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

ADAM DARKINS, MB, ChB, MPHM, MD, FRCS, Vice President for Innovation and Strategic Partnerships, Americas Region, Medtronic Plc., Medtronic
HENRY DePHILLIPS, MD, Chief Medical Officer, Teladoc, Inc.
CHARLES DOARN, MBA, Professor, Family and Community Medicine, University of Cincinnati
MARYBETH FARQUHAR, PhD, MSN, RN, Vice President, Quality, Research & Measurement, URAC
ARCHIBALD (STEWART) FERGUSON, PhD, Chief Technology Officer, Alaska Native Tribal Health Consortium
DAVID FLANNERY, MD, Medical Director, American College of Medical Genetics and Genomics
PAUL GIBONEY, MD, Director of Specialty Care, Los Angeles County Department of Health Services
NATE GLADWELL, RN, MHA, Director of Telehealth and Telemedicine, University of Utah Health Care
DON GRAF, National Telehealth Director, UnitedHealthcare
JULIE HALL-BARROW, EdD, Vice President, Virtual Health and Innovation, Children's Health, Children's Medical Center
STEVEN HANDLER, MD, PhD, CMD, Associate Professor, Chief Medical Informatics Officer, University of Pittsburgh Medical Center
YAEL HARRIS, PhD, MHS, Senior Health Researcher, Mathematica Policy Research
KRISTI HENDERSON, DNP, NP-C, FAAN, FAEN, Vice President, Virtual Care & Innovation, Seton Healthcare
MARY LOU MOEWE, MT (ASCP), PMP, ACP, FACHE, CPHIMS, Director of e-Health Initiatives, State of Tennessee, Department of Health Care Finances and Administration (HCFA), Medicaid, State of Tennessee

EVE-LYNN NELSON, PhD, Director & Professor, KU Center for Telemedicine & Telehealth, University of Kansas Medical Center
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 Physician-In-Chief, Kaiser Permanente Mid-Atlantic States
ANGELA WALKER, MD, FAAD, Direct Dermatology, Science 37

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
JASON GOLDWATER, MA, MPA, Senior Director, Quality Measurement
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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 Information Technology, Health Resources and Services Administration
ROBERT JARRIN, JD, Senior Director, Government Affairs, Qualcomm Incorporated

T A B L E O F C O N T E N T S

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

(9:14 a.m.)

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

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

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

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

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

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

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

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

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

little bit more throwing ideas at the wall.

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

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

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

And so, Marcia and I, in sort of

brainstorming came up with a couple ideas. Again, not necessarily any one of these is right. But things that are specific to telemedicine might include some measures about technical issues, right?

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Steve?

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

MEMBER GIBONEY: Yes. Exactly.

CO-CHAIR HOLLANDER: Adam?

MEMBER DARKINS: Talking to you last

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

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

CO-CHAIR HOLLANDER: Other ideas? It's the second-day hangover. Yes, so, I mean, I would just encourage people to just think of what you do or what your predominant use case is at your own institution, and say if somebody was going to measure your effectiveness and your ability to deliver care, how would they be able

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

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

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

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

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

CO-CHAIR HOLLANDER: Paul?

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Sarah?

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

CO-CHAIR HOLLANDER: Yes.

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

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

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

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

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

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

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

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

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

critical consult change or less or not at all?

CO-CHAIR HOLLANDER: Steve?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Absolutely.

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Don?

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Angela?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Angela?

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

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

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

the EKG as a filter.

CO-CHAIR HOLLANDER: Okay. Dale?

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

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

is in that transition of care.

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

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

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

this.

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Yes.

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

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

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

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

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

applied to situations.

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

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

CO-CHAIR HOLLANDER: Okay. Eve-Lynn?

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

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

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

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

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

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

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

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

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

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

MR. DEPHILLIPS: All right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Don?

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

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

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

MEMBER WALKER: That's it.

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

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

And we actually find this is exactly

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And it may not really -- maybe that

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: I agree.

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

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

CO-CHAIR HOLLANDER: Good question. Well taken. Paul, Don, Angela, Peter.

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

CO-CHAIR HOLLANDER: Okay.

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

CO-CHAIR HOLLANDER: Great point. Okay. Cool.

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

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

I think a lot of people have had the experience where they arrive at the specialist for the first visit, and the specialist says why are you here? This is why I'm here. Okay. Let's get a bunch of tests and radiology studies and stuff, and let's have you come back for a second more definitive visit, and then we can make our decision. And what we know now, is that we can actually not waste that first visit, but have a definitive first visit with the specialist.

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

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

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

CO-CHAIR HOLLANDER: Okay. Angela?

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

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

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

CO-CHAIR HOLLANDER: Peter.

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

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

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

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

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

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

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

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

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

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

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

times dramatically.

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

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

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

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

practice is informed consent in telehealth.

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

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

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

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

CO-CHAIR HOLLANDER: Yes. And,

Daniel?

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Go ahead.

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Oh.

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

CO-CHAIR HOLLANDER: Oh, okay.

MEMBER ALVERSON: Not so --- no.

CO-CHAIR HOLLANDER: Okay. I see.

MEMBER ALVERSON: So it's a different issue.

CO-CHAIR HOLLANDER: Yes. Okay. Kristi? Thanks for waiting.

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

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

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

there.

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

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

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

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

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

looking for other options.

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

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

CO-CHAIR HOLLANDER: Kristi?

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

MEMBER DEPHILLIPS: Okay.

CO-CHAIR HOLLANDER: All right. Don?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Paul?

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

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

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

CO-CHAIR HOLLANDER: Don?

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

CO-CHAIR HOLLANDER: Henry?

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

CO-CHAIR HOLLANDER: Okay. Dale?

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

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

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

CO-CHAIR HOLLANDER: Adam?

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

around it, you're creating large networks.

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

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

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

CO-CHAIR HOLLANDER: Okay. Mary?

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

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

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

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

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

MEMBER MOEWE: True.

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

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

MEMBER MOEWE: Right.

CO-CHAIR HOLLANDER: And --

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

CO-CHAIR HOLLANDER: Everybody. Right.

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

CO-CHAIR HOLLANDER: Right.

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

CO-CHAIR HOLLANDER: Oh, yes. No.

MEMBER MOEWE: Did I sound like someone?

CO-CHAIR HOLLANDER: Yeah. Yeah. Yeah. Yeah.

MEMBER MOEWE: Huge.

CO-CHAIR HOLLANDER: Henry --

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

CO-CHAIR HOLLANDER: Henry, Daniel, Dennis.

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Daniel?

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

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

CO-CHAIR HOLLANDER: But, you know, a

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Okay. Nate?

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

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

CO-CHAIR HOLLANDER: Okay. Marybeth?

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

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

CO-CHAIR HOLLANDER: All right. Daniel?

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

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

CO-CHAIR HOLLANDER: Okay, Stewart?

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

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

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

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

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

MEMBER GRAF: No, it's Natassja?

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

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

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

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

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

So the measurement is important to us

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

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

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

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

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

say what the impact is.

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Yes.

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

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

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

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

then its significance were very, very helpful.

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

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

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

We use that basically in everything

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

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

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

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

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

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

And you know, it was the thoughts of

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

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

versus something?

MEMBER RASMUSSEN: Patient-to-provider. Yes.

CO-CHAIR HOLLANDER: Okay. Okay. Marcia?

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

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

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

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

CO-CHAIR HOLLANDER: Steve?

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

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

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

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

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

MEMBER FLANNERY: CGC is a certified genetic counselor.

CO-CHAIR WARD: Thank you.

MEMBER FLANNERY: Yes.

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

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

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

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

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

MEMBER DARKINS: Yes. Yes.

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Angela?

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

MEMBER FLANNERY: Or it could be system effectiveness also.

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

MEMBER FLANNERY: Right.

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

CO-CHAIR HOLLANDER: Kristi?

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

CO-CHAIR HOLLANDER: Yes.

MEMBER HENDERSON: Yes, okay. Good.

CO-CHAIR HOLLANDER: Yes. Sarah?

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

CO-CHAIR HOLLANDER: Yes, I think --

MEMBER SOSSONG: That was just missed.

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

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

debate which ones it fits into.

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

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

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

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

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

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

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

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

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

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

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

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

relating to that particular use case?

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

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

CO-CHAIR HOLLANDER: Sarah, go ahead.

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

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

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

fit into all of them.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Right.

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

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

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

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

And what about somebody who might live

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

You take a picture of a light box and

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

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

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

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

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

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

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

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

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

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

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

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

and need to let mom know.

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

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

CO-CHAIR HOLLANDER: Yes, Chuck?

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

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

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

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

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

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

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

MEMBER WALKER: So I actually think we

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

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

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

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

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

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

clinical metrics for outcomes and such.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It's doing two things. Number one,

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

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

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

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

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

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

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

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

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

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

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

I just think for the average person

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

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

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

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

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

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

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

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

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

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

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

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

25 days out.

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

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

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

CO-CHAIR WARD: Steve.

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

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

situation?

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

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

CO-CHAIR WARD: Adam?

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

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

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

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

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

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

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

CO-CHAIR WARD: Yael?

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

So I'm thinking from a measurement

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

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

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

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

one.

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

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

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

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

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

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

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

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

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

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

Where a report becomes actionable is

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

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

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

It can provide services for standard care. It can provide services for disaster care. It can provide services for care transitions or for care coordination.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DR. LUSTIG: -- this.

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

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

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

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

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

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

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

New England Journal.

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

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

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

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

capture everything in the world that we could think of?

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

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

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

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: So, Yael?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(Off microphone comments.)

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

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

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

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

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

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

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

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

CO-CHAIR WARD: Steve, jump in there.

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

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

MR. GOLDWATER: Okay.

CO-CHAIR WARD: Sarah?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Okay.

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

CO-CHAIR HOLLANDER: Right.

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

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

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

CO-CHAIR HOLLANDER: Henry?

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

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

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

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

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

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

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

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

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

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

CO-CHAIR HOLLANDER: Yes. Yes.

MR. GOLDWATER: It is?

CO-CHAIR HOLLANDER: Yes.

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

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

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

(Off microphone comments.)

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

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

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

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

MR. GOLDWATER: Right.

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

And so if you required an FDA-approved

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

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

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

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

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

So I'm sort of taking into account,

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

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

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

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

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

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

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

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

MR. GOLDWATER: Right.

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

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

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

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

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

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

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

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

And they're either, advance a quality

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

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

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

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

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

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

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

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

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

CO-CHAIR WARD: How many --

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

MR. GOLDWATER: Yes.

MS. STREETER: But we could easily --

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

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

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

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

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

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

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

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

unsupervised you can do it.

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

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

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

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

CO-CHAIR WARD: Well, yes.

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

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

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

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

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

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

MEMBER ALVERSON: I'll make one

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

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

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

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

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

MR. GOLDWATER: That's a great idea.

CO-CHAIR WARD: Yael, are you up?

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

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

CO-CHAIR HOLLANDER: CPT.

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

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

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

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

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

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

MEMBER HARRIS: I need to --

MEMBER FARGUHAR: -- telehealth measures?

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

MEMBER FARGUHAR: Okay.

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

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

MEMBER HARRIS: As a way to deliver behavioral health?

MEMBER FARGUHAR: Right. Right.

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

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

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

MEMBER HARRIS: Got it.

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

MEMBER HARRIS: Thank you.

MEMBER FARGUHAR: Yes.

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

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

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

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

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

outcomes.

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

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

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

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

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

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

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

If the standard is the physician must tap the frontal sinus to elicit tenderness, then that's not, you're not going to be able to study that in a telemedicine environment because the physician's not going to be able to do that.

If, however, the component is frontal sinus tenderness is present, that's fine because in the office, the doc will tap the forehead.

In telemedicine, the patient will tap the forehead. Either way, you can still figure out whether there's tenderness there.

Sort of an example. So I just want to make sure we aren't so restrictive when extending it to telemedicine.

There are some benefits to telemedicine that we don't even know exist yet, and the only way we're going to find out what those benefits are is to allow a little bit of latitude in variability of how diagnoses are made and how care is given.

CO-CHAIR HOLLANDER: So I think that, you know, one of the things that we need to do, and it's not we in this NQF Committee, is we need to develop some of that stuff.

Angela and I were talking at the break, cardiologists want to listen to somebody's heart, right?

That's what cardiologists do. But let's face it, if you're seeing somebody with chest pain over and over for years, their heart

exam never freaking changes.

So you know, without them having new symptoms on a routine visit, so there's no reason to do that.

So I scribbled down, that's one of my med student projects this month, when I get back.

Rummage through 1,000 charts, and see how much, when an asymptomatic patient comes to the office, their exam changed from the last visit.

It's going to be zero. Then we put it out there, then: listening to the heart isn't going to matter.

There's some evidence to do that, and you can do the rest of the cardiovascular exam besides listen because you can have people check their pulse and do that.

So I think, for us as a group outside this forum, we have to get some of the evidence to prove that because there are people who are still going to be stubborn in the way they think.

But I think one of the things that

we're supposed to be getting done before lunch is offering some guidance on how we adjust these measures, and I think we maybe have had great conversation, but we may have strayed from that a little bit.

And I think that if we want to stay within these measures and say, yes, do it, well then we've got to look at what things are telehealth-amenable, and then it's really deeper than I can -- for me, I'm not smart enough to look at this list and know the depth of the measure and what's included.

But I think at some point, if the measure is just about achieving an outcome and doesn't give you guidance on how, then we've got to make sure that outcome can or can't be assessed by telehealth, and if it can't, we can't do it.

And if it can, maybe we need to specify it because it might have specified how it's achieved. If it's not specified how it's achieved and we can measure it by telehealth,

then telehealth should be fine.

If it's a measure that requires a visit or a measurement at some point along the line, well then we have to say, can we measure that via some telehealth modality, if it's specified that it's measured by X, by standard blood pressure guidelines, and do that. And I think those are going to be, you know, sort of, at least my broad categories of the low-hanging fruit to get in preexisting measures.

But I don't think it's as easy as what I think, you know, Jason was hoping for, saying these are the five measures that we think we should go after first, because I don't know if I know enough to do that yet.

MR. GOLDWATER: So I don't think that, I mean, I don't think we were looking to say, here are the 15 measures you should go with.

So the criteria that I've got are, I think first cut is look at the measures we have and take the ones out that are NQF-endorsed, that have, that have passed the endorsement process.

See which ones we've got left from those.

Out of those, the subset of those, then look at the ones that don't have to be modified at all, and there is a technological solution, but we're not prescriptive about what the technology's going to be. And so that'll be the first pass of the measures.

CO-CHAIR HOLLANDER: The non-endorsed ones?

MR. GOLDWATER: No, the endorsed ones --

CO-CHAIR HOLLANDER: Oh, okay. Okay.

MR. GOLDWATER: -- that are, the outcome doesn't, you know, the measure does not have to be changed in any way. It's the same measure, and that there is a technological solution.

So we may be asking some of you, is there -- like, again, I have no idea what spirometry is, but, so I might, you know, call Steve up and go, can you tell me what this is?

And is there a telehealth solution for

it? And if the answer is yes, and we don't have to be prescriptive about the technology, then that'll be the first representation of starter set measures.

And then when you get that, you can look at those and go yes, yes, yes, forget it. Or can we add these? Can we add this? Can we add this?

But then I think that gets to sort of the spirit of what you all wanted to do, which is not changing the measure, not being dependent on a particular type of technology, and it passed the NQF endorsement, which means it's strong evidence base, reliable, valid, feasible, usable, rather than a non-endorsed measure, which, I mean, you know. You've sat on the endorsement committee, so has Marybeth actually, so they can talk about, it's a joy, I'm telling you. It really is.

MEMBER FARGUHAR: And can you indicate which of those have a modifier code? Because otherwise there won't be a way to clearly

distinguish if it was provided in-person versus telehealth.

CO-CHAIR HOLLANDER: So the modifier code is about the level of service billing. It's not about the disease.

So it won't actually really help directly. So if I see somebody with asthma, I don't do asthma modifier code.

I do asthma, and they're a level 3 level of service, and the level 3 gets the modifier code.

So it's a little more difficult than that. I can't easily pull, and I may be able to out of a claims database, pull out their ICD-9 or ICD-10 code, their level of service code, and whether there's a modifier and crosswalk them to determine it.

But it's not a disease-specific modifier code. It's a billing level of service modifier code.

And then it depends on the database you're pulling out of as to whether or not you

can put those two things together. Does that make sense to those of you that don't live in that world?

MR. GOLDWATER: I think when we get a starter set, rather than modifying the measure, which I don't think we would do, it would be, in the CPT Workgroup, have they developed a modifying code for whatever measure we've seen, or does one need to be developed? Where in the billing cycle does the modification have to be made to indicate that it's a telehealth visit?

But definitely not changing the measure, because then that would require modification of every measure to incorporate telehealth, which I can tell you would be shot down by our Board in no time.

CO-CHAIR HOLLANDER: I'll also say that some of the things that we haven't really discussed a lot won't actually have a modifier code because they're bundled payments.

So if you have a surgical procedure today, and I see you back in the office in three

days, I don't submit a billing code.

So I may see you by telehealth, or I may see you in-person, but it may be hard to track it because I may just not bother filling it out since nobody pays for it.

MR. GOLDWATER: Once Meg is here and does her presentation on MIPS and sort of reviews kind of currently where we are with the legislation, then we can maybe have a brief discussion about how we want to think about that with the measures themselves, because I know there was talk, and there's certainly interest on the government's part about the measures that are going to be used for MIPS and alternate payment models, if they incorporate telehealth. That's another way of advancing this significantly.

Because that deals with payment and reimbursement, and that always moves everything forward.

CO-CHAIR WARD: Stewart?

MEMBER FERGUSON: So I just have two questions. So what I'm hearing though is that

you're going to do this exercise of going through all the endorsed NQF measures, and then we'll probably get a list from you or something that tells us, these kind of passed the test. It could be used for telehealth. These couldn't, right? Okay. So the other question I have is related to MIPS.

Is there a reason you're not also including advanced APMs in this discussion? The quality standards are a little bit different, but I think they're really, there's a lot of overlap.

MR. GOLDWATER: We are going to do APMs. So when Meg's here, she's going to talk about MIPS and APMs, and then how, just sort of where we are currently with that.

Because after the rulemaking comments were provided, there have been some changes to it.

So she's going to talk about sort of where we are, where that's going, how it affects quality measurement, and then we can talk about, you know, where it fits into APMs and MIPS

overall and value-based purchasing. And so, yes. We'll do the homework.

But I would, again, emphasize, I think what we'd like from you all is if you have use cases that apply to what you do on a day-to-day basis, to send those to us.

And then we'll use our creative powers to come up with the patient journey and how to make that into a narrative that's, I want to say moving, but effective. Is that better?

Judd sent me this email that's giving me Brendan's saying. It said, Journey, not the band. Give it a rest, man, really, seriously. Really. Def Leppard wasn't enough.

I think we're, as always, we're very efficient. We're done a bit early, and lunch is out, so why don't we take 35 minutes for lunch. Meg will be here at 1:00 to lead us in the MIPS discussion.

(Whereupon, the above-entitled matter went off the record at 12:23 p.m. and resumed at 1:03 p.m.)

MR. GOLDWATER: So I have the great luxury and privilege of introducing our guest speaker, the extraordinarily talented and very quick-witted Meg McGinty, our Director of Public Policy.

We get along so well because, one, we endlessly tease each other on most days. And two, she's exceptionally gifted and smart, which we all like to have.

So Meg spends a lot of time on the Hill analyzing legislation, and apparently tweets at this point, and I'm just kidding. And --

MS. McGINTY: I'm purplemixingbowl, if you ever see me on Twitter, purplemixingbowl is me.

MR. GOLDWATER: And so Meg and I spent quite a few hours on the Hill with staffers from Senator Alexander's officer, Senator Cassidy's office, Senator Whitehouse's office, talking about --

MS. McGINTY: Warner.

MR. GOLDWATER: Senator Warner,

talking about telehealth interoperability, 21st Century Cures, and other things.

So Meg is the residing expert at NQF on MACRA and MIPS. She just came in and said, I'm scared. I don't know that much about telehealth.

I could've jokingly said, well, neither does anybody else here. But I didn't say that. I said, I don't think anybody's interested in specific telehealth questions, that this is really just an educational session about MIPS and MACRA, advanced payment models and so forth.

So everybody is sort of on the same level playing field in terms of understanding, and then to sort of talk about what, how our framework can intersect with MACRA and MIPS and APMs, given that that ties to reimbursement, and as I said earlier, and as you all know, that drives just about everything. So without further ado, I will turn it over to you.

MS. McGINTY: All right. Thanks, Jason. I'm going to warn you, I come from a

legal and technology guru family, and I got none of the technology guru genes whatsoever.

So Jason knows that these topics are the ones that I really, especially interoperability, I really love. But telehealth is really exciting.

So I'm excited to be here, and I think there's a lot of opportunities in, and especially in the MIPS program, for telehealth services to be used and kind of infiltrate it into the measures as we go forward. So quick overview.

I'm going to start real high and break it down a little bit. I don't know where people's understandings are, so we'll just hopefully have a little bit of something for everybody.

So the MACRA, the Medicare Access and CHIP Reauthorization Act of 2015, was the much-beloved repeal of the Sustainable Growth Rate, the SGR.

Doctors, physician groups, hospitals, everybody wanted to get rid of the SGR, and so

they can with MACRA.

And what this did was it took fee-for-service and basically based in on their performance and your outcomes of your patients, along with your cost savings opportunities and your clinical practice improvement areas.

And it gave clinicians two options for payments. The one I'm going to talk most heavily about today is MIPS.

It seems to be the furthest along in development, as well as the advanced alternative payment models.

Advanced alternative payment models include your patient centered medical homes, ACOs, bundled payment programs, which may or may not be occurring, and then your future, I'm not quite sure with the new administration what's going on with those.

And MIPS is, it basically combined your three VBP programs. Meaningful use, physician quality reporting, PQRS, into one program so that it could streamline into making a

component score. So that's really high level. Next slide.

So we'll talk a little bit about MIPS first. MIPS applies to your eligible clinicians or eligible practitioners, depending on what day of the week it is.

Physician's assistants, physicians, nurse practitioners, clinical nurse specialists, certified RN anesthetists are included for the 2017 payment program.

And what this does is it combines, like I said, combined the PQRS program, the value-based payment modifier, and the Medicare EHR incentive program, affectionately referred to as meaningful use.

And it combined it -- when the rule came out, it originally combined these performance scores into a composite score of four categories.

The proposed rule was opened up, and now the 2017 payment year of reporting will only include three of the four categories, due to

overwhelming response from practitioners and hospital units, that they were unable to implement the cost and resource use program and components.

So the four categories are quality, clinical practice improvement areas, advancing care information, and cost and resource use.

The first three will be included for reporting on data in calendar year 2017. So this has already begun.

Another, I would say, compromise that CMS took into account in the comments for the proposed rule was rather than ensuring that all people, all providers that participated in the MIPS program for Medicare payment had to, mandatorily had to report, they softened that a little bit for 2017 to give practices the opportunity and the time to ramp up their reporting services.

So if you don't report anything for the calendar year 2017, you will receive a penalty. If you report something, anything, make

an effort, you'll basically be at a neutral level. You won't get the payment incentive or the penalty.

If you report a good portion, which they're qualifying as 90 days of reporting these requirements, you'd be eligible for a prorated possibility of, you may be eligible for a prorated incentive.

And if you report it all, you'll be obviously eligible for the full incentive. So we have calendar year 2017.

The measures that are included for those three programs, the quality measures, the clinical practice improvement activities, and the advancing care information started January 1st, and you have basically until October 1st to ramp it up, because you have to have 90 days of reporting to get a partial incentive payment. They'll be submitted to CMS on March 31, 2018.

So after you get your calendar year reporting program, you're able to work with your systems to gather your data and submit it prior

to the end of March.

CMS will then provide feedback on your reporting and how you performed. That was another commonly raised comment about, how will providers know what they're doing well and what they're not doing well, and how can they improve?

So a feedback period was opened for 2018 for the remainder of that year. And the adjustment payment, either a penalty above, a penalty below or an incentive above, based on your performance will be paid out at the 1st of January 2019.

So you'll receive your payment in response to your performance in 2017. So there's a 12 month gap, essentially.

What is the maximum amount of incentive and the maximum amount of penalty that one could receive? It's up to 5 percent of your payments. So if you do really, really well, you can get up to 5 percent of what you received in Medicare, in addition to your Medicare funds, paid out to you January 1st of 2019 for calendar

year 2017.

And to determine this, the scores will be weighted, and we'll go to the next slide. This is the 2017 weight. Now granted, this is post the rule being finalized, all of the comments. Originally there were four components in this including cost, which originally comprised for 10 percent, and quality only being 50, but because of the responses received in the rule-making process, CMS decided to remove the cost and resource use component and add that 10 percent quality for the 2017 reporting period.

So we look at the total here. For quality, the provider or the group needs to report on up to six measures, but it's required that you include one outcome measure.

There are 271 measures to choose from. So there is a lot of selection for the individual provider and for the individual groups and hospitals that are reporting.

So these are your treatments, your screenings, your surveys, your condition-specific

measures, immunizations, symptom management measures.

And this group, these are, many of these are NQF-endorsed. In fact, over 50 percent of them are. And we actually provide recommendations to CMS through our MAP Workgroup on the quality measures used in MIPS.

So that's an avenue if you want to insert telehealth opportunities, the MIPS, the Clinician Workgroup for MAP recommends measures for the MIPS. Any questions on that? Yes?

MEMBER RASMUSSEN: So do these six quality measures, is it six like for a healthcare system or for each individual physician or a physician group or, what does that look like?

MS. McGINTY: So it depends on how you report. If you're submitting as a physician group, it's inclusive of all the practitioners within the group, whether it be acute care settings or if it -- individual physicians, nurse practitioners, nurse practitioner anesthetists.

All of the eligible professionals

within that group. You can also report as an individual physician. It depends on how you classify, you classify your practice group for Medicare reimbursement purposes.

So there's no limit on how many people you can have in that group or not. There are some adjustments made for small practices.

Not in the quality section, but in the clinical improvement area section, there is some adjustments made on the reporting for smaller practices. Okay.

We'll go to the improvement areas. And I honestly think this is probably the greatest opportunity for telehealth services.

In fact, there is one telehealth measure. It's the third from the last. I actually included this in your, you don't have to look at this now, but when you go back home and you look at the documents on the SharePoint, I've included the measure lists for all of these three categories.

The measure is actually, or the

improvement activity, is actually use of telehealth services to expand the practice. That's really what it says. I'm sure there's a lot of services to expand your practice.

The description is use of telehealth services and analysis of data for quality improvement, such as participation in remote specialty care consultants, teleaudiology pilots that assess delivery and still deliver quality care.

So it's a very vague opportunity for you all to get involved in. But the clinical improvement areas, you have to report four improvement areas for at least a minimum of 90 days in the calendar year.

So there's a list of 92 different improvement areas on this list. Telehealth being one of the 92 that I just read, so obviously your practices would be able to report on that one.

But there are some adjustments made for small group practices and rural healthcare practices. If you have less than 15 eligible

clinicians in your grouping, however you group it, in your practice, you only have to report two instead of four.

This was another compromise that went through the rulemaking process. And I think some of the rural clinics and your community health centers felt a little bit of pressure, who haven't been required to report in the past, getting their services up to gear.

So it also, if you are a patient centered medical home or you are a designated APM medical home, but not designated as an advanced payment model specifically, you automatically fulfil this improvement activities area.

So if you work for a patient medical centered or a patient medical home, you won't have to report these improvement activities.

You'll already get that 15 percent score as completed. And then the final one is advancing care information. This is much more based on your electronic health records: interoperability, sharing, number of screenings

and all that stuff, which is not my forte by any means.

But what this does is you have to require -- to fulfil five measures in those areas of eprescribing, provide patient access to their records, request and accept summary of care, summaries of care, have a security risk analysis, and sending a summary of care.

Those are the five required measures to hit that baseline score. But if you're really great, you can report on up to nine of the additional ten to get bonus points, like extra credit.

So the practices that have made the investment in EHR technology and have really been driving this are going to benefit greatly, I think the most from the 25 percent for the advancing care information.

And there are a total of 15 measures available in that group. You have to report the five, and of the remaining ten, there are nine.

What also is required is that you have

a, and I, this is all Greek to me, a 2014, 2015, or combination of the two, annually certified EHR technology system in order to do this, in order to submit your measures.

So it's forcing everybody to have an EHR that meets these certification requirements. Yes?

MEMBER GIBONEY: Do you get partial credit for these things? So like 25 percent for advancing care information.

If you've got three of the nine measures instead of five of the nine measures, do you get 19 percent instead of 25 percent, or is it kind of an all-or-none calculus?

MS. McGINTY: So what they'll calculate you is on an individual performance score for each of these areas to make up the percentage of your total score.

So each one is weighted, and the weighting is very, very complicated. Some of the measures, particularly in the quality area, there are low impact measures, medium impact measures,

and high impact measures. So if you, as well as with the improvement activities and the advancing care information.

So if you come in with your extra credit ones, and they're all high-value advancing care information measures, you're going to jump to the top of the prioritization in the points system for that field.

Any other questions? Okay. So I want to talk a little bit about, and please feel free to chime in, share with us, offer your suggestions.

I think this is an opportunity to maybe kind of brainstorm for the report what measures or items of discussion that you should really bring to the top in order to facilitate opportunities for telehealth.

I can say telehealth is a really sexy issue on Capitol Hill. It's really sexy. People love it.

They just don't know who's going to pay for it. People are talking about it. They

see the opportunities.

They see the opportunities of technology in their personal lives and say, how can we bolster this in our federally-funded healthcare programs?

Maybe used in the private sector, how do we make it happen? I'm sure many of you are familiar with some of the restraints on telehealth as far as remote patient monitoring and origination sites, and then is there wifi and broadband, and into a whole slew of cross-industry issues.

But there is an appetite on the Hill to address this. I think we saw it in 21st Century Cures when it passed.

While there was no specific language on how, it kind of, told the field, to notify as a red flag that this is something that we're going to tackle. So it's a really exciting time. Yes?

MR. GOLDWATER: So first to echo what she said, it is, I mean, I don't know if I

would've used the word sexy, but --

MS. McGINTY: It's sexy.

MR. GOLDWATER: -- it's definitely something everybody's extremely interested in. We got more questions about that particular topic than any other topic when we were talking about Cures.

So Meg, you have, you've missed all of the discussion, the entertaining discussions prior to now. So we actually had listed all the MIPS measures that related to the topic areas in the environmental scan that were predominant.

And one of the things I think that we've all sort of concluded is we don't really want to alter the measures. We want to leave the measures the way they are. But as long as the measures can be done through the use of a telehealth technology, not being prescriptive of what technology it is, but that telehealth as a means of care delivery would still lead to the fulfillment of the process or leading to the outcome of care. And that the measures that we

may include in the framework would not require any alteration to the measure itself, but would just be measures in which telehealth could still lead to the same outcome as a means of delivery.

And that if we're going to modify those measures to be inclusive of telehealth, the measure wouldn't get modified, but the CPT code would probably get modified. So would that still fit in with this?

MS. McGINTY: I think it would so long as it wasn't in contradiction of the origination of the remote patient monitoring.

MR. GOLDWATER: Right. Okay.

MS. McGINTY: Limitations on reimbursement.

MR. GOLDWATER: Right.

MS. McGINTY: But there are, there are a lot of opportunities I think, especially in -- I list of some of the categories here.

And I think telehealth, it could work best. Equally with telehealth, chronic care is also a really hot issue right now.

So if you can marry the two of them, we have a lot of cross-pollinization between the chronic care policy proposal, the CHRONIC Act that was introduced, telehealth, Schatz's bill, Schatz-Wicker bill as well.

And those committee members on those two working groups are overlapping. I mean, we're seeing the same kind of four committee, four senators who are both chronic care, and on the telehealth bills that are going through.

So any way to improve management, maintenance of chronic care conditions with telehealth is probably one of your best bets to incorporate telehealth services.

CO-CHAIR HOLLANDER: So I was going to say, sitting here looking through the list, one of the things Jason was asking before is which preexisting measures might fight best.

I might be actually some of the cost and resource use measures, right? Because they don't really tell you how to do it.

It's just what the wraparound costs

are for that. It's probably worth looking at that.

And I'm now going to throw out sort of the big, bold idea that no one in this room could say yes to, but knowing it takes several years for measures to come through the system from when they're proposed, has NQF thought of, in the, whatever you call it, the measure development application, including or mandating comments about telehealth when people propose new measures so that measures that would be proposed in the next six months might have to address telehealth should or should not be included.

And then the scary part to everybody in this room, should there be sort of a member on every other committee that, and it might not be from this group, who has some knowledge about telehealth so that we could make sure that measures that are telehealth-appropriate, address it.

I do realize that once a measure's submitted, you can't really modify it. It is

what it is. So I think the only way for us to intervene in making sure telehealth is included in new measures is for it to have to be addressed on the original submission.

MS. McGINTY: I don't believe NQF has required or made that alteration.

CO-CHAIR HOLLANDER: No.

MS. McGINTY: I think that would change an alteration in policy. Wouldn't that, Jason?

MR. GOLDWATER: It would. Yes. We would have to. I love the idea. I think it's a great idea. But I can't just do it.

I mean, it's, yes, it would require a policy change, which would then have to go through our CEO, and then it would have to go through our Standing Advisory Committee and then our Board. And then it would be another option for developers to --

Okay. So I realize none of you have actually done this, but, Yael, Marybeth, please help me out, and tell them that it is not this

simple to just like, oh, it's a great idea. Let's just do it.

I mean, making policy changes regarding the submission of measures, I mean, one of the big issues at NQF is the burden on developers now in what they have to meet for a criteria for a measure is substantial.

And we're trying to decrease the burden so that measures don't take two to three years to develop. So if we add on something, we have to make sure that it's not adding onto the -- as great of an idea as it is. I'm all for it.

But we have to make sure it's not adding onto the burden of development, because, I'm sorry, you all don't deal with the fallback when that happens.

We have to deal with the fallback when that happens, when we get the Joint Commission or NCQA or PCPI screaming at me on the phone about, how dare you do this, blah, blah, blah. You don't know what you're doing.

And endless amounts of, and because

understandably, the more they have to do, the more money it costs, the more the government has to pay out.

And you know, we would just have to think about how that would have to be done. I'm not saying I'm not going to propose the idea.

I'm just saying, don't think it's just, you know, Helen or Shantanu's going to go, oh sure, why not? You know, it'll be a discussion about how to move forward with that. Yes.

MEMBER HARRIS: The other thing is, the hardest part of measure development is the feasibility piece. Looking at Marybeth for confirmation.

It would require that every single doctor document if the care is provided by telehealth or not.

So if you can convince every single clinician in America to document that, then maybe we could take on CMS or, you know, measure development entities to have this built in.

But otherwise, there's no feasibility. There's no way to collect that information based on the data that's already available, and that's the issue.

MR. GOLDWATER: Right. So I appreciate that. I mean, feasibility is scored through a scorecard. And we do current feasibility and future feasibility.

Is it feasible now? Will it be feasible in two to three years? Testing, just the testing of a measure to make sure it will work is, without question, the hardest, most costly, most burdensome thing to do in measure development.

That's what takes so long to do because you've got to arrange the testing with providers, especially electronic measures.

Because they have to implement the measures in at least two systems. They have to test to make sure that those measures are working.

Then they have to collect data over a

period of anywhere from 90 to 180 days just to show that the measure is working.

Because once the measure goes to a committee, the first thing they're going to want to do is, if we actually implement this measure, is it going to work and drive quality improvement?

And if they're not showing the feasibility to be able to do that, the measure will go down in flames in a minute. So Yael is right. It's not so much as they can check a box and say, sure, this will work for telehealth.

Like, we can't do attestation with measure development. Like it can't be, okay, take a pinky swear and tell me for sure that it will absolutely work in telehealth. Doesn't work that way.

CO-CHAIR HOLLANDER: So I guess maybe it's a little over-enthusiastic, what I was actually stating.

MR. GOLDWATER: I'm telling you, I'm telling you the realities of how hard that is to

do.

CO-CHAIR HOLLANDER: So --

MS. McGINTY: I could totally sell that, too, on the Hill.

CO-CHAIR HOLLANDER: No, no, no. So --

MS. McGINTY: I can that make them happy.

CO-CHAIR HOLLANDER: So let me restate, really what I'm wanting is not mandating telehealth or pushing people to do something. What I'm really trying to do is push them to say whether telehealth's appropriate or not.

So they could decide to leave it out. But without having a prompt in it for measure developers now, if you're doing a chronic care measure and you just don't think about telehealth, you won't include it.

So putting a question in the thing or a thought process in the instructions like, do you want to include telehealth in this or not. We'll let people include it.

When you define a visit, should a visit be only in-person or should it be telehealth? And maybe have some more definitions around some things that we're wrestling with. So not a policy change. Not a mandate. Just a tickler.

MS. McGINTY: Well, and I think you could really look into the CMS measure development plan as well. That might be a good avenue to pursue of wanting to get that upstream involvement of developers to consider telehealth as an opportunity.

I mean, if there are certain areas where they get equal pressure from stakeholders, those around this table, those who are elected officials to say, listen. I mean, I'm sure Schatz and Wicker would love, especially Senator Schatz, would love to include a telehealth component in measure development funds that come out of CMS.

If you give them enough pressure, you might be able to put that further upstream and

see how many flowers bloom out of it.

CO-CHAIR HOLLANDER: And if you'd just give us the phone numbers of the measure developers, we'll just call at like 2:00 in the morning.

MR. GOLDWATER: I'd be happy to give you a few, Judd. Knock yourself out, man.

MS. McGINTY: I also think though, the MAP process that we convene here at NQF is a good opportunity to discuss these things before the workgroups.

MR. GOLDWATER: Can you explain what the MAP process is just briefly because --

MS. McGINTY: Yes, sure.

MR. GOLDWATER: -- I'm not sure everybody understands.

MS. McGINTY: Sure. So the Measure, and I always say Measures, but it's not Measures, it's Measure Applications Partnership.

The MAP is convened here at NQF and we provide a pre-rulemaking advice to CMS on what measures should be included in their, in

approximately 19 federal programs from your hospital outpatients, hospital inpatients, psychiatric or rehabilitation centers, home health, hospice, VBP, all that stuff.

And we basically look at the measures and recommend what they should, for the best program possible, include in those programs themselves.

So it's a first bite of the apple. It happens before the rules come out, before the public gets a chance to comment, though they can comment through us in this process.

It's a totally transparent process, before CMS puts pen to paper and really says, these are the measures we're going to include. What do you think?

And that would be a great place to have a discussion on telehealth early on. And it would signify I think to CMS in their decision making that this is an important issue.

And I think they do think this is an important issue. I think they're definitely

getting a lot of tea leaves saying this is an important issue from different areas. So --

MR. GOLDWATER: So to me, that actually is more effective to do it there than to try to do it in the measure development process, which would just take, even a tickler would take time to do because it's, what does that mean?

What does it represent on developers? We're going to get all kinds of questions about, what do they have to do? What do they have to represent?

But I think if you go to the MAP and say, out of all these measures that we're recommending, how many of these could actually fit into telehealth or independent of technology, or platform-independent, measures not changing telehealth as a means of delivery.

We could recommend that in the MAP report that goes to CMS before the rules are developed.

MS. McGINTY: Yes. That would be --

MR. GOLDWATER: That would be, that

would require no policy change. That would just be requiring additions to the report.

MS. McGINTY: And all of the MIPS measures, the Clinician Workgroup, and we just finished up the most recent MAP.

It runs from like December to February. But the Clinician Workgroup actually evaluates the MIPS measures and the Medicare shared savings program measures.

And then your hospital measures are in the Hospitals Workgroup, and then we have a Post-Acute Care/Long-Term Care Facility, which might be another great place for telehealth opportunities.

I want to talk a little bit about the cost savings component. If you can show that telehealth is saving money, you could probably do really well when they implement the cost sharing portion of MIPS.

I think that's like the $64,000 question is, where's the money, and how is it benefitting those who are paying?

And that seems to be the difficulty that CBO, the Congressional Budget Office, has scoring telehealth bills.

They can't get a good number for the savings. They can't get a good number for the cost.

So I don't know what the next steps for this committee are, but I think an important next step to start evaluating would be, let's get the dollar analysis.

That is hands down the biggest hurdle to removing those remote patient monitoring restrictions, is originating site restrictions.

Staffers tell us over and over again, so how does this save cost? How does this apply to cost and resource use? How can we get these numbers into CBO? How can we get our bill to score positively?

And I think with the change in the administration, that's going to be a really important component to make sure that you have the information for it.

So I mean, I know it's so easy to do that. I just, totally super easy. But, yes.

MEMBER FERGUSON: So you're talking about the cost and resource use measure that comes into effect in 2018, right?

And correct me if I'm wrong, that counts like 10 percent towards your MIPS score when it comes in. Is that right? It's --

MS. McGINTY: In the proposed rule, it was 10 percent.

MEMBER FERGUSON: Right.

MS. McGINTY: I don't know if that's going to change to lesser or greater when they do implement it because they will go through another proposed rulemaking process to put that in. But I'm guessing that it would be 10 percent of your total component score.

MEMBER FERGUSON: But what you're saying though is, even if it's only 10 percent, the impact can be much greater than just our MIPS score. Your point is that data can lead perhaps to policy change or something else.

MS. McGINTY: I think so.

MEMBER FERGUSON: Okay.

MS. McGINTY: I think if that data were there, it would allow for more telehealth bills beyond just remote patient monitoring originating site issues.

So understand, it would give CBO a better opportunity to score those more appropriately and effectively.

Because I, and this is not me in my policy hat or in my great mathematician skills hat, which is not that great, I think there are a lot of savings out there.

You just have to figure out how to identify them clearly and mark them up. So, Charles.

MEMBER DOARN: So what is the accounting formula they use to calculate, the CBO use, because we've been talking about this for 30 -- I know history is a big problem, but for 30 years, this problem has arose in Congress.

And then when you go to talk to them,

they don't even realize what we did 10 years ago. You ask them about a report. Oh, they don't -- what report?

So I mean, I personally find it a little difficult to understand how CBO. I mean, clearly, this is advantageous to our challenges for sure, but I'm not sure if Congress really, or the CBO looks at opportunity costs and the cost of somebody driving from point A to point B, lost wages, all the costs associated with that. Do you know what formulas they use or --

MS. McGINTY: I do not.

MEMBER DOARN: And that would be a really nice thing for us to understand. Not necessarily for this group, but in a telemedicine community.

MS. McGINTY: Okay.

CO-CHAIR HOLLANDER: The cost to CMS. It's just the cost to the government. It's not a societal cost and whether you're saving money out of your pocket.

MEMBER DOARN: See, that therein lies

the problem.

MS. McGINTY: Yes.

MEMBER DOARN: Right? I mean, because the technology, we've talked about the last day and a half, the technology is changing so rapidly. The government's systems for accounting for technology, accounting for the costs are, I wouldn't say they are archaic, but they're not, they're not new.

They're not, they're not evolving as fast as everything else is. And therein lies the challenge in American healthcare, and we're going to see it become worse and worse.

MS. McGINTY: Yes. I agree. I agree. I think some of the issue, I mean, I've talk with Jason about this, and we've provided some guidance.

When you can equate also that a telehealth encounter is as effective or as productive as a face-to-face encounter, and some of the measures included in practice improvements actually survey on their access to services.

I think this is a great place for telehealth providers to succeed in getting those patient surveys as far as access. When you can show, and there has been success in showing in behavioral health and dermatological conditions, providing services to rural and remote individuals that they wouldn't necessarily have access to in a handy and convenient way for them, reducing the opportunity, you know, improving the opportunity costs for the patient.

The stress, the need to create, transportation. There's a lot of opportunity there as well.

So I encourage you all to like look through measure list and give it a good, hearty think, opportunity to think what, where our opportunities lie.

Because I think there's enough behavioral, expanding practice access, better practice access, beneficiary engagement are all ripe. And that's about half of the measures available. So --

MEMBER GLADWELL: I don't mean to belabor the point, but since you're in these conversations, what's your sense on why does the bar have to be reduced cost?

If we're providing the same service and we're proving that it's as effective in terms of clinical outcomes, why do we have to hit that mark?

MS. McGINTY: I don't know if there's necessarily, well, Jason, please chime in here. I don't, I think believe, I don't think they see -- they're seeing maybe the empirical evidence that this is reducing costs in the sense of cost to the patient, cost to the provider, distances traveled, stress on multiple chronic conditions.

You have a heart condition, and now you've got to figure out how to go 180 miles to get your feet checked or something.

And whatever it would be. Or your skin condition checked. It's hard to put a number with that, and if CBO was only look at the cost to CMS, they're not doing that. They're not

doing the analysis necessary to really equate the dollars to those, that time-saving.

MR. GOLDWATER: I mean, so to just sort of extend on what Meg was saying, I mean, there's really three reasons why. So the first is that's the world we live in right now. It's all about cost and reimbursement when it comes to healthcare.

And it's unfortunate. I'm not saying that's right. I don't agree with it. I think a lot of us don't agree with it.

But from a government perspective, particularly the operator of the largest insurance program, it's about cost. It's about how much is it saving us? Are we going to get the same amount of care if it was provided in-person?

The second is, the level of understanding of those that make these policy decisions, when it comes to telehealth, it's not the same as all of yours, or all of ours.

MS. McGINTY: Or mine, or not --

MR. GOLDWATER: It's not. There's, I think there's a deep understanding of the utility of telehealth from what we were gathering, and I think that there's an understanding of its benefit.

But seeing that on paper and seeing how that translates to their constituency or their groups or their areas, they can't put those pieces together without the data in front of them.

Because in order for them to make the more effective argument, they need that data that's available, which right now, the data is in bits and spurts.

It's not consistent, and there's a lot of literature on the issue. But it's, in the here and now, if this were implemented, what would be the savings immediately?

Or what savings would we see over time? What benefit would this be delivered to our patients? How would this increase access to care? I just don't think that that deep level of

understanding, and understandably, the experiences some of them have is not the same.

So I think they want, there's a greater understanding and wanting to know, but us telling them is different from us showing them. And so that's why this framework becomes important, because it collects information that they can see. That it makes a point where they can see what the costs are, the access issues are, the opportunity costs are.

It makes a more effective argument, because that's always been the barrier to greater expansion of this, is that the hard data and hard evidence is not in front of them.

And I think the third reason is, this has always been -- and Chuck's right. And I'm actually agreeing with Chuck.

So this has been an issue. It's been around forever. I mean, it's not something that's new. It's not something the CMS is just picking up. It's not something that the government has not been discussing.

I think it's been around for a long period of time, but trying to understand all of the factors that go into telehealth has been challenging. Because some people are equating telehealth or looking at telehealth in the same way they would look at in-person care.

And while I, we all agree, the way to measure it is not to make any differences. But you've all agreed that there are factors about reducing travel time, getting access to a doctor immediately, being able to follow up on treatment plans. There has to be a patient story that effectively makes those arguments. So ---

MS. McGINTY: One thing just to build on what Jason said. These people are elected. And if you can give telehealth a personal story, which is why my personal recommendation would be attached to chronic care, attached to rural health access, those are two, if you watch the Price and the Seema Verma nomination hearings, question after question after question.

If you can show the value of

telehealth in those two practice areas, you're going to get people putting a constituent face with the issue.

I mean, everybody loves their iPhone, but it doesn't vote for you. If you can put a person who can say before a member, I live in rural West Virginia and it would take me an hour and a half or two hours to get to Wheeling to see my specialist.

But I can access them from my house or from my GP's office, and I'm able to improve my dermatological conditions, improve my diabetes, monitor it better, and save a life. Those are going to be your issues.

MEMBER GRAF: Can I just make, so there's two cost topics here. One is increased cost from overutilization levels above where they are right now.

So that, I think is sort of the CMS inherent fear of, you know, of expanded adoption. The other is what we've been talking about, is how through the use of telehealth, you can

actually reduce costs per capita.

And I don't think that we necessarily keep them separate enough. They're really two different conversations, two different messages, and it's important.

Because even in the discussion we're having here, I hear them being kind of merged together, and they're different.

MR. GOLDWATER: Nate, go ahead.

MEMBER GLADWELL: I just wanted to make one quick follow-up point. I've been working with CTel and a lot of other organizations around the cost with CBO and how they score it.

I just want to make that point that if we continue to have that as kind of the hamstring crutch of why legislation doesn't pass, we're going to be having this conversation for a lot longer than today.

MS. McGINTY: And to be honest with you, 1,000 voices can beat up CBO pretty easily. So if you have the mobilization of the people who

are benefitting it, I've seen it and I've worked with it that you can overcome a CBO report that may not quite have the numbers right. So --

MEMBER FERGUSON: So I have been -- okay. So I have been trying to dot -- or, sorry, connect these dots for one, and I still don't get it with MIPS. So take the quality reporting, right? It is the biggest chunk of your MIPS score, right, and it might be the biggest opportunity for telehealth. And so we take the example that we talked about with, you know, treating COPD patients with spirometry evaluation, right? We do that. We do that over telehealth, right?

When I report that measure, I will be reporting how I did on the measure. I will not necessarily be reporting I did telehealth with it. So how have I advanced the cause of telehealth or given CMS or anybody else data to know that telehealth works? I have just told you I did well on that measure.

MS. McGINTY: Right, right.

MEMBER FERGUSON: So help me connect that dot. How does CMS suddenly go oh, hey, telehealth works for spirometry because Alaska did it. You don't know if I used telehealth. It doesn't come out in the quality measure. You just know how many -- you know my numerator and --

MS. McGINTY: You just saw --

MEMBER FERGUSON: -- denominator.

MS. McGINTY: -- your denominator, yes, yes.

MEMBER FERGUSON: So how --

MS. McGINTY: So statistically --

MEMBER FERGUSON: -- do I tell --

MS. McGINTY: -- we have your information, and I don't know the answer to this, if there is an opportunity for physician comments in the reporting process to give feedback. I mean, CMS is providing feedback to physicians and providers. I would imagine that they would be receiving feedback in that process as well. If there is a way to identify that through

commenting or through your own personal feedback on your reporting, that might be an option, but I do not -- I -- yes, I do not know what the -- the feedback and reporting process will be like for actual individuals providing that information, if it's just a matter of numbers being sent or if there will be an opportunity for an actual discussion of how this worked and how this didn't work.

These -- these measures will be going through rulemaking again, so that's another great opportunity. It is public. It is available, and CMS is listening. They could make drastic changes from between the proposed rule to the final rule, so --

MR. GOLDWATER: Peter?

MEMBER RASMUSSEN: Judd and I were talking over lunch about how, you know, a significant portion of telemedicine is -- can be done like in-person using, you know, these telemedicine technologies, and it has really just become necessary infrastructure to an

organization to practice a fair amount of medicine. And, you know, it's like a telephone system or an electronic health record, and, you know, the fatalist in me wants to just say we're just going to have to suck it up and eat these costs to -- to deliver this type of service to our patients.

Is that sort of where the government potentially is angling, is screw the health systems, we are not going to do this, and we're just going to make them do this like they did EHRs? Or, I mean what -- what is --

MS. McGINTY: I can't --

MEMBER RASMUSSEN: -- really, what is --

MS. McGINTY: -- speak for the government's perspective or rationale behind it. I would say that perhaps you are right. Less cost to the government means it is more cost on the provider, and you can have the choice to provide services this way, which may not really be a choice, to provide good care for your

patients.

I don't think that that is the general intention of the individuals on Capitol Hill who want to see the progression of this. I think they want to see funding for an infrastructure for telehealth services, from our conversations that we've had with them. How that plays out with the actual appropriations of that money and the agency budgets, it is going to be a different story.

MEMBER RASMUSSEN: Was there any -- forgive my ignorance of this, but was there any funding directly or indirectly for implementations of electronic health records?

MS. McGINTY: I can't recall.

MR. GOLDWATER: No, there wasn't. I mean, there was -- there was the incentive program, right? Right.

What's that? Right, there was a -- right, HITECH was passed, and all of a sudden, there was this expansion of an extraordinary amount of money in health IT. That was not to

buy everybody electronic health records. It was to incentivize people to buy electronic health records. So -- yes, go ahead.

CO-CHAIR HOLLANDER: I was just going to say that, you know, with respect to the CBO conversation, I went down with our, you know, senior VP at Government Affairs and met with ten people in, you know, Congress and the Senate, including, you know, Schatz's and Wicker's staff, and that is not really a thing that I had done before, but was -- was shocked at the degree of theoretical bipartisan support.

Everybody said they would support the Connect for Health bill, but everybody also said it is not the thing they are going to die on the Hill for, literally, so there was no opposition, but yet there was no momentum to force the CBO to move her head and score the bill, which was actually the stall, and I think it was exactly what Don said that everybody said to me, is fear that it is going to drive up costs.

So I think to the -- you know, Nate,

your initial comment was does there need to be cost savings? I walked out of that day-and-a-half down there not actually really concerned that there would need to be even proof that it worked or cost savings, but there was just fear that the budget is X, and we can't make the budget X plus some fraction, and that was it.

And then we went around and met with a whole bunch of federal agencies, and every one of them to a T said the thing you could get us is cost data. And, you know, it is a year later, and there's no real different cost data, and then there's a paper like the one that came out yesterday that, you know, will scare everybody to say maybe it's going to drive up utilization and drive up costs, and, you know, I don't think anything that we do in this room as an NQF committee besides getting in some measures will, you know, maybe make somebody use it, but I start thinking of the influence that all of us have in our own organizations.

And if we banded together and did

stuff, I mean, Don has claims data, you know, which alone would be problematic because you only know the claim, you don't know what the person might have done on the other side, but Henry might actually know of people who came in the Teladoc. I don't know whether you survey and know what they actually would have done if they hadn't come in. It is probably not the purview of this committee, but it probably is the purview of people sitting around the table to figure out can we get together on a listserv and brainstorm how we could get the cost data.

I mean, gee, we got a guy with publications going back to 1930 over here, you know --

(Laughter.)

CO-CHAIR HOLLANDER: -- could -- but -- but seriously, you know, could there be a call for, you know, for data related to cost in -- in the journal and get some stuff in? And I think if we -- if we decided to say, okay, let's spend an hour on a conference call not under the

purview of NQF and say how could we help get the data that might move this ahead, I bet we could come up with some pretty creative ideas to make it work.

MEMBER DOARN: Well, I could take the whole floor for the rest of the day.

So the -- we have a professional organization called the ATA, and Jon Linkous has told me repeatedly for a very long time that they go to the Hill, and they talk about policy development and maybe even help write legislation, and I said to him, I said, you know, John, there are two journals that have been around for 23 years, now 23 years, that have tens of thousands of pages, you know, thousands and thousands of articles that show that telemedicine works, with some challenges, for sure.

And he goes they don't care about the -- the evidence. They don't care about the data. All they care about is, you know, whether they're going to save money or not. And I said but there are articles in there that say that, not only

here, but in Europe as well, and in other places around the world.

So then -- so Sherilyn and I went up to talk to the Hill as the FedTel, and we sat at a table, and I asked the guy, I said have you ever looked back -- I mean, most of the people sitting at the table were 25 years old, so that's the number one problem. There was one guy that was sitting there, he was from the Congressional Research Office, and I said have you looked back at the FedTel report that we did in the 1997 time period or the Airlie House report?

And so, no, the congressional -- the guy at the Congressional Research Office was, you know, he's a gray-hair, and not sure what that means, but, you know, he's an older guy, and he said oh no, we -- what are you talking about? And I was dumbfounded by the fact that we had done all this stuff. We have the research, we've had many different meetings, not on measures, but certainly bringing very smart people together to look at technology, look at research portfolios.

They time and again produced reports that no one either looks at or sees.

And then you come to find out, it's like, well, if you have 1000 people that tell good stories in West Virginia, you're going to get the CBO to change, which is not the same as building measures that are based on evidence-based medicine, which is what we're about, versus -- I mean, it's not to say we shouldn't have good stories. I mean, we all have good stories. Some we won't talk about. But clearly, it seems to me that Congress does not really care about the data.

They care about -- it is either personality-driven -- and I have seen congressmen and senators actually say this isn't going to happen while I am in charge. So if you have that kind of mentality either in the White House over the last 25 or 30 years or God forbid what happens in the future, and going in the -- and the same on Congress and the Senate, you have that kind of a problem. So it's not about

evidence, and that is the disturbing part.

MS. McGINTY: I wouldn't say that evidence is not in the telehealth sphere in my professional experience. Evidence can be well responded -- can be well responded to.

I am a former Hill staffer. If you gave me an academic journal that is 90 pages long, I can sure as heck guarantee you I am not going to read it because I have too many other things to do. But if you can give me the evidence in a persuasive argument and in a persuasive reason, I can take that evidence directly to my boss, or I could take that evidence directly to committee staff, if I'm a personal House staffer.

It -- it is a -- it has got to be a two-pronged approach, you know. You've got to have the evidence. You've absolutely got to have, and it sounds like you have great evidence going back 30 years to show the savings and the benefits, but you also have to get the passion of the people to be willing to fall on the sword for

it, and that is -- and that is -- that is the challenge, to get those two to work together, especially when you're working with like really, really awesome evidence that is super like exciting, like a movie, you know.

So it is really -- everybody loves kids, right? Nobody is going to dislike kids, but the progression of --

MR. GOLDWATER: Don't round up there.

(Laughter.)

MR. GOLDWATER: I love kids --

MS. McGINTY: You won't get any -- you won't get any member on record saying no, let's not fund healthcare -- or healthcare for children, like, but when it comes down to the budgeting, you're still going to have members who it comes down to the dollars and what their ideology perspective of where the dollars should go, so how do you overcome the ideological perspective?

I will say you have a very good Budget Chair, this is my personal opinion, who is an RN,

Diane Black, and she is now chairing the Budget Committee.

MR. GOLDWATER: So before I get to Adam and others, I mean -- what is that? I -- yes. I think it is -- I -- so I am going to take the opposite view, Peter, and be the optimist, not the fatalist.

And I -- I think it's a multi-stage process, and I think that for a while, we have all been sort of beating on the path of we have evidence, we have data, people are doing this, here is the change. And it is just -- you know, again, I don't think everybody's level of understanding is the same, so I think it is a step back and doing it a different way, which is creating a way to effectively measure telehealth, and showing its impact across a variety of different areas, and showing the impact it can make in areas that are important to those that make these decisions and those that will be implementing these decisions.

And then I think it is about -- as,

you know, Adam was saying, which is why I think the -- the journey is such an important aspect of this framework, which is it's not just telling stories, which I understand Chuck you probably have more than everybody dating back -- I don't even want to know how far back they go. It's on the tablets in the cave that you -- no, I am just kidding.

(Laughter.)

MR. GOLDWATER: It is -- you know, I -- I think it is doing the measure framework, it is telling the stories of where -- again, and that is why we wanted to emphasize what do you think is really important about taking time, you know, reducing the amount of time to see a physician, having immediate access to care, being able to follow through and monitor particular conditions?

I mean, those things as opposed to the alternative are compelling, and then add that into the way to effectively measure this in the same way healthcare would be measured so that we

are no longer differentiating between the two, it all becomes care delivery.

It is just -- this is another mode of care delivery, and that is another sort of facet we have to work with, is that -- and I -- you know, when I have sat on these conversations with Meg, they treat it as some -- as its own entity, the telehealth is a totally different way of delivering care, and it's not a different way of delivering care. It is care delivery, it is just Paul is treating me from LA. I am not in the office with him, but he is still leveraging all of his expertise to say Jason, you need to do a spirometry test and a peak flow test with the boats, and you need to get on a bronchodilator, and here is the prescription, and I am putting a thing on it so I can monitor to make sure you're taking it.

And if you don't take it, I am going to send you a text message to say buddy, take your freaking bronchodilator, otherwise you're going to end up in the ER. Right, because Paul

is real menacing that way.

Those are the things that if we effectively do, then I think the -- the tide starts to change a bit. But I think the way it has been -- we have been going at it is we have the data, we have these academic articles, we have these journals, here is all the evidence, and they are still thinking of it as two very different forms of care, and they're not looking at the evidence because they're like if we go to this other way of providing care, it is going to cost money and it is going to not produce any savings, rather than convincing them it is just healthcare. It is just another way.

So with that, Adam.

MEMBER DARKINS: So I was just going to quickly say we did discuss cost yesterday, and in that, saying is there some systematic way we could look at cost, the answer was we can't. So it seems to me that the issue -- I mean, we could be discussing this in 20 years' time in exactly the same way, and we could be wishing this to be

different, so it seems to me the fundamental challenge is how do you relate quality to cost? And we have not done that, as I have seen it, in this.

If you can't relate quality to cost, I don't believe there is good evidence. I think there are good indications. You can say there are some savings associated with it. There's very good theoretical evidence to show that you could inflate costs, so we have to be able to show we can relate quality to cost, and there are cost savings.

That done, nobody is going to invest in something like this unless you can also show ongoing thereafter you can monitor costs and quality. So if we don't create the framework to go in there -- so I kind of see in the discussion we have just had almost a kind of wish, well, you know, let's just lobby and the rest of it. Surely this takes us a little bit back to the challenge. If we can't answer and say our framework yesterday is showing us how might we do

it, isn't there a slight dissonance here? Or am I just being a bit naive?

MR. GOLDWATER: No. I think there is a slight dissonance, but I would say I think we're on the -- I think we have enough ideas to start to rectify and put something together that will adequately and effectively produce metrics to evaluate, and I think it then becomes incumbent upon all of us that as this is being iterated, that we carefully look and read it to ensure the fact that we are driving to that because, again, when that -- those metrics are shown and can be analyzed and interpreted, it again shows that it is just another form of care delivery, but it is an effective one for those in underserved rural areas especially, and so forth.

MEMBER DARKINS: So isn't it therefore -- I am not -- I just trying to make the point, I mean, I am very optimistic. I think this is going to happen. It's how we make it happen which is why I think we're all here.

So isn't there a piece around this

fundamentally which is how you relate quality to cost, and that doesn't seem to be something -- perhaps we won't get the answer, but in the next -- before we get the report, if we could come up with a real way in which we could do that in a systematic way, I think we provide something very helpful.

MEMBER GRAF: So my question is really about defining the process. So right now, when we think about CMS and -- and restrictions of policy that is in place, and what we want to do is loosen them up as opposed to creating new, is one fundamentally -- and the approach to getting the reform, is one fundamentally different than the other, or do they both sort of work the same way? Do you know -- understand --

MS. McGINTY: Yes, no, I understand what you're saying. Which one is easier? I think it is easier to add than to remove, personally.

MEMBER GRAF: So -- so we're already biased.

MS. McGINTY: I -- I -- this is -- I -- I think it is -- I think it is easier to add than to remove. It is always easier to add into it than to strike previous law. You're going to get -- you're -- you're going to pull out from the woodworks who would be opposed when you're going to remove something that they really like, but when you're adding something, you may not get all of the interested players who may say oh, yeah, we're against this.

So I think you're already at a bit of a -- a deficit there. But those restrictions do need to be removed in order to expand the access and the use of these services.

I -- I think -- I mean, the one thing I am kind of listening here, and I haven't read the framework, and I am excited -- I am really excited for this report. It is going to be so great. It is going -- every -- it's going to be such a buzz to report, and I am so excited to work with it, but you're getting the unique opportunity to create a framework while the

restrictions are still in place, so you have a scratch draft ready to go for when they are removed.

And that is not an opportunity I think any of our committees have really had to do, so I think it is going to be very influential, and I think -- I think that alone right there, showing that you have an option, a practical application that can guide for the great and effective use of these services more easily to providers, to hospitals, to clinicians and physicians, to RNs, and to patients, before they remove it, they know what they're getting in the beginning. So I think that's a good point to sell.

MEMBER ALVERSON: So this is more of a question, Megan, and maybe to Jason, I agree with everything you said Jason, that it's all about healthcare. We tend to make telehealth something magical.

But how do we make -- how do we -- because we have talked about we're going to have the -- we'll follow the NQF's measures where

telehealth just is another means of achieving that -- that measure, and -- and I am going to go back to something that Stewart said in talking about MIPS and so on: how do we get that across to the decision-makers in -- in the legislature and the administration and so on that it was telehealth that actually augmented or enhanced achieving that measure?

Because otherwise, it seems like it gets lost. You know, we're tagging a -- so what -- what is -- I mean, it is sort of like I think about the CPT codes and a GT modifier. I mean, is there a way that people say, yes, telehealth helped us achieve that measure, which might include not only improve quality of care, but also we decreased cost, and there's a lot of -- and it's all in our -- in our framework?

But I -- but I am not sure how we get that message across because that is what happens with the Congressional Budget Office, is they just look at what is the upfront cost, not cost avoidance. Is there a way to attach these --

these endorsed NQF measures where people know that that was enhanced by telehealth? How do we do that?

MS. McGINTY: I would say first -- my first advice would be when you do comment on -- because everybody reads the Federal Register every night, correct? Yes. Everybody?

So when you do comment, I would cc any stakeholder that you think has an interest in this. So when you present your comments to CMS with their cover letters and send them in to be -- in commenting to the rule, I would take that comment and include that into a letter to the senators that you know care about it, the members of the House that you know care about it, and don't send it to their office, email it to their staffer, first and foremost.

I think if you hit from both angles -- we had some really great rural health success because we were able to hit different avenues, both from the CMS side and on the legislative side to put pressure on the Secretary to do these

things, and now they are starting to do those things. So it is -- while we think rulemaking is so great and it's public and it's transparent, everybody has a bite of the apple, you have to make sure that your bite is seen and noticed a little bit bigger than everyone else's. That would be my first advice.

MR. GOLDWATER: I mean, I think we're going to have to sort of think through modification. I mean, I think that is a really crucial issue, because modifying a measure is what we said we didn't want to do, and I understand that, and I think that would pose a number of difficulties. At the same point in time, we want to recognize that the telehealth service was provided so that we're effectively showing its utility.

Now, whether that is modifying the CPT code or the modifier and segregating those out and reporting as these were telehealth, these were in-person care, you know, that is a possibility, and seeing if -- if we can work to

have those reported to CMS as part of the MIPS program as they go through this latest iteration. But other than that, we are going to have to think through that.

I don't think that's an answer we're going to come up with today, but I think when the framework comes -- you know, the draft of the framework comes out and you're seeing the concepts and you see the starter set of measures and how they are all relating, then we can start engaging in a discussion about, you know, how do we report these in a way where the telehealth service is being highlighted?

I think that is a challenge. I am not -- I am not going to state differently. But part of that, again, is tying cost into quality, and the other part of it is, you know, ensuring that you can segregate telehealth from standard in-person care without making it whereas telehealth is sort of its own independent magical unicorn type entity, and standard care -- which, you know, that is what some people think. They think

it's a unicorn, like it is this magical thing that, you know.

I think I said that in one of the meetings. I was just like it's not a unicorn. Stop thinking --

MS. McGINTY: And I think -- I think that mindset is changing.

MR. GOLDWATER: Yes.

MS. McGINTY: I think, you know, those 25-year-olds get some of this technological advancement, and that we are lagging behind, and if I can grow a garden and share it with people, why can't I, you know, share my issues with my doctor and do all these things remotely without having to go in to see him?

I -- it is a translation between the two, and -- and the care -- care -- if you address it from a care delivery standpoint, I think you're going to get the people to eventually get onboard. It is -- it is challenging. It is challenging.

MR. GOLDWATER: Paul.

MEMBER GIBONEY: Something that Adam said about our conversation yesterday about how cost -- a really complete assessment of cost includes all these different things, right? It includes all the societal costs, the costs to the patient, travel, all that kind of stuff, and how, you know, we will be talking about it in 20 years and maybe still not be able to capture all that.

But then, so -- so that would be like the perfect accounting of cost. But then, when I hear that, you know, CMS has really -- you know, CBO is looking at, you know, what's the cost to CMS, it makes me think can we not make that perfect assessment of costs the enemy of good, which would be speaking CBO's language? And putting some effort forth in saying, okay, if CBO is interested in cost to CMS, then how do we show that telehealth as a delivery model actually reduces cost to CMS?

Because I actually believe that I can show that in my system, without including all those other features that I know are awesome

features of cost, but I actually believe that I possibly could show that the bottom line cost to CMS is actually improved. And -- and so it might be trying to speak their language even though we know that there is this much other, bigger language that we could reveal to them over time.

MR. GOLDWATER: Yael.

MEMBER HARRIS: So I just wanted to follow up on that, Paul. Absolutely. I just want to point out the task is even easier.

What I have heard from CMS is they want to know is care delivered by telehealth the same as care delivered in person in terms of cost and quality? Is quality compromised? Is it more expensive? If you can disprove that, as Jason just said earlier, it is care that is being delivered, just with the doctor or the provider not in the same place.

So they don't necessarily -- I mean, it would be great if we could prove it saves money. We all know it does. But they just need to say it is not compromising quality, and it is

not costing more care.

MR. GOLDWATER: Right. That should be the line: prove that it's not a unicorn, right? I mean, that is what we should go forward: prove that it's -- I mean, I am -- and I am kidding, and I am not kidding, which is prove that it is not some magical mythical beast. It is just healthcare. Do that, and I think we are on our way.

Stewart.

MEMBER FERGUSON: So I don't know where everybody else is in their MACRA MIPS journey.

(Laughter.)

MEMBER FERGUSON: Was that funny? Oh, okay. So -- so I just -- well, I just -- I have been very frustrated with my organization, and we needed to make that transition from meaningful use to quality payment programs, which is really what we're talking about, not MACRA. MACRA is an act --

MS. McGINTY: That is the --

MEMBER FERGUSON: -- it is a high-tech act --

(Simultaneous speaking.)

MS. McGINTY: -- quality paying programs --

MEMBER FERGUSON: Right, meaningful use is the program --

MS. McGINTY: That is right.

(Simultaneous speaking.)

MEMBER FERGUSON: -- QPP is the program, but I just wrote a job description about a month ago for a new position. We are creating a Director for Quality Payment Programs. I am guessing other organizations are doing the same thing. You can find them on Monster. They are out there, and we're asking this person to lead us in a strategy basically to maximize our MIPS score.

MS. McGINTY: Yes.

MEMBER FERGUSON: And we are kind of getting to the point now where it's not so much is telehealth reimbursed? It is not so much, you

know, can we convince people to use telehealth for these measures? We will look at the way to get the highest MIPS score we can. We will be looking at the quality measures that make sense. We will be looking at the ones where for this much money I can get this much score, and telehealth will certainly be part of some of those.

And so I think we're kind of getting to that world where it is not maybe so important to track if we use telehealth or not. Each organization will make their decisions, but they probably will have to use telehealth to really maximize their score, because you actually have to drop your costs, you have to drop your resource costs, and you have to improve your quality. And I think all of us that advocate for telehealth know that that is generally part of the solution.

So I -- I guess I can relax a little bit, and I think the quality payment programs are going to drive us into that world, and it is

probably going to become pretty irrelevant pretty soon if an organization achieved a high score because they used telehealth or not. They probably will have to for some of this and we'll probably all be there.

So I feel -- you know, I guess I don't feel as much of a need to differentiate if people achieved that quality score through telehealth or not. I think it is going to happen because we are being driven there.

MS. McGINTY: Between listening to the past -- your comment and the last comment, I wonder if almost those positions are juxtaposed, because you want to find out how you can save money to CMS, but in shared savings plans and the costs and the MIPS score and your incentive payments, if you're using healthcare -- telehealth to get more money back, essentially, how are those going to play off of each other going forward? I don't know. This is just the interesting points of the two arguments, that, you know, Paul's comment and Stewart's comment

could at the end be at heads with one another, eventually.

MEMBER RASMUSSEN: You know, while you optimists are all waiting for payment from CMS, there are some things I think that they -- that they could do to -- that would really be no cost to them that would -- that would at least help. So I am from the Cleveland Clinic. We've obviously got hospitals in Cleveland, and we've got a place in Florida and Ohio. We have no problem delivering post-surgical follow-up visits using telemedicine.

In Florida, our attorneys, and maybe they are just nervous Nellies, are reluctant to allow us to do post-op follow-up visits on Medicare patients, fearing that Medicare is going to disallow the entire hospitalization if we don't have that in-person follow-up visit post-surgery.

So that would seem to be an easy thing CMS could do, is just say we will not penalize you if you use telemedicine in these situations.

That would do at least something to help promote some adoption and not cost them anything. Is there any indication that they might be willing to do something like that?

MS. McGINTY: I have not heard that, but I also have not heard that point raised, so, I mean, unless it -- I did not read through the 1400 comments that were received in MACRA, but I did not -- I did not hear that that was one of the comments made, so maybe it's a point that needs to be raised with them, and I hope they are on the phone.

MR. GOLDWATER: I agree. I think that's a good point, Peter.

MEMBER GRAF: I wanted to -- to make a comment to sort of flip this whole discussion on its ear. You know, telehealth and the expansion of its use is happening regardless of where we are from a policy perspective at a more than exponential rate, and at some point in time, probably sooner than later, I hope, the barriers that exist today are going to be completely

flipped around, and now you're going to be asking the questions like many Medicaid organizations are asking: why aren't you using telemedicine?

And where you aren't using it, you're going to -- it is going to affect your HEDIS scores. It's going to affect your Star ratings. It's going to affect your at-risk dollars. And -- and so, you know, are we -- are we skating to where the puck is, or should we be -- or where it is going to be? Just a thought to consider.

MEMBER DOARN: I am not sure we're on the same ice pond.

MEMBER GRAF: Probably won't happen in our life.

MS. McGINTY: I think -- I mean, I think once the real barriers are removed, which by means is no small feat, as we discussed, that could be the conversation. I definitely think it could. I mean, you look through the survey measures and you see the opportunities to be able to do those through telehealth services and the amount of surveys you would get back from your

patients would be like whew, so many of them, and your --

MEMBER GRAF: And --

(Simultaneous speaking.)

MS. McGINTY: -- scores would go up.

MEMBER GRAF: Yes, and -- and, you know, from CTeL's perspective, and you hear about litigation, things like that, litigation, the possibilities of it are not, you know, you gave me telehealth and I, you know, I got screwed up. It is you had it to offer, but you didn't. And -- and so more and more, I think we should be thinking about it.

CO-CHAIR HOLLANDER: I think Peter's point comes back to when we were talking before about pre-existing measures and defining what's in it. It's like what's a visit? Like if it -- in order to do your -- and I don't know this area, but if you have to get paid for your surgery and you need a bundled post-op visit, well, what is a visit?

I am pretty sure the regulation right

now does not say you need an in-person visit. It is probably silent on it. And that is why I think it is really important to go back and look at the measures that include things and clearly try and specify that it -- it comes back to our -- you know, our thing of an actionable item. Like if you could do a post-op visit, and you can't see the wound, and the idea is to look at the wound, that is a problem, but if the idea is to see the wound and you can, and see if the body part moves and do a neuro exam and you can, well then you're getting actionable information, and that should count as a visit.

I think we have incorporated that in what we have done. The question is how can we incorporate that where they created a measure before this existed so that this can apply and yet make it clear that being silent on it does not mean you can't do it somehow? I don't have the answer to that, but hopefully we can trigger that.

MR. GOLDWATER: Okay. Meg, thank you

as always for the insight, and --

MS. McGINTY: And I encourage you all to go to your shared documents on the SharePoint. All of the measures are there, so -- .

MR. GOLDWATER: So Meg, we will continue to loop you into what we're doing, and we will continue to loop all of you into what we're doing, as this will get traction once it is done, I am sure, so we will keep you continuously informed, as will HRSA, I would assume, about how this is being received and what is being done as a result of it.

So we are now at the time for a meeting summary. So Judd, do you want to sort of summarize?

(Laughter.)

MR. GOLDWATER: Unicorn, you all remember that. I am tweeting that tomorrow.

MS. McGINTY: For real, I would just actually like to thank everybody. I think that we all have the sense that this meeting went really well, and, you know, we didn't solve all

the world's problems, but we did what we were asked to do in getting domains, subdomains, measure concepts, having robust discussions, and, you know, somehow I think Jason must have had a screening process that he did a survey and we all answered with the exact same yeses and noes on the thing because, you know, we can deal --

MR. GOLDWATER: Only with Chuck and Stewart.

CO-CHAIR HOLLANDER: Yeah, yeah. And so we -- you know, I think we, you know, can deal very well around what we needed to do, and so I think, you know, we're going to see some stuff on some more webinars, and Jason and the team is going to take the little bit of information we gave them today and make it crystal clear so everybody could use it.

But -- but I think this is cool. We -- we did -- I think we did the easy work. I think the NQF staff did the hard work in prepping us for this meeting, and so I thank them for the tremendous amount of up-front preparation. I am

sure every one of us when we heard there's an environmental scan --

(Applause.)

CO-CHAIR HOLLANDER: I think everyone when we heard we're going to review a couple hundred articles thought, crap, how can I hide from this? And -- and they did a great job of doing that and were able to sort of help, you know, put it in a framework that is useful, and I think we had a lot of discussion that probably extends beyond the scope of what was intended, but -- but good stuff in helping give us all direction going forward.

And I am kind of optimistic. And we have a conference call coming up when? It is like soon.

MR. GOLDWATER: So we will get -- you are racing ahead. We will get --

CO-CHAIR HOLLANDER: Okay.

MR. GOLDWATER: -- to next steps in just a minute.

CO-CHAIR HOLLANDER: All right. So --

so anyway, my summary is really thank you. I think everybody can look at the board and see the work we did, and we don't really need to march through it item by item, but a really impressive group, and, you know, no one was shooting spitballs across the table, and I personally had a lot of fun hanging out and learning from everybody here, so I thank you on behalf of me and Marcia.

MR. GOLDWATER: So I -- I would echo that, and I want to thank all of you profusely. This has just -- I have said this a thousand times, I will probably say it again, but this has been a terrific committee. We could not have asked for a better group of people personally and professionally.

I think the -- I mean, as much fun as we've had teasing Chuck, which is rightfully deserved, I think we have -- we have accomplished everything we needed to do. I mean, essentially, the report, what's laid out in front of us is exactly what we need. I don't think we're

unclear about anything. I think we have exactly the direction that we need to follow, and we will provide something that you all will be able to input in and shape it up to be I think an extraordinary document and a great framework that could really create some change, I hope. I am -- I am also very optimistic.

I want to thank my team, Tracy and Katie and Irvin and May. You know, they are really the brains behind the operation. I am just the face. I don't really do anything. I am kidding, but they really are wonderful people, and they are very dedicated to this, I mean, and I think that shows, so I thank them.

And I do want to thank Judd and Marcia. I am not sure why, but I want to thank them for all of their help and preparing for this meeting, knowing what to say, and really taking charge of it over the last day-and-a-half to get what we need to get done. So with that in mind, I am going to turn it over -- did you want to say something, Marcia?

CO-CHAIR WARD: Yes. Closing up on Meg's, we have gotten briefed on all that. How is the report going to integrate that? And we talked about a reduced list, and we talked about the NQF-endorsed measures and saying is part of the matrix going to pull in and look at the sweet spot between the NQF-endorsed and the MIPS? And -- and that is maybe our condensed set --

MR. GOLDWATER: Right. So one of the -- one of the requirements of the final report is that we -- as we move forward with the -- the different iterations is to incorporate how it fits into MIPS and APMs, so we will take some of what Meg said. We will probably continue to have discussions with her. We will show her those sections that we are writing so she can add her own comments, thoughts about where those intersections will lie, but yes, that is going to be a big component of this. It needs to be because that is where that can be a major driver.

Okay. So Operator, if you could open the lines for public comment, please?

THE OPERATOR: Okay. At this time, if you would like to make a public comment, please press star, then the number 1.

(No audible response.)

THE OPERATOR: And there are no public comments from the phone lines.

MR. GOLDWATER: Okay. And from the audience?

MR. JARRIN: Hi. Oh, great. Good afternoon. My name is Robert Jarrin. I am with Qualcomm Incorporated, and I wanted to make a few public comments based on the conversation that happened today. By the way, great job. I found it very engaging. This is the area of interest for Qualcomm and many others in the industry.

But quickly, Jason, during the use case discussion, you asked publicly how many spirometers, peak flow meters, inhalers, sensors there are on the marketplace. I can say there are many. They are made by not only Propeller, but Gladstone, Philips. There are others out there.

In the digital health space, those -- these devices would be medical devices. These are all cleared Class II devices. There are about 150 or so that have been cleared by the FDA in the last couple years. There are others that predate that, and that includes things like mobile ECGs, spirometers, peak flow meters, et cetera, blood glucose monitors, continuous glucose monitors, et cetera, so that's a very alive and healthy area. But they all have to be cleared by the FDA.

Then onto Dale was mentioning AMA's work in modifiers. They are not only looking at modifiers. They are looking at potentially new codes as well in addition to even modifying some existing codes and seeing whether or not they have to tweak facility fees or non-facility fees for the digital health space. I am actually on the Digital Medical Payment Advisory Group as well as my geneticist friend two doors down from you, so that is an area that the AMA is looking at.

Thirdly, Kevin with tech neutrality: completely agreed. We want to push the notion of tech neutrality. The problem is when CMS goes and defines a very neutral term like telehealth, and in the 2001 Physician Fee Schedule, for example, it specified that telehealth needed to be not store-and-forward and had to be live voice and video in addition to a number of other stipulations that were both in statute and in rulemaking.

That became the problem as to why remote patient monitoring is not included for payment in many of these things, and that is where the huge problem is because if you're looking at telehealth and you're talking about telehealth, that is a defined term by CMS. It can't be live voice and video -- I am sorry, it has to be live voice and video, it can't be store-and-forward. It has originating start restrictions. It has geographic restrictions, et cetera. So -- and then that leads to the bigger problem.

So under MIPS, I am glad that Meg came. That was the whole reason why I was here. I didn't even know that you guys wanted to touch upon that, but I would like to state for the record that the statute for the creation of MACRA specifies under CPIA, Clinical Practice Improvement Activities, that telehealth remote patient monitoring should be a part of care coordination, and unfortunately, in rulemaking, those 92 measures that Meg brought up, they didn't even include it in care coordination. They included it in expanded practice areas, which she spoke to, as well as population management.

And then in the subsequent final rulemaking, many in the industry commented, including AdvaMed and other organizations, but those comments were blown off, and that is a problem. Of those 92, about 14 of them may be construed to be able to be achieved by telehealth remote monitoring, but that is not explicit, and that is not good enough, which is why I would

say, Jason, I would recommend for NQF to be at the measurement development table, or via the MAP, whichever one politically is easier, but you guys should definitely be involved in there.

Recently, the measures for applications for measures went live, and -- and it was only like a month window. I submitted a couple measures. I know other organizations did as well, but I am not sure they are going to get any -- any room, and that -- that is terrible.

Keep in mind that MACRA also assumes obviously EHRs under Advancing Care Information. Meaningful Use Stage III does speak to coordination of care and patient engagement, specifically uploading patient-generated health data from any source into the electronic health record, but as we know, Meaningful Use Stage III has been delayed. I am not sure what that means for MACRA. That is a problem.

And very lastly, on the legislative front, I wish Meg was still here. We supported many of the -- I am sorry, the pieces of

legislation that were being contemplated, including Schatz, very vocally and open. However, it is a new legislative session. They have to be reintroduced. We have no idea what they look like. From what I hear, not only that piece of legislation, but others have diverted from what we had agreed to last time. I am not sure I can support them going forward.

You know, creating legislation is messy and it can pigeonhole you if it's not done the right way, so I would actually recommend that NQF has the power to really sway CBO, CMS, Congress, and in addition work with AMA, because everybody says that what is lacking here is evidence. They say that there is no evidence, yet AHRQ has evidence.

Darkins is one of the fathers of the evidence in this space with what he did in telehealth. He has got the biggest report on it -- or study. There are dozens of studies. There are hundreds of evaluations, but what we hear constantly back is it's not good enough because

it is spender-generated, there are no RCTs, you know, the -- that -- that, you know, it is just not good enough.

So -- so I would say, you know, when Jason said at the end he's onto something about, you know, the -- the issue with remote monitoring is that it does give you immediate access, and it helps monitor care moment-by-moment, and there's logistical improvements in the time aspects of saving time. That is all serious, and that is all delivery, but because of the way that CMS defines it, and because of the way that Congress says that it is going to cost too much, when you go to CBO, it is still stuck 30 years ago.

So, you know, maybe this is a time to change the paradigm of how this is actually viewed because it doesn't fit the existing frame. And quite frankly, it is out of the Pandora's box. We are not going backwards. Remote monitoring in medicine is here to stay, and it will be adopted by ACOs and shared savings programs, except it is going to be adopted slowly

unless NQF delivers a great report and starts a process to really validate this -- this good stuff. No pressure.

Thank you very much for listening to my comments. Have a great day.

MR. GOLDWATER: Thank you very much, Robert. And so do we have another comment?

MR. QUINN: So I just wanted to reiterate something that we talked a little bit about -- that I talked a little bit about yesterday and then heard came up again, which is the importance of thinking about structural measures of telehealth in the organization and well-describing it in consistent ways so that, when evidence is created, it can be compared.

When we look at the impact or correlation of telehealth on outcome measures or process measures, we can look back and see what the characteristics of that telehealth is. Telehealth as a general amorphous concept is going to have a hard time demonstrating the sort of impact that CBO and others want. If you look

at telehealth as a -- as an intervention that has characteristics like, you know, a model of care, different components, differentiating all of those so that it can be described and understood well and consistently, included in things like NCQA, patient-centered medical home evaluation, the same way that we have done in many ways with health IT and EHRs, it is going to -- it is going to help a lot.

If we have measures that are process measures and outcome measures without having structural measures that describe what the intervention is in consistent ways, it is just not going to get there, so --

MR. GOLDWATER: Thank you, Matt. All right. So let's go quickly to the next slide. May, if you want to take us through next steps, and then we will be dismissed.

MS. NACION: Sure. Just quickly, to reiterate, we will have a draft report coming out at the end of this month, and then our next meeting will be May 23rd. A third report will be

open for public comment June 1st to 30th.

MR. GOLDWATER: All right. Thank you all very much. Much appreciated, look forward to speaking to you all again. Thank you very much. Safe travels to all of you.

(Whereupon, the above-entitled matter 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

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter