

NATIONAL QUALITY FORUM

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CREATING A FRAMEWORK TO SUPPORT MEASURE
DEVELOPMENT FOR TELEHEALTH:
COMMITTEE IN-PERSON MEETING

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WEDNESDAY
NOVEMBER 16, 2016

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

PRESENT:

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

MARCIA WARD, PhD, Director, Rural Telehealth Center, University of Iowa

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

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

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

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 Dallas

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

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

SARAH SOSSONG, MPH, Director of Telehealth,
Massachusetts General Hospital

DANIEL SPIEGEL, MD, MBA, 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

JEAN TURCOTTE, MA, BSN, RN, Director of Tele-
ICU, Adventist Health System

ANGELA WALKER, MD, FAAD, Direct Dermatology,
Science 37

NQF STAFF:

TRACY LUSTIG, Senior Director

KATHRYN STREETER, Senior Project Manager

ALSO PRESENT:

SYLVIA TRUJILLO, AMA

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

2 9:08 a.m.

3 MR. GOLDWATER: Okay. So I know some
4 people are just trying to grab some last
5 breakfast before heads downstairs, so we can go
6 ahead and just start to begin. My name is Jason
7 Goldwater. I know I've talked to all of you over
8 the phone. It is just a delight beyond words to
9 meet all of you in person.

10 On behalf of the National Quality
11 Forum, we welcome all of you to this two-day
12 meeting and I know I have said this before, I
13 will say it again, I'm sure I'm going to repeat
14 myself in an embarrassing fashion over the next
15 couple of days, but we are absolutely thrilled to
16 have all of you here.

17 There were a lot of people that signed
18 up that wanted to participate on this committee.
19 Everyone, there legitimately could have been a
20 claim for everybody that wanted to participate.
21 But we really feel like we have the best and the
22 brightest representing telehealth.

1 There are, if I really looked at all
2 of your CVs which I did frequently, and your
3 Linked-In profiles Julie, there's no other way I
4 could have gotten your email otherwise.

5 So when I looked at everyone's CV and
6 profile and talked about it with Tracy and with
7 Katie, I mean there's probably collectively nine
8 decades' worth of expertise here in telehealth,
9 and that is so crucial, because the success of
10 projects like this really depend a lot on you and
11 depend upon the input you're going to give us,
12 how you're going to guide us in this project, how
13 you think the project should go forward and how
14 you think this project can really make a
15 difference.

16 As I said over the phone during our
17 orientation call, the last thing that we want to
18 do is produce a report that just simply sits on a
19 website and doesn't really do anything. I think
20 we have the group here that will not only help us
21 develop a very robust and comprehensive
22 framework, but will provide extremely important

1 direction on how to implement it.

2 Then we can really see the kind of
3 difference that that framework can make. So
4 again, we're thrilled to have all of you here. I
5 know, as Kristi pointed out, most of you know
6 each other already. We knew that sort of going
7 in because as I told John Linkous yesterday, I
8 said I think half your board is here, and he said
9 that's great. I'll make sure not to be at that
10 meeting. I don't know what that means.

11 But John said, you know, they've all
12 worked with each other, know each other and have
13 been involved in the area of telehealth for so
14 long that what they're going to be able to offer
15 you from different perspectives is going to be
16 terrific.

17 So what we want to do today is sort of
18 initially review the purpose and the -- you can
19 go back one slide, Katie. Back one. There you
20 go, all right. So is to sort of go over the
21 logistics, to talk about some welcome and
22 introductions. I know we've all introduced

1 ourselves over the phone, but now here we all are
2 in person so we might do this briefly once again.

3 I know restrooms are really important.
4 It's a long meeting and we still have tomorrow to
5 go too. So restrooms, exit the main conference
6 area, pass the elevators, they're on the right.
7 We will take breaks. We're not the types who are
8 going to keep you here for nine straight hours,
9 as tempting as that is.

10 So at eleven o'clock we'll take a
11 break for 15 minutes. We do have lunch at 12:30
12 which is provided by us. We'll have another one
13 at three o'clock for 15 minutes as well. I
14 realize all of you are extremely busy people, so
15 if you need to get onto the WiFi network because
16 there are messages or things that you need to
17 communicate during the day, the WiFi user name
18 and password are there and they're also available
19 in the front.

20 We do ask if you could please mute
21 your cell phone during the meeting, so that
22 whatever -- because everybody does it now. So

1 whatever Top 40 song you have on your ring tone
2 doesn't actually go off. I like hearing Taylor
3 Swift as much as the next person, but not all the
4 time.

5 So next slide. So the agenda of the
6 meeting today, we'll do some welcome and
7 introductions. We will review the purpose, the
8 objectives and particularly the scope of this
9 meeting over the next couple of days, and I will
10 stress that we do have a scope and it is very,
11 very important that we get through all of it,
12 because we're not going to see you all again
13 until March.

14 We will be having web meetings with
15 you, but there's a difference between a meeting
16 that is being done virtually and a meeting that
17 is being done in person. So we really do want to
18 make sure we get through the scope that we need
19 to. I've often told people I'm not going to let
20 anybody go until we finish until we need to
21 finish. I'm not serious about that, but we do
22 need to make sure that we get through the

1 objectives that we need to accomplish.

2 We do want to do an update on the
3 environmental scan. We do want to tell you the
4 measures that we have initially found, that we can
5 incorporate into telehealth as a means of care
6 delivery, existing measures. We want to discuss,
7 as Tracy will lead this discussion, methodologies
8 on how to modify existing measures to incorporate
9 telehealth, what new measures are needed and then
10 to discuss the initial dimensions of the
11 framework that would provide the ability to
12 utilize existing measures, to evaluate
13 telehealth, as well as developing the foundation
14 to create new measures.

15 Now I think a lot of you are familiar
16 with NQF. NQF as an organization does not, does
17 not, does not develop measures. That's not the
18 point. But what we do do is provide a framework
19 to have all of you develop measures around
20 telehealth, and if we are able to develop a
21 framework with common dimensions and common
22 elements, then we will know the types of measures

1 that are being developed and can be used, that
2 would cover a whole range of clinical areas from
3 dermatology to ICU to stroke to mental and
4 behavioral health and to others.

5 And then per NQF policy with every
6 meeting that we have, we do have to be
7 transparent and open to the public. So there
8 will be two times when we will open up this
9 discussion for public comment, and we'll wait to
10 see what comments come in and address them as
11 appropriate.

12 Next slide. So the project team. We
13 are three but we are mighty, right. Is that a
14 good characterization? Okay. So I'm Jason
15 Goldwater. I'm a senior director here at NQF. I
16 have been here for almost two years, although
17 Marcia Wilson, who will introduce herself
18 shortly, we joined roughly around the same time,
19 correct, and we feel like we have aged ten years
20 in just the two years that we have been here.
21 What's that? Right.

22 It's a busy job for sure. My

1 responsibility is I oversee the health IT
2 portfolio here at NQF. I also oversee the
3 submission of electronic measurement, and review
4 e-measures to determine compliance with NQF
5 criteria before they go to a standard committee.

6 I have been involved in the area of
7 health IT for longer than I would ever care to
8 admit. But at this point I think roughly 22
9 years. I first started when the HIPAA
10 regulations were passed.

11 Some of you may remember that when we
12 went to the electronic claims transactions
13 standards, and I was one of three people at CMS,
14 which was then called HCFA, the name it should
15 still have quite honestly, and understood what
16 that meant when we talked about loops and
17 standards and clinical vocabularies.

18 I stayed at CMS from 1997 all the way
19 through 2007, and then worked in a variety of
20 consulting, research and non-profit
21 organizations. I've worked across the spectrum
22 of health IT from standards and vocabulary, and

1 from building systems, developing systems,
2 testing systems and also doing significant
3 amounts of research on systems.

4 Telehealth has an extreme interest of
5 mine and a focus of mine for the last several
6 years. So I'm thrilled to be working on this
7 project, and I've got -- even though I said we're
8 three but we are mighty, to have two terrific
9 colleagues working with me. So Tracy.

10 MS. LUSTIG: Hi. Good morning. I'm
11 Tracy Lustig. I've been with NQF about seven
12 months, so this is actually my first project
13 starting from the beginning and going all the way
14 through. I'm very excited about it. I actually
15 had a first career as a podiatrist, so if you see
16 the boot on my foot with my broken toe, it's a
17 little bit ironic.

18 I actually caught what we call Potomac
19 Fever. I came to Washington to do a
20 Congressional fellowship and I worked in the
21 office of Senator Wyden, a lot on issues of aging
22 and at that point decided to make the transition.

1 So I was actually at the Institute of Medicine
2 for 12 years before coming here earlier this
3 year, and at the IOM I have several people I
4 worked with there when we had a two-day workshop
5 on telehealth, and so I'm very excited to come
6 back to this topic again.

7 MS. STREETER: Hi, good morning. I'm
8 Katie Streeter. I'm a senior project manager
9 here at NQF. I have been here for six years, so
10 I guess I've been here the longest. I manage a
11 variety of projects here, and I'm really looking
12 forward to this project and working with you all.

13 MR. GOLDWATER: So Tracy and I would
14 both concur that Katie is the real brains behind
15 this outfit. We're just sort of figureheads
16 speaking. Katie really does know everything
17 there is to know about NQF, so if you have any
18 questions about procedures, policies, how these
19 projects go, she is a wealth of information.

20 I think I started working with her Day
21 2 that I was here, correct, and she has not run
22 away, which is surprising. So we're still

1 working together. A couple of logistics and I
2 want to introduce our co-chairs.

3 Number one, you will see in the very
4 back that's Charles. Charles, wave your hand.
5 Right, okay. So you'll notice that he is
6 transcribing and recording this conversation.
7 That will lead to a transcript that we will need
8 to make sure that we are adequately representing
9 your thoughts. You can see that we have laptops.
10 I'm going real old school with legal pads to take
11 notes, but to make sure we get everything
12 appropriately recorded, we do have somebody here
13 to record the conversation.

14 We also will be presenting that
15 transcript to CMS and the government and to HRSA,
16 so that they can also understand what went on in
17 the meeting and what we will be using as we move
18 forward. So what that means to you is a couple
19 of things.

20 Number one, you will see these
21 microphones in front of you. While I know most
22 of you have loud, projecting voices, it's very

1 important to you use the microphone to speak, and
2 speak directly into the microphone. Whenever you
3 want to talk during the course of a conversation,
4 you don't have to raise your hand, jump up and
5 down or clear your voice in a very loud way so
6 I'm paying attention.

7 All you have to do is just do this,
8 and then when I see that, I'll make sure that
9 I'll call on you or Tracy will call on you, and
10 that's the way that we'll work it. So make sure
11 you speak into the microphone. Please put your
12 placard up like that so we know when to call on
13 you when you have something you'd like to
14 contribute to the conversation.

15 With that in mind, we are very
16 fortunate to have two great co-chairs who are
17 going to help us steer this project as we move
18 forward, and I'm gracious that I know one of them
19 really well, even though he's a Philadelphia
20 Eagles fan. I'm not going to hold that against
21 him because the Dallas Cowboys have the best
22 record in the NFL, thank you all very much.

1 So and with that, and then we also
2 have someone who we're just thrilled to have
3 aboard, who has not just experience in telehealth
4 but also rural health and in measure development,
5 and that sort of trifecta is going to be very
6 valuable here. So with that, I'll turn it over
7 to Dr. Hollander to introduce himself.

8 CHAIR HOLLANDER: Hi. I'm Judd
9 Hollander from Thomas Jefferson. I'm actually in
10 awe of sitting around this table with all of you.
11 I'm a relative newcomer to the telehealth world.
12 I hold the title of Associate Dean for Strategic
13 Health Initiatives, but most of my life was
14 actually running a large clinical research
15 program at the University of Pennsylvania, and
16 then I went back and did some business school
17 stuff, like many people do, and ended up in more
18 a business strategy role.

19 Two years ago, oh it's recorded. I
20 can't use the quote. Okay. I'll put other words
21 in. But two years ago, I took a job at Jefferson
22 where our CEO, Steve Klasko is very visionary,

1 and his really number one initiative besides
2 mergers and acquisition and conquering the world
3 is telemedicine.

4 And so when I started there, I said
5 give me some parameters. There's no budget.
6 It's like Judd go do this and no one knows what
7 Judd should be doing, and he said well, none of
8 this is really true, but this is the way you
9 should think about it. I know Sarah's heard this
10 before.

11 Assume you had \$100 million. I don't
12 give an S if you fail, and just go do something
13 that's freaking cool. So that's actually pretty
14 much my job description, or it was until I did
15 too many things that he cared about when I
16 failed. But no seriously, so we took a little
17 different approach in the telemedicine world, and
18 we grew out an enterprise-wide program, you know,
19 all at once, throw mud at the walls, see what
20 sticks.

21 We decided we're not smart enough to
22 do A and hope it works, and not do B, C, D and E,

1 and all of our successes are things we would have
2 said no to had someone come to us with a business
3 proposal.

4 So I think it's a little bit of a
5 different background, but as I sit here today and
6 look at you and read your bios and know you guys
7 have a lot more experience in the world than I
8 do, I'm actually really grateful to be here.

9 I can't believe he made me a co-chair,
10 and I'll try and do the best I can with Marcia's
11 guidance.

12 CHAIR WARD: Hi, I'm Marcia Ward and
13 I'm a professor at the University of Iowa, and I
14 don't have anything to do with the provider
15 world. I'm in the College of Public Health. I
16 do research. I've been there for 20 years.
17 Before that, I was at SRA International in Menlo
18 Park, California for 20 years. I don't move,
19 like a lot of people.

20 I am lucky enough to be directing the
21 Rural Telehealth Research Center, and it's funded
22 by the Federal Office of Rural Health Policy at

1 HRSA, and it is their telehealth-focused rural
2 health research center.

3 Steve North is one of my colleagues on
4 projects there, along with other folks at the
5 University of North Carolina and the University
6 of Southern Maine, and we do very interesting
7 projects that HRSA wants research on, with the
8 policy implication to advance the evidence base
9 for telehealth, and I am delighted to be here.

10 MR. GOLDWATER: Thank you both very
11 much. Before we get to the disclosures of
12 interest, I do want to have us go around the room
13 very briefly and introduce ourselves. A couple
14 of notes. Charles Doarn will be here. He's
15 going to be a little late. Apparently, he is
16 giving a videoconference to Macedonia about the
17 use of telehealth. That is the lamest excuse
18 I've ever heard for missing a meeting, but he
19 swears it's true.

20 But I'm sure we're going to make him
21 -- we will all tease him about that relentlessly
22 when we see him. Dr. Bashshur is possibly going

1 to be joining us by phone, but will not be able
2 to be in attendance today in person. Peter
3 Rasmussen and Mary Lou Moewe will be here
4 tomorrow.

5 So with that in mind, Dr. Don Graf
6 we'll start with you. If you could just
7 introduce yourself --

8 MS. WILSON: Could we -- we'll combine
9 the introductions and the disclosures.

10 MR. GOLDWATER: You want to do that?

11 MS. WILSON: Yes.

12 MR. GOLDWATER: Sure, okay. Go right
13 ahead.

14 MS. WILSON: Yeah, okay. Thank you,
15 good morning. My name's Marcia Wilson. I'm
16 senior vice president of Quality Measurement here
17 at NQF, and I'm filling in for our general
18 counsel. What we do typically at these
19 committees is we combine introductions with the
20 disclosure of interest. Before you were named to
21 this committee, you got probably a lengthy form
22 asking you to disclose about your activities.

1 Today, what we're going to do is ask
2 you to do an oral disclosure of anything that's
3 relevant to the subject matter before this
4 committee. Now as Jason said, this is a group
5 with incredible expertise. However, it is not
6 necessary to summarize your resume in your
7 disclosure. What we're interested in is research
8 or grants relevant to what the committee will be
9 discussing, and not only paid work but volunteer
10 work as well.

11 You may sit on a board or be part of
12 a committee, and again think in terms of what is
13 germane to this committee. Now just because you
14 disclose something it doesn't mean you have a
15 conflict, and we do these oral disclosures in the
16 spirit of openness and transparency. One
17 reminder. You sit on this committee as an
18 individual. You do not represent your employer
19 or anyone who would have nominated you.

20 What we're going to do is I'm going to
21 start with the co-chairs. They will introduce
22 themselves with their name and where they're

1 from, and if they have anything to disclose.
2 We'll go around everyone in the room that's on
3 the committee, and then we'll check to see if
4 any, a couple of our committee members have
5 joined by phone.

6 So again, it's a brief introduction
7 and if you have anything to disclose. So Judd,
8 if we could start with you.

9 CHAIR HOLLANDER: Judd Hollander,
10 Thomas Jefferson University. No disclosures
11 specific to this meeting.

12 CHAIR WARD: Marcia Ward, University
13 of Iowa. So Marcia, guide me. I have grant
14 funding from HRSA relevant to telehealth. Is
15 that what you want to know?

16 MS. WILSON: Yes, so it would be --
17 and just what is the project? What is the
18 purpose of the project?

19 CHAIR WARD: It's -- I direct the
20 Rural Telehealth Research Center, four years of
21 funding from HRSA with the purpose of furthering
22 the evidence base for rural telehealth. Thank

1 you.

2 MS. WILSON: Yes, go ahead, Don.

3 MEMBER GRAF: Don Graf, National

4 Telehealth Director, United Healthcare.

5 Disclosures. I sit on the AMA Telehealth Coding

6 Task Force. Don't believe that's any kind of a

7 conflict, but and also on the ATA Education

8 Committee. No other disclosures. Been with

9 United Healthcare, developing and expanding

10 telehealth capabilities on the national scene for

11 nine years.

12 Been doing telehealth, promoting and

13 expanding its use for over 20 years and look

14 forward to participating on the group.

15 MS. WILSON: Thank you, Paul.

16 MEMBER GIBONEY: Good morning. My

17 name is Paul Giboney. In terms of disclosures,

18 our agency receives a couple of grants from the

19 Blue Shield of California Foundation, for the

20 spread of electronic consultation and assistance

21 with them around the state of California.

22 I'm the Director of Specialty Care.

1 We've used telehealth and a bunch of other
2 interventions to help take a historically very
3 fragmented and siloed bureaucratic county
4 delivery system and really transform specialty
5 access and really turn it into something I think
6 really special for our patients.

7 MS. WILSON: Thank you.

8 MEMBER GLADWELL: Good morning, Nate
9 Gladwell, University of Utah Healthcare. No
10 specific disclosures relevant for this meeting.
11 Direct the centralized telehealth and
12 telemedicine office for University of Utah
13 Healthcare. Was established about four years ago
14 with the purpose of creating opportunities for
15 our regional clinical network, as well as our
16 Wasatch and our local Salt Lake City health
17 system around connected health and connected care
18 in all its facets and varieties. A pleasure to
19 be here.

20 MEMBER SOSSONG: Sarah Sossong from
21 Massachusetts General Hospital. I have been
22 there for about five years. Prior to that, I was

1 at both Kaiser Permanente and then the U.S. Navy,
2 also doing telemedicine activities. No
3 disclosures relevant. I mentioned ATA. I'm on
4 the executive committee of the Business and
5 Finance SES. I don't think that's as relevant
6 for this.

7 Internal to the work both at MGH and
8 at Kaiser, I've been interested in measurement
9 for a long time. So I'm thrilled that there's --
10 this group is interested in this, you know,
11 something as simple as just capturing the volume
12 we've done, patient and satisfaction, patient and
13 provider satisfaction.

14 But I think the challenge has been the
15 multi-modality of telehealth and multiple
16 specialties. So I'm glad to be here.

17 MS. WILSON: Thank you.

18 MEMBER TURCOTTE: Good morning. I'm
19 Jean Turcotte. I am with the Adventist Health
20 System, which is a 44 hospital system throughout
21 the Northeast region. I'm the director for the
22 primarily the Tele-ICU program, which we have

1 implemented in 18 of our facilities so far. But
2 I've recently inherited all our other, oversight
3 for our other telemedicine programs as well as
4 telehealth.

5 So very interested in being here to
6 learn measures and participate, and I have
7 nothing to disclose.

8 MS. WILSON: Thank you.

9 MEMBER FARQUHAR: Good morning, Mary
10 Beth Farquhar from URAC. I'm the vice president
11 for Quality, Research and Measurement. Most
12 recently, URAC has established an accreditation
13 program in telehealth and they're doing their
14 beta test at the moment, and my charge is to put
15 measures into those, which we are trying
16 desperately to do.

17 In another life I was vice president
18 for Performance Measurements at NQF, and then
19 prior to that I worked at the Agency for Health
20 Care Research and Quality and did some measure
21 development for the quality indicators, as well
22 as the CAHPS surveys.

1 MEMBER SPIEGEL: Hi. I'm Daniel
2 Spiegel. I am the National Director for Home
3 Hemodialysis and Pediatrics at Davita. I live in
4 Denver. I have nothing to disclose relevant to
5 this meeting.

6 In terms of telehealth experience,
7 we've been working on developing telehealth and
8 remote monitoring capabilities internally for
9 several years now. I'm really excited to be
10 here, so thanks for having me.

11 MEMBER DARKINS: Hi Adam Darkins. I'm
12 vice president for Innovation and for Strategic
13 Partnerships with Medtronic, a medical device
14 company. I spent 14 years building the
15 telemedicine/telehealth programs in the VA before
16 I came here.

17 I built a large, strong forward
18 network, a home telehealth network and a
19 videoconferencing network, as well as doing work
20 in building tele-ICU services and with
21 caregivers. I just say that because the only
22 disclosure I have is Medtronic has one piece of

1 it, does some home telehealth.

2 I'm not directly involved in that
3 company, I don't manage within it, and I guess it
4 could be said that indirectly I might benefit.
5 But I don't have any direct association in that
6 sense.

7 MS. WILSON: Thank you.

8 MEMBER HENDERSON: I'm Kristi
9 Henderson. I'm the vice president for Virtual
10 Care and Innovation at Ascension-Texas Ministry,
11 and clinical professor of Population Health at
12 UT-Austin.

13 Been in this role not quite a year, so
14 new from the University of Mississippi Medical
15 Center where I did telehealth, same type of
16 position in a statewide operation there. The
17 only disclosure is I am a board member of the
18 American Telemedicine Association.

19 MS. WILSON: Thank you.

20 MEMBER MEACHAM: Hi everybody. I'm
21 Megan Meacham. I'm with the Federal Office of
22 Rural Health Policy, and I just want to extend

1 the same, being thrilled that you're all together
2 here working on this project.

3 We all know that telehealth could
4 really serve great purposes especially for rural
5 populations, but also know that measurement's
6 really important. So I really look forward to
7 seeing what comes of this project over the next
8 year.

9 MEMBER HARRIS: Hi, Yael Harris,
10 Mathematica Policy Research, a senior researcher
11 there. I am thrilled to be here. There's a lot
12 of familiar faces. Looking forward to the break
13 so I can get some hugs in. I actually spent 16
14 years in the federal government working on
15 telehealth before I came to Mathematica. So
16 working at HRSA, CMS, ONC. I chaired, I
17 established and co-chaired the Federal Telehealth
18 Collaborative, what's been known as FedTel.

19 So I don't know if those need to be
20 disclosed. I've also, since I've been at
21 Mathematica, done telehealth work funded by HRSA
22 with Marcia, funded by the Assistant Secretary

1 for Health and funded by the Assistant Secretary
2 for Planning and Evaluation, although none of
3 those are currently being funded.

4 And the only other disclosure is I'm
5 related to a member of the NQF Board.

6 MS. WILSON: Thank you.

7 MEMBER TRUONG: Hi good morning
8 everyone. I'm Dennis Truong. I'm Director of
9 Telemedicine for Kaiser Permanente Mid-Atlantic.
10 I have no disclosures. So I started to do this
11 about five years ago. I'm an EM physician, and I
12 was also director at the call center and an Epic
13 physician builder. So I kind of just stumbled
14 upon telehealth as a solution for the crowding,
15 overcrowding of the ERs and the wait times, and
16 in many of our urgent cares and ERs.

17 So I stumbled upon it and here we are
18 now, and you find out many of your colleagues
19 they're starting to jump on the bandwagon too.
20 They're starting to see that, you know, this is
21 kind of the future of how we're really going to
22 save cost for the members and really provide

1 better access and a convenience for them.

2 So just really happy to be here. I'm
3 kind of a newbie to this, so it's a real pleasure
4 to meet all you.

5 MS. WILSON: Thank you.

6 MEMBER HANDLER: Good morning
7 everybody. My name's Steve Handler. I'm from
8 the University of Pittsburgh/UPMC. A practicing
9 geriatrician and have been interested in
10 telemedicine for some time. In terms of what I
11 do, the director for Telemedicine Services for
12 Geriatrics at UPMC and associate professor and do
13 a lot of research in that regard.

14 So there are several grants that are
15 active. We are in Phase 2 of a CMS innovation
16 award. So that's a cooperative agreement to
17 reduce potentially avoidable hospitalizations of
18 nursing home residents and keep them in place,
19 maintain them in place if possible and one aspect
20 is to use telemedicine to reduce those
21 potentially avoidable hospitalizations.

22 So that's more now entering our second

1 phase, which is another four years of funding.
2 We also have an AHRQ grant to do real-time
3 medication reconciliation and medication regimen
4 review that was funded by AHRQ. I also am the
5 chief medical and innovation officer for a start-
6 up company called Curvai Health, and I receive
7 salary support but non-equity position given my
8 academic appointments.

9 That company is focused on reducing
10 potentially avoidable hospitalizations in nursing
11 home residents. So my interest is really the
12 post-acute long-term care environment and that
13 focus there. So thank you for having me.

14 MS. WILSON: Thank you.

15 MEMBER DePHILLIPS: Good morning.
16 Henry DePhillips, corporate chief medical officer
17 for Teledoc. By way of background, I'm still to
18 do this day a board-certified family physician,
19 although the further away from practice I get,
20 the harder it is to pass those exams.

21 Phase 1 was ten years in private
22 practice. Had a blast. Delivered babies, made

1 house calls, if you believe that. Phase 2 I went
2 to a health insurance company for a period of
3 eight years, learned a lot about health care
4 finance, how the money flows there. Had a good
5 time.

6 In Phase 3, I've been a serial
7 entrepreneur in health care information
8 technology for the last 13 years, which makes me
9 107 years old. By way of disclosure, let's see.
10 I'm an employee of Teledoc, so I think that's
11 disclosable. We took the company public on July
12 1st of 2015, so I'm thankfully also an equity
13 owner in Teledoc, and I actually -- I live
14 outside of Nashville, Tennessee, which has a lot
15 going on in health care. So I made a small
16 personal investment in a company called E-Rounds,
17 which is a HIPAA-compliant platform to allow
18 surgeons to share operative cases with one
19 another including pictures, photos of implants,
20 X-rays, in a HIPAA-compliant fashion.

21 As a result of that, I have a board
22 seat with that company. I think the value of my

1 equity is less than the value of my investment at
2 the moment. So it may not have been a great
3 choice, but I figured I'd better disclose that.

4 MS. WILSON: Thank you.

5 MEMBER NELSON: Good morning. I'm
6 Eve-Lynn Nelson. I'm Director of Telemedicine at
7 the University of Kansas Medical Center. I've
8 been here about 20 years. I started out as a
9 telemental health provider, and I still have the
10 opportunity to see patients and families. So I'm
11 excited that the panel is also thinking broadly
12 about telehealth, including behavioral health.

13 My other hat is I direct our Heartland
14 Telehealth Resource Center, and then I work with
15 ATA around developing evidence-based guidelines
16 for child mental health. In terms of
17 disclosures, I have funding from HRSA and NIH,
18 mostly around telemental health and then also
19 some funding around Project ECHO.

20 MS. WILSON: Thank you.

21 MEMBER FLANNERY: Hello. I'm David
22 Flannery. I'm medical director at the American

1 College of Medical Genetics and Genomics, excuse
2 me. Prior to that, I was on the faculty at
3 Medical College of Georgia for 29 years, and I
4 started doing telemedicine to provide genetic
5 services in 1995, continuing all the way to the
6 time I left in 2014. So I've been an advocate
7 for promoting telemedicine among the state of
8 Georgia.

9 As far as disclosures are concerned,
10 the American College of Medical Genetics actually
11 has funding from HRSA to run what's called the
12 National Core Data Center for Regional Genetic
13 Collaboratives, and part of that includes
14 promoting the Work Group on Telegenetics. That
15 telegenetics work group, part of its grant
16 deliverables is developing some quality metrics
17 for telegenetics. So it sort of goes in both
18 directions here.

19 In terms of other disclosures, I sat
20 on the board of every organization that Paulette
21 Guy has ever created, and actually I'm now on the
22 board of a start-up and as of last week, when we

1 discussed things, the value of the stock I have
2 in that is much less than \$10,000.

3 MS. WILSON: Thank you.

4 MEMBER NORTH: I'm Steve North. I'm
5 a family doc and adolescent medicine specialist
6 in the mountains of western North Carolina. I
7 practice at a small rural health center there. I
8 help lead the Healthy Schools Network, a 33
9 school-based telemedicine program. We're in our
10 sixth year of operation, and I'm also the
11 clinical director for Mission Virtual Care is our
12 new name.

13 Mission Health is the largest health
14 system in the western part of the state, serving
15 18 counties. Most of my disclosures are support-
16 related. Through my work with Healthy Schools
17 and the Center for Rural Health Innovation, our
18 parent 501(c)(3), we have some funding from the
19 state of North Carolina and the Duke Endowment
20 for Access Issues.

21 I'm on the advisory board for the Mid-
22 Atlantic Telehealth Research Center, Resource

1 Center, and consult through that, with those
2 proceeds going directly to CRHI, not my pocket.
3 I am working with Marcia on the quality measures
4 through the HRSA-funded Rural Telehealth Research
5 Center, and also help the school-based health
6 alliance, the National School-Based Health Center
7 organization, design and consider how telehealth
8 is being used in schools.

9 MS. WILSON: Thank you.

10 MEMBER FERGUSON: Good morning,
11 everybody. I'm Stewart Ferguson. I'm with the
12 Alaska Native Tribal Health Consortium in
13 Anchorage, Alaska. It's good to see old friends
14 and colleagues here. I've been working for the
15 last 19 years in Alaska, primarily focused on
16 building out and supporting telehealth. We have
17 about 250 sites throughout the state.

18 Most recently, I've been working on
19 trying to move the Alaska Tribal Health System
20 onto a single patient record, a single EHR domain
21 that lets us share health information from the
22 most remote villages to the tertiary care

1 facilities in Anchorage.

2 Prior to that, I used to work in kind
3 of a very interesting area of mathematics and
4 health care. I was working on the inverse
5 problem, ill-posed mathematical problems, trying
6 to determine neural currents in the head and in
7 the heart that would create magnetic fields that
8 we could measure outside the body.

9 So I've actually moved into something
10 I think is a little bit more practical in health
11 care.

12 MEMBER NORTH: And the rest of us can
13 understand.

14 MEMBER FERGUSON: Yeah, ill-posed
15 problems. It's new. Full disclosure. I don't
16 know if these really matter but I'll share them.
17 I am the tribal representative to the Alaska E-
18 Health Network, which is the body that manages
19 the statewide health information exchange. I'm
20 working on the Telehealth Task Force for Medicaid
21 Redesign in the state of Alaska. I'm on the CIO
22 Council for Cerner Corporation, SREHR vendor.

1 We have funding from HRSA for a
2 National Telehealth Technology Assessment Center.
3 I work in a number of other task forces,
4 including one where we're working with the state
5 of Hawaii through the Association of State and
6 Tribal Health Organizations on kind of a mutual
7 collaboration, and we have a small LLC that we
8 spun off a number of years ago to license our
9 telehealth technology to other distributors, and
10 I'm the manager for that. But I receive
11 absolutely no compensation for that role.

12 MS. WILSON: Thank you.

13 MEMBER ALVERSON: Good morning,
14 everyone. It is fantastic to be here. I share
15 your excitement, Jason. I see so many friends
16 and colleagues and new ones here too. I'm the
17 medical director of our Center for Telehealth at
18 the University of New Mexico. Been doing that
19 for over 21 years.

20 I'm also the chair of the New Mexico
21 Telehealth Alliance, which is our non-profit
22 representing the state of New Mexico in

1 telehealth and health information technologies,
2 and then I'm the chief medical informatics
3 officer for a statewide health information
4 exchange called NMHIC, the New Mexico Health
5 Information Collaborative.

6 As many of you know, I'm like Stewart
7 past president of the American Telemedicine
8 Association. I also want to mention that I have
9 one potential -- I'll go into conflicts, but one
10 right away that I mentioned, I have to mention,
11 I'm a graduate of the University of Michigan, and
12 as you may know last weekend the University of
13 Iowa surprisingly defeated the Wolverines.

14 So that's a shock. So I have a little
15 bit of a conflict working with you Marcia, but
16 I'm also a board-certified pediatrician and
17 neonatologist, although retired now from clinical
18 practice.

19 Just in a matter of disclosure, just
20 so that I make sure it's on the record, I act as
21 a consultant advisor on various oversight
22 committees for some of our grants, CMS CMMI grant

1 on tele-stroke called the Access Grant. I'm on
2 their oversight committee.

3 Also now, also a consultant for HRSA,
4 Office for the Advancement of Telehealth, a
5 school-based health center grant called
6 Fronteris, also just, and as I think we're all
7 going to face this dynamic, changes that are
8 occurring, been asked to act as a consultant on
9 an NIH SBIR grant in teledermatology.

10 And then lastly, I have my own global
11 health efforts through what's called Health
12 Information Associates International. It's an
13 LLC for which I don't receive any compensation,
14 but really looking at global health around the
15 world and how we help them integrate telehealth.
16 So happy to be here.

17 MS. WILSON: Thank you, Dale.

18 MEMBER HALL-BARROW: Good morning.
19 Julie Hall-Barrow, vice president of Virtual
20 Health and Innovation at Children's Health System
21 in Dallas, Texas. Go Cowboys.

22 Really excited to be here. Currently

1 provide leadership for all of our telemedicine
2 programs, including our provider to provider, our
3 direct to consumer, our on-demand health care
4 program via apps, our mobile development team
5 that creates apps for families and children, and
6 lead our strategy around digital technology,
7 allowing us to gather data and integrate that
8 data into a health record no matter where they
9 are. So excited to be here.

10 MS. WILSON: Thank you.

11 MEMBER WALKER: Good morning. I'm
12 Angela Walker. I'm a board-certified
13 pediatrician and dermatologist, and I work as a
14 self-employed physician among several different
15 positions. Current conflicts of interest, I
16 serve on two committees with the American Academy
17 of Dermatology and the Telemedicine Task Force,
18 and I'm also employed in an equity owner -- in
19 two companies, Direct Dermatology that does
20 teledermatology for the California underserved,
21 as well as Science 37, that does some
22 teleresearch based out of LA.

1 MS. WILSON: Thank you, and now we'll
2 go to see if there's any committee members on the
3 phone. Peter Rasmussen, are you with us this
4 morning?

5 (No response.)

6 MS. WILSON: How about Rashid
7 Bashshur?

8 (No response.)

9 MS. WILSON: And I know Mary Lou's
10 going to be joining us tomorrow. I didn't know
11 if she was going to be on the phone today. So
12 any other people on the phone that I missed
13 specifically from the committee?

14 (No response.)

15 MS. WILSON: Okay. Again, I'll
16 reiterate that just because you disclose
17 something it does not mean you have a conflict of
18 interest.

19 However, as the committee member goes
20 on, if you feel like you have a conflict, please
21 speak up. You can approach your co-chairs or any
22 of the NQF staff. If you think a committee

1 member has a conflict or is acting in an biased
2 manner, please speak up.

3 What we don't want you to do is sit in
4 silence and feel like there's something that's
5 not quite right. We would rather you bring it up
6 and get it resolved. So based on what you've
7 heard from your colleagues or anything I've said,
8 does anyone have any questions at this time?

9 (No response.)

10 MS. WILSON: Okay, thank you very
11 much. Jason, back to you.

12 MR. GOLDWATER: Thank you very much,
13 Marcia. A brief note. I feel like we should
14 give Stewart Ferguson a gold star for longest
15 distance willing to travel for an NQF meeting,
16 all the way from Anchorage. That is dedication,
17 man really. So we greatly appreciate you coming
18 all the way out here. I don't even want to know
19 how long that plane flight was, but I hope you
20 have a good book.

21 All right. So I think what we're
22 going to do now is move on to the objectives,

1 project purpose and scope over the next couple of
2 days. The purpose, and this is really generally
3 for the project, but we certainly want to gather
4 as much information over the next day and a half
5 that we can from all of you.

6 We really want to look at the most
7 appropriate way to ensure clinical measures are
8 applied to telehealth encounters, in order to
9 appropriately measure quality of care and also to
10 guide the future development of telehealth-
11 related measurement.

12 We want to conduct a multi-stakeholder
13 review of existing and potential telehealth
14 metrics, and later on during the meeting we will
15 show the initial pass of measures that we've
16 discovered, talk about what we have seen and
17 clearly talk about what is still needed.

18 We want to identify measurement gaps,
19 what is not there currently, and certainly, you
20 know, when we talk about issues like dermatology
21 or stroke or ICU, that is certainly additional
22 areas of measurement that may be needed.

1 And then of course to develop a
2 measure framework and a set of guiding principles
3 for future telehealth measurements, and then also
4 to describe the need for future telehealth
5 measurement, because that will lead to a series
6 of action steps which will lead to the
7 implementation of the framework.

8 Next slide. So the time line of this
9 project. We have a year to do this. The project
10 was awarded September 1st of this year, right on
11 the dot, which is highly unusual with any
12 government contract, but right on the dot and the
13 project will end on August 31st, 2017, no
14 exceptions.

15 So the first thing we did was convene
16 all of you. We did a web meeting to review just
17 sort of the parameters of the environmental scan,
18 which we're going to talk about much more in-
19 depth in a few minutes. We are in the process of
20 conducting the environmental scan currently. We
21 wanted to have the in-person meeting which is
22 today to review those findings, as well as talk

1 about other areas such as measurement,
2 measurement modification as well as the
3 parameters for the framework.

4 We will develop a draft report on the
5 progress of the environmental scan. We will have
6 web meetings throughout the year. We will be
7 convening again in early March, in which we will
8 have already discussed the final results of the
9 environmental scan. We will have hopefully by
10 that point an initial set of measures that have
11 already been developed.

12 We will hopefully also have at that
13 point a modification scheme if necessary on how
14 to incorporate telehealth as a means of care
15 delivery for those measures, and then we will
16 begin to draft the measurement framework. We
17 will draft that. We will pass that on to you for
18 comments, as well as to HRSA.

19 Once those comments are brought
20 forward, we will incorporate them and come up
21 with a final telehealth measurement framework,
22 which will be published to NQF, announced to our

1 membership, announced through a variety of
2 channels so that people can begin accessing and
3 using it hopefully starting in September. That's
4 the goal.

5 Next slide. So let's begin with the
6 review of the environmental scan. So I'm really
7 happy that there's a lot of you here that are
8 researchers, because this gets sort of into the
9 weeds with the research.

10 But most NQF projects, whether we are
11 looking at building a measure framework or
12 whether we are looking at trying to understand
13 measures in a particular clinical area, we always
14 start off with an environmental scan.

15 It gives us a good idea of what's out
16 there. It also gives us an idea of what's
17 essential to help move the project forward. Also
18 gives us an idea about what's lacking. So I'm
19 happy to note that I have and Katie and Tracy and
20 I have read or are beginning to abstract a number
21 of articles written by many of you. So clearly
22 that means we've got the right choice of people

1 here on the panel, but it also indicates again
2 that there's been a lot of work that's been done
3 in this area certainly over the past several
4 years.

5 Next slide. So the scan of the
6 overview was to assist in developing a framework
7 to provide measure concepts that address the
8 ability to identify, specifically identify and
9 classify telehealth as a separate means of care
10 delivery and its impact on outcomes of care. We
11 divided this into five sections, each aligned
12 with key outcomes and influences of telehealth,
13 access to care, cost and cost effectiveness.

14 We did not group those together and
15 Henry knows I talked about this yesterday, just
16 the overall cost of telehealth services as
17 opposed to either in-person services or the
18 alternate, which is not receiving services at
19 all, and then the cost effectiveness of
20 telehealth, and then the patient experience and
21 the clinician experience.

22 I know experience is sort of a broad

1 topic. So we're sort of looking for you all to
2 help us understand the parameters for defining
3 experience. We really want to talk about
4 experience and not satisfaction, because
5 satisfaction is a little bit more subjective.

6 And the analogy that I continually
7 use, Henry sorry you're listening to this again,
8 is that if I were to tow on a plane, let's say
9 from Alaska to here, and the plane left on time
10 and it arrived on time, using standardized
11 metrics that should be high satisfaction, except
12 that it could be the worse plane ride of my life.

13 There could be so many things wrong in
14 the course of that flight that I would hate it.
15 I could also take another plane ride in which the
16 plane was delayed in leaving and arrived ab it
17 late, but it was an incredible experience. The
18 flight attendants were singing, they were
19 dancing, there was constant amounts of food, free
20 alcohol, God only knows what.

21 I'm sure some of you can probably
22 relate to what airline I must be talking about,

1 and in that case it would be a great experience,
2 and I would be highly satisfied, even though by
3 those same defined metrics it would fail. So we
4 don't want to talk about satisfaction. We do
5 want to talk about experience, even though
6 initially when the RFP was scoped, satisfaction
7 was put in there and we worked with HRSA to
8 redefine that.

9 Next. So the domains of information
10 within the environmental scan. So what we
11 initially did is we came up with a very large set
12 of search terms. Many of you saw those when we
13 had the orientation call. We expanded that set
14 based upon your recommendations, and as articles
15 came in we reviewed them at the abstract level
16 and put them in one of these five domains, and
17 I'm happy to say that every article that we found
18 fit into one of these, in some cases fit into
19 more than one of these.

20 One of them was access to care, which
21 would include things such as timely receipt of
22 health services, access to health services for

1 those living in the rural communities or
2 medically underserved areas, access to
3 appropriate health specialists based on the need
4 of the patient and so forth.

5 In terms of cost, what we looked at
6 with cost was the cost of telehealth for
7 providers as opposed to the alternative, the cost
8 of telehealth for public and private payers,
9 efficient use of services for the patient and the
10 difference in cost per service and per episode of
11 care.

12 We split that amongst cost
13 effectiveness by talking about effective
14 telehealth on patient self-management, of which
15 there has been a lot of written, the cost effect
16 on patient care as opposed to the alternative,
17 which is either in-person or no care, reduction
18 of medical errors, reduction in overuse of
19 services, cost savings of patients related to
20 travel time and time away from work, amongst
21 others.

22 This is again not a comprehensive

1 list. This is just examples. Patient experience
2 was appropriateness of services, increase in
3 patient's knowledge of care, patient's compliance
4 with care regimens, difference in morbidity and
5 mortality among specific clinical areas, and for
6 clinician experience, again there was a -- what
7 was great is there's a lot written about this.

8 I'm talking about diagnostic accuracy
9 of a telehealth application, particularly in the
10 dermatology field; comfort with telehealth
11 applications and procedures; and then the quality
12 of communications with patients, whether it be by
13 phone, interactive video, a combination of the
14 two or secure messaging.

15 Next slide. So of course, because
16 this is research, as Marcia will appreciate, we
17 have to come up with research questions before we
18 actually begin the environmental scan. So the
19 questions that we formed were did telehealth
20 provide more timely access to appropriate health
21 services, how does telehealth affect patients'
22 health and well-being compared to the

1 alternatives, how do the costs of telehealth
2 compare to in-person care delivery, and then --

3 So are both patients and clinicians
4 satisfied with the services provided through
5 telehealth. Really, that is what was the
6 experience of both patients and clinicians as
7 services were provided through a variety of
8 telehealth modalities.

9 So we began with a lit review. So we
10 had a list of I would say probably roughly 40
11 search terms that we used, and we identified
12 terms and issues applicable to telehealth through
13 literature and to facilitate what should be
14 included in each measure to concept and how to
15 clarify it through specific domains.

16 The information sources mostly, a
17 large part of this was through the peer reviewed
18 literature, and we found 400 plus articles. We
19 also found a substantial amount of gray
20 literature, a number of reports by the California
21 Health Care Foundation that have published,
22 specifically with respect to telehealth in the

1 California area.

2 We looked at reports at the Agency for
3 Health Care Research and Quality, HRSA, the
4 American Telemedicine Association, as well as the
5 National Association of Rural Health Clinics.
6 There are also some NQF reports on past studies
7 that did not directly talk about telehealth, but
8 talked about services that could be affected by
9 telehealth.

10 Those were reports on rural health
11 care coordination, population health, home and
12 community-based services, health and well-being.
13 Then we did look at legislature and proposed
14 rules under MACRA. Interestingly enough, the
15 rule was dropped after had finished abstracting -
16 - I know, after we finished getting the initial
17 abstracts of all the articles, and then this
18 1,400 page rule came out. We're still looking
19 through it.

20 Fortunately, we have a great policy
21 team here that is like coming up with highlights
22 of MACRA. So we're still working on how that

1 might affect telehealth services.

2 Next slide. Our progress to date. We
3 did look and review about 400 plus abstracts I
4 want to say. I don't even -- I lost count of how
5 many we really looked at. Then we were able to
6 get about 200 plus articles through a combination
7 of search terms that initially met our scoring
8 rubric.

9 I will tell you every potential field
10 was covered from dermatology and ICU to
11 ophthalmology to chronic disease to mental and
12 behavioral health, to stroke, to infectious
13 disease, to population health.

14 I think we did manage to cover the
15 gamut of telehealth being used in a variety of
16 areas, and in a variety of ways. Whether it was
17 just general rural health, where it was prisons,
18 where it was classrooms. We found a lot of areas
19 in which telehealth is being used.

20 We did use a scoring rubric to
21 evaluate each of the articles. We needed to make
22 sure the article fell into one of those five

1 domains that I mentioned, access, cost, cost
2 effectiveness, patient experience, clinician
3 experience. If it did not meet one of those, we
4 excluded it.

5 What we were really looking for were
6 articles in which there was some sort of, for
7 lesser or better term, an experiment of where
8 telehealth was being used and an outcome was
9 being measured due to the use of telehealth. So
10 we had to make sure it was done in a
11 scientifically rigorous manner. So a randomized,
12 control trial, a case control study, a quasi-
13 experimental study and so forth.

14 We needed to make sure that we were
15 able to get articles that talked about the
16 research and its effect on an outcome, because
17 that is how you appropriately build a measure.
18 It had to address one of the research questions
19 that we talked about. It had to have a well-
20 articulated scientific method and research
21 objectives, which most of them did.

22 There were several that we got that

1 were systemic reviews of literature. There are a
2 lot of those that are out there. We did not --
3 we will reference those in our report, but those
4 are not ones that will necessarily be included in
5 the environmental scan report unless you feel
6 otherwise.

7 And that we had to make sure that the
8 goals of the study were satisfied with their
9 published results. There were a few articles
10 that we came about of studies that are underway
11 but have not been included yet. So those are
12 ones we obviously could not use.

13 The scoring range was from 0 to 9. I
14 will tell you that no article hit a zero. We're
15 happy about that. Articles that were a 6 or
16 above are ones that we would abstract. So 151 of
17 those articles are ones that scored a 6 or above,
18 and we are still abstracting those articles.
19 We've made a lot of remarkable progress, but
20 we're still in the process of abstracting the
21 necessary information.

22 Next slide. So when we abstract the

1 articles, we're including the author, the date of
2 study. We did not go any further back than 2006
3 at this point. We wanted to cover a ten year
4 period. We want to talk about the disease type,
5 again to make sure we're covering every spectrum
6 of possible uses of telehealth.

7 The telehealth modality, whether it
8 was store and forward, remote monitoring, mobile
9 health, videoconferencing or other, or a
10 combination of modalities. The nature of the
11 intervention and the type of study, the duration
12 of the study and the number of patients, the
13 primary outcomes and in a number of cases there
14 were also secondary outcomes that we referenced.

15 The specific focuses of the literature
16 talked about the disease areas and modalities
17 that were most effective. We found obviously a
18 large number of articles in mental and behavioral
19 health, in dermatology, in ICU, in stroke and
20 also in chronic disease.

21 Where telehealth increases the access
22 of care, the cost and cost effectiveness as well

1 as the patient and clinician experience, and then
2 we wanted to look at particular factors which we
3 think will be elements, as we'll talk about
4 later, that will make up this overall framework,
5 which would be diagnostic accuracy, which is a
6 big area in the telehealth area, the impact, the
7 therapeutic impact, the technical accuracy of
8 telehealth services and what the overall patient
9 outcome is.

10 Then we wanted also to look at the
11 impact of telehealth on both rural, which we
12 found a lot of, and urban areas as well.

13 So let's begin the discussion.
14 There's a number of issues that we would really
15 love to hear your input on and advice on, areas
16 you think that we have not covered and need to
17 cover, areas we may have missed. I know that we
18 are still abstracting articles, and that we have
19 not finished that work yet.

20 But as we move through the literature
21 given the breadth of knowledge at this table, are
22 there areas that we have not covered? What areas

1 or themes should we be concentrating on, either
2 in procuring articles or evaluating them? We
3 talked about access, cost, cost effectiveness,
4 patient and clinician experience.

5 Is there something that we're missing?
6 Is there something we should get rid of? Is
7 there something we should be adding, and then
8 what are the most important areas in the
9 literature review, apart from what we have
10 discussed, that we need to consider that would be
11 important in developing the measure framework?

12 And then overall, this is going to be
13 the foundational piece. I mean we will build the
14 framework off of what we see. So from that then,
15 what again leveraging all of your expertise, what
16 areas -- what would you like to see in the
17 environmental scan report? Adam.

18 MEMBER DARKINS: Just one thought
19 comes to mind for me was that linking to existing
20 quality initiatives. They're almost all based
21 around the hospital. So when
22 telemedicine/telehealth programs are small and

1 many of the evaluations in the studies are from
2 single hospitals or single -- and around single
3 providers, the purpose of this really, in my
4 opinion, is how you develop large networks to
5 deliver care.

6 Current health care systems don't have
7 mechanisms to accredit and do quality across
8 networks as opposed to individual hospitals. So
9 I think there's an element to this which is not
10 how you say we've got existing quality systems,
11 how do you put them on, but how would we do this
12 when it's a network which is distributed, and
13 doesn't have the core processes which normally
14 are reliant for delivery of physical services.

15 MR. GOLDWATER: Okay, Nate.

16 MEMBER GLADWELL: Yeah, Nate Gladwell.
17 Wondering if you have sliced the lit review in
18 any way to take a deeper look at medical
19 associations in particular. For example, the
20 American Podiatric Medical Association. What's
21 their specific stance on telehealth, their
22 guidance around quality metrics? If the data is

1 sliced in that way, that would be really helpful.

2 MR. GOLDWATER: Okay. Don.

3 MEMBER GRAF: Yeah. I wonder if the
4 -- a few that I'm going to mention have been
5 already considered. One was actual improved
6 health outcomes through telehealth. The other is
7 really about maybe effective communication,
8 standardized messaging, you know, the promotion
9 and engagement and the quality around that, and
10 then actual proficiency of use among providers
11 through education or attestation or types of
12 initiatives.

13 MR. GOLDWATER: Okay, Judd.

14 CHAIR HOLLANDER: So I have a couple
15 of comments that all relate to clear definitions
16 of the outcomes we're going to use in the
17 environmental scan. So the first, you know, Don
18 just talked about improved outcomes, but is that
19 the goal or is the goal to get the same outcome
20 at less cost, you know? What is okay?

21 I think we need to know what we're
22 looking for as we're deciding whether the article

1 achieves its goal. The second thing is I guess,
2 and maybe this is just my bias. The term
3 clinician experience, leaving diagnostic accuracy
4 embedded within that, I kind of lose the fact
5 that it's diagnostic accuracy, you know.

6 It seems to me that it sounds more
7 like satisfaction even if that's not intended.
8 Then the other comment on diagnostic accuracy is
9 I'm not sure that's what we want to go for as
10 providers of telemedicine. We want to go for do
11 I have the right actionable intervention at the
12 end of the encounter, and I'll give you a simple
13 example.

14 I may see somebody with a urinary
15 tract infection. I give them the right
16 antibiotic. Am I right, am I wrong? I'm never
17 going to know if I'm right or I'm wrong on
18 telemedicine. But if you're an in-person visit
19 and I get a culture for E. coli, I know it's an
20 E. coli UTI. I don't actually care about the
21 diagnostic accuracy on that. I care about
22 whether the symptoms resolved.

1 So I think we have to be really
2 careful in how we define our outcomes in
3 evaluating the studies, or we will bias it so
4 telemedicine can't win on some and automatically
5 wins on others. For example, if we're comparing
6 to Choosing Wisely guidelines, where if you see
7 somebody with a non-traumatic headache you're not
8 supposed to get imaging, I'm never going to do
9 that on telemedicine. Most people don't have a
10 CAT scan in their house.

11 But I'm going to do that in the
12 emergency department some of the time. So I
13 think how we define the outcome will determine
14 whether or not telemedicine is the same or better
15 than what we're comparing it to. So I think we
16 need to be thoughtful in advance of that.

17 MR. GOLDWATER: Okay. Yael.

18 MEMBER SPIEGEL: I was just wondering
19 if there's been any thought given to the
20 different levels, or sorry, is that not me?

21 MR. GOLDWATER: It's okay. Go ahead,
22 then. I'll call Yael afterwards.

1 MEMBER SPIEGEL: I apologize. Sorry,
2 I didn't hear Yael.

3 MR. GOLDWATER: That's okay.

4 MEMBER SPIEGEL: Sorry Yael.
5 Different levels of communication. So are we
6 holding a phone conversation to the same
7 standards of care that we hold a text message
8 with pictures, that we hold a videoconference? I
9 think there's a lot more information to be
10 gleaned from certain types of telehealth
11 interactions than others.

12 MR. GOLDWATER: Okay. Now Yael.

13 MEMBER HARRIS: Thank you. So two
14 comments. The first -- they all build on what
15 everyone has said. The first is that the
16 provider experience of care, pulling out the
17 technology component of it, because a lot of
18 times the technology affects the provider's
19 experience. But it may just be that it was level
20 of technical assistance to set up the technology,
21 or there were factors outside of the control.

22 If you're in an area where there's,

1 you know, connectivity problems, that shouldn't
2 be held against the technology use itself. It's
3 something else that needs to be addressed.

4 The other is looking at -- I don't
5 know if I want to say by geography or by setting,
6 but there's a lot of literature out there on
7 rural telehealth, and I think if we could
8 separate it out, because obviously I think
9 everyone in this room agrees telehealth has a lot
10 of benefit, regardless of whether you're in a
11 rural area or not, but trying to group it all
12 together.

13 So perhaps looking at by, for example,
14 a nursing home setting, by whether you're in an
15 urban or even an inner city environment, just to
16 make sure that our findings and the measures we
17 develop are robust across settings and not
18 restricted to rural.

19 MEMBER HANDLER: So I had a comment
20 about the framework which may help us, and I was
21 wondering also if we could get a copy of some of
22 the slides you went over, because it's a little

1 bit hard to follow some of the logic, the
2 operational definitions. I know we covered that,
3 for example on the phone call. But if that's
4 possible.

5 MR. GOLDWATER: Sure.

6 MEMBER HANDLER: So two things. One,
7 what seems to me as I'm hearing this is one of
8 the ways to take the framework here is really,
9 and many in this room may have heard of this, is
10 really the Quadruple Aim, right. Could we
11 consider aligning our mission in the way on which
12 we're codifying and operationalizing this with
13 the Quadruple Aim proposed in Advance.

14 Start with the IOM but now Advance,
15 which does include of course the clinician
16 experience. And then if that's something that we
17 would consider as a group, I think that would
18 help. I also would like to add some feedback and
19 perhaps a little more to those operational
20 definitions, where you basically went in and you,
21 you know, made some statements as to what to
22 include and what not to.

1 What I mean by that is if you've
2 already started your literature review, is there
3 an opportunity for us to now make comments on
4 that or the ship has already started to sail?

5 MR. GOLDWATER: No. You can still
6 make comments on that, since we're right in the
7 middle of it. So we --

8 MEMBER HANDLER: So is that possible
9 even to do? Would you like us to do that now as
10 a group? I mean how would you like that to occur
11 in terms of feedback, and perhaps that's from the
12 co-chairs or yourself? Like so to me, it would
13 probably be best, we'd want to align the group on
14 the framework and the operational definitions
15 before we get too far.

16 MR. GOLDWATER: Sure.

17 MEMBER HANDLER: Right. I think
18 that's one of the most important things I would
19 think.

20 MR. GOLDWATER: I agree. Eve-Lynn?

21 MEMBER NELSON: I would just echo. I
22 think Quadruple Aim is a great idea, both from

1 the workforce issues and then also the
2 satisfaction not just of the provider delivering
3 the service, but also the rural doc and the
4 consulting doc in those situations.

5 What I wanted to mention from the
6 behavioral side is the question that I always
7 get, is is the relationship the same? You all
8 really got at that some looking at the
9 communication and mentioning that, but just
10 looking at some of the relationship measures. I
11 did a very painful study about a decade ago now
12 where we coded every six seconds you coded the
13 interaction and then tried to get at some of
14 those relationship things.

15 But just kind of that range of
16 measurement style, where it may be coding a
17 videotape, it may be asking questions about
18 relationship. It's just still always the
19 question I get when doing presentations.

20 Then if I could just add one, one
21 other comment. I think this goes to cost
22 effectiveness, but from a telehealth resource

1 center perspective, you know, there's a lot of
2 focus on how do you implement well, what are the
3 readiness factors? I think it fits in with
4 dissemination and implementation. But I really,
5 I see those two worlds not coming together as
6 much as you hope, telehealth and D&I science.

7 I just think that we could perhaps
8 encourage some of the D&I best practices, which
9 again I think go to cost effectiveness.

10 MR. GOLDWATER: Okay, Marcia.

11 CHAIR WARD: Following up on Steve's
12 comment, I'm just struggling -- thank you. I'm
13 just struggling with the term of clinician
14 experience. I think we can all do the
15 translation of what that includes, but then when
16 I think about a report coming out of this,
17 everybody who reads the report is maybe going to
18 have a different perception when they see
19 clinician experience.

20 Can we just relabel it? I don't know
21 to what, but something that was closer to quality
22 clinical processes, clinical outcomes.

1 MR. GOLDWATER: Okay. Dr. North.

2 MEMBER NORTH: I'm interested in this
3 idea of patient experience and relationships and
4 how we fit this into the continuity of care that
5 a patient experiences. So it's great that you
6 saw the cardiologist from Memphis, but does that
7 make a difference three months later or six
8 months later to the care you're receiving, either
9 through remote home monitoring or your primary
10 care physician's office?

11 So how do we couch that so that this
12 is not -- so that processes are not disparate but
13 instead integrated into a single care stream?

14 MR. GOLDWATER: Okay, Sarah.

15 MEMBER SOSSONG: So building off of
16 her point, I think just in terms of the
17 framework, it would be helpful in terms of the
18 scan to look at all of the different specialty
19 groups that have come up with measures. I think
20 that's been one of our struggles, is the measures
21 and outcomes can be so different across the
22 different specialties.

1 So first specialty-specific and then
2 modality-specific. I think it would be really
3 useful if ultimately we came up with modality-
4 specific measures, because they really are very
5 different across the different, you know, e-
6 visits, second opinions, virtual visits or tool
7 consults.

8 I think to the point around
9 implementation, that's something that we have
10 tried to break out in the survey work we've done,
11 you know, what's the process versus the outcome.
12 So I think something that got it, you know, a
13 practice that's trying to implement, how do they
14 know if they're on track or not? How is that
15 implementation working?

16 So having that both process and
17 outcomes piece. Like many others here, I
18 struggle with the experience word. It sounds a
19 lot like satisfaction. As we talk to the payers,
20 they're often much more interested in clinical
21 outcomes. So I think whether it's very explicit
22 that's included in patient and clinical

1 experience or a separate category. I think that
2 would be helpful.

3 I think Judd you made a great point
4 there. Is it the same or is it better? I think
5 we need to be careful about that. I think we've
6 seen circumstances where it is actually better,
7 but I don't think that should necessarily be the
8 expectation. Really, the goal for us has been to
9 show that it's the same, but we've been surprised
10 before.

11 Then the last thing that we struggle
12 with in case there's something we can add here is
13 also evaluating our clinicians. You know, we
14 have a patient coordinator who does test calls
15 with our patients and physicians as they are
16 onboarded for video visits, for example, and
17 while we do a one-time training for physicians
18 and send out a monthly newsletter we have found
19 that, you know, a year in, they may be having
20 video visits with the patients like this, or
21 having other people in the room.

22 So how do we evaluate the ongoing

1 effectiveness and telepresenting skills is one of
2 the words used. Again, I'm not sure if that fits
3 within the scope of this, but that would be
4 something.

5 MR. GOLDWATER: Mary Beth?

6 MEMBER FARQUHAR: A couple of points.
7 I have to follow up on Steve's point of
8 operational definitions. Right in this committee
9 we've used the word telehealth and telemedicine,
10 and nobody has defined it yet. So I think that
11 would be something that needed to be included in
12 the environmental scan.

13 I'm not having such a hard time with
14 patient experience of care, because basically
15 I've cut my teeth on it, so you know basically
16 experience of care, I think, is an important
17 aspect, in particular because it's actionable for
18 the clinician to work on these areas.

19 One area that I don't see here is
20 patient outcomes. That's one of those areas that
21 I think is going to be more and more important as
22 MACRA is implemented.

1 MR. GOLDWATER: Paul.

2 MEMBER GIBONEY: And going on what
3 Steve North was saying, it made me think that
4 although it can be part of access to care, one of
5 the benefits that I've seen over and over again
6 with telehealth is the fact that these providers
7 that are communicating either with their patients
8 directly or with each other, you know, the
9 coordination and the synergy is so much greater.

10 The transitions of care from primary
11 care to specialist, or from patient to
12 specialist, are so much greater. Access doesn't
13 quite describe it, because you can have great
14 access to a cardiology, and your PCP has no idea
15 of what happened in that interaction. But you
16 know, telehealth has this ability to bring
17 multiple elements of the medical team and the
18 patient kind of into one place at the same time,
19 so everybody knows what's going on.

20 And then you have these super-great
21 hand offs of care, and I -- I'm just not sure I
22 see that particular element of the power of

1 telehealth in one of these five domains.

2 MR. GOLDWATER: Okay, Don.

3 MEMBER GRAF: Considering the
4 appropriateness of the use of technology from the
5 patient or the -- and clinician experience, it's
6 important to keep into consideration
7 appropriateness when there may be -- especially
8 in the advent of a lot of the consumer
9 applications that are out there, that a physician
10 may have three patients all with the same
11 diagnosis, all very similar, may choose to use
12 telehealth in two of those instances but because
13 of psychosocial reasons, because of compliance
14 reasons, may not find it appropriate for the
15 third.

16 So as we're managing these experiences
17 and expectations, considering the appropriateness
18 is probably going to be important.

19 MR. GOLDWATER: Okay, Dale.

20 MEMBER ALVERSON: A couple of comments
21 about the framework. I understand -- just a
22 couple of comments regarding the domains and the

1 framework, and I understand that this term
2 patient experience/clinician experience probably
3 comes from the Triple Aim and the Quadruple Aim
4 now.

5 I would suggest perhaps we change that
6 domain to patient effectiveness, just like you
7 have cost and clinical effectiveness, because
8 that's when it gets into diagnostic accuracy.
9 There are also the aspects of comparative
10 effectiveness, which can be just as important.

11 So I would just suggest maybe
12 experience sounds a little bit more obscure,
13 where effectiveness may be a better term. The
14 other thing I want to make sure that we've
15 included in the environmental scan is the aspect
16 of looking at health information technologies in
17 general, which is an area Jason you're very
18 involved in, but some of the same outcomes are
19 reflected when you look at the impact of an
20 electronic health record or a health information
21 exchange.

22 So make sure that you're including

1 that, and many of us are involved in both areas,
2 in a lot of the same metrics we're looking at.
3 Does the health information exchange, access to
4 health information have an impact? So those are
5 a couple of my comments.

6 MR. GOLDWATER: Okay, Henry.

7 MEMBER DePHILLIPS: Thanks Jason, and
8 forgive me if I may have mentioned this during
9 the phone call, but this is the National Quality
10 Forum. And so noticeably absent from an
11 articulation standpoint is quality of care. It's
12 woven in, right, diagnostic accuracy, patient
13 outcomes, but quality of care is clearly
14 addressed.

15 But as I think about the development
16 of the final work product and where it's going,
17 those who are thinking about purchasing
18 telemedicine services, regulators who are
19 thinking about regulating or legislating about
20 telemedicine services, the first concern that all
21 of them have is, am I going to allow something or
22 buy something that is less than the current

1 standard of care from a quality standpoint.

2 So I'm wondering if we shouldn't be a
3 little more explicit at calling out quality of
4 care. We're doing it anyway, but just call it
5 out a little bit more richly in the articulation
6 of what we're doing.

7 MR. GOLDWATER: Before I get back to
8 Judd, Katie, can we go back to the slide with the
9 domains, with the five. Judd.

10 CHAIR HOLLANDER: Yeah. I was just
11 going to sort of add on to some comments. I
12 don't know that there's anything new, but there's
13 a question here, you know, for NQF actually. So
14 the first is I thought Yael's idea is really
15 important, you know, that we don't separate out
16 based on location.

17 Like if it works in a rural nursing
18 home, it should work in an urban nursing home.
19 As I reflect back on my time I was on the
20 Cardiovascular Measures Committee, I never saw a
21 measure proposed based on geography, right. You
22 know, if you use a biomarker and it works, you

1 use a biomarker.

2 So I think although this work is done
3 for HRSA, I think it would behoove this committee
4 to focus on what works and what doesn't work, and
5 if we need to tie it to something like access,
6 then we should tie it to patients who don't have
7 access for A do wonderful with B. But it
8 shouldn't be tied to their geographic location.
9 So I think that's a really, really important
10 point for us.

11 The second thing, someone raised care
12 coordination, and I think care coordination is a
13 huge thing. It probably can fit into one of
14 these domains, be it patient or clinician
15 experience or access to care. So I think we have
16 a chance to put together a framework that not
17 just helps lead by putting together a framework,
18 but leads by putting together what expectations
19 are for products down the road.

20 So this is my question. If we start
21 suggesting there's measurements that include care
22 coordination, or interoperability, does it put

1 pressure on vendors of telemedicine services and
2 providers of telemedicine service to make sure
3 that they are coordinating care and developing
4 systems that are interoperable?

5 So you know, this is sort of like do
6 you want a reactionary court or do you want to
7 interpret the laws? But I think, you know, if
8 we're leading in quality, we all know the biggest
9 quality deficit in medical care is lack of care
10 coordination and lack of interoperability.

11 So I think a framework that clearly
12 says we should be measuring that will help
13 advance what we think is right for, you know,
14 patient-clinician experience, cost effectiveness,
15 access to care. It will improve all of these
16 domains.

17 MR. GOLDWATER: Right, Stephen. Oh,
18 I'm sorry, Angela. I'll go to Angela first.
19 Yeah, sorry.

20 MEMBER WALKER: Sorry. I think my
21 card didn't get seen perfect.

22 MR. GOLDWATER: That's all right, no

1 problem.

2 MEMBER WALKER: So I just wanted to
3 expand a little bit on comments that Judd, Paul
4 and Steve I think have all made, in regards to
5 care coordination and coming with this
6 connectivity piece. I think we struggle as
7 practitioners often with the silos of care that
8 we have established over time as patients move in
9 and out of certain clinic spaces or across state
10 lines and things like that.

11 And I think in the environmental scan,
12 even the wording and the semantics that we're
13 using might eat into some of that. So when you
14 talk about classifying telehealth as a separate
15 means of care delivery, I think you miss some of
16 that care coordination piece.

17 So maybe defining it as a distinct
18 type of care delivery would be more appropriate,
19 because I do want to see telehealth be a care
20 modality that's integrated into the care that I'm
21 otherwise providing. Looking at that, sometimes
22 the appropriateness is a huge piece of

1 telehealth.

2 So there are some settings where it
3 works really, really well and there are some
4 settings where it really may not. This may be
5 counterintuitive to what some may think but
6 dermatology, though, is a very visual specialty.
7 It's also a very procedural specialty. So it may
8 be that managing, you know, possible melanoma
9 with medication is never the right way to go.

10 I still need to figure out how do I
11 get that patient into a clinic where a biopsy can
12 be done, an excision with what, you know, is a
13 lymph node biopsy if appropriate can be done. So
14 that piece of it can't be lost with this new care
15 modality. If there's been a standard of care
16 that's been developed or there's already another
17 initiative for standard of care in the brick and
18 mortar buildings, I think that that's the same
19 level of care that we would expect telehealth to
20 abide by.

21 So when we use the example of things
22 like UTI for example, if it's considered

1 appropriate to get a culture, I think in
2 telemedicine you can still treat that patient
3 without being seen in a brick and mortar
4 building, but there may need to be a new work
5 flow found for how they can collect urine, submit
6 to a lab and how those results seen back by the
7 physician who's prescribing an antibiotic.

8 MR. GOLDWATER: Sure. Okay, Stephen.

9 MEMBER HANDLER: So my only point was
10 in response to Judd, was with regard to kind of
11 leading the industry, and so there are care
12 coordination codes as you know now, CPT E&M codes
13 for that, and I don't think that they include
14 telemedicine per se yet, right? So I guess the
15 question is as new CPT E&M codes come out,
16 there's an open opportunity for commentary and
17 clinicians and other organizations can promote
18 that.

19 So I don't know is this body the right
20 place to do that though, to promote the specific
21 technology? And I just want -- I'm just trying
22 to understand your point. Should we be promoting

1 a problem and solution set, because that's what
2 I'm hearing in that regard.

3 I'm all about care transition. That's
4 what I do all the time, you know, dealing with
5 patients that transfer from hospital to nursing
6 home, to home, et cetera, and I'd love to see
7 that. But I don't know if that's the right thing
8 to do or not. I think the better way to handle
9 it is as CPT E&M codes is to them back them and
10 promote their utility and why they'd be better to
11 be -- or possibly covered or should be covered or
12 a trial should be done. I'm not sure. I didn't
13 know if we wanted to have a discussion about that
14 or not further.

15 MR. GOLDWATER: I think when we start
16 to look at, which will be later on, the
17 discussion of measures, and identifying gaps and
18 where telehealth measures could be potentially
19 developed. I think that's where that
20 conversation is more or less appropriate. I
21 don't think that there's an issue with discussing
22 a problem and a solution that telehealth would --

1 that modality of care would be a solution to, as
2 long as it can be operationalized to some degree
3 into something that can be measured, and
4 something that, as Henry pointed out, improves
5 quality.

6 If we can do that, then I think that's
7 fine. If it's a general statement about well,
8 telehealth can improve care coordination and we
9 can't identify a particular problem in which a
10 metric would be helpful, then I think that --
11 that's something that sounds out of scope.

12 MEMBER HANDLER: But this brings up a
13 different question then, if I understand this
14 correctly. Do all of our recommendations have to
15 be evidence-based, because if you think about
16 this, given the flow that I'm hearing, so this is
17 a perfect example.

18 I think that probably everybody in
19 this room would agree that transitional care is
20 poor and that additional modalities are needed.
21 It's possible, right, that telemedicine may help
22 that. But without proof, i.e. without your

1 literature review proving that, should our group
2 make that recommendation?

3 MR. GOLDWATER: So as a general
4 concept yes, because --

5 MEMBER HANDLER: Okay.

6 MR. GOLDWATER: Let's make sure I --
7 let me make clear about what we're trying to do.
8 You're not promoting a measure. If it were a
9 measure, it would have -- there would have to be
10 a strong evidence base to that.

11 Promoting a concept of telehealth will
12 help facilitate better care transitions, I don't
13 think as a concept is wrong to be bringing up,
14 and then if that becomes a foundational part of
15 the framework for people to develop measures
16 from, then they will get specific into how
17 telehealth will work on care transitions across
18 settings, not necessarily restricted to
19 geography, and then it will have to be that
20 evidence base.

21 So this is -- this is a little bit
22 different than a measures consensus development

1 group, where we're looking at measures and we
2 have to evaluate by evidence base. This is
3 conceptual. It is what would telehealth serve
4 and be advantageous towards, and then from that,
5 you know, people such as Marcia or Yael or
6 Marybeth can develop those measures with the
7 evidence base from it.

8 MEMBER HANDLER: Okay.

9 MR. GOLDWATER: Thanks. Eve-Lynn.

10 MEMBER NELSON: I again would agree
11 with the care coordination point. I think
12 thinking about that broadly may benefit. For
13 example, we do work with schools, as I know Steve
14 and others do. So it's not, you know, broadly
15 thinking about the care coordination between
16 systems of care. So it could be schools, it
17 would be welfare, it could be other child-serving
18 systems.

19 But there's some real unique benefits
20 of telehealth, and that's one thing I think
21 others are touching upon too. Can we encourage
22 thinking about the unique benefits of telehealth

1 that may not be captured by these traditional
2 measures?

3 MR. GOLDWATER: Yes, absolutely, and
4 I think the framework, as we move forward, really
5 needs to focus on that. What unique about
6 telehealth is not present in our existing
7 measurement environment, which as Adam pointed
8 out, is mostly hospital or ambulatory case-based,
9 or you know, now becoming strongly focused on
10 patient-reported outcome measures. Don.

11 MEMBER GRAF: Maybe a cousin to care
12 coordination, care integration, wherein for
13 example Medicaid contracts across the country are
14 integrating and requiring the integration of
15 physical and behavioral health, and uses of
16 telehealth to be able to facilitate that.

17 The other is in integrating the social
18 determinants along with the clinical, where we're
19 seeing ever-expanding integration with folks like
20 those working on aging and others to be part of
21 the process for overall outcomes.

22 MR. GOLDWATER: Steve.

1 MEMBER NORTH: I think it would be
2 helpful in this conversation if we knew where the
3 gaps in evidence were, because there's a lot of
4 evidence for stroke being of benefit when
5 delivered through telehealth. There's not a
6 whole lot of evidence around toenail fungus, for
7 example.

8 So where should we be focusing?
9 What's a sort of a concept that we're trying to
10 support, versus where is there clear evidence in
11 easy reach?

12 MR. GOLDWATER: Well, I'll confess
13 toenail fungus did not enter my mind, but thank
14 you. Certainly something to know. Dale.

15 MEMBER ALVERSON: Just a couple of
16 procedural things, Jason. Someone had mentioned
17 they wish they could see these slides or have a
18 copy. It's downloadable from your site. So if
19 people haven't already done that, you can
20 download these slides for your review.

21 MR. GOLDWATER: Absolutely, right.

22 MEMBER ALVERSON: The other is that I

1 notice another gentleman just entered the room
2 who --

3 MR. GOLDWATER: Yes, from Macedonia.

4 MEMBER ALVERSON: Who has not been
5 introduced nor has he given his disclosures so --

6 MR. GOLDWATER: You can't hide, Chuck.

7 MEMBER DOARN: No. The reason why I
8 was late, I actually had to give a lecture by
9 Skype to Macedonia, so I'm sorry. I apologize
10 for being late.

11 MR. GOLDWATER: Sure you did.

12 MEMBER DOARN: I decided to walk from
13 the Hilton. Some nice property along the way.
14 No, is this the literature -- well I guess --

15 MR. GOLDWATER: Introduce yourself and
16 if you have any disclosures.

17 MEMBER DOARN: So I have -- no, I have
18 no disclosures, but I have a lot of interests. I
19 am actually the editor of the Telemedicine and e-
20 Health Journal along with Ron Merrell, and have
21 been at that now for 12 years, taking over from
22 Rashid. I don't know if Rashid is here or not

1 today, and what I find most amazing is that here
2 we sit talking about all these things that's
3 missing from the literature but, you know, has
4 anybody ever offered to actually write this
5 stuff?

6 Because we get more manuscripts from
7 the rest of the world than we do the U.S., which
8 blows me away because most of the work that's
9 being done in this field is here, I mean because
10 we're still trying to screw around and, you know,
11 right down the street, whether we're going to pay
12 for it or whether we're going to sue for it or
13 whatever.

14 Where the rest of the world's like you
15 know, we're just going to do it. The part that
16 kind of bothers me is that there is a lot missing
17 from the literature, but there's also a lot
18 that's been published and a lot that's been done.

19 I actually started yesterday, so I
20 don't have it ready. I actually mentioned on our
21 phone call that there were a number of different
22 reports done in the 1990's by the federal

1 government, one that was delivered to Vice
2 President Gore at the time, and I went in my many
3 boxes in the basement looking for it, couldn't
4 find it.

5 But there is a number of things out
6 there, we just have to find it. There's the
7 Health Information Applications Working Group,
8 which is an organization that Dena started, with
9 representation from each federal agency.

10 I actually work at NASA headquarters
11 as well. The Joint Working Group, which was a
12 sort of -- it wasn't legislated, but it was sort
13 of set in stone by the Clinton administration and
14 every agency participated in that, some more than
15 others.

16 Now we have FedTel, which I'm the co-
17 chair with -- it was Sherilyn Pruitt, now it's
18 Bill England. There's also the early House
19 Report. There's a number of others, and then I
20 started thinking about different conferences.
21 The National Library of Medicine had a conference
22 in 1997.

1 Rashid had two meetings at the
2 University of Michigan; several of us
3 participated in that, and then there was the
4 National Center for Research Resources, the
5 Conference on the Future of Telehealth in 2009,
6 and that resulted in about 12 manuscripts. Then
7 there was the telehealth, White Papers: the Road
8 Map for the Future, which again several of us
9 participated in that Pam Whitten had, which also
10 resulted in a number of manuscripts, all
11 published in the journal.

12 So that was just sort of -- and then
13 of course there's the empirical evidence series
14 that Rashid's been writing. So that's his -- I
15 haven't finished that, so it's not ready for
16 prime time. But that's a teaser. The other
17 thing that I mention or point out, I'm trying to
18 look at these.

19 If I look at these five different
20 categories, the underlying theme for all those
21 seem to be missing, and I don't know if you
22 talked about it before I arrived. But the terms

1 technology, innovation, and informatics. Dale
2 just mentioned informatics a moment ago. The
3 basic structure of the future of medicine is
4 based on those three things, and they don't
5 appear here.

6 If we assume that we're making
7 decisions purely based on cost, the consumers are
8 going to start demanding we change and we're not
9 really good at changing, as I've watched over the
10 last 12-15 years. But I think technology, and
11 I'll use an example if we look at quality of
12 service.

13 I can do a cholecystectomy with a
14 butter knife and get results, right, with a dull
15 butter knife right, and I can use a da Vinci
16 robot. Now I would never use a butter knife even
17 if it was sterile, but having just given this
18 lecture in Macedonia or by Skype, they actually
19 use kitchen utensils as rib spreaders to keep the
20 chest open, and many of you have maybe heard me
21 talk about that before.

22 The quality, I mean the patient

1 survived, the patient recovered, the patient was
2 fine, right. We've done surgery in remote
3 jungles where the patients come back and they're
4 fine, and the cost is one-tenth it costs to do it
5 at the Mayo Clinic, not picking on the Mayo
6 Clinic. I guess it could be Cleveland Clinic.

7 So the point is that the technology is
8 part of that and shouldn't be left out. There
9 are papers that have been written around the
10 world, some of them coming out of Taiwan or China
11 or South Korea, that show these technologies that
12 have a lot of value, and sometimes I've seen it,
13 and this goes to the NASA example.

14 I've seen NASA scientists say the
15 Russians don't have any frigging idea what
16 they're talking about. I sit back in amazement
17 because they actually have a lot more experience
18 on long duration space flight than NASA itself
19 does, where the space station is changing.

20 So sometimes what we see in the rest
21 of the world doesn't necessarily apply here,
22 because people are unwilling to listen to it,

1 unwilling to read it, unwilling to reference it
2 and I think part of our environmental scan of the
3 literature should include not only the
4 telemedicine journals, and I have a whole list of
5 different journals, but there's also the
6 specialty journals, Dermatology.

7 I know Joe Caveter, for instance,
8 publishes a lot there, April Armstrong and
9 others.

10 MR. GOLDWATER: And we have a lot of
11 those.

12 MEMBER DOARN: Informatics and so
13 forth. So I have not seen the list of the actual
14 literature. I don't know what's missing, and so
15 I don't know if you're going to --

16 MR. GOLDWATER: Because we're still --

17 MEMBER DOARN: Still doing it, okay.

18 MR. GOLDWATER: So because you were
19 lecturing in Macedonia or so you say, we were --

20 MEMBER DOARN: I tried to find a
21 Starbucks on the way from my meeting. I did see
22 some nice property to rent, but anyway --

1 MR. GOLDWATER: We were talking about
2 we've reviewed articles at the abstract level.
3 We've started to pull the articles. We're now
4 abstracting the articles and we're really just in
5 the beginning stages of it, which may alter or
6 change based upon this discussion.

7 So we didn't want to get so far into
8 it that we were done, and then have everyone say
9 oh, you're going about this all wrong and then
10 like oh God. So we just started it, and then we
11 can make adjustments and changes.

12 MEMBER DOARN: So I promise not to be
13 the elephant in the room.

14 MR. GOLDWATER: It's too late for that
15 Chuck. So Dr. Flannery, then Yael, then Daniel,
16 and then I'm going to have to stop for a minute
17 so we can review what we've discussed.

18 MEMBER FLANNERY: All right, okay. To
19 follow up on the comments there, it's a literary
20 review in a repository some place that we can
21 actually look at and see?

22 MR. GOLDWATER: It will be when it's

1 completed, yes.

2 MEMBER FLANNERY: Not before then
3 though?

4 MR. GOLDWATER: Is there anything in
5 particular, Dr. Flannery, you wanted to see? The
6 articles themselves or --

7 MEMBER FLANNERY: If there's just like
8 a listing of all the results of your literature
9 review and citations.

10 MR. GOLDWATER: I think we can
11 probably post the articles that we've collected
12 to date online, on the SharePoint site.

13 MEMBER FLANNERY: Because if you're
14 looking for gaps in the literature search, it
15 would be nice to see what you found.

16 MR. GOLDWATER: Sure.

17 MEMBER FLANNERY: You know, et cetera.
18 And the other thing that follows up on technology
19 is that part of the power of telemedicine is its
20 being very disruptive, including new models of
21 care. I'm not sure where you fit that into this
22 rubric.

1 MR. GOLDWATER: Sure, okay. Steven.

2 MEMBER HANDLER: One other point of
3 clarification, is the literature review
4 restricted to the United States that you're
5 doing?

6 MR. GOLDWATER: No.

7 MEMBER HANDLER: Okay, thanks. Or
8 English language or what are the restrictions of
9 your review?

10 MR. GOLDWATER: The only restrictions
11 were articles that were later than 2006 we
12 excluded, and they had to meet our search
13 parameters. If it was in a language other than
14 English, that might have been problematic, given
15 I'm not sure that we speak any languages other
16 than English. Fortunately, I will tell you that
17 hasn't been a problem yet.

18 But yes, we've gotten articles from
19 Norway, Denmark, and a lot of them from Chuck's
20 journal. So he's right, there are a lot of
21 articles that are coming from other countries.
22 But yeah, we had not limited just to United

1 States. The gray literature, the California
2 Health Care Foundation reports that, yes, is all
3 U.S.-based. Yael.

4 MEMBER HARRIS: Thank you. So this
5 brings us back to some conversations we had
6 before Chuck, you know, destroyed the flow we had
7 going on here.

8 So responding to Angela and then I
9 think Steve's comments about evidence and about
10 standards, and I think we just need to take into
11 consideration that obviously if standards are
12 there, that's how medicine should be practiced,
13 whether it's used telehealth or not.

14 But there's a lot of standards that
15 are being developed for medicine, behavioral
16 health is one of the most robust.

17 Teledermatology has some standards in terms of
18 image size, you know, stroke is very advanced.
19 There are other areas, and I am one of the people
20 to agree, that telehealth does not necessarily
21 work for every type of medicine practiced.

22 But I would say that there's a lot of

1 medical practices where telehealth would work or
2 have a lot of potential to work. We don't have
3 standards there. So I don't want to throw the
4 baby out with the bath water. I just learned
5 this weekend what that meant, so if anyone wants
6 to find out from a historical perspective.

7 But realistically, I want to make sure
8 we take into consideration the fact that if we're
9 going to be thinking about -- we're not
10 developing measures, but thinking about a
11 framework, not disregarding areas where
12 telehealth could help, because there hasn't been
13 enough evidence and research to show that it
14 works in that area.

15 Because in a lot of cases like
16 behavioral health, before they said it may not
17 work in some areas, until they had the standards
18 to say this is how and why it works, and this is
19 how and why it doesn't. So I just wanted to put
20 that on the books, in that standards and evidence
21 fit together, but that doesn't preclude us from
22 thinking about different uses of telemedicine as

1 we develop this framework.

2 MR. GOLDWATER: Okay. Daniel and then
3 Adam.

4 MEMBER SPIEGEL: Thanks. I just
5 wanted to comment quickly on some of the
6 potential information listed here. So in cost
7 effectiveness I see effect on patient self-
8 management and in patient experience I see
9 compliance with care measurements. I didn't see
10 patient health engagement, which I think can be a
11 powerful leading indicator of both of those
12 things in ultimate health outcomes.

13 MR. GOLDWATER: Uh-huh, okay. Adam.

14 MEMBER DARKINS: I was going to go
15 back to something that Henry said earlier, which
16 was really on the quality of care and something
17 aligned with that, which is patient safety.
18 We're naturally, given the group you've got,
19 self-selected to be pretty much favorable in
20 terms of this whole area, and also --

21 I mean I don't think it's our job to
22 promote it, but to provide the framework, which

1 means it's done safely. By its very nature it's
2 an area which is really very developmental. So
3 it isn't as though we can lay down certain
4 frameworks and say this is absolutely how it has
5 to be.

6 People are going to kind of push the
7 limits of this. So it seems to me there's a
8 piece around this, which is how do we deal with
9 uncertainty and say with something which is going
10 to be evolving, how do we lay out a pathway, and
11 there's an element of that which is around
12 patient safety?

13 I mean this isn't in a sense academic
14 or it could be where, you know, it's all very
15 interesting. But the bottom line is as a result
16 of what we do, we're helping create a framework
17 that means people will get care in ways they
18 otherwise wouldn't do. So it seems to me that's
19 a kind of fundamental underpinning. It certainly
20 has been in things I've done.

21 MR. GOLDWATER: All right Judd, and
22 then we'll review a little bit.

1 CHAIR HOLLANDER: Yeah. I just wanted
2 to, I guess, go with Yael's comment, which went
3 with Angela's comment regarding the standards,
4 and I think it's another definition thing up
5 front. Most of the standards that exist in
6 America, endorsed by guidelines, are consensus
7 standards based on little or no evidence, right.

8 There are, you know, 1C at best
9 recommendations. And so I think it's important
10 that as we're talking about telemedicine, if
11 we're going to hold it to a standard, we compare
12 it to an evidence-based and not consensus
13 standard, because when that consensus standard
14 was made, telemedicine didn't exist.

15 So this is a disruptive technology
16 designed to change care. But if we hold, for
17 example, and you know, people can agree or
18 disagree that this is good medical care right
19 now, but we have one of our pulmonologists who
20 takes care of his asthma patients by
21 telemedicine. He can't listen to their lungs in
22 any way, shape or form. But the alternative in

1 the real -- what?

2 MALE PARTICIPANT: Why can't he?

3 CHAIR HOLLANDER: Well, with the
4 technology he has available right now, he's not,
5 okay. And so but the truth of the matter is he's
6 now learned he doesn't believe he needs to,
7 because these were patients that he was getting a
8 phone call about, and now rather than dealing
9 with a phone call, he's actually seeing them and
10 he believes it's more information.

11 But if a standard exists on how to
12 take care of an asthma patient, it's always going
13 to include listening to their lungs, and it's
14 never going to consider the fact that they used
15 to get dealt with on a phone call and video. No
16 one, I think, would argue that video is less than
17 a phone call.

18 And so I think we really need to be
19 careful if we're going to anchor ourselves to
20 current standards of in-patient visits. That
21 concept scares me, but if we're going to do it,
22 we should require it be a 1A level of care. It

1 should be based on randomized controlled trials
2 that's the right thing for that patient.

3 Because you know, I'm an ER doc, so
4 this is my bias and disclosure. I'm used to
5 people from other professional societies, whether
6 it be ID, pulmonary or somewhere else, telling me
7 how I should practice, and if I spun around three
8 times, they might not be able to find the
9 emergency department. It's a different set of
10 patients, and telemedicine is a different set of
11 patients. So I think we just need to acknowledge
12 that.

13 MR. GOLDWATER: Okay. All right.
14 Let's review just -- yes Chuck.

15 MEMBER DOARN: There were two items.
16 One, you mentioned the date 2006. How many
17 people have been to the University of Arizona
18 archives besides maybe Dale. So there's a box
19 there that Ron Weinstein has on the STARPAHC
20 program, which is a NASA program from the 1970's,
21 and there's a series of manuscripts in those
22 boxes that really haven't seen the light of day.

1 They've been published, but they're
2 hard to find. They are redundant to everything
3 that's been published since then, the barriers,
4 the challenges, the technology, everything we've
5 talked about, standards. So I'm not sure using
6 the date, arbitrary date of 2006 is the right
7 approach.

8 There are lots of things that have
9 been written prior to that that haven't really
10 changed. Yes, we have faster internet. We have
11 mobile phones, but the challenges that we have
12 faced in 1990 are kind of the same. So I would
13 think about that.

14 The second thing is the guidelines,
15 the ATA has developed a series of guidelines with
16 both evidence base and a lot of peers, some in
17 the room, that actually have gone off and had
18 different sessions where they've actually
19 developed these guidelines.

20 Now whether they're the most
21 appropriate guidelines or whether they need to
22 continue to evolve, they are out there and the

1 AMA is actually working with the ATA on some of
2 that as well. So not, you know, to throw water
3 on the idea that there are no guidelines. There
4 are.

5 And then the third thing, the Center
6 for Connective Policy actually -- I actually -- I
7 used this is in a slide last night at George
8 Mason, 17 states have defined telehealth. 41
9 states have defined telemedicine.

10 But Utah, as an example, has no
11 definition. They call it digital health
12 services. So each state might be different in the
13 way they define it --

14 FEMALE PARTICIPANT: And how they pay
15 for it.

16 MEMBER DOARN: And how they pay for
17 it. That's another big challenge as well. So it
18 may behoove us to look at what each state does
19 and help, at least maybe in the introductory part
20 of this report, because the literature search is
21 important, but actually looking at what states
22 are doing I think is important as well.

1 MR. GOLDWATER: Okay. Julie.

2 MEMBER HALL-BARROW: Yeah, just around
3 the technology piece, as we look at this data,
4 you know, I just think specifically about remote
5 patient monitoring and the compliance piece of
6 medications, which is self-reported. So we may
7 have some findings that say oh, this doesn't do
8 as well.

9 But if we were using a more reputable,
10 you know, technology that allows us to know when
11 they actually took it and where, because we
12 actually have a digital sensor embedded, co-
13 encapsulated, we get way better data, you know,
14 for our kids. I have teenagers, they're liars
15 typically. You know, did you take it? Yes. You
16 know, they're just very reactive to that
17 question. I can say that.

18 But you know, when you actually have
19 the real data because it was ingested, that data
20 is actually more defined. So we won't have some
21 of that data now, but I'd hate for us to be so
22 narrow that we would say no, this is not driven

1 if we had a technology that maybe is evolving
2 that would provide it for us.

3 MR. GOLDWATER: Sure. All right. Let
4 me just go back and review. First of all again,
5 thank you all very much for the robust
6 discussion. I expected nothing less, so I'm
7 thrilled for all of the comments and know you're
8 not going to have us restart at zero. We are
9 right where we need to be in terms of where this
10 discussion needs to go.

11 The first thing I heard in a couple of
12 areas is that, you know, the project is entitled
13 telehealth. That's how it was brought to us.
14 So how do you want to, because I think this is
15 going to be important to define in the beginning
16 of this report and in the framework to follow,
17 how would you want to define telehealth as
18 opposed to telemedicine?

19 What do you believe the differences
20 are between the two? Are they synonymous terms,
21 are they not? Yael.

22 MEMBER HARRIS: So I spent a lot of

1 time on this, and Chuck and I actually wrote a
2 paper, I don't even know how many years ago now,
3 looking at all the different federal agencies and
4 how they define telehealth, and not a single one
5 uses the same definition. In fact, branches of
6 the same agency use different definitions.

7 I would like to argue, and this is
8 not, you know. There's no consensus on this, so
9 you can disagree with me all you want. I would
10 like to argue that telemedicine is a subset of
11 telehealth, and that telehealth is far more
12 broad-reaching, and I think digital health is
13 really the best way of putting it, because
14 telehealth includes strong forward face-to-face
15 remote monitoring.

16 Tele-education, which is not
17 necessarily, you know, it could be phone-based
18 education. Group-based cognitive behavioral
19 therapy. So I think telehealth is more of an
20 umbrella term, and I think we need to think
21 broadly. When you go into mobile, text messaging
22 is a little, you know, back and forth text

1 messaging is not the same thing as I sent a
2 reminder to take your medicine.

3 I don't want to start deciding that.
4 I'm not a doctor in terms of what is medically
5 appropriate. They both have had effect though in
6 the literature. So I see telehealth as anything
7 where you're not actually face to face in front
8 of the patients, but you are providing some sort
9 of service benefit that actually benefits the
10 outcome of the patient.

11 MR. GOLDWATER: Okay. Anyone else?
12 Hold on, Chuck. Nate, go ahead.

13 MEMBER GLADWELL: I would agree with
14 the previous comment, and then just articulate
15 for the definition of telehealth, I think it is
16 important to say that telemedicine, again my own
17 personal perspective, is the clinical diagnostic
18 using audiovisual or remote technologies between
19 a clinician and a patient.

20 When the outcome is a clinical
21 diagnostic decision, telehealth then becomes kind
22 of everything else, which is the challenge.

1 MR. GOLDWATER: Right, okay. Chuck
2 and then --

3 MEMBER DOARN: Well, I think that one
4 of the things that the American Telemedicine
5 Association maybe back in the 1998, 1997 or so,
6 there was a lot of frustration by the nurses.
7 They didn't like the term telemedicine. They
8 wanted to call it, you know, telenursing or
9 telehealth. That's sort of where this kind of
10 started back in that time period.

11 But telemedicine really is, you know,
12 many different definitions. As Yael was pointing
13 out, the federal government has way too many
14 definitions, and there's really no way to have a
15 single definition because of legislative intent.
16 So NASA astronauts, men and women in uniform, the
17 VA, Indian Health Service, all our unique, their
18 populations.

19 The rest of us fall into, you know,
20 American citizens as all those other people are
21 as well. So having a unique definition for
22 telemedicine might be kind of challenging, and

1 then you start talking about e-health, mobile
2 health and the way you spell those words is
3 unique and depends on who you talk to.

4 So trying to come up with a unique
5 definition with a rapidly changing technology is
6 sort of, you know, it's a challenge for sure.

7 MR. GOLDWATER: Okay, Dale.

8 MEMBER ALVERSON: I just -- did you
9 think you were going to ever to get this, you'll
10 going to summarize now the outcomes of our
11 discussion? I don't think so.

12 MR. GOLDWATER: No, I did -- good, but
13 I'm going to.

14 MEMBER ALVERSON: You're very flexible
15 Jason.

16 MR. GOLDWATER: I'm going to.

17 MEMBER ALVERSON: And I want to
18 compliment you on that flexibility.

19 MR. GOLDWATER: It was a great thought
20 Dale, wasn't it?

21 MEMBER ALVERSON: It was, but -- and
22 we still may get to that. I just want to refer,

1 and I don't want to put Adam on the spot, but I
2 quote Adam from his book, this whole idea of
3 tele, and where the derivation of that term came
4 from, which really means at a distant or remote.
5 So it's television, telephone, telescope, and I
6 don't think -- telegram.

7 You know, when we talk about
8 telemedicine or telehealth, it really is
9 provision of those services, however you want to
10 define them then, over distance. I don't know
11 Adam, if you want to comment on that. But it
12 always struck me and I actually quote that a lot,
13 because people say well I don't know. What is
14 this? It seems so mysterious, telemedicine,
15 telehealth and so on.

16 So I kind of like the way that you had
17 framed it, and then it doesn't seem so confusing.
18 That's simply what it is, provision of health
19 care services over a distance.

20 MR. GOLDWATER: Mic on.

21 MEMBER DARKINS: That was a time I was
22 trying to make sense of it. I think so that's

1 the derivation of the word, which is where it was
2 putting tele onto things is where it came from.

3 It seems to me what's happened is the
4 field has gone forward. People tried to own it
5 at particular times, and so as a new group of
6 people get involved in it or it spreads. So the
7 whole thing of mobile health is now disappearing.
8 It's losing its luster.

9 So I think there are sort of
10 fashionable words and things. I like what I
11 think Dale does, Jay Sanders says also. I think
12 the term is going to disappear. I think it will
13 become assimilated in just the normal delivery of
14 care.

15 So I think what one needs is kind of
16 you have to define something in terms of what the
17 scope of it is. But I think the more you try and
18 slice and dice this and try and come up with
19 precise terminologies, we're just going to go
20 round and round and round in circles.

21 So it seems to me to find the thing to
22 be, and I don't think -- what I'd like to find is

1 a good, encompassing discussion that really ends
2 up just being able to put people into the frame,
3 because we could spend half our time in the next
4 six months and still I don't think that any
5 further to really have been clear on what the
6 definitions are.

7 MR. GOLDWATER: Right, and before I
8 get to Stewart, it's not to come up with a hard
9 and fast definition. It's just for us to get, I
10 think, some clarity about how you all generally
11 distinguish between the two, to provide some
12 context for the word.

13 But Adam, I agree. If we were to say
14 -- if I were to say okay, we're going to come up
15 with a standard definition now, we would be here
16 until next week and Stewart would get really
17 angry because he's got to go back to Alaska. So
18 with that in mind, Stewart.

19 MEMBER FERGUSON: So I hate to
20 hesitate to disagree with Yael, but I think the
21 only people that really try to slice and dice the
22 definition of telemedicine and telehealth are

1 people that sit on committees like this. I think
2 people that do this, people out in the field that
3 are doing this, don't really care what we call
4 it.

5 Some of them consider it to be
6 telehealth because they're doing health care.
7 Some of them think it's medical so they call it
8 telemedicine. ATA, it was always a fun debate at
9 the ATA board to whether we should rename it and
10 stop calling ourselves the American Telemedicine
11 Association and become the American Telehealth
12 Association.

13 If you'd want to stir up the board
14 members you'd propose this. ATA now on their
15 website say there is no difference between the
16 words, and I think -- actually, I think that's
17 the way we are evolving at this point. I think
18 it's kind of capricious to try to pick between
19 them. I would prefer that we choose not to have
20 that debate and just accept either word as
21 referring to health care provided over
22 telecommunications.

1 MR. GOLDWATER: Okay, all right. So
2 -- oh Adam, go ahead, sure.

3 MEMBER DARKINS: Just to say Stewart,
4 I totally agree with you. Somebody who's in the
5 field doing it, who is just trying to deliver
6 care doesn't. But if you're trying to develop in
7 a hospital or a health system or a payer, unless
8 you've got some framework to put it in, you can't
9 do it.

10 So one of the reasons that this --
11 it's difficult to grow some of these things is
12 because there isn't that framework. So I think
13 there's a kind of -- you know, I accept what you
14 say. I just wanted to challenge that. But I
15 think that's one of the reasons this field has
16 struggled.

17 MR. GOLDWATER: Okay. So with that in
18 mind, on the second part of the attempted summary
19 of the discussion Dale, we'll take some time. So
20 why don't we take a 15 minute break now and then
21 we'll come back, and what I want to then go over
22 are these domains and see how we refine and

1 specialize these, so that we're clear about the
2 information that we're getting.

3 So now you can all do the hugs that
4 you wanted to do in the beginning, and I'm a big
5 hugger.

6 (Whereupon, the above-entitled matter
7 went off the record at 10:58 a.m. and resumed at
8 11:19 a.m.)

9 MR. GOLDWATER: Several people have
10 asked about the event for tonight. So, as is
11 typical with -- when we invite out of town guests
12 -- I know, it's all about food, isn't it? Right.
13 You come here to talk, but you really want to
14 come here and eat and drink. I get it. So,
15 there will be a dinner tonight. Katie, do you
16 have details on that?

17 MS. STREETER: So we have a large group
18 reservation at a restaurant nearby. At --

19 MR. GOLDWATER: It's Siroc, isn't it?

20 MS. STREETER: Yes, Siroc. And it's
21 915 15th Street. So it's right across from
22 McPherson Square. They specialize in local

1 seafood and they were able to meet our request
2 for having separate checks, which is something we
3 require for the reimbursements.

4 So if you are interested -- I know
5 several of you indicated on the travel request
6 form that you were interested -- but I'm supposed
7 to call them mid-afternoon to kind of give them a
8 better idea of numbers. So I guess we can do
9 maybe a hand count before we break for lunch if
10 you want to think about it, and I can let them
11 know the number.

12 PARTICIPANT: What time was it?

13 MS. STREETER: Oh, it's for 5:30.

14 MR. GOLDWATER: Right, it's good to
15 beat the lobbyist crowd, which hits around seven.
16 Right? Trust me. So, I will, unfortunately not
17 be able to join you all for dinner as I was
18 telling Dale and Stewart. I have to play the
19 role of dad tonight and help my teenage daughter
20 study for two exams. So, I hope you all have a
21 great time and I'll hear all about it. And
22 hopefully she'll do well, or I'm going to get

1 really angry that I missed dinner and she didn't
2 do well. So --

3 All right, so let's pick up. What I
4 would like to discuss now -- and again, thank you
5 all so very much for the very robust
6 conversation. It's always very, very helpful.
7 And, again, I think all of you who are so
8 committed to this makes running and facilitating
9 this meeting so much easier.

10 I do want to go to the domains of
11 information that you see in front of you. I know
12 that, I think Dale's recommendation is a good
13 one. Instead of patient experience and clinician
14 experience -- what are we going to call those
15 now? Right. Patient effectiveness and clinician
16 effectiveness. Clinical effectiveness. And so
17 we'll change those.

18 But looking at those five domains, and
19 even with the changes that we will make, are
20 those adequate for the information that we need
21 to be gathering? If not, what needs to be
22 changed or added? And in the potential

1 information that aligns to those domains, are we
2 looking for the right things, or do we need to
3 re-scope that a bit? Steven?

4 MR. HANDLER: So, perhaps I'm
5 descending slightly. I mean, I believe that we
6 should consider keeping it as the experience if
7 we agree with the quadruple aim, which does use
8 experience and does articulate fairly
9 straightforwardly how to quantify that, how to
10 measure that, etc. And I could provide examples
11 if that's of interest to the group. Just
12 throwing that out there.

13 MR. GOLDWATER: I'll hold you on to
14 that, maybe. We'll get -- we'll get back to
15 that. Let's -- let's see the discussion on the
16 domains. Because I want to make sure that we
17 have those domains going forward. So, as I said,
18 we're already abstracting articles. We need to
19 make sure we're aligning them in the appropriate
20 place. Marybeth?

21 MEMBER FARQUHAR: I agree with Steven.
22 I think we should have a patient experience

1 because that's totally different than patient
2 effectiveness. Patient experience is basically
3 what a patient experiences from their point of
4 view. And patient effectiveness, according to
5 what you have here, is things that we can look at
6 versus what the patient can tell us. So, that's
7 --

8 MR. GOLDWATER: Would it be helpful,
9 then, to do two? Patient experience and patient
10 effectiveness? Add a domain? Would that be
11 satisfactory, or do you think that that is adding
12 on too much information? Paul? And then --

13 MEMBER GIBONEY: Well, in response to
14 that question, I think it might be adding too
15 much if we -- I think we should try to come up
16 with one or the other.

17 MR. GOLDWATER: Okay.

18 MEMBER GIBONEY: But -- but the
19 additional domain, I just wanted throw out --
20 because I talked about it earlier -- but, you
21 know what -- what does the group feel about
22 adding a domain that -- that captures that

1 coordination of patients' care between providers
2 and -- and different places and different roles
3 in the care?

4 It just -- it's not access and it --
5 you might be able to put it into patient
6 experience or patient effectiveness, but I don't
7 know. It seems to spell out a slightly different
8 role of telehealth. So, you know, I wanted to
9 think what the group thought about adding a
10 domain around coordination of care, transitions
11 of care between providers in telehealth.

12 MR. GOLDWATER: Sarah?

13 MEMBER SOSSONG: I just wanted to ask
14 what the patient effectiveness would look like?
15 I would advocate for both clinician experience
16 and clinical effectiveness. I think that was the
17 point that some of us were making earlier about
18 the clinical outcomes. I think patient
19 experience captures a lot.

20 But the clinical experience -- I
21 think, from our perspective, the administrative
22 burden that clinicians are facing right now is

1 huge. And we have a lot of hospital initiatives
2 around reducing administrative burdens. So, what
3 leadership has said is, anything that we can do
4 that helps that will advance the telehealth
5 agenda.

6 So I think it's enough to call that
7 out. So, I guess I would advocate for the two
8 clinical -- clinical effectiveness, clinical
9 experience and patient --

10 MR. GOLDWATER: Judd?

11 CHAIR HOLLANDER: So I wonder whether
12 those both can't fall under clinical experience
13 and be defined in the potential -- both fall into
14 clinical effectiveness, but the clinician
15 experience can be defined as part of the clinical
16 effectiveness.

17 But -- but I do think it's a little
18 different when we talk about patient experience
19 and patient effectiveness. I would agree, I
20 prefer the term patient experience. But on the
21 clinical side, we're trying to be effective
22 clinicians. So -- so I -- I would make that

1 distinction.

2 With respect to care coordination, I'm
3 just wondering whether it needs to be a separate
4 domain or it could be embedded within the pre-
5 existing domains and -- and called out. I -- I
6 could see that it could actually fit under pretty
7 much most of them. Right? Because it'd be a
8 better patient experience if you coordinated, but
9 it would be a clinical experience or clinical
10 effectiveness if you coordinated care. It
11 certainly might improve access if you went from
12 provider A to provider B and -- and they set it
13 up.

14 So I think it's an important thing to
15 capture. And I'm not arguing with it being a
16 separate domain. I'm just throwing out, you
17 know, what is the best way to capture it?

18 MR. GOLDWATER: David?

19 MEMBER FLANNERY: Just to follow up
20 what Sarah was talking about about administrative
21 burdens and all that kind of stuff. It's almost
22 more like system effectiveness that you're

1 looking at. Not simply the clinical experience -
2 - the patient experience -- but the system
3 effectiveness delivering health care.

4 MR. GOLDWATER: Okay. Anybody else?
5 Judd?

6 CHAIR HOLLANDER: So, you know, that's
7 a -- I think a really interesting and important
8 point. And I -- this is a question for, you
9 know, Jason and QF.

10 Because in the end when measures are
11 developed, the measures get assigned to a group
12 who's responsible for them. Like, the measure
13 might be about the provider or the health system
14 or the payer. And -- and it takes those things
15 into account.

16 I don't know whether we need to
17 comment on that now, or that gets covered later
18 were in attribution.

19 MR. GOLDWATER: Steven?

20 MEMBER HANDLER: Yes, I very much like
21 the concept of the health system as a stakeholder
22 added to this list. Once again, you could

1 conceivably in the way we framed it before is
2 access to care gets moved to the patient
3 experience. Because frankly that's the whole
4 reason in what patients need, right?

5 So, I don't know how much we want to,
6 you know, revise this continually, but I think
7 that -- I'm not sure how important it is, but
8 once again there's -- there are other frameworks
9 that we could consider. I don't know how best to
10 do that as a group right now in an effective way.

11 MR. GOLDWATER: Would you like
12 additional concepts, though, to add to this list?

13 MEMBER HANDLER: I -- what we haven't
14 here said, for example, is under the clinician
15 experience -- they're efficiency. Physician or
16 clinician efficiency. Right? That's an
17 important part.

18 I mean, we often talk about windshield
19 time for the physician as much as we talk about
20 windshield time for the patient. So things of
21 that nature are not on this list. And that
22 improves, by definition, access to more patients,

1 etc. So, I think that there are other concepts
2 that could be added as well, for example.

3 MR. GOLDWATER: Steven, do you -- to
4 follow up on that, is there a handful you want to
5 talk about? Before I move on to Henry?

6 MEMBER HANDLER: I could just rat out a
7 couple.

8 MR. GOLDWATER: That's fine. I've got
9 a list.

10 MEMBER HANDLER: Without looking at
11 that, I'm just going to read through what I have.
12 So, in terms of patient experiences, it's access
13 to care, enhanced quality, decreased variability
14 in care -- I'm not sure that that's on here.

15 MR. GOLDWATER: No, it's not.

16 MEMBER HANDLER: Increased
17 satisfaction. And then, the healthcare -- that's
18 the quadruple aim -- focusing on the provider.
19 Increased efficiency, increased critical
20 thinking, increased job satisfaction. And
21 another concept here is teamwork and the creation
22 of the concept: can we create new inter- or

1 multidisciplinary teams through this technology
2 that didn't exist before?

3 MR. GOLDWATER: Okay.

4 MEMBER HANDLER: So, those are just
5 some.

6 MR. GOLDWATER: Henry? Thank you.

7 MEMBER DePHILLIPS: Thanks. The -- the
8 last two companies I have been with were all
9 about consumer-facing activities to engage people
10 in their healthcare. And one of the things --
11 and I'm a product of this industry, right?
12 Private practice health insurance company.

13 One of the things that I find about
14 the industry that we're in is that it's extremely
15 provider-centric. And if you kind of listen to
16 many of the comments about clinician experience
17 versus clinician efficiency versus -- versus
18 outcomes -- very provider-centric.

19 I would argue that telemedicine
20 represents -- at least provider to patient
21 telemedicine -- represents the first real foray
22 of our industry to become a consumer-centric

1 industry. And so -- and truthfully, in the last
2 two companies I was with, we had to hire people
3 that had no healthcare experience in order to
4 engage consumers well.

5 Because everybody in the healthcare
6 industry -- no offense, I'm part of it -- quite
7 frankly, just doesn't know how to engage
8 consumers really well. If you have a healthcare
9 background, you just don't know how to do that
10 really well.

11 And so, I guess, the reason I'm making
12 the comment is because the patient experience
13 access that you have on this slide is critically
14 important. And I'm going to push hard to
15 preserve it in its current form because it's
16 really, really important. And that's going to be
17 a measure of success and I think, therefore,
18 should be an outcome measure for the industry as
19 it moves forward.

20 I think on the clinician side, I was
21 kind of tracking with a couple of the comments.
22 When you said potentially switching clinician

1 experience to clinician effectiveness, I thought
2 to myself, okay, what do we lose when we make
3 that change? And I think -- I think it is
4 important to explain the clinician experience. I
5 think effectiveness sort of falls under the
6 quality umbrella that I referenced earlier. The
7 effectiveness of the -- the effectiveness of the
8 technology -- you know, the outcomes, basically.

9 So, to a lesser degree, I probably
10 would argue that the clinician experience should
11 also sort of be maintained as close as it can to
12 its current, I think, well thought out form.

13 MR. GOLDWATER: Okay. Steve?

14 MEMBER NORTH: I feel that we're
15 getting bogged down in language and that we need
16 to make sure that the domains match with other
17 standards out there so that they can be easily
18 compared. And I -- standards which you've used
19 before.

20 Could we eliminate the word cost-
21 effectiveness and make that just an effectiveness
22 column? And would that -- would that eliminate

1 some of this discussion of patient effectiveness,
2 clinician effectiveness, system effectiveness?

3 MR. GOLDWATER: Okay. Dale?

4 MEMBER ALVERSON: I agree with
5 everything that's been said so far. And I don't
6 want to get hung up on the terminology because I
7 think that you could argue that you could capture
8 this in a lot of these other domains. I -- I
9 certainly understand it's -- this actually comes
10 up -- for those of you involved with STEM --
11 there's also what's called STEAM where you
12 include art.

13 I -- you know, I think we can get hung
14 up on the terminology. As long as it gets
15 captured. I don't know about the rest of you,
16 but I actually made a list of what I thought were
17 reasonable outcome measures that people have
18 used. I've got like over 30 of them. And would
19 it be helpful to share them with you offline?

20 MR. GOLDWATER: Sure.

21 MEMBER ALVERSON: To send them to you?
22 And then you can see, where do those fit in?

1 MR. GOLDWATER: Sure.

2 MEMBER ALVERSON: Because, you know,
3 looking at the triple aim and then the quadruple
4 aim, certainly that becomes, you know, how do we
5 deal with improving the providers working --
6 dealing with burnout -- all that kind of stuff --
7 telehealth, that stuff -- fit into that in a
8 meaningful way?

9 But, I just want to -- I'm just trying
10 to think about ways that we can help you in sort
11 of categorizing this --

12 MR. GOLDWATER: Sure -- sure -- so, I -
13 - I -- I don't want to get too hung up on, your
14 right, on terminology. I mean that -- it's not
15 to lead to a two-hour discussion on how we define
16 cost, for example.

17 But what I want to make sure is, again,
18 relying on your expertise, you know, are these
19 capturing all of the necessary components of
20 information as respect to telehealth to build a
21 framework around? So, that's what I want to make
22 sure -- we're getting all of that in. Don?

1 MEMBER GRAF: Yes, I speak to a lot of
2 providers that are not now using telehealth. And
3 they don't have an experience yet, but they have
4 real defined expectations that may or may not be
5 -- fit within, kind of, our discussion. So, as
6 we're thinking about experience or
7 appropriateness or whatever we choose, consider
8 those that aren't using it and what they're
9 expectations are. Because in this expanding
10 market, there's -- that's a big group.

11 MR. GOLDWATER: Right. Right. Okay.
12 Paul?

13 MEMBER GIBONEY: Going off of what Judd
14 was saying, who is -- I mean, I think how you
15 word things and how you frame things and how you
16 package things also depends on who -- who you
17 anticipate the audience for your product is going
18 to be. You can want things, you can split
19 things.

20 Do we -- I mean, historically for NQF,
21 who -- who are -- who are the biggest consumers
22 of -- of -- you know, of the work that comes out

1 -- is it -- is it CMS? Is it payers? Is it
2 insurers? You know, I mean, whenever I'm trying
3 to implement something, I'm always trying to also
4 think about who -- who -- who's on the other end
5 of this? And -- and what do they need to hear?
6 And how do they need to hear it?

7 You know, you could -- you could lump
8 access into a lot of things, but if you're
9 talking to insurers, you want to keep that
10 separated out because that is like one of their
11 highest elements. At least in specialty care.

12 So anyway, may -- maybe you could give
13 us some guidance as we think about who is -- who
14 is the audience for this? Maybe that would
15 inform the way we packaged it.

16 MR. GOLDWATER: So it's -- really it's
17 all of the above. It's payers, it's providers
18 especially. It's healthcare plans. It's all of
19 those that really look to assess and use a metric
20 to evaluate quality in some particular area. I
21 think with telehealth -- even though I, you know,
22 completely concur with EIO. You don't want to

1 start moving this geographically.

2 But it will also really apply to rural
3 health clinics, to safety-net providers, to
4 federal telehealth centers. I mean, this might
5 be a little bit more expansive, but really every
6 healthcare entity that provides services -- you
7 know, this is where it becomes useful. Nate?

8 MEMBER GLADWELL: I hate to be
9 redundant, but feel it's value here. I do like
10 the concept that we do have domains and keeping
11 it at that level. That there's domains.

12 And I feel like these areas, with the
13 addition of cost effectiveness potentially
14 switching to system effectiveness, in my opinion
15 captures all the domains we've talked about. And
16 I think does it well.

17 MR. GOLDWATER: Okay. Angela?

18 MEMBER WALKER: I was going to speak in
19 defense of system effectiveness as well, also
20 thinking about care coordination, safety and
21 quality which were some other terms that had been
22 thrown out this morning. I also think one thing

1 that may be missing here, Charles had mentioned
2 kind of the -- the three-vein technology,
3 innovation and informatics.

4 And I think that informatics piece may
5 not yet be represented. It may fall under a
6 system effectiveness. It may be its own entity.
7 But, looking forward for things like population
8 health, public health -- definitely with some
9 public health researchers in the room, it'd be
10 interested to know your -- your thoughts.

11 Anything that may allow us to over
12 time further evaluate and kind of reiterate some
13 of the guidelines. And also serve as that
14 maintenance of guidelines, which I think as we
15 get more and more into evidence-based medicine is
16 going to be important.

17 MR. GOLDWATER: Okay. Stewart?

18 MEMBER FERGUSON: So I agree with
19 everybody's comments on changing cost to system
20 effectiveness. One of the things I'm noticing is
21 two of the metrics are comparative. They're
22 comparing telehealth to the alternative. And

1 then one of your research questions focuses on
2 alternatives. So I just want to be clear that
3 when we say alternative, we're not talking about
4 traditional in-person visit, we're also talking
5 alternative meaning they don't get any care.

6 MR. GOLDWATER: Exactly. Exactly.

7 MEMBER FERGUSON: Is that right?
8 Because that's probably the biggest impact
9 telehealth has, right? Okay.

10 MR. GOLDWATER: Right. Right. Good
11 point. Eve-Lynn?

12 MEMBER NELSON: Under the patient
13 experience, might think about including some of
14 the care giver experience for that. I think
15 about our telehospice project which really, you
16 know, was the patient but also the caregivers is
17 really important. And with the patient
18 experience, things like quality of life and
19 functioning, you know, more functional outcomes
20 might fall under that.

21 MR. GOLDWATER: Okay. Great. Sarah?

22 MEMBER SOSSONG: Just one last point

1 that from my perspective, I think, using the word
2 effectiveness rather than system effectiveness,
3 without getting too much in the semantics, is
4 helpful. Just because effectiveness covers
5 clinical effectiveness, quality, all those other
6 things. And I think the one thing that we think
7 about a lot is what is the effectiveness of the
8 different telehealth modalities?

9 So, if we're using an e-consult or an
10 e-visitor or a second opinion or virtual visit,
11 we think more actually about what's the right
12 telehealth modality than the in-person versus
13 virtual option. And I think that's where we
14 internally could use help and really figure out -
15 - this could help guide us in terms of what is
16 the progression of telehealth modalities.

17 MR. GOLDWATER: Okay. Angela, did you
18 have another comment? Yes --

19 MEMBER SOSSONG: I just, you know,
20 trying to think of a framework. I'm thinking we
21 have multiple audiences for this framework. And
22 I think we need to think about the measures are

1 for doctors or clinicians to demonstrate that
2 they're value -- providing good care, obviously.
3 The measures are for payers to justify the value
4 of this care.

5 The measures are from a -- I don't
6 know if it's a population or a public perspective
7 to validate that telehealth, tele -- whatever you
8 want to call it, is health -- healthcare. Not,
9 you know, this -- not that I don't agree with the
10 term ehealth or digital health, but, it's a -- it
11 puts this divide. So we need to think that -- we
12 need to put the framework in the picture of,
13 we're not just developing measures just --

14 I mean, my perspective and I think
15 Adam pointed this out well from Stewart's comment
16 is, doctors just think of it as practicing
17 medicine. Exactly. And I think that's great.
18 Those of us who have been in the policy world
19 think of it as, what do we need to do to get the
20 payers to cover this? You know?

21 How do we need to justify it? And,
22 exactly, it's -- not just compared to in-person

1 care because they may not have gotten in-person
2 care. But I think we need to keep all of these
3 perspectives in mind developing this framework so
4 we don't think of it as -- I mean, from my
5 perspective, I keep thinking of it as, what
6 measures does CMS need to demonstrate that
7 they'll reimburse it for Medicare?

8 But I have a -- a very biased
9 perspective. I think other people bring
10 different perspectives and we need to keep each
11 of those perspectives in mind in this framework -
12 - that there's multiple audiences for the
13 measures that will be developed out of this
14 framework.

15 MR. GOLDWATER: Okay. Judd?

16 CHAIR HOLLANDER: Not a different
17 domain, but under the potential information, I
18 think we haven't spent a lot of time talking
19 about connectivity and does the technology work?
20 And -- and so we've spent a lot of time on
21 disease focus and care coordination in the
22 specific domains.

1 But I think within -- within the
2 effectiveness groups or the experience groups, we
3 should specifically call out, are you able to
4 connect? Can you see what you need to see? You
5 know, issues with the technology.

6 MR. GOLDWATER: Okay. Anyone else in
7 respect to the domains? I do appreciate the
8 conversation and happy -- I -- I think we'll
9 switch cost effectiveness to just general system
10 effectiveness which, I think, will encompass all
11 of these elements.

12 We will certainly expand a little bit
13 in the domains where you all spoke of. But other
14 than that, we will keep them the way they are.
15 And again, most of the literature we've found
16 does fall into all of these. We have not found
17 any outliers as of yet.

18 There are two other things I do want
19 to talk about -- one of which came up on the
20 phone call, one of which came up this morning.

21 Quality measurement always is about
22 the encounter between the patient and the

1 provider. And so, there has -- there was some
2 discussion on defining a telehealth encounter.

3 And does that differ, in some ways,
4 substantially or not from an in-person encounter?
5 And how would we distinguish those two if there
6 is a -- if there is some disparity between the
7 two of them? And how would we incorporate that
8 into a framework? So, anyone's thoughts on that?
9 This is the one question you all are not going to
10 talk about? Really -- okay, thank you, Henry.

11 (Laughter.)

12 Was like, this out of all of them, is
13 going to keep you quiet? All right, Henry, go
14 ahead.

15 MEMBER DePHILLIPS: Yes, actually, I'm
16 a little prepped because I got asked this
17 yesterday during the ATA get together by an
18 attorney of all people. So, there's a lot of
19 modalities. There's a lot of technology. It's
20 moving quickly.

21 A quick side story. The last day that
22 I testified in front of the Texas Medical Board

1 before the lawsuit went forward, the ear looker
2 that plugs into your iPhone -- real -- real-time
3 streaming video of a tympanic membrane was
4 released to the market. It was in U.S.A. Today.
5 So I talked about how poetically historic it was
6 that that was the day that I was testifying to
7 TMB. None of them found it funny, by the way. I
8 did. I thought it was hysterical.

9 But, so -- so -- but -- but the point
10 I am trying to make is, you know, there's
11 existing technology. There's technology that
12 will be invented tomorrow as soon as we leave
13 here. I -- I -- the answer to the question is
14 that I -- I -- I think that, from a quality
15 standpoint, the standard of care has to be met.

16 And doctors are trained to understand
17 what information you need to gather to make an
18 accurate diagnosis and to render an appropriate
19 treatment plan, and what information that you
20 need to get to make that diagnosis by diagnosis.

21 And so I -- my hope is that we don't
22 sort of get down in the weeds of the various

1 technologies and which one's appropriate or not.
2 Because the day we finish that exercise, the
3 following day something else will be invented to
4 change it. I don't think we need to keep coming
5 back here and -- although I wouldn't mind having
6 dinner with you guys pretty often, but --

7 So my hope is, that where this group
8 sort of lands is that at the end of the day, the
9 use of technology is going to revolve around what
10 technology do you have to have in order to gather
11 the right amount of information? Remote ICU is a
12 great example.

13 If you have mission control all of the
14 -- you know, all of the data/information on the
15 patient. Then whether you're in the room,
16 outside the patient's room or in a room in
17 another distant hospital and you have all that
18 same information, then that tele-ICU experience
19 is going to be just fine, and the quality of care is
20 going to be just fine.

21 That's kind of an extreme example so -
22 - so -- my hope is that the information gathered

1 will sort of determine what technology is most
2 appropriate. And we don't have to really comment
3 on that on a diagnosis-by-diagnosis basis.

4 MR. GOLDWATER: Okay. Okay. Anyone
5 else? Yes, Judd?

6 CHAIR HOLLANDER: So, I -- I actually
7 think that's great. I want to just draw a
8 distinction between standards of care -- which is
9 actually a legal term, not a medical term -- and
10 it's what the -- what a similar provider in the
11 same specialty for the same patient is likely to
12 do in the same situation. That -- that's really
13 not what we're talking about.

14 But -- but it seems to me, despite
15 state laws clearly saying different things, the
16 average telemedicine provider is not
17 accomplishing the average in-patient visit. And
18 should that show up in court, there -- some
19 people believe it won't matter what the law says
20 because that's not what standard of care means.
21 You shouldn't be held to that standard.

22 But -- but I think it -- it's -- and I

1 think Henry said this pretty well, it's, do you
2 have enough information to make a medical
3 decision? That -- that's the only thing that's
4 important. You don't need the same information,
5 you just need enough information to have an
6 actionable response to the communication or the
7 medical problem in hand.

8 And once you can treat the patient
9 appropriately and you have enough information,
10 then going forward makes sense. And -- and I
11 don't think that's very well-articulated in a lot
12 of position papers of a lot of societies. But I
13 think it's really relevant to telehealth --
14 telemedicine. Whatever we're calling this.

15 MR. GOLDWATER: Okay. Any other
16 thoughts? Adam?

17 MEMBER DARKINS: I mean, there are
18 instances where telehealth/telemedicine is
19 certainly not equivalent. You can't make a
20 diagnosis and you can't treat a patient. And
21 that's partly because limitations in the
22 technology exist at the moment. And sometimes

1 it's because of issues to do with both the
2 patient and the provider.

3 So I think the idea it's kind of all
4 or none -- certainly my experience developing
5 services, if you can create a business case for a
6 program where 65% of what would have been done
7 face to face is done virtually and you make sure
8 appropriately the 35% that you can't manage
9 appropriately virtually is sent into what might
10 be traditional care, then that works fine.

11 So I think it's -- it has to be seen
12 in the context. If it isn't either or. And I
13 think to your point earlier, you were saying the
14 telephone -- video is better than telephone. I
15 would disagree with what you said.

16 Because if by virtue of seeing
17 somebody by video instead of telephone your
18 threshold to refer somebody to be seen in person
19 isn't correct. So the person who would have been
20 sent by telephone directly to see care for some
21 reason your threshold is wrong, then you haven't
22 made the right decision. So I think, there's a

1 way in which this is approached as being
2 certainty. As though telehealth you can be
3 certain.

4 I think the issue is about relative
5 degrees of uncertainty. So if you could be bound
6 within a certain area, this isn't exact the same
7 make sense of work and you can do it. So, I
8 think it isn't either/or, I think it's a spectrum
9 of using both.

10 MR. GOLDWATER: Okay. Any other --
11 Don?

12 MEMBER GRAF: The ability to replicate
13 the in person visit virtually is really going to
14 be defined by as much the specialty that's -- so,
15 audio signal in one instance. Visual in another
16 is going to be critical. And the ability to have
17 the appropriate technology to support that the
18 replication of that visit is then just sort of by
19 definition going to be critical.

20 MR. GOLDWATER: Right. Right. Chuck?

21 MEMBER DOARN: So, what happens if we
22 develop guidelines and in the next five years a

1 system comes out with an AI built into it that
2 will tell you exactly what's wrong with you? Or
3 -- or you have technology you can --

4 MR. GOLDWATER: That would -- that
5 would be totally cool, though.

6 (Laughter.)

7 MEMBER DOARN: Or you can reach out --
8 yes, that would be cool. Or, you can reach out
9 and touch somebody remotely with a glove and --
10 and actually do a -- or, auscultation of the
11 abdomen. I mean, the guidelines that we're
12 talking about now, we've been talking about, like
13 I said, for a long time.

14 And now we're going to see the
15 technology change so rapidly that the guidelines
16 -- the way the government approves technology,
17 the FDA, all -- all that stuff. You can't even
18 keep, you know, pace. And so, the concern I
19 would have is, moving forward we have so many
20 things that, you know, the way we practice
21 surgeries, for example. Basically we've been
22 doing the same things for 100 years.

1 Like, there's a robot at the
2 University of Nebraska you can inject into the
3 body will actually do the surgery, and then they
4 can take it out. That's not ready for prime
5 time, but the point is that the technology
6 fundamentally changes the practice of medicine.
7 And we're -- we're talking about developing laws
8 and regulations and reimbursement and, you know,
9 quality measures and so forth for the way we used
10 to practice medicine.

11 Unfortunately, we're still practicing
12 it that same way, but -- but we're in that
13 transition period. You know, the odd thing, a
14 few years ago it talked about the perfect storm.
15 You know, we're -- we're moving away from that
16 and I think that -- and I hear a lot of our
17 discussion is in that same mindset.

18 But I think, since we're sitting here
19 in Washington D.C. a lot of the challenges that
20 the next administration faces -- not that they
21 have very many challenges -- but we're going to
22 see a lot of change and I'm not sure the medical

1 community -- certainly the medical schools are
2 not preparing students.

3 I mean the medical -- our medical
4 students, they come in to me and they say, hey,
5 we want you to have separate lectures for us on
6 telemedicine, ehealth and telehealth and so forth
7 because we're not learning it in the actual
8 curriculum.

9 Because you can't change the
10 curriculum because it's focused on specific
11 things. For those that are M.D.s, I mean, when
12 you're in medical school you've got to learn that
13 -- that certain set of skills, and then you get
14 out and it's like, well, how do I run a business?
15 What about lawyers? I hope there's no lawyers in
16 the room -- I'm just kidding.

17 But you have all these challenges, and
18 we're focused on the way we used to practice
19 medicine. And that's what my biggest concern is
20 -- how do we keep that in mind? Because we're
21 still in that mindset, but start thinking about
22 the future because the technology we're talking

1 about is going to -- is -- is really
2 earthshattering.

3 I mean, and again, coming from a NASA
4 background -- we're -- we're developing
5 technologies for healthcare on a Mars mission
6 because you're not talking to anybody and you may
7 not have a physician. So those things you see in
8 movies is -- science fiction movies -- are
9 actually more real than -- you can't go down to
10 buy it, you know, at the medical store or
11 whatever, but -- but I think we need to think
12 about that as an underlying theme.

13 MR. GOLDWATER: Okay. Yes, Don?

14 MEMBER GRAF: Just a quick comment to
15 add to what you're saying, but it really kind of
16 also ties into that the -- the data and
17 informatics associated with all of that and the
18 quality around that. These learning algorithms
19 that are being developed where, you know, your
20 Alexis app's going to be talking to you not you
21 asking it questions about, you know, health
22 management and chronic disease management.

1 So -- so, I mean, at the end of the
2 day it's really about where are -- are we
3 addressing today? Or are we going to be skating
4 to where the puck is going to be? You know, that
5 kind of a thought. I'm curious if -- if we've
6 given consideration to the future which is right
7 around the corner.

8 MR. GOLDWATER: Okay, so let me quickly
9 -- let me quickly address this and then I'll get
10 to Christy and to Adam and to Nate.

11 The beauty of designing a conceptual
12 framework is that it's open to continual updates
13 and changes. So, if we were to design a standard
14 set of measures today -- which we are not going
15 to do -- then I think that there is an
16 understandable concern that we are locking
17 ourselves into our existing environment and not
18 thinking about what's next. And if we've all
19 learned something from health IT it is, it
20 changes by the hour. Where we are now -- I mean,
21 I always bring this up.

22 When HIPPA came out, and they were

1 going to mandate that every claims transaction
2 had to be submitted electronically, you would
3 have thought the world was about to come to an
4 end. I mean, the states were, oh my god, this is
5 the end of the world. We'll never be able to do
6 this.

7 And now, of course, it's done without
8 any second guessing. So, it switches so
9 continuously. Now, granted, Chuck, you read way
10 too much science fiction and see far too many
11 movies -- which we all really like about you.
12 And clearly the inventions that you're talking
13 about I really hope come to pass.

14 But, you know we, we keep the
15 frameworks with concepts of what's really
16 important when we're talking about providing care
17 from a distance? And what are the things that we
18 have to really be focused on? How we get to that
19 point -- you know, what technology is used to
20 accomplish those ends, I think the framework will
21 adapt to.

22 But there's always going to be the

1 need to use technology to increase access.

2 There's always going to be the need to use
3 technology to be effective. There's always going
4 to be the need to use technology to improve
5 outcomes. There's always going to be that need.

6 Whether it's a da Vinci robot, whether
7 it's a hologram that is a -- got a Gamma Knife --
8 and I'm clearly making all of this up and have no
9 idea what I'm talking about. That's -- oh, I'm -
10 - thank you, Chris. I don't know what I'm
11 talking about, but -- you know, if those kinds of
12 things existed, we would still be measuring the
13 ultimate outcome of that. You know, what -- a
14 robot did this. Did it lead to the outcome that
15 by evidence and science says it needs to? So, I
16 think your point's very well made. And that's
17 why we're doing a framework not measures. We're
18 doing something that can be adapted and adjusted
19 as we move forward. Kristi?

20 MEMBER HENDERSON: Yes, so -- along
21 those same lines, I kept thinking while we were
22 out on the break. Around identification of

1 unique measures that are not out there now that
2 would help us show the value of telehealth and I
3 --

4 When I think about the new models of
5 care, making sure whether it's in the cost area
6 or where we look at it, around new work forces --
7 or, new ways that we use the existing work
8 forces. If caregivers are now part of the
9 workforce, to think about that as well in the
10 cost and that we will use everybody differently.
11 And we will become more efficient.

12 So it's not just the cost per visitor
13 encounter, it's now because I was able to be more
14 efficient and use different workforce, the total
15 cost of care is different. So I would just say
16 we ought to broaden our thought around cost as
17 well. Because there's not a CPT code for
18 everything that's an expense in healthcare. So
19 we don't even know baseline to know how we impact
20 that. But to think about that in our measures.

21 MR. GOLDWATER: Okay. Adam? Or did --
22 oh, Nate. Sorry.

1 MEMBER GLADWELL: Yes, couple of
2 thoughts along these lines because I think this
3 is critically important as far as how we define
4 the experience or the -- the visit in comparison
5 with an in-person visit. I think the viewpoint
6 of the purchaser is critical in this conversation
7 as we try to advance telehealth throughout the
8 nation. The purchaser is the absolutely -- in my
9 mind, the most critical component to all of this
10 right now.

11 Be that the consumer, be that the
12 payer -- or other health systems of your
13 services. And -- and as we think about the new
14 models of care -- population management, ACO --
15 regardless of -- of the purchaser, how the -- how
16 the experience is codified is going to be
17 critical.

18 And so my -- my basis is -- and it
19 goes back to something Judd says, it's the
20 information given in the scenario to make a
21 decision. So if that's a -- a text message with
22 a -- with a picture, if that's good enough in

1 that scenario to make a clinical decision, you
2 know, we need to sort of think about that. But
3 that's my -- my perspective. It's the viewpoint
4 of the purchaser.

5 MR. GOLDWATER: So it's -- Nate your
6 point's well taken. And we will have a purchaser
7 here tomorrow who purchases -- primarily
8 responsible for the purchasing of LL services for
9 the State of Tennessee, particularly the TennCare
10 program.

11 So, we certainly acknowledge how
12 crucial they are to this discussion. Fortunately
13 they -- she couldn't be here today, but she'll be
14 here tomorrow and we'll grill her relentlessly
15 about what she needs to contribute. So, anybody
16 else about this?

17 So, the second point before we move on
18 from the literature -- or, the environmental
19 scan, is there was a talk earlier today about
20 ultimately the objective of any sort of
21 telehealth framework, and eventually any type of
22 telehealth measure is improved outcomes, which is

1 always the point of a quality measure.

2 So, how do we -- or do you feel that
3 the term improved outcomes means something
4 different, to some extent, or needs to be further
5 defined with respect to telehealth as opposed to
6 a normal improved outcome that's wrapped into a
7 quality measure?

8 And I -- so I say that because some of
9 the literature that we have started to review --
10 and I say this is in particular with dermatology
11 -- that the way they viewed an improved outcome
12 was -- was the digital image that they were
13 receiving remotely --

14 So it was stored and forwarded.
15 Somebody is taking a picture, storing it and then
16 forwarding it to a dermatologist that specialized
17 in something. And was the image clear enough for
18 a diagnosis to be made? Was the image as good
19 enough as it would be if they were in person?
20 And were they able to make a either correct
21 referral, or a correct treatment protocol off the
22 basis of that image and that's how they evaluated

1 the outcome?

2 What happened after that wasn't
3 discussed. But what happened because of the
4 process of that is what was discussed. So,
5 because of that then, you know, do we need to
6 take a further look at what we mean by improved
7 outcome, or is there -- do we just think that the
8 definition remains the same as it would for any
9 sort of quality measure? Judd?

10 CHAIR HOLLANDER: So -- so -- so I
11 think we got to look at outcome a little
12 differently here. Because really what we're
13 talking about -- telemedicine is a visit. Right?
14 You know, it -- it's really we -- we don't look
15 at other measures as it's the visit. So, you
16 know, the example you gave, which could be biased
17 for me to think, eh, that's nothing.

18 If I have a six-month wait to see a
19 dermatologist and two-thirds of the time I could
20 say, it's not melanoma, don't worry about it.
21 But one-third of the time I can't tell anything
22 at all from the image, that's horrible data if

1 you look at it from an outcome.

2 But if now my appointment time dropped
3 from 60 days to 12 days and I see melanoma
4 patients earlier -- I -- we're probably not going
5 to have studies that track survival of melanoma
6 patients who've come in to the clinic not via
7 telemedicine visit because the clinic visit was
8 freed up as a result of someone else not coming
9 in -- it -- it gets really complicated.

10 And, you know, we talked a little bit
11 on the conference call, but it hasn't come up
12 today that this is a visit. And -- and so we
13 haven't discussed, should a telemedicine visit
14 fit into other measures simply as an acceptable
15 visit? And -- and so, you know, sometimes you go
16 to the doctor. Doctor doesn't know what's wrong.
17 That's okay. You know?

18 And so I -- I think the outcome
19 definition gets -- gets really tricky. But we
20 can get around some of it if we just say, did
21 they do the visit? Or, should it count as a
22 visit and we try and separate that out a little

1 bit? I -- I --

2 MR. GOLDWATER: Okay. Angela?

3 MEMBER WALKER: Yes, I think we
4 struggled a little bit with measurement of
5 outcomes. Unfortunately because there's not a
6 lot of universal patient identification in our
7 records systems currently. And where a patient
8 may have a digital image uploaded, I make a
9 diagnosis and would love to make what the final
10 outcome was.

11 They may never see me back either
12 through photo or through a in-clinic visit
13 appointment. They may not come back because they
14 got better. They may just not come back -- they
15 did worse. They may have gone somewhere else and
16 received care in some other setting.

17 So, it gets really difficult to track.
18 So we kind of separate out the adequacy of photos
19 and kind of the -- the workflow. What can we
20 accomplish with the teledermatology? As well as,
21 we'd love to look at patient outcomes, but there
22 are tons of obstacles in front of us.

1 MR. GOLDWATER: Okay. Adam?

2 MEMBER DARKINS: At the risk of
3 introducing another poorly defined thing into the
4 equation, I was going to say, one of our choices,
5 I think, in the current environment is do we want
6 to put outcomes in the context of value based
7 care?

8 Because, in many ways, we can look at
9 this through the prism of what an individual
10 clinician may find. But if you think about what
11 it draws together is, we've chosen to say system
12 effectiveness rather than cost effectiveness. So
13 value based care really is ill defined. But it
14 really brings that perspective of how do you
15 create value across a continuum?

16 So I would just put that we ought to
17 try and weave that in and see what we think about
18 it as we go along. If we don't include it, it's
19 going to seem as though we're somewhat out of
20 touch with where things currently are.

21 MR. GOLDWATER: Sure. Don?

22 MEMBER GRAF: I wanted to tie in to

1 something that Judd said a minute ago is that the
2 value may not be the virtual visit itself, but it
3 may be the timeliness of being able to access
4 that care. When we -- or, from a compliance
5 standpoint, no shows, two-visit appointments,
6 therapy treatments and post cochlear implant and,
7 you know, leading to outcome. Or not, if
8 patients aren't compliant maybe showing up. Or --
9 timely access to -- to care. So I just wanted to
10 add that.

11 MR. GOLDWATER: Okay. Paul?

12 MEMBER GIBONEY: I think one of the
13 things that becomes problematic when you think
14 about it as a visitor encounter is a lot of
15 telehealth nowadays is clinicians communicating
16 with other clinicians without the patient in the
17 middle. It's the primary care doctor reaching
18 out to the specialist saying here's all the
19 clinical information. Can you help me with the
20 case?

21 And then we've found in our system
22 that, you know, 25-30% of the time the patient

1 never needs to go to see the specialist at all.
2 The PCP is actually able to continue caring for
3 the patient within the medical home.

4 And the patient's not necessarily even
5 aware that that happened. And so it's certainly
6 adding value. It's certainly improving, you
7 know, the healthcare. But it's -- it's -- and it
8 is an encounter between the PCP and the
9 specialist, it's just not what we term as a visit
10 because the patient is not interacting directly
11 with the specialist.

12 MR. GOLDWATER: Right. Okay. Steve?

13 MEMBER NORTH: John and Don's comments
14 on are we utilizing our specialists to the
15 highest level of their effectiveness so that that
16 patient is prepared to have the biopsy when they
17 enter the room with melanoma?

18 Brought up the conversation I was
19 having with Greg Chadwick, the Dean of East
20 Carolina's dental school around virtual
21 dentistry. I -- we haven't mentioned dental. I
22 think we -- are we -- am I now --

1 MR. GOLDWATER: No, not --

2 (Simultaneous speaking.)

3 MEMBER NORTH: Uncovering something
4 that's limited data on teledentistry --

5 MR. GOLDWATER: Yes.

6 MEMBER NORTH: But as we develop this
7 conceptual framework, we probably want to include
8 that somehow. So, backtracking a little.

9 MR. GOLDWATER: Dale?

10 MEMBER ALVERSON: I want to reinforce,
11 Paul, you just sort of almost took the words out
12 of my mouth. But I think about the ECHO model,
13 which does not include the patient at all. And
14 it is a case review model so that -- you know,
15 however you want to define visit, that's where a
16 case is decided.

17 And they've already shown -- and
18 they've done looking at outcome measures -- that
19 using an ECHO clinic, a virtual clinic case
20 review, has similar outcomes as an in-person
21 visit and review. So, I think, just maintaining
22 that broad scope when we talk about telehealth,

1 that there are other methods besides ones in
2 which the patient's directly involved.

3 MR. GOLDWATER: So, Adam did you have
4 anything else to contribute? Or -- okay, never
5 mind. Chuck?

6 MEMBER DOARN: You know, we talk about
7 a visit, we're talking about a patient seeing the
8 physician.

9 MR. GOLDWATER: Right.

10 MEMBER DOARN: But what about remote
11 monitoring where the patient is being monitored
12 remotely? Remote monitoring. And the
13 information is being collected by a computer.

14 The computer is doing a time-weight
15 average and saying, you know, calling somebody
16 that needs to be called, or updating the file if
17 it needs to be updated, but not really doing
18 anything. Your outcome measures are being -- I
19 mean, the outcome of the patient -- managing the
20 patient is better because the patient is being
21 managed on a regular basis and not waiting to go
22 to the doctor.

1 I want to make sure that that's not
2 forgotten about because we're going to see a lot
3 more of that. You know, people have these
4 devices that -- they can download them on their
5 phones. They can get them from their home
6 healthcare organizations and so forth.

7 So it -- I don't to -- us to consume
8 that every interaction is doctor to patient or
9 doctor to doctor. One doctor talking to another
10 doctor is the practice of medicine. It's not
11 telemedicine, it's not telehealth. It's just a
12 doctor talking to another doctor. Right? I
13 mean, it -- it falls under that concept.

14 But you know, as we talked about
15 earlier, the practice of medicine is using these
16 tools. So really as -- you know, as Jay Sanders
17 has been saying for years, it's -- it's really
18 the practice of medicine, right?

19 But I don't want us to lose track of
20 the fact that it may only be, you know, the
21 physician sending -- or the surgeon sending the
22 patient home saying, I want -- because, you know,

1 it's a 500-mile drive for you, or a 300-mile
2 whatever it is. I want you to take this little
3 device that the home-healthcare aid is going to
4 bring to you.

5 And I'm going to call you on Tuesday
6 at 9:00 in the morning, and you're going to take
7 that wand, it's nice and easy to use, you're
8 going to point it at your bone. I'm going to
9 look at your bone. You're going to be fine.

10 Or, do we have you drive the car, you
11 know, 300 miles from the middle of nowhere to the
12 hospital to have the doctor go, your wound looks
13 fine? If somebody's saying -- and I've heard
14 this said before -- I don't believe in that
15 because I need to see the patient in my office.
16 I need to be able to put my arm around, saying
17 everything's going to be fine, Mrs. Smith. Your
18 husband's going to be fine.

19 Or, do we save a huge amount of money
20 and just do it, you know, that way? That remote
21 -- remote -- remoteness of this shouldn't be left
22 out. So when Judd was talking about, you know,

1 the patient at the counter. I mean there's a
2 huge business model around that.

3 But there's also a huge business model
4 around -- business model, excuse me, around the
5 remote monitoring part of telehealth.

6 MR. GOLDWATER: Right. Angela?

7 MEMBER WALKER: I might also comment
8 that if there's a way to bring the patient in to
9 some of those doctor-to-doctor consultations,
10 that opens up the conversation a little more and
11 includes them, engages them into the care
12 service. So that's another way to go.

13 I also wanted to back track a little
14 bit and say in the space of teledermatology you
15 could -- also in the practice of telehealth or
16 telemedicine -- there have been several studies
17 looking at outcomes that use a theoretical
18 patient. So if the literature search hasn't come
19 across these already, it would be a good
20 direction to look. And that's the secret shopper
21 studies.

22 Because they can look at image review

1 or a theoretical patient presentation and see,
2 was the -- the standard of care met? Or the --
3 the correct practice or diagnosis made? When
4 it's known, but it may not be a true patient.

5 MR. GOLDWATER: Okay. Sarah?

6 MEMBER SOSSONG: Picking up on a couple
7 of these points. Going back to that modality
8 framework. If we look at synchronous --
9 synchronous remote patient monitoring.

10 I think if we think about the
11 synchronous visits, a lot of the things that
12 we're thinking about with traditional visits will
13 be captured. I think there's, again, tremendous
14 value in the e-consult second opinions when, in
15 that world, we think about turn-around times, how
16 often the input between clinicians resulted in a
17 change in treatment, how often the ultimately
18 needed to be seen by the specialist.

19 So, I think if we separate into those
20 different modalities, that's something -- and
21 then, again, remote patient monitoring being the
22 third one. That would be very helpful, again, in

1 thinking about which is the right modality to use
2 and would, I think, address a lot of these
3 concerns.

4 MR. GOLDWATER: I think this -- this
5 conversation will sort of come to a head when we
6 start looking at measures and how those may need
7 to be modified, or how we start building measures
8 that would incorporate -- obviously, it has to
9 incorporate the encounter.

10 And then it has to improve, what are
11 we looking at the metric to say that the measure
12 was successful or, you know -- the provider
13 succeeded at the measure. The provider failed at
14 the measure. So that's -- I think it will -- it
15 will come to a head. Don?

16 MEMBER GRAF: I wanted to ask a
17 question relative to scope. Like, through an
18 example. If a speech therapist working with a
19 TBI patient submits a sample of speech pattern
20 that is pinged against a -- an array database of
21 similar and -- and -- and recommended results
22 based on algorithms comes back to that -- to that

1 speech therapist who's either validated that
2 their course of treatment is appropriate or can
3 tweak it appropriately.

4 Raises a discussion to more of the
5 telehealth maybe related, as opposed to this
6 traditional telemedicine encounters. Is that out
7 of scope?

8 MR. GOLDWATER: I don't believe that it
9 is. Do you? I think that that sort of is
10 exactly within the scope of it. It is certainly
11 a modality.

12 (Simultaneous speaking.)

13 MR. GOLDWATER: What's that?

14 MEMBER GRAF: Improved outcomes.

15 MR. GOLDWATER: Yes, I mean it's --
16 it's a different modality. But you're right, the
17 ultimate outcome is is there improvement as a
18 result of information being collected and shared?
19 Or distributed remotely so that information could
20 be gathered then to confirm a diagnosis and of
21 course a treatment? Or to make alterations based
22 upon what they're doing.

1 So I -- I don't think that would fall
2 out of scope at all. Eve-Lynn?

3 MEMBER NELSON: The project ECHO and
4 some of the provider consults, I think one thing
5 that's harder to capture is you're hoping it's
6 not a one off. But then, whatever they learn
7 from that particular case is going to then ripple
8 out and affect the population surge and not just
9 that one case. It's -- it's just a lot harder to
10 get. I know project ECHO is trying to get their
11 minds around that.

12 MR. GOLDWATER: Yes. Steve?

13 MEMBER NORTH: I'm concerned about what
14 Don said because of this -- because of mission
15 creep. So you're taking a piece of patient data
16 and -- which is a recorded thing at this point.
17 Which, is that the same as an echocardiogram?
18 And active image?

19 And sending it electronically and
20 comparing it -- so if you use technology to --
21 use Watson to look at the echocardiogram. Where
22 does what we're trying to look at stop? Is that

1 still telehealth? Or because we're looking at a
2 frame -- conceptual framework -- is everything
3 open for interpretation? I just want to push
4 back a little bit. Respectfully, of course.

5 MR. GOLDWATER: Well, you know, because
6 it's a conceptual framework, I don't think
7 anything is totally discounted at this point.
8 But we have to keep in mind, as we'll talk about
9 more tomorrow, that when you're developing a
10 framework, it is to do -- the primary purpose is
11 to be a foundation for future development of
12 measures that will effectively and objectively
13 assess the outcome of care.

14 It -- a framework also then should be
15 incorporating what already exists, if it can, and
16 there's no hard or fast rule that it can. It
17 also has to provide dimensions and elements for
18 future development so that as all of you, or
19 those of you that will follow you, are developing
20 measures in the area of chronic disease, care
21 coordination -- whatever it may be -- and
22 telehealth becomes the modality of care that's

1 going to be used, that those dimensions will be
2 incorporated.

3 And so that all of the telehealth
4 measures will reflect similar types of elements
5 so that there's not wide disparity of measures.
6 Because for those of you -- and I know Marybeth
7 can speak to this -- that have been doing
8 measures for a long time, one of the longstanding
9 inherent problems in quality measurement is
10 variability. Which is, a measure is created and
11 then another measures is created that is somewhat
12 similar but not completely similar to the measure
13 that was just created. There's like, a small
14 difference.

15 And then there's another measure
16 created that's similar to both of those measures
17 with a very slight difference. And on and on and
18 on and on. So you end up with, you know, 30
19 different measures of A1C. And, you know, which
20 one do you use?

21 So, we don't want to get into that.
22 Because that, I think, would ultimately cause the

1 framework to be something that could not be
2 implemented. What we want to do is, are there
3 standard sets of dimensions and elements that we
4 know telehealth measures have to touch on? Not
5 all of them at once, but they have to touch on
6 them. Because then we will be able to uniquely
7 understand that this is a measure that talks
8 about telehealth.

9 And as people develop the measures,
10 they will understand that those measures talk
11 about telehealth. And there won't be this
12 constant type of variability because the elements
13 will be consistent throughout measured
14 development. And if we have to modify existing
15 measures to incorporate telehealth, then we can,
16 you know, do that as well.

17 That's something we want to -- it's a
18 hard thing to avoid, but it is something we
19 certainly want to talk about. And then we have
20 to sort of also talk about appropriate
21 attribution of the measure. But I think that
22 also gets to what Judd and Yael have been talking

1 about fairly consistently. Which is, the measure
2 should not be geographically sliced. It should
3 be a measure that talks about long-term care,
4 post-acute care. It should talk about home
5 healthcare. It should talk about diabetes. It
6 shouldn't be diabetes in a rural health center
7 safety net clinic critical access hospital. It
8 should be a diabetes measure that telehealth as a
9 care delivery can provide a possibility for an
10 improved outcome. And then I think we really
11 have something that can be implemented.

12 So, that's why it's really good to
13 have, you know, measure developers here. Because
14 they're aware of all the inherent problems that
15 have existed for the 20 years that we've all been
16 trying to do this. So, Megan?

17 MEMBER MEACHAM: I don't know what the
18 protocol is -- if I can jump in?

19 MR. GOLDWATER: Yes, you can. Please.

20 MEMBER MEACHAM: I just wanted to
21 reiterate that we -- we're definitely -- you
22 know, the Federal Office of Rural Health Policy

1 has sponsored this program, or this project. And
2 our intent was not to have, like, rural-specific
3 measures.

4 We just want to ensure that any
5 framework has rural considerations so it works
6 for rural. And I know that there's a number of
7 rural representatives on here, so I have all the
8 faith that you will do that. So I just wanted to
9 echo that. Not geographically different.

10 MR. GOLDWATER: Right. Thank you,
11 Megan. Marcia?

12 CHAIR WARD: So I'll admit, I'm
13 confused.

14 (Laughter.)

15 MR. GOLDWATER: Microphone.

16 CHAIR WARD: The word health outcomes -
17 - if you can clarify. Because when I think about
18 the NQF measures, I think of all these process of
19 care measures. That was the safe ground that CMS
20 first adopted.

21 But we're talking health outcomes.
22 And so are we really tied in, locked in -- what -

1 - what's the wording that --

2 MR. GOLDWATER: What a good question,
3 Marcia. So the initial -- so this is leading to
4 the next part of the discussion. What we
5 initially proposed was to just look at outcome
6 measures. Not process. Not structure. Just
7 outcome measures.

8 And outcome measures that could be --
9 that were structured electronically so that it
10 could -- for example, if a telehealth modality is
11 feeding information into an EHR -- which gets
12 back to the informatics, interoperability, use of
13 health information exchange -- that it could then
14 be reported out. It's already been formatted.
15 It already has been standardized. It's already
16 in -- you know, modeled appropriately to be used.

17 So we've stuck with just outcomes.
18 That does not mean that we can't do process
19 measures. Structural measures I would tell you,
20 we might want to consider. There's not that many
21 that are electronic. And the ones that are --
22 very, very specific. And I'm not sure what --

1 you know, we did an initial pass of that just to
2 look, and I didn't see anything that, I think,
3 would benefit telehealth uniquely about that.

4 That doesn't mean we can't look at
5 other sources. But right now we just focused on
6 -- and what we're going to look at today are just
7 outcome measures. That does not mean that we
8 can't do process.

9 There are -- now, the reason why we
10 would consider not doing process measures are
11 one, the Federal Government, as we get to sort of
12 Adam's discussion of value-based care, there's a
13 strong emphasis from the government to not do
14 more process measures and to focus on outcome
15 measures. Particularly patient-reported outcome
16 measures.

17 Given that there are means of
18 collecting patient data that are far more
19 frequent than there were five years ago. The
20 other one is, you know, if we're going to talk
21 about process, there are numerous different
22 telehealth processes that can be used, so how do

1 we then decide on one? And -- and align that
2 with either an existing measure or a develop a
3 process measure? So, that's why we just decided
4 to stick with outcomes initially.

5 But we fully expected that the
6 discussion of this group would tell us yes,
7 that's great. Let's just stick with outcomes.
8 Or, you know, we should really stick with process
9 measures too and go after those. So, but we just
10 did outcomes in the short term. So, it was a
11 great question. Yes. Kristi?

12 MEMBER HENDERSON: Where does the
13 measures for telehealth when we're looking at
14 wellness fit in? So, care gaps, population
15 health, things to change the trajectory of
16 disease or -- or -- where -- where do those
17 measures fit in? And do -- do -- or do they?

18 MR. GOLDWATER: So, we found some
19 initial measures that talked about wellness,
20 maintenance and wellbeing. And, you know, I
21 think that as you look at those, you can sort of
22 help us frame whether or not incorporating

1 telehealth into that would still -- you know, if
2 you're talking about an existing measure, right?

3 The -- the last thing we want to do is
4 alter the measure. We don't want to change the -
5 - the outcome or the objective of the measure.
6 And that's what makes this difficult. Because we
7 have 600-plus NQF endorsed measures. There are
8 over 2500 quality measures nationally.

9 And I'm sure Marybeth can laugh with
10 me, back in the mid-90s when everyone was trying
11 to figure out how to do this. Nobody knew how to
12 measure an outcome or a process. And now we
13 can't get enough of it. We measure -- we're
14 measuring every conceivable thing.

15 So, we don't want to change the intent
16 of the measure. What we want to do is make sure
17 the measure is reflective of telehealth. And so,
18 as you start to look at those measures, you know,
19 how do you then think telehealth can be
20 incorporated in such a manner that the meaning of
21 the measure isn't compromised? It's still
22 producing a metric that the physician can use to

1 evaluate quality and we're incorporating
2 telehealth.

3 And I realize that's a tall order and
4 so I'm not envious of you. And I'm real happy
5 you're here, because that's what you're going to
6 do. You're going to solve all of these problems
7 for us, and I'm going to smile broadly as I leave
8 the room tomorrow. But, that's -- that's sort of
9 where we are. Don?

10 MEMBER GRAF: And to that end,
11 important to make the distinction in looking at
12 preventative to separate how many steps I took,
13 you know, when I look at my Fitbit from
14 retinopathy screening for diabetic patients or
15 something.

16 MR. GOLDWATER: Right, right, right.
17 Absolutely. Okay. Any other discussions about
18 the environmental scan?

19 (No audible response).

20 MR. GOLDWATER: All right. Why don't
21 we switch to the next topic, which starts to talk
22 about the measures. What's that? Do you want to

1 take the lunch break now?

2 Is lunch out? Oh, lunch is out. All
3 right, well, so this is going to be like the bulk
4 of what we're going to talk about over next day-
5 and-a-half. So I don't want Dale to get hungry.
6 So --

7 (Laughter.)

8 MR. GOLDWATER: After this what's that?
9 Oh, I'm sorry. Right. So we need to open this
10 up for public comment. So, operator, if you can
11 open up the lines.

12 OPERATOR: Okay. Just tell me if you
13 would like to make a comment. Please press star,
14 then the number one.

15 (Pause.)

16 Okay, and at this time, there are no
17 public comments.

18 MR. GOLDWATER: Okay. So, with that,
19 let's break for lunch. What's that? What's
20 that? Oh, you guys, I'm sorry. We have a
21 comment from Ann --

22 (Simultaneous speaking.)

1 MR. GOLDWATER: One public of AMA. Go
2 ahead. Thank you, Tracy.

3 MS. TRUJILLO: I'll be quick.

4 MR. GOLDWATER: No, no, no. It's fine.

5 MS. TRUJILLO: First of all I'd like
6 to thank NQF for this very important work and we
7 really appreciate the opportunity to both observe
8 the process and hopefully learn from the process
9 to accelerate these really essential tools into
10 clinical practice -- that are effective and
11 improve patient health outcomes. Just a couple
12 of comments from today's extremely well-
13 facilitated discussion and some really insightful
14 comments.

15 My name is Sylvia Trujillo. I'm from
16 the American Medical Association here in the D.C.
17 Office. With regard to the domains that were
18 discussed, we would like to emphasize, based on
19 existing AMA policy, very strong support for the
20 consideration and integration of care
21 coordination as a component into the -- the
22 evaluation that is being undertaken and into the

1 framework. Whether it's integrated throughout
2 the existing domains, or probably even --
3 probably more helpful from our perspective, an
4 independent domain.

5 But really we believe that the work
6 that you've done and the way that you all will
7 inform that discussion would be tremendously
8 helpful in addressing that issue because we do
9 believe that care coordination remains one of the
10 single largest challenges to healthcare delivery.
11 So we strongly support that.

12 With regard to the patient experience
13 domain, we would like to acknowledge the comments
14 made to incorporate and reflect the increasing
15 need for care giver participation as well. You
16 heard yesterday, we were -- on the same panel.

17 By 2050 the paradigm of our population
18 distribution will be turned on its head. It used
19 to be that for every one elderly person, there
20 were a large number of young people. 2050, for
21 every elderly person, there will be -- for every
22 two elderly people, there will be only one young

1 person.

2 And so, the need to build a scalable
3 infrastructure very rapidly -- an incredible
4 need. So caregivers will play an essential role
5 in expanding the workforce and capacity. I'd
6 also like to note that it's helpful to know the
7 scope.

8 Are we skating to the puck where it
9 is? Or where it's going? And we think that
10 that's actually two conversations. And so it's
11 helpful to find that out so that we know those
12 two issues. They're both very valuable, though.
13 Because we think the puck is moving very quickly
14 to a different space.

15 And then last on the improved
16 outcomes, we would just like to validate a number
17 of comments that were made by the group. And
18 this is really taken from our experience in the
19 diagnostics space -- the clinical testing
20 diagnostic space. That it is not simply whether
21 or not -- if you're a cancer patient and you have
22 a full recovery, oftentimes it can mean that if

1 you have a diagnostic tool, it may end the
2 medical journey.

3 And so the way that you think about
4 improved outcome matters. Because quite
5 obviously, continuing to go through the
6 healthcare system without a resolution to an
7 incurable cancer when it could have been
8 addressed early on and you could go on about your
9 -- your life, what was left of it, is very
10 important. So thank you again.

11 MR. GOLDWATER: Oh, sorry. I'm the one
12 forgetting the mic. All right, so we'll take a
13 break for lunch and we'll reconvene at 1:00. So,
14 thank you all very much.

15 (Whereupon, the above-entitled matter
16 went off the record at 12:26 p.m. and resumed at
17 1:04 p.m.)

18 MR. GOLDWATER: All right, so we're
19 going to just start again in a couple of minutes.
20 I think before we get to this next part we do
21 have a -- excuse me -- a handout of the sort of
22 initial cut of quality measures that we found to

1 be subject to discussion.

2 Let me emphasize the words subject to
3 discussion, not these are going to be the ones we
4 use. They're the ones, after we sort of talk
5 about how we arrived at those measures -- just to
6 sort of talk about them broadly and then probably
7 talk about them a little specifically.

8 Chuck, I'm afraid to say, they don't
9 involve multiple robots, lasers or Gamma Knives.
10 So, I'm sorry. No, not at all. All right.

11 So, I'll give everybody just like two
12 or three more minutes. What I'm going to have do
13 -- have is Katie is going to pass these out. If
14 you all could just look at them. I'll give you a
15 chance to sort of look, reflect on them. And
16 then maybe in -- in ten minutes we'll start the
17 discussion. And that point you can sort of see
18 them and --

19 We wanted -- didn't want to put them
20 on slides because it would have -- it would have
21 been about ten different -- ten additional slides
22 which would have been cumbersome, to say the

1 least.

2 (Whereupon, the above-entitled matter
3 went off the record at 1:06 p.m. and resumed at
4 1:11 p.m.)

5 MR. GOLDWATER: Okay, so what we're
6 going to need to talk about now, there's three
7 topics to cover in the afternoon. One is to talk
8 about existing measures that we have initially
9 reviewed and come up with that are not
10 telehealth-specific at all. They are already
11 existing measures, a few of which are NQF-
12 endorsed measures, and to talk about if those are
13 appropriate to telehealth and how telehealth
14 could be incorporated into them.

15 Secondly, we're going to talk about
16 with respect to these existing measures,
17 understanding we do not want to change the intent
18 and the objective or the outcome of the measure,
19 what recommendations, if any, do you have to
20 potentially modify these measures so telehealth
21 is incorporated as a primary means of care
22 delivery, and then third is we'll start our

1 discussion on what the dimensions of the
2 framework will be, which will take up the bulk of
3 tomorrow's conversation.

4 So next slide.

5 Judd, are you going to dinner tonight?

6 CHAIR HOLLANDER: Yes.

7 MR. GOLDWATER: Okay, there's another
8 one. All right.

9 So in addition to reviewing the
10 literature, we also reviewed and established a
11 potential library of measures that could be used
12 to evaluate telehealth and incorporate it as a
13 means of care delivery. As I discussed with you
14 earlier, we just initially focused on outcome
15 measures and we did not use every measure we
16 found because some of them would not be
17 appropriate, so we did have some exclusion
18 criteria that we initially used to apply, and
19 that's not to say that that, these are hard and
20 fast, that we can't refine these, that we can't
21 go back and do this, but these are the ones that
22 we initially leveraged.

1 We -- measures that were not relevant
2 specifically to acute care, care coordination,
3 patient safety, cost, resource use, population
4 health, health and well-being, home and
5 community-based services, emergency care,
6 surgery, dermatology, ophthalmology, and mental
7 and behavioral health, I should also say stroke
8 as well, if measures did not relate to those,
9 they were removed, which really that wasn't a
10 major issue with what we had.

11 Any measures that were duplicate, we
12 removed. We took the measures from the
13 meaningful use selection of measures, the AHRQ,
14 National Measures Quality Database, and from the
15 NQF, what we call our Quality Positioning System,
16 which is basically our database of all NQF-
17 endorsed measures.

18 So by the way, let me stop. Does
19 everyone understand what we mean when we say NQF-
20 endorsed measure?

21 (No audible response.)

22 MR. GOLDWATER: I know some -- okay,

1 some people do not. All right, so a three-minute
2 review. To be endorsed by NQF, a measure comes
3 to us as part of a clinical area because CMS has
4 opened up a project. They want measures let's
5 say on cancer, so measure developers usually
6 under contract or part of the specialty societies
7 will submit measures.

8 They come to us. We review them
9 initially to make sure that they are complete,
10 that they have filled out all their forms
11 completely. If they are e-measures, they're
12 going to come out of an EHR or a registry, that
13 they're formatted appropriately, they mapped the
14 data model they have to, and that the value sets,
15 whether they're in a claims-based measure or an
16 e-measure, are coming from the National Library
17 of Medicine's Value Set Clearing House, which
18 Katie and I have far too much experience in.

19 After that, the measures then go to a
20 standing committee, consensus-based committee,
21 which was formed in much the same way this one
22 is. People volunteer, so this would be a group

1 of specialists that are oncologists,
2 hematologists, nurses that specialize in cancer
3 care, payers, patient advocates. And it's
4 usually a group of somewhere between 25 to 30
5 people.

6 The measures go to them. They review
7 them all and determine whether the measures have
8 met a very stringent criteria, which is they've
9 demonstrated an importance of this to measure and
10 report, that the measure is valid, the measure is
11 reliable, the measure is feasible, which is
12 extremely important when it comes to e-measures,
13 and that the measure is usable, so it's not
14 something that would interrupt workflow.

15 If it passes all of those criteria,
16 it's then recommended for endorsement. An NQF
17 endorsement means that it can then be used in
18 federal, national federal quality reporting
19 programs, like the Physician Quality Reporting
20 System, the Inpatient Hospital Reporting, and so
21 meaningful use and so forth and so on.

22 So AHRQ's very vast database, which is

1 amazing because it has everything, has all,
2 obviously, NQF-endorsed measures, and then our
3 database. That's all it has, so there would,
4 obviously, be some duplicates, so we remove
5 those.

6 Measures that consisted exclusively of
7 provider practice or health plan characteristics,
8 we also removed measures that talked about
9 patient or provider satisfaction, which side
10 note, we didn't see any, but those would have
11 also been removed, and very specially-based
12 measures would also be excluded, such as those
13 potentially for cancer care, obstetrics,
14 pediatrics.

15 Initially, we thought HIV care, but
16 then we saw one we thought might be relevant, and
17 others that were highly specialized. Again, if
18 we feel there's a feeling those specialized
19 measures should be put back in and that
20 telehealth would be appropriate, obviously, we
21 can do that.

22 Next slide. So what we're asking you

1 to do, the conceptual model that we're looking to
2 develop, we're going to ask both NQF, our own
3 clinical staff, as well as all of you to follow
4 and examine these measures on the, by the
5 following.

6 The importance of these measures as it
7 relates to telehealth and the specific condition
8 the measure was developed around, and you'll see
9 in the handout here that we've listed the focus
10 area, and then the description of the measure,
11 the feasibility of the measure to incorporate
12 telehealth based on the availability of the data
13 and the resources needed to obtain them, and that
14 a common understanding of the measure so that the
15 incorporation of telehealth is seamless and does
16 not distort the intent of the measure, and that
17 is incredibly important because, for two reasons.

18 One if it distorts the measure, then
19 it has to go through an entire review process
20 again, which means the measure, for telehealth at
21 least, would not be able to be used. And, then
22 secondly, if it distorts the measure, we have to

1 go to the measure steward, who is ultimately the
2 one responsible for the maintenance of this
3 measure.

4 Measures are developed, and then
5 there's a steward, somebody who's in charge of
6 the measure. Now, sometimes those are one in the
7 same group. Most -- a lot of times, they're two
8 different groups.

9 So if we change a measure and it's
10 completely different, then we've got to go to
11 steward of this measure and go, "Oh, by the way,
12 we like your measure and we totally changed it
13 for telehealth," and then they'd have to agree to
14 that, which just through common knowledge,
15 they're probably going to say no unless we're
16 going to pay them, which we're not going to do,
17 so we don't want to change the measure.

18 So I understand this is a tall order,
19 but we don't want to change it. We just want to
20 see how telehealth can be incorporated into this.

21 Next slide. So the prioritization of
22 -- one of the other things we want to do in

1 addition to evaluating the measures is also to
2 prioritize them. So which ones do you think are
3 really important and really critical to be
4 included in the framework?

5 There's a lot of measures in front of
6 you. We don't expect that every one of them will
7 be incorporated into the framework, but we do
8 want to sort of prioritize those that you think
9 are really important and would have a significant
10 impact on telehealth and would also help advance
11 telehealth as well.

12 So some of the criteria to potentially
13 consider are the importance to measure and
14 report, so what measures would have the greatest
15 potential of driving improvement, so what
16 telehealth measures would have the greatest
17 impact on outcome that you can see, and then
18 which ones are feasible? How could they be
19 implemented easily so they could be reported on?
20 And can they obtain data? Will the data be
21 standardized? Will the data be easily
22 attributable to wherever it's coming from?

1 And more importantly, you know, one of
2 the things that happens is if there's a lot of
3 telehealth providers that are submitting data on
4 the same measure, you do compare. You know,
5 that's one of the things you want to do is to be
6 able to compare providers and see who's meeting a
7 higher quality threshold than another one so that
8 that provider that's not meeting that threshold
9 can then be -- we can find out what's going on,
10 what are the issues surrounding that, and more
11 specifically, what could we do to improve that.

12 So with that in mind, your initial
13 thoughts on these measures. Every one of them,
14 Steve, tell me. No, I'm kidding.

15 I mean, here's what we could show you.
16 So a lot of what these measures, these focus
17 areas, really do align with what we found in the
18 literature. There were a lot of -- there's a lot
19 of literature that talks about the effect of
20 telehealth on chronic disease, particularly
21 around diabetes and hypertension. There was a
22 number of those measures.

1 There were some on cancer. Initially,
2 we were going to take cancer out, but then we
3 looked at these measures and thought maybe these
4 are ones we need to possibly include if we, just
5 to get some opinions from you as to whether or
6 not telehealth would be something that would be
7 effective here largely because tele-oncology is
8 widely, it's starting to be used.

9 We looked at infectious disease,
10 metabolism and nutrition, which sort of gets to
11 the health and well-being. Pain management, we
12 found quite a few as well. Given the
13 significance and importance of that as a public
14 health crisis, with thought we would include
15 those as well.

16 As Eve-Lynn will be thrilled to know,
17 lots of mental and behavioral health measures.
18 There were also issues on falls, respiratory
19 care, VTE, urinary incontinence, and then one on
20 cardiac care, perinatal care, nephrologic care
21 that were broad enough not to be so specific that
22 we would have excluded them initially.

1 So thoughts? I'm just going to open
2 it up right now, so what are your thoughts on
3 these? Go ahead.

4 CHAIR WARD: I'm looking, for example,
5 at the falls measure, and the biggest criteria
6 for measuring is, would we get pushback on what's
7 attributable to telehealth? So a lot of these
8 measures seem to encompass quite a period of
9 time, and there could be some telehealth visits,
10 but there could be all sorts of other team-based
11 care, and so we would get pushback on attributing
12 some measures to telehealth visits, non-
13 telehealth.

14 MR. GOLDWATER: Right. Okay.
15 Judd.

16 CHAIR HOLLANDER: Yes. So I think I
17 would love it, and maybe other people would, if
18 you would take one of these measures and tell us
19 how you see it applying to telehealth for the
20 same reasons as Marcia. So, you know, my
21 background in measures is on cardiovascular, --

22 MR. GOLDWATER: Right.

1 CHAIR HOLLANDER: -- and so there were
2 measures that I think were approved. I'm not 100
3 percent sure, that, you know, within seven days
4 of discharge, if you have heart failure, you need
5 to do a visit. So does telemedicine count as a
6 visit?

7 That would be an easy way for me to
8 incorporate it. That's not on the list. And a
9 bunch of cardiovascular stuff we're getting into
10 cardiac rehab or getting a visit, and those don't
11 show up here, but as I read, I'll pick like the,
12 you know, any one of the diabetic ones --

13 MR. GOLDWATER: Right.

14 CHAIR HOLLANDER: -- or one of the
15 blood pressure ones, which is just saying, you
16 know, are you controlling the blood pressure, are
17 you controlling the hemoglobin A1c? So I can see
18 telemedicine being a mechanism to achieve that
19 goal, but I don't see it as being a telemedicine-
20 specific measure.

21 So back to the original question
22 before I babbled is just to see the vision of how

1 this measure got here and how you see it applying
2 would certainly help me, and from head nodding,
3 maybe a couple of others, understand how to
4 interpret this.

5 MR. GOLDWATER: So one of the --
6 that's a great question, Judd, and before I get
7 to others, you know, one of the major sort of
8 issues that we had to sort of wrestle with when
9 we started the project was if we're going to
10 start building a framework where we have to
11 include what's already been done, that's
12 challenging because there are a lot of outcome
13 measures.

14 These are all outcome measures and
15 nothing to do with telehealth. And we can't
16 reinvent a measure that says the same thing. I
17 mean, that, you know, these are -- that apart
18 from being duplicative, it's unnecessary.

19 And we had to try to find out, is
20 there a way to take these existing measures and
21 prioritize and to determine which ones are really
22 important, and then is there a way to modify the

1 measure without taking that's intent or objective
2 away where it could be used as a means of
3 evaluating telehealth?

4 And I -- again, I recognize that
5 that's very challenging. We certainly could not
6 come up with a solution ourselves, and that's why
7 we wanted to initially come up with some
8 measures.

9 And, Judd, the idea was, is there a
10 way, or is there a methodology to follow, if
11 possible, where we can use these as telehealth
12 measures and in some way incorporate telehealth
13 as a means of delivery or this just becomes the
14 same measure and it's just applied to a
15 telehealth encounter without any modification,
16 and then in which case if that's what, if that's
17 the recommendation to follow, then what measures
18 do we really consider to be important?

19 And the criteria that I went over on
20 what we excluded, was that appropriate or should
21 we be putting more exclusion criteria or should
22 we be adding more measures? I mean there were,

1 you know, roughly 120-some odd measures, so we
2 didn't want to use every conceivable measure.

3 We wanted to have some manageable list
4 to move forward with, so what we're looking for
5 is, are these measures appropriate for
6 telehealth, is there a way to modify them to
7 incorporate telehealth as a means of delivery
8 without changing the measure, and what would be
9 the best way to go forward with this?

10 So glad there's discussion.

11 Nate, I'll start with you.

12 MEMBER GLADWELL: Just a clarifying
13 question to try to make sense of it in my own
14 head, I'm pretty simpleminded, but tele-ICU,
15 obviously, is a major modality in telehealth.
16 One of the metrics that they often cite is
17 mortality, right, reduction in mortality.

18 MR. GOLDWATER: Right.

19 MEMBER GLADWELL: So am I to
20 understand that there's no -- based on the
21 exclusion criteria, there's no measure around
22 mortality that would make sense to fit in this

1 conversation?

2 MR. GOLDWATER: There were none that
3 we -- there were none that we initially saw, no.

4 MEMBER GLADWELL: Okay. That helps me
5 understand.

6 MR. GOLDWATER: Sarah.

7 MEMBER SOSSONG: I think perhaps my
8 question is along the same lines, is simple and
9 progressive. We spent a lot of time talking
10 about the domains, and so I'm thinking about
11 access effectiveness, cost to patient and
12 provider effectiveness. Do you see all of these
13 fit within one of these buckets?

14 I guess I was thinking that we would
15 then go down, there would be five different
16 buckets, each with a set of a lot of different
17 measures, and so I think, you know, thinking
18 about, you know, 30-day readmissions, cost
19 standardized medical expense.

20 MR. GOLDWATER: Right.

21 MEMBER SOSSONG: So I think this all
22 seems very clinical, which is one important

1 category, but if you could just comment on how
2 we'll get back to those five --

3 MR. GOLDWATER: So we haven't done --
4 we wanted to sort of get input on the measures
5 first before we started doing sort of the
6 crosswalk between the measure and the domain
7 area, but like the first measure which talks
8 about the prevention and management of obesity
9 for adults with those that have a BMI, you know,
10 greater than or equal to 25 and making sure
11 they've reduced their weight by the, by now the 5
12 percent threshold is in our area that would
13 somewhat be an access issue.

14 So do they have access to a provider
15 that is helping them manage their diabetes if
16 they are presenting with a BMI higher than that
17 and monitoring their weight on a regular basis to
18 ensure that they're moving to that threshold that
19 would meet this quality measure? But, again,
20 going to Marcia's issue, that's a time-based
21 measure.

22 They -- you know, nobody loses five

1 percent of weight overnight, so it's something
2 that, again, to be considered. And measure is
3 really looking at an encounter, one particular
4 encounter, so this would be multiple encounters
5 to determine whether that measure is met and do
6 we want to incorporate that now.

7 So Steve.

8 MEMBER NORTH: A quick scan of these,
9 all of them are standard measures of care. And
10 as we've talked about sort of non-inferiority of
11 telehealth, it doesn't seem like any of them need
12 to be modified if you begin to integrate
13 telehealth into this outcome goal.

14 And this goes along with coordination
15 of care that Paul has been advocating for as one
16 of our domains that we know that in my rural
17 practice, I don't have a nutritionist, but if I
18 bring the nutritionist in for two visits, and
19 over the course of the year, does the patient
20 decrease their BMI?

21 That measure doesn't need to be
22 modified or changed because I've changed the

1 modality of delivery. I'm still trying to
2 achieve the same goal, --

3 MR. GOLDWATER: Right.

4 MEMBER NORTH: -- so maybe I'm still
5 five minutes ago in the conversation trying to
6 understand what the difference is.

7 MR. GOLDWATER: Okay.

8 Marybeth.

9 MEMBER FARQUHAR: I'm looking at the
10 measures and I see that there are a lot of
11 chronic conditions, --

12 MR. GOLDWATER: Right.

13 MEMBER FARQUHAR: -- so that assumes
14 that, and maybe I'm wrong here, that assumes that
15 there's multiple visits of these folks, so I'm a
16 little confused as to why there's nothing that
17 includes care coordination or transition of care
18 or timely transmission of records, discharge
19 records, or anything like that in here.

20 MR. GOLDWATER: Again, because the
21 initial focus was just outcome-based measures,
22 not --

1 MEMBER FARQUHAR: Okay.

2 MR. GOLDWATER: -- process-based, so
3 we didn't come across any measures such as that,
4 but, again, if those are measures we need to look
5 at or inventory, then we will.

6 MEMBER FARQUHAR: Yes. With the
7 measures you picked here, it's chronic care, so I
8 assume that you're looking at rural areas that
9 you're going to have people come on a consistent
10 basis.

11 The other area too, I'm going to beat
12 CAHPS to death here, is that getting care quickly
13 or getting the needed care would be something
14 that would be appropriate for telehealth --

15 MR. GOLDWATER: Okay.

16 MEMBER FARQUHAR: -- to include.

17 MR. GOLDWATER: Daniel.

18 MEMBER SPIEGEL: Thanks. Again, maybe
19 I'm a little slow here, but I just want to make
20 sure I understand.

21 MR. GOLDWATER: Guys, none of you are
22 slow. This is tough. I'm not -- I mean, I

1 appreciate all the qualifiers, but none of you
2 are slow. This is really hard. We understand
3 this. This is why you're here, so --

4 MEMBER SPIEGEL: Fair enough.

5 MR. GOLDWATER: I mean, I can't solve
6 this, neither can Tracy or Katie, and we've
7 certainly have had numerous discussions about
8 this, so thank you, but none of you are slow.
9 Chuck maybe, but none -- no, I'm kidding.

10 (Laughter.)

11 MEMBER SPIEGEL: So I guess I just
12 want to understand the intent of picking these
13 particular measures. Is it that using these
14 measures we come up with a framework for how we
15 would adapt any measure or any appropriate
16 measure for telehealth if an adaption was
17 acquired?

18 MR. GOLDWATER: That's correct.

19 MEMBER SPIEGEL: Okay, got it. So
20 it's not that this would be the list of measures
21 that would be included in any sort of NQF-
22 endorsed -- okay, got it. Perfect.

1 MR. GOLDWATER: No. These are --
2 these are measures, if you so chose them, would
3 be part of the framework. It'd be like an
4 initial pass of measures for people to use, how
5 do we incorporate telehealth as part of that.

6 MEMBER SPIEGEL: Got it, thanks.

7 MR. GOLDWATER: Dale.

8 MEMBER ALVERSON: I may be just
9 reinforcing what many people have already said,
10 but what this reminds of is CPT coding.

11 MR. GOLDWATER: Yes.

12 MEMBER ALVERSON: You know, rather
13 than saying there's got to be something specific
14 to telehealth, rather than creating new CPT
15 codes, we just -- well, CMS uses the GT modifier.

16 MR. GOLDWATER: Right.

17 MEMBER ALVERSON: So in a sense, I
18 sort of look at a lot of these things, I could
19 see telehealth playing a role in perhaps
20 facilitating achievement of those outcomes, but
21 we don't have to create a new one. It's just --
22 it's almost like a GT modifier for each one of

1 these, these outcome measures. That's where
2 telehealth could be applied.

3 And then I would also agree, I think
4 there's some outcomes that seem to be missing
5 here, but I haven't had a chance to read through
6 it in general, but I think about the sort of
7 storm forward, and maybe that's in here about
8 diabetic retinopathy, and not only providing
9 access to looking at retinal scans, but also
10 intervening and preventing blindness by seeing
11 sight-threatening retinopathy. So I don't know
12 if that's in here, but that --

13 MR. GOLDWATER: It's not.

14 MEMBER ALVERSON: -- seems to me an
15 important outcome --

16 MR. GOLDWATER: Okay.

17 MEMBER ALVERSON: -- where telehealth,
18 you know, accelerates that.

19 MR. GOLDWATER: Okay.

20 Adam.

21 MEMBER DARKINS: A couple of points
22 made back to there's no real biologic

1 plausibility that telehealth in itself is going
2 to create changes in any of those measures, and
3 so in many ways, you could say that the standard
4 should be how appropriately telehealth should be
5 used in the context of an overall care management
6 program or program aimed at delivering those
7 ends.

8 MR. GOLDWATER: Okay.

9 MEMBER DARKINS: And I think there's
10 sort of risk of unintended consequences.
11 Firstly, it'd be difficult to know what the
12 denominator is when you're practically measuring
13 quality standards when you have this kind of
14 mixed economy.

15 And a couple of anecdotes. When we
16 implemented a large home telehealth program and
17 got to about 25, 30,000 patients, we looked at
18 outcomes, there was 1 of 21 regions that decided
19 it wouldn't adhere to the policies of the
20 program.

21 They took instead of a self-management
22 approach, they took a very medical model approach

1 of saying, "This is about how you manage people
2 in remote situations in community as you might do
3 in hospital." We saw a 40 percent increase in
4 utilization.

5 So some of these measures, you might
6 well -- there isn't a clear baseline of what the,
7 what the findings would be if you were to do it
8 in the kind of settings, so I think you're not
9 necessarily going to -- there isn't the evidence
10 I want to say with how it might be applied, so
11 you may well find this really confounds
12 everything when you start to do it.

13 And the last quick thing I was going
14 to say is back to tele-ICU. We're looking at
15 measures for tele-ICU in terms of line infection,
16 in terms of extubation of ventilators, et cetera.
17 One of the things that we found is it made more
18 sense to try and looking at quality measures
19 around virtual team working than it did those
20 kind of measures.

21 And the reason for that is if you're
22 using a telehealth program to manage 6, 10, 12,

1 14 ICUs, the first thing you have to do is get
2 common policies on how you manage some of those
3 things. So it isn't the intervention of suddenly
4 saying, "We're going to provide remote care," is
5 going to suddenly put it right.

6 The first thing you have to do is make
7 sure they have a common policy for extubation, et
8 cetera, and then you standardize. So I think it
9 could be misleading to just put those in without
10 those -- so I think it's how it's applied, not --

11 MR. GOLDWATER: Okay.

12 Steven.

13 MEMBER HANDLER: Okay, so I will start
14 with a caveat. I woke up at 3:00 in the morning,
15 so I'm a little tired and I'm still a little
16 confused about this.

17 So I was on -- I just went to the NQF,
18 and to me, when I looked at this list, I said,
19 "To me, some of the things that I would think
20 would be on this would be 30 readmissions." The
21 outcomes that I would look for are not here.

22 MR. GOLDWATER: Okay.

1 MEMBER HANDLER: And I thought we
2 started this discussion with the framework. That
3 is the things that, for example, how we would
4 structure the data. What I think for me would be
5 most useful, this seems very abstract.

6 MR. GOLDWATER: Okay.

7 MEMBER HANDLER: Okay. What I would
8 love to see is all of the NQF-endorsed measures,
9 even if there's 120, that's what you said there
10 are, I don't know the exact number. Six hundred,
11 oh, great.

12 MR. GOLDWATER: Well, wait. So wait,
13 hold on. Small caveat there.

14 MEMBER HANDLER: Oh, okay.

15 MR. GOLDWATER: Those are -- those are
16 process structure outcome, patient reported
17 outcome. That's every kind of measure. I think
18 just in terms of pure outcome measures, there's
19 roughly maybe 80 outcome -- what?

20 A hundred and fifty, oh, so I was way
21 off.

22 MEMBER HANDLER: So my thoughts were,

1 I'll just throw out something random, so you take
2 the 150, you create Adelphi or you create a
3 structure or a web, and you take your 150, and
4 then you take your framework as columns, and for
5 each one, we see how many they hit on the
6 framework that we logically talked about.

7 MR. GOLDWATER: Okay.

8 MEMBER HANDLER: The more that apply
9 in terms of the framework that we agree upon,
10 whatever that is, the more likely that we should
11 as a group endorse that particular NQF, you know,
12 metric I would think. To me, right now, I'm
13 having a hard time because I feel like this is
14 very abstract.

15 So as a geriatrician, I look at falls,
16 I still have no idea how telemedicine is going to
17 help with falls, right, in particular, you know,
18 looking at this unless we're going to have a
19 process that goes along with medication regimen
20 review or team or a lot, a lot, a lot around it,
21 and I'm going to have to fill in a lot around
22 that.

1 MR. GOLDWATER: Right.

2 MEMBER HANDLER: So that's -- I'm
3 sorry. So I'm having -- I am having trouble with
4 this. It's too abstract for me. I'd love to
5 ground it in the work we've just done or that
6 we're building on frankly, and then go and
7 review, not 600, true, but if you wanted in the
8 outcomes help us define, give us the universe of
9 outcomes that we should select from and help us
10 go that way. That's just a suggestion.

11 MR. GOLDWATER: Understood.

12 Yael.

13 It's a great idea by the way.

14 MEMBER HARRIS: So no caveat. I think
15 I know everything, but the question I have is,
16 again, we're trying to compare care delivered
17 through telehealth versus care delivered either
18 face-to-face or care not delivered at all, and so
19 I want to keep that in mind with some of these
20 measures because when I look at some of these
21 measures, they could be biased the other way.

22 So, for example, some of these

1 measures where we have better detection of fecal
2 impaction for pain medication, for example. It
3 would appear that we're actually doing poorly or,
4 you know, if we're seeing the patient more
5 frequently, we're going to detect things, like
6 depression. Whereas, we would not be able to
7 detect those things if the patient didn't come
8 back in.

9 So I wanted to just make sure -- I'm
10 not trying to paint a rosy picture and not show
11 the full picture if telehealth is not effective,
12 but I also don't want to paint telehealth as
13 having -- we're measuring negative outcomes that
14 can be better detected because telehealth is
15 improving access to care so we can make those
16 assessments in infections.

17 MR. GOLDWATER: Understood.

18 Julie.

19 MEMBER HALL-BARROW: As I looked at
20 these, of course, representing the pediatric
21 field --

22 MR. GOLDWATER: Right.

1 MEMBER HALL-BARROW: -- there's none.

2 MR. GOLDWATER: I know.

3 MEMBER HALL-BARROW: And, so, you
4 know, we have 28 measures in NQF, and I looked
5 at, you know, looking at the -- there's several
6 really quickly that could be added, so it's in
7 the whole spectrum, cradle to grave, but I am
8 representing that kind of group that I'm focused
9 on, and I think what I struggle with
10 continuously, legislatively, and regulatory is
11 that there's not enough evidence or no quality
12 factors or nothing to gauge the pediatric arena,
13 so I'd love if we could --

14 MR. GOLDWATER: Got it.

15 MEMBER HALL-BARROW: -- add that to
16 the spectrum.

17 MR. GOLDWATER: David.

18 MEMBER FLANNERY: I want to follow up
19 on what Marcia was commenting about with chronic
20 disease management. You could have a hybrid
21 model of care, you could have in-person visits,
22 telemedicine visits, and how you track them, what

1 Dale is getting to, is how you track the
2 telemedicine visits versus the inpatient, in-
3 person visits, and then could look to see how
4 much telemedicine contributed to the outcome.

5 There's a real challenge here. You
6 need to think about how you would do that and,
7 you know, how you operationalize these kind of
8 things.

9 MR. GOLDWATER: Okay.

10 Sarah.

11 MEMBER SOSSONG: So just going back to
12 the ultimate goal of this, I think as we have
13 gone to insurers, legislators and advocated for
14 telehealth, where we have gotten stuck is in the
15 fact that we have very clinically specific
16 measures, and so what I would hope that we could
17 do is come up with things that can be very
18 general and overarching across the clinical -- I
19 agree with everyone that said we're not looking
20 to achieve anything different through telehealth
21 than we are with in-person care.

22 If anything, what are the right ways

1 that we can --

2 MR. GOLDWATER: Right.

3 MEMBER SOSSONG: -- advise on the
4 clinical protocols and guidelines for how
5 clinicians use this, so, again, back to the
6 process outcomes access. What are the things
7 where when Blue Cross Blue Shield says, "Well,
8 how have you impacted cost?" they don't want it
9 broken down by clinical area.

10 They want on average across 10,000
11 visits, it's been X. So I think the more that we
12 can come up with something that would be common
13 for everyone across those types of things, that
14 would be helpful in advancing reimbursement and
15 other regulatory --

16 MR. GOLDWATER: Sure.

17 MEMBER SOSSONG: -- agendas.

18 MR. GOLDWATER: Okay. So I understand
19 that. I also understand that, you know, we
20 queried the database, right? And the database
21 said, "Here are the measures." And we went, "Oh,
22 that's nice," and then we applied the criteria

1 and said, "Oh, these are the measures that are
2 left," knowing full well that most of them were
3 based on chronic disease, which if you look at
4 NQF and measures in general, there's a large
5 slant of process and outcome measures to chronic
6 disease.

7 We knew there -- we saw immediately
8 there were no pediatric measures. We saw
9 immediately there were no dermatology measures.
10 We saw there were no ophthalmology measures. So
11 we saw the things that we've gotten a lot of
12 literature on about the effectiveness of
13 telehealth. There were no measures that we were
14 able to find.

15 So, again, the exercise is not this is
16 the list and this is what we're going with,
17 people, so you better come up with a way of how
18 we're going to do it. It's this is the initial
19 pass.

20 If we find this is not satisfactory
21 and is really not going to help objectively
22 assess and evaluate the use of telehealth

1 services in a way that is important to those that
2 are actually providing those services or managing
3 networks that are providing those services, we
4 are just fine with scrapping this and going to do
5 something else. It's not an issue.

6 As for, I think, the development of
7 measures that are reflective of what you see in
8 the field and what would be the most helpful, I
9 think that's the next step of this, which is to
10 build a framework on how those would be
11 developed.

12 So Angela, and then Kristi, and then
13 Judd. Sorry, I'm not forgetting you.

14 Oh, all right, Chuck, I'll get to you
15 eventually.

16 Go ahead, Angela.

17 MEMBER WALKER: Looking down this
18 list, and I think I could see some type of tele
19 use for just about everything listed, including
20 falls, but one thing I don't see as much of is
21 the acute episodic care, which is really more of
22 what, I think, some disciplines are using

1 telehealth or telemedicine for, so that might be
2 one thing to add. And if it's not incorporated
3 already on the list of measures, a new one to
4 develop.

5 And then I completely agree with
6 what's already been said about where does this
7 fit into the system, what's the piece in the
8 workflow that may be missing. And there may be
9 things that are more specific to a separate or
10 distinct practice modality for care that needs a
11 measure developed, so things like communication
12 and coordination of care, all those things we've
13 already addressed, that may not be here.

14 MR. GOLDWATER: Okay.

15 Kristi.

16 MEMBER HENDERSON: Yes, so I love the
17 idea that you had Steven around going down all
18 these measures. So I'm sitting here looking at
19 the outcome measures and, you know, the
20 readmissions and the acute episodic outcomes and
21 the mortality rates. Those are things that tele-
22 emergency, tele-stroke, the eICU program are

1 impacting.

2 And the falls, to that question, eICU
3 and tele-sitter programs all over are impacting
4 falls, so I think that and linking them to the
5 domain could be a great exercise. And all of us
6 would have a unique perspective and could make
7 that a really robust list.

8 MR. GOLDWATER: Judd.

9 CHAIR HOLLANDER: So, you know, I want
10 Marcia so she could stand between, you know, me
11 and Jason. I want to vote to blow this up. I
12 just think it's -- and I'll tell you why. And
13 going back to -- no, I mean, I know it's fine.

14 I think when I read these measures,
15 and this is going to sound silly, but it's true,
16 it doesn't matter how you achieve the goal. So
17 if I need to get to hemoglobin A1c under X, and I
18 give you a Cheerio every day and you're under X
19 at the time frame, you meet the goal, so
20 telemedicine is just a thing you could use in
21 here to achieve the goal, and so it makes me
22 think that it's really not about the outcomes

1 because in all the outcome measures that I'm
2 familiar with, and I'm sure there's a million I'm
3 not, is you hit the outcome, right?

4 That's the goal. It doesn't matter
5 how you do it. So telemedicine can be a tool
6 that helps you get the outcome, but I don't think
7 we need to say that. I think it's in the process
8 measures where we need to define does
9 telemedicine have a role.

10 So if the process measure says, "Do a
11 visit within seven days of discharge," saying
12 that the visit can be telemedicine because the
13 evidence supports a telemedicine visit is no
14 worse than an in-person visit, then that's where
15 the change is really dramatic.

16 So I think I'd break it down into two
17 things. One is where telemedicine is just a tool
18 that can be embedded within the measure, but you
19 don't need to say it because it doesn't tell you
20 how to accomplish the goal within the measure, so
21 we can stay silent on that.

22 That's actually probably most of the

1 outcome measures, then it's actually the process
2 measures that tell you, "You need to get A, B, or
3 C done by such and such a date or time," and then
4 we need to figure out whether telemedicine should
5 be A, B, C, or D in the process measures, so our
6 focus might actually be in the wrong spot.

7 MR. GOLDWATER: So a side note. So,
8 Judd, if you're going to give me a Cheerio a day
9 to control my diabetes, I'm never seeing you as a
10 physician.

11 Chuck.

12 MEMBER DOARN: I'm curious from a
13 management informatics perspective if these
14 measures are, no matter what the focus area is,
15 obviously, it has some things missing, if you
16 change from ICD-9 to ICD-10 whether those
17 measures would change and change appreciably, or
18 if you look at DSM, the most current issue of the
19 DSM, whether they would change as well.

20 And then not only things like
21 dermatology and imaging and medication adherence,
22 things like that, tele-stroke missing, I'm

1 wondering if patient management, the way we
2 actually manage healthcare itself, I don't -- I
3 mean, again, I don't know if there are measures
4 out there in that regard, but if there are,
5 they're probably in journals you probably didn't
6 look at because they're not necessarily going to
7 be telemedicine-related, so I'm just curious
8 about that.

9 And then the last thing about falls,
10 you know, telemedicine and telehealth's not going
11 to prevent falls, but you're going to be able to
12 monitor, on a patient-centered medical home be
13 able to monitor where the patient is and actually
14 be able to provide faster response, you know,
15 maybe when the fall, you know, the meter on their
16 wrist, you know, calls 911 or something. So
17 that's the whole technology thing again.

18 MR. GOLDWATER: Stewart.

19 MEMBER FERGUSON: So actually, I'm
20 going to follow-through on what Judd said because
21 I've been thinking the same thing, and that is,
22 are we trying to come up with measures that

1 measure the efficacy or value of telehealth or
2 measure the value of programs that may or may not
3 use telehealth because they're very different.

4 Most of these are program measures,
5 and you may use telehealth for 10 or 50 or 100
6 percent of it, and it's hard to say, but it
7 wouldn't tell you if telehealth was particularly
8 effective. It tells you your program was
9 effective.

10 You know, we do diabetes management.
11 We might only use it for retinal screening, we
12 might also use it for foot screening, or we may
13 use it for something very minor. We just might
14 measure their hemoglobin. We might get the same
15 score in all three, but it wouldn't tell us if
16 telehealth was particularly effective.

17 So I guess that's a question. Are we
18 trying to come up with measures that really tell
19 us if telehealth is effective or --

20 MR. GOLDWATER: Yes.

21 MEMBER FERGUSON: -- are we trying to
22 come up --

1 MR. GOLDWATER: It's the former.

2 MEMBER FERGUSON: So we're trying to
3 look for measures that are more focused and put a
4 lens on telehealth?

5 MR. GOLDWATER: Yes, that's correct.

6 MEMBER FERGUSON: Because these
7 actually don't really do that then very
8 effectively.

9 MR. GOLDWATER: Okay. Okay.

10 Daniel.

11 MEMBER SPIEGEL: I actually just
12 wanted to second what Judd said. I've been
13 thinking about this for a few weeks now and
14 trying to think of why would we want to change
15 outcome measures. I'm struggling with, you know,
16 how telemedicine or telehealth, whatever we call
17 it, would make a difference in the outcome.

18 I mean, maybe it does make a
19 difference in the outcome at the end of the day,
20 but it doesn't make a difference in how we
21 measure it, so I actually just wanted to second
22 Judd's point.

1 MR. GOLDWATER: So before I get to
2 Nate, let me try to recap what we've been told so
3 far, and then focus that discussion as we move
4 forward. So I think what I'm hearing from all of
5 you passive-aggressive individuals is that you
6 don't really like -- I'm kidding.

7 That although I think this was a good
8 first effort, this isn't really providing the
9 utility for telehealth that would be beneficial.
10 And I appreciate -- I think we all three of us --
11 we greatly appreciate that and that really
12 validates why we have all of you here.

13 So the next approach would be then to
14 query the AHRQ database again, the NQF database,
15 probably the meaningful use, although there'll be
16 a lot of cross application, and not focus on
17 outcome, but focus on process measures?

18 Is that some agreement or focus on
19 outcome measures or process, or both?

20 Yael.

21 MEMBER HARRIS: I would say both. And
22 one of the things I was going to throw out there

1 is that maybe we want to look at both general --
2 as we talked about -- things that we think
3 telehealth could impact, and then look at
4 specific conditions as well because they're both
5 -- so when we look at tele-ICU, what -- let's
6 think about what are the outcomes and the
7 processes that we think it will impact that we
8 want to measure, and then in general, let's think
9 about why would we use telehealth. And then in
10 general, what are the things that we want to
11 measure there -- you know, timely care -- and are
12 there measures related to that.

13 So I want to think in terms of
14 specific use cases because we know telehealth has
15 been very effective in certain areas, and there's
16 outcome measures that would demonstrate that. And
17 then we'd also want to demonstrate -- and there
18 may not be measures out there, but at least think
19 about what we would want -- areas where we know
20 telehealth has an impact, but we don't know what
21 measures are there -- is there a measure that
22 already exists or should we start thinking about

1 a measure that could demonstrate this.

2 MR. GOLDWATER: Okay. So before I get
3 to that -- so process and outcome measures,
4 should they be only e-measures, so only
5 electronic, or should they be chart-based and e-
6 measures.

7 Okay, caveat to that, e-measures are
8 ones that can be integrated into a registry or an
9 EHR. Chart-based measures are, you abstract the
10 information off of a chart, and then report that
11 out.

12 If we are to go to both and you want
13 to do process and outcome measures, you're
14 roughly looking at potentially evaluating in
15 excess of 8 to 900 measures. Which, you know, is
16 commendable that you all want to do that, but I'm
17 going to go on record and say you're probably not
18 going to get that done.

19 So we do need to think of criteria to
20 narrow that down so that we have a cohort of
21 measures that you can examine and that we would
22 then ask you -- and we would also do this

1 internally -- to evaluate the measures across the
2 domains that we have already gone over, and those
3 measures that fall into those most effectively
4 would be the ones we would consider moving
5 forward with, which we don't have to make a final
6 decision until we meet in May.

7 Nate.

8 MEMBER GLADWELL: I just want to make
9 an observational comment around outcome versus
10 process measures. I think we don't -- my opinion
11 is we don't want to go down the wormhole that
12 core measures is probably still stuck in, which
13 is, you know, the academic, say, process doesn't
14 get to outcomes. You hope process gets to
15 outcomes, but not necessarily.

16 And measuring process tends to be
17 easier, so that typically is the measurement that
18 gets created and tracked. I would like to really,
19 really urge us to consider outcomes being the
20 higher focus in terms of measurement. I'm not a
21 measurement expert, but then we can avoid a lot
22 of the issues that core measures run into and

1 other process-related measurements run into
2 around evolving technologies and processes
3 related to that.

4 MR. GOLDWATER: Okay.

5 Steven.

6 MEMBER HANDLER: So I think in an
7 ideal world, we'd like to do both, but we have a
8 limited amount of time and people, so I'm going
9 to throw out some crazy ideas since I didn't get
10 much sleep.

11 MR. GOLDWATER: You'll fit right in.

12 MEMBER HANDLER: Great. So is it
13 possible to divide and conquer? Is it possible
14 to break the group up into those who want to do
15 process versus those who want to do outcome?

16 MR. GOLDWATER: It is, absolutely --

17 MEMBER HANDLER: Because --

18 MR. GOLDWATER: -- as long as there's
19 concurrence on the group that the decisions that
20 are made by each one of those subgroups are ones
21 you go through with, and that --

22 MEMBER HANDLER: Only because it seems

1 to me that we all agree that they're important,
2 but if we -- I think one of the most important
3 things would be to figure that out today what
4 we're going to do, what path we're going to take,
5 but I would say that if we take a path, it should
6 be outcomes also. I'm going to just vote that
7 right now because we have to also understand who
8 are we serving.

9 I mean, it all goes back to who is the
10 most important stakeholder, right, and the
11 funder, Megan, right. Well, I mean, no, really,
12 so what -- so should we hear from our
13 stakeholder, what does our main stakeholder want
14 from this, what is the outcome. I mean --

15 MEMBER MEACHAM: Well, so I didn't --
16 I didn't want to, you know, bias or sway. I want
17 this to be a true consensus-based entity outcome.
18 I would say that there's been some discussion. I
19 think I've been nodding a little bit more. We
20 really want to be able to compare the telehealth
21 -- care provided through telehealth versus care
22 provided in other ways or not provided at all to

1 the extent that's possible to really compare.

2 I think I understand where you're
3 going with actually picking a list of measures,
4 whether they be process or outcome. But I think
5 ultimately, it's more important to look at that
6 end goal of how do we differentiate the modality
7 that the care was provided so that the
8 comparisons can be made and it's apples to apples
9 and not apples to oranges or two separate sets of
10 measures.

11 And then -- because we run into this
12 issue with rural a lot where, you know, rural
13 development for measures, but then they don't
14 really match up with the measures that are being
15 used mainstream, and then we can never really
16 compare the care that's provided in rural and
17 urban, but really we need measures that just work
18 in all settings.

19 So that's where we're getting with the
20 telehealth as well. But I think, you know, in --
21 you know, that's our bias, but we also do
22 understand that CMS, the payers, the providers

1 are also important, and that's where, you know,
2 we're -- we wanted your all input because we
3 can't think of it all.

4 So did I muddy that more than --

5 MR. GOLDWATER: No, not all. I think
6 that was -- that was pretty clear actually.

7 Adam.

8 MEMBER DARKINS: I wanted to raise a
9 flag about the implementation of these if they
10 went forwards. I don't know whether that's
11 normally something NQF thinks about.

12 MR. GOLDWATER: Yes, absolutely.

13 MEMBER DARKINS: But it's not easy to
14 start a telehealth program if it's just 20
15 patients in the pilot, and part of that is a
16 study. Doing some outcome measures is relatively
17 easy, but if one is trying to grow a program,
18 when I get back to managing across a network,
19 some of the smaller organizations might most
20 benefit from this, are going to be the ones that
21 don't have the IT systems.

22 And if you're trying to get staff to

1 actually do the face -- the sort of cold face
2 care of the patient to build up a huge
3 administrative backload -- particularly in small
4 rural primary care areas -- you're going to kill
5 the whole thing without getting the measures.

6 So I think before thinking you're
7 going to suddenly extract 600 measures, it should
8 be much more focused and actually think of the
9 practicalities of how we'd do it at the same
10 time.

11 MR. GOLDWATER: Right. So, before I
12 get to Daniel and Marybeth, you know, that's what
13 I was going to bring up, which is we have to
14 figure out some way of narrowing down that very
15 large set of measures into a -- not just a
16 workable cohort, but a workable cohort that could
17 be implemented.

18 MEMBER DARKINS: Just as a follow-up.
19 I just say to give you an example, tele-ICU.

20 MR. GOLDWATER: Right.

21 MEMBER DARKINS: There was no evidence
22 that tele-ICU is beneficial in the sense that --

1 as far as I'm aware, unless something's changed -
2 - there's not been a randomized controlled trial
3 that shows the benefits to an intensivist
4 physically if they're doing it virtually. So, to
5 build a whole edifices of measures based on
6 things for which there's evidence.

7 Now, practically, it makes ICU much
8 easier to deliver in ways when you don't have an
9 intensivist if that's the standard of care. So I
10 think that part of the way to push this down is
11 for some of these things there is no evidence
12 that telehealth will impact, so one of the ways
13 is perhaps look at things we actually do know it
14 will impact and make it easier.

15 MR. GOLDWATER: Okay.

16 Marybeth.

17 MEMBER FARQUHAR: I agree that we
18 should be looking at outcomes first and then
19 process second. However, for the process -- to
20 help narrow it a little bit, maybe we can do some
21 crosscutting measures that would go across all of
22 the -- all of the specialties that we're looking

1 at and the chronic conditions. That might help
2 narrow the list a little bit.

3 MR. GOLDWATER: Paul.

4 MEMBER GIBONEY: So I'm trying to
5 think about kind of what was -- what was being
6 said about how do we come up with this comparison
7 between, you know, something delivered by
8 telehealth versus not by telehealth or not at
9 all, and the concept of outcomes measures. And I
10 guess -- I guess as I look at this list and think
11 of all the other lists and all the comments that
12 I completely agree with that the outcomes
13 measures, you know, it's just -- it's just the
14 right care however it's being delivered.

15 I just wonder if there is a way to
16 pull out some of these outcomes measures, and
17 then identify which of those measures are -- have
18 a -- where telehealth has like a high rate of
19 impact or not just -- I mean, you can kind of
20 dream up the way telehealth would apply to any of
21 these measures, but in some of them, you could
22 say, oh, wow, telehealth is a real game-changer

1 in a certain scenario and a certain place.

2 And I'm wondering is there a way -- if
3 we wanted to pursue the outcomes route -- is
4 there a way to identify certain measures -- maybe
5 even a handful of them -- where telehealth has a
6 more dramatic impact or a more visible or obvious
7 impact.

8 I'm not exactly sure which of those it
9 would be, but I'm just kind of trying to think
10 about how we get through a very large list of
11 measures, and also address both the outcomes and
12 process.

13 MR. GOLDWATER: Right. So before
14 following up, I think, you know, one of the
15 ideas, to go back to what Steven was proposing,
16 was to look at those measures against the
17 domains. And I think that the measures that meet
18 the most domains or meet all of them in the minds
19 of those that are evaluating would have the
20 greatest impact on telehealth, and those are the
21 ones we would move forward with or we would at
22 least propose to move forward with when we

1 convene again.

2 The question I have -- which we'll get
3 to, I guess, after the discussion is concluded --
4 is -- and I do want to stress this, you're
5 talking about an awful lot of measures here if we
6 do process an outcome. I mean a considerable
7 number of measures, and we need to narrow that
8 down so that it's a much more workable list.

9 Now, we can do that in one of two
10 ways. We can define criteria that we can then go
11 apply and do that when we pull down the list of
12 measures from these databases, or you can tell us
13 which categories or clinical areas are the most
14 impactful with respect to telehealth and those
15 are the measures that we focus on specifically.

16 Yael.

17 MEMBER HARRIS: So since I am the one
18 who kind of resides wide, or at least NQF side
19 about, oh, my God, you want to do all those
20 measures, what if you started with e-measures,
21 and then if there were areas where there are --
22 so we would identify where are the areas where we

1 really think we need to be measuring.

2 And if there is no e-measure in that
3 area, then for those areas, go look at the non-e-
4 measures. And so Kristi and I were talking about
5 examples, which is timeliness of care. There may
6 not be a good measure you can pull from an EHR
7 for that, but that doesn't mean there isn't a
8 good, you know, chart abstracted measure that you
9 could use to time to cath.

10 You know, so there -- we don't have to
11 start with the whole universe of measures. Start
12 with what you have as e-measures, and then once
13 we've -- that seem relevant, and once we've
14 reviewed those, there are areas where we will
15 still want measures in terms of timeliness of
16 access, in terms of outcomes that would be or
17 processes that really are important to measure
18 for telehealth. And if those don't exist in e-
19 measure, that's when we look to chart-based
20 measures.

21 MR. GOLDWATER: Okay.

22 Henry.

1 MEMBER DEPHILLIPS: Just a couple of
2 kind of guiding principles. I won't sound slow
3 because you admonished the group, but I will say
4 in this drawer, I'm not the sharpest knife.
5 How's that?

6 So here's how I think about what we're
7 trying to do. First of all, you know, when we
8 look at the evidence, there's some, but then
9 there's other things that telemedicine is even
10 currently doing for which there is no evidence,
11 right? So if we're relying on outcomes, we're
12 going to fall short.

13 And I'm guessing the reason this group
14 is here is because we need to like take the
15 current situation, and then figure out something
16 to move forward that sounds like a really good
17 idea, but for which there's no evidence.

18 Same with measures. You know, I
19 acknowledge this is a starting point. I actually
20 agree with you, Todd. We should throw it out. I
21 think we're better off with a fresh sheet of
22 paper than we are with this. No offense, but --

1 but, you know, as I think about the conversation,
2 I'm a real fan of sort of simplicity. I'm kind of
3 a concrete thinker, so as we think about measures
4 of telemedicine, you know, there's the way things
5 are done before telemedicine came on the scene,
6 and then there's kind of how things are done with
7 telemedicine, right?

8 If you look at outcomes, the easiest
9 one is mortality. Very easy to measure, not very
10 subjective. Then you move up, and then there's
11 morbidity, right, and then there's measures that
12 make sense for each of the different forms of
13 telemedicine. So, for example, for tele-stroke, a
14 measure could be percentage of patients who are
15 appropriate for thrombolytics and actually
16 receive thrombolytics with and without a
17 telemedicine program, whatever.

18 So I'm kind of thinking that as we
19 develop measures, we -- and I agree with the
20 outcomes approach. I think if we try to do
21 process, it may be too much just given the scope
22 and bandwidth of the group, although, maybe

1 later.

2 But as we think about outcomes, you
3 know, for each of the different sort of flavors
4 of telemedicine that are in the marketplace,
5 there's probably a core set of medical issues
6 that are addressed by each of those flavors, and
7 there's probably a core set of reasonably well-
8 known outcomes that are pretty acceptable for
9 each of those sort of disease processes. And I
10 think if we just start -- a starting point could
11 be to focus on those outcomes sort of with and
12 without a telemedicine component.

13 Going back to something David said,
14 yes, there's a whole lot of entities that are
15 going to have, like, traditional in-care, in-
16 person care, and then like moving forward, it'll
17 be partly in-person and partly with telemedicine.
18 No reason you can't measure traditional care and
19 -- with a blended telemedicine. That's not -- you
20 can still measure that. Just because there's in-
21 person care with the telemedicine group doesn't
22 mean you have to throw it out.

1 So I guess I would -- my guess is if
2 we stay kind of concrete, stay kind of near the
3 center of the disease processes that the various
4 flavors of telemedicine treat, look at sort of
5 traditionally measured outcomes, and then layer
6 in the impact of telemedicine, I think that might
7 be a safe starting point.

8 MR. GOLDWATER: Chuck, I did see you,
9 but Marcia did hers first, so wait. Go ahead.

10 CHAIR WARD: So I think Henry used the
11 term flavors of telemedicine, and that's what
12 comes to mind for me. And I'm hearing different
13 things here. I'm hearing that it would be nice
14 to have a set of measures that apply in all the
15 flavors, and I think that's a really hard thing
16 to do. It's a beautiful thing to do, but I think
17 it's going to be a hard thing to do and it's
18 going to be a very limited set of measures that
19 would really apply everywhere.

20 When Yael and I worked on a project,
21 we had all -- and it was just for tele-ed
22 measures -- there were all condition measures,

1 like timeliness, length of stay, but then there
2 were condition-specific measures, like tele-
3 stroke and the timeliness, fibrinolytics,
4 whatever, and so we probably need to decide
5 whether we're going to do specialty and look at
6 where measures are more clearly associated
7 probably with the delivery of the telemedicine
8 model or whether our goal is going to be coming
9 up with the crosscutting whatever.

10 MR. GOLDWATER: I have an idea, but
11 let me get to Chuck before he, you know, has a --

12 MEMBER DOARN: I think I solved it.

13 MR. GOLDWATER: You did? I can't wait
14 to hear it.

15 MEMBER DOARN: If I ask everybody in
16 the room to look at -- we have 10,000 patient
17 records over here, I need to know how many
18 patients have BMI of 90, take high blood pressure
19 medicine in an age group whatever it is, would
20 take us pretty much all week, right?

21 But if I have an informatics system, I
22 press a couple -- you know, put a couple of

1 queries in there and I get the answer in a matter
2 of minutes, perhaps seconds. So we know that
3 there are already some measures already out there
4 sort of on this now not so good of a piece of
5 paper, right?

6 Why not -- why don't we develop a
7 matrix. On the left side you have ICD-9, 10, 9 or
8 10 codes, key categories, we know what they are,
9 they're published, you download it, put it in an
10 Excel spreadsheet. It is tough? Can be used?
11 Yes or no. Is there a measure? Yes or no. And
12 then you put the measure in it.

13 And within -- by the end of this week,
14 you'd know exactly what's missing. I mean, it's
15 not rocket science.

16 MR. GOLDWATER: I understand.

17 MEMBER DOARN: I can say that because
18 of rocket science. But the point is that it seems
19 to me that, you know, we have all this
20 information, but it's not being portrayed in the
21 right way, so by putting it in a simple matrix --
22 again, an Excel spreadsheet or whatever tool you

1 want to use -- we know what the codes are -- we
2 know what the categories are I should say, not
3 necessarily the codes -- and it's telehealth --
4 you can use telehealth/telemedicine for virtually
5 anything.

6 Is it smart to do that? Probably not,
7 but if you know there are measures already in --
8 in some of these databases, you can put them in
9 this sheet, you sort of have some of them here.

10 MR. GOLDWATER: Right.

11 MEMBER DOARN: And certainly within,
12 you know, a few weeks, maybe months, you'd have
13 that whole database built -- if you want to call
14 it a database -- and then we could maybe send it
15 out to the group and say what do you guys think.

16 Maybe divide us into five different
17 categories and please look at these categories or
18 these conditions, and then go back and say, yes,
19 there's some telemedicine in here, there's not.
20 I mean that's one way I think of organizing the
21 information better --

22 MR. GOLDWATER: Okay.

1 MEMBER DOARN: Unless I'm like way off
2 base.

3 MR. GOLDWATER: No, it's a perfectly
4 good idea.

5 Megan.

6 MEMBER MEACHAM: And I'm going to ask
7 Jason, Tracy, and Katie to just like cut my mic
8 if I'm giving wrong information here.

9 MR. GOLDWATER: You're not.

10 MEMBER MEACHAM: But I think that --
11 and I don't want to give anyone a free pass to
12 not come up with all the answers because I expect
13 you to come up with all the answers, but in the
14 event that you're not able to --

15 (Laughter.)

16 MEMBER MEACHAM: Oh, that's right.
17 We'll talk later. We'll talk later. We'll just
18 throw your report away and we'll just -- I'll
19 give it to Yael to edit.

20 I just -- I also want to add that I
21 think, you know, if, say, something -- there's
22 just some roadblock and you can't get to an

1 answer, you can just make a recommendation in the
2 report as well because this is going to go to
3 CMS, it's going to go out to the public, and so I
4 think, you know, not a full report of just
5 recommendations and not coming to any type of
6 consensus or plans moving forward, but I see a
7 recommendation as perfectly acceptable.

8 Like in order to further this or to
9 implement this, CMS would need to do XYZ or so
10 and so would have to do this before we can figure
11 out how to do this or a pilot would need to be
12 had first. And I think that's a perfectly
13 acceptable portion of the report, correct?

14 MR. GOLDWATER: Yes, absolutely. And
15 my feeling is we're probably going to end up with
16 that. Hopefully, not for the entire report, but
17 I think there are going to be a couple of things
18 where we're just simply going to run out of time.

19 The issues are going to take too long
20 to delve into and to try to come up with a
21 reasonable solution that can be implemented would
22 be challenging, so we would have to then go

1 forward with recommendations. Assuming those
2 recommendations are followed -- that's a big if -
3 - but if they are, then we can convene again and
4 decide how to operationalize those.

5 Judd, and then Steven, and then
6 Angela.

7 CHAIR HOLLANDER: I think one of the
8 reasons this conversation is difficult for me to
9 follow at times is I'm questioning whether we're
10 confusing a discussion on measure development --
11 which is not the purview of this committee --
12 with the discussion on developing a framework for
13 measures.

14 So a lot of the discussion is around,
15 oh, we know it works here. We have -- NQF has a
16 really nice process and we've sort of skipped a
17 step, right? We did an environmental scan to see
18 where the evidence is, but we don't have that
19 done yet, so it seemed to me that once the
20 environmental scan is done, then we need to
21 crosswalk that with the measures that do exist
22 now.

1 And what we're really looking for is
2 the framework development, and then where are the
3 gaps between what we find on the environmental
4 scan and where no measures exist. And in the
5 end, we're really left with two things that to me
6 are relatively simple, but complex to do.

7 One is, are we incorporating
8 telemedicine by giving permission to use it into
9 preexisting measures? That's largely what we're
10 doing. And then, are we defining measures that
11 need to be done to show telemedicine is -- that's
12 really a study, are we really going to have
13 measures that show telemedicine is as good as the
14 alternatives. But that's not really what measures
15 are.

16 Measures are after we've done the scan
17 and we know telemedicine exists, are we getting
18 it done and accomplishing our goals. So I think
19 we're a little bit circular because the process
20 you've laid out is perfect, but the discussion is
21 a lot around developing measures, and that's not
22 what we should be talking about.

1 MR. GOLDWATER: Right. So I think
2 after Steven and Angela talk, let me sort of
3 circle back, sort of summarize, and then propose
4 a direction on going forward, and then we have
5 Chuck's direction, and then we can decide which
6 one is better, which will obviously be mine. I'm
7 kidding.

8 Steven.

9 Just kidding, Chuck.

10 MEMBER HANDLER: I actually -- Judd, I
11 think what you said is exactly what I was going
12 to say. I think we're missing the whole purpose
13 of the environmental scan, which is the evidence
14 base for what works.

15 And I think that what we should all do
16 is once that's done, if nothing else, is not just
17 have a general recommendation, but what we should
18 be doing is recommending the evidence. And we
19 should compare the evidence to the metrics and
20 measures that are available, look at the gaps
21 where they don't exist, and perhaps what we
22 recommend then is that additional measures -- we

1 don't do that, but additional measures be
2 developed based on the gap between the evidence
3 that suggest it works and what's not developed
4 yet.

5 I think that's the perfect logical
6 sequence. And I agree that nailed it for me
7 frankly. That logic is now clear in my mind.

8 Getting back to the -- I don't know
9 that we can do the ICD-9, 10 approach because --
10 and I do want to say this -- once again, there
11 are many clinical environments that don't have --
12 I'll repeat this -- that don't have an electronic
13 medical record, yes.

14 Nursing homes don't have electronic
15 medical records, home health, many don't have
16 electronic medical records, telemonitoring don't
17 have, so we don't want to exclude these important
18 clinical environments and just make -- make it
19 quote unquote convenient to use an e-record or an
20 e, you know, measure, so I'm going to just want
21 to make sure that's clear to everybody that we
22 can't just throw that out -- those important

1 environments away. That was a second soapbox
2 statement. Sorry.

3 MR. GOLDWATER: Not a soapbox.

4 Angela.

5 MEMBER WALKER: This might also be
6 what you're going to address and clarify more for
7 me, but I'd like to know what the output is of
8 this group and what its utilization will be,
9 because I'm a little concerned if we think about
10 using what we develop as a way to compare patient
11 outcomes currently through either a standard
12 practice or a telemedicine utilization. Because I
13 would imagine that there's a lot of telemedicine
14 already integrated into practices and workflows
15 that people are doing, and so unless they're
16 following strictly this is a clinical measure and
17 we're going to test it in a brick and mortar
18 standard clinic setting as we've always known
19 versus a strict telemedicine that follows these
20 specific practices, you're not going to get a
21 very clear answer. And to do something like that
22 would be --

1 MR. GOLDWATER: Right.

2 MEMBER WALKER: -- big and require a
3 randomized controlled trial --

4 MR. GOLDWATER: Yes.

5 MEMBER WALKER: -- you know, with
6 standard procedures and all of that.

7 MR. GOLDWATER: Yes, and IRB approval.

8 MEMBER WALKER: So I just want to know
9 whatever it is that we -- exactly, whatever it is
10 that we develop, we recognize and understand very
11 clearly how it will practically be used so that
12 we can best meet those practical applications.

13 MR. GOLDWATER: So let me clarify the
14 ultimate purpose of the exercise when we finish
15 in August. So it's to build a measure -- a
16 framework that will provide a foundation for
17 future measure development that specifically
18 deals with telehealth -- telehealth outcomes,
19 potentially telehealth processes, other factors
20 of telehealth that we may not consider or other
21 factors of telehealth that are still being
22 developed -- that is adaptable and amenable to

1 future developments and technology.

2 Any good framework will always take
3 advantage of what's already been done. You know,
4 you don't want to start a framework and say we're
5 going to do everything from new and not take into
6 consideration what's being done.

7 Now, if -- for example, I sat and was
8 a senior director on the health IT inpatient
9 safety project when we did the same thing. That
10 was a lot easier because that was what are all
11 the measures of patient safety that already
12 exist? There was no ambiguity. Either this helps
13 save patients' lives or it does not. This is
14 where error will happen or error will not occur.
15 That was very simple to do. And then it was
16 there was already a sociotechnical model that
17 Hardeep Singh had developed that said here are
18 the eight dimensions of patient safety, and we
19 could use that as the foundation for the
20 framework and build measures around those eight
21 dimensions.

22 That was -- that was, you know, it

1 took time and discussion about what was
2 important, how to prioritize what measures we
3 wanted to include, but there was no ambiguity.
4 There was these are patient safety measures or
5 they're not.

6 This is a lot more difficult because
7 there are not measures that specifically say if
8 you use telehealth, we hope this will happen.
9 There are no measures that state that. There are
10 no measures that say the intersection of
11 telehealth will cause Judd to give you a Cheeto a
12 day to reduce your diabetes. I mean, I'm
13 kidding, but, you know, there's nothing that says
14 that.

15 And telehealth is measured in terms of
16 what are the ultimate outcomes. And the problem
17 is that there are a number of outcome measures
18 that we already have that have already been
19 published, that are already in use, that have
20 already been endorsed, but they don't incorporate
21 telehealth as a means of care delivery.

22 They don't -- they focus on an in-

1 person encounter. I go to the hospital and I
2 have -- I'm having a heart attack, do they give
3 me aspirin right away? I go to the physician's
4 office, my BMI is over 25, they say, you need to
5 do this and lose five percent of your weight when
6 you come back in 90 days.

7 Those are the way the measures are
8 shaped up. So the issue then was how do we --
9 building a foundation for future measure
10 development will be somewhat challenging, but
11 what we really have to then reach consensus on
12 are what are the elements, what are the
13 dimensions, what are the things every telehealth
14 measure has to take into consideration?

15 It's the what's already existing that
16 is problematic because what measures do we choose
17 that we think we could incorporate into the
18 framework that would discuss or would at least
19 elucidate the effectiveness and utility of
20 telehealth services. And that's challenging
21 because do you -- what measures do you take?

22 Do you take just your outcome measures

1 because that's what everyone is interested in?
2 And in particular that's what the federal
3 government is interested in. They're not
4 interested in process measures anymore.

5 They've been abundantly clear to us.
6 As Elisa will say, they're really -- I mean,
7 people are still going to submit them. That's
8 just not going to -- it's not going to stop, but
9 they really want outcome measures, they want
10 patient-reported outcome measures.

11 That's the focus. That's why we chose
12 outcomes initially. They're not really interested
13 in process measures. But if we're going to do
14 process measures or we're going to do outcome
15 measures or we're going to do both of them, yes,
16 Yael, that's a lot of measures. We're not
17 intimidated by the fact that it's a lot of
18 measures. The problem is what measures would be
19 most impactful, what measures would be most
20 useful.

21 So how do we take this large universe
22 of measures -- I mean, there's 535 electronic

1 process measures that we could pull today. And I
2 don't want you to go through that exercise of
3 evaluating all of those. That's a lot to do.

4 Do we then finish the literature
5 review, understand in the literature review
6 analysis the areas of clinic -- the clinical
7 areas of which telehealth is having the greatest
8 impact, that we can see through the literature
9 that that's undeniably true.

10 And we're not just going to do that by
11 just systematically saying, oh, the preponderance
12 of articles show that dermatology is affected by
13 telehealth. I mean, one, we probably already
14 know this.

15 I mean, we have proposed some
16 statistical analysis to really show, is there is
17 significance between the application of a
18 telehealth modality and the outcome that they're
19 referencing in the literature? And we will
20 present to you what we found and show that these
21 are the outcomes that are the strongest.

22 Once we get to that point, then do you

1 want us to start pulling the outcome and process
2 measures that relate just to those areas of which
3 we're indicating that telehealth has the
4 strongest, most significant impact on, and then
5 evaluate those measures -- as Steven proposed --
6 in a matrix that shows, you know, which ones meet
7 all of these domains, and then those are the
8 measures that we start to go forward with.

9 I'm perfectly fine with that. It's
10 not that I don't like Chuck's ICD-9 -- ICD-9,
11 ICD-10 example. I do because as much as I tease
12 him, I really do like and respect him, and my
13 eight-year-old thinks he's the coolest guy ever
14 because he works for NASA. But the problem with
15 that is is that in the measurement world, you
16 know, ICD values are just really used as value
17 sets.

18 They're just used to codify a clinical
19 concept. And I really think listing all of the
20 ICD values, and then trying to find cross-walking
21 measures that match to those ICD-10 values, one,
22 it's going to take a lot of time.

1 (Off microphone comment.)

2 MR. GOLDWATER: Right, but still
3 you're talking about not just a significant
4 amount of time, but also I'm not -- I would want
5 to make sure that there's utility to that. I
6 think one of the approaches to sort of
7 incorporate what I'm saying and what you're
8 saying is once the literature review is done, we
9 have an idea of these fields of where we think
10 telehealth will be very impactful and the data is
11 showing that, that we pull out outcome and
12 process measures.

13 I would strongly suggest at the moment
14 we stay with electronic ones initially. If you
15 find that there are gaps in what's not there,
16 then we'll go to the claims-based measures. And
17 I'm not saying that for my benefit, Tracy's or
18 Katie's because we have a gazillion things. It's
19 for your benefit because I'm not -- I don't want
20 to give you a matrix of 400 measures, then go,
21 Angela, good luck, you got two weeks, no
22 complaining, this is what you wanted, and blame

1 it on Al if you really get upset, right?

2 So don't -- you know, that's the --
3 what's that? No, I'll always blame Al, but it's
4 just the -- I think that's that kind of the
5 better approach.

6 And then while we're taking like
7 here's the measure, here's the clinical focus
8 area, here are the measures, here's the five
9 domains, mark off if you think tele -- if it fits
10 into all, which one of these it fits off into,
11 here are the ICD codes that it represents, then I
12 think we combine both of those together.

13 Does that sound like a reasonable idea
14 to go forward with? In that case, you know,
15 we'll probably have this to you in mid-January
16 because the environmental scan will be finished
17 at the -- I think it's the beginning of January,
18 correct, we have to have it done? The 5th, and
19 then it's going to have to go to you all for
20 review. It will have to also go out for public
21 comment.

22 I think once we get the review back

1 from you, then we can start pulling the measures.
2 And you can all start the exercise and we can
3 actually -- when we convene again in March, we
4 can then go over this and determine which ones we
5 want to use.

6 Is that a better approach?

7 (No audible response.)

8 MR. GOLDWATER: If you really want to
9 take a vote, Don --

10 MEMBER GRAF: I'm asking you if you
11 want to.

12 MR. GOLDWATER: No. I mean, at this
13 point -- what's that? Yes. Does anyone not like
14 the idea? The ayes have it, and so -- do you not
15 like the idea?

16 MEMBER SPIEGEL: No, I don't mind the
17 idea. I just want to --

18 MR. GOLDWATER: You're totally
19 outnumbered, dude, really.

20 (Laughter.)

21 MEMBER SPIEGEL: I don't mind the
22 idea. I just want to say that it's not important

1 that we look at every single measure.

2 MR. GOLDWATER: Right.

3 MEMBER SPIEGEL: It's important that
4 we get a representative sample --

5 MR. GOLDWATER: Yes.

6 MEMBER SPIEGEL: -- of the different
7 types of measures that allow us to create the
8 framework.

9 MR. GOLDWATER: That's correct.

10 MEMBER SPIEGEL: And I think we should
11 be cautious when we're going through these
12 measures to not include any that are unnecessary.

13 MR. GOLDWATER: Right.

14 MEMBER SPIEGEL: So just wanted to say
15 that.

16 MR. GOLDWATER: Right. So I think --
17 again, I think when we have the areas of where
18 we're understanding they're most impactful, that
19 the literature and the analysis support, we'll
20 make sure that the process and outcome electronic
21 measures directly relate to those -- I mean, I
22 couldn't agree with you more, Daniel.

1 I don't -- we don't want to have
2 superfluous measures. We look at enough of those
3 in the course of the day.

4 Adam.

5 MEMBER DARKINS: I agree with what's
6 been said, and just for thought, again, I come
7 back to telehealth doesn't in its own right
8 change some of the things, so we go through an
9 evidence review and we end up studies of 50, 100,
10 150 patients, which are really neither here nor
11 there.

12 There is equivocal evidence, so in the
13 end, it's not the one other thing to perhaps run
14 in parallel and think of. If I want to think of
15 a rationale for telehealth, then one of the
16 things you could base it on is the IOM and
17 Crossing the Quality Chasm.

18 So the issue is not whether or not
19 telehealth is used for type 1 diabetes. It's how
20 it helps coordinate the recognized problems of
21 the barriers between the different pieces, the
22 healthcare system, and how you bring it together,

1 so how you coordinate those pieces together.

2 So if I want to look -- and so, the
3 value of telehealth is -- and the coordination,
4 if you'd like, the holistic management of patient
5 across the different sectors, there's a piece
6 around it where to be of value and thinking about
7 take your program out. One of the difficulties is
8 to show just locally that your benefits and
9 patients aren't deteriorating.

10 So you create a new program, you want
11 to end up managing people in primary care and
12 secondary care link together, so pure -- but to
13 dissect out, there are going to be some people
14 who have had telehealth, some people had a bit of
15 telehealth, some people had no telehealth. You're
16 going to have this hodgepodge of how you're
17 actually going to make sense of what it is.

18 So if one ended up saying that you
19 used existing measures, but what we'd really like
20 to see is how well it was coordinated, so it
21 isn't kind of in there. But one of the other
22 pieces would be, is there a way you can actually

1 bring together the coordination between the
2 different pieces. Because that's really -- and
3 that strength is going back to the IOM, which for
4 me has always been something to base it on.
5 Otherwise, we're just going to get something
6 which is just a bit of a hodgepodge --

7 MR. GOLDWATER: Right.

8 MEMBER DARKINS: -- where you say,
9 well, we're managing diabetes, where are we
10 managing it, how are we managing it. Does that -
11 -

12 MR. GOLDWATER: It makes perfect
13 sense. So I think when we -- again, when we meet
14 again and we have, I think, hopefully, a cohort
15 of measures, part of that discussion is, how do
16 we effectively tie this into telehealth through
17 care coordination, incorporating dimensions of
18 the framework, expanding out the measure,
19 whatever it may be.

20 I agree, I think, just taking a
21 straight cut of measures and saying, okay, now
22 these for telehealth. In some cases that might

1 work and some cases, it'll necessitate future
2 discussion, so point well stated.

3 Sarah.

4 MEMBER SOSSONG: I was just curious if
5 you could clarify at what point in the process
6 we'll do the gap analysis and be able to add
7 measures. I think part of it is collecting
8 everything that's in the literature, but then --
9 and I think, to Dale's point earlier, I too have
10 a list of 50 things that I've been tracking over
11 the years that -- there are just too many things
12 for us to internally measure, and it didn't make
13 sense for MGH to do it alone.

14 Again, I think, you know, if every one
15 of us sent you the top 20 things that we --

16 MR. GOLDWATER: Oh, please, please
17 don't do that.

18 MEMBER SOSSONG: But I think that just
19 because it's not in the literature doesn't mean
20 that it's not important.

21 MR. GOLDWATER: I understand.

22 MEMBER SOSSONG: So how -- where in

1 the process will we capture that, is my question.

2 MR. GOLDWATER: So I think that'll
3 come down to the next meetings after we present
4 that initial slate of measures. One of the
5 things we would be instructing you to do is
6 what's not there. You know, here's what we've
7 seen, here's what the analysis shows, here's the
8 measures that map to the analysis, but, Sarah, I
9 don't foresee us coming up with here's 20
10 measures and all your problems are solved.

11 It's great. We just solved the -- I
12 mean, Megan would be thrilled, I'd be thrilled,
13 we'd all be thrilled, but I don't think that's
14 going to happen. There are going to be gaps, and
15 so it's important that you tell us what those
16 gaps are and whether, one, we can go back and
17 find a measure that maps to that gap or, b,
18 whether that's going to necessitate a future
19 development of a measure to map to meet that gap.

20 I mean, that's part of what NQF's
21 process has always been, which is, what are the
22 current gaps in measurement and how do we fill

1 those. Does that answer your question?

2 MEMBER SOSSONG: I think so. I think
3 ultimately what I'm hoping for is that we can
4 ultimately just agree on 20 things that we will
5 measure. I think right now there's just such --
6 every organization is doing it their own way.

7 MR. GOLDWATER: Right.

8 MEMBER SOSSONG: Payers are doing it
9 differently. So I think it will not be perfect.
10 Whenever we land, it will not be perfect.

11 MR. GOLDWATER: No.

12 MEMBER SOSSONG: But just coming up
13 with something as a starting place and I guess
14 that's the whole point of the framework, but I
15 think that will be a start for all of us in
16 moving the agenda forward.

17 MR. GOLDWATER: So, Chuck, Sarah is
18 now my new favorite person because we love when
19 people are like, you know, it's not going to be
20 perfect, but this is a great place to start. We
21 really enjoy when people have that perspective
22 because, again, we're not going to solve all the

1 problems of the world.

2 Dale.

3 MEMBER ALVERSON: Jason -- and I'll
4 defer it to your experience and the staff's
5 experience from NQF. And maybe you can help me
6 with just responding to a specific case example.
7 I'm just picking this out as one example.

8 And let's take tele-stroke, okay? So
9 the outcome measure that we're looking at with
10 tele-stroke is there are more eligible patients
11 who would be eligible for tPA being treated with
12 tPA. We're not trying to prove that tPA makes it
13 -- is going to improve the outcome of stroke.
14 That's pretty well established.

15 MR. GOLDWATER: Can you explain what
16 tPA is for the non-clinicals?

17 MEMBER ALVERSON: I'm sorry. Tissue
18 plasminogen activator, so it's a clot-dissolving
19 drug. But the point -- the point is, we're not
20 trying to do that, but we're trying to show that,
21 that more patients who are eligible for that
22 treatment -- which decreases the risk of brain

1 damage, maybe even eliminates brain damage for
2 ischemic organ death.

3 So what -- what I -- when I'm trying
4 to get input from you is there already is
5 evidence that patients treated with this clot-
6 dissolving drug will have better outcomes. We're
7 just trying to show that if you use telehealth
8 that we'll get more patients who are eligible for
9 that treatment on treatment. And we're already
10 showing that. I mean many of us are.

11 So how do we develop that into an
12 outcome measure to make sense that you would say,
13 that makes sense. Because it's not that we're
14 trying to say this clot-dissolving drug improve
15 outcomes for patients with ischemic stroke, but
16 does telehealth improve getting more patients on
17 treatment.

18 Where does that fit in to your
19 approach as an outcome measure? Because that's
20 what -- that's just one small example. I used
21 already diabetic retinopathy detecting --

22 MR. GOLDWATER: Right.

1 MEMBER ALVERSON: -- sight-threatening
2 retinopathy early, preventing blindness. So how
3 do we fit that into an outcome measure that makes
4 sense from NQF's standpoint?

5 MR. GOLDWATER: So it's not a measure
6 already, it's just something you're tracking or
7 is it a --

8 MEMBER ALVERSON: Right. I mean --

9 MR. GOLDWATER: It is a measure? It's
10 a measure --

11 MEMBER ALVERSON: Right, it's a
12 measure.

13 MR. GOLDWATER: Okay.

14 MEMBER ALVERSON: It's a measure. What
15 telehealth does -- so what telehealth does is
16 increases the number of patients who are eligible
17 for that treatment that we know can have a
18 positive outcome by using telehealth. I mean
19 that's why we do tele-stroke.

20 I mean, many patients aren't being
21 treated. Now that leads to a lot of other --
22 other effects that is if you prevent brain

1 damage, you prevent the need for rehabilitation,
2 speech therapy, and so on. That leads to cost
3 avoidance as well, as well as better outcome for
4 that patient and a lot of other issues.

5 But I'm just trying to make sure I
6 understand where that fits in to how NQF would
7 look at that when we're not really trying to
8 create a new measure, but where does telehealth
9 impact that measure.

10 MR. GOLDWATER: Okay.

11 Marcia, I'll let you talk, and then I
12 can answer that also.

13 CHAIR WARD: So I think that's a great
14 example. There's a lot of studies of tele-stroke
15 that have measured appropriate patients who
16 receive the appropriate therapy. There are NQF-
17 endorsed measures right now that is patient
18 should -- appropriate patients should receive
19 that appropriate therapy, and so there's going to
20 be a great match there, and that's a good example
21 I think for everybody to have in their mind of at
22 least one measure is going to come out of this

1 that's got a strong evidence base.

2 MR. GOLDWATER: Right.

3 Jean.

4 MEMBER TURCOTTE: I just want to build
5 on what Dale was talking about. My background is
6 more the -- the ICU, the stroke, the tele-
7 psychiatry.

8 MR. GOLDWATER: Right.

9 MEMBER TURCOTTE: And the outcomes --
10 I think we agree that the outcomes should be just
11 as good, but in my world, a lot of what we
12 struggle to measure and to look at is, is the
13 process better.

14 Tele-ICU, we can look at all the
15 various clinical outcomes, but the idea is when
16 you have something like tele-ICU, you have an
17 intensivist at that bedside within 90 seconds --

18 MR. GOLDWATER: Sure.

19 MEMBER TURCOTTE: -- and so everything
20 that happens is so much better, but then how do
21 you measure that?

22 MR. GOLDWATER: Right.

1 MEMBER TURCOTTE: It's the same with
2 the tPA. You know, the gold standard is within
3 60 minutes that patient receives that tPA, but
4 that doesn't mean -- the gold standard is to give
5 it. We can't control every patient through
6 telehealth that receives it may not do well, and
7 every patient outside of telehealth may, but it
8 has nothing to do with the fact that we've
9 implemented the process.

10 MR. GOLDWATER: Right.

11 MEMBER TURCOTTE: So I just want to
12 say that in support of that -- and I know we want
13 to avoid the process -- but a lot of it really
14 comes down to we're trying to prove that
15 telehealth is a very viable way to deliver care -
16 -

17 MR. GOLDWATER: Sure.

18 MEMBER TURCOTTE: -- so we have -- how
19 do we do that and not really look at process
20 outcomes as well?

21 MR. GOLDWATER: So thank you all, both
22 of you, for those comments. I think when we

1 start going down what we -- what we identify
2 through our analysis and come up with those list
3 of measures, there will obviously be measures
4 that you probably have -- that have already been
5 developed or are already being used that have a
6 strong evidence base that demonstrate the utility
7 of telehealth.

8 Those can be incorporated into that.
9 I'm not -- you know, the list that we might come
10 up with in January is by no means the end result,
11 the final result, and the only thing we're going
12 forward with. It will be the result of data and
13 measures that we pulled from the available
14 sources that we have.

15 There will be sources you all are
16 going to have access to and know of that we're
17 not going to have access to that. Now, you can
18 send us those measures and we can incorporate
19 that into the matrix or when we meet again, you
20 can discuss how those need to be inputted into
21 the matrix, and then we can all discuss them to
22 make sure that's something we want to go forward

1 with.

2 But absolutely there is no desire to
3 be excluding existing measures that are
4 effectively providing an objective way of
5 understanding the utility of the telehealth on
6 either process or outcomes. That's certainly not
7 anything we would want to exclude.

8 It's just our availability to get that
9 information may be somewhat limited. So if you
10 want to send that to me, Dale, you're more than
11 welcome to and we'll include it. If not, we'll
12 include it when we do the review in early May --
13 early March.

14 Does that sound reasonable?

15 (No audible response.)

16 MR. GOLDWATER: Okay. Any other
17 questions?

18 (No audible response.)

19 MR. GOLDWATER: So I'm just amazed at
20 how efficient we are. I'd love to say it's all
21 me, so I will, it's all me. Okay, I'm totally
22 kidding.

1 So I think we're pretty much where we
2 need to be, so you want to take a break now?

3 (No audible response.)

4 MR. GOLDWATER: So why don't we take a
5 break. We'll convene at 3:00, and then we'll
6 start discussing the dimensions and elements of
7 the framework for future measure development, not
8 measures that already exist.

9 And, Judd, I will just go trash this
10 to make you permanently -- all right.

11 Thank you all very much for a very
12 productive discussion and helping us sort of
13 frame this issue, which was challenging.

14 (Whereupon, the above-entitled matter
15 went off the record at 2:54 p.m. and resumed at
16 3:06 p.m.)

17 MR. GOLDWATER: All right, so we are
18 just past 3:00. Again, I want to thank all of
19 you for all the vigorous discussion, and also a
20 big thanks that we are on schedule. Elisa will
21 tell you that keeping on schedule at an NQF
22 meeting - Marybeth I'm sure can concur - is a

1 challenge to say the least.

2 So we're thrilled that we are right
3 where we need to be, and I know that we're
4 getting to the real bulk of what we want to
5 discuss now. So that certainly bodes well, that
6 we've got - I think we'll probably do this for
7 about another hour. And then we'll probably
8 break for the day and let you guys go change
9 clothes, get ready for dinner, whatever you're
10 going to go do, and then we'll convene again
11 tomorrow and try to finish this out.

12 So what we're going to discuss now and
13 tomorrow is the actual measure of framework. What
14 we're going to look to try to develop that will
15 be the foundation for future measure development
16 in the area of Telehealth, something that is
17 implementable, something that is actionable, and
18 something that is flexible. So when robots come
19 from the sky to take care of us we can find a way
20 to measure.

21 So, you know, it's - and Chuck brings
22 up a great point. Technology changes and evolves

1 all the time, and I think some of the
2 complexities around developing frameworks and
3 health IT is it sort of takes the snapshot right
4 then. Like, this is where we are now and let's
5 focus on now, and not necessarily sort of
6 evolving it.

7 Technology is going to change, I mean,
8 who would've known we'd have 35,000 mobile health
9 apps that are available now and growing? I mean,
10 how many of those are actually good - it's in
11 the millions? Oh, so -- you're reading different
12 data than me - so we have, you know, a large
13 variety of those.

14 We've got smart watches, we've got
15 smart phones, we - I don't know how many of you
16 are wearing a Fitbit, I am wearing mine today.
17 For all the physicians in the room, you will
18 notice I am wearing it and I have averaged 10,000
19 steps for the last five days. Thank you very
20 much. So -

21 (Off microphone comment.)

22 MR. GOLDWATER: What's that? I feel

1 great. I feel good, no stress, no anxiety, no
2 anything.

3 (Off microphone comment.)

4 MR. GOLDWATER: Okay, thanks a lot
5 Julie for wrecking my buzz at the moment.

6 (Off microphone comment.)

7 MR. GOLDWATER: No, no, no. I gave my
8 daughter one of my old ones. She has no earthly
9 idea what to do with it, she's just, you know, so
10 anyway. All right, so we'll go ahead and begin
11 our discussion of the measure framework. So
12 let's get to the first slide which really is sort
13 of the rationale, why we're going to do this.
14 And what I want to first discuss is these
15 questions that we pose because these will be
16 published and will be part of why we are doing
17 this.

18 And what I do want to know from all of
19 you is, are these the right questions to ask? Do
20 we need to add more or do we need to delete them?
21 Do we need to alter them? A measure framework
22 for Telehealth would help address its effects of

1 Telehealth services on quality, access, costs.
2 So the first question is does Telehealth provide
3 more timely access to appropriate health
4 services? Does it - how does it affect
5 patient's health and well-being as compared to
6 the alternatives, which would be either - in
7 this particular case, it would be no care at all.

8 How are the -- do the costs of
9 Telehealth compare to the in person care
10 delivery? Again, rewording this - I guess we're
11 going to have to reword it based on our
12 discussion earlier today. Were both patients and
13 clinic -- what were the experiences of patients
14 and clinicians with the services provided through
15 Telehealth?

16 And then - again, probably changing
17 this based on the conversation this morning -
18 what's the effect of Telehealth on rural health
19 providers and the economic health of rural
20 communities? So looking at those five questions,
21 are there ones we need to change, add, delete, so
22 forth? Don?

1 MEMBER GRAF: Instead of rural, could
2 we - could we say where access to care is
3 difficult? So we're not getting stuck into this,
4 how many --

5 MR. GOLDWATER: Sure, yes. Okay,
6 perfect.

7 MEMBER GRAF: And just to help me
8 remember in changing how does cost of Telehealth,
9 is it costs including - costs, what I read in my
10 checkbook, or costs savings as well?

11 MR. GOLDWATER: It's cost -- yes, it's
12 cost savings, cost and cost savings.

13 MEMBER GRAF: Okay, thank you.

14 MR. GOLDWATER: Okay, anything else?

15 MEMBER MEACHAM: So just really quick,
16 I'd want to - I'm fine with taking the word
17 rural out, but I'd want to make sure that the
18 group doesn't forget about rural. Anything we do
19 come up with has to also work for rural, so
20 thanks.

21 MR. GOLDWATER: Understood. Steve?

22 MEMBER NORTH: So I think that the

1 cost - the economic health of rural communities
2 though. The benefit of keeping a stroke patient
3 in a critical access hospital financially, for
4 that rural hospital, is very different than
5 preventing the transfer from the hospital in
6 suburban, you know, Dallas to the big center in
7 Dallas. Because of the economies of scale there
8 - just the first city on my mind all the time,
9 and I hate the Cowboys.

10 But anyway -- yes, so make sure HRSA
11 gets that in the record too - but, so do we have
12 to tease that out in some way? Because we're
13 looking at - because it really is looking at two
14 different measures - because I think economic
15 health of rural communities is very important.

16 MR. GOLDWATER: Okay, any - Stewart?

17 MEMBER FERGUSON: So I am a Cleveland
18 Browns fan, just in case --

19 MR. GOLDWATER: Oh, God. I'm so
20 sorry.

21 MEMBER FERGUSON: So, you know, you
22 guys can talk about your records. We haven't won

1 a game this year. So on number three, do you
2 want to change it to how your costs of Telehealth
3 compared to the alternatives rather than saying
4 in person? In person is not always the opposite
5 of Telehealth, and the alternative may be they
6 don't get care and that has a cost obviously.

7 MR. GOLDWATER: Sure. Okay, Judd?

8 CHAIR HOLLANDER: And I think, you
9 know, cost - is it to the patient, is it to the
10 payer, is it to society? Can it be all of them?
11 I mean, I know that's a really complicated thing
12 to address and I guess we could leave it open.
13 But, you know, maybe somewhere in this we'd want
14 to say cost can be decided any one of these ways
15 depending on the particular measure.

16 MR. GOLDWATER: Okay, Steven?

17 MEMBER HANDLER: So a couple points
18 just in looking at this, as I retyped it just to
19 - so alternatives probably isn't the best way to
20 frame it either. Because - you may want to say
21 to the current approach to care or something. We
22 can wordsmith it, but it's not just no care at

1 all. You could think about it in the way that
2 care is delivered, i.e. which clinicians are
3 providing it through the same type of Telehealth
4 or telemedicine services.

5 Or it could even be a different type
6 of telemedicine, it could be Telehealth versus
7 real, you know, synchronous, et cetera. So I
8 think we need to think through that a little bit
9 more, as I was thinking through that. And with
10 regard to rural, because we view, or I view,
11 nursing homes - once again, it's a more -- a
12 different way of framing it is low resource or
13 resource poor. Right? So they - oftentimes
14 they'll say they have Wi-Fi, but their bandwidth
15 is like, point, you know one two kilobytes per
16 second. And they call that WiFi and connectivity,
17 so that's not real. So another way of framing it
18 is just resource poor settings.

19 MR. GOLDWATER: Okay. Okay, all
20 right. Anyone else? Paul?

21 MEMBER GIBONEY: So that first one, it
22 - there's an assumption there that faster is

1 always better, and something that we've been
2 learning is that that actually is not true. When
3 doctors talk and they're coordinating the care,
4 sometimes they will come up with a plan that
5 actually says I want to see the patient
6 in-clinic, but they actually don't need to come
7 in as soon as possible.

8 Like, like if my next available
9 appointment is next week actually that's not
10 optimal, because I want you to start a treatment
11 and I'm going to see them in four weeks. You
12 know, and a fracture is a good, you know, so
13 someone has an appropriately reduced fracture.
14 The orthopedic surgeon does actually not want to
15 see them that week, they actually want to allow
16 that fracture to heal.

17 So they can see them in four weeks,
18 retake the X-ray, and see what happens. And so
19 what we've been starting to explore and develop
20 in our system is instead of just saying faster is
21 better, starting to say what is the right time to
22 - for that specialty care? Whatever that next

1 step is, whether it's being delivered in the
2 medical home, whether it is being delivered in a
3 couple of weeks.

4 And especially, I mean,
5 ophthalmologists will tell you if they identify a
6 patient with mild retinopathy, a disease in the
7 eyes from diabetes, they actually don't want to
8 see them in two weeks. Actually, their
9 recommendation is three months or six months down
10 the road to keep an eye on it. Right? And so, I
11 don't know, I might - I mean, this is a very new
12 concept that we're just exploring and it may even
13 be too new for this. But I would almost say does
14 Telehealth provide right, timely - the right
15 access, the right time access to appropriate
16 health service.

17 MR. GOLDWATER: Okay.

18 MEMBER GIBONEY: Instead of just this
19 assumption that every patient is a cookie cutter,
20 it doesn't matter their unique needs or unique co
21 morbidities, faster is always better. And to be
22 honest it's kind of a waste of resources when you

1 think of it that way.

2 MR. GOLDWATER: Right. Okay, let's -
3 Stewart?

4 MEMBER FERGUSON: I thought we were
5 moving away from questioning satisfaction, and I
6 see it on your fourth bullet there. And earlier
7 in the day we talked about clinician and patient,
8 or clinician and patient experience.

9 MR. GOLDWATER: Yes.

10 MEMBER FERGUSON: Do we want to kind
11 of change that to say to how do we tell how it's
12 impacted the patient and clinician's experience?
13 And not really just say satisfaction, that seems
14 a little bit outright and not what we're looking
15 for.

16 MR. GOLDWATER: Sure, okay. Before I
17 call on Dale just let me make sure I write this
18 down. All right, Dale, go ahead.

19 MEMBER ALVERSON: I just want to say
20 how much I appreciate Stewart's really insightful
21 comments. I do, I sincerely - see? But no,
22 what I was going to -- I just want to reinforce

1 what Paul just said because it's the right care,
2 at the right time, at the right place. And money
3 of the things - many things we're finding in our
4 experience with Telehealth is a lot of times you
5 might be avoiding a transfer, but also an
6 unnecessary referral.

7 And we've got tons of examples of
8 that, they're anecdotal, but tons of that. So I
9 don't know how to - what's the right modifier on
10 timely, but it's true. Because a lot of the
11 things -- they think a patient ought to be seen
12 by somebody and you say no they don't. That's
13 not even, that's not a necessary referral that
14 you need to make, or you don't need to see them
15 that soon, as you just mentioned.

16 But somehow I don't know how to -
17 what's the best word to capture that, but it's,
18 it's always, it's at the right time and right
19 place. So I don't know if anybody else wants to
20 comment on that, but we find that a lot. And I
21 just talked to - I was at a meeting on Monday
22 where that came up, where somebody was waiting.

1 I went to go transfer the patient, but they
2 needed to see some -- an orthopedic surgeon or a
3 neurosurgeon, but they really didn't. So we
4 avoided that unnecessary use of resources.

5 MR. GOLDWATER: Chuck?

6 MEMBER DOARN: I -- so these five
7 questions are the only five questions, or?

8 MR. GOLDWATER: No. I mean, these are
9 the first five we came up with.

10 MEMBER DOARN: Oh, because I was
11 thinking of how does Telehealth and telemedicine
12 impact the work flow and the management of the
13 actual provider -- provision of care? So if you
14 have a, if you have a situation where -- and
15 this, they've done this with UC Health with the
16 city of Cincinnati. They have the Tele-medicine
17 Clinic, or office, set up so you can go to that
18 office.

19 And I asked my primary care physician
20 when I was there, I said I've been reading all
21 the stuff you're doing. He goes we're finally,
22 we're doing this. How many cases have you done

1 this? Two, one of them was a demonstration and
2 that was like six months ago.

3 And so, but say for instance it's up
4 and it's robust, then the physicians are seeing
5 patients every ten, 15 minutes -- well, normally.
6 Then at maybe two every hour, two every two
7 hours, whatever it is there's a work flow. And
8 so how does that impact the overall structure of
9 the office? That has cost associated with it, it
10 has efficiency associated with it, but I'm not
11 sure if that's an underlying theme for all of
12 these or if it's a specific question by itself.

13 MR. GOLDWATER: I think it's a
14 specific question by itself, I think it could
15 certainly be looked at that way. Daniel?

16 MEMBER SPIEGEL: So I'm not sure if
17 this belongs in here or not. It's closely
18 related to costs, but I wonder if we should flesh
19 out something about just overall utilization
20 patterns. So utilization of the healthcare
21 system overall and then shifting patterns and
22 sites of care. Because I could see how

1 introducing Telehealth in a particular market or
2 a particular environment could move patients
3 around from one site of care to another, or
4 increase certain types of visits and decrease
5 others.

6 MR. GOLDWATER: Okay, Kristi?

7 MEMBER HENDERSON: Yes, I might be
8 echoing what they just said, but I emphasize
9 those again. Because I think the work flow is
10 huge, the benefit to the work flow and research
11 utilization, but also the workforce. We have a
12 huge issue with workforce shortage, and this is
13 what this is addressing in a lot of ways -- so
14 those three combined.

15 MR. GOLDWATER: Okay. Judd?

16 CHAIR HOLLANDER: Yes, I think I'm
17 just trying to summarize it in a question up top.

18 MR. GOLDWATER: Okay.

19 CHAIR HOLLANDER: And I think the big
20 question is, you know, something like does
21 Telehealth provide high value care? Or is
22 Telehealth associated with improved value for

1 healthcare delivery? And then everything is
2 really drilling down to that to some degree.

3 MR. GOLDWATER: Right. Steven?

4 MEMBER HANDLER: So, in my
5 pseudo-delirium, since I did patient reach --
6 medication safety research for a decade. I just
7 thought of, Paul, as you were thinking about
8 this, this is the five rights of medication
9 safety. Right? The right patient drug, dose,
10 route, and time really could be the same
11 framework for telemedicine.

12 I don't know if that's ever been said
13 before, maybe the NQF can claim that, I don't
14 have to. But really, that's really what it's all
15 about. It's really the right -- selecting the
16 right patient, using the right drug. You remove
17 drug, and that's the type of telemedicine, right?
18 Whether it's storm forward, you know, synchronize
19 -- the dose would be the frequency. The route,
20 we can play with that a little bit later. And
21 then time -- but you get the point.

22 MR. GOLDWATER: I get the point.

1 MEMBER HANDLER: Give me another half
2 an hour, I'll work it out, okay?

3 MR. GOLDWATER: Have a drink, get some
4 sleep, we'll talk about it tomorrow, all right?

5 MEMBER HANDLER: Give me a half an
6 hour to recharge.

7 (Off microphone comment.)

8 MEMBER HANDLER: Right, maybe some
9 ICD10 codes so you can hear Chuck, and then we'll
10 be good. The other point I was going to make is
11 underscore that I agree, the socio-technical
12 aspects of this, the work flow is really
13 critical. And I think it's important, not just
14 as it relates to satisfaction, but as it relates
15 to the workforce.

16 My -- I have a theory that I believe
17 that we can, if we do this right, we can empower
18 and change nursing dynamics -- let's say in the
19 nursing home, once again that's where I live --
20 and make people want to work in that environment.
21 And also empower them and change the
22 relationships between physicians and nurses and

1 -- where they want to work in that environment,
2 et cetera. So I really hope that that's
3 something that could be accomplished by the
4 technology, changing them from the reporters of
5 information to active clinicians engaged with --
6 as a team.

7 MR. GOLDWATR: Perfect. Angela?

8 MEMBER WALKER: So we can't,
9 unfortunately, claim the five rights. They're
10 already owned, but review them because they may
11 applicable to things we will develop in
12 Telehealth. In the clinical decision support
13 space, they talk about the right information to
14 right people, through the right channels and the
15 right formats at the right times.

16 (Off microphone comment.)

17 MEMBER WALKER: Yes, so -- yes, so
18 it's not developed by us but we can use it.

19 (Off microphone comment.)

20 MEMBER WALKER: Or just add intel to
21 health.

22 MR. GOLDWATER: Don?

1 MEMBER GRAF: In the practice
2 management model, I wanted to make sure that as
3 we consider increasing clinical efficiencies and
4 expanding provider capacity -- I'm not sure
5 whether they fit into of these questions or
6 they're separate questions. But it's really just
7 sort of changing the practice patterns when
8 virtual capabilities are introduced into service
9 delivery models.

10 MR. GOLDWATER: Marcia?

11 CHAIR WARD: So looping back to our
12 domains, and we talked about structure is
13 commonly a domain and we decided to not look at
14 it because there aren't any measures. But people
15 are talking about workforce and that's often
16 considered a structural model. So did we miss
17 something, you know, as we're talking about these
18 things and, again, the domain set.

19 MR. GOLDWATER: So that does bring up
20 a question, that if, I mean, there's clearly a
21 consensus here that work flow and workforce
22 needed to be added into one of the questions. So

1 I think what that would mean is that we would
2 probably have to evaluate, at least examine, you
3 know, some structural measures that exist that
4 might relate to that.

5 I think that's, you know, the only
6 real relevant thing to do because if it becomes
7 an important part of the framework we have to
8 build measures for that, and we should also look
9 to see what exists. So off the top of my head,
10 Marcia, from an e-measure standpoint, I don't
11 know of any that are electronic in that four
12 month structure. But certainly I think that's
13 something we can look at, it's a great point.
14 Just to add more measures that we can look at,
15 that's right. Yes, Chuck?

16 MEMBER DOARN: I think part of that
17 workforce discussion is also this concept of
18 training. There -- although there are a number
19 of -- I'm sure we all get these emails about this
20 training program that's in San Diego -- or these
21 training programs, that happens to be the one I
22 saw the other day -- about getting a master's

1 degree in mobile health or e-health.

2 So there are education models out
3 there now that are showing, whether it's a
4 certificate program to, normally, four graduate
5 level courses, that might be part of the
6 evaluation. I know the ATA, usually on Saturday
7 before the annual meeting, they have a series of
8 educational activities to try to showcase what
9 you should do and what you shouldn't do, and so
10 forth. And so there might be some measures
11 embedded in some of that that we could take a
12 look at.

13 MR. GOLDWATER: Okay, great. Nate?

14 MEMBER GLADWELL: A couple of points,
15 third bullet point question should be how do
16 instead of how to. I thought I'd point that out.
17 But no, instead of comparing Telehealth to
18 in-person I think, and we might have captured it
19 already, but what's the overall impact to cost of
20 Telehealth. You look at a program like Project
21 Echo, which there is no in-person meeting to
22 compare it to, what is the cost of that to an

1 ecosystem of health? I think it's important.

2 MR. GOLDWATER: Okay. Stewart?

3 MEMBER FERGUSON: So I was going to
4 add to that conversation about the five rights,
5 and I thought maybe we could have five not lefts.
6 So we could have not left without -- no, no --
7 not left without care, not left waiting, not left
8 wasting money, not left dissatisfied, and not
9 left sick.

10 MR. GOLDWATER: Pretty good. Stewart,
11 please do me favor and email that to me. All
12 right. No, seriously do email me that, Stewart,
13 if you could. That would be -- I'm being not
14 facetious, which is unusual for me, but I'm being
15 really serious about doing that. Okay, any other
16 comments on the questions? This is terrific,
17 really, it's certainly issues we had not
18 considered in the initial scan of the literature.
19 Any other areas?

20 MEMBER HENDERSON: So I was sitting
21 here looking at your structural measures, and
22 there's several that actually are of interest.

1 Not, I mean, for example tracking of clinical
2 results between visits. I hadn't even thought of
3 that one, but that's what we're saying even with
4 home monitoring. What are we able to do in
5 between? So I think there's some in that
6 structural category that may be of benefit to us.

7 MR. GOLDWATER: Are those e-measures
8 or are they just regular measures?

9 MEMBER HENDERSON: Well, they're just
10 your regular measures. And not all these, these
11 are on your list, but -- not all of these are
12 endorsed by NQF, but they're on your list under
13 structure.

14 MR. GOLDWATER: Okay, all right.
15 Kristi, we'll definitely look at, I mean, if this
16 looks like it's going to become part of the
17 framework then we're going to have to look at
18 them.

19 MEMBER HENDERSON: Yes, there's
20 nursing hours per -- yes, all that, yes.

21 MR. GOLDWATER: Right, yes. So I
22 think we might have to do a somewhat of a

1 deviation from the e-measure space as it comes to
2 structural measures. Because in terms of
3 electronic measurement for structure measures, I
4 know at NQF we only have two and none of them
5 relate to what you just talked about. We might
6 have to deviate away from that a little bit, but
7 that's fine. Evelyn?

8 MEMBER NELSON: Where does the --
9 where do adherence to compliance measures fall?
10 Are they in these structure measures or are they
11 in the outcome measures?

12 MR. GOLDWATER: Adherence compliance,
13 those would be process-based measures I think.

14 MEMBER NELSON: Because I think those
15 continue to be important. And then I just, on
16 that last question, I think of course economic
17 health is important, but I think we're talking
18 about broader community benefit, workforce. But
19 just community engagement, those type of measures
20 as well.

21 MR. GOLDWATER: Okay. Before we move
22 on, I do want to tease out one thing. You know,

1 there was some consensus that economic health of
2 rural communities is important. I think that
3 would be important for HRSA as well, being the
4 sponsor of this project. Can we, can you all
5 expand a little bit on what are the important
6 factors to consider when talk about economic
7 health of rural communities? Go ahead, Nate.

8 MEMBER GLADWELL: Yes, I'll take the
9 first stab. We work in six states that are
10 mostly rural, so we think about this a lot. I
11 mean I think there's a lot of opportunity that
12 Telehealth provides for, particularly, local
13 hospital/local providers -- rural or underserved,
14 it doesn't matter -- where if Telehealth is
15 provided in a timely way from the right level of
16 care the patient's able to stay in the community.
17 Thus impacting the hospital's bottom line at
18 keeping one more patient, so that's one aspect.
19 I mean, that's one narrow aspect and I'm sure
20 there's a lot more that I missed. But that's
21 just a critical component, is revenue generated
22 by patients staying closer to home.

1 MR. GOLDWATER: Adam? Mic?

2 MEMBER DARKINS: Before I joined the
3 clinic, just for an example, the hospital it
4 would've closed if it weren't for the fact that
5 services in telepathology and services for mental
6 health were both provided remotely. So I think
7 that's something which is worth considering, that
8 for critical access hospitals there are ways you
9 can help them.

10 MR. GOLDWATER: Can you expand a
11 little bit? Why would they have closed?

12 MEMBER DARKIN: Couldn't get access to
13 physicians in those areas.

14 MR. GOLDWATER: Okay.

15 MEMBER DARKIN: Parts the country
16 where people, despite all inducements, didn't
17 want to live.

18 MR. GOLDWATER: Kristi?

19 MEMBER HENDERSON: Yes -- just to
20 expand on that -- so that's where I started all
21 of my work, was with three critical access
22 hospitals that were threatening to close. So we

1 were able to keep them open and increase local
2 admissions 20%. It was a Band-Aid station
3 before, so if you keep that, patients using the
4 resources there, they -- it just expands into
5 everything they say and do. And it's all a, you
6 know, we were able to bring new businesses in
7 because they had a thriving healthcare
8 environment. So it's a huge issue, but I think
9 that it can be understood.

10 MR. GOLDWATER: Sure, great. Don?

11 MEMBER GRAF: Kind of the opposite of
12 what Nate was talking about. Rural hospitals
13 that are using and relying on Telehealth
14 technology that expand their population -- so
15 that they're no longer considered rural, no
16 longer ineligible for current reimbursement --
17 is, you know, kind of the opposite.

18 MR. GOLDWATER: Sure.

19 MEMBER GRAF: But an impact.

20 MR. GOLDWATER: Steve?

21 MEMBER NORTH: Thinking about
22 additional services brought to rural communities

1 via Telehealth, telepharmacology. You know, how
2 do we, you know, lab oversight provided
3 virtually. So are those falling under this or
4 are they --

5 MR. GOLDWATER: Yes, absolutely.

6 Eve-Lynn?

7 MEMBER NELSON: Also with recruitment
8 and retention at the rural sites, just with more
9 job satisfaction, less isolation, those sorts of
10 things.

11 MR. GOLDWATER: Yael?

12 MEMBER HARRIS: I think I'm going to
13 say, repeat what everyone else said basically.
14 But that was all happening, Megan. I blame
15 Megan. So basically bringing jobs to the
16 community, we talked about. Also, getting trust
17 within the community because if, you know, they
18 think the hospital can treat conditions then the
19 hospital gets training, whatever they need to
20 provide that type of specialty service.

21 The entire cachet of the hospital and
22 the community increases, which means that

1 patients feel the satisfaction, first of all.
2 But they also have much more confidence in going
3 to the hospital instead of bypassing that
4 hospital and going to the one down the street.
5 So, and then that results in jobs and revenue for
6 the staff, and jobs outside of the medical team
7 for people who could work in the hospital as
8 well. So it supports the whole community.

9 MR. GOLDWATER: Sure. Dale?

10 MEMBER ALVERSON: Sort of following in
11 that, one of the things that we talked about in
12 Telehealth -- and again, I'm not sure how you get
13 the measure on this. But when patients leave the
14 community to get their care outside of the
15 community, then they're spending their money
16 outside of the community.

17 MR. GOLDWATER: Right.

18 MEMBER ALVERSON: So you're losing
19 money in the community. By keeping the patient
20 in the community, and the family in the
21 community, it keeps the dollars there. The other
22 thing that I wanted to add, and we actually are

1 working closely on the state level with economic
2 development, is the fact that a lot of decisions
3 about businesses to move to a community, they
4 might actually find attractive if they look
5 carefully at what kind of health services are
6 available.

7 So if they can see that, the quality
8 of healthcare being provided to the systems in
9 that community, they're more apt to come and
10 they're more apt to stay. So that's become a big
11 issue in economic development, particularly in
12 New Mexico and rural communities who would like
13 to attract more business. And they're going to
14 look at education, access to education, they're
15 going to look at access to healthcare services.

16 The only thing I don't know, and
17 again, I would look to all of you at NQF, is how
18 do you measure that? But that's sort of the,
19 that's sort of the promise of better healthcare
20 in a community. It keeps the businesses there,
21 it attracts businesses there.

22 MR. GOLDWATER: Right. Paul?

1 MEMBER GIBONEY: This applies to rural
2 communities and the retention of physicians and
3 all of that, but I think it goes broader is --
4 it's just the fact that a lot of the Telehealth
5 technology is Project Echo, eConsult, others.
6 Because they create this conversation, they are a
7 great opportunity for dissemination of new
8 information and new knowledge to providers.

9 So you've got a new medication that
10 hits the market, and you've got a provider who's
11 working in rural New Mexico or something like
12 that, you know, Telehealth provides the
13 opportunity for that provider to start using a
14 new medicine that maybe they're not as familiar
15 with because they've got the guidance.

16 Or the, you know, help from the
17 specialist. And so, that only helps the economic
18 of the rural communities by, you know, allowing
19 the providers to stay there. But just in terms
20 of dissemination of new therapies, new
21 treatments, new approaches, overall Telehealth
22 really contributes to that.

1 MR. GOLDWATER: Okay, sure. Stewart?

2 MEMBER FERGUSON: I wonder if it
3 should be broadened to be socioeconomic health,
4 and the reason I bring that up is it's hard, I
5 think, sometimes to separate the two, especially
6 in real remote communities, you know. Therapies,
7 for instance are huge for us, and getting
8 therapies out to rural areas is enormous. If we
9 don't get therapies out there we don't have
10 physical therapy, speech therapy.

11 People have trauma, they get in
12 accidents, they don't recover well, that has an
13 economic impact. It also has a social impact,
14 isolates families with, you know, you have all
15 those things. We have drug and rehab problems,
16 we have suicide problems. We can only offer that
17 through Telehealth and that has an economic
18 impact, but it's got a much stronger impact on
19 the community.

20 So, and I would like to echo what you
21 said about the provider turnover. Provider
22 turnover's huge in areas, and Telehealth keeps

1 providers. But it also lets you hire local
2 providers and support them remotely, which is way
3 cheaper than bringing in, you know, brand new
4 nurses, so.

5 MR. GOLDWATER: Good point, very good
6 point. Any other comments on the questions?
7 Thank you all for this, this is -- not only does
8 the list expand, I think it gets a lot more
9 focused into those areas of Telehealth that are
10 important. Dale?

11 MEMBER ALVERSON: On that last bullet
12 because I think it's an important one, but how do
13 you measure that? I mean, how do you measure the
14 economic --

15 MR. GOLDWATER: No, you have to tell
16 me how to do that. I'm not going to tell you how
17 to do it, it's a framework though.

18 MEMBER ALVERSON: Well, you're the
19 expert though.

20 MR. GOLDWATER: You have to.

21 MEMBER ALVERSON: I don't -- no, I
22 mean, but I don't -- I'm thinking about what you

1 said, is it measurable? You know, and how, you
2 know, so how do you measure that? Has there been
3 any other aspects of what you've done at NQF
4 where you kind of relate that to economic impact
5 in the community?

6 MR. GOLDWATER: There's been a couple
7 that relate to economics, but it's a very, very
8 specific measure of a very, very specific
9 condition that's costly. And by utilizing a
10 particular process ahead of time, you reduce cost
11 over a period of time. And then there's the
12 analysis about if you prevent 30 day hospital
13 readmissions, the cost savings that accrue as a
14 result of that. Not to mentioned the life
15 savings that occur as a result of that.

16 Again, I don't think that -- the point
17 of these questions are some overarching about why
18 the framework's going to be developed. And some
19 of the issues the framework's going to address.
20 I don't know if we have to specifically look at
21 building a measure on how to appropriately
22 address socioeconomic health as a whole. But we

1 can certainly look at measure concepts that talk
2 about different elements of socioeconomic health
3 that are perhaps measurable, and that still
4 relates to that particular question.

5 If we find as we're moving along that
6 -- and this really won't be decided until March,
7 when we really start to drill into what these
8 specific concepts are going to be. If we find
9 that it's just becoming very difficult to
10 objectively create concepts that measure, you
11 know, some of the areas of provider retention or
12 some of the socioeconomic areas that Stewart has
13 described.

14 You know, we might talk about
15 rewording that, or we might talk about perhaps
16 rethinking that so that we can come up with
17 something that would adequately reflect that. I
18 don't think the question now is, you know, how
19 can we measure that, I think it is overall what
20 do you want the framework to reflect. And then
21 as we start to develop the dimensions and
22 elements of it, can we incorporate those to build

1 out those measures. And if we can't, then we
2 move on to something.

3 I mean, that's, again, it's sort of a
4 -- it's, this is not the hard and fast process
5 that's set in stone. This is a fluid process
6 that once we develop the final report, which all
7 of you will have substantial input into, then it
8 will be sort of complete. But you're right,
9 there may be areas where we're not going to be
10 able to come up with an objective concept. Adam?

11 MEMBER DARKIN: One other little piece
12 just for completeness, just to put in, is the
13 educational benefit. I think the education is
14 not a formal education, but the fact that some
15 people -- somebody might not have seen something
16 since medical school. And to begin with, you end
17 up -- they see something when they do a joint
18 consultation, and after a while they then can
19 take over doing it. And Project Echo formalizes
20 that, in a way of doing it.

21 And I know where Steven's found it,
22 but nursing homes, you can end up getting nursing

1 aides and others who really are -- they're not
2 very well skilled, they don't know how to handle
3 something. And after about three or four times
4 when you help them through something, you end up
5 finding you really enhanced the skills down the
6 stream in terms of doing, which is a direct
7 effect.

8 MR. GOLDWATER: Yes, great. Chuck?

9 CHAIR HOLLANDER: I think taking that,
10 you know, maybe a step further, we haven't
11 discussed resident training. You know, or, you
12 know, we're actually looking at a program where
13 we're going to use multi-party video. So that
14 the attendings, who normally are at home and the
15 next day signed a note, you know, can now be
16 patched into the room or participate in the call.
17 If not just to teach the residents, you know,
18 medicine, but it also will teach them, you know,
19 how to interact on Telehealth.

20 And so, I think there's a lot of
21 opportunities to use this and actually
22 demonstrate how it outcomes in trainees. You

1 know, are they better at doing A,B, and C by X
2 period of time because they now get more
3 mentorship without being too much of a burden to
4 their supervising clinician.

5 MR. GOLDWATER: Okay. Sure, Nate?

6 MEMBER GLADWELL: One last impact on
7 rural is one being able to send residents to
8 rural locations. And having oversight from the,
9 you know, from the central academic facility in a
10 much more sophisticated way. And then two, when
11 we think about studies -- when you look at
12 medical studies, most studies are based on
13 population density. Because that's where you can
14 draw, you know, your participants.

15 We've started extending study
16 applications out to rural locations to have a
17 better understanding of how the impact of rural
18 populations are on patient studies. And
19 Telehealth certainly impacts that, so much more
20 long term, longitudinal effect, but definitely
21 impactful.

22 MR. GOLDWATER: Okay. Kristi?

1 MEMBER HENDERSON: Yes, so just to
2 extend on that. It's not even just residents,
3 it's so much bigger than that. It's everybody
4 being able to practice at the top of their
5 license and collaborate and co-manage. So it's
6 around that, maximizing your resources, and
7 Telehealth allows that to happen. So PAs and
8 nurse practitioners, and all of those groups, the
9 same thing.

10 MR. GOLDWATER: Okay, perfect. Great,
11 any other comments or questions? Okay, next
12 slide. All right, now the fun stuff. All right,
13 so in building a framework there are dimensions
14 and there are elements and the dimensions shape.
15 And so for some of you that were in the
16 Philadelphia meeting -- that Judd did a great job
17 of putting together, it was an awful lot of fun
18 -- these slides are going to look really familiar
19 to you, so my apologies for the repetition.

20 But a framework has a definition, it
21 has, you know, surrounds, how it's going to be
22 defined, the elements or components from which

1 measures are going to be developed from. So,
2 again, looking at the literature at the time that
3 we were discussing our proposed approach to this.
4 There were five dimensions that seemed to come to
5 the top about how to incorporate this in a
6 framework and that measures of Telehealth should
7 incorporate these, one or more of these, in some
8 way.

9 One of which is the technical
10 capacity, is it safe, is it accurate? Diagnostic
11 accuracy, does Telehealth, whatever modality of
12 Telehealth, provide the correct diagnosis? What
13 is the diagnostic impact? Does Telehealth
14 provide useful information for a physician to
15 appropriate care? What is the therapeutic
16 impact? Does the Telehealth validity influence
17 therapy? And then finally the patient outcome,
18 which is overall does the use of Telehealth
19 improve a patient's health?

20 So I probably want to spend the
21 remaining 15 or 20 minutes -- I don't even think
22 we're going to get through this in that. But I

1 do want to start with this, your thoughts on
2 these dimensions. Are they -- are we describing
3 these adequately -- accurately, rather? Are
4 these dimensions adequate? Are they too
5 overreaching because we're not going to be able
6 to develop measures that are really going to get
7 to this? Are there additional ones that we need
8 to add or are there ones that we need to be
9 removing? So, Adam?

10 MEMBER DARKIN: How do you overlap
11 with the Joint Commission on things like this?

12 MR. GOLDWATER: I don't believe we
13 are.

14 MEMBER DARKIN: Okay. And the only
15 other thing I'd put in, kind of overlaps with
16 patient safety, is continuity of operations. In
17 the sense that, I mean, I find a really good way
18 to understand whether a program is meaningful or
19 not is to ask what people would do if the
20 technology fails. And with a lot of programs,
21 they end up saying well, we'd actually do what we
22 always do, which means they've got commissions in

1 the exact same places doing exactly the same
2 things.

3 So, reflectively, the program is
4 redundant. If you've got something which is
5 really providing quality, reducing cost, and is
6 effective, then you really have a very good
7 continuity of operations plan. A, to how you get
8 the system back up as quickly as possible, and
9 really it's sort of a disaster recovery. But if
10 you can't get it out, have your -- shift patients
11 elsewhere and deal with it.

12 MR. GOLDWATER: Great. Kristi?

13 MEMBER HENDERSON: So I may be saying
14 partially the same thing, but it's around that
15 coordination of care, so you prevent duplication
16 or unnecessary treatment also.

17 MR. GOLDWATER: Okay, Yael?

18 MEMBER HARRIS: Well, you asked if we
19 were overstating on the framework, and I think
20 the framework is overstating to some extent. I
21 think when you look at things like technical
22 capacity, we're not measuring does the technology

1 work or not. So you have the component the
2 technology, is the technology working is it not
3 -- it's how did the technology impact care.

4 So you've got to assume the
5 technology's working, or -- I think if we try to
6 frame it too broadly we're looking at things that
7 are not, shouldn't be the scope of this. It
8 should be not looking at, you know, was the
9 technology functioning, it should be looking at
10 -- assuming the technology was working and that
11 it was being used for the right purpose, you
12 know, did it have the outcome we were hoping?
13 Did it improve care, not harm, et cetera?

14 So, and I think that goes down around
15 all of them, in terms of, you know, diagnostic
16 accuracy. Well, if a doctor makes a wrong
17 diagnosis was it because he used Telehealth
18 versus -- or he or she, sorry -- or would he or
19 she have made the same misdiagnosis in person as
20 well? Or would there have been no diagnosis at
21 all because there was no access to healthcare?
22 So I just want to clarify that what we're saying

1 here is not putting everything on it's the fault
2 or the responsibility of the technology, it's
3 really technology as the enabler.

4 MR. GOLDWATER: No, so let me clarify
5 before I get to anybody else. So for technical
6 capacity we're not asking the broad question of
7 is the technology working. What we're asking for
8 is assuming the technology is being utilized, is
9 it providing safe and accurate care through the
10 delivery?

11 For diagnostic accuracy, through the
12 use of Telehealth is a physician able to make a
13 correct diagnosis. And though -- if you want to
14 consider that being over reaching, my counter
15 argument to that is that most of the articles
16 about dermatology, particularly teledermatology,
17 focus a lot on this.

18 That the use of images in-store and
19 forward are indicating that physicians, or
20 dermatologists, are able to make a correct
21 diagnosis from the images that they are seeing
22 that are being delivered by a nurse or a nurse

1 practitioner. They're taking a picture and
2 sending it to a dermatologist, so that's why
3 we're interested.

4 And I agree, we don't want to get
5 broad because that's overstretching and not
6 producing anything useful. So that's why all of
7 these sort of italicized subsets are under there,
8 to try to hint at what we're trying to get at.
9 Steve?

10 MEMBER NORTH: As far as dimensions to
11 the framework, something we've been spending some
12 time talking about, economic impact. Is that
13 appropriate here?

14 MR. GOLDWATER: Yes, but what
15 specifically should we be looking at with
16 economic impact? I mean --

17 MEMBER NORTH: There are a lot of
18 things that fall under that umbrella, everything
19 from the socioeconomic impact that Stewart was
20 discussing to cost effectiveness of the
21 delivering mechanism.

22 MR. GOLDWATER: Okay, Stewart?

1 MEMBER FERGUSON: I was actually going
2 to say financial impact, same thing. I was
3 thinking actually cost and return might be the
4 two areas under that.

5 MR. GOLDWATER: Cost and return?

6 MEMBER FERGUSON: Cost and return.

7 MR. GOLDWATER: Okay. And again, I
8 mean, when we come up with a dimension we want to
9 keep sort of the subset very, very brief.
10 Because it narrows it to a point where, you know,
11 it's easier -- if you come up -- and again, for
12 those of you that have developed, taken the
13 onerous job of developing measures -- sorry,
14 Marcia. When you have really broad parameters
15 it's really difficult to build a measure.
16 Because it's -- the level of detail that's
17 necessary to put into that for how do you come up
18 with a numerator and a denominator, and
19 exclusions and exclusions.

20 It's hard, so when we talk about a
21 framework dimension we really want to have a very
22 brief statement that really narrows down these

1 sort of overarching ideas. So I think cost and
2 return for economic impact is good and I think,
3 hopefully, gets at the, some of the elements that
4 Steve was talking about. Other thoughts, Judd?

5 CHAIR HOLLANDER: Sort of a friendly
6 amendment to diagnostic accuracy, in that
7 sometimes you don't need a diagnosis. You may be
8 able to achieve the goals and get to the critical
9 action that you need to make, but not know a
10 diagnosis. So it may be just, you know, another
11 sentence that goes with it in the document, but
12 not -- you know, in my world it's about ruling
13 out things, it's not about diagnosing things.
14 And so I just need to get the right set of
15 information to make a decision.

16 MR. GOLDWATER: Okay, Chuck?

17 MEMBER DOARN: When you talk about
18 technical capacity, I have to think that there's
19 two parts there. One is the people and one is
20 the hardware/software. And a lot of times, you
21 know, you might have the good intention of
22 developing and I'll use the Divinci as an

1 example.

2 They put the Divinci in place in some
3 hospital, I think it's in Knoxville. It's in the
4 corner, never use it, because it's -- nobody
5 knows how to use it or nobody thinks it's of
6 value. And I think a lot of times in
7 telemedicine, you know, even though you train
8 people on how to use the equipment, the turnover
9 is great. And we saw this several times over the
10 last 25 or 30 years where you have the systems
11 aren't, they're not maintainable.

12 Because the people who are supposed to
13 maintain them don't have any idea, you know. And
14 we learned this the hard way many times when the
15 equipment was a lot more expensive. So I think,
16 when you look at the technical capacity, to think
17 about, not only the equipment itself, the
18 software and hardware part, and how you maintain
19 that with software licenses and so forth, but the
20 people who are actually using it.

21 Whether it's an IT guy or gal or it's
22 a physician, whether it's a nurse. Whoever is

1 using it, their level of competency, it becomes
2 very critical I think in maintaining it. The
3 systems are getting easier to use, but
4 nevertheless there's still that concern.

5 MR. GOLDWATER: Okay. Daniel?

6 MEMBER SPIEGEL: Could you explain a
7 little bit more what you mean by diagnostic
8 impact? I guess in my mind adding more useful
9 information to the diagnosis is supposed to
10 reorient the differential. And then, ultimately,
11 get you to a more accurate diagnosis. So what
12 is, what's the difference there?

13 MR. GOLDWATER: So diagnostic -- and
14 so I'm going to use the literature as the
15 reference point here. So the way it was
16 described was diagnostic accuracy really is,
17 through the use of whatever modality of
18 Telehealth you are using and wherever you are
19 using it, is the provider. Whether it's a
20 dermatologist, ophthalmologist, general
21 practitioner, whoever it may be, are they able to
22 make a correct diagnosis of the base of the

1 information they're receiving through the
2 Telehealth application.

3 Can they get that and say, okay I know
4 what this is? So again, we've looked at -- we
5 have started to look like at a number of
6 dermatology studies. I'm not focusing that
7 because Angela's, like, right there. But I
8 mentioned because, you know, it's very prominent
9 in that literature, that they're taking a lot of
10 high quality images and sending them to
11 dermatologists. Who are commenting that the
12 image quality is as high as if they would have
13 taken it in their own office.

14 And from that, then they are able to
15 make a correct diagnose off of what they see. The
16 impact is, is what they are receiving useful
17 enough? Is it something that is providing enough
18 basis for which they are then able to make a
19 diagnosis and then provide the appropriate care
20 that comes with that? And where we've seen that
21 in the literature has, to date, this is not
22 everything, but to date, has been in the areas of

1 mental and behavioral health.

2 Where the information that is being
3 sent to appropriate mental health therapists,
4 particularly in areas where they're using the
5 modality, like cognitive behavioral therapy.
6 That they're getting information about a
7 situation where somebody is suffering from
8 generalized anxiety disorder or major depressive
9 disorder, and understand from that then that they
10 can then employ CBT as an appropriate therapeutic
11 protocol.

12 So the impact of that information is
13 they're able -- it's useful enough for them to
14 then follow forward with what they need to do.
15 If you think we're conflating those two terms and
16 maybe one of them is maybe not necessary, that's
17 perfectly fine. I'm just, again, pointing out
18 what we found when we were reviewing the
19 literature initially.

20 MEMBER SPIEGEL: Yes, I guess I just
21 don't know if diagnostic accuracy and therapeutic
22 impact cover it and if you need that additional

1 -- sorry, yes. I don't know if you need that
2 additional diagnostic impact component, if those
3 two other surrounding pieces are there.

4 MR. GOLDWATER: Okay.

5 MEMBER SOSSONG: My thought around
6 that, maybe going to the process question, but
7 when we think about the second opinions work
8 we're doing, we're often -- it's not --
9 e-consults for dermatology are a great example, right?

10 Yes, you can compare an image side by
11 side on the photo and on the skin. But with
12 second opinions for example, we're looking at how
13 often is there a change in diagnosis or a change
14 in treatment plan or avoided surgery. So perhaps
15 there's a broader term that would capture those
16 types of things and examine all the e-consults.
17 Are you avoiding a referral, avoiding surgery?

18 MR. GOLDWATER: Okay, Marcia? Mic?

19 CHAIR WARD: I'll learn eventually.
20 Diagnostic accuracy, diagnostic impact and
21 therapeutic impact into care decisions?

22 MR. GOLDWATER: Okay, so let me ask

1 this. What would your recommendation be? We
2 take out diagnostic impact and leave the others,
3 and then add, you know, economic impact would be,
4 probably would replace diagnostic impact with the
5 cost and return being the subset under that.

6 Okay, Chuck?

7 MEMBER DOARN: I got picked first. I
8 think diagnostic impact -- if you use
9 telemedicine or Telehealth and the person is in
10 their home and you're monitoring them remotely,
11 the useful information that's coming out of that
12 -- I'm not sure that's the right term. But I
13 think that's different than accuracy, you know,
14 you've been diagnosed with a disease.

15 There's a treatment protocol, you send
16 the patient home, they take their medication, and
17 then you're going to monitor them. You're going
18 to continue to have an impact on managing their
19 healthcare, so to me they're actually two
20 separate things. And maybe they could be
21 combined in some way, but I wouldn't delete them.

22 MR. GOLDWATER: Okay, Judd?

1 CHAIR HOLLANDER: I was going to echo
2 very similar to what Chuck just said. I mean, if
3 I was getting rid of one of them I'd get rid of
4 accuracy and keep the impact. Because if you've
5 got the impact right you've probably got the
6 accuracy right, but I mean maybe it could be one,
7 diagnostic accuracy and/or impact, so it depends
8 on the specific disease, you choose one. But I
9 would hate to eliminate impact because I think
10 that's more important than accuracy.

11 MR. GOLDWATER: Okay. Henry?

12 MEMBER DEPHILLIPS: I care a little
13 bit less about whether you collapse or keep the
14 -- how you name everything. But, and I'll use
15 our world as an example, all three of those have
16 important elements in them that I think need to
17 be preserved. So I would just be concerned about
18 losing sight. So diagnostic accuracy, you know,
19 in our world the number one diagnosis is
20 sinusitis.

21 And the question everybody asks is how
22 do you -- how does the diagnostic accuracy in

1 person compare with the diagnostic accuracy
2 remote? So correct diagnosis is clearly on the
3 radar of those who purchase the service,
4 diagnostic impact is also important. So, you
5 know, at the moment about 4% of the folks that
6 use our service get referred on because they need
7 something else that we don't offer. Like a lab
8 test or an x-ray or, you know, whatever.

9 And so useful information is important
10 because as more and more ubiquitous, inexpensive
11 information gathering tools, like devices, the
12 useful information will go up and your diagnostic
13 impact is going to expand. You're going to be
14 able to diagnose more using telemedicine than you
15 would without the additional information. And
16 then of course therapeutic impact and, Sarah, I
17 think your example is a good one, even on the
18 second opinion thing. Because if you are able to
19 successfully avoid surgery, as an example, that
20 is a therapeutic impact.

21 I mean, that patient got probably
22 higher quality care because they didn't undergo a

1 procedure that they didn't need. So anyway, I
2 would just advocate for all three of those -- the
3 thought process around the three categories to be
4 preserved even if you collapse them.

5 MR. GOLDWATER: Right, understood.

6 Okay, Stewart?

7 MEMBER FERGUSON: I would actually
8 keep therapeutic and collapse the other two,
9 diagnostic. I don't like the phrase useful
10 information, a lot of information is useful, we
11 always use the phrase necessary and sufficient.
12 And that's one of the things that happens a lot
13 of times, is a very condensed model of
14 information the physician gets. You have to make
15 sure it's good quality images, but sometimes
16 there has to be more with it.

17 So you need the necessary, minimally
18 necessary and sufficient. But therapeutic, you
19 know, planning treatment and doing those other
20 things, are really separate from diagnosis. And
21 so, I do echo what you were just saying, that we
22 need to keep therapeutic on there as a separate

1 topic.

2 MR. GOLDWATER: Okay, Judd? Oh,
3 Marcia? Mic?

4 CHAIR WARD: We talked about a whole
5 bunch of other things, other concepts and I'm not
6 seeing them on the list. And so, if this is a
7 framework that's going to encompass everything,
8 do we need to go back and revisit the workforce?
9 And the things that aren't quite so clinical?

10 MR. GOLDWATER: I think when we get to
11 tomorrow and we start looking at the elements,
12 which we're going to map to the domains of the
13 literature review. And we sort of understand how
14 those intersect, that's at what point we can
15 decide how you want to expand that. You know,
16 how do you want to expand the elements? Do you
17 want to expand the dimensions? Can some of those
18 elements that you're talking about fit into one
19 of those dimensions? Do we need to create a new
20 dimension and new elements?

21 I mean, that's why we're ending at
22 4:00 and we'll talk about this tomorrow, because

1 that's a big talk. Because, again, this is so
2 crucial to finishing this work is understanding
3 the dimensions and the elements. And keep in
4 mind something, when we finish the framework --
5 and this becomes the basis for measure
6 development -- you don't have to put all of these
7 in to every measure that you do. The measure's
8 got to touch one or more, in that we have this --
9 because in every Telehealth measure that we look
10 at we'll have one or more of these, and then we
11 all know those are Telehealth measures.

12 When you reduce variability, you have,
13 you encompass all of the elements, you hopefully
14 have appropriate attribution. We sort of remove
15 ourselves from some of the inherent problems of
16 quality measurement that have sort of plagued the
17 enterprise for quite a while. Do you have
18 anything else to add, Henry? No? Well, Chuck
19 did. Yes, Chuck, go ahead.

20 MEMBER DOARN: I'd like, you know, as
21 I was thinking about earlier today, somebody made
22 a comment about it being too clinically oriented.

1 And if you look at these five items, they're all
2 clinical except the very first one. And there's
3 nothing wrong with that, but maybe it becomes a
4 six-legged table. And you have personnel or
5 management or organization or, you know, some
6 kind of term that's an actual management
7 component of managing healthcare, managing
8 personnel, managing the technology. Where --
9 because telemedicine and Telehealth aren't just
10 necessarily about providing the best care.

11 I mean, that's the underlying theme,
12 but part of doing it is -- you're doing it for a
13 variety of reasons, there's the shortage of
14 physicians, the shortage of allied health
15 workers. The distance between point A and B is,
16 you know, a million miles or whatever it is. So
17 you -- I think that maybe there's room for that
18 sixth category.

19 MR. GOLDWATER: I agree.

20 MEMBER DOARN: You know, and again we
21 can talk more about it tomorrow.

22 MR. GOLDWATER: Yes, I think that's

1 something we've learned, which I'm grateful for,
2 truly, that the three of us have gathered.
3 Because a lot of what we've looked at from the
4 literature, you know, is very clinically focused.
5 It's about a particular clinical area of care and
6 a study that's been done, and how they've
7 utilized Telehealth regarding that. Whether it
8 be ICU or stroke or dermatology or ophthalmology
9 or whatever it may be.

10 So I'm very appreciative of really
11 leveraging this expertise on the non-clinical
12 elements of this. And I think those are found,
13 you know, foundational elements for a framework.
14 How we're going to incorporate those, you know
15 whether they become dimensions or whether they
16 become elements or what they may become, you
17 know, that'll be tomorrow's discussion. But I
18 think we'll really come out.

19 I'm very confident -- because I'm not
20 letting any of you go home -- that by tomorrow,
21 you know, we'll have a very solid list of
22 elements and dimensions that we can then really

1 work from for the existing measures. And then,
2 you know, how we come up with measure concepts
3 when we meet in March. So I feel great about
4 that, which is -- this is how I wanted to feel
5 when I left, so thank you all. No thanks to you.

6 MEMBER DOARN: No, no it's -- but I
7 think in that venue though, and again I was
8 thinking of one of my graduate students, they're
9 trying to look at one area of a particular thing
10 that we're studying.

11 And I'm like, you know, go into this
12 series of manuscripts and these journals and look
13 for something different, right? This is all
14 about developing apps and the struggle with
15 people who are trying to do that. And so, in
16 this venue there's a number of articles and
17 health affairs that relate. I don't have any
18 idea which journals you looked at.

19 MR. GOLDWATER: All of them.

20 MEMBER DOARN: But there may be --
21 there are several journals out there, maybe
22 they're IT journals, maybe they're management,

1 maybe they're nursing journals, that are
2 addressing some of these issues that are not even
3 on the radar. Because we didn't think about
4 that, I mean, I think using some of these new --
5 this new terminology, maybe, that we start
6 pointing in that direction.

7 MR. GOLDWATER: No, I can certainly
8 see after this we'll probably add on to the lit
9 review -- I'm sorry to say that Katie -- for some
10 terms. We -- the breadth of the literature that
11 we have is fair in the sense that we've covered
12 from Health Affairs to AJMC to New England
13 Journal of Medicine to results from aim year
14 conferences to ICS conferences to, you know, the
15 things you go to, Chuck, that no one else goes
16 to.

17 But a lot of these journals, computing
18 journals, I mean a large variety of them -- and
19 then your journal, Chuck, has been, you know,
20 great. Right. So, but I think we'll probably --
21 it's almost needed that we'll have to go back,
22 refine the search a little bit more to pull up

1 some of these non-clinical elements. But I think
2 that'll be real helpful, and again I think I'm
3 really appreciative. I know we all are very
4 appreciative of just the added dimensions of this
5 because it makes for a very robust framework.
6 And will make for a great way to develop
7 measures, so.

8 MEMBER DOARN: Is it possible for you
9 to send us a list of the journals that you have
10 looked at?

11 MR. GOLDWATER: So actually, by
12 tomorrow we will post all of the articles that
13 we've pulled to date. And we'll have it on the
14 share point site that's accessible to all of you,
15 so you can look at it whenever you want. And
16 then as we get more we will post more on there.
17 You'll see, I mean, you're going to see
18 yourselves in some of them. So you're welcome
19 ahead of time, right? Okay. All right, well I
20 think that's going to end if for today. So,
21 operator, if you could open up the line for
22 public comment, please?

1 OPERATOR: If you would like to ask a
2 question or make a comment please press Star 1.
3 And we have no comments at this time.

4 MR. GOLDWATER: Okay and do we have
5 any comments from the back? We do, Ann. Ann has
6 comments, so.

7 MS. TRUJILLO: It s actually an offer
8 and an observation. So in the description that
9 you all developed, it was helpful and I was
10 thinking about a pathway forward. And the
11 complexity is staggering, but we will just offer
12 this shared experience -- which I reached out to
13 Jason and some of you already are on the CBT
14 Telehealth services workgroup. That a parallel
15 and complimentary process, to the one that you're
16 engaged in, involved a decision by the CBT
17 editorial panel to look at the CBT code set to --
18 which is a code set that describes services and
19 procedures.

20 It does not describe outcomes. There
21 are some codes, that's a latent set of codes
22 around quality, but it's latent and it's only

1 CMS. So just a clarification, I'm talking about
2 the codes that describe services and procedures.
3 And so, a decision was made to update the code
4 set to reflect new digital medicine, service and
5 procedures. And the approach was to create three
6 tranches.

7 The first tranche was those codes that
8 the participants were aware that were being
9 offered. And that the code as it exists today --
10 the description of the service and procedure
11 today could serve as a descriptor for both in
12 person and virtual. That was tranche number one.
13 And based on an environmental scan, there is a
14 new appendix to the code set for those codes that
15 have an appendix that will -- I'm sorry, a
16 modifier that will tell you whether or not the
17 service is provided virtually or in person.

18 It will not tell you outcome and it
19 will not tell you a quality measure, but it will
20 tell you I provided the service. It doesn't tell
21 you by what method, but it will tell you if it
22 was in person or virtual. Right, it's technology

1 neutral.

2 The second tranche is a process that's
3 ongoing, which are existing codes that may need
4 modification. That the service can be provided
5 both virtually and in person, and the current
6 descriptor may intimate or explicitly provide
7 that it is person. When, in fact, it can be
8 offered both virtually and in person.

9 And the last tranche are those
10 services and procedures that may not be described
11 in any existing code. And may, in fact, may be a
12 new service and procedure that has emerged as a
13 result of these new technologies and services.
14 The work remains ongoing, but in fact this effort
15 can be both complementary and we can learn from
16 this process.

17 And, perhaps, you all may be able to
18 utilize our process. I address at least one
19 aspect of what I heard a lot of folks talking
20 about in here, how do we differentiate between
21 whether the service went in person or virtual?
22 And you may want to consider that in a

1 development of some of the measures, or use of
2 existing measures.

3 There is, potentially, a way to know
4 whether it was virtual or in person without
5 altering the existing description of the quality
6 measure. So it could reduce significantly at
7 least the initial tranche of quality measures,
8 that you may want to say yes these are quality
9 measures as described that can be used both
10 virtually and in person.

11 And we will be able to tell if there's
12 an associated service that also is described as
13 either virtual or in person. And have the
14 benefit of growing the evidence base too, so that
15 we will know over time whether or not there are
16 differences between the in person and virtual as
17 well. So we are happy to keep you updated.

18 MR. GOLDWATER: Please so.

19 MS. TRUJILLO: And we are happy to
20 share with you all information about which
21 services and procedures. We'll, as of January 1,
22 2017, be eligible for that modifier. And these

1 are for synchronous services, asynchronous is
2 present some interesting issues that we think
3 you're going to run into as well. So I think
4 that'll be opportunities for us to talk. Thank
5 you.

6 MR. GOLDWATER: Great, terrific, any
7 other comments? All right, thank you all so
8 much. Enjoy dinner at Siroc, it's amazing, and
9 do not believe a word Tracy and Katie say about
10 me at all. Thank you.

11 (Whereupon, the above-entitled matter
12 went off the record at 4:12 p.m.)
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A,B 331:1	133:12 135:13 140:8	118:11 120:13 122:2	adolescent 37:5
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C E R T I F I C A T E

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