HANDLER: Yes, two points earlier
21 that not all patients can actually participate in
22 the informed consent process, because of

1 cognitive impairment issues. That's just meant
2 to be noted.

3 MEMBER DARKINS: But just to say that
4 the normal process of informed consent in any
5 healthcare organization gives --- you have
6 processes in place joined up with delegated
7 authorities and such. I wasn't trying to get
8 into the weeds of it, but absolutely, it would
9 fit into the normal practices and any policy
10 related to informed consent and telehealth
11 relates exactly to those kinds of provisions.

12 CO-CHAIR HOLLANDER: Right. Okay.
13 And, Dale, was your comment on informed consent
14 or not? Otherwise, you're going to have to back
15 away from the microphone, because Kristi's up
16 next. Not informed consent? No?

17 MEMBER ALVERSON: It's sort of
18 interrelated, it has to do with patient choice,
19 but ---

20 CO-CHAIR HOLLANDER: Okay. Go ahead.

21 MEMBER ALVERSON: What I wanted to
22 point out -- and I still look at Don, because

1 when we found, like take Medicaid patients, we
2 spend, oh, \$10 million to \$15 million for travel
3 and per diem if you can't get your care within 65
4 miles of your place of residence.

5 And what the payers are beginning to
6 say, like Medicaid, if you could have gotten that
7 visit through telemedicine, you're going to have
8 to get that through --- we're not going to --- at
9 least you can go, but we're not going to pay.

10 So there may be an unintended
11 consequence, but I have a feeling that as we say
12 that telemedicine is a reasonable alternative to
13 an in-person visit, that that's going to tend to
14 happen. I mean I don't know how you would look
15 at it as a payer.

16 But we'll say that's great, you want
17 to travel, that's fine, but we're not going to
18 pay for that. Right now Medicaid in our state
19 does.

20 CO-CHAIR HOLLANDER: Well, you know,
21 it's far beyond my expertise, but if CMS adopts a
22 measure that they consider good for telemedicine,

1 it's even hard for me to imagine that they'll
2 adopt the measure, but then not pay for the
3 visit.

4 So, hopefully, if we could come up
5 with good measures that they believe would drive
6 better care, it will lead to reimbursement for
7 things they believe drive better care.

8 MEMBER ALVERSON: Yes. It's not
9 paying for the visit, it's paying for the
10 additional entitlement of paying for travel.

11 CO-CHAIR HOLLANDER: Oh.

12 MEMBER ALVERSON: That's what I'm --
13 we spend \$10 million to \$15 million for Medicaid
14 patients to travel to get their care that they
15 can't get close.

16 CO-CHAIR HOLLANDER: Oh, okay.

17 MEMBER ALVERSON: Not so --- no.

18 CO-CHAIR HOLLANDER: Okay. I see.

19 MEMBER ALVERSON: So it's a different
20 issue.

21 CO-CHAIR HOLLANDER: Yes. Okay.

22 Kristi? Thanks for waiting.

1 MEMBER HENDERSON: So, just a couple
2 things on workforce and remote monitoring. So we
3 talked about the burnout piece, but I'd also want
4 the flip of that -- retention. People can work
5 longer, maybe extend their careers, because they
6 are able to do their practice in telemedicine.
7 So both sides of that. But also around how it
8 impacts the workforce shortage.

9 So if you're doing co-management, you
10 learn with a specialist and a generalist. So you
11 learn, and you do more and more and more, so you
12 can expand kind of your skill set. So how many -
13 -- what's the shortage look like if everyone's
14 really maximizing their capabilities and that
15 were able to load bear the work across the
16 country?

17 The other piece is around remote
18 monitoring. So we talked about frequency of
19 transmitted information or when it's reviewed,
20 but also when is it acted upon, as well. Things
21 like PHQ-9 for depression, quality of life
22 indicators, all of those, would come into play

1 there.

2 Are we able to improve quality of
3 life, because of our ability to keep them
4 healthier at home? And then med compliance and
5 med adherence from monitoring pill bottle use and
6 things like that.

7 CO-CHAIR HOLLANDER: And related?
8 Okay. Go ahead, Henry.

9 MEMBER DEPHILLIPS: A quick, very fast
10 comment related to that comment. On the
11 physician piece, I totally acknowledge what
12 Angela said and Kristi just endorsed.

13 But I do want to share also the other
14 side of that, and that is the key to building a -
15 -- the telemedicine network has been to sort for
16 providers who are interested in doing
17 telemedicine.

18 The average experience that --- in our
19 network, 3200 whatever, is 20 years. So you
20 think it's young, people who grew up with
21 iPhones, but it's really docs who are at the peak
22 of their careers, the second half of their career

1 looking for other options.

2 And I have to tell you, the
3 satisfaction for those who choose to do --- which
4 is only about one in four providers by the way.
5 Three out of four still have zero interest in
6 doing this, at least as of today.

7 The satisfaction of a couple decades
8 of slugging it out in the trenches, and then all
9 of a sudden being able to use an iPad and
10 generate an alternate stream of income and work
11 from home and just --- like it's a whole new
12 enthusiastic vista for some docs who participate
13 in it. So I just wanted to share that side of
14 the network as well.

15 CO-CHAIR HOLLANDER: Kristi?

16 MEMBER HENDERSON: Not just physicians
17 either. This is nurses, the whole entire care
18 team.

19 MEMBER DEPHILLIPS: Okay.

20 CO-CHAIR HOLLANDER: All right. Don?

21 MEMBER GRAF: And I was going to echo
22 the remote patient monitoring concept as a way of

1 effective -- adding effectiveness to the
2 processes, turning the camera on.

3 So when you're checking for like
4 medication management and you say, did you fill
5 the script? Yes, but I don't know what the blue
6 pill is. Well, hold it up, let me see it, or
7 looking at the patients, seeing that they're
8 completely yellow or something. And there's just
9 so much more than just an RN or somebody
10 responding to a threshold alert being triggered
11 by phone.

12 CO-CHAIR HOLLANDER: Yes. And so in
13 some of the last comments, you guys have sort of
14 made me wonder whether there's a downside in
15 terms of some preventive care, right.

16 If you can get all of your sort of
17 acute problems dealt with, and your chronic
18 problems dealt with, are you less likely to go
19 and get your flu vaccine? Are you less likely to
20 get your stool guaiac done?

21 So I think it's really how does it
22 help with maintenance of care? It might actually

1 be really useful, but people tend not to go when
2 they feel well. Like it might actually make
3 hypertension control more difficult.

4 We can remotely monitor someone who's
5 got severe hypertension, but are we now not going
6 to identify people that have hypertension
7 earlier, because they don't have a need to ever
8 go to their primary care doctor? So there
9 actually could be a downside as systems develop
10 better ways to intervene with the sick, that
11 they're less able to care for the well. I don't
12 know.

13 So we were supposed to stop this at
14 10:00 and then prioritize the 10,000 ideas we
15 had. I actually am not sure. I'll look for
16 Jason for guidance on this, but I think it may be
17 worth doing this by email after the meeting, and
18 the prioritization. I think we came up with a
19 boatload of really good ideas.

20 And I would recommend, and I'm open
21 for any other suggestion in the world, is that we
22 don't try and take the probably 150 things that

1 are there and put them in an order from one to
2 150, but we probably take what goes around and
3 make them priority A, B, and C.

4 You know, super high priority,
5 intermediate priority, lower but still important
6 or just high priority and other, so we don't
7 degrade the other. But I'm not sure what you
8 think is the best way to separate them out
9 ultimately in the report.

10 MR. GOLDWATER: So I think what we're
11 going to do --- and I've written down all of your
12 -- well, I don't think it's 150, but it's pretty
13 close. And I've made side notes about where I
14 think what domains or subdomains are going to
15 fall under, which I am sure the team is doing as
16 well.

17 So I think what we'll do is we'll go
18 back over the concepts, we'll categorize them as
19 we think fit. We will send these to you for
20 your edits and comments.

21 What I would probably ask now is in
22 the remaining time that we have, two things. The

1 first is are there any of these concepts that you
2 all have explained or brought forth in the last
3 couple of hours, including yesterday, that you
4 really feel are of a high priority? I mean, we
5 really do need to include these as concepts.

6 Regardless of where all the others
7 fall out, there really does need to be an
8 emphasis on these particular concepts. And I
9 would ask that of you, and then I would ask that
10 of the government, because I know that
11 ultimately, the framework will come out and will
12 allow people the foundation to develop measures
13 which we've talked about.

14 But the government's also going to use
15 this as a way of sort of moving telehealth
16 forward. So I know Megan mentioned yesterday
17 that the productivity issues were those, some
18 that she was concerned or that HRSA was really
19 focused on.

20 So I want to ask all of you, I guess
21 in the next maybe five or 10 minutes, are there
22 any particular concepts you really think are of

1 incredibly high priority and then Megan ask that
2 of you, as well.

3 CO-CHAIR HOLLANDER: So I'm going to
4 have them just put back up here, because these
5 are what we did in the last meeting in ways of
6 dimensions of evaluation to develop the measure
7 concepts. I think as we went through the ideas
8 that people were throwing out, every one of them
9 pretty much can be mapped to a domain or a
10 subdomain, so I'm not worried about that.

11 I guess one of the thing for, Jason,
12 is that these are the dimensions of evaluation
13 that we thought were really important last time.
14 I think, based on the conversation, we would
15 probably are these are really important. It's
16 not really clear to me how these get structured
17 in the domain, subdomain and the measure
18 concepts. Like how are these items used?

19 MR. GOLDWATER: So generally, the way
20 that we would be presenting the concept is we
21 would have the domain and the subdomain, your
22 concept and then sort of what dimensions they

1 touch. So that way, at a glance, you can see
2 where it applies, what it's touching.

3 And if we find that there was a
4 concept that was brought forward that --- and
5 just off of what I have, I don't see any that are
6 not touching at least one of these. If there's
7 one that's not touching, then we would bring that
8 to your attention and say this is not within the
9 framework you all wanted. Do you want to change
10 that or do you want to eliminate it?

11 CO-CHAIR HOLLANDER: Paul?

12 MEMBER GIBONEY: So just in response
13 to what seems most pressing or most urgent or
14 most important, I said it yesterday, but I really
15 feel like the access to care, validating
16 telehealth as care, you know, kind of the
17 conversation that we're having with our state
18 trying to say can we use telehealth to meet
19 access standards?

20 Right now, we're not allowed to. And
21 that, essentially, threatens the entire viability
22 of the entire telehealth approach. And so that

1 one, to me, seems to rise up to a level of
2 importance that this group can help clarify for
3 CMS -- that this is care that it meets access to
4 specialty care, access to primary care or
5 whatever in whatever model we choose. But that
6 seems to be a pretty high priority to me.

7 CO-CHAIR HOLLANDER: Don?

8 MEMBER GRAF: And mine's going to be
9 travel and all that's associated with it, because
10 it is very impacting.

11 CO-CHAIR HOLLANDER: Henry?

12 MEMBER DEPHILLIPS: Just a quick
13 comment on the government thing. I can't
14 remember the source, source, someone in the room,
15 I'm sure, knows whether it was CMS or whether it
16 was multiple state levels, but there are several
17 Medicaid plans that are now able, under their
18 jurisdiction, to include the telemedicine network
19 in network adequacy to meet the needs of their
20 operation in Medicaid in multiple states, so the
21 precedent has been set somewhere.

22 CO-CHAIR HOLLANDER: Okay. Dale?

1 MEMBER ALVERSON: Important thing
2 from my standpoint, Jason, is time, timeliness.
3 So we talked about time from request to time of
4 consult, and we see that in dermatology, where it
5 could take six months.

6 And, of course, there's an implication
7 that more timely care is, there's quicker
8 diagnosis, better -- sooner intervention, better
9 outcomes. But timeliness from request to the
10 actual consult --- timeliness for the appropriate
11 decision-making.

12 And so I think about even like
13 telestroke, timely access in that narrow window
14 to determine whether a patient qualifies for tPA.
15 So time is a big factor, I think, that should be
16 high on the list that we can use --- take
17 advantage of with telemedicine.

18 CO-CHAIR HOLLANDER: Adam?

19 MEMBER DARKINS: Mine would be
20 consistency, I think. And the reason I say that
21 is that having developed telemedicine programs in
22 --- across 150 hospitals, one of the things

1 around it, you're creating large networks.

2 A lot of the standard-setting that's
3 done and the accreditation is done around
4 individual buildings and institutions. So if we
5 feel the importance of this is going to be how we
6 develop very large networks, I think it's
7 important you don't get lots of conflicting
8 standards.

9 So I wasn't trying to make a big deal
10 about informed consent. One of the reasons it
11 was important for me to have a policy for
12 informed consent was that if you end up having a
13 patient linking to a clinician, and the referring
14 one and the consulting one both have different
15 policies, and the poor patient is sitting there
16 saying if these folks can't even work in their
17 own mind whether or not they need me to be
18 consenting, what's going on here?

19 So I think from the delivery piece,
20 that kind of consistency is going to be important
21 of how we try and get consistency if we want to
22 develop large networks.

1 CO-CHAIR HOLLANDER: Okay. Mary?

2 MEMBER MOEWE: Just from the travel
3 component going back to what you said, Don. I
4 think that there's a huge savings that we could
5 see across the state, any state, and federal
6 government with correction travel. We have ---
7 if we could mandate, which is possible, any state
8 could mandate telemedicine for a correction
9 environment, there is a huge cost to having
10 guards accompany a patient at a correction
11 institution to a hospital.

12 There is a huge safety issue with it,
13 as well. And, generally, many correctional
14 facilities don't have an electronic health record
15 yet. So they have paper documents that have to
16 accompany a patient with them, and oftentimes
17 they forget to even bring those, because it's
18 such an issue when you transport a patient.

19 I mean, there's concern whether or not
20 they really need to go to the hospital, if
21 they're faking it, and there's behavioral health
22 issues going on along with medical issues. And

1 it would be an enormous savings -- I mean,
2 gazillions of dollars, because it's just not even
3 quantifiable. And the safety aspect of it would
4 be amazing.

5 CO-CHAIR HOLLANDER: Right. So maybe
6 as a broader thing, rather than just corrections,
7 because that's kind of narrow, is provider
8 safety, and it can then be added --

9 MEMBER MOEWE: True.

10 CO-CHAIR HOLLANDER: -- expanded to
11 actually provide a sort of missed days from work.
12 And I'm thinking back to when the whole Ebola
13 thing broke, we actually used an iPad out there,
14 and just set the triage nurse four feet further
15 away, so they are less likely to get sneezed on
16 for everybody who came in.

17 And we didn't really track it, but it
18 made sense to me that if you're just not getting
19 sneezed and coughed on, you're less likely to get
20 sick during the flu season. And so maybe that --
21 - it's not actually retention, but it's days that
22 providers could go to work.

1 MEMBER MOEWE: Right.

2 CO-CHAIR HOLLANDER: And --

3 MEMBER MOEWE: And it's not just
4 provider safety, it's the people who have to
5 accompany --

6 CO-CHAIR HOLLANDER: Everybody.
7 Right.

8 MEMBER MOEWE: -- that prisoner. And
9 I know you're saying a broad spectrum of not --

10 CO-CHAIR HOLLANDER: Right.

11 MEMBER MOEWE: -- not just prisoners,
12 but there's a huge market for this in the
13 correctional environment. Huge.

14 CO-CHAIR HOLLANDER: Oh, yes. No.

15 MEMBER MOEWE: Did I sound like
16 someone?

17 CO-CHAIR HOLLANDER: Yeah. Yeah.
18 Yeah. Yeah.

19 MEMBER MOEWE: Huge.

20 CO-CHAIR HOLLANDER: Henry --

21 MEMBER MOEWE: All right, I'll shut up
22 now.

1 CO-CHAIR HOLLANDER: Henry, Daniel,
2 Dennis.

3 MEMBER DEPHILLIPS: The concept here
4 -- so I want to make sure that -- I'm pretty
5 sure it's going to happen, but I just want to be
6 explicit about it, is how when we construct our
7 framework we define sort of benefit.

8 Old example. The last -- when I was
9 in the health plan world, the last thing the CFO
10 wanted was an incredibly successful mammography
11 screening program, drove up costs incredibly,
12 downstream benefit, to some, has never been
13 proven.

14 Current example, Stewart, you gave a
15 great one. You were able to do retinal screening
16 on a bunch of diabetics who either have never had
17 it done or would never have had it done, and a
18 third of those need follow-up care.

19 So if you're doing a financial impact
20 study on that, it's going to be hugely expensive,
21 including transportation costs in Alaska. But if
22 you look at the benefit and health to the

1 patients who receive the care, it's hugely
2 beneficial.

3 So I just --- from a concept
4 standpoint, I want to make sure that the greater
5 good is taken into account in addition to just
6 the money, which a lot of people tend to focus
7 on.

8 CO-CHAIR HOLLANDER: Daniel?

9 MEMBER SPIEGEL: This concept was
10 discussed yesterday, and I think probably
11 mentioned again today. But as long as we're
12 pointing out ones that we think are really
13 important, I think there's a clinical
14 effectiveness concept, which definitely boils to
15 the top for me, which is sort of percentage or --
16 not to create the measure, but percentage of
17 appropriate cases that are handled without the
18 need for a face-to-face visit.

19 And I don't know how you get to
20 appropriateness, but somebody will develop a
21 measure to figure that out.

22 CO-CHAIR HOLLANDER: But, you know, a

1 lot of the measures are about variability, again.
2 So if data shows it's 75 percent for Complaint X,
3 then if you're doing 99 percent, maybe you're
4 under-ordering stuff, and if you're doing 20
5 percent, maybe you're over-ordering stuff.

6 Dennis?

7 MEMBER TRUONG: I just want to bring
8 together a couple of comments from others that I
9 wanted to bring the point across, is that, so
10 traditionally, we tend to --- we're taking about
11 someone else measuring the amount of telehealth
12 visits that become face-to-face visits. And we
13 want to try to measure that in some level whether
14 it was coding of something within the EMRs.

15 But on the flipside, as Dale and Judd
16 mentioned about the ability to up-triage
17 patients, a patient who used telemedicine as a
18 triage tool, well, if it's in a place like Paul
19 was talking about where you do have the access to
20 follow up care access to labs, radiology, those
21 kind of things, that might be more of a situation
22 where you don't get dinged for face-to-face

1 becoming --- I mean telemedicine basically
2 becoming face-to-face, but more of that this and
3 more the interconnectivity of the network that
4 you're trying to form that would make telehealth
5 that much more powerful. I just want to bring
6 that up.

7 CO-CHAIR HOLLANDER: Okay. Dale,
8 Peter, and then we'll go to Megan, and then we'll
9 take a break.

10 MEMBER ALVERSON: Just want to add on
11 to what Henry said. And that's just a -- and
12 this might be a harder one to measure, but
13 avoidance of more expensive care or consequences
14 of not getting appropriate care.

15 And it goes like to retinal screening
16 in studies, and I think you're showing this as
17 well, picked up a very high percentage of
18 patients who got their first retinal scan, who
19 actually had sight-threatening retinopathy and,
20 again, blindness was prevented.

21 And this maybe goes more to a system
22 cost issue, but the cost of treating somebody who

1 goes blind for rehabilitations could have paid
2 for that whole system for doing the retinal
3 screening.

4 So there is a benefit of avoiding
5 unnecessary complications by not getting timely
6 care. So just -- I think that's an important
7 measure. I just -- I'm not sure, Jason, how easy
8 that is to measure to say well, because we did
9 this intervention, we prevented blindness, but we
10 certainly have seen some examples of that.

11 CO-CHAIR HOLLANDER: Okay. So the
12 people who have their things up, we'll hit all of
13 them, and then we're going to take a break. So
14 if you're thing's not up, please don't put it up,
15 because we'll talk after the break on that. So,
16 Peter?

17 MEMBER RASMUSSEN: My perspective, in
18 terms of what's priority, I'm feeling that there
19 are not only healthcare systems that are getting
20 into the remote patient monitoring business, but
21 just startup companies that are in this space.
22 And I think that would be a priority area to put

1 some quality metrics around that behavior to try
2 to provide some protection to the public, in
3 terms of slipshod care delivery.

4 CO-CHAIR HOLLANDER: Okay. Nate?

5 MEMBER GLADWELL: This is an item that
6 I don't think has been discussed yet today, is
7 how patients feel more empowered and at the
8 center of their care. I know this is a dangerous
9 room to make that comment.

10 But moving from an experience where a
11 hospital is where you go to receive healthcare
12 and moving it more to the patient's environment,
13 I think is a critical component for what
14 telehealth brings to the table. Don't know where
15 it goes. Don't know how to put it in, but I
16 think it ought to be mentioned.

17 CO-CHAIR HOLLANDER: Okay. Marybeth?

18 MEMBER FARQUHAR: To follow up on Adam
19 and Dennis with regard to consistency, care
20 coordination and transitions of care are
21 extremely important, particularly if there's like
22 one-off visits or whatever.

1 And the other thing that I wanted to
2 bring up that probably wasn't brought up is self-
3 management support, so that folks can actually
4 follow through on their care and, basically, be
5 healthier.

6 CO-CHAIR HOLLANDER: All right.
7 Daniel?

8 MEMBER SPIEGEL: All right. I just
9 want to follow up on something that Dale said
10 about sort of avoiding higher costs of care or
11 sites of higher costs of care.

12 Maybe one way to get at that is sort
13 of site of initial presentation for various
14 disease types, because I know in the dialysis
15 world half of our patients show up in the
16 hospital with end-stage renal disease. And we'd
17 prefer to them to go to a nephrologist first and
18 be followed until they actually need dialysis.

19 CO-CHAIR HOLLANDER: Okay, Stewart?

20 MEMBER FERGUSON: Again, I agree with
21 Henry, Dale, Daniel about trying to measure
22 adverse outcomes. But I think also quality of

1 care is a big part, like I'll often read that.

2 I just wanted to kind of put a plug
3 in, Adam had a really good concept there about
4 consistency, and we have learned in telemedicine,
5 the best way to kill telemedicine is to be very
6 inconsistent to one day do a response in four
7 hours and the next day wait 10 days.

8 And it's a good process measure. How
9 consistent, you know, what's that bell curve
10 around your response time? So not just how fast
11 it is, but what's the distribution might be a
12 very interesting measure.

13 CO-CHAIR HOLLANDER: Okay. And is
14 there another one? No? And, Megan, you have
15 something?

16 MEMBER GRAF: No, it's Natassja?

17 MS. MEACHAM: Yes, I've asked Natassja
18 Manzanero with our Office for the Advancement of
19 Telehealth to join me. I am a senior advisor in
20 the office, so I can speak broadly to a lot of
21 topics. Natasha is more of our child health
22 expert.

1 So I'm going to start with the big
2 picture of why we're the ones doing this, and I
3 think it'll help answer some of the questions on
4 what's important to us, and then I'm going to ask
5 Natassja to fill in the pieces that I miss.

6 So kind of big picture, our office is
7 tasked with advising the Secretary of Health and
8 Human Services on any issues and policies that
9 impact the rural.

10 Currently, the government reimburses
11 telehealth, and there's a rural angle to it. So
12 while we do understand that telehealth has
13 important impact, beyond rural, the way that
14 we're advising the secretary has to do with
15 Medicare reimbursement and what we know about
16 telehealth and the reimbursement angle for the
17 CMS side of things.

18 Then slightly then more directly in
19 our office, the Office for the Advancement of
20 Telehealth, it's a \$17 million division, and we
21 fund telehealth programs.

22 So the measurement is important to us

1 because we need to be able to advise the
2 secretary on what's going on with telehealth --
3 what are we seeing.

4 And the we also need to continue to
5 show that our programs are effective, but we need
6 measurement to be able to do so. And then the
7 idea is that like things can eventually grow and
8 expand and be replicated in other areas.

9 So I think everything you're touching
10 on, like I hope you see me nodding my head
11 throughout the last day and a half, I think
12 you're touching on all the really important
13 things.

14 As Jason said, yesterday I mentioned
15 that the productivity, the travel, those ones are
16 important to us, because, again, it shows --- it
17 helps us show the impact of our programs and
18 helps to continue to fund those programs.

19 But also what we've found with a lot
20 of those types of measures is that everyone
21 measures them so differently, there's not that
22 consistent measurement, so we're not able to even

1 say what the impact is.

2 So while the quality and the
3 timeliness, the cost, the cost savings, safety,
4 all of those things are very important. But the
5 reason that I kept kind of coming back to and in
6 our statement of work we talked about those like
7 the really non-clinical travel impact on the
8 patient.

9 If we could get to some agreement as
10 a committee at the end, like once we get through
11 this, maybe the next step is, okay, we've agreed
12 that these are important. These are the ones
13 where we already have measures, these are the
14 ones where we don't have measures, but we
15 recommend that maybe that should be measured in
16 this particular way.

17 Or we need to continue to look at how
18 we're going to standardize how we're measuring
19 this particular thing. So do you have anything
20 to add?

21 MS. MANZANERO: Yes. So in 2012,
22 there was a meeting at HRSA that convened

1 stakeholder groups, such as this one, on
2 telehealth. I think a few of you were there.
3 But one of the goals was to convene a meeting
4 like this to do a full study of telehealth, and
5 so I think we are accomplishing that today.

6 And what we want to do is focus on the
7 priorities. And I think that we have hit some of
8 these top priorities here today. We actually did
9 a recent Telehealth Compendium with several folks
10 in the federal government; so NASA, ONC helped us
11 with Department of Justice, Bureau of Prisons.

12 Actually, the Telehealth Compendium
13 became public on November 16th. So if you look
14 on ONC's website, the Telehealth Compendium,
15 there's a list of federal telehealth work that
16 has --- that is currently being done that we know
17 of, that we've researched over the past six
18 months, that we've discovered.

19 So that's kind of informing us on the
20 current work being done across the federal
21 government on telehealth. And so we feel that
22 this work, along with the current funding

1 opportunity announcements of the new Telehealth
2 Resource Centers, which provide free technical
3 assistance for rural and under-served providers
4 on telehealth, will help inform us more on these
5 priority topics for moving telehealth forward.

6 So ---

7 MS. MEACHAM: The last thing I want to
8 add is and you guys, again have all touched on
9 this, is that we definitely do not want to create
10 a separate measurement framework for telehealth,
11 but how do we makes sure that telehealth is being
12 measured in the way that our traditional care is
13 being measured so that we can have these
14 comparisons and that telehealth is appropriately
15 being accounted for.

16 When we're looking at the quality of
17 our population nationwide, we need to make sure
18 that all healthcare encounters are being
19 measured.

20 MR. GOLDWATER: Okay. That's great.
21 Thank you both very much. So I'm glad we touched
22 on all of your major issues. And thank you all

1 very much. And so, let's take 15, and we'll come
2 back and do the use cases after that. Is that
3 all right? He's nodding yes. You can't see it.

4 CO-CHAIR HOLLANDER: Yes.

5 MR. GOLDWATER: All right. Okay. 15
6 minutes. Thanks a lot.

7 (Whereupon, the above entitled matter
8 went off the record at 10:35 a.m. and resumed at
9 11:03 a.m.)

10 MR. GOLDWATER: Okay. So now we are
11 officially on the record. So what we're going to
12 turn to now, I think we've had, again, a really
13 robust discussion of a lot of concepts and thank
14 you all for sort of taking some time to
15 prioritize those that were really significant,
16 because that helps us out a lot, about how to
17 highlight that in the report going forward. And
18 that doesn't mean that we can't continue to
19 evolve that as we move on.

20 And again, thanks to Megan and Tassja
21 for their insight. I think that was very helpful
22 about how they're going to use the framework, and

1 then its significance were very, very helpful.

2 So one of the things we're going to do
3 is now just go over some test use cases. We did
4 send an email to all of you, that if you had any
5 use cases to send to us.

6 We did get several from a number of
7 people. We're not going to go through all of
8 them because that would take up a majority of the
9 meeting. But what we're going to do is sort of
10 divide this into two parts. One is of some very
11 broad type use cases that Judd's going to go
12 over. And then some specific ones, which will be
13 samples of some of the ones you've sent to us.

14 And so I'm smiling when I'm saying
15 this because as we had conversations with Judd
16 and Marcia over the use cases, you know, Judd
17 said this was really important because he wants
18 to pressure test the criteria of measure concept
19 development against the use cases, and I have to
20 tell Judd, that's sort of become the term of our
21 team, is pressure test.

22 We use that basically in everything

1 that we do. So you know, what are we doing this
2 weekend?

3 Well, we'll pressure test some ideas
4 before we go out. What are we going to have for
5 lunch? Well, let's pressure test the idea of a
6 salad versus a sandwich.

7 It's really been, it's become such a
8 phrase, we'd like to put it on T-shirts and wear
9 them, but we haven't gotten to that point yet.

10 So really, we love that phrase. So we
11 wanted to just let you know, Judd, you're in our
12 minds all the time.

13 I'm not sure what that says about us,
14 but anyways, so I'm going to turn this over to
15 you and let you walk through it.

16 CO-CHAIR HOLLANDER: Okay. So let's
17 go to the -- so this is stolen from a colleague
18 of mine on the Pennsylvania Task Force where
19 we're doing similar stuff with telehealth as NQF,
20 but in a smaller manner. And we were trying to
21 develop a framework system for this.

22 And you know, it was the thoughts of

1 that group that, we don't want to talk about
2 telederm and neuro-stroke and eICU, and can we
3 broaden it out so that all of the use cases could
4 fit within one framework.

5 So this literally was an email the day
6 before I sent this to Jason on somebody's first
7 thoughts, wordsmith.

8 So it's not the refined end product of
9 that group. But I thought that you could
10 probably break down most telemedicine-specific,
11 disease-specific use cases by these three
12 categories. One is if its synchronous versus
13 asynchronous, the other is, is it provider-to-
14 provider versus consumer-to-provider. And then,
15 you know, right now the originating site or the
16 location of the telemedicine is relevant.

17 And so this is up here to say, what
18 other broad categories might interdigitate so
19 that every telemedicine use case or most
20 telemedicine use cases that deal with patient
21 care could be categorized by these terms? And
22 again, this was early thoughts.

1 And then we'll get into a couple of
2 specific examples of use cases that this group
3 sent in, and see whether it fits within this and
4 can fit within our domains and sub-domains as
5 well.

6 Oh, okay. Stewart, you're up, and
7 then Peter. Oh, Peter, go ahead.

8 MEMBER RASMUSSEN: I mean, I agree.
9 This covers almost everything. I'm just thinking
10 that since you've termed one thing originating
11 site, and the other thing provider-to-provider,
12 maybe you could be more consistent across these
13 two things by just saying inpatient telemedicine
14 versus ambulatory telemedicine.

15 Those, recasting those two points,
16 then you have really just consistency or
17 provider-to-provider or provider-to-patient at
18 home or, you know, outside of the facility.
19 Something, just, it just seems ---

20 (Simultaneous speaking.)

21 CO-CHAIR HOLLANDER: So changing
22 originating site to something more, something

1 versus something?

2 MEMBER RASMUSSEN: Patient-to-
3 provider. Yes.

4 CO-CHAIR HOLLANDER: Okay. Okay.
5 Marcia?

6 CO-CHAIR WARD: So, I look at these
7 and I think of who, what, where, which leaves out
8 when and why.

9 CO-CHAIR HOLLANDER: So how would you
10 classify when and why?

11 CO-CHAIR WARD: So I'm thinking back
12 to some of the examples that people were throwing
13 out before and when, appropriateness, some things
14 like that.

15 The why are we using telehealth?
16 What's the advantage to it? Thinking in terms of
17 those concepts.

18 CO-CHAIR HOLLANDER: Steve?

19 MEMBER NORTH: Yes, I think that the
20 when, going back to Paul's earlier comments about
21 delaying that visit to the specialist two to
22 three months because you've initiated a care

1 based on the consult, needs to -- really fits in
2 that, when do you do this measure that we would
3 need to include in almost any framework and test
4 case.

5 CO-CHAIR HOLLANDER: Other thoughts?
6 Okay, so let's go to specific use cases. And
7 here, we'll just take them one at a time. Do you
8 want to read them? And this is your case.

9 CO-CHAIR WARD: So for the record, I
10 get to read these. A cancer clinic at a
11 community hospital wishes to provide NCCN level
12 services to breast cancer patients, but cannot
13 hire a genetic counselor.

14 Using telemedicine, they can set up
15 virtual genetic evaluation sessions with a CGC,
16 and I don't know what that is, for a family
17 history assessment, risk stratification
18 counseling, and only order genetic tests when
19 they are appropriate. And so --

20 MEMBER FLANNERY: CGC is a certified
21 genetic counselor.

22 CO-CHAIR WARD: Thank you.

1 MEMBER FLANNERY: Yes.

2 CO-CHAIR WARD: So I think part of the
3 idea of this test use and stress testing was, do
4 our domains and our sub-domains and things
5 capture what you want to measure given this
6 particular test use case.

7 CO-CHAIR HOLLANDER: And they're
8 posted on the big boards.

9 MEMBER DARKINS: I put a caveat that
10 I think that in some of these instances you would
11 need to have clinical pathways or guidelines to
12 go with it.

13 I think you can make the case for it,
14 but I think there are exceptions to those cases.
15 And you have a framework for some of these things
16 when you have delegated authorities.

17 MEMBER FLANNERY: That's why I put in
18 the NCCN guideline.

19 MEMBER DARKINS: Yes. Yes.

20 CO-CHAIR HOLLANDER: No. So I guess
21 the question here is not is it the best level of
22 care as described, but if someone did a measure

1 around this type of thing, really does it -- not
2 how do you do the measure but does it fit within
3 our domains and sub-domains, or is there just
4 something missing from the domains and sub-
5 domains so that these things don't fit?

6 And it's not really, this is a
7 recommended measure. This is just something,
8 probably David came up with, but you know, each
9 of these, somebody from the group came up with,
10 and just put out there.

11 And now, as long as we think this is
12 covered by a domain and sub-domain, that's all we
13 need to comment on.

14 If it's not, then we need to think,
15 well, did we miss something in the domains and
16 sub-domains?

17 MEMBER GOBONEY: This is -- this is
18 largely, I think, fits into the access measure.
19 I mean, you've got an entity that can't hire the
20 genetic counselor because they don't have the
21 volume or money to justify it, or the genetic
22 counselors are a very scarce resource and they

1 can't compete with other players in the market to
2 get them.

3 So it's an access issue. But the
4 telehealth proposes a solution to that by, you
5 know, setting up something. So I think it, I
6 think it fits most cleanly in access.

7 CO-CHAIR HOLLANDER: Angela?

8 MEMBER WALKER: So I, too, thought
9 access initially, and then with the NCCN level
10 service, I wonder if there's some type of
11 guideline there for appropriateness of testing
12 that wouldn't be ordered otherwise? And so would
13 it then best fit in effectiveness for kind of
14 clinical effectiveness?

15 MEMBER FLANNERY: Or it could be
16 system effectiveness also.

17 MEMBER WALKER: Right. And how do you
18 decide if you had a --

19 MEMBER FLANNERY: Right.

20 MEMBER WALKER: -- use case like this,
21 where it fit best?

22 CO-CHAIR HOLLANDER: Kristi?

1 MEMBER HENDERSON: Does it matter it,
2 because it fits in all of them to me. Is that
3 okay?

4 CO-CHAIR HOLLANDER: Yes.

5 MEMBER HENDERSON: Yes, okay. Good.

6 CO-CHAIR HOLLANDER: Yes. Sarah?

7 MEMBER SOSSONG: I meant to make this
8 update earlier, but my notes for access have
9 noted that, excuse me, that access for, it was
10 access to care team and system, and I see this as
11 fitting in with the access to the care team and
12 system because to provide the genetic counseling
13 is providing system access. So I would just make
14 that, add it to the access sub-domain.

15 CO-CHAIR HOLLANDER: Yes, I think --

16 MEMBER SOSSONG: That was just missed.

17 CO-CHAIR HOLLANDER: So I think, and
18 I'll look to, you know, Jason for guidance on
19 this.

20 I think as we go through these use
21 cases, like if it fits into one domain and sub-
22 domain, we're done, and we don't actually need to

1 debate which ones it fits into.

2 And if it actually fits into multiple
3 ones, that's fine. Right? So we just want to
4 make sure it fits somewhere on the map.

5 And then if someone disagrees -- so I
6 guess the important thing is, someone says, yes,
7 I think it fits somewhere or defines it, and then
8 if someone thinks, no, it doesn't fit there,
9 that's worthy of debate.

10 But if everybody says, oh, it could
11 also fit here. Then we probably don't need to
12 necessarily have that conversation. Yes?

13 MR. GOLDWATER: Correct. But let me
14 caveat that a bit by saying, this is what would
15 be helpful.

16 So when you look at a use case, you
17 know, what domain or domains does it fall under?
18 And obviously some of these are going to cross-
19 apply.

20 They're going to be, there's going to
21 be overlap. What sub-domains do they apply to?
22 And again, there could be overlap.

1 I can clearly see Kristi's argument
2 that they fit into all of them. Honestly, there
3 could an argument made that they fit into every
4 one.

5 So what would help -- there's two
6 things that would be helpful here. One is, if
7 you think that they're overlapping in domains,
8 how would you go about choosing what domain it
9 should go under?

10 You know, what, in your mind, what
11 sort of the criteria or what do you think is
12 necessary to be classifying that appropriately?

13 Because we're going to run into this,
14 I'm sure, on more than one occasion. And we're
15 going to run into this, I think, when we start
16 teasing out the measure concepts and possibly the
17 measures.

18 So it would be interesting to sort of
19 get your insights into how you think you should
20 classify this appropriately.

21 And then secondly, do you see the
22 measure concepts that you all have discussed

1 relating to that particular use case?

2 Can you see -- especially the ones
3 that you all viewed as being very important, do
4 you see some of those relating to that?

5 Can you see that they can be derived
6 from that use case, or do you see that there are
7 other measure concepts, perhaps you haven't been
8 able to identify yet, that could be created from
9 that use case as well? That would be helpful to
10 us.

11 CO-CHAIR HOLLANDER: Sarah, go ahead.

12 MEMBER SOSSONG: Clarifying question.
13 So when you, so when we look at that first
14 example, how do you see that that would fit under
15 just one of the concepts, your sub-concepts?

16 I just, I think the way we developed
17 the framework was, the intention was that any one
18 use case could tie to all of those, depending on
19 what you're looking at. So is the intent to look
20 at the primary?

21 MR. GOLDWATER: No, I don't think that
22 there's an issue with the overlap and having them

1 fit into all of them.

2 I think we're, what we're trying to
3 understand is, you know, how -- if there's one
4 where you could see it relating to access,
5 relating to experience, relating to
6 effectiveness, do you think that there's a way
7 that you are able to, understanding that it
8 overlaps, classify them into one of the domains,
9 or do you think that that classification's
10 unnecessary and that we should just be leveraging
11 all of them?

12 DR. BURSTIN: Just one reflection from
13 our Attribution Committee we did just a few
14 months ago.

15 They actually used the use cases
16 slightly differently, which was the idea that
17 they used these as illustrative examples to be
18 able to make the sort of principles and the
19 guidance they offer about attribution kind of
20 feel more alive to people as they looked at it.

21 So it's not so much they tried to peg
22 them into, this fits this principle or this part

1 of the report. But instead, it's a way to make
2 your concepts and the domains kind of come alive.

3 So it might be that these could cross
4 pretty easily and still be able to tell the story
5 better in terms of the framework.

6 MEMBER DOARN: Oh, I wonder, you know,
7 going into the future, if this person seeks
8 counseling and the person they actually talked to
9 is the system, it's not a person.

10 It's an AI system, you know, the -- I
11 think it's USC, developed an avatar to talk to
12 veterans about post-traumatic stress disorder.
13 It's still in development, but that's five years
14 ago.

15 So now we're now five years from now,
16 the measures we're developing today, would they
17 apply if the actual person is talking to a
18 system, not an actual human being? Would they
19 fit?

20 MEMBER ALVERSON: One of the things
21 that maybe Helen and Jason and others could help
22 out, but see, what IT said, I was looking at the

1 first one about the cancer clinic example,
2 there's a metric that could be about access, that
3 we've improved access to that service.

4 There could be a metric related to
5 financial impact, that more appropriate decisions
6 were made. Does that -- does that patient need
7 genetic testing or not?

8 And then, the same thing with
9 experience. Obviously the patient who's
10 concerned now, do I have some kind of genetic
11 marker that makes me more at risk?

12 That fits, there might be a different
13 metric. And then, the same thing then when you
14 look at effectiveness.

15 So to me, and I -- and so I'm sort of
16 seeing going sort of maybe from bottom up, but I
17 say, well, I see a metric for each one of those
18 domains just based on that use case. And they're
19 not the -- they're not the same metric.

20 MR. GOLDWATER: Okay. Very helpful.
21 And I think that I think cuts to what, I think
22 what was seeming to be said on both sides.

1 So it sort of shows how it aligns with
2 what you all have thought of, and it also sort of
3 brings that to light. So it's very helpful.
4 Angela?

5 MEMBER WALKER: Yes. I'm thinking now
6 a little bit from the level of the system and
7 trying to increase adoption of telesystems, and
8 it might be useful for my organization to have
9 some model to go look at for how to design
10 something, what to look at to pressure test it.
11 What are my metrics and I'm trying to look at.

12 So the use case in this setting would
13 be really valuable to me if I had it clearly
14 defined in each of the domains or sub-domains and
15 what kind of the metric or measure is I'm testing
16 so that I can clearly evaluate that specific use
17 case in my organization.

18 And I don't know how much of that
19 should be part of the report, but anything that
20 can make it very transparent, so as an
21 organization that just needs that model to look
22 at first, I have that available to me.

1 CO-CHAIR WARD: Okay, let's try
2 another one, and I'm going to skip to the fourth
3 one, so it's another specialty.

4 Telemanagement of skin disease.
5 Largely the patients with acne, psoriasis, and
6 eczema who have chronic ongoing skin disease, but
7 have a known diagnosis and treatment regimen,
8 routine surveillance and monitoring of skin
9 disease for therapeutic changes or to refill, I'm
10 sorry, medications.

11 So are there other issues for this one
12 other than what we've already talked about that
13 applied to the first test use case?

14 MEMBER DARKINS: Why not include an
15 evidence base for these? I mean -- I just --
16 they're fine, but why not actually provide some
17 references and give a specific evidence case for
18 the effectiveness?

19 Because it seems to me, you know,
20 you're kind of throwing, putting things out there
21 and saying, well, you could do this if you do
22 that. I mean --

1 CO-CHAIR HOLLANDER: Confusion on the
2 purpose. These are not designed to say these
3 should be measures at all.

4 MEMBER DARKINS: No, no. I understand
5 that. What you're using these is as examples.

6 CO-CHAIR HOLLANDER: Right.

7 MEMBER DARKINS: So I assume you might
8 put this in the report and say in the report,
9 here are some examples of how we would do it.

10 So I'm saying, if you're going to do
11 that, it seems to me you would actually not just
12 say, well, you know, here's what we're thinking.

13 You'll actually say based on some
14 evidence, and just define it round there.
15 Because surely evidence is what we're about.

16 Because I think if you look at that,
17 I mean, the answer is, telemanagement for skin
18 disease, largely patients with acne, psoriasis,
19 yes, it's kind of okay, but on the other hand,
20 you can't do a full skin analysis necessarily
21 easily by telehealth.

22 And what about somebody who might live

1 in a -- in an area where they're exposed to sun,
2 you might worry about melanoma.

3 So, and also, what about some of the
4 aspects around how you might end up doing routine
5 surveillance, which you might do as part of a
6 routine checkup, some things you might do. So it
7 seems to be, it's all fine.

8 But it's kind of -- so if you could
9 give an example that says, here is publication,
10 here's an evidence base, here's some evidence of
11 what it is, I think it would be stronger because
12 it seems to me otherwise we're kind of putting
13 out suppositions. Does that make any sense?

14 MEMBER WALKER: Yes. And some of the
15 evidence already exists, especially in the
16 psoriasis population, to treat psoriasis in this,
17 in this mechanism.

18 I'm kind of envisioning as kind of the
19 backwards approach. So perhaps I'm in a
20 community where telemedicine would make a lot of
21 sense to manage some of these chronic skin
22 diseases.

1 And I need the framework or the
2 organization in mind to think about these at a
3 higher level without just the one-off report.

4 And some of the evidence, as it's
5 generated, would then lead to the bigger study,
6 the bigger picture.

7 The measures, as I understand it, is
8 kind of the -- does this meet a specific
9 threshold for quality?

10 And over time you could envision kind
11 of creating that measure and having a metric to
12 measure specifically with each of these, does it
13 meet some threshold.

14 MR. GOLDWATER: So Adam, I think your
15 point's very well-stated, and we do have, you
16 know, I think the literature we found and
17 literature we'll continue to review.

18 When we put these into the report,
19 they'll be the evidence base indicating why the
20 use case is appropriate.

21 I think for the -- for this exercise,
22 it's, again, you know, did, it's more of an

1 identification that the domains and sub-domains
2 are appropriate here.

3 That use cases such as this with an
4 evidence base could be developed into measure
5 concepts, eventually into measures. That
6 everything you've done up to date fits into this.

7 If it has not, then you know, as Judd
8 said, other additional things we need to add or
9 take out.

10 But you're absolutely right. When
11 this, when it goes into the report, there has to
12 be an evidence base about why we're using those.
13 Sure.

14 MEMBER GOBONEY: In terms of just what
15 categories this fits in, I can see it could
16 possibly -- there would be measures around
17 patient experience, if the patient likes doing
18 the home monitoring and not having to, you know,
19 go into the doctor's office as frequently.

20 I could imagine there would be
21 technical or operational effectiveness, like how
22 well do we deploy whatever, you know, the cameras

1 or the portal or uploading of the pictures or the
2 communication between the patient and the
3 physician.

4 So I could imagine there would also be
5 some of the operational or technical
6 effectiveness as well.

7 MEMBER DOARN: Well, that's sort of
8 along the same lines. But I was thinking of, you
9 know, taking a picture of a lesion or a wound in
10 a home that has a 25 watt light bulb and the
11 curtains are drawn and it's a crappy camera.

12 The patient may or may not know how to
13 take the picture, how far away to get from the
14 lesion and so forth.

15 And then the actually quality of the
16 image itself once it's uploaded, are there, I
17 mean, does that fall under clinical effectiveness
18 or is that systems, or is not part of that?

19 Because the quality, you know, quality
20 of the image -- same thing with, you know, x-rays
21 on a light box in foreign countries.

22 You take a picture of a light box and

1 the radiologist comes, okay, and goes yes, okay,
2 it's a broken bone or whatever.

3 But the quality may not be the same as
4 a, as a radiologist or a dermatologist may want
5 to see in their office.

6 So I'm just curious about, it's again,
7 the technical part, but it's the quality of
8 capturing the image, and then if you're going to
9 have the patient do that, do you train them on
10 what kind of camera to use or how far to hold it
11 away from the skin? Are you -- is there a
12 dialogue going on when you're doing this?

13 CO-CHAIR WARD: My perception from
14 this is we did such a fabulous job of identifying
15 domains and sub-domains that these test cases
16 definitely fit. Can anybody think of a test case
17 that stretches what we came up with yesterday?

18 MS. MEACHAM: Oh, man. I don't even
19 know if this is relevant for the conversation.

20 I'm just, we had a grantee partnership
21 meeting recently, and our acting administrator,
22 Jim Macrae, came in and asked, you know, if you

1 could wave a magic wand, what would you fix in
2 your communities to improve healthcare in rural?

3 And a lot of people were talking
4 about, especially with the Medicaid population,
5 they're getting, you know, like cell phones
6 provided or paid for.

7 They're running out of data at the end
8 of the month. They're not answering their calls
9 because you don't, they don't have any minutes.

10 So that's been going through my mind
11 a little bit over the last two days. So like,
12 what if you've got a patient and they, you know,
13 they have broadband, they have a phone, but then
14 they run out of data so they just --

15 MEMBER NORTH: Yes, I think that
16 that's a real issue in my community. And I think
17 that that would all fall under the financial
18 impact and cost domain, and then, and then bleed
19 over into patient experience and caregiver
20 experience.

21 I get real frustrated when I cannot
22 reach my patients and have changed a kid's meds

1 and need to let mom know.

2 MEMBER RASMUSSEN: And it also can go
3 to technical effectiveness.

4 So I actually believe your concern can
5 be addressed in a lot of these domains and sub-
6 domains.

7 CO-CHAIR HOLLANDER: Yes, Chuck?

8 MEMBER DOARN: The, you know, as, I'm
9 the co-chair of the Federal Telemedicine Working
10 Group with Bill England, and one of the things we
11 had recently was the FCC came and showed us some
12 broadband maps and some of the metrics they're
13 using to look at how you can reach more and more
14 Americans.

15 And it always amazes me when you look
16 at the Verizon maps, you know, oh, we cover 90
17 percent of the country, which is absolutely
18 false.

19 I mean, I live in Ohio and just north
20 of Cincinnati, my in-laws, they can't, it's hard
21 to get the phone to work in a certain part of the
22 house.

1 So if the government decides that
2 we're going to start rolling this out, then that
3 means that everyone has to have access to
4 broadband, whether, as we were talking about
5 earlier, whether it's to do your taxes or get a
6 license to open a nail salon, you have to be able
7 to use the web, which means you have to have
8 bandwidth.

9 And if we're going to now push
10 healthcare in this direction, it has to be there.
11 And so the person, it's like, well, we're going
12 to send you home and we're going to monitor your
13 wound healing post-surgery, but you have to go to
14 the clinic in the city or the town you live in.

15 So is that really, it's kind of a
16 combination of both telemedicine and distance
17 care, where you have to actually go somewhere to
18 be linked to somewhere else.

19 MR. GOLDWATER: But Chuck, clearly, is
20 auditioning for the next T-Mobile commercial.
21 Verizon's all false. It doesn't cover anything.

22 MEMBER WALKER: So I actually think we

1 would struggle to find a problem that wouldn't
2 fit into the domains that we've identified.

3 I really actually think we've done a
4 fantastic job. But I want to challenge the
5 group, because I think the utility and usefulness
6 of the report would be increased exponentially if
7 we could dissect out some of these use cases and
8 say, where all do they fit in the domains and
9 sub-domains, and how could you test those?

10 It goes back to what I had said
11 earlier about pick the problem you're trying to
12 solve.

13 And looking at number four, just
14 because it is skin and it's what I'm most
15 familiar with. It's not just skin. It's any
16 chronic disease.

17 So you could envision this for
18 hypertension, for diabetes control, you know, for
19 anything.

20 And looking at, you know, what does
21 the telesystem mean for patient satisfaction, for
22 provider ease of providing care, for meeting

1 clinical metrics for outcomes and such.

2 So if you can break it down and give
3 anybody who's looking at trying to increase
4 adoption or increase organization of these types
5 of care modalities in a specific system, what are
6 the things that they should consider that we've
7 already considered in each of these domains, so
8 they know how to look at the problem and how to
9 look at its effectiveness in their own
10 communities?

11 MEMBER DOARN: I didn't say much this
12 morning, so now I'll say it all. So we just
13 finished a textbook on telemedicine disasters.

14 So you look at Katrina, you look at
15 9/11, you look at other things that have occurred
16 or will occur, even on CNN this morning, they
17 were talking about an earthquake in California
18 one day.

19 And if most of the infrastructure is
20 destroyed but you can have mobility, I'm
21 wondering if, how those four domains can actually
22 be applied in a telemedicine disaster, which

1 we've been doing for many, many decades now.

2 But I'm just curious if that's one of
3 those test cases that actually would really push
4 these things to the limit.

5 CO-CHAIR HOLLANDER: Answering that,
6 I would say, well, it's access, right? Because
7 the patients can't get out of the area. So it
8 clearly meets access.

9 It may be a hell of a lot less costly
10 than flying everybody out on a helicopter to get
11 them someplace. So there's probably some
12 finance.

13 There's probably some experiential
14 things for everybody that fit in there. And then
15 in terms of effectiveness and system
16 effectiveness and clinical effectiveness, it
17 probably hits.

18 I would say that caring for somebody
19 in a disaster, in almost every scenario, probably
20 hits every one of those domains.

21 I think it's actually a great thing to
22 highlight because it actually does help with

1 funding and does help at HHS with getting money,
2 because my understanding is that Tom Price is
3 really engaged with, you know, disaster and ASPR
4 right now.

5 And so I think tying a lot of this
6 stuff in telehealth and capabilities to disaster
7 management is, you know, a nice thing to do.

8 So I think it's a great point, but I
9 think it fits everywhere.

10 MEMBER HALL-BARROW: So I just want to
11 say too, so in some instances, we're actually
12 driving for them to improve our own internal
13 system quality measures.

14 For example, in our transplant
15 patients, we actually don't want them in our
16 hospitals.

17 We're actually encouraging through
18 telemedicine, instead of twice a week coming back
19 to our facility, you're only going to come back
20 once. We're going to do the other visit via
21 telemedicine.

22 It's doing two things. Number one,

1 we're hoping to improve outcomes, but we're also
2 looking at our system quality outcomes of
3 acquired infections inside of our hospital.

4 So I think there's -- I think I see it
5 fitting in here. I just want to be sure that
6 that is sometimes a motive to help in the overall
7 quality of the health system.

8 MEMBER ALVERSON: I just want to
9 underscore, actually, what Judd said in response
10 to Chuck.

11 That there is, I do believe like
12 disaster medicine fits into this. And one of
13 them, not only access to services, particularly
14 when infrastructure's disrupted, but access to
15 information, and that's on there.

16 And in Hurricane Sandy, that actually
17 -- the health information exchange stood up, so
18 when people came into a disaster clinic, they
19 were able to pull up their medications.

20 You know, I'm on meds, but it's like
21 a little blue pill for my blood pressure. But
22 they could actually pull it up and see it.

1 So I think disaster medicine does fit,
2 actually, in that, certainly in the access domain
3 and sub-domains.

4 MEMBER FERGUSON: So I kind of agree
5 with, it seems to be a consensus, it's hard to
6 think of a use case that doesn't fit.

7 So I think the domains are good. I
8 think, going back to Angela's point though, I
9 think for a person reading this, it might be
10 really interesting if we had a use case that
11 really almost solely focused on access or one
12 that solely focused on financial impact.

13 Just to give examples of those.
14 Because my initial thought was, they're all
15 access at some level. But they aren't.

16 You can think of use case that would
17 be really effectiveness or one of the others. So
18 I wonder if our homework assignment is to try to
19 find a good use case where it's really just one
20 of them, and then have some examples where they
21 span two or three.

22 I just think for the average person

1 reading this, it helps explain our domains, I
2 think a little bit better.

3 MR. GOLDWATER: So, I'm sorry, Mary
4 Lou, two seconds. So it would be very helpful if
5 you all had use cases that could just fit into
6 one domain.

7 I mean, I will say that we can
8 certainly pull those out from the literature that
9 we've reviewed.

10 There's plenty of use cases where we
11 can look, you know, parts of all of these. But I
12 think why we like Judd's idea initially when we
13 were requesting it from you is that it was
14 actually coming from people that are doing this.

15 That makes it a lot more impactful
16 rather than just pulling it out of a literature
17 and saying, well, here's a use case that, you
18 know, Stewart did 20 years ago.

19 I'm just kidding, but, or Chuck did in
20 1972, and we should look at this and see its
21 applicability.

22 And you know, it's a lot, it's more

1 impactful and useful if, you know, like Steve
2 sends a use case of something he does in his
3 community hospital every day and see every day,
4 and says, this is a use case, here's how it
5 applies.

6 Because when people look at this,
7 they'll be able to relate to that and see, ah, I
8 do the same thing. This is measuring exactly the
9 kinds of things that I deal with. So --

10 MEMBER MOEWE: Just to add onto what
11 Charles said about the disaster, with Hurricane
12 Katrina they had a huge problem with the nursing
13 home patients not having their medication
14 information when they -- when they came, when
15 they came to the ERs.

16 One of the things we can do with the
17 claims data that we have for all patients, and
18 that would be not just Medicaid, but anyone who
19 has claims data, which is everyone pretty much.

20 We can give you that data, and then we
21 would have all the prescriptions. It wouldn't be
22 like last week, but it's about accurate to 20 to

1 25 days out.

2 So at least you would be able to make
3 prescriptions and you could do that via
4 telemedicine I think pretty accurately based on
5 what they had in the past.

6 You know, I don't know, I just, I was
7 thinking of that. That might be a really good
8 use case because it's -- wouldn't be that
9 difficult to gather that information quickly
10 through the HIEs, and we have it on everybody.

11 And that's something we are putting
12 into our care coordination tool through the HIE
13 component of it. So we have the Medicaid claims
14 data with all the prescription information on it.

15 CO-CHAIR WARD: Steve.

16 MEMBER NORTH: You know, I think any
17 clinical scenario, you're going to be able to
18 meet, you're going to be able to find a measure
19 that would fit in, or an evaluation criteria,
20 that's going to fit in all those domains.

21 So the use cases really are, what is
22 that organization trying to look at in this

1 situation?

2 That, those are the ones where, that's
3 the only way we're going to find sort of one
4 domain situations, that we only want to look at
5 the technology failure rate in telestroke.

6 CO-CHAIR HOLLANDER: Adam's up, and
7 then --

8 CO-CHAIR WARD: Adam?

9 MEMBER DARKINS: I just wanted to sort
10 of say something about the intended audience for
11 this.

12 So I was trying to think, if I were a
13 CMO of a large healthcare organization and I was
14 looking at this, if you tried to sort of sell
15 telehealth, sometimes it often seems, yes,
16 interesting, but so what?

17 I've been struggling with what seems
18 to be missing for me, and what was, what's
19 missing for me in this is the concept of the
20 continuum of care.

21 So this fits into an overall range of
22 services that cross the continuum of care. So in

1 what, one really wants somebody to take to this
2 and say, I get this enough that I want to put the
3 processes in place and I'm going to invest the
4 time and energy. Because it'll be lots of time
5 and energy to put it in place.

6 So I think use cases are really good
7 and we can come up with a lot more. Whether it's
8 a use case or whether it's an explanation, I
9 think the fact that it doesn't sound like, you
10 know, we're kind of raising our hands and saying,
11 think of telehealth, think of telehealth, think
12 of telehealth, because it sounds a bit isolated.

13 But if we could make the case around
14 the continuum of care more broadly, I think it
15 would make a stronger case if we could get that
16 in somehow. I'm not sure how, but just a
17 suggestion.

18 CO-CHAIR WARD: Yael?

19 MEMBER HARRIS: I guess I want to
20 understand if these are going to be included in
21 the report.

22 So I'm thinking from a measurement

1 development standpoint. You know, we develop
2 measures on behalf of CMS, and you know, CMS is
3 going to have to fund these measures and, you
4 know, I worry that they're going to look at these
5 use cases and specifically develop measures for
6 these use cases.

7 In which case, I'm worried that either
8 they don't cover all scenarios, they cover all of
9 our domains but they don't cover all scenarios,
10 or they're so specific.

11 So I'll use the cancer clinic. Not
12 that it's not a great example, but I think the
13 question is, a patient has a condition where
14 there's not a specialist or service to provide --
15 a provider that can best provide those services.

16 And this fits with teleED, this fits
17 with, you know, stroke, this, I'm just thinking
18 we need more generic situations for measure
19 development, and when I'm thinking through all of
20 the conditions, and I encourage you all, like
21 Eve-Lynn, you're probably one of the most rare
22 uses of telehealth, but probably a very valuable

1 one.

2 All of our -- we all bring different
3 perspectives. Our, do our scenarios fit into
4 these?

5 And I mean, I'm a big fan of mobile
6 health. I think it fits into the third bullet.
7 But one of the things I don't think we -- I see
8 here is the use of Project ECHO.

9 So the use of education, whether it's
10 directly to patients or, in terms of a group
11 educational session, or directly to the provider
12 who doesn't have that skill set.

13 So I just want to make sure that if
14 these are included in the report, we are
15 providing CMS, we're not just telling CMS, okay,
16 think about measures in these categories.

17 And I don't mean to exclude CMS, but
18 that's the measure funder for measure
19 development, but I want to think, CMS, don't just
20 think these are the only use cases because you
21 don't have that concrete background on telehealth
22 and we bring that diverse level of experience.

1 MR. GOLDWATER: So I'll interject.
2 Excellent point. I don't have to say that, but
3 it was an excellent point.

4 And so the way, you know, again, the
5 overarching directive, when we started talking to
6 Megan and Natassja and Girma and others, was the
7 last thing that our team wants to do, and really
8 NQF wants to do, is to produce a report that is
9 unactionable.

10 That it's not something people will
11 pick up and use. That is a waste of time. It's
12 a waste of your time, it's a waste of ours, and
13 it's a waste of funding.

14 And having done government contracting
15 for longer than I would care to admit on both
16 sides of the aisle as a contract officer and as a
17 contractor, I'm very in tune to not wasting money
18 and not wasting time.

19 So the section that this would fit in
20 is not, here are the use cases. Take these and
21 develop measures.

22 Where a report becomes actionable is

1 when you show, here is the relationship of the
2 domains, sub-domains, and concepts we've come up
3 with to what is actually going on day to day in
4 telehealth environments.

5 And here's how you formulate measures
6 from those that would effectively show how
7 telehealth is being used or where the variances
8 are between telehealth and standard care so that
9 it then pushes telehealth forward.

10 And I think Adam makes a good point,
11 which is, it'll be wrapped up into -- there's
12 such a focus on the government for this continuum
13 of care from the time that you are an infant
14 until the time that you are an older adult, that
15 telehealth can provide those services within that
16 continuum, whether it is on an individual patient
17 level, whether it is on a community or population
18 health level.

19 It can provide services for standard
20 care. It can provide services for disaster care.
21 It can provide services for care transitions or
22 for care coordination.

1 Here are just some use cases of where
2 it applies to what's been discussed so that they
3 don't think, anybody that reads this report
4 doesn't pick it up and think, oh, they were just
5 thinking in the abstract.

6 They were abstracting, you know, they
7 got a bunch of researchers around a room and
8 people that have been involved in telehealth, and
9 they're just sort of abstractly coming up with
10 these concepts and ideas, and it's not relating
11 to the real world.

12 It's just relating to what they think
13 is appropriate, which is why, again, I'm
14 emphasizing that I can work with a team and we
15 can identify use cases through the literature,
16 but it's more impactful if you all tell us the
17 use cases that you're dealing with on a regular
18 basis or have dealt with in the past that we can
19 then apply this framework to just to show the
20 relationship of what you all have discussed as
21 crucial and important to what's actually going
22 on.

1 Because then it makes a much stronger
2 statement of, this is how telehealth can really
3 be used in the continuum of care, advance the
4 quality of care, advance the quality of life,
5 increase access, be cost efficient, create a
6 better experience, be more effective. And then
7 that report gets traction.

8 And I know that because we did a --
9 what is it, an Antimicrobial -- sorry, I'm not a
10 physician, Stewardship Playbook, maybe six months
11 ago.

12 It was not funded by the government.
13 It was independently funded. But they
14 specifically laid out, here are use cases that
15 are happening in hospitals. Here's how the
16 Playbook could be applied.

17 And it was the most -- it is the most
18 downloaded report that NQF has ever had for that,
19 I mean, it's a hot topic clearly, but
20 specifically because people could look at that
21 and go, ah, this is what's happening in my
22 hospital. Here's how I can apply it.

1 MEMBER DARKINS: So just a quick
2 suggestion, how about doing, instead of use
3 cases, how about doing a patient journey?

4 And doing a patient journey without
5 telehealth, and then a patient journey with
6 telehealth saying what the difference would be,
7 and then perhaps even saying, how would we put in
8 quality measurements?

9 Examples of the kind of way we would
10 put a framework in to then make it safe and
11 effective.

12 MR. GOLDWATER: I don't know, that's
13 a great idea. Tracy, do you want to say
14 something? Are you doing that now? That's a --

15 DR. LUSTIG: Yes, I'm actually working
16 with the team that did the Antimicrobial
17 Playbook.

18 So it had to be less than a year
19 because I think it was right after I started
20 working here that the Playbook came out.

21 But we've been doing work on advanced
22 illness care, and we're actually putting out,

1 it's like a two-page issue brief, and you follow
2 a patient's journey through the different
3 settings, and it shows how quality measures apply
4 in each phase of the care process. And it sounds
5 very similar to --

6 MR. GOLDWATER: Yes. That's a good,
7 yes.

8 DR. LUSTIG: -- this.

9 MR. GOLDWATER: So I would ask, again,
10 send the use cases and then let us sort of weave
11 those together into the journey.

12 That's a -- maybe that's what we'll
13 call the report. The Journey. That sounds like
14 an Oprah novel. Go ahead, Yael.

15 MEMBER HARRIS: So just to follow up
16 on what we said earlier, love that idea, but I
17 want to just keep cognitive of, we don't want to
18 develop a whole separate set of measures.

19 We want to look at what measures can
20 be applied to both care with or without
21 telehealth, or basically care in the absence of
22 telehealth.

1 So just, you know, as we do the
2 journey, not thinking through what new measures
3 need to be there, but what measures exist or can
4 be tweaked so that they encompass both.

5 CO-CHAIR WARD: But as I understand
6 it, a second component to that is then where are
7 the gaps? That that's another charge of this in
8 addition to that. Dale? Oh.

9 MEMBER ALVERSON: Okay. I just want
10 to respond also, since ECHO sort of started in
11 our backyard, I actually believe that ECHO gets
12 captured here, but perhaps it, in the report,
13 needs to be pointed out, since it's getting so
14 much attention nationally, even with recent
15 legislation, and that is -- it certainly can go
16 to the provider's or care team's experience,
17 because that, actually, some of the studies that
18 have been published by Dr. Arora and the team,
19 have really pointed out about how caregivers feel
20 more confident in managing complex chronic
21 diseases like Hepatitis C, but it also can go
22 into effectiveness. And that was published in

1 New England Journal.

2 So I'm sure that was, in an
3 environmental scan, that was pulled out as well.
4 So there's some, actually some metrics where they
5 looked at, not only was there comparative
6 effectiveness by using telehealth in treatment of
7 patients, Hep C, but they also pointed out that
8 more minorities got treated through the ECHO
9 clinic than they would have in-person at the
10 university because you could reach out to them.

11 I'm just saying that you might want
12 to, because ECHO does get a lot of attention,
13 pull that out.

14 But I think that these, we've done
15 such a good job in capturing all the
16 possibilities in these domains and sub-domains
17 that even ECHO fits in fairly well.

18 CO-CHAIR HOLLANDER: I think I was
19 just going to say that it's important because
20 we've spent two days going through, thinking in
21 our minds, and some of it out loud in different
22 areas saying, do these domains and sub-domains

1 capture everything in the world that we could
2 think of?

3 And so I think a lot to Adam's point
4 and other things that are echoed that in this
5 report it should say, here's four or five
6 examples of the gazillion things that were
7 pressure tested at the meeting just to show
8 where, so it's really clear that these are not
9 any more representative of anything else.

10 And then it alleviates the concern
11 that Jason raised that we've functioned in the
12 abstract, because clearly we didn't.

13 But I don't think we need to feel
14 compelled to give, you know, this much detail on
15 things.

16 We might actually prefer to say, we
17 pressure tested use cases from, and go back to
18 the framework on the page before that were both
19 synchronous and asynchronous, that were both from
20 home and from the hospital, and were both from
21 here and from there, to show across a whole
22 variety of different diseases, whether they'd be

1 acute care disease or chronic care diseases, and
2 they all fell into this domain.

3 Here's four or five or whatever
4 specific examples for those who want to drill
5 down deeper and see.

6 And then I think we can alleviate
7 those concerns. We cannot pigeonhole us into
8 these are the use cases.

9 We can actually say telederm rather
10 than chronic care because before we said we've
11 done it through multiple areas of different
12 diseases.

13 You know, and hopefully that'll work
14 to alleviate the concerns everybody has around
15 the table, assuming someone doesn't just look at
16 the table with these four uses. Sarah?

17 MEMBER SOSSONG: And my point was
18 going to be exactly aligned to that. I think
19 that the differentiation between, excuse me,
20 modalities, so whether it's synchronous,
21 asynchronous, clinician-to-patient, clinician-to-
22 clinician, is really helpful.

1 So I'm just mocking up a little table,
2 but I think to everyone's point, putting in some
3 examples almost to highlight that these -- all of
4 these different measure domains would fit within
5 all of the different modality combinations we've
6 described.

7 I think it could be done relatively
8 briefly, and I think in combination with the
9 patient journey would be really nice.

10 So I think that, you know, some of the
11 ones in the table could then map to the patient
12 journey, but I think would make it really clear
13 to people that this is comprehensive and
14 addresses all of these different areas. So happy
15 to share that outside.

16 CO-CHAIR HOLLANDER: So, Yael?

17 MEMBER HARRIS: Just want to see if
18 NQF can also add, building on what Dale said,
19 recommendations that look at measures that can be
20 stratified.

21 So I'm thinking disparities is a key
22 issue. But we can also look at geographical

1 disparities, HPSA versus non-HPSA which gets at
2 yesterday's RAND article which is, wasn't focused
3 on the areas where there was other sources of
4 care.

5 MR. GOLDWATER: So, yes, we can
6 probably make recommendations for stratification.
7 I would probably say we're not going to do that
8 off the basis of disparities largely because
9 we're in the middle of a socioeconomic trial with
10 disparities.

11 And so there's not a very good method
12 about how to go about doing that for measurement
13 yet.

14 So I think geographically, and perhaps
15 those that are germane to telehealth, yes, but
16 disparities in care, that's certainly an issue.

17 But that's a larger, more global issue
18 with measurement that's not specific to just
19 telehealth. So we'll probably stay away from
20 that until the trial has concluded.

21 CO-CHAIR HOLLANDER: So can I just
22 actually read from a book chapter from 1962? No,

1 I'm just kidding. So this is, this is a patient
2 journey in a book chapter.

3 It's actually an example that Brendan
4 Carr gave, and you know, many of you met him last
5 night at dinner and know him.

6 But, and I actually, there's three
7 examples in here. One is, and they're not real
8 patients so I can use the name, Francis is a 63
9 year old retired teacher with mild to moderate
10 heart failure.

11 She notices one morning she's a little
12 more winded than usual and texts her doctor's
13 office.

14 The office responds with a text link
15 to 10 different time slots for a video visit
16 later that day.

17 She selects one and later that day has
18 a 10 minute video chat with her doctor who
19 suggests some alterations to her medications.

20 She feels reassured and goes to bed,
21 but awakens in the middle of the night with
22 shortness of breath, gets frightened and touches,

1 it's a JeffConnect chapter, JeffConnect app on
2 her phone where she's connected with an emergency
3 physician with minutes, within minutes.

4 They chat. The emergency physician is
5 reassured by her respiratory rate and the patient
6 is reassured by seeing a physician.

7 She takes an additional dose of
8 diuretic and the on-demand doctor schedules an
9 early morning visit by the community paramedicine
10 team who checks her blood pressure, heart rate,
11 oxygenation, and weight, and then participates in
12 a five minute check-in to review her medication
13 plan with her primary care provider.

14 They leave her with a Bluetooth scale
15 that communicates with the office of her PCP, and
16 they discuss a plan for diuresis to achieve a
17 five pound weight loss over the next few days.

18 It's sort of like, that's one of, you
19 know, three sort of journeys he's put together to
20 do that.

21 I mean, is that the kind of thing we
22 want? Okay. So I'll forward you the proofs of

1 the chapter. They're not yet published, but --

2 (Off microphone comments.)

3 CO-CHAIR HOLLANDER: You can change
4 whatever you would like.

5 Okay. Looking at the agenda, I think
6 wrapping up the discussion on this, and we talked
7 about switching a little bit here, the agenda
8 item, which is What are the Most Important
9 Measures Identified, and really look at existing
10 measures, and we're going to pull up from the
11 report that we saw previously where NQF went
12 through and identified NQF measures and measures
13 from other sources that already exist and are
14 getting used so that we can review some of those
15 and have a concept of what those are.

16 MR. GOLDWATER: So I think what I was
17 talking to Marcia and Judd about earlier was, as
18 we start to go through these, you know, the point
19 of the exercise is not to evaluate each measure.
20 God forbid. We've already done that.

21 It's -- out of these, because we
22 included these in the report because these are

1 the measures that applied to the use cases and
2 studies that were most prevalent in the
3 literature that we identified.

4 Do you think that some of these relate
5 to telehealth, could be used for telehealth? Do
6 you think that they need to be modified in some
7 manner to incorporate telehealth as a means of
8 care delivery?

9 Or do you think that they need to just
10 simply be left alone, and I see Steve nodding his
11 head.

12 So -- and they're just measured in the
13 way that they, any quality of care in counter
14 would be measured, it's just telehealth is just
15 modality of being used?

16 CO-CHAIR WARD: Steve, jump in there.

17 MEMBER NORTH: Yes, I don't think you
18 want to make the mental health one be a via
19 telehealth or not via telehealth.

20 Because the goal is to show that this
21 is a non-inferior, if not better. And so you're
22 just going to muddy the waters.

1 MR. GOLDWATER: Okay.

2 CO-CHAIR WARD: Sarah?

3 MEMBER SOSSONG: I think the other
4 important thing to highlight, so I agree. Not a
5 clinician, but all of these, no reason to make
6 different measures.

7 I think there is wide acceptance of
8 synchronous as an appropriate replacement for in-
9 person, but I think oftentimes there's not
10 acknowledgment to the value of the asynchronous.

11 So we're starting to use asynchronous
12 doctor-to-patient for ADHD management. But the
13 payers don't recognize that as meeting the HEDIS
14 requirements for in-person visits.

15 E-consults for dermatology are a great
16 example. So if there's a way to incorporate that
17 asynchronous also counts, I think making that
18 call too --

19 CO-CHAIR HOLLANDER: Yes, so I have a
20 -- I'm going to differ with Steve a little bit.
21 I think where, you know, and I haven't read these
22 measures, but if controlling high blood pressure

1 and the only thing that's relevant is the high
2 blood pressure is controlled at the end of the
3 day, then I wholeheartedly agree with you.

4 But if you need to control high blood
5 pressure as documented by sitting on a chair for
6 five minutes in an upright position in an office
7 visit and not moving as compared to doing it on a
8 Bluetooth wireless device and getting feedback,
9 then it makes a difference.

10 So my concern, having lived through a
11 couple of years of sitting on one of the measure
12 committees evaluating, there's words like visit.

13 There's words like blood pressure.
14 There's assumptions or explicit criteria that it
15 be done in an office setting.

16 And so I think that, from my own
17 personal thing, I would like us to be able to
18 suggest to the measure developers and the measure
19 stewards on these measures, that they go back and
20 define, you know, telemedicine.

21 So if, in fact, you need to have a
22 visit for heart failure within seven days after

1 discharge, so a video visit might count, but a
2 Bluetooth scale weighing them might not. And so
3 I'm not even sure that all of telemedicine or
4 telehealth as a phrase, meets it.

5 So I think that, you know,
6 unfortunately someone has to do a -- maybe a
7 shallow dive into these measures and say, what
8 kind of telehealth, what kind of digital
9 technology should meet the criteria to be
10 included?

11 And you know, if it's just you achieve
12 the outcome, then who cares? Then we can stay
13 silent on what it is.

14 But we might have to weigh in or have
15 them decide how can the outcome be determined?
16 And then if they specified that, their thing is
17 really a process measure like having the right
18 number of visits or the right amount of follow-
19 up.

20 What is follow-up and which
21 telemedicine technologies qualify? So I think it
22 gets tricky and it's measure by measure. Steve?

1 Okay.

2 MEMBER NORTH: So, Judd, I agree that
3 the individual measures may need to be tweaked
4 because in our own ACO, blood pressure 140 over
5 90 only counts towards the measure if it's done
6 within the context of an office visit.

7 CO-CHAIR HOLLANDER: Right.

8 MEMBER NORTH: Not you stopped by and
9 had the nurse check. So that specificity and
10 descriptors do need to be adjusted.

11 I guess what I was advocating for was
12 not creating a separate box of, or list of
13 measures that just take these and say, with
14 telehealth, with telehealth, with telehealth.
15 Yes.

16 So I agree that they need to be fine-
17 tuned around those definitions to make them more
18 inclusive.

19 CO-CHAIR HOLLANDER: Henry?

20 MEMBER DePHILLIPS: I'm going to throw
21 this out just for the group to think about to the
22 extent anyone wants to.

1 In the legislative and regulatory
2 world, we actually advocate for a technology-
3 neutral approach.

4 And the reason is, because the
5 technology is advancing and changing so quickly
6 that there's no regulatory or legislative body
7 that could keep up with it.

8 So if you say this is the technology
9 that's to be used, you know, a year later
10 something better's going to come along and it'll
11 take two years to pass a bill to change this
12 technology.

13 I'm wondering, listening to you talk
14 about the differences in technology, if we need
15 to be at least cautious about specifying in the
16 measures what technology is being used for the
17 same reason.

18 I don't want the measures to become
19 obsolete within 6, 12, 18 months. Hopefully
20 they're a little more durable than that.

21 So I just want to think about
22 technology neutrality and maybe focus on care

1 where the provider of care and the recipient of
2 care in the same place at the same time versus
3 care where they're not and other modalities are
4 used, to the extent that we can do that.

5 MR. GOLDWATER: So I guess I
6 completely agree with both Steve and Henry. So
7 let me just ask a question, and please forgive my
8 non-clinical ignorance here. Clinical ignorance,
9 rather.

10 So I have no idea what spirometry is,
11 but is spirometry evaluation, is that possible
12 through telehealth?

13 CO-CHAIR HOLLANDER: Yes. Yes.

14 MR. GOLDWATER: It is?

15 CO-CHAIR HOLLANDER: Yes.

16 MR. GOLDWATER: Okay. So that is
17 something that you could so you could get the
18 outcome from that using telehealth.

19 So in that particular case, no need to
20 be altering the measure, and no need to be
21 prescriptive about the type of technology as you
22 can,\ -- is that where you like blow into the

1 tube and make the boat go, and if, okay. I had
2 to do that when I was young.

3 (Off microphone comments.)

4 CO-CHAIR HOLLANDER: It's still, it's
5 still a bunch of hot air.

6 MR. GOLDWATER: Yes, thank you. Being
7 an asthmatic when I was younger, I had to do that
8 far more frequently than I would care to.

9 And I know, I mean, can we, is it
10 possible to measure, I know Propeller Health
11 formally Asthmapolis, I mean, they have a device
12 where you can measure bronchodilator therapy and
13 use. Are there other devices where that's
14 possible to monitor?

15 CO-CHAIR HOLLANDER: Well, there
16 probably are. And one of the issues gets around
17 is how the FDA regulates these devices.

18 MR. GOLDWATER: Right.

19 CO-CHAIR HOLLANDER: So which, and
20 frankly, their stance is not to require approval
21 of the majority of these devices.

22 And so if you required an FDA-approved

1 device, then that would be a big change. In
2 fact, you couldn't use Teladoc or, you know, any
3 of the commercial telehealth vendors, which, so
4 it's kind of hard to define what's an acceptable
5 device.

6 On the other hand, who has any clue
7 how that nurse takes your blood pressure and
8 whether it's right when you sit down for five
9 minutes? And so I'm not sure it's a different
10 standard.

11 MR. GOLDWATER: The reason I'm asking,
12 Judd, is it sort of gets back to what I said
13 yesterday.

14 That when, if we want to look at
15 measures that exist and we want to include in the
16 report, you don't want to include, you know, a
17 large number of measures because that inhibits
18 the acting on the framework.

19 So you want, you know, essentially
20 like a starter set of measures. Measures that
21 already exist where telehealth is there.

22 So I'm sort of taking into account,

1 you know, Steve's comment of let's not alter the
2 measure, create a new box, use an existing
3 measure.

4 And Henry's where the technology
5 itself is not important, it's the fact that it
6 can be done at a distance or does not require an
7 in-person visit.

8 So I think in maybe looking at some of
9 these measures, you know, which ones are where
10 telehealth could be the most impactful, where no
11 alternations to the measure is needed, where
12 there's a technological solution, or in this case
13 solutions, where that could be done.

14 Because if you present, you know, 15
15 measures and say, you know, telehealth can be
16 used here.

17 It can do all of these things. None
18 of the measures have to be altered. No new box.
19 Doesn't matter of the technology solution as long
20 as it is fitting in, you know, it's a solution
21 that does not require an in-person visit so you
22 can do spirometry from wherever you have -- I

1 still don't know what that is. Well, from
2 wherever you are.

3 Then I think that's a good starter set
4 to go with because I think that's, for a lot of
5 health systems, that's easily implementable
6 because they're probably already doing it
7 already.

8 CO-CHAIR WARD: Let me jump in here
9 because there are NQF-endorsed measures.

10 MR. GOLDWATER: Right.

11 CO-CHAIR WARD: How many, and so
12 reviewing those and finding out, are there any
13 that would not be applicable?

14 MR. GOLDWATER: Right. So off the --
15 off the top of my head I can't, I don't know
16 which ones of those are endorsed or not. We can
17 certainly find that out.

18 But I know the two mental health ones
19 are endorsed. I know the three chronic, four
20 chronic disease are endorsed measures.

21 So did anybody -- does everyone know
22 what NQF endorsement means? Do I need to go do a

1 little briefing on what that little -- all right,
2 Henry. Three minutes.

3 So NQF doesn't -- we don't create
4 measures, and I'm supposed to say that like
5 anytime I say anything about measurement, I'm
6 supposed to qualify that by saying, we don't
7 develop measures.

8 We are the body that endorses
9 measures, which means it has to go through a
10 criteria that Marcia went through yesterday,
11 Marcia and Katie went through yesterday.

12 And if it passes that criteria, it
13 gets the endorsement, which means it gets a
14 number that indicates that NQF has endorsed the
15 measure, which means a committee of individuals
16 with experience in a clinical area, such a
17 cardiovascular disease, which Judd was on, have
18 reviewed the measures, feel that there's a strong
19 evidence case, they're reliable, they're valid,
20 they're feasible, they're usable, and that they
21 would advance quality.

22 And they're either, advance a quality

1 outcome, advance a quality process, or advance
2 the structural situation around the measure
3 itself.

4 So if they are NQF-endorsed, typically
5 the government, now this is changing a bit, but
6 the government will only use NQF-endorsed
7 measures for its value-based purchasing program.

8 So pay-for-performance, the inpatient
9 quality reporting program, PQRS, meaningful use,
10 although those had some non-NQF-endorsed
11 measures.

12 And although the law has changed a bit
13 where NQF-endorsement is no longer required, CMS
14 tends to prefer that NQF-endorsed measures are
15 used because it has met that rather extensive
16 criteria.

17 And I know, you know, Marybeth and
18 Yael and others have submitted measures and have
19 watched as they've gone down because they haven't
20 met the criteria.

21 That's always a fun meeting to have
22 when you reject somebody's measure they've been

1 spending a year a half on. You should join in,
2 Chuck. It's great fun.

3 But you know, if they pass it, they
4 get the number and then it can be used. So I
5 know some of those are endorsed.

6 I can't, off the top of my head, know
7 which, Katie's been here longer than anybody. I
8 don't --

9 CO-CHAIR WARD: How many --

10 MS. STREETER: I don't know of the top
11 of my head.

12 MR. GOLDWATER: Yes.

13 MS. STREETER: But we could easily --

14 MR. GOLDWATER: We could find that out
15 pretty easily.

16 CO-CHAIR WARD: So, let me throw out,
17 you talked about a starter set, and it seems to
18 me like a starter place would be looking at the
19 NQF-endorsed measures and seeing if any of them
20 we wouldn't think could be applicable.

21 MEMBER DARKINS: Could I ask Marybeth
22 a question on this? If I may, so I mean, I think

1 using the existing measures, I'd be one of many
2 who said we should use existing measures because
3 you don't duplicate things.

4 Help me, if you could, with mental
5 health, for example. So one of the assumptions
6 here is if we're going to use existing measures,
7 there's an equivalence between how you would do
8 something in-person with how you would do it
9 face-to-face and where you could.

10 If part of the reason for an overall
11 quality management program is patient safety,
12 then when you do mental health, so excuse me
13 drawling down, but adult mental major depressive
14 disorder.

15 So if you're developing services, you
16 would want to have patient selection criteria to
17 make sure that you don't end up having suicidal
18 patients inappropriately being treated.

19 That means you don't have the ability
20 to provide the services. So across state lines
21 there could be difficulties doing it. How you
22 have ways of contact, that if somebody is

1 unsupervised you can do it.

2 So therefore, you would make a case I
3 think to be able to say, there should be some
4 process measures or some structural measures that
5 would fit with doing it appropriate, safely.

6 Do I make sense there? So therefore,
7 we've not really talked about structure, process,
8 and outcome in terms of the measures we're doing.
9 I don't know quite where that will fit in.

10 And if we were strategically trying to
11 think, are we going to be thinking about how do
12 we kind of vaguely think about what might the
13 outcome measures, at some time in the future,
14 that might be there at the expense of saying,
15 look, there are some very clear structure and
16 process issues we need to get in place.

17 Because otherwise this thing is going
18 to go down the toilet. Does that --

19 CO-CHAIR WARD: Well, yes.

20 MR. GOLDWATER: I think that's a fair
21 representation. I think, you know, there's a
22 much bigger emphasis now to be developing outcome

1 measures because, where we have a glut of process
2 measures.

3 And in fact, there seems to be an
4 overwhelming reliance on evaluating process of
5 payer.

6 So the general sort of dearth of
7 outcome measures is sort of universal to quality
8 measurement.

9 So I think that there are certainly
10 things that we could be applying now, but I think
11 one of the things, you know, as we start, as you
12 start to review the measure concepts once they're
13 compiled is, you know, are there additional
14 concepts around structural or process that need
15 to be added that could be evaluated now so that
16 it leads to outcomes in the future.

17 And that's certainly something to
18 write about. That, you know, we're setting the
19 stage for not evaluating telehealth at the
20 moment, but having it be sustainable many years
21 down the line.

22 MEMBER ALVERSON: I'll make one

1 comment just in response to what Adam said. And
2 that is, that actually gets captured in part of
3 the access when you brought up the term
4 appropriateness.

5 So I think that'll be captured in the
6 report. That sometimes maybe telehealth isn't
7 appropriate, and there needs to be criteria for
8 that. So that's a different issue.

9 What I wanted to bring up though, the
10 metaphor about rather than creating new measures
11 for these measures that have already been
12 established, remind me, and I don't know if
13 anybody from AMA is here, but the CPT codes.

14 Most of us have felt, rather than
15 creating new telemedicine CPT codes, we use a
16 modifier that -- so that they at least know that
17 it was provided virtually as opposed to in-
18 person.

19 So I think there's a metaphor there
20 where, rather than creating new measures, we can
21 actually fit into those that have already been
22 endorsed by NQF.

1 MR. GOLDWATER: That's a great idea.

2 CO-CHAIR WARD: Yael, are you up?

3 MEMBER HARRIS: So I just want to
4 point out, Girma Alemu just let me know about the
5 fact the NCQA has a call out that ends on March
6 22nd for comment on telehealth measures specific
7 to behavior health to be included in HEDIS.

8 So I encourage everyone here to look
9 at that and comment. And then the other thing
10 is, I agree with using ICD-10 codes. There are
11 GT modifiers that --

12 CO-CHAIR HOLLANDER: CPT.

13 MEMBER HARRIS: CPT. Sorry. I only
14 had one cup of coffee this morning. But there's
15 GT codes that CMS uses and had picked codes
16 specific to telehealth.

17 So when we think through this, rather
18 than trying to reinvent the wheel, look at
19 measures we can develop around those.

20 I know they're restrictive to what CMS
21 will reimburse. But if we're going to start with
22 a core set, let's start with something that's

1 already there rather than suggesting measures
2 where there is no modifier code for that issue.

3 MEMBER FARGUHAR: Can I ask you a
4 quick question though? The telehealth that
5 they're doing, they're taking the measures that
6 they have, but all they're doing is adding the
7 telehealth setting to these as existing measures.

8 Is that right? That's what they want
9 to comment on, not --

10 MEMBER HARRIS: I need to --

11 MEMBER FARGUHAR: -- telehealth
12 measures?

13 MEMBER HARRIS: -- read it in more
14 detail. I just started looking at it. It's --

15 MEMBER FARGUHAR: Okay.

16 MEMBER HARRIS: I can send the website
17 out to everyone.

18 MEMBER FARGUHAR: Yes, I think, I
19 think it's that they're going to add telehealth
20 services --

21 MEMBER HARRIS: As a way to deliver
22 behavioral health?

1 MEMBER FARGUHAR: Right. Right.

2 MEMBER HARRIS: Got it. But then why
3 are they having us, that, I mean, that would beg
4 the question what we talked about earlier. Why
5 do they need a separate measure?

6 If we can assume that telehealth
7 delivers care just as well as face-to-face care,
8 except we get to our access issue, why do we need
9 a separate measure?

10 MEMBER FARGUHAR: My understanding is
11 that they're adding the service to an existing
12 measure so that you can count --

13 MEMBER HARRIS: Got it.

14 MEMBER FARGUHAR: -- telehealth as an
15 office visit, per se, if that's what --

16 MEMBER HARRIS: Thank you.

17 MEMBER FARGUHAR: Yes.

18 MEMBER GRAF: There's also a next step
19 that's being discussed within that same document
20 where they're soliciting for non-behavioral
21 health. And it answers --- specific question
22 relative to non-behavioral health.

1 MEMBER WALKER: All right. I just
2 want to emphasize, while outcomes are, yes,
3 definitely important, if we're really looking at
4 teledelivery of care being the same care I'm
5 giving, I don't want us to bias the report in any
6 way with there being a dearth of outcomes,
7 measures, if that's where we should go with this.
8 Because I think the proof in the pudding for this
9 type of care delivery is really the process.

10 And if it creates new measures that
11 are alongside later-to-be-developed outcomes
12 measures, I think that's what's really important
13 in the teledelivery is the process. That's how
14 it's different.

15 MEMBER GRAF: So I wanted to go back
16 to something Henry said relative to technology-
17 agnostic.

18 And I want to, I don't know, challenge
19 it a little bit in that we don't throw the baby
20 out with the bathwater when you think about how
21 new technology is actually moving the needle in
22 our ability to get better effectiveness and

1 outcomes.

2 So I look here at the inhalers now are
3 smart inhalers where they're tracking and
4 recording usage and just additional data that can
5 be used hopefully to improve outcomes. So I just
6 wanted to make sure that we are clear on that
7 technology issue.

8 CO-CHAIR HOLLANDER: Henry? Response,
9 counter-response?

10 MEMBER DePHILLIPS: No, I'm totally
11 cool with that. There's been a couple of
12 comments about extending existing measures from
13 the in-person care scenario to a telemedicine
14 scenario, and I think, similar to what my earlier
15 comments on there's a minimum level of quality
16 but not too much that's kind of a sweet spot,
17 right, that allows innovation but guards against
18 bad innovation.

19 I think the same thing is true for the
20 measures as applied to telemedicine. And so I
21 want to just be cautious that we don't
22 circumscribe how the measure is gathered

1 comparing current in-person care to remote care
2 so much that the innovative and quality is
3 present, but sort of testing component about
4 possible changes in how to make a diagnosis or
5 how to render care, how to give a treatment, is
6 stifled.

7 I just gave you, I guess a random
8 example that occurred to me. So the number one
9 diagnosis in our episodic care program is
10 sinusitis.

11 If the standard is to, so it's like
12 five diagnostic criteria in our evidence-based
13 clinical practice guideline, regardless of the
14 modality of care.

15 If the standard is the physician must
16 tap the frontal sinus to elicit tenderness, then
17 that's not, you're not going to be able to study
18 that in a telemedicine environment because the
19 physician's not going to be able to do that.

20 If, however, the component is frontal
21 sinus tenderness is present, that's fine because
22 in the office, the doc will tap the forehead.

1 In telemedicine, the patient will tap
2 the forehead. Either way, you can still figure
3 out whether there's tenderness there.

4 Sort of an example. So I just want to
5 make sure we aren't so restrictive when extending
6 it to telemedicine.

7 There are some benefits to
8 telemedicine that we don't even know exist yet,
9 and the only way we're going to find out what
10 those benefits are is to allow a little bit of
11 latitude in variability of how diagnoses are made
12 and how care is given.

13 CO-CHAIR HOLLANDER: So I think that,
14 you know, one of the things that we need to do,
15 and it's not we in this NQF Committee, is we need
16 to develop some of that stuff.

17 Angela and I were talking at the
18 break, cardiologists want to listen to somebody's
19 heart, right?

20 That's what cardiologists do. But
21 let's face it, if you're seeing somebody with
22 chest pain over and over for years, their heart

1 exam never freaking changes.

2 So you know, without them having new
3 symptoms on a routine visit, so there's no reason
4 to do that.

5 So I scribbled down, that's one of my
6 med student projects this month, when I get back.

7 Rummage through 1,000 charts, and see
8 how much, when an asymptomatic patient comes to
9 the office, their exam changed from the last
10 visit.

11 It's going to be zero. Then we put it
12 out there, then: listening to the heart isn't
13 going to matter.

14 There's some evidence to do that, and
15 you can do the rest of the cardiovascular exam
16 besides listen because you can have people check
17 their pulse and do that.

18 So I think, for us as a group outside
19 this forum, we have to get some of the evidence
20 to prove that because there are people who are
21 still going to be stubborn in the way they think.

22 But I think one of the things that

1 we're supposed to be getting done before lunch is
2 offering some guidance on how we adjust these
3 measures, and I think we maybe have had great
4 conversation, but we may have strayed from that a
5 little bit.

6 And I think that if we want to stay
7 within these measures and say, yes, do it, well
8 then we've got to look at what things are
9 telehealth-amenable, and then it's really deeper
10 than I can -- for me, I'm not smart enough to
11 look at this list and know the depth of the
12 measure and what's included.

13 But I think at some point, if the
14 measure is just about achieving an outcome and
15 doesn't give you guidance on how, then we've got
16 to make sure that outcome can or can't be
17 assessed by telehealth, and if it can't, we can't
18 do it.

19 And if it can, maybe we need to
20 specify it because it might have specified how
21 it's achieved. If it's not specified how it's
22 achieved and we can measure it by telehealth,

1 then telehealth should be fine.

2 If it's a measure that requires a
3 visit or a measurement at some point along the
4 line, well then we have to say, can we measure
5 that via some telehealth modality, if it's
6 specified that it's measured by X, by standard
7 blood pressure guidelines, and do that. And I
8 think those are going to be, you know, sort of,
9 at least my broad categories of the low-hanging
10 fruit to get in preexisting measures.

11 But I don't think it's as easy as what
12 I think, you know, Jason was hoping for, saying
13 these are the five measures that we think we
14 should go after first, because I don't know if I
15 know enough to do that yet.

16 MR. GOLDWATER: So I don't think that,
17 I mean, I don't think we were looking to say,
18 here are the 15 measures you should go with.

19 So the criteria that I've got are, I
20 think first cut is look at the measures we have
21 and take the ones out that are NQF-endorsed, that
22 have, that have passed the endorsement process.

1 See which ones we've got left from those.

2 Out of those, the subset of those,
3 then look at the ones that don't have to be
4 modified at all, and there is a technological
5 solution, but we're not prescriptive about what
6 the technology's going to be. And so that'll be
7 the first pass of the measures.

8 CO-CHAIR HOLLANDER: The non-endorsed
9 ones?

10 MR. GOLDWATER: No, the endorsed ones
11 --

12 CO-CHAIR HOLLANDER: Oh, okay. Okay.

13 MR. GOLDWATER: -- that are, the
14 outcome doesn't, you know, the measure does not
15 have to be changed in any way. It's the same
16 measure, and that there is a technological
17 solution.

18 So we may be asking some of you, is
19 there -- like, again, I have no idea what
20 spirometry is, but, so I might, you know, call
21 Steve up and go, can you tell me what this is?

22 And is there a telehealth solution for

1 it? And if the answer is yes, and we don't have
2 to be prescriptive about the technology, then
3 that'll be the first representation of starter
4 set measures.

5 And then when you get that, you can
6 look at those and go yes, yes, yes, forget it.
7 Or can we add these? Can we add this? Can we
8 add this?

9 But then I think that gets to sort of
10 the spirit of what you all wanted to do, which is
11 not changing the measure, not being dependent on
12 a particular type of technology, and it passed
13 the NQF endorsement, which means it's strong
14 evidence base, reliable, valid, feasible, usable,
15 rather than a non-endorsed measure, which, I
16 mean, you know. You've sat on the endorsement
17 committee, so has Marybeth actually, so they can
18 talk about, it's a joy, I'm telling you. It
19 really is.

20 MEMBER FARGUHAR: And can you indicate
21 which of those have a modifier code? Because
22 otherwise there won't be a way to clearly

1 distinguish if it was provided in-person versus
2 telehealth.

3 CO-CHAIR HOLLANDER: So the modifier
4 code is about the level of service billing. It's
5 not about the disease.

6 So it won't actually really help
7 directly. So if I see somebody with asthma, I
8 don't do asthma modifier code.

9 I do asthma, and they're a level 3
10 level of service, and the level 3 gets the
11 modifier code.

12 So it's a little more difficult than
13 that. I can't easily pull, and I may be able to
14 out of a claims database, pull out their ICD-9 or
15 ICD-10 code, their level of service code, and
16 whether there's a modifier and crosswalk them to
17 determine it.

18 But it's not a disease-specific
19 modifier code. It's a billing level of service
20 modifier code.

21 And then it depends on the database
22 you're pulling out of as to whether or not you

1 can put those two things together. Does that
2 make sense to those of you that don't live in
3 that world?

4 MR. GOLDWATER: I think when we get a
5 starter set, rather than modifying the measure,
6 which I don't think we would do, it would be, in
7 the CPT Workgroup, have they developed a
8 modifying code for whatever measure we've seen,
9 or does one need to be developed? Where in the
10 billing cycle does the modification have to be
11 made to indicate that it's a telehealth visit?

12 But definitely not changing the
13 measure, because then that would require
14 modification of every measure to incorporate
15 telehealth, which I can tell you would be shot
16 down by our Board in no time.

17 CO-CHAIR HOLLANDER: I'll also say
18 that some of the things that we haven't really
19 discussed a lot won't actually have a modifier
20 code because they're bundled payments.

21 So if you have a surgical procedure
22 today, and I see you back in the office in three

1 days, I don't submit a billing code.

2 So I may see you by telehealth, or I
3 may see you in-person, but it may be hard to
4 track it because I may just not bother filling it
5 out since nobody pays for it.

6 MR. GOLDWATER: Once Meg is here and
7 does her presentation on MIPS and sort of reviews
8 kind of currently where we are with the
9 legislation, then we can maybe have a brief
10 discussion about how we want to think about that
11 with the measures themselves, because I know
12 there was talk, and there's certainly interest on
13 the government's part about the measures that are
14 going to be used for MIPS and alternate payment
15 models, if they incorporate telehealth. That's
16 another way of advancing this significantly.

17 Because that deals with payment and
18 reimbursement, and that always moves everything
19 forward.

20 CO-CHAIR WARD: Stewart?

21 MEMBER FERGUSON: So I just have two
22 questions. So what I'm hearing though is that

1 you're going to do this exercise of going through
2 all the endorsed NQF measures, and then we'll
3 probably get a list from you or something that
4 tells us, these kind of passed the test. It
5 could be used for telehealth. These couldn't,
6 right? Okay. So the other question I have is
7 related to MIPS.

8 Is there a reason you're not also
9 including advanced APMs in this discussion? The
10 quality standards are a little bit different, but
11 I think they're really, there's a lot of overlap.

12 MR. GOLDWATER: We are going to do
13 APMs. So when Meg's here, she's going to talk
14 about MIPS and APMs, and then how, just sort of
15 where we are currently with that.

16 Because after the rulemaking comments
17 were provided, there have been some changes to
18 it.

19 So she's going to talk about sort of
20 where we are, where that's going, how it affects
21 quality measurement, and then we can talk about,
22 you know, where it fits into APMs and MIPS

1 overall and value-based purchasing. And so, yes.
2 We'll do the homework.

3 But I would, again, emphasize, I think
4 what we'd like from you all is if you have use
5 cases that apply to what you do on a day-to-day
6 basis, to send those to us.

7 And then we'll use our creative powers
8 to come up with the patient journey and how to
9 make that into a narrative that's, I want to say
10 moving, but effective. Is that better?

11 Judd sent me this email that's giving
12 me Brendan's saying. It said, Journey, not the
13 band. Give it a rest, man, really, seriously.
14 Really. Def Leppard wasn't enough.

15 I think we're, as always, we're very
16 efficient. We're done a bit early, and lunch is
17 out, so why don't we take 35 minutes for lunch.
18 Meg will be here at 1:00 to lead us in the MIPS
19 discussion.

20 (Whereupon, the above-entitled matter
21 went off the record at 12:23 p.m. and resumed at
22 1:03 p.m.)

1 MR. GOLDWATER: So I have the great
2 luxury and privilege of introducing our guest
3 speaker, the extraordinarily talented and very
4 quick-witted Meg McGinty, our Director of Public
5 Policy.

6 We get along so well because, one, we
7 endlessly tease each other on most days. And
8 two, she's exceptionally gifted and smart, which
9 we all like to have.

10 So Meg spends a lot of time on the
11 Hill analyzing legislation, and apparently tweets
12 at this point, and I'm just kidding. And --

13 MS. MCGINTY: I'm purplemixingbowl, if
14 you ever see me on Twitter, purplemixingbowl is
15 me.

16 MR. GOLDWATER: And so Meg and I spent
17 quite a few hours on the Hill with staffers from
18 Senator Alexander's officer, Senator Cassidy's
19 office, Senator Whitehouse's office, talking
20 about --

21 MS. MCGINTY: Warner.

22 MR. GOLDWATER: Senator Warner,

1 talking about telehealth interoperability, 21st
2 Century Cures, and other things.

3 So Meg is the residing expert at NQF
4 on MACRA and MIPS. She just came in and said,
5 I'm scared. I don't know that much about
6 telehealth.

7 I could've jokingly said, well,
8 neither does anybody else here. But I didn't say
9 that. I said, I don't think anybody's interested
10 in specific telehealth questions, that this is
11 really just an educational session about MIPS and
12 MACRA, advanced payment models and so forth.

13 So everybody is sort of on the same
14 level playing field in terms of understanding,
15 and then to sort of talk about what, how our
16 framework can intersect with MACRA and MIPS and
17 APMS, given that that ties to reimbursement, and
18 as I said earlier, and as you all know, that
19 drives just about everything. So without further
20 ado, I will turn it over to you.

21 MS. MCGINTY: All right. Thanks,
22 Jason. I'm going to warn you, I come from a

1 legal and technology guru family, and I got none
2 of the technology guru genes whatsoever.

3 So Jason knows that these topics are
4 the ones that I really, especially
5 interoperability, I really love. But telehealth
6 is really exciting.

7 So I'm excited to be here, and I think
8 there's a lot of opportunities in, and especially
9 in the MIPS program, for telehealth services to
10 be used and kind of infiltrate it into the
11 measures as we go forward. So quick overview.

12 I'm going to start real high and break
13 it down a little bit. I don't know where
14 people's understandings are, so we'll just
15 hopefully have a little bit of something for
16 everybody.

17 So the MACRA, the Medicare Access and
18 CHIP Reauthorization Act of 2015, was the much-
19 beloved repeal of the Sustainable Growth Rate,
20 the SGR.

21 Doctors, physician groups, hospitals,
22 everybody wanted to get rid of the SGR, and so

1 they can with MACRA.

2 And what this did was it took fee-for-
3 service and basically based in on their
4 performance and your outcomes of your patients,
5 along with your cost savings opportunities and
6 your clinical practice improvement areas.

7 And it gave clinicians two options for
8 payments. The one I'm going to talk most heavily
9 about today is MIPS.

10 It seems to be the furthest along in
11 development, as well as the advanced alternative
12 payment models.

13 Advanced alternative payment models
14 include your patient centered medical homes,
15 ACOs, bundled payment programs, which may or may
16 not be occurring, and then your future, I'm not
17 quite sure with the new administration what's
18 going on with those.

19 And MIPS is, it basically combined
20 your three VBP programs. Meaningful use,
21 physician quality reporting, PQRS, into one
22 program so that it could streamline into making a

1 component score. So that's really high level.

2 Next slide.

3 So we'll talk a little bit about MIPS
4 first. MIPS applies to your eligible clinicians
5 or eligible practitioners, depending on what day
6 of the week it is.

7 Physician's assistants, physicians,
8 nurse practitioners, clinical nurse specialists,
9 certified RN anesthetists are included for the
10 2017 payment program.

11 And what this does is it combines,
12 like I said, combined the PQRS program, the
13 value-based payment modifier, and the Medicare
14 EHR incentive program, affectionately referred to
15 as meaningful use.

16 And it combined it -- when the rule
17 came out, it originally combined these
18 performance scores into a composite score of four
19 categories.

20 The proposed rule was opened up, and
21 now the 2017 payment year of reporting will only
22 include three of the four categories, due to

1 overwhelming response from practitioners and
2 hospital units, that they were unable to
3 implement the cost and resource use program and
4 components.

5 So the four categories are quality,
6 clinical practice improvement areas, advancing
7 care information, and cost and resource use.

8 The first three will be included for
9 reporting on data in calendar year 2017. So this
10 has already begun.

11 Another, I would say, compromise that
12 CMS took into account in the comments for the
13 proposed rule was rather than ensuring that all
14 people, all providers that participated in the
15 MIPS program for Medicare payment had to,
16 mandatorily had to report, they softened that a
17 little bit for 2017 to give practices the
18 opportunity and the time to ramp up their
19 reporting services.

20 So if you don't report anything for
21 the calendar year 2017, you will receive a
22 penalty. If you report something, anything, make

1 an effort, you'll basically be at a neutral
2 level. You won't get the payment incentive or
3 the penalty.

4 If you report a good portion, which
5 they're qualifying as 90 days of reporting these
6 requirements, you'd be eligible for a prorated
7 possibility of, you may be eligible for a
8 prorated incentive.

9 And if you report it all, you'll be
10 obviously eligible for the full incentive. So we
11 have calendar year 2017.

12 The measures that are included for
13 those three programs, the quality measures, the
14 clinical practice improvement activities, and the
15 advancing care information started January 1st,
16 and you have basically until October 1st to ramp
17 it up, because you have to have 90 days of
18 reporting to get a partial incentive payment.
19 They'll be submitted to CMS on March 31, 2018.

20 So after you get your calendar year
21 reporting program, you're able to work with your
22 systems to gather your data and submit it prior

1 to the end of March.

2 CMS will then provide feedback on your
3 reporting and how you performed. That was
4 another commonly raised comment about, how will
5 providers know what they're doing well and what
6 they're not doing well, and how can they improve?

7 So a feedback period was opened for
8 2018 for the remainder of that year. And the
9 adjustment payment, either a penalty above, a
10 penalty below or an incentive above, based on
11 your performance will be paid out at the 1st of
12 January 2019.

13 So you'll receive your payment in
14 response to your performance in 2017. So there's
15 a 12 month gap, essentially.

16 What is the maximum amount of
17 incentive and the maximum amount of penalty that
18 one could receive? It's up to 5 percent of your
19 payments. So if you do really, really well, you
20 can get up to 5 percent of what you received in
21 Medicare, in addition to your Medicare funds,
22 paid out to you January 1st of 2019 for calendar

1 year 2017.

2 And to determine this, the scores will
3 be weighted, and we'll go to the next slide.
4 This is the 2017 weight. Now granted, this is
5 post the rule being finalized, all of the
6 comments. Originally there were four components
7 in this including cost, which originally
8 comprised for 10 percent, and quality only being
9 50, but because of the responses received in the
10 rule-making process, CMS decided to remove the
11 cost and resource use component and add that 10
12 percent quality for the 2017 reporting period.

13 So we look at the total here. For
14 quality, the provider or the group needs to
15 report on up to six measures, but it's required
16 that you include one outcome measure.

17 There are 271 measures to choose from.
18 So there is a lot of selection for the individual
19 provider and for the individual groups and
20 hospitals that are reporting.

21 So these are your treatments, your
22 screenings, your surveys, your condition-specific

1 measures, immunizations, symptom management
2 measures.

3 And this group, these are, many of
4 these are NQF-endorsed. In fact, over 50 percent
5 of them are. And we actually provide
6 recommendations to CMS through our MAP Workgroup
7 on the quality measures used in MIPS.

8 So that's an avenue if you want to
9 insert telehealth opportunities, the MIPS, the
10 Clinician Workgroup for MAP recommends measures
11 for the MIPS. Any questions on that? Yes?

12 MEMBER RASMUSSEN: So do these six
13 quality measures, is it six like for a healthcare
14 system or for each individual physician or a
15 physician group or, what does that look like?

16 MS. MCGINTY: So it depends on how you
17 report. If you're submitting as a physician
18 group, it's inclusive of all the practitioners
19 within the group, whether it be acute care
20 settings or if it -- individual physicians, nurse
21 practitioners, nurse practitioner anesthetists.

22 All of the eligible professionals

1 within that group. You can also report as an
2 individual physician. It depends on how you
3 classify, you classify your practice group for
4 Medicare reimbursement purposes.

5 So there's no limit on how many people
6 you can have in that group or not. There are
7 some adjustments made for small practices.

8 Not in the quality section, but in the
9 clinical improvement area section, there is some
10 adjustments made on the reporting for smaller
11 practices. Okay.

12 We'll go to the improvement areas.
13 And I honestly think this is probably the
14 greatest opportunity for telehealth services.

15 In fact, there is one telehealth
16 measure. It's the third from the last. I
17 actually included this in your, you don't have to
18 look at this now, but when you go back home and
19 you look at the documents on the SharePoint, I've
20 included the measure lists for all of these three
21 categories.

22 The measure is actually, or the

1 improvement activity, is actually use of
2 telehealth services to expand the practice.
3 That's really what it says. I'm sure there's a
4 lot of services to expand your practice.

5 The description is use of telehealth
6 services and analysis of data for quality
7 improvement, such as participation in remote
8 specialty care consultants, teleaudiology pilots
9 that assess delivery and still deliver quality
10 care.

11 So it's a very vague opportunity for
12 you all to get involved in. But the clinical
13 improvement areas, you have to report four
14 improvement areas for at least a minimum of 90
15 days in the calendar year.

16 So there's a list of 92 different
17 improvement areas on this list. Telehealth being
18 one of the 92 that I just read, so obviously your
19 practices would be able to report on that one.

20 But there are some adjustments made
21 for small group practices and rural healthcare
22 practices. If you have less than 15 eligible

1 clinicians in your grouping, however you group
2 it, in your practice, you only have to report two
3 instead of four.

4 This was another compromise that went
5 through the rulemaking process. And I think some
6 of the rural clinics and your community health
7 centers felt a little bit of pressure, who
8 haven't been required to report in the past,
9 getting their services up to gear.

10 So it also, if you are a patient
11 centered medical home or you are a designated APM
12 medical home, but not designated as an advanced
13 payment model specifically, you automatically
14 fulfil this improvement activities area.

15 So if you work for a patient medical
16 centered or a patient medical home, you won't
17 have to report these improvement activities.

18 You'll already get that 15 percent
19 score as completed. And then the final one is
20 advancing care information. This is much more
21 based on your electronic health records:
22 interoperability, sharing, number of screenings

1 and all that stuff, which is not my forte by any
2 means.

3 But what this does is you have to
4 require -- to fulfil five measures in those areas
5 of eprescribing, provide patient access to their
6 records, request and accept summary of care,
7 summaries of care, have a security risk analysis,
8 and sending a summary of care.

9 Those are the five required measures
10 to hit that baseline score. But if you're really
11 great, you can report on up to nine of the
12 additional ten to get bonus points, like extra
13 credit.

14 So the practices that have made the
15 investment in EHR technology and have really been
16 driving this are going to benefit greatly, I
17 think the most from the 25 percent for the
18 advancing care information.

19 And there are a total of 15 measures
20 available in that group. You have to report the
21 five, and of the remaining ten, there are nine.

22 What also is required is that you have

1 a, and I, this is all Greek to me, a 2014, 2015,
2 or combination of the two, annually certified EHR
3 technology system in order to do this, in order
4 to submit your measures.

5 So it's forcing everybody to have an
6 EHR that meets these certification requirements.
7 Yes?

8 MEMBER GIBONEY: Do you get partial
9 credit for these things? So like 25 percent for
10 advancing care information.

11 If you've got three of the nine
12 measures instead of five of the nine measures, do
13 you get 19 percent instead of 25 percent, or is
14 it kind of an all-or-none calculus?

15 MS. MCGINTY: So what they'll
16 calculate you is on an individual performance
17 score for each of these areas to make up the
18 percentage of your total score.

19 So each one is weighted, and the
20 weighting is very, very complicated. Some of the
21 measures, particularly in the quality area, there
22 are low impact measures, medium impact measures,

1 and high impact measures. So if you, as well as
2 with the improvement activities and the advancing
3 care information.

4 So if you come in with your extra
5 credit ones, and they're all high-value advancing
6 care information measures, you're going to jump
7 to the top of the prioritization in the points
8 system for that field.

9 Any other questions? Okay. So I want
10 to talk a little bit about, and please feel free
11 to chime in, share with us, offer your
12 suggestions.

13 I think this is an opportunity to
14 maybe kind of brainstorm for the report what
15 measures or items of discussion that you should
16 really bring to the top in order to facilitate
17 opportunities for telehealth.

18 I can say telehealth is a really sexy
19 issue on Capitol Hill. It's really sexy. People
20 love it.

21 They just don't know who's going to
22 pay for it. People are talking about it. They

1 see the opportunities.

2 They see the opportunities of
3 technology in their personal lives and say, how
4 can we bolster this in our federally-funded
5 healthcare programs?

6 Maybe used in the private sector, how
7 do we make it happen? I'm sure many of you are
8 familiar with some of the restraints on
9 telehealth as far as remote patient monitoring
10 and origination sites, and then is there wifi and
11 broadband, and into a whole slew of cross-
12 industry issues.

13 But there is an appetite on the Hill
14 to address this. I think we saw it in 21st
15 Century Cures when it passed.

16 While there was no specific language
17 on how, it kind of, told the field, to notify as
18 a red flag that this is something that we're
19 going to tackle. So it's a really exciting time.
20 Yes?

21 MR. GOLDWATER: So first to echo what
22 she said, it is, I mean, I don't know if I

1 would've used the word sexy, but --

2 MS. MCGINTY: It's sexy.

3 MR. GOLDWATER: -- it's definitely
4 something everybody's extremely interested in.
5 We got more questions about that particular topic
6 than any other topic when we were talking about
7 Cures.

8 So Meg, you have, you've missed all of
9 the discussion, the entertaining discussions
10 prior to now. So we actually had listed all the
11 MIPS measures that related to the topic areas in
12 the environmental scan that were predominant.

13 And one of the things I think that
14 we've all sort of concluded is we don't really
15 want to alter the measures. We want to leave the
16 measures the way they are. But as long as the
17 measures can be done through the use of a
18 telehealth technology, not being prescriptive of
19 what technology it is, but that telehealth as a
20 means of care delivery would still lead to the
21 fulfillment of the process or leading to the
22 outcome of care. And that the measures that we

1 may include in the framework would not require
2 any alteration to the measure itself, but would
3 just be measures in which telehealth could still
4 lead to the same outcome as a means of delivery.

5 And that if we're going to modify
6 those measures to be inclusive of telehealth, the
7 measure wouldn't get modified, but the CPT code
8 would probably get modified. So would that still
9 fit in with this?

10 MS. MCGINTY: I think it would so long
11 as it wasn't in contradiction of the origination
12 of the remote patient monitoring.

13 MR. GOLDWATER: Right. Okay.

14 MS. MCGINTY: Limitations on
15 reimbursement.

16 MR. GOLDWATER: Right.

17 MS. MCGINTY: But there are, there are
18 a lot of opportunities I think, especially in --
19 I list of some of the categories here.

20 And I think telehealth, it could work
21 best. Equally with telehealth, chronic care is
22 also a really hot issue right now.

1 So if you can marry the two of them,
2 we have a lot of cross-pollinization between the
3 chronic care policy proposal, the CHRONIC Act
4 that was introduced, telehealth, Schatz's bill,
5 Schatz-Wicker bill as well.

6 And those committee members on those
7 two working groups are overlapping. I mean,
8 we're seeing the same kind of four committee,
9 four senators who are both chronic care, and on
10 the telehealth bills that are going through.

11 So any way to improve management,
12 maintenance of chronic care conditions with
13 telehealth is probably one of your best bets to
14 incorporate telehealth services.

15 CO-CHAIR HOLLANDER: So I was going to
16 say, sitting here looking through the list, one
17 of the things Jason was asking before is which
18 preexisting measures might fight best.

19 I might be actually some of the cost
20 and resource use measures, right? Because they
21 don't really tell you how to do it.

22 It's just what the wraparound costs

1 are for that. It's probably worth looking at
2 that.

3 And I'm now going to throw out sort of
4 the big, bold idea that no one in this room could
5 say yes to, but knowing it takes several years
6 for measures to come through the system from when
7 they're proposed, has NQF thought of, in the,
8 whatever you call it, the measure development
9 application, including or mandating comments
10 about telehealth when people propose new measures
11 so that measures that would be proposed in the
12 next six months might have to address telehealth
13 should or should not be included.

14 And then the scary part to everybody
15 in this room, should there be sort of a member on
16 every other committee that, and it might not be
17 from this group, who has some knowledge about
18 telehealth so that we could make sure that
19 measures that are telehealth-appropriate, address
20 it.

21 I do realize that once a measure's
22 submitted, you can't really modify it. It is

1 what it is. So I think the only way for us to
2 intervene in making sure telehealth is included
3 in new measures is for it to have to be addressed
4 on the original submission.

5 MS. MCGINTY: I don't believe NQF has
6 required or made that alteration.

7 CO-CHAIR HOLLANDER: No.

8 MS. MCGINTY: I think that would
9 change an alteration in policy. Wouldn't that,
10 Jason?

11 MR. GOLDWATER: It would. Yes. We
12 would have to. I love the idea. I think it's a
13 great idea. But I can't just do it.

14 I mean, it's, yes, it would require a
15 policy change, which would then have to go
16 through our CEO, and then it would have to go
17 through our Standing Advisory Committee and then
18 our Board. And then it would be another option
19 for developers to --

20 Okay. So I realize none of you have
21 actually done this, but, Yael, Marybeth, please
22 help me out, and tell them that it is not this

1 simple to just like, oh, it's a great idea.

2 Let's just do it.

3 I mean, making policy changes
4 regarding the submission of measures, I mean, one
5 of the big issues at NQF is the burden on
6 developers now in what they have to meet for a
7 criteria for a measure is substantial.

8 And we're trying to decrease the
9 burden so that measures don't take two to three
10 years to develop. So if we add on something, we
11 have to make sure that it's not adding onto the -
12 - as great of an idea as it is. I'm all for it.

13 But we have to make sure it's not
14 adding onto the burden of development, because,
15 I'm sorry, you all don't deal with the fallback
16 when that happens.

17 We have to deal with the fallback when
18 that happens, when we get the Joint Commission or
19 NCQA or PCPI screaming at me on the phone about,
20 how dare you do this, blah, blah, blah. You
21 don't know what you're doing.

22 And endless amounts of, and because

1 understandably, the more they have to do, the
2 more money it costs, the more the government has
3 to pay out.

4 And you know, we would just have to
5 think about how that would have to be done. I'm
6 not saying I'm not going to propose the idea.

7 I'm just saying, don't think it's
8 just, you know, Helen or Shantanu's going to go,
9 oh sure, why not? You know, it'll be a
10 discussion about how to move forward with that.
11 Yes.

12 MEMBER HARRIS: The other thing is,
13 the hardest part of measure development is the
14 feasibility piece. Looking at Marybeth for
15 confirmation.

16 It would require that every single
17 doctor document if the care is provided by
18 telehealth or not.

19 So if you can convince every single
20 clinician in America to document that, then maybe
21 we could take on CMS or, you know, measure
22 development entities to have this built in.

1 But otherwise, there's no feasibility.
2 There's no way to collect that information based
3 on the data that's already available, and that's
4 the issue.

5 MR. GOLDWATER: Right. So I
6 appreciate that. I mean, feasibility is scored
7 through a scorecard. And we do current
8 feasibility and future feasibility.

9 Is it feasible now? Will it be
10 feasible in two to three years? Testing, just
11 the testing of a measure to make sure it will
12 work is, without question, the hardest, most
13 costly, most burdensome thing to do in measure
14 development.

15 That's what takes so long to do
16 because you've got to arrange the testing with
17 providers, especially electronic measures.

18 Because they have to implement the
19 measures in at least two systems. They have to
20 test to make sure that those measures are
21 working.

22 Then they have to collect data over a

1 period of anywhere from 90 to 180 days just to
2 show that the measure is working.

3 Because once the measure goes to a
4 committee, the first thing they're going to want
5 to do is, if we actually implement this measure,
6 is it going to work and drive quality
7 improvement?

8 And if they're not showing the
9 feasibility to be able to do that, the measure
10 will go down in flames in a minute. So Yael is
11 right. It's not so much as they can check a box
12 and say, sure, this will work for telehealth.

13 Like, we can't do attestation with
14 measure development. Like it can't be, okay,
15 take a pinky swear and tell me for sure that it
16 will absolutely work in telehealth. Doesn't work
17 that way.

18 CO-CHAIR HOLLANDER: So I guess maybe
19 it's a little over-enthusiastic, what I was
20 actually stating.

21 MR. GOLDWATER: I'm telling you, I'm
22 telling you the realities of how hard that is to

1 do.

2 CO-CHAIR HOLLANDER: So --

3 MS. MCGINTY: I could totally sell
4 that, too, on the Hill.

5 CO-CHAIR HOLLANDER: No, no, no. So
6 --

7 MS. MCGINTY: I can that make them
8 happy.

9 CO-CHAIR HOLLANDER: So let me
10 restate, really what I'm wanting is not mandating
11 telehealth or pushing people to do something.
12 What I'm really trying to do is push them to say
13 whether telehealth's appropriate or not.

14 So they could decide to leave it out.
15 But without having a prompt in it for measure
16 developers now, if you're doing a chronic care
17 measure and you just don't think about
18 telehealth, you won't include it.

19 So putting a question in the thing or
20 a thought process in the instructions like, do
21 you want to include telehealth in this or not.
22 We'll let people include it.

1 When you define a visit, should a
2 visit be only in-person or should it be
3 telehealth? And maybe have some more definitions
4 around some things that we're wrestling with. So
5 not a policy change. Not a mandate. Just a
6 tickler.

7 MS. MCGINTY: Well, and I think you
8 could really look into the CMS measure
9 development plan as well. That might be a good
10 avenue to pursue of wanting to get that upstream
11 involvement of developers to consider telehealth
12 as an opportunity.

13 I mean, if there are certain areas
14 where they get equal pressure from stakeholders,
15 those around this table, those who are elected
16 officials to say, listen. I mean, I'm sure
17 Schatz and Wicker would love, especially Senator
18 Schatz, would love to include a telehealth
19 component in measure development funds that come
20 out of CMS.

21 If you give them enough pressure, you
22 might be able to put that further upstream and

1 see how many flowers bloom out of it.

2 CO-CHAIR HOLLANDER: And if you'd just
3 give us the phone numbers of the measure
4 developers, we'll just call at like 2:00 in the
5 morning.

6 MR. GOLDWATER: I'd be happy to give
7 you a few, Judd. Knock yourself out, man.

8 MS. MCGINTY: I also think though, the
9 MAP process that we convene here at NQF is a good
10 opportunity to discuss these things before the
11 workgroups.

12 MR. GOLDWATER: Can you explain what
13 the MAP process is just briefly because --

14 MS. MCGINTY: Yes, sure.

15 MR. GOLDWATER: -- I'm not sure
16 everybody understands.

17 MS. MCGINTY: Sure. So the Measure,
18 and I always say Measures, but it's not Measures,
19 it's Measure Applications Partnership.

20 The MAP is convened here at NQF and we
21 provide a pre-rulemaking advice to CMS on what
22 measures should be included in their, in

1 approximately 19 federal programs from your
2 hospital outpatients, hospital inpatients,
3 psychiatric or rehabilitation centers, home
4 health, hospice, VBP, all that stuff.

5 And we basically look at the measures
6 and recommend what they should, for the best
7 program possible, include in those programs
8 themselves.

9 So it's a first bite of the apple. It
10 happens before the rules come out, before the
11 public gets a chance to comment, though they can
12 comment through us in this process.

13 It's a totally transparent process,
14 before CMS puts pen to paper and really says,
15 these are the measures we're going to include.
16 What do you think?

17 And that would be a great place to
18 have a discussion on telehealth early on. And it
19 would signify I think to CMS in their decision
20 making that this is an important issue.

21 And I think they do think this is an
22 important issue. I think they're definitely

1 getting a lot of tea leaves saying this is an
2 important issue from different areas. So --

3 MR. GOLDWATER: So to me, that
4 actually is more effective to do it there than to
5 try to do it in the measure development process,
6 which would just take, even a tickler would take
7 time to do because it's, what does that mean?

8 What does it represent on developers?
9 We're going to get all kinds of questions about,
10 what do they have to do? What do they have to
11 represent?

12 But I think if you go to the MAP and
13 say, out of all these measures that we're
14 recommending, how many of these could actually
15 fit into telehealth or independent of technology,
16 or platform-independent, measures not changing
17 telehealth as a means of delivery.

18 We could recommend that in the MAP
19 report that goes to CMS before the rules are
20 developed.

21 MS. MCGINTY: Yes. That would be --

22 MR. GOLDWATER: That would be, that

1 would require no policy change. That would just
2 be requiring additions to the report.

3 MS. MCGINTY: And all of the MIPS
4 measures, the Clinician Workgroup, and we just
5 finished up the most recent MAP.

6 It runs from like December to
7 February. But the Clinician Workgroup actually
8 evaluates the MIPS measures and the Medicare
9 shared savings program measures.

10 And then your hospital measures are in
11 the Hospitals Workgroup, and then we have a Post-
12 Acute Care/Long-Term Care Facility, which might
13 be another great place for telehealth
14 opportunities.

15 I want to talk a little bit about the
16 cost savings component. If you can show that
17 telehealth is saving money, you could probably do
18 really well when they implement the cost sharing
19 portion of MIPS.

20 I think that's like the \$64,000
21 question is, where's the money, and how is it
22 benefitting those who are paying?

1 And that seems to be the difficulty
2 that CBO, the Congressional Budget Office, has
3 scoring telehealth bills.

4 They can't get a good number for the
5 savings. They can't get a good number for the
6 cost.

7 So I don't know what the next steps
8 for this committee are, but I think an important
9 next step to start evaluating would be, let's get
10 the dollar analysis.

11 That is hands down the biggest hurdle
12 to removing those remote patient monitoring
13 restrictions, is originating site restrictions.

14 Staffers tell us over and over again,
15 so how does this save cost? How does this apply
16 to cost and resource use? How can we get these
17 numbers into CBO? How can we get our bill to
18 score positively?

19 And I think with the change in the
20 administration, that's going to be a really
21 important component to make sure that you have
22 the information for it.

1 So I mean, I know it's so easy to do
2 that. I just, totally super easy. But, yes.

3 MEMBER FERGUSON: So you're talking
4 about the cost and resource use measure that
5 comes into effect in 2018, right?

6 And correct me if I'm wrong, that
7 counts like 10 percent towards your MIPS score
8 when it comes in. Is that right? It's --

9 MS. MCGINTY: In the proposed rule, it
10 was 10 percent.

11 MEMBER FERGUSON: Right.

12 MS. MCGINTY: I don't know if that's
13 going to change to lesser or greater when they do
14 implement it because they will go through another
15 proposed rulemaking process to put that in. But
16 I'm guessing that it would be 10 percent of your
17 total component score.

18 MEMBER FERGUSON: But what you're
19 saying though is, even if it's only 10 percent,
20 the impact can be much greater than just our MIPS
21 score. Your point is that data can lead perhaps
22 to policy change or something else.

1 MS. MCGINTY: I think so.

2 MEMBER FERGUSON: Okay.

3 MS. MCGINTY: I think if that data
4 were there, it would allow for more telehealth
5 bills beyond just remote patient monitoring
6 originating site issues.

7 So understand, it would give CBO a
8 better opportunity to score those more
9 appropriately and effectively.

10 Because I, and this is not me in my
11 policy hat or in my great mathematician skills
12 hat, which is not that great, I think there are a
13 lot of savings out there.

14 You just have to figure out how to
15 identify them clearly and mark them up. So,
16 Charles.

17 MEMBER DOARN: So what is the
18 accounting formula they use to calculate, the CBO
19 use, because we've been talking about this for 30
20 -- I know history is a big problem, but for 30
21 years, this problem has arose in Congress.

22 And then when you go to talk to them,

1 they don't even realize what we did 10 years ago.
2 You ask them about a report. Oh, they don't --
3 what report?

4 So I mean, I personally find it a
5 little difficult to understand how CBO. I mean,
6 clearly, this is advantageous to our challenges
7 for sure, but I'm not sure if Congress really, or
8 the CBO looks at opportunity costs and the cost
9 of somebody driving from point A to point B, lost
10 wages, all the costs associated with that. Do
11 you know what formulas they use or --

12 MS. MCGINTY: I do not.

13 MEMBER DOARN: And that would be a
14 really nice thing for us to understand. Not
15 necessarily for this group, but in a telemedicine
16 community.

17 MS. MCGINTY: Okay.

18 CO-CHAIR HOLLANDER: The cost to CMS.
19 It's just the cost to the government. It's not a
20 societal cost and whether you're saving money out
21 of your pocket.

22 MEMBER DOARN: See, that therein lies

1 the problem.

2 MS. MCGINTY: Yes.

3 MEMBER DOARN: Right? I mean, because
4 the technology, we've talked about the last day
5 and a half, the technology is changing so
6 rapidly. The government's systems for accounting
7 for technology, accounting for the costs are, I
8 wouldn't say they are archaic, but they're not,
9 they're not new.

10 They're not, they're not evolving as
11 fast as everything else is. And therein lies the
12 challenge in American healthcare, and we're going
13 to see it become worse and worse.

14 MS. MCGINTY: Yes. I agree. I agree.
15 I think some of the issue, I mean, I've talk with
16 Jason about this, and we've provided some
17 guidance.

18 When you can equate also that a
19 telehealth encounter is as effective or as
20 productive as a face-to-face encounter, and some
21 of the measures included in practice improvements
22 actually survey on their access to services.

1 I think this is a great place for
2 telehealth providers to succeed in getting those
3 patient surveys as far as access. When you can
4 show, and there has been success in showing in
5 behavioral health and dermatological conditions,
6 providing services to rural and remote
7 individuals that they wouldn't necessarily have
8 access to in a handy and convenient way for them,
9 reducing the opportunity, you know, improving the
10 opportunity costs for the patient.

11 The stress, the need to create,
12 transportation. There's a lot of opportunity
13 there as well.

14 So I encourage you all to like look
15 through measure list and give it a good, hearty
16 think, opportunity to think what, where our
17 opportunities lie.

18 Because I think there's enough
19 behavioral, expanding practice access, better
20 practice access, beneficiary engagement are all
21 ripe. And that's about half of the measures
22 available. So --

1 MEMBER GLADWELL: I don't mean to
2 belabor the point, but since you're in these
3 conversations, what's your sense on why does the
4 bar have to be reduced cost?

5 If we're providing the same service
6 and we're proving that it's as effective in terms
7 of clinical outcomes, why do we have to hit that
8 mark?

9 MS. MCGINTY: I don't know if there's
10 necessarily, well, Jason, please chime in here.
11 I don't, I think believe, I don't think they see
12 -- they're seeing maybe the empirical evidence
13 that this is reducing costs in the sense of cost
14 to the patient, cost to the provider, distances
15 traveled, stress on multiple chronic conditions.

16 You have a heart condition, and now
17 you've got to figure out how to go 180 miles to
18 get your feet checked or something.

19 And whatever it would be. Or your
20 skin condition checked. It's hard to put a
21 number with that, and if CBO was only look at the
22 cost to CMS, they're not doing that. They're not

1 doing the analysis necessary to really equate the
2 dollars to those, that time-saving.

3 MR. GOLDWATER: I mean, so to just
4 sort of extend on what Meg was saying, I mean,
5 there's really three reasons why. So the first
6 is that's the world we live in right now. It's
7 all about cost and reimbursement when it comes to
8 healthcare.

9 And it's unfortunate. I'm not saying
10 that's right. I don't agree with it. I think a
11 lot of us don't agree with it.

12 But from a government perspective,
13 particularly the operator of the largest
14 insurance program, it's about cost. It's about
15 how much is it saving us? Are we going to get
16 the same amount of care if it was provided in-
17 person?

18 The second is, the level of
19 understanding of those that make these policy
20 decisions, when it comes to telehealth, it's not
21 the same as all of yours, or all of ours.

22 MS. MCGINTY: Or mine, or not --

1 MR. GOLDWATER: It's not. There's, I
2 think there's a deep understanding of the utility
3 of telehealth from what we were gathering, and I
4 think that there's an understanding of its
5 benefit.

6 But seeing that on paper and seeing
7 how that translates to their constituency or
8 their groups or their areas, they can't put those
9 pieces together without the data in front of
10 them.

11 Because in order for them to make the
12 more effective argument, they need that data
13 that's available, which right now, the data is in
14 bits and spurts.

15 It's not consistent, and there's a lot
16 of literature on the issue. But it's, in the
17 here and now, if this were implemented, what
18 would be the savings immediately?

19 Or what savings would we see over
20 time? What benefit would this be delivered to
21 our patients? How would this increase access to
22 care? I just don't think that that deep level of

1 understanding, and understandably, the
2 experiences some of them have is not the same.

3 So I think they want, there's a
4 greater understanding and wanting to know, but us
5 telling them is different from us showing them.
6 And so that's why this framework becomes
7 important, because it collects information that
8 they can see. That it makes a point where they
9 can see what the costs are, the access issues
10 are, the opportunity costs are.

11 It makes a more effective argument,
12 because that's always been the barrier to greater
13 expansion of this, is that the hard data and hard
14 evidence is not in front of them.

15 And I think the third reason is, this
16 has always been -- and Chuck's right. And I'm
17 actually agreeing with Chuck.

18 So this has been an issue. It's been
19 around forever. I mean, it's not something
20 that's new. It's not something the CMS is just
21 picking up. It's not something that the
22 government has not been discussing.

1 I think it's been around for a long
2 period of time, but trying to understand all of
3 the factors that go into telehealth has been
4 challenging. Because some people are equating
5 telehealth or looking at telehealth in the same
6 way they would look at in-person care.

7 And while I, we all agree, the way to
8 measure it is not to make any differences. But
9 you've all agreed that there are factors about
10 reducing travel time, getting access to a doctor
11 immediately, being able to follow up on treatment
12 plans. There has to be a patient story that
13 effectively makes those arguments. So ---

14 MS. MCGINTY: One thing just to build
15 on what Jason said. These people are elected.
16 And if you can give telehealth a personal story,
17 which is why my personal recommendation would be
18 attached to chronic care, attached to rural
19 health access, those are two, if you watch the
20 Price and the Seema Verma nomination hearings,
21 question after question after question.

22 If you can show the value of

1 telehealth in those two practice areas, you're
2 going to get people putting a constituent face
3 with the issue.

4 I mean, everybody loves their iPhone,
5 but it doesn't vote for you. If you can put a
6 person who can say before a member, I live in
7 rural West Virginia and it would take me an hour
8 and a half or two hours to get to Wheeling to see
9 my specialist.

10 But I can access them from my house or
11 from my GP's office, and I'm able to improve my
12 dermatological conditions, improve my diabetes,
13 monitor it better, and save a life. Those are
14 going to be your issues.

15 MEMBER GRAF: Can I just make, so
16 there's two cost topics here. One is increased
17 cost from overutilization levels above where they
18 are right now.

19 So that, I think is sort of the CMS
20 inherent fear of, you know, of expanded adoption.
21 The other is what we've been talking about, is
22 how through the use of telehealth, you can

1 actually reduce costs per capita.

2 And I don't think that we necessarily
3 keep them separate enough. They're really two
4 different conversations, two different messages,
5 and it's important.

6 Because even in the discussion we're
7 having here, I hear them being kind of merged
8 together, and they're different.

9 MR. GOLDWATER: Nate, go ahead.

10 MEMBER GLADWELL: I just wanted to
11 make one quick follow-up point. I've been
12 working with CTel and a lot of other
13 organizations around the cost with CBO and how
14 they score it.

15 I just want to make that point that if
16 we continue to have that as kind of the hamstring
17 crutch of why legislation doesn't pass, we're
18 going to be having this conversation for a lot
19 longer than today.

20 MS. MCGINTY: And to be honest with
21 you, 1,000 voices can beat up CBO pretty easily.
22 So if you have the mobilization of the people who

1 are benefitting it, I've seen it and I've worked
2 with it that you can overcome a CBO report that
3 may not quite have the numbers right. So --

4 MEMBER FERGUSON: So I have been --
5 okay. So I have been trying to dot -- or, sorry,
6 connect these dots for one, and I still don't get
7 it with MIPS. So take the quality reporting,
8 right? It is the biggest chunk of your MIPS
9 score, right, and it might be the biggest
10 opportunity for telehealth. And so we take the
11 example that we talked about with, you know,
12 treating COPD patients with spirometry
13 evaluation, right? We do that. We do that over
14 telehealth, right?

15 When I report that measure, I will be
16 reporting how I did on the measure. I will not
17 necessarily be reporting I did telehealth with
18 it. So how have I advanced the cause of
19 telehealth or given CMS or anybody else data to
20 know that telehealth works? I have just told you
21 I did well on that measure.

22 MS. MCGINTY: Right, right.

1 MEMBER FERGUSON: So help me connect
2 that dot. How does CMS suddenly go oh, hey,
3 telehealth works for spirometry because Alaska
4 did it. You don't know if I used telehealth. It
5 doesn't come out in the quality measure. You
6 just know how many -- you know my numerator and
7 --

8 MS. MCGINTY: You just saw --

9 MEMBER FERGUSON: -- denominator.

10 MS. MCGINTY: -- your denominator,
11 yes, yes.

12 MEMBER FERGUSON: So how --

13 MS. MCGINTY: So statistically --

14 MEMBER FERGUSON: -- do I tell --

15 MS. MCGINTY: -- we have your
16 information, and I don't know the answer to this,
17 if there is an opportunity for physician comments
18 in the reporting process to give feedback. I
19 mean, CMS is providing feedback to physicians and
20 providers. I would imagine that they would be
21 receiving feedback in that process as well. If
22 there is a way to identify that through

1 commenting or through your own personal feedback
2 on your reporting, that might be an option, but I
3 do not -- I -- yes, I do not know what the -- the
4 feedback and reporting process will be like for
5 actual individuals providing that information, if
6 it's just a matter of numbers being sent or if
7 there will be an opportunity for an actual
8 discussion of how this worked and how this didn't
9 work.

10 These -- these measures will be going
11 through rulemaking again, so that's another great
12 opportunity. It is public. It is available, and
13 CMS is listening. They could make drastic
14 changes from between the proposed rule to the
15 final rule, so --

16 MR. GOLDWATER: Peter?

17 MEMBER RASMUSSEN: Judd and I were
18 talking over lunch about how, you know, a
19 significant portion of telemedicine is -- can be
20 done like in-person using, you know, these
21 telemedicine technologies, and it has really just
22 become necessary infrastructure to an

1 organization to practice a fair amount of
2 medicine. And, you know, it's like a telephone
3 system or an electronic health record, and, you
4 know, the fatalist in me wants to just say we're
5 just going to have to suck it up and eat these
6 costs to -- to deliver this type of service to
7 our patients.

8 Is that sort of where the government
9 potentially is angling, is screw the health
10 systems, we are not going to do this, and we're
11 just going to make them do this like they did
12 EHRs? Or, I mean what -- what is --

13 MS. MCGINTY: I can't --

14 MEMBER RASMUSSEN: -- really, what is
15 --

16 MS. MCGINTY: -- speak for the
17 government's perspective or rationale behind it.
18 I would say that perhaps you are right. Less
19 cost to the government means it is more cost on
20 the provider, and you can have the choice to
21 provide services this way, which may not really
22 be a choice, to provide good care for your

1 patients.

2 I don't think that that is the general
3 intention of the individuals on Capitol Hill who
4 want to see the progression of this. I think
5 they want to see funding for an infrastructure
6 for telehealth services, from our conversations
7 that we've had with them. How that plays out
8 with the actual appropriations of that money and
9 the agency budgets, it is going to be a different
10 story.

11 MEMBER RASMUSSEN: Was there any --
12 forgive my ignorance of this, but was there any
13 funding directly or indirectly for
14 implementations of electronic health records?

15 MS. MCGINTY: I can't recall.

16 MR. GOLDWATER: No, there wasn't. I
17 mean, there was -- there was the incentive
18 program, right? Right.

19 What's that? Right, there was a --
20 right, HITECH was passed, and all of a sudden,
21 there was this expansion of an extraordinary
22 amount of money in health IT. That was not to

1 buy everybody electronic health records. It was
2 to incentivize people to buy electronic health
3 records. So -- yes, go ahead.

4 CO-CHAIR HOLLANDER: I was just going
5 to say that, you know, with respect to the CBO
6 conversation, I went down with our, you know,
7 senior VP at Government Affairs and met with ten
8 people in, you know, Congress and the Senate,
9 including, you know, Schatz's and Wicker's staff,
10 and that is not really a thing that I had done
11 before, but was -- was shocked at the degree of
12 theoretical bipartisan support.

13 Everybody said they would support the
14 Connect for Health bill, but everybody also said
15 it is not the thing they are going to die on the
16 Hill for, literally, so there was no opposition,
17 but yet there was no momentum to force the CBO to
18 move her head and score the bill, which was
19 actually the stall, and I think it was exactly
20 what Don said that everybody said to me, is fear
21 that it is going to drive up costs.

22 So I think to the -- you know, Nate,

1 your initial comment was does there need to be
2 cost savings? I walked out of that day-and-a-
3 half down there not actually really concerned
4 that there would need to be even proof that it
5 worked or cost savings, but there was just fear
6 that the budget is X, and we can't make the
7 budget X plus some fraction, and that was it.

8 And then we went around and met with
9 a whole bunch of federal agencies, and every one
10 of them to a T said the thing you could get us is
11 cost data. And, you know, it is a year later,
12 and there's no real different cost data, and then
13 there's a paper like the one that came out
14 yesterday that, you know, will scare everybody to
15 say maybe it's going to drive up utilization and
16 drive up costs, and, you know, I don't think
17 anything that we do in this room as an NQF
18 committee besides getting in some measures will,
19 you know, maybe make somebody use it, but I start
20 thinking of the influence that all of us have in
21 our own organizations.

22 And if we banded together and did

1 stuff, I mean, Don has claims data, you know,
2 which alone would be problematic because you only
3 know the claim, you don't know what the person
4 might have done on the other side, but Henry
5 might actually know of people who came in the
6 Teladoc. I don't know whether you survey and
7 know what they actually would have done if they
8 hadn't come in. It is probably not the purview
9 of this committee, but it probably is the purview
10 of people sitting around the table to figure out
11 can we get together on a listserv and brainstorm
12 how we could get the cost data.

13 I mean, gee, we got a guy with
14 publications going back to 1930 over here, you
15 know --

16 (Laughter.)

17 CO-CHAIR HOLLANDER: -- could -- but
18 -- but seriously, you know, could there be a call
19 for, you know, for data related to cost in -- in
20 the journal and get some stuff in? And I think
21 if we -- if we decided to say, okay, let's spend
22 an hour on a conference call not under the

1 purview of NQF and say how could we help get the
2 data that might move this ahead, I bet we could
3 come up with some pretty creative ideas to make
4 it work.

5 MEMBER DOARN: Well, I could take the
6 whole floor for the rest of the day.

7 So the -- we have a professional
8 organization called the ATA, and Jon Linkous has
9 told me repeatedly for a very long time that they
10 go to the Hill, and they talk about policy
11 development and maybe even help write
12 legislation, and I said to him, I said, you know,
13 John, there are two journals that have been
14 around for 23 years, now 23 years, that have tens
15 of thousands of pages, you know, thousands and
16 thousands of articles that show that telemedicine
17 works, with some challenges, for sure.

18 And he goes they don't care about the
19 -- the evidence. They don't care about the data.
20 All they care about is, you know, whether they're
21 going to save money or not. And I said but there
22 are articles in there that say that, not only

1 here, but in Europe as well, and in other places
2 around the world.

3 So then -- so Sherilyn and I went up
4 to talk to the Hill as the FedTel, and we sat at
5 a table, and I asked the guy, I said have you
6 ever looked back -- I mean, most of the people
7 sitting at the table were 25 years old, so that's
8 the number one problem. There was one guy that
9 was sitting there, he was from the Congressional
10 Research Office, and I said have you looked back
11 at the FedTel report that we did in the 1997 time
12 period or the Airlie House report?

13 And so, no, the congressional -- the
14 guy at the Congressional Research Office was, you
15 know, he's a gray-hair, and not sure what that
16 means, but, you know, he's an older guy, and he
17 said oh no, we -- what are you talking about?
18 And I was dumbfounded by the fact that we had
19 done all this stuff. We have the research, we've
20 had many different meetings, not on measures, but
21 certainly bringing very smart people together to
22 look at technology, look at research portfolios.

1 They time and again produced reports that no one
2 either looks at or sees.

3 And then you come to find out, it's
4 like, well, if you have 1000 people that tell
5 good stories in West Virginia, you're going to
6 get the CBO to change, which is not the same as
7 building measures that are based on evidence-
8 based medicine, which is what we're about, versus
9 -- I mean, it's not to say we shouldn't have good
10 stories. I mean, we all have good stories. Some
11 we won't talk about. But clearly, it seems to me
12 that Congress does not really care about the
13 data.

14 They care about -- it is either
15 personality-driven -- and I have seen congressmen
16 and senators actually say this isn't going to
17 happen while I am in charge. So if you have that
18 kind of mentality either in the White House over
19 the last 25 or 30 years or God forbid what
20 happens in the future, and going in the -- and
21 the same on Congress and the Senate, you have
22 that kind of a problem. So it's not about

1 evidence, and that is the disturbing part.

2 MS. MCGINTY: I wouldn't say that
3 evidence is not in the telehealth sphere in my
4 professional experience. Evidence can be well
5 responded -- can be well responded to.

6 I am a former Hill staffer. If you
7 gave me an academic journal that is 90 pages
8 long, I can sure as heck guarantee you I am not
9 going to read it because I have too many other
10 things to do. But if you can give me the
11 evidence in a persuasive argument and in a
12 persuasive reason, I can take that evidence
13 directly to my boss, or I could take that
14 evidence directly to committee staff, if I'm a
15 personal House staffer.

16 It -- it is a -- it has got to be a
17 two-pronged approach, you know. You've got to
18 have the evidence. You've absolutely got to
19 have, and it sounds like you have great evidence
20 going back 30 years to show the savings and the
21 benefits, but you also have to get the passion of
22 the people to be willing to fall on the sword for

1 it, and that is -- and that is -- that is the
2 challenge, to get those two to work together,
3 especially when you're working with like really,
4 really awesome evidence that is super like
5 exciting, like a movie, you know.

6 So it is really -- everybody loves
7 kids, right? Nobody is going to dislike kids,
8 but the progression of --

9 MR. GOLDWATER: Don't round up there.

10 (Laughter.)

11 MR. GOLDWATER: I love kids --

12 MS. MCGINTY: You won't get any -- you
13 won't get any member on record saying no, let's
14 not fund healthcare -- or healthcare for
15 children, like, but when it comes down to the
16 budgeting, you're still going to have members who
17 it comes down to the dollars and what their
18 ideology perspective of where the dollars should
19 go, so how do you overcome the ideological
20 perspective?

21 I will say you have a very good Budget
22 Chair, this is my personal opinion, who is an RN,

1 Diane Black, and she is now chairing the Budget
2 Committee.

3 MR. GOLDWATER: So before I get to
4 Adam and others, I mean -- what is that? I --
5 yes. I think it is -- I -- so I am going to take
6 the opposite view, Peter, and be the optimist,
7 not the fatalist.

8 And I -- I think it's a multi-stage
9 process, and I think that for a while, we have
10 all been sort of beating on the path of we have
11 evidence, we have data, people are doing this,
12 here is the change. And it is just -- you know,
13 again, I don't think everybody's level of
14 understanding is the same, so I think it is a
15 step back and doing it a different way, which is
16 creating a way to effectively measure telehealth,
17 and showing its impact across a variety of
18 different areas, and showing the impact it can
19 make in areas that are important to those that
20 make these decisions and those that will be
21 implementing these decisions.

22 And then I think it is about -- as,

1 you know, Adam was saying, which is why I think
2 the -- the journey is such an important aspect of
3 this framework, which is it's not just telling
4 stories, which I understand Chuck you probably
5 have more than everybody dating back -- I don't
6 even want to know how far back they go. It's on
7 the tablets in the cave that you -- no, I am just
8 kidding.

9 (Laughter.)

10 MR. GOLDWATER: It is -- you know, I
11 -- I think it is doing the measure framework, it
12 is telling the stories of where -- again, and
13 that is why we wanted to emphasize what do you
14 think is really important about taking time, you
15 know, reducing the amount of time to see a
16 physician, having immediate access to care, being
17 able to follow through and monitor particular
18 conditions?

19 I mean, those things as opposed to the
20 alternative are compelling, and then add that
21 into the way to effectively measure this in the
22 same way healthcare would be measured so that we

1 are no longer differentiating between the two, it
2 all becomes care delivery.

3 It is just -- this is another mode of
4 care delivery, and that is another sort of facet
5 we have to work with, is that -- and I -- you
6 know, when I have sat on these conversations with
7 Meg, they treat it as some -- as its own entity,
8 the telehealth is a totally different way of
9 delivering care, and it's not a different way of
10 delivering care. It is care delivery, it is just
11 Paul is treating me from LA. I am not in the
12 office with him, but he is still leveraging all
13 of his expertise to say Jason, you need to do a
14 spirometry test and a peak flow test with the
15 boats, and you need to get on a bronchodilator,
16 and here is the prescription, and I am putting a
17 thing on it so I can monitor to make sure you're
18 taking it.

19 And if you don't take it, I am going
20 to send you a text message to say buddy, take
21 your freaking bronchodilator, otherwise you're
22 going to end up in the ER. Right, because Paul

1 is real menacing that way.

2 Those are the things that if we
3 effectively do, then I think the -- the tide
4 starts to change a bit. But I think the way it
5 has been -- we have been going at it is we have
6 the data, we have these academic articles, we
7 have these journals, here is all the evidence,
8 and they are still thinking of it as two very
9 different forms of care, and they're not looking
10 at the evidence because they're like if we go to
11 this other way of providing care, it is going to
12 cost money and it is going to not produce any
13 savings, rather than convincing them it is just
14 healthcare. It is just another way.

15 So with that, Adam.

16 MEMBER DARKINS: So I was just going
17 to quickly say we did discuss cost yesterday, and
18 in that, saying is there some systematic way we
19 could look at cost, the answer was we can't. So
20 it seems to me that the issue -- I mean, we could
21 be discussing this in 20 years' time in exactly
22 the same way, and we could be wishing this to be

1 different, so it seems to me the fundamental
2 challenge is how do you relate quality to cost?
3 And we have not done that, as I have seen it, in
4 this.

5 If you can't relate quality to cost,
6 I don't believe there is good evidence. I think
7 there are good indications. You can say there
8 are some savings associated with it. There's
9 very good theoretical evidence to show that you
10 could inflate costs, so we have to be able to
11 show we can relate quality to cost, and there are
12 cost savings.

13 That done, nobody is going to invest
14 in something like this unless you can also show
15 ongoing thereafter you can monitor costs and
16 quality. So if we don't create the framework to
17 go in there -- so I kind of see in the discussion
18 we have just had almost a kind of wish, well, you
19 know, let's just lobby and the rest of it.
20 Surely this takes us a little bit back to the
21 challenge. If we can't answer and say our
22 framework yesterday is showing us how might we do

1 it, isn't there a slight dissonance here? Or am
2 I just being a bit naive?

3 MR. GOLDWATER: No. I think there is
4 a slight dissonance, but I would say I think
5 we're on the -- I think we have enough ideas to
6 start to rectify and put something together that
7 will adequately and effectively produce metrics
8 to evaluate, and I think it then becomes
9 incumbent upon all of us that as this is being
10 iterated, that we carefully look and read it to
11 ensure the fact that we are driving to that
12 because, again, when that -- those metrics are
13 shown and can be analyzed and interpreted, it
14 again shows that it is just another form of care
15 delivery, but it is an effective one for those in
16 underserved rural areas especially, and so forth.

17 MEMBER DARKINS: So isn't it therefore
18 -- I am not -- I just trying to make the point, I
19 mean, I am very optimistic. I think this is
20 going to happen. It's how we make it happen
21 which is why I think we're all here.

22 So isn't there a piece around this

1 fundamentally which is how you relate quality to
2 cost, and that doesn't seem to be something --
3 perhaps we won't get the answer, but in the next
4 -- before we get the report, if we could come up
5 with a real way in which we could do that in a
6 systematic way, I think we provide something very
7 helpful.

8 MEMBER GRAF: So my question is really
9 about defining the process. So right now, when
10 we think about CMS and -- and restrictions of
11 policy that is in place, and what we want to do
12 is loosen them up as opposed to creating new, is
13 one fundamentally -- and the approach to getting
14 the reform, is one fundamentally different than
15 the other, or do they both sort of work the same
16 way? Do you know -- understand --

17 MS. MCGINTY: Yes, no, I understand
18 what you're saying. Which one is easier? I
19 think it is easier to add than to remove,
20 personally.

21 MEMBER GRAF: So -- so we're already
22 biased.

1 MS. MCGINTY: I -- I -- this is -- I
2 -- I think it is -- I think it is easier to add
3 than to remove. It is always easier to add into
4 it than to strike previous law. You're going to
5 get -- you're -- you're going to pull out from
6 the woodworks who would be opposed when you're
7 going to remove something that they really like,
8 but when you're adding something, you may not get
9 all of the interested players who may say oh,
10 yeah, we're against this.

11 So I think you're already at a bit of
12 a -- a deficit there. But those restrictions do
13 need to be removed in order to expand the access
14 and the use of these services.

15 I -- I think -- I mean, the one thing
16 I am kind of listening here, and I haven't read
17 the framework, and I am excited -- I am really
18 excited for this report. It is going to be so
19 great. It is going -- every -- it's going to be
20 such a buzz to report, and I am so excited to
21 work with it, but you're getting the unique
22 opportunity to create a framework while the

1 restrictions are still in place, so you have a
2 scratch draft ready to go for when they are
3 removed.

4 And that is not an opportunity I think
5 any of our committees have really had to do, so I
6 think it is going to be very influential, and I
7 think -- I think that alone right there, showing
8 that you have an option, a practical application
9 that can guide for the great and effective use of
10 these services more easily to providers, to
11 hospitals, to clinicians and physicians, to RNs,
12 and to patients, before they remove it, they know
13 what they're getting in the beginning. So I
14 think that's a good point to sell.

15 MEMBER ALVERSON: So this is more of
16 a question, Megan, and maybe to Jason, I agree
17 with everything you said Jason, that it's all
18 about healthcare. We tend to make telehealth
19 something magical.

20 But how do we make -- how do we --
21 because we have talked about we're going to have
22 the -- we'll follow the NQF's measures where

1 telehealth just is another means of achieving
2 that -- that measure, and -- and I am going to go
3 back to something that Stewart said in talking
4 about MIPS and so on: how do we get that across
5 to the decision-makers in -- in the legislature
6 and the administration and so on that it was
7 telehealth that actually augmented or enhanced
8 achieving that measure?

9 Because otherwise, it seems like it
10 gets lost. You know, we're tagging a -- so what
11 -- what is -- I mean, it is sort of like I think
12 about the CPT codes and a GT modifier. I mean,
13 is there a way that people say, yes, telehealth
14 helped us achieve that measure, which might
15 include not only improve quality of care, but
16 also we decreased cost, and there's a lot of --
17 and it's all in our -- in our framework?

18 But I -- but I am not sure how we get
19 that message across because that is what happens
20 with the Congressional Budget Office, is they
21 just look at what is the upfront cost, not cost
22 avoidance. Is there a way to attach these --

1 these endorsed NQF measures where people know
2 that that was enhanced by telehealth? How do we
3 do that?

4 MS. MCGINTY: I would say first -- my
5 first advice would be when you do comment on --
6 because everybody reads the Federal Register
7 every night, correct? Yes. Everybody?

8 So when you do comment, I would cc any
9 stakeholder that you think has an interest in
10 this. So when you present your comments to CMS
11 with their cover letters and send them in to be
12 -- in commenting to the rule, I would take that
13 comment and include that into a letter to the
14 senators that you know care about it, the members
15 of the House that you know care about it, and
16 don't send it to their office, email it to their
17 staffer, first and foremost.

18 I think if you hit from both angles --
19 we had some really great rural health success
20 because we were able to hit different avenues,
21 both from the CMS side and on the legislative
22 side to put pressure on the Secretary to do these

1 things, and now they are starting to do those
2 things. So it is -- while we think rulemaking is
3 so great and it's public and it's transparent,
4 everybody has a bite of the apple, you have to
5 make sure that your bite is seen and noticed a
6 little bit bigger than everyone else's. That
7 would be my first advice.

8 MR. GOLDWATER: I mean, I think we're
9 going to have to sort of think through
10 modification. I mean, I think that is a really
11 crucial issue, because modifying a measure is
12 what we said we didn't want to do, and I
13 understand that, and I think that would pose a
14 number of difficulties. At the same point in
15 time, we want to recognize that the telehealth
16 service was provided so that we're effectively
17 showing its utility.

18 Now, whether that is modifying the CPT
19 code or the modifier and segregating those out
20 and reporting as these were telehealth, these
21 were in-person care, you know, that is a
22 possibility, and seeing if -- if we can work to

1 have those reported to CMS as part of the MIPS
2 program as they go through this latest iteration.
3 But other than that, we are going to have to
4 think through that.

5 I don't think that's an answer we're
6 going to come up with today, but I think when the
7 framework comes -- you know, the draft of the
8 framework comes out and you're seeing the
9 concepts and you see the starter set of measures
10 and how they are all relating, then we can start
11 engaging in a discussion about, you know, how do
12 we report these in a way where the telehealth
13 service is being highlighted?

14 I think that is a challenge. I am not
15 -- I am not going to state differently. But part
16 of that, again, is tying cost into quality, and
17 the other part of it is, you know, ensuring that
18 you can segregate telehealth from standard in-
19 person care without making it whereas telehealth
20 is sort of its own independent magical unicorn
21 type entity, and standard care -- which, you
22 know, that is what some people think. They think

1 it's a unicorn, like it is this magical thing
2 that, you know.

3 I think I said that in one of the
4 meetings. I was just like it's not a unicorn.
5 Stop thinking --

6 MS. MCGINTY: And I think -- I think
7 that mindset is changing.

8 MR. GOLDWATER: Yes.

9 MS. MCGINTY: I think, you know, those
10 25-year-olds get some of this technological
11 advancement, and that we are lagging behind, and
12 if I can grow a garden and share it with people,
13 why can't I, you know, share my issues with my
14 doctor and do all these things remotely without
15 having to go in to see him?

16 I -- it is a translation between the
17 two, and -- and the care -- care -- if you
18 address it from a care delivery standpoint, I
19 think you're going to get the people to
20 eventually get onboard. It is -- it is
21 challenging. It is challenging.

22 MR. GOLDWATER: Paul.

1 MEMBER GIBONEY: Something that Adam
2 said about our conversation yesterday about how
3 cost -- a really complete assessment of cost
4 includes all these different things, right? It
5 includes all the societal costs, the costs to the
6 patient, travel, all that kind of stuff, and how,
7 you know, we will be talking about it in 20 years
8 and maybe still not be able to capture all that.

9 But then, so -- so that would be like
10 the perfect accounting of cost. But then, when I
11 hear that, you know, CMS has really -- you know,
12 CBO is looking at, you know, what's the cost to
13 CMS, it makes me think can we not make that
14 perfect assessment of costs the enemy of good,
15 which would be speaking CBO's language? And
16 putting some effort forth in saying, okay, if CBO
17 is interested in cost to CMS, then how do we show
18 that telehealth as a delivery model actually
19 reduces cost to CMS?

20 Because I actually believe that I can
21 show that in my system, without including all
22 those other features that I know are awesome

1 features of cost, but I actually believe that I
2 possibly could show that the bottom line cost to
3 CMS is actually improved. And -- and so it might
4 be trying to speak their language even though we
5 know that there is this much other, bigger
6 language that we could reveal to them over time.

7 MR. GOLDWATER: Yael.

8 MEMBER HARRIS: So I just wanted to
9 follow up on that, Paul. Absolutely. I just
10 want to point out the task is even easier.

11 What I have heard from CMS is they
12 want to know is care delivered by telehealth the
13 same as care delivered in person in terms of cost
14 and quality? Is quality compromised? Is it more
15 expensive? If you can disprove that, as Jason
16 just said earlier, it is care that is being
17 delivered, just with the doctor or the provider
18 not in the same place.

19 So they don't necessarily -- I mean,
20 it would be great if we could prove it saves
21 money. We all know it does. But they just need
22 to say it is not compromising quality, and it is

1 not costing more care.

2 MR. GOLDWATER: Right. That should be
3 the line: prove that it's not a unicorn, right?
4 I mean, that is what we should go forward: prove
5 that it's -- I mean, I am -- and I am kidding,
6 and I am not kidding, which is prove that it is
7 not some magical mythical beast. It is just
8 healthcare. Do that, and I think we are on our
9 way.

10 Stewart.

11 MEMBER FERGUSON: So I don't know
12 where everybody else is in their MACRA MIPS
13 journey.

14 (Laughter.)

15 MEMBER FERGUSON: Was that funny? Oh,
16 okay. So -- so I just -- well, I just -- I have
17 been very frustrated with my organization, and we
18 needed to make that transition from meaningful
19 use to quality payment programs, which is really
20 what we're talking about, not MACRA. MACRA is an
21 act --

22 MS. MCGINTY: That is the --

1 MEMBER FERGUSON: -- it is a high-tech
2 act --

3 (Simultaneous speaking.)

4 MS. MCGINTY: -- quality paying
5 programs --

6 MEMBER FERGUSON: Right, meaningful
7 use is the program --

8 MS. MCGINTY: That is right.

9 (Simultaneous speaking.)

10 MEMBER FERGUSON: -- QPP is the
11 program, but I just wrote a job description about
12 a month ago for a new position. We are creating
13 a Director for Quality Payment Programs. I am
14 guessing other organizations are doing the same
15 thing. You can find them on Monster. They are
16 out there, and we're asking this person to lead
17 us in a strategy basically to maximize our MIPS
18 score.

19 MS. MCGINTY: Yes.

20 MEMBER FERGUSON: And we are kind of
21 getting to the point now where it's not so much
22 is telehealth reimbursed? It is not so much, you

1 know, can we convince people to use telehealth
2 for these measures? We will look at the way to
3 get the highest MIPS score we can. We will be
4 looking at the quality measures that make sense.
5 We will be looking at the ones where for this
6 much money I can get this much score, and
7 telehealth will certainly be part of some of
8 those.

9 And so I think we're kind of getting
10 to that world where it is not maybe so important
11 to track if we use telehealth or not. Each
12 organization will make their decisions, but they
13 probably will have to use telehealth to really
14 maximize their score, because you actually have
15 to drop your costs, you have to drop your
16 resource costs, and you have to improve your
17 quality. And I think all of us that advocate for
18 telehealth know that that is generally part of
19 the solution.

20 So I -- I guess I can relax a little
21 bit, and I think the quality payment programs are
22 going to drive us into that world, and it is

1 probably going to become pretty irrelevant pretty
2 soon if an organization achieved a high score
3 because they used telehealth or not. They
4 probably will have to for some of this and we'll
5 probably all be there.

6 So I feel -- you know, I guess I don't
7 feel as much of a need to differentiate if people
8 achieved that quality score through telehealth or
9 not. I think it is going to happen because we
10 are being driven there.

11 MS. MCGINTY: Between listening to the
12 past -- your comment and the last comment, I
13 wonder if almost those positions are juxtaposed,
14 because you want to find out how you can save
15 money to CMS, but in shared savings plans and the
16 costs and the MIPS score and your incentive
17 payments, if you're using healthcare --
18 telehealth to get more money back, essentially,
19 how are those going to play off of each other
20 going forward? I don't know. This is just the
21 interesting points of the two arguments, that,
22 you know, Paul's comment and Stewart's comment

1 could at the end be at heads with one another,
2 eventually.

3 MEMBER RASMUSSEN: You know, while you
4 optimists are all waiting for payment from CMS,
5 there are some things I think that they -- that
6 they could do to -- that would really be no cost
7 to them that would -- that would at least help.
8 So I am from the Cleveland Clinic. We've
9 obviously got hospitals in Cleveland, and we've
10 got a place in Florida and Ohio. We have no
11 problem delivering post-surgical follow-up visits
12 using telemedicine.

13 In Florida, our attorneys, and maybe
14 they are just nervous Nellies, are reluctant to
15 allow us to do post-op follow-up visits on
16 Medicare patients, fearing that Medicare is going
17 to disallow the entire hospitalization if we
18 don't have that in-person follow-up visit post-
19 surgery.

20 So that would seem to be an easy thing
21 CMS could do, is just say we will not penalize
22 you if you use telemedicine in these situations.

1 That would do at least something to help promote
2 some adoption and not cost them anything. Is
3 there any indication that they might be willing
4 to do something like that?

5 MS. MCGINTY: I have not heard that,
6 but I also have not heard that point raised, so,
7 I mean, unless it -- I did not read through the
8 1400 comments that were received in MACRA, but I
9 did not -- I did not hear that that was one of
10 the comments made, so maybe it's a point that
11 needs to be raised with them, and I hope they are
12 on the phone.

13 MR. GOLDWATER: I agree. I think
14 that's a good point, Peter.

15 MEMBER GRAF: I wanted to -- to make
16 a comment to sort of flip this whole discussion
17 on its ear. You know, telehealth and the
18 expansion of its use is happening regardless of
19 where we are from a policy perspective at a more
20 than exponential rate, and at some point in time,
21 probably sooner than later, I hope, the barriers
22 that exist today are going to be completely

1 flipped around, and now you're going to be asking
2 the questions like many Medicaid organizations
3 are asking: why aren't you using telemedicine?

4 And where you aren't using it, you're
5 going to -- it is going to affect your HEDIS
6 scores. It's going to affect your Star ratings.
7 It's going to affect your at-risk dollars. And
8 -- and so, you know, are we -- are we skating to
9 where the puck is, or should we be -- or where it
10 is going to be? Just a thought to consider.

11 MEMBER DOARN: I am not sure we're on
12 the same ice pond.

13 MEMBER GRAF: Probably won't happen in
14 our life.

15 MS. MCGINTY: I think -- I mean, I
16 think once the real barriers are removed, which
17 by means is no small feat, as we discussed, that
18 could be the conversation. I definitely think it
19 could. I mean, you look through the survey
20 measures and you see the opportunities to be able
21 to do those through telehealth services and the
22 amount of surveys you would get back from your

1 patients would be like whew, so many of them, and
2 your --

3 MEMBER GRAF: And --

4 (Simultaneous speaking.)

5 MS. MCGINTY: -- scores would go up.

6 MEMBER GRAF: Yes, and -- and, you
7 know, from CTel's perspective, and you hear about
8 litigation, things like that, litigation, the
9 possibilities of it are not, you know, you gave
10 me telehealth and I, you know, I got screwed up.
11 It is you had it to offer, but you didn't. And
12 -- and so more and more, I think we should be
13 thinking about it.

14 CO-CHAIR HOLLANDER: I think Peter's
15 point comes back to when we were talking before
16 about pre-existing measures and defining what's
17 in it. It's like what's a visit? Like if it --
18 in order to do your -- and I don't know this
19 area, but if you have to get paid for your
20 surgery and you need a bundled post-op visit,
21 well, what is a visit?

22 I am pretty sure the regulation right

1 now does not say you need an in-person visit. It
2 is probably silent on it. And that is why I
3 think it is really important to go back and look
4 at the measures that include things and clearly
5 try and specify that it -- it comes back to our
6 -- you know, our thing of an actionable item.
7 Like if you could do a post-op visit, and you
8 can't see the wound, and the idea is to look at
9 the wound, that is a problem, but if the idea is
10 to see the wound and you can, and see if the body
11 part moves and do a neuro exam and you can, well
12 then you're getting actionable information, and
13 that should count as a visit.

14 I think we have incorporated that in
15 what we have done. The question is how can we
16 incorporate that where they created a measure
17 before this existed so that this can apply and
18 yet make it clear that being silent on it does
19 not mean you can't do it somehow? I don't have
20 the answer to that, but hopefully we can trigger
21 that.

22 MR. GOLDWATER: Okay. Meg, thank you

1 as always for the insight, and --

2 MS. MCGINTY: And I encourage you all
3 to go to your shared documents on the SharePoint.
4 All of the measures are there, so -- .

5 MR. GOLDWATER: So Meg, we will
6 continue to loop you into what we're doing, and
7 we will continue to loop all of you into what
8 we're doing, as this will get traction once it is
9 done, I am sure, so we will keep you continuously
10 informed, as will HRSA, I would assume, about how
11 this is being received and what is being done as
12 a result of it.

13 So we are now at the time for a
14 meeting summary. So Judd, do you want to sort of
15 summarize?

16 (Laughter.)

17 MR. GOLDWATER: Unicorn, you all
18 remember that. I am tweeting that tomorrow.

19 MS. MCGINTY: For real, I would just
20 actually like to thank everybody. I think that
21 we all have the sense that this meeting went
22 really well, and, you know, we didn't solve all

1 the world's problems, but we did what we were
2 asked to do in getting domains, subdomains,
3 measure concepts, having robust discussions, and,
4 you know, somehow I think Jason must have had a
5 screening process that he did a survey and we all
6 answered with the exact same yeses and noes on
7 the thing because, you know, we can deal --

8 MR. GOLDWATER: Only with Chuck and
9 Stewart.

10 CO-CHAIR HOLLANDER: Yeah, yeah. And
11 so we -- you know, I think we, you know, can deal
12 very well around what we needed to do, and so I
13 think, you know, we're going to see some stuff on
14 some more webinars, and Jason and the team is
15 going to take the little bit of information we
16 gave them today and make it crystal clear so
17 everybody could use it.

18 But -- but I think this is cool. We
19 -- we did -- I think we did the easy work. I
20 think the NQF staff did the hard work in prepping
21 us for this meeting, and so I thank them for the
22 tremendous amount of up-front preparation. I am

1 sure every one of us when we heard there's an
2 environmental scan --

3 (Applause.)

4 CO-CHAIR HOLLANDER: I think everyone
5 when we heard we're going to review a couple
6 hundred articles thought, crap, how can I hide
7 from this? And -- and they did a great job of
8 doing that and were able to sort of help, you
9 know, put it in a framework that is useful, and I
10 think we had a lot of discussion that probably
11 extends beyond the scope of what was intended,
12 but -- but good stuff in helping give us all
13 direction going forward.

14 And I am kind of optimistic. And we
15 have a conference call coming up when? It is
16 like soon.

17 MR. GOLDWATER: So we will get -- you
18 are racing ahead. We will get --

19 CO-CHAIR HOLLANDER: Okay.

20 MR. GOLDWATER: -- to next steps in
21 just a minute.

22 CO-CHAIR HOLLANDER: All right. So --

1 so anyway, my summary is really thank you. I
2 think everybody can look at the board and see the
3 work we did, and we don't really need to march
4 through it item by item, but a really impressive
5 group, and, you know, no one was shooting
6 spitballs across the table, and I personally had
7 a lot of fun hanging out and learning from
8 everybody here, so I thank you on behalf of me
9 and Marcia.

10 MR. GOLDWATER: So I -- I would echo
11 that, and I want to thank all of you profusely.
12 This has just -- I have said this a thousand
13 times, I will probably say it again, but this has
14 been a terrific committee. We could not have
15 asked for a better group of people personally and
16 professionally.

17 I think the -- I mean, as much fun as
18 we've had teasing Chuck, which is rightfully
19 deserved, I think we have -- we have accomplished
20 everything we needed to do. I mean, essentially,
21 the report, what's laid out in front of us is
22 exactly what we need. I don't think we're

1 unclear about anything. I think we have exactly
2 the direction that we need to follow, and we will
3 provide something that you all will be able to
4 input in and shape it up to be I think an
5 extraordinary document and a great framework that
6 could really create some change, I hope. I am --
7 I am also very optimistic.

8 I want to thank my team, Tracy and
9 Katie and Irvin and May. You know, they are
10 really the brains behind the operation. I am
11 just the face. I don't really do anything. I am
12 kidding, but they really are wonderful people,
13 and they are very dedicated to this, I mean, and
14 I think that shows, so I thank them.

15 And I do want to thank Judd and
16 Marcia. I am not sure why, but I want to thank
17 them for all of their help and preparing for this
18 meeting, knowing what to say, and really taking
19 charge of it over the last day-and-a-half to get
20 what we need to get done. So with that in mind,
21 I am going to turn it over -- did you want to say
22 something, Marcia?

1 CO-CHAIR WARD: Yes. Closing up on
2 Meg's, we have gotten briefed on all that. How
3 is the report going to integrate that? And we
4 talked about a reduced list, and we talked about
5 the NQF-endorsed measures and saying is part of
6 the matrix going to pull in and look at the sweet
7 spot between the NQF-endorsed and the MIPS? And
8 -- and that is maybe our condensed set --

9 MR. GOLDWATER: Right. So one of the
10 -- one of the requirements of the final report is
11 that we -- as we move forward with the -- the
12 different iterations is to incorporate how it
13 fits into MIPS and APMS, so we will take some of
14 what Meg said. We will probably continue to have
15 discussions with her. We will show her those
16 sections that we are writing so she can add her
17 own comments, thoughts about where those
18 intersections will lie, but yes, that is going to
19 be a big component of this. It needs to be
20 because that is where that can be a major driver.

21 Okay. So Operator, if you could open
22 the lines for public comment, please?

1 THE OPERATOR: Okay. At this time, if
2 you would like to make a public comment, please
3 press star, then the number 1.

4 (No audible response.)

5 THE OPERATOR: And there are no public
6 comments from the phone lines.

7 MR. GOLDWATER: Okay. And from the
8 audience?

9 MR. JARRIN: Hi. Oh, great. Good
10 afternoon. My name is Robert Jarrin. I am with
11 Qualcomm Incorporated, and I wanted to make a few
12 public comments based on the conversation that
13 happened today. By the way, great job. I found
14 it very engaging. This is the area of interest
15 for Qualcomm and many others in the industry.

16 But quickly, Jason, during the use
17 case discussion, you asked publicly how many
18 spirometers, peak flow meters, inhalers, sensors
19 there are on the marketplace. I can say there
20 are many. They are made by not only Propeller,
21 but Gladstone, Philips. There are others out
22 there.

1 In the digital health space, those --
2 these devices would be medical devices. These
3 are all cleared Class II devices. There are
4 about 150 or so that have been cleared by the FDA
5 in the last couple years. There are others that
6 predate that, and that includes things like
7 mobile ECGs, spirometers, peak flow meters, et
8 cetera, blood glucose monitors, continuous
9 glucose monitors, et cetera, so that's a very
10 alive and healthy area. But they all have to be
11 cleared by the FDA.

12 Then onto Dale was mentioning AMA's
13 work in modifiers. They are not only looking at
14 modifiers. They are looking at potentially new
15 codes as well in addition to even modifying some
16 existing codes and seeing whether or not they
17 have to tweak facility fees or non-facility fees
18 for the digital health space. I am actually on
19 the Digital Medical Payment Advisory Group as
20 well as my geneticist friend two doors down from
21 you, so that is an area that the AMA is looking
22 at.

1 Thirdly, Kevin with tech neutrality:
2 completely agreed. We want to push the notion of
3 tech neutrality. The problem is when CMS goes
4 and defines a very neutral term like telehealth,
5 and in the 2001 Physician Fee Schedule, for
6 example, it specified that telehealth needed to
7 be not store-and-forward and had to be live voice
8 and video in addition to a number of other
9 stipulations that were both in statute and in
10 rulemaking.

11 That became the problem as to why
12 remote patient monitoring is not included for
13 payment in many of these things, and that is
14 where the huge problem is because if you're
15 looking at telehealth and you're talking about
16 telehealth, that is a defined term by CMS. It
17 can't be live voice and video -- I am sorry, it
18 has to be live voice and video, it can't be
19 store-and-forward. It has originating start
20 restrictions. It has geographic restrictions, et
21 cetera. So -- and then that leads to the bigger
22 problem.

1 So under MIPS, I am glad that Meg
2 came. That was the whole reason why I was here.
3 I didn't even know that you guys wanted to touch
4 upon that, but I would like to state for the
5 record that the statute for the creation of MACRA
6 specifies under CPIA, Clinical Practice
7 Improvement Activities, that telehealth remote
8 patient monitoring should be a part of care
9 coordination, and unfortunately, in rulemaking,
10 those 92 measures that Meg brought up, they
11 didn't even include it in care coordination.
12 They included it in expanded practice areas,
13 which she spoke to, as well as population
14 management.

15 And then in the subsequent final
16 rulemaking, many in the industry commented,
17 including AdvaMed and other organizations, but
18 those comments were blown off, and that is a
19 problem. Of those 92, about 14 of them may be
20 construed to be able to be achieved by telehealth
21 remote monitoring, but that is not explicit, and
22 that is not good enough, which is why I would

1 say, Jason, I would recommend for NQF to be at
2 the measurement development table, or via the
3 MAP, whichever one politically is easier, but you
4 guys should definitely be involved in there.

5 Recently, the measures for
6 applications for measures went live, and -- and
7 it was only like a month window. I submitted a
8 couple measures. I know other organizations did
9 as well, but I am not sure they are going to get
10 any -- any room, and that -- that is terrible.

11 Keep in mind that MACRA also assumes
12 obviously EHRs under Advancing Care Information.
13 Meaningful Use Stage III does speak to
14 coordination of care and patient engagement,
15 specifically uploading patient-generated health
16 data from any source into the electronic health
17 record, but as we know, Meaningful Use Stage III
18 has been delayed. I am not sure what that means
19 for MACRA. That is a problem.

20 And very lastly, on the legislative
21 front, I wish Meg was still here. We supported
22 many of the -- I am sorry, the pieces of

1 legislation that were being contemplated,
2 including Schatz, very vocally and open.
3 However, it is a new legislative session. They
4 have to be reintroduced. We have no idea what
5 they look like. From what I hear, not only that
6 piece of legislation, but others have diverted
7 from what we had agreed to last time. I am not
8 sure I can support them going forward.

9 You know, creating legislation is
10 messy and it can pigeonhole you if it's not done
11 the right way, so I would actually recommend that
12 NQF has the power to really sway CBO, CMS,
13 Congress, and in addition work with AMA, because
14 everybody says that what is lacking here is
15 evidence. They say that there is no evidence,
16 yet AHRQ has evidence.

17 Darkins is one of the fathers of the
18 evidence in this space with what he did in
19 telehealth. He has got the biggest report on it
20 -- or study. There are dozens of studies. There
21 are hundreds of evaluations, but what we hear
22 constantly back is it's not good enough because

1 it is spender-generated, there are no RCTs, you
2 know, the -- that -- that, you know, it is just
3 not good enough.

4 So -- so I would say, you know, when
5 Jason said at the end he's onto something about,
6 you know, the -- the issue with remote monitoring
7 is that it does give you immediate access, and it
8 helps monitor care moment-by-moment, and there's
9 logistical improvements in the time aspects of
10 saving time. That is all serious, and that is
11 all delivery, but because of the way that CMS
12 defines it, and because of the way that Congress
13 says that it is going to cost too much, when you
14 go to CBO, it is still stuck 30 years ago.

15 So, you know, maybe this is a time to
16 change the paradigm of how this is actually
17 viewed because it doesn't fit the existing frame.
18 And quite frankly, it is out of the Pandora's
19 box. We are not going backwards. Remote
20 monitoring in medicine is here to stay, and it
21 will be adopted by ACOs and shared savings
22 programs, except it is going to be adopted slowly

1 unless NQF delivers a great report and starts a
2 process to really validate this -- this good
3 stuff. No pressure.

4 Thank you very much for listening to
5 my comments. Have a great day.

6 MR. GOLDWATER: Thank you very much,
7 Robert. And so do we have another comment?

8 MR. QUINN: So I just wanted to
9 reiterate something that we talked a little bit
10 about -- that I talked a little bit about
11 yesterday and then heard came up again, which is
12 the importance of thinking about structural
13 measures of telehealth in the organization and
14 well-describing it in consistent ways so that,
15 when evidence is created, it can be compared.

16 When we look at the impact or
17 correlation of telehealth on outcome measures or
18 process measures, we can look back and see what
19 the characteristics of that telehealth is.
20 Telehealth as a general amorphous concept is
21 going to have a hard time demonstrating the sort
22 of impact that CBO and others want. If you look

1 at telehealth as a -- as an intervention that has
2 characteristics like, you know, a model of care,
3 different components, differentiating all of
4 those so that it can be described and understood
5 well and consistently, included in things like
6 NCQA, patient-centered medical home evaluation,
7 the same way that we have done in many ways with
8 health IT and EHRs, it is going to -- it is going
9 to help a lot.

10 If we have measures that are process
11 measures and outcome measures without having
12 structural measures that describe what the
13 intervention is in consistent ways, it is just
14 not going to get there, so --

15 MR. GOLDWATER: Thank you, Matt. All
16 right. So let's go quickly to the next slide.
17 May, if you want to take us through next steps,
18 and then we will be dismissed.

19 MS. NACION: Sure. Just quickly, to
20 reiterate, we will have a draft report coming out
21 at the end of this month, and then our next
22 meeting will be May 23rd. A third report will be

1 open for public comment June 1st to 30th.

2 MR. GOLDWATER: All right. Thank you
3 all very much. Much appreciated, look forward to
4 speaking to you all again. Thank you very much.
5 Safe travels to all of you.

6 (Whereupon, the above-entitled matter
7 went off the record at 2:30 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: 03-08-17

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