NATIONAL QUALITY FORUM

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Operator: This is Conference #: 84423473.

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

Jason Goldwater: Good afternoon, everyone. This is Jason Goldwater from the National Quality Forum. I'm in a room with Katie Streeter, May Nacion and Irvin Singh. We're very happy to be talking to you on a Friday afternoon. We thank all of you for taking some time out of today on Friday, out of all days, and for those of you that are in D.C., we appeared to be in the middle of monsoon season.

So, we are greatly appreciative of your time. What we are going to do this afternoon is to review the memo that we send out a couple of weeks ago, that was a summary of the comments that we received on the Telehealth Final Framework Report. We only have one more webinar after today and that last webinar, were really just be sort of a summarization of the final framework, how it will be going forward and give the public opportunity to offer input or comments rather.

However, for this particular call, we do need to get through the memo, look at all of the comments that were received, and find way of addressing them. We're going to leave this to you all to dictate to us how you would like us to respond, what do you like the comments to say, and more important if you want to make any changes to the framework report and those changes should be like.

So, with that in mind, the NQF team which has generally been pretty active in our meeting thus far, is actually going to take us that back, and we do our – very lucky, we have both Judd and Marcia on the phone today, and they're going to lead you through this discussion. We will be here to offer any clarification if we need to, and if there are any questions that you have about a particularly comment or section of the report, we'll be happy to address those.

But other than that, we are going to leave it to all of you to respond. And once we're done, we'll recap out comments. We'll open it up for public comments, and then we will be able to end today's call.

So with that in mind, Judd, Marcia, I will turn – oh, we need to do a roll call, I'm sorry. So I'm going to turn it over to May to do a quick roll call. And then, we will turn it over to Judd and Marcia.

May Nacion: Hello. As I call your name, please just let me know if you're on the line. Judd Hollander?

Judd Hollander: Yes.

May Nacion: OK. Marcia Ward?

Marcia Ward: Here.

May Nacion: OK. Dale Alverson?

Adam Darkins?

Rashid Bashshur?

Henry DePhillips?

Henry DePhillips: Yes, ma'am.

May Nacion: OK. Charles Doarn?

Charles Doarn: Here.

May Nacion: Marybeth Farquhar?

Marybeth Farquhar: Here.

May Nacion: Steward Ferguson?

Steward Ferguson: Here.

May Nacion: David Flannery?

David Flannery: Present.

May Nacion: Paul Giboney?

Paul Giboney: I'm here.

May Nacion: Nate Gladwell?

Don Graf?

Don Graf: Yes.

May Nacion: Julie Hall-Barrow?

Steven Handler?

Yael Harris?

Kristi Henderson?

Kristi Henderson: Here.

May Nacion: Mary Lou Maowe?

Eve-Lynn Nelson?

Eve-Lynn Nelson: Here.

May Nacion: Stephen North?

Peter Rasmussen?

Sarah Sossong?

Sarah Sossong: Present.

May Nacion: Oh, thanks. Daniel Spiegel?

Daniel Spiegel: Here. Here.

May Nacion: OK, thank you. Dennis Truong?

Jean Turcotte?

And Angela Walker?

Angela Walker: Here.

May Nacion: OK. Thank you, all right.

Jason Goldwater: Hey, thank you all very much for the roll call. And now, we will officially turn it over to Judd and Marcia.

Judd Hollander: OK. Well, thanks. What Marcia and I decided to do is just also work actually off the telehealth folks comment memo which is open in front of you. And just to alternate which one of us would lead discussions and themes. She pointed out that I was more odd, so I should take the odd number in this, so I'll begin with Theme Number One.

And, well, actually, really just read through this summary comment and not goes through the Excel spreadsheet that everybody received, at least not until the end of the call. And then, if there are comments that someone thinks are not well-categorized in the summary sheet here, then we'll take comments on other individual thing that fall outside of the comment memo.

And so, we'll begin with Theme number 1 where comments are surrounding the Definition of Telehealth. And really, I'm going to read what's here, so if it's not open in front of you, people can comment based on what would actually is here.

So one comment has suggested the report be expanded to specifically include definitions for telemedicine, remote monitoring and health, e-health and telehealth, to recognize the importance of coverage and payment considerations.

And other comments suggested using the broader definition of telehealth or removing the definition of telehealth completely. It sounds like a lot of our discussion in the room.

So specific comment, there were five or six here is that, there should be a clear notation that Medicare's definition of telehealth is different from a broader understanding of telehealth, with regard to HRSA's definition, should we note this definition's shortcomings and ensure that it's not deferred to in a blanket fashion, should be specify the context of Medicare measurement, especially CMS' reimbursement practices, should be consider a technology neutral or simpler definition of telehealth, and should be clearly distinguish between synchronous and asynchronous forms of telehealth.

And so, our charge on theme number one, similar to all the other themes, is to think about what I just read based on the comments that we received and see whether or not we might actually want to change the definition that's in the document.

I don't know if NQF staff could open the draft report to the page where we have our comments about the definition of telehealth, so we could show committee members exactly what that is.

So here, it states in the middle that HRSA defines telehealth as the use of electronic information and telecommunications technology to support and promote long distance clinical healthcare, patient and professional health-related education, public health and health administration. Although no standard definition exits but it's an important area of health information technology across both private and public sectors. There were generally consensus that telehealth supports our range of activities including – and then it lists a range of activity.

So, I guess, the question is, should we make it more specific or should we make it more narrow, should we leave it as it is in the document in front of you, and how should we incorporate the comments from the post-comment memo. And I'll open that up for discussion among committee members at this time.

Daniel Spiegel: Hey, Judd, this is Daniel Spiegel here. So I read our current definition from HRSA in a pretty broad sense. And I guess, I don't think that we want to necessarily make judgment on what kinds or types of potential telehealth might be better than others which you couldn't infer if you narrow the definition too much.

So, I kind of like having a broad definition right now. So, that's my comment.

Eve-Lynn Nelson: This is Eve-Lynn. I'd like to suggest considering adding some of the HRSA funded telehealth resource center, resources around defining telehealth. They have link called a framework for defining telehealth that gets up some of the nuances that are mentioned in some of the comments. And they also tend to have some resources that, you know, as definitions evolve, a resource centers either try to have resources that – with that.

So, I just wanted to ask if that link to the resource center materials might be added.

Judd Hollander: Other thoughts and comments?

Adam Darkins: It's Adam Darkins. I just think that it's necessary for there to be an internal consistency around what it is we're doing in terms of framework. Because in the end, we're not really trying to sort of deal with world hunger.

So I think there is a little bit around that HRSA framework, that it's very broad. It could mean this thing goes anywhere. So it may be that that's the intent in which case there'll be an intent – can wander in the future or there may be a statement that says, look, this is somewhat unclear, it's evolving. Here is a standard definition from the point of what we're doing. This is where we think that's really important, that we navigate. Does that make sense?

Judd Hollander: Yes. Other …

Paul Giboney: This is – Paul Giboney here. I like at least one of the commentators suggested that we remove the phrase at long distance from the standard definition. Telehealth is evolving so quickly even within facility use, so that people in one facility can – one part of a large facility can seamlessly communicate and coordinate with people with another, you know, another end, you know, it might be a 15-minute walk away in a large facility or whatever, or even within, you know, within a network or clinics that's within short geography of each other.

Now, the first thing I wanted to say was I like the idea of not defining it as only occurring over long distances. And then, I do like keeping it broad, technology will always change, and we don't want us to be hampered because we've been too specific within the types of technologies or the types of devices that are available to us now. So I also support the idea of keeping it broad, to give us a little bit more – give a little bit more flexibility to address things that might come up in the future.

The last thing I thought is, one of the commentators suggested that we remove the definition of telehealth completely and while I don't think we necessarily need to do that, I like the heart behind that which I read should be why do – if telehealth is providing us something of high value to the patient, now why do we have to make the distinction, between whether it's, you know, offered via telehealth or whether offered via an in-person visit.

I like that idea or that concept, I just – but I still think that we – we still require a definition but I at least like the concept of not trying to parse those two out, so the in-person versus telehealth. So completely if both are adding high value to the patient care. Just a couple of thoughts there.

Judd Hollander: So I think what I'm hearing from every one of the people who spoke is a desire to keep the definition broad. So let me ask the pointed question, is there anybody that would prefer the narrows the definition on the committee?

OK, hearing none that I think we have …

Natassja Manzanero: Hi, this is …

Judd Hollander: OK, go ahead.

Natassja Manzanero: Hi, this is Natassja Manzanero from HRSA. And …

Judd Hollander: Hi, Natassja.

Natassja Manzanero: And, I just want to – hi, how are you? I just wanted to reemphasize that this was a HRSA HHS sponsored project. And that's the reason why we're using this definition. However, we do acknowledge that there are many different variations of telehealth, which also leads us to mention that, you know, telehealth is changing rapidly. So we can acknowledge that this definition and the included element of asynchronous/synchronous and now I am learning that there's a new fifth element of robotics for telehealth types.

So the purposes of this paper as the course of subject to change as telehealth evolve, so I do like the broad but specific definition for the purposes of this paper.

Judd Hollander: So, Natassja, would you and would other members of the committee be good with a statement that says, in no way is this document, you know, intended to limit the definition of telehealth, but one example of a definition is the HRSA definition. We obviously can't change that language and although I would agree with Paul that we don't want to do this only for long distance, if we're making it clear that that is one example but the intent of this document is broadly to include things that presently would be considered telehealth and may in the future be considered telehealth, then I think the document may serve the broad of purpose but it, you know, puts the HRSA definition as the example of a definition that currently fits.

Natassja Manzanero: Yes, we would be comfortable with that, yes.

Judd Hollander: Are others on in this call comfortable with that approach to address these items?

Charles Doarn: This is Chuck. I think if you clarify in the document that this is an example of a definition, might be the – I mean I'm of the opinion that there's too many definitions already. But I think if you state that this is one example of what HRSA believes as you recall from the paper we wrote there's – I mean HHS has six different definitions, at least they did a few years ago.

And then, with regard to technology, not far in a future, at least on a NASA side where you're going to have A.I. in the one of the focal points that delivering healthcare, so that need a synchronous or asynchronous.

So I think if you try to pigeon hole some kind of technology, you know, we're actually going to be right back at this in a few years trying to do different definitions. So I think it's broad as it can be and as inclusive is probably the best way to go.

Judd Hollander: OK. So I think we're uniform on that approach. Jason, do you think that's efficient feedback for NQF staff that are make revisions?

Jason Goldwater: Yes. We got it, thank you.

Judd Hollander: OK. So I'll turn it over to Marcia for Theme Two.

Marcia Ward: OK. Theme two is Emphasis on Rural versus Urban Settings. And I'll read this also a few commentators noted the differences between rural and urban settings should be taken into account. They raised the following issues, number one, availability of specialty and subspecialty services in rural or frontier communications. Number two, high travel cost facing rural or frontier patients; number three, rural with broadband infrastructure; and number four, special considerations for first nations.

And I'm going to show several bullet points. The first one is the nature of telehealth practice can be different than that in urban areas as rural generalist providers could use telehealth to connect with specialists to whom urban providers would make a non-telehealth referral.

Bullet two is, many rural frontier patients face longer distances to health services than urban residents. The result is a higher travel cost, which is part of rural surcharge and most healthcare use.

Bullet three is, many rural frontier communities have limited broadband capacities which inversely affect the cost of broadband. The lower volumes of services also amplify the high cost broadband services.

Bullet four, is many Native Americans are served by the Indian Health Service through direct provision of services by IHS facilities and personnel, and through contracted, non-IHS providers. There are unique problems and challenges with these arrangements such, as securing reimbursement with services, measures and standards may need to be different than in other environments.

And then another commenter noted the need for appropriate standards for rural/frontier health, which may be different than those for urban settings. And the final comment was, conversely commenters noted that rural and urban settings share many similarities, such as the value of connected health and challenges and such as functionality and financially with commuting.

So as I look through our – the document on page four, right after the second paragraph of the introduction, the first paragraph having to do with what we just discussed with definition. There is one paragraph that specifically talks about challenges in rural and that's paragraph two on page four. And then, the top paragraph on page five also discusses a little bit rurality challenges.

And I guess in I'm reading into this, a suggestion I would throw out is I think number of these comments make some good specific points. And we could maybe just elaborate a little more with some of these examples in paragraph two, and that would address number of these comments. So that's my suggestion. But I want to hear from the other folks.

Charles Doarn: So how – this is Chuck. How does this theme compare urban versus rural, when you have a large cities that have rural areas embedded in them? For instance, New York City by the Brooklyn Bridge, very difficult to get access

to healthcare at a major hospital because of the traffic, because of the location. So almost be consider rural not in a sense of, you know, in the middle of Kansas or in the middle of Alaska, but I don't see how this addresses that. Does that make any sense?

You have ions of people in large cities that don't have bandwidth – they don't have access either because people are too afraid to go up in – like in the Washington D.C. People are afraid to go up above Capitol Hill because of the dangers of crime when they come out of their house in the evening. So they have limited access.

Marcia Ward: This is Marcia again, I think some of the discussion that we had when we were meeting face-to-face is I think that this emphasis on rural, is maybe the historic and a huge driver for the development of telehealth, but now we're beginning to see applications in urban areas and expansion into urban areas.

And as you mentioned, Chuck, specific needs in urban areas, and so maybe adding a sentence reflecting that development would be appropriate.

Charles Doarn: I think that will be a good idea.

Adam Darkins: Adam Darkins. This is something where it's one of little bees in my bonnet. I think this reflects the immaturity and how small scale most telehealth remains. So if the vision of what we're doing is to try and grow this. My personal opinion is this, that it's about how you develop large networks.

It happens to be that the resources that you're going to need in rural areas, most of them exist in urban areas. The fact is that specially concentrated in urban areas. So if you look at somewhere like Norway, Norway is providing services out to rural communities. But they do from large urban settings, it logically make sense.

The network is both urban and rural. The extent to which it – it is either depends on the health needs. And it depends upon the size of the network. So I think personally, to get too caught up in this thing of is it rural, is it urban, is kind of short term, it's about the immaturity of what it is and long term, it didn't go make a difference. That's my personal opinion for its worth.

Judd Hollander: So I want to support that opinion because, you know, I could go into more detail on published paper. But I question the relevance of these comments for this report because we're developing a measure framework and although we give some background on pages four and five, the goal of the report is not to summarize how things exist in the rural areas or the Indian Health Service nor is it actually right measures that are specific for rural areas, urban areas or the Indian Health Service, it's to provide a framework so that other people can write the measures that they'd be most appropriate with then be reviewed.

So although many of the comments, in fact all of the comments are probably true, I don't know that they're directly relevant to what the purpose of our report is, which is to write a measure of framework. So I am perfectly fine with amending those two paragraphs to be more broad, which is I think in line with what Adam is saying.

I just – this is like a background paragraph or two, and the people who would submit measures to National Quality Forum would pluck out the measures they think are most relevant and then the committee reviewing them would decide that they meet the criteria to be a measure or not.

And I don't know that any four of these things is directly relevant to developing a measure framework except that maybe we want to say and maybe we don't that depending on the community – if we're going to do measures that are only relevant for a specific community, they may be different than measures in another community. But in my time on NQF, I don't believe I saw a measure that said treat heart disease like this if you're here and treat heart disease like that if you're there.

So I'm content with leaving the report as it is.

Paul Giboney: This is Paul Giboney. I agree with everything Judd just said.

Sarah Sossong: This is Sarah Sossong, agreed.

(Crosstalk)

Female: I agree with that.

Marcia Ward: OK. This is Marcia. Do you want to – if we leave it the way it is, do you want to add a sentence though that emphasizes that it's expanding more into urban areas?

Male: Yes.

Paul Giboney: Absolutely.

Female: Yes.

Female: Could it be something you feel like across geographies? I think the comment about suburban as well as urban was it's already in there, but I think it's a good point.

Marcia Ward: OK. So what I was hearing was leave it the way it is, but add something that emphasizes the applications outside of rural frontier.

Jason Goldwater: Right. OK. That sounds good. We got it.

Marcia Ward: OK. Back to an odd number, Judd.

Judd Hollander: All right. So we are now on theme three, Alterations and Additions to Domains and Subdomains. And this is I think because we spent very little time debating what these things would be. So, I'm just joking there obviously.

So, I think everybody on the committee knows, but before I read the comment, obviously our major domain were access to care, financial impact and cost, experience and effectiveness. And each of them had three to four subdomains that largely for each one were related to patient, family and caregiver, the care team, the health system payer and society. You know, that's not exactly true for all of them but generally along that framework.

So the comment here is that one comment is – one commenter suggested adding communication effectiveness and quality of communication. So our

effectiveness domains are system, clinical, operational and technical effectiveness.

Another commenter recommended further refining the financial impact/cost domain to differentiate between charges and costs. I think in that one, we're pretty specific that it's cost, its financial impact and cost, so whether or not we want to have charges would be something different.

And another commenter suggested a number of modifications and recommendations on the following domains under effectiveness, subdomain, system effectiveness and measurement concept timeliness and the amount of time it takes to connect with provider for an urgent emergent consult. So the question is whether or not we think our effectiveness domains system, clinical, operational and technical already set in the framework for that.

Under the financial impact and/or effectiveness subdomains, the recommendation is financial impact to healthcare and/or operational effectiveness and measurement concept travel, add, measure for quantifying telehealth staffing efficiencies.

Under domain access subdomain, access to information and measure concept actionable information change what is data access and telehealth for those who treat the patients to reflect access to specific data such as visual, auditory and other information required for a guy who knows this.

Under the domain effectiveness and subdomain clinical effectiveness and measurement concept actionable information and whether telehealth offers the same quality of services across the population of similar patients, i.e., all settings and conditions.

And other commenter suggested that the addition and integrity of usability within the three subdomains of effectiveness, efficiency and satisfaction. And a final comment that requested clarification with regards to accessibility noting that the report alludes to the concept of necessity which is not consistent with the standard definitions of accessibility.

So I know that's mouthful both for me to read and for you to hear, but I guess the question is, is that one of those recommendations that is important enough for us to include that does not already fit with any of the domains and subdomains that we had there.

And you will recall that we went through – I think it's in the bottom, page seven, top of page eight, as you're scrolling. As you recall, we went through a whole bunch of measures and potential measurement concepts and we're able to plug everything we thought of in the meeting into actually more than one of the domains and subdomains.

So have we found anything from these comments that we would have missed?

Charles Doarn: Judd, on the very first one about the amount of time it takes to connect with the provider for urgent/emergent consult, I'm troubled by companies like Verizon and – so that's what I have, and other carriers for telecommunications and cellphones or mobile networks where you're driving by a fire station in a very – a large city which is supposed to have lots of bandwidth and the phone, you know, goes out.

So I'm thinking that one of – and the further away from a city, you go to a middle of nowhere, sometimes you don't get connectivity at all. And if we are going to promulgate telehealth across the United States by using communication networks, they have to be reliable and cost effective and all that stuff. But it seems to me, not only the amount of time, but if I connect to a patient and I may able to have an interaction, I don't the call to be dropped, you know?

And that becomes – then if they reconnect it and it drops again, both the clinician and the patient become very frustrated and it's like, well, this isn't going to work. So I don't know because I don't have – I have this memo in front of me and I don't have anything else. I don't – I know we talked a little bit about but I don't recall if that’s actually enumerated in some way in the document.

Judd Hollander: So, let me just respond to places where I think that might be covered and you will now just have to tell me about if I got this right.

So, under effectiveness, we have system effectiveness, we have operational effectiveness and we have technical effectiveness. So, I can imagine that those issues could fit in to anyone of those three. And under experience, we have the patient family and caregiver experience act in the care team experience. And one can imagine in my mind that those hiccups and problems could be codified there.

And again coming back to what we all know, our job is to make sure the domains and subdomains can capture these things but not to determine the specifics of what measures someone else might submit. So, it's entirely possible, someone will submit a very specific measure addressing the comments that you made. And I guess the question I ask is, have we given a framework whereby they can submit that measure and still be compliant with the framework?

Marcia Ward: This is Marcia. I feel like we've covered all these suggestions. As you said, you know, we can't cover actually everything in all the detail. I feel live we've covered all these concepts.

Charles Doarn: (Thanks).

Judd Hollander: Is there anybody on the committee who feels differently? Does anybody on the committee feel like maybe we could take some of these things here and maybe modify or sent into two of the text under the domain, can make it clear that the domains and subdomains we pick account for these issues.

Angela Walker: Would giving some more examples potentially help with that?

Marcia Ward: Yes. I think it rather – it just, you know, just a little bit of editing of the text.

Judd Hollander: I would be happy to make the recommendation to NQF that either they tweak the text or I have an example to whatever they think will account for the majority of these comments and make it clear that they do pick within the domains and subdomains.

I'm reasonably sure that people that haven't seen this document and didn't spend, you know, four days in rooms debating it. We'll take a little while to see how, you know, their particular need fits within the document. But, I'm also reasonably comfortable that we really haven't found something that we don't think fits within this yet.

Jason Goldwater: Judd, this is Jason. So, I think we can go back and modify the text slightly, to ensure that this has been covered. And I think that, that posts the most difficulty and to address Angela's comment if we – as we're going through, we take an example, we'll illustrate that more clearly then we can go ahead and do that, or we just have to make sure it's consistent enough text.

Judd Hollander: OK. That sounds like a great plan. I'll turn it back to Marcia for Theme Four.

Marcia Ward: OK. Theme Four is Alterations and/or Additions to Measure Concepts. And there were set of bullet points here. And I went through this bullet points in crosswalk them. I think we used – addressed a number of this, maybe there's a couple in here that we could add a little bit of information too.

So, the first bullet is decreased length of stay in hospitals. And actually, what I was looking at in the text of the report is we talked about the four domains, so describe the domains and the subdomains. And then, the report goes to a section on page 10 called prioritizing the measure concepts.

And then, it talks about six different measure concepts, which include travel, timeliness of care, actionable information, added value of telehealth to provide or evidence-based best practices, patient empowerment and care coordination. And that's where I found a lot of the information.

The first bullet is …

Jason Goldwater: What's wrong? Hello?

Marcia Ward: My audio is back.

Jason Goldwater: OK.

Henry DePhillips: Thank you, Jason. I want to make sure it wasn't me.

Jason Goldwater: It wasn't you, Henry.

Henry DePhillips: I was going to tell you that me at first bullet.

Jason Goldwater: All right.

Judd Hollander: And do we have Marcia back? All right. We were warned this might happen, and she's at a library of a rural area, illustrating the points of the last comments where …

Charles Doarn: I was proven, right.

Judd Hollander: OK. So, anyway, you know …

Marcia Ward: This is Marcia, so sorry about that.

Judd Hollander: All yours again.

Marcia Ward: I don't know where you were, keep going.

Judd Hollander: We just kept saying Marcia, Marcia, where is Marcia. And now we found you.

Marcia Ward: OK, all right. So, everybody, I'm in the mountains of Idaho and my call got drop, so I'll try this again.

So, the first bullet was decreased length of stay in the hospital and on page 14, I saw that listed. The next bullet was, the ability of telehealth for the same quality of services across the population of similar patients. I also saw this on page 14. Next one was if travel eliminated for a specific patient encounter because of telehealth services.

And on page 12, in the box, there measure concepts, and the two that were listed there same pretty similar to me, maybe too similar, and I thought maybe we could actually substitute this one, these are sort examples of the measure concept of travel. And I thought we could put this one into addresses person's comments.

The next bullet is readmissions or preventable readmissions and also on page 14, in a box, it talks about adverse events. And I thought we could specifically add this particular, there's measure concepts, the first one is decrease length of stay which is another one in the bullets. I thought we could add a bullet which was decrease, preventable readmissions. And actually an added on, the next bullets needs to get reworded, the wordiness incorrect on it.

The next comment was, the ability to engage in meaningful activities including those to promote health and/or prevent illness or injury such as activities of daily living, self-management of patient – I'm sorry self management of health.

And we have a whole measure concept which has to do with patient empowerment and I thought this was certainly included in here but maybe, you know, a slight edit could emphasize this point or add this point as an example.

The next bullet is usability and that's the one that – I'm not sure where we've addressed it. And so, hold that in your mind usability. The next one is time to receipt of a consult via telehealth compared to in-person. And again on page 12, I think this is addressed, the next bullet is quality of the information was sufficient to make an accurate diagnosis and appropriate treatment plan. I thought this was addressed on page 14.

Another commenter suggested the clarification of language and intent of the following measure concepts and its components. And the first bullet, that is rephrase the measure concept, patient demonstrated increased confidence in care plan to patients confidence to enact care plan. And, you know, some of these are just specific wording. This was on page 15 in a box and we could make that change.

The next specific suggestion was the measure concept of connectivity, is clear and timely, could be changed, there implies an audio visual component and I guess that's true. I don't know if we need to say anything about that or do anything about to correct that. As somebody thinks that they're making a

point there, that commenter and we need to expand something but hold that thought in your mind.

The next bullet is clarified what is meant by duration of the visit. And I wasn't sure what that referred to so hold that one. The next bullet is the concept of the instructions for care were clear to the patient seems to be redundant to the concept of the patient demonstrated increase understanding of care. And this is in box on page 17, and those did sound redundant to me and I thought we could do just a little a bit of editing there.

And the last bullet, specific suggestion was recommended measuring patient satisfaction relative to usual care. And we talked about that in page 15, again under patient empowerment. And we talked about this a lot in our meetings and webinars but we're not recommending patient satisfaction specifically as a domain but we've got the patient experience and this is certainly subsumed under that. So I don't know if there's anything there that we need to get called out.

So, the rest that's in the memo, said the commenter noted, that the measure concepts are not unique to telehealth, and encourage the committee to identify the highest priority areas for measurement. Another commenter noted that the need to differentiate between the possible uses of the proposed measure concepts, there's concern that measures will be developed but should not be use in accountability programs.

And then another commenter noted their concern of the sheer number of perimeters outlined, and how prioritization was necessary. The commenter elaborated further stating the report does not differentiate between possible uses of the proposed parameters. There might be a move to developed measures for some of the concepts that really should not be used in accountability programs. The commenter also added how their report discusses the potential to decrease readmissions the result of leveraging telehealth, that fails to include readmissions in any of the measure concepts. And that was one of those points where I thought we could throw it in as one of the examples.

So, for any of you out there, especially that that concede this or have this open, any suggestion or how we address these comments?

(Crosstalk)

Marcia Ward: Go ahead.

(Charles Doarn): No, I said it all looks good to me.

Marcia Ward: OK. There's the one about usability and it was the only specific one that I didn't know whether that was important to address or in fact whether we had addressed it, I didn't cross walk completely.

(Crosstalk)

Male: What is usability?

Judd Hollander: So my recollection and someone could correct me if I'm wrong, that the measure concepts are not the same as the domains and subdomains obviously. And they are just examples of types of things that could be measured. So, I don't believe it was our intent to pick everything in the world that might be measured. I do believed it was our intent to give some examples, so people could understand, you know, what our relevant measure concepts with telehealth.

I think your approach, Marcia, as you went through and highlighted some of the tweaks or changes seems to make sense to me, it does seem like we fit specifically highlight things like readmission. It also does seem to me to make sense that we don't really highlight things that directly associate with patient satisfactions into with downplaying that.

So I think I like your recommendation and some clarifications within the text where these things might have been unclear to one or more of the commenters. But I don't know that we need to, you know, add a ton of things.

Daniel Spiegel: Judd, this is Daniel. I agree – I think usability is actually called out in the experience domain, although it doesn't show up as a separate measure concept. Like if the question is does it, does it rise to a level of providing an

example of the measure concept that fits usability, is or is that covered sufficiently in the discussion of the domains.

Judd Hollander: You know, I think the one interesting thing, is we give examples of things that worked, and met the measurements. We don't actually give examples of things that went wrong and didn't beat the measurements. So it might actually be worth taking one example of something that would fail at one of the important domains.

We could still discuss them in terms of measure concept that it was addressing. But, you know, it might be nice when your phone call connects and reconnects six times or your video visit does to highlight that that would fell on some components depending on what the measure is. It might actually be despite the fact that it might fell at, you know, technical effectiveness. It might actually meet the criteria of providing an acceptable, actionable information by the patient to go to the next step.

So, maybe an example where there is an essence some conflict between success on some subdomains and failures on other subdomains might actually be relevant because that would be a different type of example.

Angela Walker: Was the context of the usability comments, the usability of telehealth or the usability of the framework?

Jason Goldwater: The usability of telehealth.

Angela Walker: Thanks.

Paul Giboney: This is Paul. The second bullet under the theme, the ability of telehealth to offer the same quality of services across the population of similar patient, it kind of goes through one of the, I don't know, I think one of the fundamental flaws in the way some people think about telehealth is that the goal is somehow demonstrate equivalency to in-person care as if the in-person care is flawless and is the gold standard.

I would argue that in many scenarios, telehealth doesn't just offer the same quality of services. It actually offers better and improved quality services

because of speed access to expertise or information. The ability to better coordinate care, the ability to better personalize care to the needs of a particular patient, the ability to avoid either costly or difficult transportation for patients that are in poor health.

I mean, there's a million examples in my mind of how, you know, the goal here is not just to say, yes, telehealth is equivalent to in-person care. But I think in many scenarios, it's actually better care.

And so, I just want to make sure that we avoid language in this document that somehow assumed that we've got care perfect now and all we have to do is demonstrate the telehealth that's somehow equivalent to our perfect in-person care that we all offer. I hope you can hear the sarcasm in my voice.

Judd Hollander: Sarcasm heard.

Marcia Ward: Yes. This is Marcia. I'm looking at the report on page 10 which opens – before that section on page 10, there is a whole thing that describes the domains and then they're heading for – which starts on page 10 that goes into these 10 measure – I'm sorry, six measure concepts, so it's prioritizing the measure concepts.

And I wonder if just changing that heading a little bit. We did go through a methodology and they turned out to be the measure concepts that we thought were most important too. Then, I've read through this, I don't know, possibly that gives it a different sort of meaning to them and maybe helpful to talk about examples of concepts that fit within domains or something like, across domains, something that helps the reader to get the right mindset as they are starting to read this section.

Judd Hollander: Can we change where it says, "the highest priority" to just having high priority?

Marcia Ward: Yes.

Jason Goldwater: Yes, we can do that.

Marcia Ward: So …

Jason Goldwater: We should have a list examples of measure concepts that were not included just a few examples to sort of – that they were thinking about these things but they weren't included because it's not an exhaustive list.

Marcia Ward: OK. Any other comments on this section? So it sounds like a little bit of editing. We're trying into more suggestions.

Eve-Lynn Nelson: I wanted to comment on the bullet point four, impacts of telehealth on workforce shortage. So I think that encompass in the access and availability component, but in our group discussions, we've talked quite a bit about (ECHO) and telementoring in some of those telehealth examples.

I want to suggest that might be a good other case study to include because most of the case study we have are very, you know, clinician to patient focus. And just because the group did talk about those other uses of telehealth, I think that kind of example might help address that question around work force.

Marcia Ward: OK. And as we get to Theme Number Six, you want to hold that thought, because there are some suggestions but adding some more case examples and that's a good example of one that we could consider adding.

Eve-Lynn Nelson: Thank you.

Marcia Ward: Anybody else? OK. So Jason and team, I'm hearing some edits, are you OK with what we suggested?

Jason Goldwater: Yes. We've got it. Thank you so much, Marcia.

Marcia Ward: OK. So Judd, Theme Five.

Judd Hollander: All right, Theme Five is Alterations and/or Additions to the Existing Measures List. Some commenters requested additional clarification on how the existing measure set should incorporate telehealth and/or remote monitoring.

It's unclear how the framework outlined in the report would be applied to pre-existing measures. It's unclear on how measuring use of telehealth and/or remote monitoring would be incorporated and distinguished from face-to-face delivery. And consider clarifying the intent of initial measures selected as many are not specified enough to capture telehealth.

Another commenter suggested adding two specific measures, full risk assessment and depression screening and follow-up plan. A number of commenters expressed addition of specialty-specific measures such as Pediatric Primary Care, Internal Medicine Primary Care. A commenter recommended adding sets of measures that are appropriate for rural and urban providers. A commenter recommended that services provided in-person or virtually should be subject to the same quality measures, utilize existing quality measures for virtual services.

One commenter urged NQF to expand the current initial measures lists to include all NQF-endorsed measures. Another commenter expressed concern that the existing and proposed telehealth measures are entirely based off of electronic health record data elements and/or claims data, as opposed to utilizing data that's collected at the time of the encounter. The commenter also provided a clinical scenario to describe their concern.

So, the questions for the mid-committee is, I guess, I'm going to break down into two large ones. The first one is, do we need to specify how the – how tele – this measure framework will be apply to pre-existing measures, which seems to be an important concern. And the other is, do we want to add to one measure list in any other ways recommended. I open the floor for discussion.

Marcia Ward: Yes. This is Marcia. And I actually saw – I've got the report in front of me and we've gone through the domains. We go to the measure concepts. And then the report goes into the case studies. And I'm not sure, again, I have a – look closely enough to see where we pull up or refer to the different appendixes. And so this list of measures is actually in an appendix.

And so, Jason and team, if we've clearly stated that, I just didn't see it, that if we didn't clearly state it to be able to, again, the naive reader let them know

and frame what those appendixes are. It must be in here, some place, I just didn't – I don't know where it is.

Jason Goldwater: OK. Yes. We'll look. I think we did delineate it, but I will double check.

Judd Hollander: And then, do we specifically address and I know we spent a lot of time to saving this. And I don't know that there was a purview of the committee to tell, you know, my recollection is, you can't go back and just add telehealth to preexisting measures, then would need to – the next time they go through the, you know, the measure review process have that added. But maybe it does make sense to have a paragraph about, you know, how would you proposing new telehealth measures? This would be framework. I'm sure that's in there somewhere.

But this is what we hope will happen with measures that a preexisting, is the next time they come up with review, people will look to see whether telehealth should – is appropriate or not appropriate to include in there. And whether or not, the same measure should hold for the same type of disease or the same, you know, criteria, whether it would be telehealth or whether – and this we did discuss a bunch, whether it's the outcome of the measure is just doing a visit with the next number of days where the telehealth or remote monitoring was storing forward information can count as "visit".

But I don't think …

Marcia Ward: Yes.

Judd Hollander: … yes, to just say, hey, we're going to go back and add this on to all those measures. But we would hope the measure developer as this they come forward for re-approval would look this over.

Helen Burstin: Yes. Judd, this is Helen Burstin. I think that's – those are really good points that I think we can consider as part of our process. As I've mentioned, some of these are already come up, for example, around remote blood pressure monitoring, et cetera. So, I think it's a really important point that makes the support much more actionable. So, thank you for that.

Judd Hollander: Other thoughts or comments on ways to address the issues raised by the commenters in Theme Five?

Jason Goldwater: Yes. Judd, I think it's – I think your point is really well-taken. And I agree with you. We should have some paragraph for commentary in there about the intent of this framework and how we hope it will be used with existing measures.

Judd Hollander: And maybe we just add a comment that says those initial measures in Appendix D are not meant to be all inclusive.

Any other thoughts from anybody on Theme Five or shall we turn it over to Marcia for Theme Six? All yours, Marcia.

Marcia Ward: OK. So the use cases, we had described three use cases and what the commenter said was just mostly suggestions for the possibility of other use cases. Although this – a first comment, commentator slammed on our first use case not being up to date. And so the commenter suggested that we revise the heart failure case study to reflect today's approach to heart failure remote monitoring.

The commenter stated that the case study in its current form describes very old technology with an approach that would have been deployed 20 years ago. The commenter also suggested to distinguish – how telehealth is used as a tool to deliver care based on the classification as a Medicare program instead of how it would be classified for private payers.

So, why don't we address that one first, clinicians on the field? Does anybody think that we need to change this and, Judd, I'm really going to rely on you as an expert.

Judd Hollander: Well, I sent the case in, so if I screwed something up, I'm probably not the best one to revise it.

Charles Doarn: No. I was thinking, as a non-clinician, it would seem to me that maybe there needs to be two different cases. One for private payer, one for Medicare, does it resolve that. Part of the question.

But I'm often am troubled by these comments that we are using old technology and being in the technology business as it were at least with future of human exploration of space, we look at all kinds of really cool tools, same in the military.

Some of those aren't necessary ready for prime time. But I think about the iPhone 7 to the iPhone 8 or the Samsung 7 to the Samsung 8. Within 6 to 12 months, these things change.

So, if you put a case in here, these measures are going to be use for the next five, six years, however long they're left before they're renewed. The technology itself is going to change rapidly. So, I don't know, this one example and if Judd put the case in there, I mean, obviously, he does this stuff. I mean, you know, Judd, you know how to do these things, this person who's commenting using a different technology. I don't know how you address that with – because technology is changing so fast.

Judd Hollander: Yes. And, you know, I'm looking at the case now. And it does mention the Bluetooth-enabled scale. It doesn't mention any specific technology and 99 percent of the world is not capable of doing what's even in this case.

So I think I would suggest that to the commenter who probably is very experienced of doing telehealth in heart failure. Maybe there's something more that that person does, but to the average person taking care of heart failure patients, they don't go anywhere near the amount of telemedicine in this case.

So I'm actually comfortable with leaving as it is. It is used there as an illustrative example to show what the framework domains, subdomains and measure concepts related to it are. At no point does it say, this is the ideal thing which driving to get to in the next 5 to 10 years.

Jason Goldwater: Judd, this is Jason. So I was just going to clarify that that was the point of the use cases. We're not to showcase the capabilities of telehealth, but rather how the framework would apply to telehealth situation.

Marcia Ward: OK. So, yes, I'm reading to the case and it talks about a mobile health application and on demand doctor schedule and then as Judd said the Bluetooth. I feel like it's hitting on some appropriate examples.

Jason Goldwater: We could – I mean, you could replace the morning visit with other remote monitoring capabilities if you want to make it a little more techie.

Marcia Ward: Yes. So that addresses the next commenters suggestion which was, that we explore remote monitoring capabilities and services, and how they may affect measures. They also followed up with the distinction between synchronous communication and asynchronous data capture and communications, and how the distinctions key in the formulation of existing and future measures. And the commenter suggests to add a fourth use case discussing population management of a diabetic population, using telehealth and remote monitoring technologies.

And then another commenter noted the difficulty of interpreting case studies due to this focus on the individual patient. The commenters suggested a focus on measuring the impact and effectiveness of telehealth at the population level.

And so, these are suggestions, you know, we could add a case. I was thinking of Angela and a (Durham) case having to do with asynchronous communication. We could add something that's specifically with the case related to remote monitoring. We could add a case, you know, that talks about population health, use of registry, so things like that.

And so, I think there was some examples here that we could expand it if we wanted to, and even we mentioned bringing in work force in particular could be a – possibility for a case.

Angela Walker: I'll add in the ...

(Off-Mic)

Marcia Ward: Or we can leave it the way it is.

Adam Darkins: Just one comment from the case study. It doesn't actually show anything to do with effectiveness. I mean, essentially it is an anecdote. The anecdote doesn't really put together systems exist. It basically says look, here is a way you could do it. Here are some things you can put together. It outlines the process to this – the care process for an individual. There's no sense at the end whether it's better or worse or indifferent compared to how it might have been if they've just gone along to emergency room.

So I mean, I don't – I mean, I think it's illustrative to somebody doesn't understand what this thing is. It give some kind of sense like, saying – somebody said, I don't know what snow is. You know, when they come form the dessert. But I don't really think it outlines in a really definitive way that says, this thing has real effectiveness. And gives you a sense about what it is.

Jason Goldwater: I guess, I'm not sure that was the intent of the examples, Adam. I kind of read them as scenarios upon which you apply the framework and potential measures.

Adam Darkins: Yes. So I think as such, so I was saying what they relate too, by saying it's out of date and other things. I think there are no more than just illustrative for somebody who doesn't really know the field perhaps, somebody who knew the field particularly. You might get a little more sophisticated. So it seems they're OK for what they are and two years from now, things may be done slightly differently. So they're just the kind of, you know, a (pointer).

Jason Goldwater: Yes. I guess I still find them helpful from a clinician perspective to think about what is the scenario and under what kind of situation would the – would new measures apply or what existing measures apply. But I agree they're just examples.

Adam Darkins: They don't give you a sense in anyway about appropriateness. So it's just says "Look, here is something you could to do. Instead of going to see a physician you might have a video visit, you wait a day for it". You know, you could end up using an app in the middle of the night, send something, et cetera. It's just kind of trying to outlined something.

But I think the thing which isn't there and neither, you know, perhaps should it be is anything that relates to appropriateness.

Marcia Ward: Yes. This is Marcia, getting back again. These are supposed to illustrate proposed measure concepts. And so again, in the report, it gives a paragraph about this particular situation with the patient and provider. And then it talks about the framework domains and the subdomains and the measure concepts that this might, you know, cross walk on to.

And so I feel like the purposes is met with these as examples of, you know, flushing out, giving a little bit of context as we talked about some of these rather abstract, you know, domains, and walks through how they might be applied or which ones might be applied.

Judd Hollander: Yes. So for people who don't have this open, let me read sort of the preamble before the case studies. One of the point that the committee wanted to emphasize within the framework, where is the usefulness of case studies to help provide context for the proposed measure concept. And demonstrate how to turn this into measures in the future.

In this manner the patient generally using telehealth incorporates the ability to discern whether the use of telehealth services differs markedly from that of an in-person-patient encounter. The committee put forth the following case studies to illustrate the use of telehealth for both provided to patient interactions as well as the provider to provider interactions.

So we are only putting them forth to talk about two types of interactions in an illustrative manner and not to cover everything, you know, and every type of attribution that may exist. I do think that if we had one that look at how to do it at the population level, well, that might be OK. And I do like, that some of these are hybrid using in-person visit and telehealth visits, because I think that's the real world. There aren't really patients who are all the time, going to be seen by solely telehealth for the most part, because most the state regulations won't allow reimbursement for that to showing how things work back and forth, I personally prefer.

But I think the preamble makes it clear there are about just context for proposed measure concepts that they are not meant to develop measures or show you how to analyze the measure afterwards.

Marcia Ward: I agree. So with what Judd just said, are people feeling like we would be well-served to add another case or we got one on managing mild to moderate heart failure symptoms. We felt one resuscitation and transfer. We've got one in knee surgery and related health encounters.

So they're not – as Judd said, not covering every thing that preamble says, it's between the patient and provider. If people, you know, people fee like we need to add another one, please speak up.

Male: I like the idea of providing one that focuses on that system or for measuring population health, although I can't think of one off the top of my head.

Marcia Ward: OK. And I could specifically get that work force issues. It could include something, you know, population health. We could develop something like that. How do others feel?

Charles Doarn: So the objective to have these cases illustrate to the users of these measures. And half a dozen different kinds of approaches, to help them understand how it fits their particular situation, I mean, it's basically, kind of like an example of how you could apply in this case or in this case or in that case, is that basically the fundamental reason for the cases.

Jason Goldwater: Chuck, this is Jason, yes. It's design to, again, illustrate how the framework can be used in particular situation.

Charles Doarn: And so the total document is, how many cases in it then?

Jason Goldwater: Just three.

Marcia Ward: Three.

Charles Doarn: So are those three cases similar to the kinds of things you might see and rural versus urban, a major medical center versus a small hospital in a big town. I mean, you could probably have, you know, 20 different cases and the price

still wouldn't address everything, but out of the three cases we have sufficient enough for the average user to understand how you apply these or would two or three or four or five more cases be more illustrative or would it be overkill?

Adam Darkins: Can I make your suggestion about a population health one? I don't know whether it would be.

So – and again, I mean, I think they're good. I think they point things out, they're helpful for the notion they kind of framework. I'm not sure that if I was a busy manager or I was a CEO that they would – I think oh yes, that sounds good. But it doesn't really strike anything.

So if you had something, it was more around, you know, a hospital, small rural hospital that was having length of stay that were longer, wasn't beating performance targets, was having troubles with block beds and wasn't being able to bring in some routine cases.

And one of the things identified was heart failure, so they introduced the program around the management of heart failure. Specifically about how you could monitor people with heart failure and their population with heart failure that were coming in on a regular basis in terms of instituting that program. What they were therefore able to do was to institute care, more proactively coordinate the care, deal with the (buyer) psychosocial problems and it meant that – they had the reduction in hospital admissions.

And I think from the literature, you could probably get that. You would get the idea that this is not around, anecdotally, how the one person might benefit which again is really good. You might give a sense of the systems approach and how somebody might pull it together and where that might be, you know, it kind of feeds into the being a business case. Does that make sense?

Male: Yes. Definitely, I agree.

Marcia Ward: Yes. Adam, I like the suggestion, this is Marcia. And I think actually we could just to add a couple of sentences to the first case on heart failure and set it up as, you know, part of a registry, it does talk about, you know, all these points of care and I think we could bring in …

Adam Darkins: I don't think you can do it in a couple of sentences. I think that these are heavily weighted into the technology. You have to sort of inform people about technology but it's not about how in the middle of the night you look at an app.

It's really much more on how the systematic you do something and relates more to the outcomes. So I think certainly you can, but I think if you want to get the spirits of it, you have to do something which is more on the population health rather than just say, well, we've done this case study, and here's two sentence, this is one person, you can multiply this up 50 times and make a business case to do it in the clinic.

I maybe hearing you wrongly, but I think if you want to do something, it needs perhaps more formal – more, formal, you know, an additional case study or reworking it.

Marcia Ward: OK.

Jason Goldwater: Hi, this is Jason. So, I think we can certainly develop a use case sort of based on Adam's parameters. There's enough in the literature that we have on file that would support that.

Adam Darkins: I saw these on the papers you wrote from the V.A. I mean, pretty clearly, you can see reduction heart failure admissions and it made sense, it predicated to be able to grow program. So I think what it help, is it helps that, you know, some of you might be the CEO – particularly the CFO. If they read it or, you know, to be ammunition for somebody say, hey, maybe we could do this, that you know this is where we are headed. Thanks, Jason.

Eve-Lynn Nelson: I think with the heart failure example, you could perhaps add a behavioral indicator which is depression or quality of life if you're looking at kind of the broader use of telehealth around the chronic illness population.

Marcia Ward: OK.

(Crosstalk)

Female: A colleague in dermatology. Sorry.

Male: I was …

Marcia Ward: A colleague in – go ahead.

Adam Darkins: I was going to say that if you – I think one of the things depends on this, is an anecdote like that is just sort of saying well this is a hypothetical case. I think that if you're going to do it, you're going to do the population level, it might be good to do it from the literature. If you're going the literature and you've got depression in the literature then add it.

But otherwise, it comes across a little bit as being, well, it's like a kind of theoretical recipe for a cake where you could bake this, you could put this in whereas opposed to saying, well, look, this is the cake, this is how it was baked.

So, I mean, I think just to add things in because they sound like a good – again, I mean, in the literature if this be – if you can really quote, depression and heart failure how it was put in and featured then I would just recommend something more concrete.

Eve-Lynn Nelson: Well, I'll be glad to send the studies we did.

Adam Darkins: Yes.

Eve-Lynn Nelson: They're on in literature.

Female: A dermatology colleague had made a similar request in regards to what does this really look like for our discipline for our specialty. So, if you're going to expand any of these scenarios and indicate where it might also be used for another department or discipline, my request might be to look at a number of departments or disciplines with the clause that read, not exclusive to these but the way each these departments could envision how it would work for them, or how's it been publishing a literature to have work.

Marcia Ward: OK. I heard another voice at one point. Did anybody else have another comment?

Eve-Lynn Nelson: I just would continue to encourage an (ECHO) or telementoring type example. I think that could be helpful to try to have that set of folks also consider the importance of the measure framework. But this seems like sometimes that telementoring world – and they have a certain set of measures. And then telemedicine has a certain set of measures.

I just think it could be helpful to have greater adaption of the framework if we had an example that more looked at that kind of telementoring type approach especially with a hot topic like pain management or something like that.

Marcia Ward: OK. Jason, I heard you say that you folks at NQF are comfortable pulling together something in a case study that had to do with population and health, what about some of these other examples?

Jason Goldwater: I mean, I think within the population health or certainly with those some of the others we'll see. I think we can look on how we can incorporate work force as an issue. And we can certainly look and see what we can find on tele-education or telementoring.

I think the one thing and this was discussed also in the in-person meeting, the second one. We don't want to be overly top heavy with use cases, that they're again, they really just the service ways of using the framework. So that it doesn't seems so abstract which was what all of you were stating in the meeting that we don't provide some sort of example that illustrates how it could be use that will come off as being – really only useful of those who are involved and telehealth and will seem somewhat obstruct.

So certainly, we can do the population out one, we'll look at one potentially for telementoring and tele-education.

Judd Hollander: And I think that will be more than enough. I agree, we don't want to have too many of these then people will think that if you don't fit into one of these example that it doesn't work for you.

Adam Darkins: Sorry to be picky and (speak). Can I just mention about (ECHO)?

I mean, I think (ECHO) was a fabulous program. It's a very different animal from most of what we've been talking about. And so, I think if you want to do telementoring, where the patient isn't necessarily present. The quality measures become very different than they are if you're really thinking about the kind of modalities we've been talking about.

So I think that I – it just would beg at least pointing people in the direction back to the definitions of things of being a little, people could get kind of go down the path where they don't necessarily understand what we're talking about, where they've got to. So, if you going to put in (ECHO) as a specific thing, then that I think you need to sort of make the distinction further back around some of the differences between whether the patient is present or not present.

Judd Hollander: So could we include as part of the population telehealth one some telementoring and counseling sessions within that? And that way we could hit both things and only at one more case.

Jason Goldwater: Yes. So I think we could try.

Marcia Ward: Yes. And I think that would definitely hit the workforce issue.

Judd Hollander: So I think, Jason, we're through with the six themes. And I believe we now turn it back to you and your team. Well, I guess, the last question we have is does anybody feel compelled to discuss any one comment that they may have noticed on the Excel spreadsheet of all the comments that might not have been captured by the summary of the six themes.

And if no one has any of them, then I believe we turn it back to Jason and the NQF team for further comments and directions.

Jason Goldwater: Thank you all very, very much, so extremely helpful. At this point, we will open it up for public comment. Operator, can you open the line?

Operator: At this time, if you like to make a comment, please press star then the number one.

OK. We do have a question from John Chuo.

John Chuo: Hi. Thank you very much. John Chuo from Children's Hospital of Philadelphia. Two comments, if I may.

I think this is a great work and very exciting. I was hoping that perhaps one of the cases could involve a pediatric case. I think there's a lot of effort to use telemedicine in pediatrics. And so, it would be helpful if there was some pediatric content even as one of the cases or maybe for the transport cases, that second case maybe if there was a pediatric spin to it. That would be great.

Then my second comment is, and I may have missed this, as I was looking through the document, I did not see any major concept that's related to patient safety. And I was wondering if in the key areas of measurement, you have six areas. I was wondering if one of them or if there's a chance to even add a key area of measurement in the area of patient safety because I think it has a lot of unintended consequences that could potentially happen with it. And it'll be nice to be able to measure some of those and safety is one of them. Thank you very much.

Judd Hollander: So, John, this is Judd. I'll comment that we do believe we have patient safety very much included in this. And that would fall under clinical effectiveness. And so, again, you know, trying to collapse down categories, so that, you know, we could have something that's functional and not a long laundry list of everything. We've had discussion, you know, when we had the face-to-face meetings and we believe that access might be a patient safety issue, clinical effectiveness might be a patient safety issue.

And so, there is opportunity for people who want to proposed measures, you know, in fact using the terminology patient safety to fit within the domains and subdomains as they're highlighted here.

John Chuo: OK, got it, got it. So I guess I was looking – I guess I didn't particularly see that as standing out. So maybe some language in the document that points to that. I guess I'm – in table two for instance in the domain and subdomains of telehealth measurements framework, one of the categories of effectiveness – clinical effectiveness there. So that's good.

So it's good to – and maybe in the line, in domain four, effectiveness in the bullet point where you specifically explained clinical effectiveness, perhaps – maybe insert a patient safety language in there and maybe that would just do it.

Judd Hollander: OK. Thanks for that suggestion.

John Chuo: Yes, thank you.

Operator: And your next comment comes from the line of (Dina Plaskon).

(Dina Plaskon): Thank you. I will agree that this is a mammoth effort and greatly appreciate it and in many ways overdo. I just have a few comments based on the discussion actually. And the first and it relates to the definition of telehealth and the role of distance.

I've been involved in the field for very long time. And the actual original first definition was at a distance providing services at a distance not necessarily – and it's interesting and would evolve not necessarily the – basically the use of the term long – let me see how they use it, long distance. And in fact, the issue of urban versus rural was very, very much discussed from almost the beginning of the field of telehealth.

And the fact that it's – that a lot of the funding from HRSA went to rural had to do with how Congress provided the funding. And then when Medicare chose to limit the impact on the dollars, it did indeed, relate to limiting it to rural. But a lot of the discussion has gone on. And in some areas of asynchronous, for example, and teleradiology and other areas like that, there really hasn't been much of a distinction. And the only I would caution you is not to make it sound like people are just discovering the urban dimension.

It's not a new thing. I think it's something that has in a way that more explicitly evolve. So just be careful about how I worded that from the perspective of where history has been. And also if you look and edit the document a little bit, a lot of it does relate to geographic barriers. And I think it would be very easy, as I think Marcia pointed out, just sort of interject some, not only just one sentence but a little bit where essentially the overcoming the barriers to access to health services, which gets to page eight and the concept under access when it says access is the technology necessary for a telehealth consultation.

The concept is necessity is I think a tricky one, what does it mean to be necessary? Would you prefer maybe a term appropriate, because when you introduce a concept that necessity and access together, I think you open up a can of worms. And I think, in terms of case studies, you might want to consider actually emergency rooms. And the use of telehealth to support emergency rooms care at a distance, which there are quite a bit of literature on that. And that demonstrates both, I think in some ways, a mentoring function of helping local providers provide services, as well as essentially some history there with the services that I think would demonstrate a number of concepts.

With that, I'll just stop talking.

Judd Hollander: OK. Thank you for those comments. Does anybody on the committee have any thoughts they would like to share? Go ahead, Chuck.

Jason Goldwater: This is Chuck. I think what (Dina) was saying is absolutely correct. I mean, you know, for those of us who've been in this for a long, long time, we've seen a lot of things and I don't think there's anybody out there that hasn't seen everything. And (Dina) certainly has seen a lot. And so I think her comments are very important that and should be taken note off.

Judd Hollander: I will comment, (Dina), that the second case is actually an emergency department case, you may not have the document open in front of you. It's in the – and we weren't clear when we're talking about it. It is actually an emergency department case where somebody gets an essence in mentoring

thought that word is not use to begin aggressive resuscitation, and then is transferred.

And with respect to John's comment, I'd ask John to pull up the document and read it. It doesn't actually specify whether it's an adult or a child. And so, I would be curious that if we just insert a bill three year old presents with, you know, would that solve the pediatric thing and with the medicine then be appropriate for that case. So, it would be worth knowing that.

So, what we maybe accomplished too of the, you know, the public comment goals in basically making a very little tweak to case (number two).

(Dina Plaskon): You know, this is (Dina) again. On that second case study which is, you're right, that is at emergency room setting. I guess, I'm thinking about some of the ones that I've seen where basically what has happened is that the patient has been managed at the local hospital rather than being transferred and that – this is a demonstration of essentially transfer.

But I think one of the interesting studies that have been done and a lot of work is actually the ability to maintain a patient in a rural hospital. And one of the side effects of that which has been beneficial to the rural hospital is being able to maintain services that otherwise would not have been able to provide. And so, has led to the sustainability of services in rural areas because that hospital can now survive.

And I'm not sure, I didn't pick that up in any of the cases, and maybe again you were looking at how these measurements would work. But part of the measurement is effectiveness of services and the effectiveness of services maybe to keep people in the highest quality but lowest cost facility. And that's the system kind of issue that Adam was getting at, at some – at least at some point.

Judd Hollander: Right. No, I think that's good point and I believe it from the framework perspective should be captured exactly as you say and the system effectiveness.

(Dina Plaskon): So, I mean that's where I think I didn't get it from the cases, and so, again if you're looking at some systems kind of things, maybe that's it. And I wasn't clear when I was talking to that emergency room. So, I apologize.

Judd Hollander: Are there other public comments?

Operator: At this time, there are no public comments.

Jason Goldwater: OK. Thank you all very much. I guess May we'll turn it over for next steps and then I'll have some closing thoughts.

May Nacion: Hello, everyone. OK. Thank you so much for all the comments we received. And we will be revising the report based on these comments. So, our last web meeting will actually be on August 29th, from 1:00 to 3:00 p.m. And during that time, as Jason mentioned in the beginning, we'll discuss the changes we've made in the final report and the next steps to come up after that.

Jason Goldwater: OK, so a couple of notes. As May said, we'll go back and we'll make the adjustments to the final report. In addition to that, we will finalize our responses to all of the comments that we're received and that is going to be placed as an appendix in the final report, so people can refer to it as to what comments were made and what the responses were when they read the report after its release and afterwards.

A couple of final thoughts and final notes. So, we will be – the meeting on August 29th, again, is just relate to review the changes that we made here in the final comments from the public and then we will go forward the release of the report. And secondly, sort of I guess one of personal theme now but do you want to mention this. We are, of course, grateful to all of you and we can't thank you enough for all of the input that you provided into what I think is an outstanding report.

And that we'll do a lot of good for the telehealth community. I am about pleased and somewhat sad to announce that one of our team members, Irvin Singh, who has been with us for a while, is going to be leaving NQF as of next week. On a personal level, we're all very sad because we really like Irvin. He's been a great presence and clearly this framework would not be

where it is without him. But I'm happy to announce that he has been accepted into Dental School, which is why he's leaving.

So, on a professional level, we're very happy for him. He is moving back to Florida, which is kind of a bomber, because we're not going to see him unless we go to Florida, which none of us have any desire to do anytime soon. But we are very happy to Irvin, very happy for him. We wish him the very best and we do thank him for all these contributions. I will say we're all getting very self-conscious about our teeth now because he's going to Dental School. But I did want to all the committee is on the phone to acknowledge his contributions and thank him on behalf of all of us.

(Charles Doarn): There are a lot of research out there on teledentistry, so (he) got a head start.

Jason Goldwater: Really? You had to go there.

Irvin Singh: I'll read all the articles even going back ...

Jason Goldwater: 1975.

Irvin Singh: (1970) ...

(Crosstalk)

Jason Goldwater: That's right. We'll be sure to do that.

Male: (Inaudible) teeth, they were still wearing dentures.

Jason Goldwater: All right. Well, thank you all very much again for meeting with us on a Friday afternoon. We appreciate everything that you have contributed and all of your comments, we'll go ahead and get to work starting next week and we look forward to talk with you all real soon. Have a wonderful weekend and we'll talk shortly.

Male: See you guys. See you everybody.

Jason Goldwater: Thanks, everybody.

(Off-Mic)

Female: Thank you.

Female: Thank you.

END