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, MPHM, 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

A G E N D A

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

9:08 a.m.

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

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

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

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

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

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

direction on how to implement it.

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

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

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

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

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

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

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

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

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

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

objectives that we need to accomplish.

We do want to do an update on the environmental scan. We do want to tell you the measures that we have initially found, that we ca incorporate into telehealth as a means of care delivery, existing measures. We want to discuss, as Tracy will lead this discussion, methodologies on how to modify existing measures to incorporate telehealth, what new measures are needed and then to discuss the initial dimensions of the framework that would provide the ability to utilize existing measures, to evaluate telehealth, as well as developing the foundation to create new measures.

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

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

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

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

It's a busy job for sure. My

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: You want to do that?

MS. WILSON: Yes.

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

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

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

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

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

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

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

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

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

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

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

you.

MS. WILSON: Yes, go ahead, Don.

MEMBER GRAF: Don Graf, National Telehealth Director, United Healthcare. Disclosures. I sit on the AMA Telehealth Coding Task Force. Don't believe that's any kind of a conflict, but and also on the ATA Education Committee. No other disclosures. Been with United Healthcare, developing and expanding telehealth capabilities on the national scene for nine years.

Been doing telehealth, promoting and expanding its use for over 20 years and look forward to participating on the group.

MS. WILSON: Thank you, Paul.

MEMBER GIBONEY: Good morning. My name is Paul Giboney. In terms of disclosures, our agency receives a couple of grants from the Blue Shield of California Foundation, for the spread of electronic consultation and assistance with them around the state of California.

I'm the Director of Specialty Care.

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

MS. WILSON: Thank you.

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

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

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

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

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

MS. WILSON: Thank you.

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

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

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

MS. WILSON: Thank you.

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

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

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

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

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

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

it, does some home telehealth.

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

MS. WILSON: Thank you.

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

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

MS. WILSON: Thank you.

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

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

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

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

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

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

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

MS. WILSON: Thank you.

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

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

better access and a convenience for them.

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

MS. WILSON: Thank you.

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

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

So that's more now entering our second

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

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

MS. WILSON: Thank you.

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

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

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

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

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

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

MS. WILSON: Thank you.

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

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

MS. WILSON: Thank you.

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

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

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

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

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

MS. WILSON: Thank you.

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

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

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

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

MS. WILSON: Thank you.

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

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

facilities in Anchorage.

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

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

MEMBER NORTH: And the rest of us can understand.

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

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

MS. WILSON: Thank you.

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

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

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

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

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

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

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

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

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

MS. WILSON: Thank you, Dale.

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

Really excited to be here. Currently

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

MS. WILSON: Thank you.

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

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

(No response.)

MS. WILSON: How about Rashid Bashshur?

(No response.)

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

(No response.)

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

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

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

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

(No response.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I know experience is sort of a broad

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

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

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

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

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

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

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

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

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

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

This is again not a comprehensive

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

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

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

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

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

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

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

California area.

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

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

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

might affect telehealth services.

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

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

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

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

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

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

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

There were several that we got that

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

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

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

Next slide. So when we abstract the

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay, Nate.

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

sliced in that way, that would be really helpful.

MR. GOLDWATER: Okay. Don.

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

MR. GOLDWATER: Okay, Judd.

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

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

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

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

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

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

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

MR. GOLDWATER: Okay. Yael.

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

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

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

MR. GOLDWATER: That's okay.

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

MR. GOLDWATER: Okay. Now Yael.

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

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

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

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

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

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

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

MR. GOLDWATER: Sure.

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

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

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

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

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

MR. GOLDWATER: Sure.

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

MR. GOLDWATER: I agree. Eve-Lynn?

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

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

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

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

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

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

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

MR. GOLDWATER: Okay, Marcia.

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

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

MR. GOLDWATER: Okay. Dr. North.

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

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

MR. GOLDWATER: Okay, Sarah.

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

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

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

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

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

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

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

So how do we evaluate the ongoing

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

MR. GOLDWATER: Mary Beth?

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

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

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

MR. GOLDWATER: Paul.

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

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

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

telehealth in one of these five domains.

MR. GOLDWATER: Okay, Don.

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

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

MR. GOLDWATER: Okay, Dale.

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

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

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

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

So make sure that you're including

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

MR. GOLDWATER: Okay, Henry.

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

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

standard of care from a quality standpoint.

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

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

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

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

use a biomarker.

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

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

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

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

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

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

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

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

MR. GOLDWATER: That's all right, no

problem.

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

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

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

telehealth.

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

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

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

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

MR. GOLDWATER: Sure. Okay, Stephen.

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

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

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

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

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

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

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

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

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

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

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

MEMBER HANDLER: Okay.

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

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

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

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

MEMBER HANDLER: Okay.

MR. GOLDWATER: Thanks. Eve-Lynn.

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

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

that may not be captured by these traditional measures?

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

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

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

MR. GOLDWATER: Steve.

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

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

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

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

MR. GOLDWATER: Absolutely, right.

MEMBER ALVERSON: The other is that I

notice another gentleman just entered the room who --

MR. GOLDWATER: Yes, from Macedonia.

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

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

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

MR. GOLDWATER: Sure you did.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The quality, I mean the patient

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

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

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

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

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

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

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

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

MR. GOLDWATER: Because we're still --

MEMBER DOARN: Still doing it, okay.

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

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

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

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

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

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

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

MR. GOLDWATER: It will be when it's

completed, yes.

MEMBER FLANNERY: Not before then though?

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

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

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

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

MR. GOLDWATER: Sure.

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

MR. GOLDWATER: Sure, okay. Steven.

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

MR. GOLDWATER: No.

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

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

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

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

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

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

But there's a lot of standards that are being developed for medicine, behavioral health is one of the most robust. Teledermatology has some standards in terms of image size, you know, stroke is very advanced. There are other areas, and I am one of the people to agree, that telehealth does not necessarily work for every type of medicine practiced.

But I would say that there's a lot of

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

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

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

we develop this framework.

MR. GOLDWATER: Okay. Daniel and then Adam.

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

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

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

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

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

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

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

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

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

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

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

the real -- what?

MALE PARTICIPANT: Why can't he?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FEMALE PARTICIPANT: And how they pay for it.

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

MR. GOLDWATER: Okay. Julie.

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

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

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

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

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

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

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

MEMBER HARRIS: So I spent a lot of

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay, Dale.

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

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

MEMBER ALVERSON: You're very flexible Jason.

MR. GOLDWATER: I'm going to.

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

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

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

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

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

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

MR. GOLDWATER: Mic on.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PARTICIPANT: What time was it?

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay.

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

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

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

MR. GOLDWATER: Sarah?

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

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

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

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

MR. GOLDWATER: Judd?

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

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

distinction.

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

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

MR. GOLDWATER: David?

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

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

MR. GOLDWATER: Okay. Anybody else? Judd?

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

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

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

MR. GOLDWATER: Steven?

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

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

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

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

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

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

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

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

MEMBER HANDLER: I could just rat out a couple.

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

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

MR. GOLDWATER: No, it's not.

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

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

MR. GOLDWATER: Okay.

MEMBER HANDLER: So, those are just some.

MR. GOLDWATER: Henry? Thank you.

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay. Steve?

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

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

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

MR. GOLDWATER: Okay. Dale?

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

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

MR. GOLDWATER: Sure.

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

MR. GOLDWATER: Sure.

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

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

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

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

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

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

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

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

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

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

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

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

start moving this geographically.

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

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

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

MR. GOLDWATER: Okay. Angela?

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

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

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

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

MR. GOLDWATER: Okay. Stewart?

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

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

MR. GOLDWATER: Exactly. Exactly.

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

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

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

MR. GOLDWATER: Okay. Great. Sarah?

MEMBER SOSSONG: Just one last point

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay. Judd?

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

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

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

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

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

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Right. Right. Chuck?

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay. Yes, Don?

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

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

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

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

When HIPPA came out, and they were

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

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

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

But there's always going to be the

need to use technology to increase access. There's always going to be the need to use technology to be effective. There's always going to be the need to use technology to improve outcomes. There's always going to be that need.

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

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

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

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

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

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

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

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

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

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

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

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

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

always the point of a quality measure.

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

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

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

the outcome?

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

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

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

you look at it from an outcome.

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

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

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

bit? I -- I --

MR. GOLDWATER: Okay. Angela?

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

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

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

MR. GOLDWATER: Okay. Adam?

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

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

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

MR. GOLDWATER: Sure. Don?

MEMBER GRAF: I wanted to tie in to

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

MR. GOLDWATER: Okay. Paul?

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

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

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

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

MR. GOLDWATER: Right. Okay. Steve?

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

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

MR. GOLDWATER: No, not --

(Simultaneous speaking.)

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: Dale?

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

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

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

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

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

MR. GOLDWATER: Right.

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Right. Angela?

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

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

Because they can look at image review

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

MR. GOLDWATER: Okay. Sarah?

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

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

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

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

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

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

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

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

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

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

(Simultaneous speaking.)

MR. GOLDWATER: What's that?

MEMBER GRAF: Improved outcomes.

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

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

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

MR. GOLDWATER: Yes. Steve?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Yes, you can. Please.

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

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

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

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

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

(Laughter.)

MR. GOLDWATER: Microphone.

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

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

- what's the wording that --

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

evaluate quality and we're incorporating telehealth.

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

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

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

(No audible response).

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

take the lunch break now?

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

(Laughter.)

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

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

(Pause.)

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

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

(Simultaneous speaking.)

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

MS. TRUJILLO: I'll be quick.

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

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

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

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

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

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

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

person.

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

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

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

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

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

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

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

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

be subject to discussion.

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

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

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

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

least.

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

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

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

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

So next slide.

Judd, are you going to dinner tonight?

CHAIR HOLLANDER: Yes.

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

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

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

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

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

(No audible response.)

MR. GOLDWATER: I know some -- okay,

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

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

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

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

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

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

So AHRQ's very vast database, which is

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

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

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

Next slide. So what we're asking you

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Right. Okay.

Judd.

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Right.

CHAIR HOLLANDER: -- or one of the blood pressure ones, which is just saying, you know, are you controlling the blood pressure, are you controlling the hemoglobin A1c? So I can see telemedicine being a mechanism to achieve that goal, but I don't see it as being a telemedicine-specific measure.

So back to the original question before I babbled is just to see the vision of how

this measure got here and how you see it applying would certainly help me, and from head nodding, maybe a couple of others, understand how to interpret this.

MR. GOLDWATER: So one of the -- that's a great question, Judd, and before I get to others, you know, one of the major sort of issues that we had to sort of wrestle with when we started the project was if we're going to start building a framework where we have to include what's already been done, that's challenging because there are a lot of outcome measures.

These are all outcome measures and nothing to do with telehealth. And we can't reinvent a measure that says the same thing. I mean, that, you know, these are -- that apart from being duplicative, it's unnecessary.

And we had to try to find out, is there a way to take these existing measures and prioritize and to determine which ones are really important, and then is there a way to modify the

measure without taking that's intent or objective away where it could be used as a means of evaluating telehealth?

And I -- again, I recognize that that's very challenging. We certainly could not come up with a solution ourselves, and that's why we wanted to initially come up with some measures.

And, Judd, the idea was, is there a way, or is there a methodology to follow, if possible, where we can use these as telehealth measures and in some way incorporate telehealth as a means of delivery or this just becomes the same measure and it's just applied to a telehealth encounter without any modification, and then in which case if that's what, if that's the recommendation to follow, then what measures do we really consider to be important?

And the criteria that I went over on what we excluded, was that appropriate or should we be putting more exclusion criteria or should we be adding more measures? I mean there were,

you know, roughly 120-some odd measures, so we didn't want to use every conceivable measure.

We wanted to have some manageable list to move forward with, so what we're looking for is, are these measures appropriate for telehealth, is there a way to modify them to incorporate telehealth as a means of delivery without changing the measure, and what would be the best way to go forward with this?

So glad there's discussion.

Nate, I'll start with you.

MEMBER GLADWELL: Just a clarifying question to try to make sense of it in my own head, I'm pretty simpleminded, but tele-ICU, obviously, is a major modality in telehealth. One of the metrics that they often cite is mortality, right, reduction in mortality.

MR. GOLDWATER: Right.

MEMBER GLADWELL: So am I to understand that there's no -- based on the exclusion criteria, there's no measure around mortality that would make sense to fit in this

conversation?

MR. GOLDWATER: There were none that we -- there were none that we initially saw, no.

MEMBER GLADWELL: Okay. That helps me understand.

MR. GOLDWATER: Sarah.

MEMBER SOSSONG: I think perhaps my question is along the same lines, is simple and progressive. We spent a lot of time talking about the domains, and so I'm thinking about access effectiveness, cost to patient and provider effectiveness. Do you see all of these fit within one of these buckets?

I guess I was thinking that we would then go down, there would be five different buckets, each with a set of a lot of different measures, and so I think, you know, thinking about, you know, 30-day readmissions, cost standardized medical expense.

MR. GOLDWATER: Right.

MEMBER SOSSONG: So I think this all seems very clinical, which is one important

category, but if you could just comment on how we'll get back to those five --

MR. GOLDWATER: So we haven't done -- we wanted to sort of get input on the measures first before we started doing sort of the crosswalk between the measure and the domain area, but like the first measure which talks about the prevention and management of obesity for adults with those that have a BMI, you know, greater than or equal to 25 and making sure they've reduced their weight by the, by now the 5 percent threshold is in our area that would somewhat be an access issue.

So do they have access to a provider that is helping them manage their diabetes if they are presenting with a BMI higher than that and monitoring their weight on a regular basis to ensure that they're moving to that threshold that would meet this quality measure? But, again, going to Marcia's issue, that's a time-based measure.

They -- you know, nobody loses five

percent of weight overnight, so it's something that, again, to be considered. And measure is really looking at an encounter, one particular encounter, so this would be multiple encounters to determine whether that measure is met and do we want to incorporate that now.

So Steve.

MEMBER NORTH: A quick scan of these, all of them are standard measures of care. And as we've talked about sort of non-inferiority of telehealth, it doesn't seem like any of them need to be modified if you begin to integrate telehealth into this outcome goal.

And this goes along with coordination of care that Paul has been advocating for as one of our domains that we know that in my rural practice, I don't have a nutritionist, but if I bring the nutritionist in for two visits, and over the course of the year, does the patient decrease their BMI?

That measure doesn't need to be modified or changed because I've changed the

modality of delivery. I'm still trying to achieve the same goal, --

MR. GOLDWATER: Right.

MEMBER NORTH: -- so maybe I'm still five minutes ago in the conversation trying to understand what the difference is.

MR. GOLDWATER: Okay.

Marybeth.

MEMBER FARQUHAR: I'm looking at the measures and I see that there are a lot of chronic conditions, --

MR. GOLDWATER: Right.

MEMBER FARQUHAR: -- so that assumes that, and maybe I'm wrong here, that assumes that there's multiple visits of these folks, so I'm a little confused as to why there's nothing that includes care coordination or transition of care or timely transmission of records, discharge records, or anything like that in here.

MR. GOLDWATER: Again, because the initial focus was just outcome-based measures, not --

MEMBER FARQUHAR: Okay.

MR. GOLDWATER: -- process-based, so we didn't come across any measures such as that, but, again, if those are measures we need to look at or inventory, then we will.

MEMBER FARQUHAR: Yes. With the measures you picked here, it's chronic care, so I assume that you're looking at rural areas that you're going to have people come on a consistent basis.

The other area too, I'm going to beat CAHPS to death here, is that getting care quickly or getting the needed care would be something that would be appropriate for telehealth --

MR. GOLDWATER: Okay.

MEMBER FARQUHAR: -- to include.

MR. GOLDWATER: Daniel.

MEMBER SPIEGEL: Thanks. Again, maybe I'm a little slow here, but I just want to make sure I understand.

MR. GOLDWATER: Guys, none of you are slow. This is tough. I'm not -- I mean, I

appreciate all the qualifiers, but none of you are slow. This is really hard. We understand this. This is why you're here, so --

MEMBER SPIEGEL: Fair enough.

MR. GOLDWATER: I mean, I can't solve this, neither can Tracy or Katie, and we've certainly have had numerous discussions about this, so thank you, but none of you are slow. Chuck maybe, but none -- no, I'm kidding.

(Laughter.)

MEMBER SPIEGEL: So I guess I just want to understand the intent of picking these particular measures. Is it that using these measures we come up with a framework for how we would adapt any measure or any appropriate measure for telehealth if an adaption was acquired?

MR. GOLDWATER: That's correct.

MEMBER SPIEGEL: Okay, got it. So it's not that this would be the list of measures that would be included in any sort of NQF-endorsed -- okay, got it. Perfect.

MR. GOLDWATER: No. These are -- these are measures, if you so chose them, would be part of the framework. It'd be like an initial pass of measures for people to use, how do we incorporate telehealth as part of that.

MEMBER SPIEGEL: Got it, thanks.

MR. GOLDWATER: Dale.

MEMBER ALVERSON: I may be just reinforcing what many people have already said, but what this reminds of is CPT coding.

MR. GOLDWATER: Yes.

MEMBER ALVERSON: You know, rather than saying there's got to be something specific to telehealth, rather than creating new CPT codes, we just -- well, CMS uses the GT modifier.

MR. GOLDWATER: Right.

MEMBER ALVERSON: So in a sense, I sort of look at a lot of these things, I could see telehealth playing a role in perhaps facilitating achievement of those outcomes, but we don't have to create a new one. It's just -- it's almost like a GT modifier for each one of

these, these outcome measures. That's where telehealth could be applied.

And then I would also agree, I think there's some outcomes that seem to be missing here, but I haven't had a chance to read through it in general, but I think about the sort of storm forward, and maybe that's in here about diabetic retinopathy, and not only providing access to looking at retinal scans, but also intervening and preventing blindness by seeing sight-threatening retinopathy. So I don't know if that's in here, but that --

MR. GOLDWATER: It's not.

MEMBER ALVERSON: -- seems to me an important outcome --

MR. GOLDWATER: Okay.

MEMBER ALVERSON: -- where telehealth, you know, accelerates that.

MR. GOLDWATER: Okay.

Adam.

MEMBER DARKINS: A couple of points made back to there's no real biologic

plausibility that telehealth in itself is going to create changes in any of those measures, and so in many ways, you could say that the standard should be how appropriately telehealth should be used in the context of an overall care management program or program aimed at delivering those ends.

MR. GOLDWATER: Okay.

MEMBER DARKINS: And I think there's sort of risk of unintended consequences. Firstly, it'd be difficult to know what the denominator is when you're practically measuring quality standards when you have this kind of mixed economy.

And a couple of anecdotes. When we implemented a large home telehealth program and got to about 25, 30,000 patients, we looked at outcomes, there was 1 of 21 regions that decided it wouldn't adhere to the policies of the program.

They took instead of a self-management approach, they took a very medical model approach

of saying, "This is about how you manage people in remote situations in community as you might do in hospital." We saw a 40 percent increase in utilization.

So some of these measures, you might well -- there isn't a clear baseline of what the, what the findings would be if you were to do it in the kind of settings, so I think you're not necessarily going to -- there isn't the evidence I want to say with how it might be applied, so you may well find this really confounds everything when you start to do it.

And the last quick thing I was going to say is back to tele-ICU. We're looking at measures for tele-ICU in terms of line infection, in terms of extubation of ventilators, et cetera. One of the things that we found is it made more sense to try and looking at quality measures around virtual team working than it did those kind of measures.

And the reason for that is if you're using a telehealth program to manage 6, 10, 12,

14 ICUs, the first thing you have to do is get common policies on how you manage some of those things. So it isn't the intervention of suddenly saying, "We're going to provide remote care," is going to suddenly put it right.

The first thing you have to do is make sure they have a common policy for extubation, et cetera, and then you standardize. So I think it could be misleading to just put those in without those -- so I think it's how it's applied, not --

MR. GOLDWATER: Okay.

Steven.

MEMBER HANDLER: Okay, so I will start with a caveat. I woke up at 3:00 in the morning, so I'm a little tired and I'm still a little confused about this.

So I was on -- I just went to the NQF, and to me, when I looked at this list, I said, "To me, some of the things that I would think would be on this would be 30 readmissions." The outcomes that I would look for are not here.

MR. GOLDWATER: Okay.

MEMBER HANDLER: And I thought we started this discussion with the framework. That is the things that, for example, how we would structure the data. What I think for me would be most useful, this seems very abstract.

MR. GOLDWATER: Okay.

MEMBER HANDLER: Okay. What I would love to see is all of the NQF-endorsed measures, even if there's 120, that's what you said there are, I don't know the exact number. Six hundred, oh, great.

MR. GOLDWATER: Well, wait. So wait, hold on. Small caveat there.

MEMBER HANDLER: Oh, okay.

MR. GOLDWATER: Those are -- those are process structure outcome, patient reported outcome. That's every kind of measure. I think just in terms of pure outcome measures, there's roughly maybe 80 outcome -- what?

A hundred and fifty, oh, so I was way off.

MEMBER HANDLER: So my thoughts were,

I'll just throw out something random, so you take the 150, you create Adelphi or you create a structure or a web, and you take your 150, and then you take your framework as columns, and for each one, we see how many they hit on the framework that we logically talked about.

MR. GOLDWATER: Okay.

MEMBER HANDLER: The more that apply in terms of the framework that we agree upon, whatever that is, the more likely that we should as a group endorse that particular NQF, you know, metric I would think. To me, right now, I'm having a hard time because I feel like this is very abstract.

So as a geriatrician, I look at falls, I still have no idea how telemedicine is going to help with falls, right, in particular, you know, looking at this unless we're going to have a process that goes along with medication regimen review or team or a lot, a lot, a lot around it, and I'm going to have to fill in a lot around that.

MR. GOLDWATER: Right.

MEMBER HANDLER: So that's -- I'm sorry. So I'm having -- I am having trouble with this. It's too abstract for me. I'd love to ground it in the work we've just done or that we're building on frankly, and then go and review, not 600, true, but if you wanted in the outcomes help us define, give us the universe of outcomes that we should select from and help us go that way. That's just a suggestion.

MR. GOLDWATER: Understood.

Yael.

It's a great idea by the way.

MEMBER HARRIS: So no caveat. I think I know everything, but the question I have is, again, we're trying to compare care delivered through telehealth versus care delivered either face-to-face or care not delivered at all, and so I want to keep that in mind with some of these measures because when I look at some of these measures, they could be biased the other way.

So, for example, some of these

measures where we have better detection of fecal impaction for pain medication, for example. It would appear that we're actually doing poorly or, you know, if we're seeing the patient more frequently, we're going to detect things, like depression. Whereas, we would not be able to detect those things if the patient didn't come back in.

So I wanted to just make sure -- I'm not trying to paint a rosy picture and not show the full picture if telehealth is not effective, but I also don't want to paint telehealth as having -- we're measuring negative outcomes that can be better detected because telehealth is improving access to care so we can make those assessments in infections.

MR. GOLDWATER: Understood.

Julie.

MEMBER HALL-BARROW: As I looked at these, of course, representing the pediatric field --

MR. GOLDWATER: Right.

MEMBER HALL-BARROW: -- there's none.

MR. GOLDWATER: I know.

MEMBER HALL-BARROW: And, so, you know, we have 28 measures in NQF, and I looked at, you know, looking at the -- there's several really quickly that could be added, so it's in the whole spectrum, cradle to grave, but I am representing that kind of group that I'm focused on, and I think what I struggle with continuously, legislatively, and regulatory is that there's not enough evidence or no quality factors or nothing to gauge the pediatric arena, so I'd love if we could --

MR. GOLDWATER: Got it.

MEMBER HALL-BARROW: -- add that to the spectrum.

MR. GOLDWATER: David.

MEMBER FLANNERY: I want to follow up on what Marcia was commenting about with chronic disease management. You could have a hybrid model of care, you could have in-person visits, telemedicine visits, and how you track them, what

Dale is getting to, is how you track the telemedicine visits versus the inpatient, in-person visits, and then could look to see how much telemedicine contributed to the outcome.

There's a real challenge here. You need to think about how you would do that and, you know, how you operationalize these kind of things.

MR. GOLDWATER: Okay.

Sarah.

MEMBER SOSSONG: So just going back to the ultimate goal of this, I think as we have gone to insurers, legislators and advocated for telehealth, where we have gotten stuck is in the fact that we have very clinically specific measures, and so what I would hope that we could do is come up with things that can be very general and overarching across the clinical -- I agree with everyone that said we're not looking to achieve anything different through telehealth than we are with in-person care.

If anything, what are the right ways

that we can --

MR. GOLDWATER: Right.

MEMBER SOSSONG: -- advise on the clinical protocols and guidelines for how clinicians use this, so, again, back to the process outcomes access. What are the things where when Blue Cross Blue Shield says, "Well, how have you impacted cost?" they don't want it broken down by clinical area.

They want on average across 10,000 visits, it's been X. So I think the more that we can come up with something that would be common for everyone across those types of things, that would be helpful in advancing reimbursement and other regulatory --

MR. GOLDWATER: Sure.

MEMBER SOSSONG: -- agendas.

MR. GOLDWATER: Okay. So I understand that. I also understand that, you know, we queried the database, right? And the database said, "Here are the measures." And we went, "Oh, that's nice," and then we applied the criteria

and said, "Oh, these are the measures that are left," knowing full well that most of them were based on chronic disease, which if you look at NQF and measures in general, there's a large slant of process and outcome measures to chronic disease.

We knew there -- we saw immediately there were no pediatric measures. We saw immediately there were no dermatology measures. We saw there were no ophthalmology measures. So we saw the things that we've gotten a lot of literature on about the effectiveness of telehealth. There were no measures that we were able to find.

So, again, the exercise is not this is the list and this is what we're going with, people, so you better come up with a way of how we're going to do it. It's this is the initial pass.

If we find this is not satisfactory and is really not going to help objectively assess and evaluate the use of telehealth

services in a way that is important to those that are actually providing those services or managing networks that are providing those services, we are just fine with scrapping this and going to do something else. It's not an issue.

As for, I think, the development of measures that are reflective of what you see in the field and what would be the most helpful, I think that's the next step of this, which is to build a framework on how those would be developed.

So Angela, and then Kristi, and then Judd. Sorry, I'm not forgetting you.

Oh, all right, Chuck, I'll get to you eventually.

Go ahead, Angela.

MEMBER WALKER: Looking down this list, and I think I could see some type of tele use for just about everything listed, including falls, but one thing I don't see as much of is the acute episodic care, which is really more of what, I think, some disciplines are using

telehealth or telemedicine for, so that might be one thing to add. And if it's not incorporated already on the list of measures, a new one to develop.

And then I completely agree with what's already been said about where does this fit into the system, what's the piece in the workflow that may be missing. And there may be things that are more specific to a separate or distinct practice modality for care that needs a measure developed, so things like communication and coordination of care, all those things we've already addressed, that may not be here.

MR. GOLDWATER: Okay.

Kristi.

MEMBER HENDERSON: Yes, so I love the idea that you had Steven around going down all these measures. So I'm sitting here looking at the outcome measures and, you know, the readmissions and the acute episodic outcomes and the mortality rates. Those are things that tele-emergency, tele-stroke, the eICU program are

impacting.

And the falls, to that question, eICU and tele-sitter programs all over are impacting falls, so I think that and linking them to the domain could be a great exercise. And all of us would have a unique perspective and could make that a really robust list.

MR. GOLDWATER: Judd.

CHAIR HOLLANDER: So, you know, I want Marcia so she could stand between, you know, me and Jason. I want to vote to blow this up. I just think it's -- and I'll tell you why. And going back to -- no, I mean, I know it's fine.

I think when I read these measures, and this is going to sound silly, but it's true, it doesn't matter how you achieve the goal. So if I need to get to hemoglobin A1c under X, and I give you a Cheerio every day and you're under X at the time frame, you meet the goal, so telemedicine is just a thing you could use in here to achieve the goal, and so it makes me think that it's really not about the outcomes

because in all the outcome measures that I'm familiar with, and I'm sure there's a million I'm not, is you hit the outcome, right?

That's the goal. It doesn't matter how you do it. So telemedicine can be a tool that helps you get the outcome, but I don't think we need to say that. I think it's in the process measures where we need to define does telemedicine have a role.

So if the process measure says, "Do a visit within seven days of discharge," saying that the visit can be telemedicine because the evidence supports a telemedicine visit is no worse than an in-person visit, then that's where the change is really dramatic.

So I think I'd break it down into two things. One is where telemedicine is just a tool that can be embedded within the measure, but you don't need to say it because it doesn't tell you how to accomplish the goal within the measure, so we can stay silent on that.

That's actually probably most of the

outcome measures, then it's actually the process measures that tell you, "You need to get A, B, or C done by such and such a date or time," and then we need to figure out whether telemedicine should be A, B, C, or D in the process measures, so our focus might actually be in the wrong spot.

MR. GOLDWATER: So a side note. So, Judd, if you're going to give me a Cheerio a day to control my diabetes, I'm never seeing you as a physician.

Chuck.

MEMBER DOARN: I'm curious from a management informatics perspective if these measures are, no matter what the focus area is, obviously, it has some things missing, if you change from ICD-9 to ICD-10 whether those measures would change and change appreciably, or if you look at DSM, the most current issue of the DSM, whether they would change as well.

And then not only things like dermatology and imaging and medication adherence, things like that, tele-stroke missing, I'm

wondering if patient management, the way we actually manage healthcare itself, I don't -- I mean, again, I don't know if there are measures out there in that regard, but if there are, they're probably in journals you probably didn't look at because they're not necessarily going to be telemedicine-related, so I'm just curious about that.

And then the last thing about falls, you know, telemedicine and telehealth's not going to prevent falls, but you're going to be able to monitor, on a patient-centered medical home be able to monitor where the patient is and actually be able to provide faster response, you know, maybe when the fall, you know, the meter on their wrist, you know, calls 911 or something. So that's the whole technology thing again.

MR. GOLDWATER: Stewart.

MEMBER FERGUSON: So actually, I'm going to follow-through on what Judd said because I've been thinking the same thing, and that is, are we trying to come up with measures that

measure the efficacy or value of telehealth or measure the value of programs that may or may not use telehealth because they're very different.

Most of these are program measures, and you may use telehealth for 10 or 50 or 100 percent of it, and it's hard to say, but it wouldn't tell you if telehealth was particularly effective. It tells you your program was effective.

You know, we do diabetes management. We might only use it for retinal screening, we might also use it for foot screening, or we may use it for something very minor. We just might measure their hemoglobin. We might get the same score in all three, but it wouldn't tell us if telehealth was particularly effective.

So I guess that's a question. Are we trying to come up with measures that really tell us if telehealth is effective or --

MR. GOLDWATER: Yes.

MEMBER FERGUSON: -- are we trying to come up --

MR. GOLDWATER: It's the former.

MEMBER FERGUSON: So we're trying to look for measures that are more focused and put a lens on telehealth?

MR. GOLDWATER: Yes, that's correct.

MEMBER FERGUSON: Because these actually don't really do that then very effectively.

MR. GOLDWATER: Okay. Okay.

Daniel.

MEMBER SPIEGEL: I actually just wanted to second what Judd said. I've been thinking about this for a few weeks now and trying to think of why would we want to change outcome measures. I'm struggling with, you know, how telemedicine or telehealth, whatever we call it, would make a difference in the outcome.

I mean, maybe it does make a difference in the outcome at the end of the day, but it doesn't make a difference in how we measure it, so I actually just wanted to second Judd's point.

MR. GOLDWATER: So before I get to Nate, let me try to recap what we've been told so far, and then focus that discussion as we move forward. So I think what I'm hearing from all of you passive-aggressive individuals is that you don't really like -- I'm kidding.

That although I think this was a good first effort, this isn't really providing the utility for telehealth that would be beneficial. And I appreciate -- I think we all three of us -- we greatly appreciate that and that really validates why we have all of you here.

So the next approach would be then to query the AHRQ database again, the NQF database, probably the meaningful use, although there'll be a lot of cross application, and not focus on outcome, but focus on process measures?

Is that some agreement or focus on outcome measures or process, or both?

Yael.

MEMBER HARRIS: I would say both. And one of the things I was going to throw out there

is that maybe we want to look at both general -- as we talked about -- things that we think telehealth could impact, and then look at specific conditions as well because they're both -- so when we look at tele-ICU, what -- let's think about what are the outcomes and the processes that we think it will impact that we want to measure, and then in general, let's think about why would we use telehealth. And then in general, what are the things that we want to measure there -- you know, timely care -- and are there measures related to that.

So I want to think in terms of specific use cases because we know telehealth has been very effective in certain areas, and there's outcome measures that would demonstrate that. And then we'd also want to demonstrate -- and there may not be measures out there, but at least think about what we would want -- areas where we know telehealth has an impact, but we don't know what measures are there -- is there a measure that already exists or should we start thinking about

a measure that could demonstrate this.

MR. GOLDWATER: Okay. So before I get to that -- so process and outcome measures, should they be only e-measures, so only electronic, or should they be chart-based and e-measures.

Okay, caveat to that, e-measures are ones that can be integrated into a registry or an EHR. Chart-based measures are, you abstract the information off of a chart, and then report that out.

If we are to go to both and you want to do process and outcome measures, you're roughly looking at potentially evaluating in excess of 8 to 900 measures. Which, you know, is commendable that you all want to do that, but I'm going to go on record and say you're probably not going to get that done.

So we do need to think of criteria to narrow that down so that we have a cohort of measures that you can examine and that we would then ask you -- and we would also do this

internally -- to evaluate the measures across the domains that we have already gone over, and those measures that fall into those most effectively would be the ones we would consider moving forward with, which we don't have to make a final decision until we meet in May.

Nate.

MEMBER GLADWELL: I just want to make an observational comment around outcome versus process measures. I think we don't -- my opinion is we don't want to go down the wormhole that core measures is probably still stuck in, which is, you know, the academic, say, process doesn't get to outcomes. You hope process gets to outcomes, but not necessarily.

And measuring process tends to be easier, so that typically is the measurement that gets created and tracked. I would like to really, really urge us to consider outcomes being the higher focus in terms of measurement. I'm not a measurement expert, but then we can avoid a lot of the issues that core measures run into and

other process-related measurements run into around evolving technologies and processes related to that.

MR. GOLDWATER: Okay.

Steven.

MEMBER HANDLER: So I think in an ideal world, we'd like to do both, but we have a limited amount of time and people, so I'm going to throw out some crazy ideas since I didn't get much sleep.

MR. GOLDWATER: You'll fit right in.

MEMBER HANDLER: Great. So is it possible to divide and conquer? Is it possible to break the group up into those who want to do process versus those who want to do outcome?

MR. GOLDWATER: It is, absolutely --

MEMBER HANDLER: Because --

MR. GOLDWATER: -- as long as there's concurrence on the group that the decisions that are made by each one of those subgroups are ones you go through with, and that --

MEMBER HANDLER: Only because it seems

to me that we all agree that they're important, but if we -- I think one of the most important things would be to figure that out today what we're going to do, what path we're going to take, but I would say that if we take a path, it should be outcomes also. I'm going to just vote that right now because we have to also understand who are we serving.

I mean, it all goes back to who is the most important stakeholder, right, and the funder, Megan, right. Well, I mean, no, really, so what -- so should we hear from our stakeholder, what does our main stakeholder want from this, what is the outcome. I mean --

MEMBER MEACHAM: Well, so I didn't -- I didn't want to, you know, bias or sway. I want this to be a true consensus-based entity outcome. I would say that there's been some discussion. I think I've been nodding a little bit more. We really want to be able to compare the telehealth -- care provided through telehealth versus care provided in other ways or not provided at all to

the extent that's possible to really compare.

I think I understand where you're going with actually picking a list of measures, whether they be process or outcome. But I think ultimately, it's more important to look at that end goal of how do we differentiate the modality that the care was provided so that the comparisons can be made and it's apples to apples and not apples to oranges or two separate sets of measures.

And then -- because we run into this issue with rural a lot where, you know, rural development for measures, but then they don't really match up with the measures that are being used mainstream, and then we can never really compare the care that's provided in rural and urban, but really we need measures that just work in all settings.

So that's where we're getting with the telehealth as well. But I think, you know, in -- you know, that's our bias, but we also do understand that CMS, the payers, the providers

are also important, and that's where, you know, we're -- we wanted your all input because we can't think of it all.

So did I muddy that more than --

MR. GOLDWATER: No, not all. I think that was -- that was pretty clear actually.

Adam.

MEMBER DARKINS: I wanted to raise a flag about the implementation of these if they went forwards. I don't know whether that's normally something NQF thinks about.

MR. GOLDWATER: Yes, absolutely.

MEMBER DARKINS: But it's not easy to start a telehealth program if it's just 20 patients in the pilot, and part of that is a study. Doing some outcome measures is relatively easy, but if one is trying to grow a program, when I get back to managing across a network, some of the smaller organizations might most benefit from this, are going to be the ones that don't have the IT systems.

And if you're trying to get staff to

actually do the face -- the sort of cold face care of the patient to build up a huge administrative backload -- particularly in small rural primary care areas -- you're going to kill the whole thing without getting the measures.

So I think before thinking you're going to suddenly extract 600 measures, it should be much more focused and actually think of the practicalities of how we'd do it at the same time.

MR. GOLDWATER: Right. So, before I get to Daniel and Marybeth, you know, that's what I was going to bring up, which is we have to figure out some way of narrowing down that very large set of measures into a -- not just a workable cohort, but a workable cohort that could be implemented.

MEMBER DARKINS: Just as a follow-up. I just say to give you an example, tele-ICU.

MR. GOLDWATER: Right.

MEMBER DARKINS: There was no evidence that tele-ICU is beneficial in the sense that --

as far as I'm aware, unless something's changed -- there's not been a randomized controlled trial that shows the benefits to an intensivist physically if they're doing it virtually. So, to build a whole edifices of measures based on things for which there's evidence.

Now, practically, it makes ICU much easier to deliver in ways when you don't have an intensivist if that's the standard of care. So I think that part of the way to push this down is for some of these things there is no evidence that telehealth will impact, so one of the ways is perhaps look at things we actually do know it will impact and make it easier.

MR. GOLDWATER: Okay.

Marybeth.

MEMBER FARQUHAR: I agree that we should be looking at outcomes first and then process second. However, for the process -- to help narrow it a little bit, maybe we can do some crosscutting measures that would go across all of the -- all of the specialties that we're looking

at and the chronic conditions. That might help narrow the list a little bit.

MR. GOLDWATER: Paul.

MEMBER GIBONEY: So I'm trying to think about kind of what was -- what was being said about how do we come up with this comparison between, you know, something delivered by telehealth versus not by telehealth or not at all, and the concept of outcomes measures. And I guess -- I guess as I look at this list and think of all the other lists and all the comments that I completely agree with that the outcomes measures, you know, it's just -- it's just the right care however it's being delivered.

I just wonder if there is a way to pull out some of these outcomes measures, and then identify which of those measures are -- have a -- where telehealth has like a high rate of impact or not just -- I mean, you can kind of dream up the way telehealth would apply to any of these measures, but in some of them, you could say, oh, wow, telehealth is a real game-changer

in a certain scenario and a certain place.

And I'm wondering is there a way -- if we wanted to pursue the outcomes route -- is there a way to identify certain measures -- maybe even a handful of them -- where telehealth has a more dramatic impact or a more visible or obvious impact.

I'm not exactly sure which of those it would be, but I'm just kind of trying to think about how we get through a very large list of measures, and also address both the outcomes and process.

MR. GOLDWATER: Right. So before following up, I think, you know, one of the ideas, to go back to what Steven was proposing, was to look at those measures against the domains. And I think that the measures that meet the most domains or meet all of them in the minds of those that are evaluating would have the greatest impact on telehealth, and those are the ones we would move forward with or we would at least propose to move forward with when we

convene again.

The question I have -- which we'll get to, I guess, after the discussion is concluded -- is -- and I do want to stress this, you're talking about an awful lot of measures here if we do process an outcome. I mean a considerable number of measures, and we need to narrow that down so that it's a much more workable list.

Now, we can do that in one of two ways. We can define criteria that we can then go apply and do that when we pull down the list of measures from these databases, or you can tell us which categories or clinical areas are the most impactful with respect to telehealth and those are the measures that we focus on specifically.

Yael.

MEMBER HARRIS: So since I am the one who kind of resides wide, or at least NQF side about, oh, my God, you want to do all those measures, what if you started with e-measures, and then if there were areas where there are -- so we would identify where are the areas where we

really think we need to be measuring.

And if there is no e-measure in that area, then for those areas, go look at the non-e-measures. And so Kristi and I were talking about examples, which is timeliness of care. There may not be a good measure you can pull from an EHR for that, but that doesn't mean there isn't a good, you know, chart abstracted measure that you could use to time to cath.

You know, so there -- we don't have to start with the whole universe of measures. Start with what you have as e-measures, and then once we've -- that seem relevant, and once we've reviewed those, there are areas where we will still want measures in terms of timeliness of access, in terms of outcomes that would be or processes that really are important to measure for telehealth. And if those don't exist in e-measure, that's when we look to chart-based measures.

MR. GOLDWATER: Okay.

Henry.

MEMBER DEPHILLIPS: Just a couple of kind of guiding principles. I won't sound slow because you admonished the group, but I will say in this drawer, I'm not the sharpest knife. How's that?

So here's how I think about what we're trying to do. First of all, you know, when we look at the evidence, there's some, but then there's other things that telemedicine is even currently doing for which there is no evidence, right? So if we're relying on outcomes, we're going to fall short.

And I'm guessing the reason this group is here is because we need to like take the current situation, and then figure out something to move forward that sounds like a really good idea, but for which there's no evidence.

Same with measures. You know, I acknowledge this is a starting point. I actually agree with you, Todd. We should throw it out. I think we're better off with a fresh sheet of paper than we are with this. No offense, but --

but, you know, as I think about the conversation, I'm a real fan of sort of simplicity. I'm kind of a concrete thinker, so as we think about measures of telemedicine, you know, there's the way things are done before telemedicine came on the scene, and then there's kind of how things are done with telemedicine, right?

If you look at outcomes, the easiest one is mortality. Very easy to measure, not very subjective. Then you move up, and then there's morbidity, right, and then there's measures that make sense for each of the different forms of telemedicine. So, for example, for tele-stroke, a measure could be percentage of patients who are appropriate for thrombolytics and actually receive thrombolytics with and without a telemedicine program, whatever.

So I'm kind of thinking that as we develop measures, we -- and I agree with the outcomes approach. I think if we try to do process, it may be too much just given the scope and bandwidth of the group, although, maybe

later.

But as we think about outcomes, you know, for each of the different sort of flavors of telemedicine that are in the marketplace, there's probably a core set of medical issues that are addressed by each of those flavors, and there's probably a core set of reasonably well-known outcomes that are pretty acceptable for each of those sort of disease processes. And I think if we just start -- a starting point could be to focus on those outcomes sort of with and without a telemedicine component.

Going back to something David said, yes, there's a whole lot of entities that are going to have, like, traditional in-care, in-person care, and then like moving forward, it'll be partly in-person and partly with telemedicine. No reason you can't measure traditional care and -- with a blended telemedicine. That's not -- you can still measure that. Just because there's in-person care with the telemedicine group doesn't mean you have to throw it out.

So I guess I would -- my guess is if we stay kind of concrete, stay kind of near the center of the disease processes that the various flavors of telemedicine treat, look at sort of traditionally measured outcomes, and then layer in the impact of telemedicine, I think that might be a safe starting point.

MR. GOLDWATER: Chuck, I did see you, but Marcia did hers first, so wait. Go ahead.

CHAIR WARD: So I think Henry used the term flavors of telemedicine, and that's what comes to mind for me. And I'm hearing different things here. I'm hearing that it would be nice to have a set of measures that apply in all the flavors, and I think that's a really hard thing to do. It's a beautiful thing to do, but I think it's going to be a hard thing to do and it's going to be a very limited set of measures that would really apply everywhere.

When Yael and I worked on a project, we had all -- and it was just for tele-ed measures -- there were all condition measures,

like timeliness, length of stay, but then there were condition-specific measures, like tele-stroke and the timeliness, fibrinolytics, whatever, and so we probably need to decide whether we're going to do specialty and look at where measures are more clearly associated probably with the delivery of the telemedicine model or whether our goal is going to be coming up with the crosscutting whatever.

MR. GOLDWATER: I have an idea, but let me get to Chuck before he, you know, has a --

MEMBER DOARN: I think I solved it.

MR. GOLDWATER: You did? I can't wait to hear it.

MEMBER DOARN: If I ask everybody in the room to look at -- we have 10,000 patient records over here, I need to know how many patients have BMI of 90, take high blood pressure medicine in an age group whatever it is, would take us pretty much all week, right?

But if I have an informatics system, I press a couple -- you know, put a couple of

queries in there and I get the answer in a matter of minutes, perhaps seconds. So we know that there are already some measures already out there sort of on this now not so good of a piece of paper, right?

Why not -- why don't we develop a matrix. On the left side you have ICD-9, 10, 9 or 10 codes, key categories, we know what they are, they're published, you download it, put it in an Excel spreadsheet. It is tough? Can be used? Yes or no. Is there a measure? Yes or no. And then you put the measure in it.

And within -- by the end of this week, you'd know exactly what's missing. I mean, it's not rocket science.

MR. GOLDWATER: I understand.

MEMBER DOARN: I can say that because of rocket science. But the point is that it seems to me that, you know, we have all this information, but it's not being portrayed in the right way, so by putting it in a simple matrix -- again, an Excel spreadsheet or whatever tool you

want to use -- we know what the codes are -- we know what the categories are I should say, not necessarily the codes -- and it's telehealth -- you can use telehealth/telemedicine for virtually anything.

Is it smart to do that? Probably not, but if you know there are measures already in -- in some of these databases, you can put them in this sheet, you sort of have some of them here.

MR. GOLDWATER: Right.

MEMBER DOARN: And certainly within, you know, a few weeks, maybe months, you'd have that whole database built -- if you want to call it a database -- and then we could maybe send it out to the group and say what do you guys think.

Maybe divide us into five different categories and please look at these categories or these conditions, and then go back and say, yes, there's some telemedicine in here, there's not. I mean that's one way I think of organizing the information better --

MR. GOLDWATER: Okay.

MEMBER DOARN: Unless I'm like way off base.

MR. GOLDWATER: No, it's a perfectly good idea.

Megan.

MEMBER MEACHAM: And I'm going to ask Jason, Tracy, and Katie to just like cut my mic if I'm giving wrong information here.

MR. GOLDWATER: You're not.

MEMBER MEACHAM: But I think that -- and I don't want to give anyone a free pass to not come up with all the answers because I expect you to come up with all the answers, but in the event that you're not able to --

(Laughter.)

MEMBER MEACHAM: Oh, that's right. We'll talk later. We'll talk later. We'll just throw your report away and we'll just -- I'll give it to Yael to edit.

I just -- I also want to add that I think, you know, if, say, something -- there's just some roadblock and you can't get to an

answer, you can just make a recommendation in the report as well because this is going to go to CMS, it's going to go out to the public, and so I think, you know, not a full report of just recommendations and not coming to any type of consensus or plans moving forward, but I see a recommendation as perfectly acceptable.

Like in order to further this or to implement this, CMS would need to do XYZ or so and so would have to do this before we can figure out how to do this or a pilot would need to be had first. And I think that's a perfectly acceptable portion of the report, correct?

MR. GOLDWATER: Yes, absolutely. And my feeling is we're probably going to end up with that. Hopefully, not for the entire report, but I think there are going to be a couple of things where we're just simply going to run out of time.

The issues are going to take too long to delve into and to try to come up with a reasonable solution that can be implemented would be challenging, so we would have to then go

forward with recommendations. Assuming those recommendations are followed -- that's a big if -- but if they are, then we can convene again and decide how to operationalize those.

Judd, and then Steven, and then Angela.

CHAIR HOLLANDER: I think one of the reasons this conversation is difficult for me to follow at times is I'm questioning whether we're confusing a discussion on measure development -- which is not the purview of this committee -- with the discussion on developing a framework for measures.

So a lot of the discussion is around, oh, we know it works here. We have -- NQF has a really nice process and we've sort of skipped a step, right? We did an environmental scan to see where the evidence is, but we don't have that done yet, so it seemed to me that once the environmental scan is done, then we need to crosswalk that with the measures that do exist now.

And what we're really looking for is the framework development, and then where are the gaps between what we find on the environmental scan and where no measures exist. And in the end, we're really left with two things that to me are relatively simple, but complex to do.

One is, are we incorporating telemedicine by giving permission to use it into preexisting measures? That's largely what we're doing. And then, are we defining measures that need to be done to show telemedicine is -- that's really a study, are we really going to have measures that show telemedicine is as good as the alternatives. But that's not really what measures are.

Measures are after we've done the scan and we know telemedicine exists, are we getting it done and accomplishing our goals. So I think we're a little bit circular because the process you've laid out is perfect, but the discussion is a lot around developing measures, and that's not what we should be talking about.

MR. GOLDWATER: Right. So I think after Steven and Angela talk, let me sort of circle back, sort of summarize, and then propose a direction on going forward, and then we have Chuck's direction, and then we can decide which one is better, which will obviously be mine. I'm kidding.

Steven.

Just kidding, Chuck.

MEMBER HANDLER: I actually -- Judd, I think what you said is exactly what I was going to say. I think we're missing the whole purpose of the environmental scan, which is the evidence base for what works.

And I think that what we should all do is once that's done, if nothing else, is not just have a general recommendation, but what we should be doing is recommending the evidence. And we should compare the evidence to the metrics and measures that are available, look at the gaps where they don't exist, and perhaps what we recommend then is that additional measures -- we

don't do that, but additional measures be developed based on the gap between the evidence that suggest it works and what's not developed yet.

I think that's the perfect logical sequence. And I agree that nailed it for me frankly. That logic is now clear in my mind.

Getting back to the -- I don't know that we can do the ICD-9, 10 approach because -- and I do want to say this -- once again, there are many clinical environments that don't have -- I'll repeat this -- that don't have an electronic medical record, yes.

Nursing homes don't have electronic medical records, home health, many don't have electronic medical records, telemonitoring don't have, so we don't want to exclude these important clinical environments and just make -- make it quote unquote convenient to use an e-record or an e, you know, measure, so I'm going to just want to make sure that's clear to everybody that we can't just throw that out -- those important

environments away. That was a second soapbox statement. Sorry.

MR. GOLDWATER: Not a soapbox.

Angela.

MEMBER WALKER: This might also be what you're going to address and clarify more for me, but I'd like to know what the output is of this group and what its utilization will be, because I'm a little concerned if we think about using what we develop as a way to compare patient outcomes currently through either a standard practice or a telemedicine utilization. Because I would imagine that there's a lot of telemedicine already integrated into practices and workflows that people are doing, and so unless they're following strictly this is a clinical measure and we're going to test it in a brick and mortar standard clinic setting as we've always known versus a strict telemedicine that follows these specific practices, you're not going to get a very clear answer. And to do something like that would be --

MR. GOLDWATER: Right.

MEMBER WALKER: -- big and require a randomized controlled trial --

MR. GOLDWATER: Yes.

MEMBER WALKER: -- you know, with standard procedures and all of that.

MR. GOLDWATER: Yes, and IRB approval.

MEMBER WALKER: So I just want to know whatever it is that we -- exactly, whatever it is that we develop, we recognize and understand very clearly how it will practically be used so that we can best meet those practical applications.

MR. GOLDWATER: So let me clarify the ultimate purpose of the exercise when we finish in August. So it's to build a measure -- a framework that will provide a foundation for future measure development that specifically deals with telehealth -- telehealth outcomes, potentially telehealth processes, other factors of telehealth that we may not consider or other factors of telehealth that are still being developed -- that is adaptable and amenable to

future developments and technology.

Any good framework will always take advantage of what's already been done. You know, you don't want to start a framework and say we're going to do everything from new and not take into consideration what's being done.

Now, if -- for example, I sat and was a senior director on the health IT inpatient safety project when we did the same thing. That was a lot easier because that was what are all the measures of patient safety that already exist? There was no ambiguity. Either this helps save patients' lives or it does not. This is where error will happen or error will not occur. That was very simple to do. And then it was there was already a sociotechnical model that Hardeep Singh had developed that said here are the eight dimensions of patient safety, and we could use that as the foundation for the framework and build measures around those eight dimensions.

That was -- that was, you know, it

took time and discussion about what was important, how to prioritize what measures we wanted to include, but there was no ambiguity. There was these are patient safety measures or they're not.

This is a lot more difficult because there are not measures that specifically say if you use telehealth, we hope this will happen. There are no measures that state that. There are no measures that say the intersection of telehealth will cause Judd to give you a Cheeto a day to reduce your diabetes. I mean, I'm kidding, but, you know, there's nothing that says that.

And telehealth is measured in terms of what are the ultimate outcomes. And the problem is that there are a number of outcome measures that we already have that have already been published, that are already in use, that have already been endorsed, but they don't incorporate telehealth as a means of care delivery.

They don't -- they focus on an in-

person encounter. I go to the hospital and I have -- I'm having a heart attack, do they give me aspirin right away? I go to the physician's office, my BMI is over 25, they say, you need to do this and lose five percent of your weight when you come back in 90 days.

Those are the way the measures are shaped up. So the issue then was how do we -- building a foundation for future measure development will be somewhat challenging, but what we really have to then reach consensus on are what are the elements, what are the dimensions, what are the things every telehealth measure has to take into consideration?

It's the what's already existing that is problematic because what measures do we choose that we think we could incorporate into the framework that would discuss or would at least elucidate the effectiveness and utility of telehealth services. And that's challenging because do you -- what measures do you take?

Do you take just your outcome measures

because that's what everyone is interested in? And in particular that's what the federal government is interested in. They're not interested in process measures anymore.

They've been abundantly clear to us. As Elisa will say, they're really -- I mean, people are still going to submit them. That's just not going to -- it's not going to stop, but they really want outcome measures, they want patient-reported outcome measures.

That's the focus. That's why we chose outcomes initially. They're not really interested in process measures. But if we're going to do process measures or we're going to do outcome measures or we're going to do both of them, yes, Yael, that's a lot of measures. We're not intimidated by the fact that it's a lot of measures. The problem is what measures would be most impactful, what measures would be most useful.

So how do we take this large universe of measures -- I mean, there's 535 electronic

process measures that we could pull today. And I don't want you to go through that exercise of evaluating all of those. That's a lot to do.

Do we then finish the literature review, understand in the literature review analysis the areas of clinic -- the clinical areas of which telehealth is having the greatest impact, that we can see through the literature that that's undeniably true.

And we're not just going to do that by just systematically saying, oh, the preponderance of articles show that dermatology is affected by telehealth. I mean, one, we probably already know this.

I mean, we have proposed some statistical analysis to really show, is there is significance between the application of a telehealth modality and the outcome that they're referencing in the literature? And we will present to you what we found and show that these are the outcomes that are the strongest.

Once we get to that point, then do you

want us to start pulling the outcome and process measures that relate just to those areas of which we're indicating that telehealth has the strongest, most significant impact on, and then evaluate those measures -- as Steven proposed -- in a matrix that shows, you know, which ones meet all of these domains, and then those are the measures that we start to go forward with.

I'm perfectly fine with that. It's not that I don't like Chuck's ICD-9 -- ICD-9, ICD-10 example. I do because as much as I tease him, I really do like and respect him, and my eight-year-old thinks he's the coolest guy ever because he works for NASA. But the problem with that is is that in the measurement world, you know, ICD values are just really used as value sets.

They're just used to codify a clinical concept. And I really think listing all of the ICD values, and then trying to find cross-walking measures that match to those ICD-10 values, one, it's going to take a lot of time.

(Off microphone comment.)

MR. GOLDWATER: Right, but still you're talking about not just a significant amount of time, but also I'm not -- I would want to make sure that there's utility to that. I think one of the approaches to sort of incorporate what I'm saying and what you're saying is once the literature review is done, we have an idea of these fields of where we think telehealth will be very impactful and the data is showing that, that we pull out outcome and process measures.

I would strongly suggest at the moment we stay with electronic ones initially. If you find that there are gaps in what's not there, then we'll go to the claims-based measures. And I'm not saying that for my benefit, Tracy's or Katie's because we have a gazillion things. It's for your benefit because I'm not -- I don't want to give you a matrix of 400 measures, then go, Angela, good luck, you got two weeks, no complaining, this is what you wanted, and blame

it on Al if you really get upset, right?

So don't -- you know, that's the -- what's that? No, I'll always blame Al, but it's just the -- I think that's that kind of the better approach.

And then while we're taking like here's the measure, here's the clinical focus area, here are the measures, here's the five domains, mark off if you think tele -- if it fits into all, which one of these it fits off into, here are the ICD codes that it represents, then I think we combine both of those together.

Does that sound like a reasonable idea to go forward with? In that case, you know, we'll probably have this to you in mid-January because the environmental scan will be finished at the -- I think it's the beginning of January, correct, we have to have it done? The 5th, and then it's going to have to go to you all for review. It will have to also go out for public comment.

I think once we get the review back

from you, then we can start pulling the measures. And you can all start the exercise and we can actually -- when we convene again in March, we can then go over this and determine which ones we want to use.

Is that a better approach?

(No audible response.)

MR. GOLDWATER: If you really want to take a vote, Don --

MEMBER GRAF: I'm asking you if you want to.

MR. GOLDWATER: No. I mean, at this point -- what's that? Yes. Does anyone not like the idea? The ayes have it, and so -- do you not like the idea?

MEMBER SPIEGEL: No, I don't mind the idea. I just want to --

MR. GOLDWATER: You're totally outnumbered, dude, really.

(Laughter.)

MEMBER SPIEGEL: I don't mind the idea. I just want to say that it's not important

that we look at every single measure.

MR. GOLDWATER: Right.

MEMBER SPIEGEL: It's important that we get a representative sample --

MR. GOLDWATER: Yes.

MEMBER SPIEGEL: -- of the different types of measures that allow us to create the framework.

MR. GOLDWATER: That's correct.

MEMBER SPIEGEL: And I think we should be cautious when we're going through these measures to not include any that are unnecessary.

MR. GOLDWATER: Right.

MEMBER SPIEGEL: So just wanted to say that.

MR. GOLDWATER: Right. So I think -- again, I think when we have the areas of where we're understanding they're most impactful, that the literature and the analysis support, we'll make sure that the process and outcome electronic measures directly relate to those -- I mean, I couldn't agree with you more, Daniel.

I don't -- we don't want to have superfluous measures. We look at enough of those in the course of the day.

Adam.

MEMBER DARKINS: I agree with what's been said, and just for thought, again, I come back to telehealth doesn't in its own right change some of the things, so we go through an evidence review and we end up studies of 50, 100, 150 patients, which are really neither here nor there.

There is equivocal evidence, so in the end, it's not the one other thing to perhaps run in parallel and think of. If I want to think of a rationale for telehealth, then one of the things you could base it on is the IOM and Crossing the Quality Chasm.

So the issue is not whether or not telehealth is used for type 1 diabetes. It's how it helps coordinate the recognized problems of the barriers between the different pieces, the healthcare system, and how you bring it together,

so how you coordinate those pieces together.

So if I want to look -- and so, the value of telehealth is -- and the coordination, if you'd like, the holistic management of patient across the different sectors, there's a piece around it where to be of value and thinking about take your program out. One of the difficulties is to show just locally that your benefits and patients aren't deteriorating.

So you create a new program, you want to end up managing people in primary care and secondary care link together, so pure -- but to dissect out, there are going to be some people who have had telehealth, some people had a bit of telehealth, some people had no telehealth. You're going to have this hodgepodge of how you're actually going to make sense of what it is.

So if one ended up saying that you used existing measures, but what we'd really like to see is how well it was coordinated, so it isn't kind of in there. But one of the other pieces would be, is there a way you can actually

bring together the coordination between the different pieces. Because that's really -- and that strength is going back to the IOM, which for me has always been something to base it on. Otherwise, we're just going to get something which is just a bit of a hodgepodge --

MR. GOLDWATER: Right.

MEMBER DARKINS: -- where you say, well, we're managing diabetes, where are we managing it, how are we managing it. Does that --

MR. GOLDWATER: It makes perfect sense. So I think when we -- again, when we meet again and we have, I think, hopefully, a cohort of measures, part of that discussion is, how do we effectively tie this into telehealth through care coordination, incorporating dimensions of the framework, expanding out the measure, whatever it may be.

I agree, I think, just taking a straight cut of measures and saying, okay, now these for telehealth. In some cases that might

work and some cases, it'll necessitate future discussion, so point well stated.

Sarah.

MEMBER SOSSONG: I was just curious if you could clarify at what point in the process we'll do the gap analysis and be able to add measures. I think part of it is collecting everything that's in the literature, but then -- and I think, to Dale's point earlier, I too have a list of 50 things that I've been tracking over the years that -- there are just too many things for us to internally measure, and it didn't make sense for MGH to do it alone.

Again, I think, you know, if every one of us sent you the top 20 things that we --

MR. GOLDWATER: Oh, please, please don't do that.

MEMBER SOSSONG: But I think that just because it's not in the literature doesn't mean that it's not important.

MR. GOLDWATER: I understand.

MEMBER SOSSONG: So how -- where in

the process will we capture that, is my question.

MR. GOLDWATER: So I think that'll come down to the next meetings after we present that initial slate of measures. One of the things we would be instructing you to do is what's not there. You know, here's what we've seen, here's what the analysis shows, here's the measures that map to the analysis, but, Sarah, I don't foresee us coming up with here's 20 measures and all your problems are solved.

It's great. We just solved the -- I mean, Megan would be thrilled, I'd be thrilled, we'd all be thrilled, but I don't think that's going to happen. There are going to be gaps, and so it's important that you tell us what those gaps are and whether, one, we can go back and find a measure that maps to that gap or, b, whether that's going to necessitate a future development of a measure to map to meet that gap.

I mean, that's part of what NQF's process has always been, which is, what are the current gaps in measurement and how do we fill

those. Does that answer your question?

MEMBER SOSSONG: I think so. I think ultimately what I'm hoping for is that we can ultimately just agree on 20 things that we will measure. I think right now there's just such -- every organization is doing it their own way.

MR. GOLDWATER: Right.

MEMBER SOSSONG: Payers are doing it differently. So I think it will not be perfect. Whenever we land, it will not be perfect.

MR. GOLDWATER: No.

MEMBER SOSSONG: But just coming up with something as a starting place and I guess that's the whole point of the framework, but I think that will be a start for all of us in moving the agenda forward.

MR. GOLDWATER: So, Chuck, Sarah is now my new favorite person because we love when people are like, you know, it's not going to be perfect, but this is a great place to start. We really enjoy when people have that perspective because, again, we're not going to solve all the

problems of the world.

Dale.

MEMBER ALVERSON: Jason -- and I'll defer it to your experience and the staff's experience from NQF. And maybe you can help me with just responding to a specific case example. I'm just picking this out as one example.

And let's take tele-stroke, okay? So the outcome measure that we're looking at with tele-stroke is there are more eligible patients who would be eligible for tPA being treated with tPA. We're not trying to prove that tPA makes it -- is going to improve the outcome of stroke. That's pretty well established.

MR. GOLDWATER: Can you explain what tPA is for the non-clinicals?

MEMBER ALVERSON: I'm sorry. Tissue plasminogen activator, so it's a clot-dissolving drug. But the point -- the point is, we're not trying to do that, but we're trying to show that, that more patients who are eligible for that treatment -- which decreases the risk of brain

damage, maybe even eliminates brain damage for ischemic organ death.

So what -- what I -- when I'm trying to get input from you is there already is evidence that patients treated with this clot-dissolving drug will have better outcomes. We're just trying to show that if you use telehealth that we'll get more patients who are eligible for that treatment on treatment. And we're already showing that. I mean many of us are.

So how do we develop that into an outcome measure to make sense that you would say, that makes sense. Because it's not that we're trying to say this clot-dissolving drug improve outcomes for patients with ischemic stroke, but does telehealth improve getting more patients on treatment.

Where does that fit in to your approach as an outcome measure? Because that's what -- that's just one small example. I used already diabetic retinopathy detecting --

MR. GOLDWATER: Right.

MEMBER ALVERSON: -- sight-threatening retinopathy early, preventing blindness. So how do we fit that into an outcome measure that makes sense from NQF's standpoint?

MR. GOLDWATER: So it's not a measure already, it's just something you're tracking or is it a --

MEMBER ALVERSON: Right. I mean --

MR. GOLDWATER: It is a measure? It's a measure --

MEMBER ALVERSON: Right, it's a measure.

MR. GOLDWATER: Okay.

MEMBER ALVERSON: It's a measure. What telehealth does -- so what telehealth does is increases the number of patients who are eligible for that treatment that we know can have a positive outcome by using telehealth. I mean that's why we do tele-stroke.

I mean, many patients aren't being treated. Now that leads to a lot of other -- other effects that is if you prevent brain

damage, you prevent the need for rehabilitation, speech therapy, and so on. That leads to cost avoidance as well, as well as better outcome for that patient and a lot of other issues.

But I'm just trying to make sure I understand where that fits in to how NQF would look at that when we're not really trying to create a new measure, but where does telehealth impact that measure.

MR. GOLDWATER: Okay.

Marcia, I'll let you talk, and then I can answer that also.

CHAIR WARD: So I think that's a great example. There's a lot of studies of tele-stroke that have measured appropriate patients who receive the appropriate therapy. There are NQF-endorsed measures right now that is patient should -- appropriate patients should receive that appropriate therapy, and so there's going to be a great match there, and that's a good example I think for everybody to have in their mind of at least one measure is going to come out of this

that's got a strong evidence base.

MR. GOLDWATER: Right.

Jean.

MEMBER TURCOTTE: I just want to build on what Dale was talking about. My background is more the -- the ICU, the stroke, the tele-psychiatry.

MR. GOLDWATER: Right.

MEMBER TURCOTTE: And the outcomes -- I think we agree that the outcomes should be just as good, but in my world, a lot of what we struggle to measure and to look at is, is the process better.

Tele-ICU, we can look at all the various clinical outcomes, but the idea is when you have something like tele-ICU, you have an intensivist at that bedside within 90 seconds --

MR. GOLDWATER: Sure.

MEMBER TURCOTTE: -- and so everything that happens is so much better, but then how do you measure that?

MR. GOLDWATER: Right.

MEMBER TURCOTTE: It's the same with the tPA. You know, the gold standard is within 60 minutes that patient receives that tPA, but that doesn't mean -- the gold standard is to give it. We can't control every patient through telehealth that receives it may not do well, and every patient outside of telehealth may, but it has nothing to do with the fact that we've implemented the process.

MR. GOLDWATER: Right.

MEMBER TURCOTTE: So I just want to say that in support of that -- and I know we want to avoid the process -- but a lot of it really comes down to we're trying to prove that telehealth is a very viable way to deliver care --

MR. GOLDWATER: Sure.

MEMBER TURCOTTE: -- so we have -- how do we do that and not really look at process outcomes as well?

MR. GOLDWATER: So thank you all, both of you, for those comments. I think when we

start going down what we -- what we identify through our analysis and come up with those list of measures, there will obviously be measures that you probably have -- that have already been developed or are already being used that have a strong evidence base that demonstrate the utility of telehealth.

Those can be incorporated into that. I'm not -- you know, the list that we might come up with in January is by no means the end result, the final result, and the only thing we're going forward with. It will be the result of data and measures that we pulled from the available sources that we have.

There will be sources you all are going to have access to and know of that we're not going to have access to that. Now, you can send us those measures and we can incorporate that into the matrix or when we meet again, you can discuss how those need to be inputted into the matrix, and then we can all discuss them to make sure that's something we want to go forward

with.

But absolutely there is no desire to be excluding existing measures that are effectively providing an objective way of understanding the utility of the telehealth on either process or outcomes. That's certainly not anything we would want to exclude.

It's just our availability to get that information may be somewhat limited. So if you want to send that to me, Dale, you're more than welcome to and we'll include it. If not, we'll include it when we do the review in early May -- early March.

Does that sound reasonable?

(No audible response.)

MR. GOLDWATER: Okay. Any other questions?

(No audible response.)

MR. GOLDWATER: So I'm just amazed at how efficient we are. I'd love to say it's all me, so I will, it's all me. Okay, I'm totally kidding.

So I think we're pretty much where we need to be, so you want to take a break now?

(No audible response.)

MR. GOLDWATER: So why don't we take a break. We'll convene at 3:00, and then we'll start discussing the dimensions and elements of the framework for future measure development, not measures that already exist.

And, Judd, I will just go trash this to make you permanently -- all right.

Thank you all very much for a very productive discussion and helping us sort of frame this issue, which was challenging.

(Whereupon, the above-entitled matter went off the record at 2:54 p.m. and resumed at 3:06 p.m.)

MR. GOLDWATER: All right, so we are just past 3:00. Again, I want to thank all of you for all the vigorous discussion, and also a big thanks that we are on schedule. Elisa will tell you that keeping on schedule at an NQF meeting - Marybeth I'm sure can concur - is a

challenge to say the least.

So we're thrilled that we are right where we need to be, and I know that we're getting to the real bulk of what we want to discuss now. So that certainly bodes well, that we've got - I think we'll probably do this for about another hour. And then we'll probably break for the day and let you guys go change clothes, get ready for dinner, whatever you're going to go do, and then we'll convene again tomorrow and try to finish this out.

So what we're going to discuss now and tomorrow is the actual measure of framework. What we're going to look to try to develop that will be the foundation for future measure development in the area of Telehealth, something that is implementable, something that is actionable, and something that is flexible. So when robots come from the sky to take care of us we can find a way to measure.

So, you know, it's - and Chuck brings up a great point. Technology changes and evolves

all the time, and I think some of the complexities around developing frameworks and health IT is it sort of takes the snapshot right then. Like, this is where we are now and let's focus on now, and not necessarily sort of evolving it.

Technology is going to change, I mean, who would've known we'd have 35,000 mobile health apps that are available now and growing? I mean, how many of those are actually good - it's in the millions? Oh, so -- you're reading different data than me - so we have, you know, a large variety of those.

We've got smart watches, we've got smart phones, we - I don't know how many of you are wearing a Fitbit, I am wearing mine today. For all the physicians in the room, you will notice I am wearing it and I have averaged 10,000 steps for the last five days. Thank you very much. So -

(Off microphone comment.)

MR. GOLDWATER: What's that? I feel

great. I feel good, no stress, no anxiety, no anything.

(Off microphone comment.)

MR. GOLDWATER: Okay, thanks a lot Julie for wrecking my buzz at the moment.

(Off microphone comment.)

MR. GOLDWATER: No, no, no. I gave my daughter one of my old ones. She has no earthly idea what to do with it, she's just, you know, so anyway. All right, so we'll go ahead and begin our discussion of the measure framework. So let's get to the first slide which really is sort of the rationale, why we're going to do this. And what I want to first discuss is these questions that we pose because these will be published and will be part of why we are doing this.

And what I do want to know from all of you is, are these the right questions to ask? Do we need to add more or do we need to delete them? Do we need to alter them? A measure framework for Telehealth would help address its effects of

Telehealth services on quality, access, costs. So the first question is does Telehealth provide more timely access to appropriate health services? Does it - how does it affect patient's health and well-being as compared to the alternatives, which would be either - in this particular case, it would be no care at all.

How are the -- do the costs of Telehealth compare to the in person care delivery? Again, rewording this - I guess we're going to have to reword it based on our discussion earlier today. Were both patients and clinic -- what were the experiences of patients and clinicians with the services provided through Telehealth?

And then - again, probably changing this based on the conversation this morning - what's the effect of Telehealth on rural health providers and the economic health of rural communities? So looking at those five questions, are there ones we need to change, add, delete, so forth? Don?

MEMBER GRAF: Instead of rural, could we - could we say where access to care is difficult? So we're not getting stuck into this, how many --

MR. GOLDWATER: Sure, yes. Okay, perfect.

MEMBER GRAF: And just to help me remember in changing how does cost of Telehealth, is it costs including - costs, what I read in my checkbook, or costs savings as well?

MR. GOLDWATER: It's cost -- yes, it's cost savings, cost and cost savings.

MEMBER GRAF: Okay, thank you.

MR. GOLDWATER: Okay, anything else?

MEMBER MEACHAM: So just really quick, I'd want to - I'm fine with taking the word rural out, but I'd want to make sure that the group doesn't forget about rural. Anything we do come up with has to also work for rural, so thanks.

MR. GOLDWATER: Understood. Steve?

MEMBER NORTH: So I think that the

cost - the economic health of rural communities though. The benefit of keeping a stroke patient in a critical access hospital financially, for that rural hospital, is very different than preventing the transfer from the hospital in suburban, you know, Dallas to the big center in Dallas. Because of the economies of scale there - just the first city on my mind all the time, and I hate the Cowboys.

But anyway -- yes, so make sure HRSA gets that in the record too - but, so do we have to tease that out in some way? Because we're looking at - because it really is looking at two different measures - because I think economic health of rural communities is very important.

MR. GOLDWATER: Okay, any - Stewart?

MEMBER FERGUSON: So I am a Cleveland Browns fan, just in case --

MR. GOLDWATER: Oh, God. I'm so sorry.

MEMBER FERGUSON: So, you know, you guys can talk about your records. We haven't won

a game this year. So on number three, do you want to change it to how your costs of Telehealth compared to the alternatives rather than saying in person? In person is not always the opposite of Telehealth, and the alternative may be they don't get care and that has a cost obviously.

MR. GOLDWATER: Sure. Okay, Judd?

CHAIR HOLLANDER: And I think, you know, cost - is it to the patient, is it to the payer, is it to society? Can it be all of them? I mean, I know that's a really complicated thing to address and I guess we could leave it open. But, you know, maybe somewhere in this we'd want to say cost can be decided any one of these ways depending on the particular measure.

MR. GOLDWATER: Okay, Steven?

MEMBER HANDLER: So a couple points just in looking at this, as I retyped it just to - so alternatives probably isn't the best way to frame it either. Because - you may want to say to the current approach to care or something. We can wordsmith it, but it's not just no care at

all. You could think about it in the way that care is delivered, i.e. which clinicians are providing it through the same type of Telehealth or telemedicine services.

Or it could even be a different type of telemedicine, it could be Telehealth versus real, you know, synchronous, et cetera. So I think we need to think through that a little bit more, as I was thinking through that. And with regard to rural, because we view, or I view, nursing homes - once again, it's a more -- a different way of framing it is low resource or resource poor. Right? So they - oftentimes they'll say they have Wi-Fi, but their bandwidth is like, point, you know one two kilobytes per second. And they call that WiFi and connectivity, so that's not real. So another way of framing it is just resource poor settings.

MR. GOLDWATER: Okay. Okay, all right. Anyone else? Paul?

MEMBER GIBONEY: So that first one, it - there's an assumption there that faster is

always better, and something that we've been learning is that that actually is not true. When doctors talk and they're coordinating the care, sometimes they will come up with a plan that actually says I want to see the patient in-clinic, but they actually don't need to come in as soon as possible.

Like, like if my next available appointment is next week actually that's not optimal, because I want you to start a treatment and I'm going to see them in four weeks. You know, and a fracture is a good, you know, so someone has an appropriately reduced fracture. The orthopedic surgeon does actually not want to see them that week, they actually want to allow that fracture to heal.

So they can see them in four weeks, retake the X-ray, and see what happens. And so what we've been starting to explore and develop in our system is instead of just saying faster is better, starting to say what is the right time to - for that specialty care? Whatever that next

step is, whether it's being delivered in the medical home, whether it is being delivered in a couple of weeks.

And especially, I mean, ophthalmologists will tell you if they identify a patient with mild retinopathy, a disease in the eyes from diabetes, they actually don't want to see them in two weeks. Actually, their recommendation is three months or six months down the road to keep an eye on it. Right? And so, I don't know, I might - I mean, this is a very new concept that we're just exploring and it may even be too new for this. But I would almost say does Telehealth provide right, timely - the right access, the right time access to appropriate health service.

MR. GOLDWATER: Okay.

MEMBER GIBONEY: Instead of just this assumption that every patient is a cookie cutter, it doesn't matter their unique needs or unique co morbidities, faster is always better. And to be honest it's kind of a waste of resources when you

think of it that way.

MR. GOLDWATER: Right. Okay, let's - Stewart?

MEMBER FERGUSON: I thought we were moving away from questioning satisfaction, and I see it on your fourth bullet there. And earlier in the day we talked about clinician and patient, or clinician and patient experience.

MR. GOLDWATER: Yes.

MEMBER FERGUSON: Do we want to kind of change that to say to how do we tell how it's impacted the patient and clinician's experience? And not really just say satisfaction, that seems a little bit outright and not what we're looking for.

MR. GOLDWATER: Sure, okay. Before I call on Dale just let me make sure I write this down. All right, Dale, go ahead.

MEMBER ALVERSON: I just want to say how much I appreciate Stewart's really insightful comments. I do, I sincerely - see? But no, what I was going to -- I just want to reinforce

what Paul just said because it's the right care, at the right time, at the right place. And money of the things - many things we're finding in our experience with Telehealth is a lot of times you might be avoiding a transfer, but also an unnecessary referral.

And we've got tons of examples of that, they're anecdotal, but tons of that. So I don't know how to - what's the right modifier on timely, but it's true. Because a lot of the things -- they think a patient ought to be seen by somebody and you say no they don't. That's not even, that's not a necessary referral that you need to make, or you don't need to see them that soon, as you just mentioned.

But somehow I don't know how to - what's the best word to capture that, but it's, it's always, it's at the right time and right place. So I don't know if anybody else wants to comment on that, but we find that a lot. And I just talked to - I was at a meeting on Monday where that came up, where somebody was waiting.

I went to go transfer the patient, but they needed to see some -- an orthopedic surgeon or a neurosurgeon, but they really didn't. So we avoided that unnecessary use of resources.

MR. GOLDWATER: Chuck?

MEMBER DOARN: I -- so these five questions are the only five questions, or?

MR. GOLDWATER: No. I mean, these are the first five we came up with.

MEMBER DOARN: Oh, because I was thinking of how does Telehealth and telemedicine impact the work flow and the management of the actual provider -- provision of care? So if you have a, if you have a situation where -- and this, they've done this with UC Health with the city of Cincinnati. They have the Tele-medicine Clinic, or office, set up so you can go to that office.

And I asked my primary care physician when I was there, I said I've been reading all the stuff you're doing. He goes we're finally, we're doing this. How many cases have you done

this? Two, one of them was a demonstration and that was like six months ago.

And so, but say for instance it's up and it's robust, then the physicians are seeing patients every ten, 15 minutes -- well, normally. Then at maybe two every hour, two every two hours, whatever it is there's a work flow. And so how does that impact the overall structure of the office? That has cost associated with it, it has efficiency associated with it, but I'm not sure if that's an underlying theme for all of these or if it's a specific question by itself.

MR. GOLDWATER: I think it's a specific question by itself, I think it could certainly be looked at that way. Daniel?

MEMBER SPIEGEL: So I'm not sure if this belongs in here or not. It's closely related to costs, but I wonder if we should flesh out something about just overall utilization patterns. So utilization of the healthcare system overall and then shifting patterns and sites of care. Because I could see how

introducing Telehealth in a particular market or a particular environment could move patients around from one site of care to another, or increase certain types of visits and decrease others.

MR. GOLDWATER: Okay, Kristi?

MEMBER HENDERSON: Yes, I might be echoing what they just said, but I emphasize those again. Because I think the work flow is huge, the benefit to the work flow and research utilization, but also the workforce. We have a huge issue with workforce shortage, and this is what this is addressing in a lot of ways -- so those three combined.

MR. GOLDWATER: Okay. Judd?

CHAIR HOLLANDER: Yes, I think I'm just trying to summarize it in a question up top.

MR. GOLDWATER: Okay.

CHAIR HOLLANDER: And I think the big question is, you know, something like does Telehealth provide high value care? Or is Telehealth associated with improved value for

healthcare delivery? And then everything is really drilling down to that to some degree.

MR. GOLDWATER: Right. Steven?

MEMBER HANDLER: So, in my pseudo-delirium, since I did patient reach -- medication safety research for a decade. I just thought of, Paul, as you were thinking about this, this is the five rights of medication safety. Right? The right patient drug, dose, route, and time really could be the same framework for telemedicine.

I don't know if that's ever been said before, maybe the NQF can claim that, I don't have to. But really, that's really what it's all about. It's really the right -- selecting the right patient, using the right drug. You remove drug, and that's the type of telemedicine, right? Whether it's storm forward, you know, synchronize -- the dose would be the frequency. The route, we can play with that a little bit later. And then time -- but you get the point.

MR. GOLDWATER: I get the point.

MEMBER HANDLER: Give me another half an hour, I'll work it out, okay?

MR. GOLDWATER: Have a drink, get some sleep, we'll talk about it tomorrow, all right?

MEMBER HANDLER: Give me a half an hour to recharge.

(Off microphone comment.)

MEMBER HANDLER: Right, maybe some ICD10 codes so you can hear Chuck, and then we'll be good. The other point I was going to make is underscore that I agree, the socio-technical aspects of this, the work flow is really critical. And I think it's important, not just as it relates to satisfaction, but as it relates to the workforce.

My -- I have a theory that I believe that we can, if we do this right, we can empower and change nursing dynamics -- let's say in the nursing home, once again that's where I live -- and make people want to work in that environment. And also empower them and change the relationships between physicians and nurses and

-- where they want to work in that environment, et cetera. So I really hope that that's something that could be accomplished by the technology, changing them from the reporters of information to active clinicians engaged with -- as a team.

MR. GOLDWATR: Perfect. Angela?

MEMBER WALKER: So we can't, unfortunately, claim the five rights. They're already owned, but review them because they may applicable to things we will develop in Telehealth. In the clinical decision support space, they talk about the right information to right people, through the right channels and the right formats at the right times.

(Off microphone comment.)

MEMBER WALKER: Yes, so -- yes, so it's not developed by us bit we can use it.

(Off microphone comment.)

MEMBER WALKER: Or just add intel to health.

MR. GOLDWATER: Don?

MEMBER GRAF: In the practice management model, I wanted to make sure that as we consider increasing clinical efficiencies and expanding provider capacity -- I'm not sure whether they fit into of these questions or they're separate questions. But it's really just sort of changing the practice patterns when virtual capabilities are introduced into service delivery models.

MR. GOLDWATER: Marcia?

CHAIR WARD: So looping back to our domains, and we talked about structure is commonly a domain and we decided to not look at it because there aren't any measures. But people are talking about workforce and that's often considered a structural model. So did we miss something, you know, as we're talking about these things and, again, the domain set.

MR. GOLDWATER: So that does bring up a question, that if, I mean, there's clearly a consensus here that work flow and workforce needed to be added into one of the questions. So

I think what that would mean is that we would probably have to evaluate, at least examine, you know, some structural measures that exist that might relate to that.

I think that's, you know, the only real relevant thing to do because if it becomes an important part of the framework we have to build measures for that, and we should also look to see what exists. So off the top of my head, Marcia, from an e-measure standpoint, I don't know of any that are electronic in that four month structure. But certainly I think that's something we can look at, it's a great point. Just to add more measures that we can look at, that's right. Yes, Chuck?

MEMBER DOARN: I think part of that workforce discussion is also this concept of training. There -- although there are a number of -- I'm sure we all get these emails about this training program that's in San Diego -- or these training programs, that happens to be the one I saw the other day -- about getting a master's

degree in mobile health or e-health.

So there are education models out there now that are showing, whether it's a certificate program to, normally, four graduate level courses, that might be part of the evaluation. I know the ATA, usually on Saturday before the annual meeting, they have a series of educational activities to try to showcase what you should do and what you shouldn't do, and so forth. And so there might be some measures embedded in some of that that we could take a look at.

MR. GOLDWATER: Okay, great. Nate?

MEMBER GLADWELL: A couple of points, third bullet point question should be how do instead of how to. I thought I'd point that out. But no, instead of comparing Telehealth to in-person I think, and we might have captured it already, but what's the overall impact to cost of Telehealth. You look at a program like Project Echo, which there is no in-person meeting to compare it to, what is the cost of that to an

ecosystem of health? I think it's important.

MR. GOLDWATER: Okay. Stewart?

MEMBER FERGUSON: So I was going to add to that conversation about the five rights, and I thought maybe we could have five not lefts. So we could have not left without -- no, no -- not left without care, not left waiting, not left wasting money, not left dissatisfied, and not left sick.

MR. GOLDWATER: Pretty good. Stewart, please do me favor and email that to me. All right. No, seriously do email me that, Stewart, if you could. That would be -- I'm being not facetious, which is unusual for me, but I'm being really serious about doing that. Okay, any other comments on the questions? This is terrific, really, it's certainly issues we had not considered in the initial scan of the literature. Any other areas?

MEMBER HENDERSON: So I was sitting here looking at your structural measures, and there's several that actually are of interest.

Not, I mean, for example tracking of clinical results between visits. I hadn't even thought of that one, but that's what we're saying even with home monitoring. What are we able to do in between? So I think there's some in that structural category that may be of benefit to us.

MR. GOLDWATER: Are those e-measures or are they just regular measures?

MEMBER HENDERSON: Well, they're just your regular measures. And not all these, these are on your list, but -- not all of these are endorsed by NQF, but they're on your list under structure.

MR. GOLDWATER: Okay, all right. Kristi, we'll definitely look at, I mean, if this looks like it's going to become part of the framework then we're going to have to look at them.

MEMBER HENDERSON: Yes, there's nursing hours per -- yes, all that, yes.

MR. GOLDWATER: Right, yes. So I think we might have to do a somewhat of a

deviation from the e-measure space as it comes to structural measures. Because in terms of electronic measurement for structure measures, I know at NQF we only have two and none of them relate to what you just talked about. We might have to deviate away from that a little bit, but that's fine. Evelyn?

MEMBER NELSON: Where does the -- where do adherence to compliance measures fall? Are they in these structure measures or are they in the outcome measures?

MR. GOLDWATER: Adherence compliance, those would be process-based measures I think.

MEMBER NELSON: Because I think those continue to be important. And then I just, on that last question, I think of course economic health is important, but I think we're talking about broader community benefit, workforce. But just community engagement, those type of measures as well.

MR. GOLDWATER: Okay. Before we move on, I do want to tease out one thing. You know,

there was some consensus that economic health of rural communities is important. I think that would be important for HRSA as well, being the sponsor of this project. Can we, can you all expand a little bit on what are the important factors to consider when talk about economic health of rural communities? Go ahead, Nate.

MEMBER GLADWELL: Yes, I'll take the first stab. We work in six states that are mostly rural, so we think about this a lot. I mean I think there's a lot of opportunity that Telehealth provides for, particularly, local hospital/local providers -- rural or underserved, it doesn't matter -- where if Telehealth is provided in a timely way from the right level of care the patient's able to stay in the community. Thus impacting the hospital's bottom line at keeping one more patient, so that's one aspect. I mean, that's one narrow aspect and I'm sure there's a lot more that I missed. But that's just a critical component, is revenue generated by patients staying closer to home.

MR. GOLDWATER: Adam? Mic?

MEMBER DARKINS: Before I joined the clinic, just for an example, the hospital it would've closed if it weren't for the fact that services in telepathology and services for mental health were both provided remotely. So I think that's something which is worth considering, that for critical access hospitals there are ways you can help them.

MR. GOLDWATER: Can you expand a little bit? Why would they have closed?

MEMBER DARKIN: Couldn't get access to physicians in those areas.

MR. GOLDWATER: Okay.

MEMBER DARKIN: Parts the country where people, despite all inducements, didn't want to live.

MR. GOLDWATER: Kristi?

MEMBER HENDERSON: Yes -- just to expand on that -- so that's where I started all of my work, was with three critical access hospitals that were threatening to close. So we

were able to keep them open and increase local admissions 20%. It was a Band-Aid station before, so if you keep that, patients using the resources there, they -- it just expands into everything they say and do. And it's all a, you know, we were able to bring new businesses in because they had a thriving healthcare environment. So it's a huge issue, but I think that it can be understood.

MR. GOLDWATER: Sure, great. Don?

MEMBER GRAF: Kind of the opposite of what Nate was talking about. Rural hospitals that are using and relying on Telehealth technology that expand their population -- so that they're no longer considered rural, no longer ineligible for current reimbursement -- is, you know, kind of the opposite.

MR. GOLDWATER: Sure.

MEMBER GRAF: But an impact.

MR. GOLDWATER: Steve?

MEMBER NORTH: Thinking about additional services brought to rural communities

via Telehealth, telephramacology. You know, how do we, you know, lab oversight provided virtually. So are those falling under this or are they --

MR. GOLDWATER: Yes, absolutely. Eve-Lynn?

MEMBER NELSON: Also with recruitment and retention at the rural sites, just with more job satisfaction, less isolation, those sorts of things.

MR. GOLDWATER: Yael?

MEMBER HARRIS: I think I'm going to say, repeat what everyone else said basically. But that was all happening, Megan. I blame Megan. So basically bringing jobs to the community, we talked about. Also, getting trust within the community because if, you know, they think the hospital can treat conditions then the hospital gets training, whatever they need to provide that type of specialty service.

The entire cachet of the hospital and the community increases, which means that

patients feel the satisfaction, first of all. But they also have much more confidence in going to the hospital instead of bypassing that hospital and going to the one down the street. So, and then that results in jobs and revenue for the staff, and jobs outside of the medical team for people who could work in the hospital as well. So it supports the whole community.

MR. GOLDWATER: Sure. Dale?

MEMBER ALVERSON: Sort of following in that, one of the things that we talked about in Telehealth -- and again, I'm not sure how you get the measure on this. But when patients leave the community to get their care outside of the community, then they're spending their money outside of the community.

MR. GOLDWATER: Right.

MEMBER ALVERSON: So you're losing money in the community. By keeping the patient in the community, and the family in the community, it keeps the dollars there. The other thing that I wanted to add, and we actually are

working closely on the state level with economic development, is the fact that a lot of decisions about businesses to move to a community, they might actually find attractive if they look carefully at what kind of health services are available.

So if they can see that, the quality of healthcare being provided to the systems in that community, they're more apt to come and they're more apt to stay. So that's become a big issue in economic development, particularly in New Mexico and rural communities who would like to attract more business. And they're going to look at education, access to education, they're going to look at access to healthcare services.

The only thing I don't know, and again, I would look to all of you at NQF, is how do you measure that? But that's sort of the, that's sort of the promise of better healthcare in a community. It keeps the businesses there, it attracts businesses there.

MR. GOLDWATER: Right. Paul?

MEMBER GIBONEY: This applies to rural communities and the retention of physicians and all of that, but I think it goes broader is -- it's just the fact that a lot of the Telehealth technology is Project Echo, eConsult, others. Because they create this conversation, they are a great opportunity for dissemination of new information and new knowledge to providers.

So you've got a new medication that hits the market, and you've got a provider who's working in rural New Mexico or something like that, you know, Telehealth provides the opportunity for that provider to start using a new medicine that maybe they're not as familiar with because they've got the guidance.

Or the, you know, help from the specialist. And so, that only helps the economic of the rural communities by, you know, allowing the providers to stay there. But just in terms of dissemination of new therapies, new treatments, new approaches, overall Telehealth really contributes to that.

MR. GOLDWATER: Okay, sure. Stewart?

MEMBER FERGUSON: I wonder if it should be broadened to be socioeconomic health, and the reason I bring that up is it's hard, I think, sometimes to separate the two, especially in real remote communities, you know. Therapies, for instance are huge for us, and getting therapies out to rural areas is enormous. If we don't get therapies out there we don't have physical therapy, speech therapy.

People have trauma, they get in accidents, they don't recover well, that has an economic impact. It also has a social impact, isolates families with, you know, you have all those things. We have drug and rehab problems, we have suicide problems. We can only offer that through Telehealth and that has an economic impact, but it's got a much stronger impact on the community.

So, and I would like to echo what you said about the provider turnover. Provider turnover's huge in areas, and Telehealth keeps

providers. But it also lets you hire local providers and support them remotely, which is way cheaper than bringing in, you know, brand new nurses, so.

MR. GOLDWATER: Good point, very good point. Any other comments on the questions? Thank you all for this, this is -- not only does the list expand, I think it gets a lot more focused into those areas of Telehealth that are important. Dale?

MEMBER ALVERSON: On that last bullet because I think it's an important one, but how do you measure that? I mean, how do you measure the economic --

MR. GOLDWATER: No, you have to tell me how to do that. I'm not going to tell you how to do it, it's a framework though.

MEMBER ALVERSON: Well, you're the expert though.

MR. GOLDWATER: You have to.

MEMBER ALVERSON: I don't -- no, I mean, but I don't -- I'm thinking about what you

said, is it measurable? You know, and how, you know, so how do you measure that? Has there been any other aspects of what you've done at NQF where you kind of relate that to economic impact in the community?

MR. GOLDWATER: There's been a couple that relate to economics, but it's a very, very specific measure of a very, very specific condition that's costly. And by utilizing a particular process ahead of time, you reduce cost over a period of time. And then there's the analysis about if you prevent 30 day hospital readmissions, the cost savings that accrue as a result of that. Not to mentioned the life savings that occur as a result of that.

Again, I don't think that -- the point of these questions are some overarching about why the framework's going to be developed. And some of the issues the framework's going to address. I don't know if we have to specifically look at building a measure on how to appropriately address socioeconomic health as a whole. But we

can certainly look at measure concepts that talk about different elements of socioeconomic health that are perhaps measurable, and that still relates to that particular question.

If we find as we're moving along that -- and this really won't be decided until March, when we really start to drill into what these specific concepts are going to be. If we find that it's just becoming very difficult to objectively create concepts that measure, you know, some of the areas of provider retention or some of the socioeconomic areas that Stewart has described.

You know, we might talk about rewording that, or we might talk about perhaps rethinking that so that we can come up with something that would adequately reflect that. I don't think the question now is, you know, how can we measure that, I think it is overall what do you want the framework to reflect. And then as we start to develop the dimensions and elements of it, can we incorporate those to build

out those measures. And if we can't, then we move on to something.

I mean, that's, again, it's sort of a -- it's, this is not the hard and fast process that's set in stone. This is a fluid process that once we develop the final report, which all of you will have substantial input into, then it will be sort of complete. But you're right, there may be areas where we're not going to be able to come up with an objective concept. Adam?

MEMBER DARKIN: One other little piece just for completeness, just to put in, is the educational benefit. I think the education is not a formal education, but the fact that some people -- somebody might not have seen something since medical school. And to begin with, you end up -- they see something when they do a joint consultation, and after a while they then can take over doing it. And Project Echo formalizes that, in a way of doing it.

And I know where Steven's found it, but nursing homes, you can end up getting nursing

aides and others who really are -- they're not very well skilled, they don't know how to handle something. And after about three or four times when you help them through something, you end up finding you really enhanced the skills down the stream in terms of doing, which is a direct effect.

MR. GOLDWATER: Yes, great. Chuck?

CHAIR HOLLANDER: I think taking that, you know, maybe a step further, we haven't discussed resident training. You know, or, you know, we're actually looking at a program where we're going to use multi-party video. So that the attendings, who normally are at home and the next day signed a note, you know, can now be patched into the room or participate in the call. If not just to teach the residents, you know, medicine, but it also will teach them, you know, how to interact on Telehealth.

And so, I think there's a lot of opportunities to use this and actually demonstrate how it outcomes in trainees. You

know, are they better at doing A,B, and C by X period of time because they now get more mentorship without being too much of a burden to their supervising clinician.

MR. GOLDWATER: Okay. Sure, Nate?

MEMBER GLADWELL: One last impact on rural is one being able to send residents to rural locations. And having oversight from the, you know, from the central academic facility in a much more sophisticated way. And then two, when we think about studies -- when you look at medical studies, most studies are based on population density. Because that's where you can draw, you know, your participants.

We've started extending study applications out to rural locations to have a better understanding of how the impact of rural populations are on patient studies. And Telehealth certainly impacts that, so much more long term, longitudinal effect, but definitely impactful.

MR. GOLDWATER: Okay. Kristi?

MEMBER HENDERSON: Yes, so just to extend on that. It's not even just residents, it's so much bigger than that. It's everybody being able to practice at the top of their license and collaborate and co-manage. So it's around that, maximizing your resources, and Telehealth allows that to happen. So PAs and nurse practitioners, and all of those groups, the same thing.

MR. GOLDWATER: Okay, perfect. Great, any other comments or questions? Okay, next slide. All right, now the fun stuff. All right, so in building a framework there are dimensions and there are elements and the dimensions shape. And so for some of you that were in the Philadelphia meeting -- that Judd did a great job of putting together, it was an awful lot of fun -- these slides are going to look really familiar to you, so my apologies for the repetition.

But a framework has a definition, it has, you know, surrounds, how it's going to be defined, the elements or components from which

measures are going to be developed from. So, again, looking at the literature at the time that we were discussing our proposed approach to this. There were five dimensions that seemed to come to the top about how to incorporate this in a framework and that measures of Telehealth should incorporate these, one or more of these, in some way.

One of which is the technical capacity, is it safe, is it accurate? Diagnostic accuracy, does Telehealth, whatever modality of Telehealth, provide the correct diagnosis? What is the diagnostic impact? Does Telehealth provide useful information for a physician to appropriate care? What is the therapeutic impact? Does the Telehealth validity influence therapy? And then finally the patient outcome, which is overall does the use of Telehealth improve a patient's health?

So I probably want to spend the remaining 15 or 20 minutes -- I don't even think we're going to get through this in that. But I

do want to start with this, your thoughts on these dimensions. Are they -- are we describing these adequately -- accurately, rather? Are these dimensions adequate? Are they too overreaching because we're not going to be able to develop measures that are really going to get to this? Are there additional ones that we need to add or are there ones that we need to be removing? So, Adam?

MEMBER DARKIN: How do you overlap with the Joint Commission on things like this?

MR. GOLDWATER: I don't believe we are.

MEMBER DARKIN: Okay. And the only other thing I'd put in, kind of overlaps with patient safety, is continuity of operations. In the sense that, I mean, I find a really good way to understand whether a program is meaningful or not is to ask what people would do if the technology fails. And with a lot of programs, they end up saying well, we'd actually do what we always do, which means they've got commissions in

the exact same places doing exactly the same things.

So, reflectively, the program is redundant. If you've got something which is really providing quality, reducing cost, and is effective, then you really have a very good continuity of operations plan. A, to how you get the system back up as quickly as possible, and really it's sort of a disaster recovery. But if you can't get it out, have your -- shift patients elsewhere and deal with it.

MR. GOLDWATER: Great. Kristi?

MEMBER HENDERSON: So I may be saying partially the same thing, but it's around that coordination of care, so you prevent duplication or unnecessary treatment also.

MR. GOLDWATER: Okay, Yael?

MEMBER HARRIS: Well, you asked if we were overstating on the framework, and I think the framework is overstating to some extent. I think when you look at things like technical capacity, we're not measuring does the technology

work or not. So you have the component the technology, is the technology working is it not -- it's how did the technology impact care.

So you've got to assume the technology's working, or -- I think if we try to frame it too broadly we're looking at things that are not, shouldn't be the scope of this. It should be not looking at, you know, was the technology functioning, it should be looking at -- assuming the technology was working and that it was being used for the right purpose, you know, did it have the outcome we were hoping? Did it improve care, not harm, et cetera?

So, and I think that goes down around all of them, in terms of, you know, diagnostic accuracy. Well, if a doctor makes a wrong diagnosis was it because he used Telehealth versus -- or he or she, sorry -- or would he or she have made the same misdiagnosis in person as well? Or would there have been no diagnosis at all because there was no access to healthcare? So I just want to clarify that what we're saying

here is not putting everything on it's the fault or the responsibility of the technology, it's really technology as the enabler.

MR. GOLDWATER: No, so let me clarify before I get to anybody else. So for technical capacity we're not asking the broad question of is the technology working. What we're asking for is assuming the technology is being utilized, is it providing safe and accurate care through the delivery?

For diagnostic accuracy, through the use of Telehealth is a physician able to make a correct diagnosis. And though -- if you want to consider that being over reaching, my counter argument to that is that most of the articles about dermatology, particularly teledermatology, focus a lot on this.

That the use of images in-store and forward are indicating that physicians, or dermatologists, are able to make a correct diagnosis from the images that they are seeing that are being delivered by a nurse or a nurse

practitioner. They're taking a picture and sending it to a dermatologist, so that's why we're interested.

And I agree, we don't want to get broad because that's overstretching and not producing anything useful. So that's why all of these sort of italicized subsets are under there, to try to hint at what we're trying to get at. Steve?

MEMBER NORTH: As far as dimensions to the framework, something we've been spending some time talking about, economic impact. Is that appropriate here?

MR. GOLDWATER: Yes, but what specifically should we be looking at with economic impact? I mean --

MEMBER NORTH: There are a lot of things that fall under that umbrella, everything from the socioeconomic impact that Stewart was discussing to cost effectiveness of the delivering mechanism.

MR. GOLDWATER: Okay, Stewart?

MEMBER FERGUSON: I was actually going to say financial impact, same thing. I was thinking actually cost and return might be the two areas under that.

MR. GOLDWATER: Cost and return?

MEMBER FERGUSON: Cost and return.

MR. GOLDWATER: Okay. And again, I mean, when we come up with a dimension we want to keep sort of the subset very, very brief. Because it narrows it to a point where, you know, it's easier -- if you come up -- and again, for those of you that have developed, taken the onerous job of developing measures -- sorry, Marcia. When you have really broad parameters it's really difficult to build a measure. Because it's -- the level of detail that's necessary to put into that for how do you come up with a numerator and a denominator, and exclusions and exclusions.

It's hard, so when we talk about a framework dimension we really want to have a very brief statement that really narrows down these

sort of overarching ideas. So I think cost and return for economic impact is good and I think, hopefully, gets at the, some of the elements that Steve was talking about. Other thoughts, Judd?

CHAIR HOLLANDER: Sort of a friendly amendment to diagnostic accuracy, in that sometimes you don't need a diagnosis. You may be able to achieve the goals and get to the critical action that you need to make, but not know a diagnosis. So it may be just, you know, another sentence that goes with it in the document, but not -- you know, in my world it's about ruling out things, it's not about diagnosing things. And so I just need to get the right set of information to make a decision.

MR. GOLDWATER: Okay, Chuck?

MEMBER DOARN: When you talk about technical capacity, I have to think that there's two parts there. One is the people and one is the hardware/software. And a lot of times, you know, you might have the good intention of developing and I'll use the Divinci as an

example.

They put the Divinci in place in some hospital, I think it's in Knoxville. It's in the corner, never use it, because it's -- nobody knows how to use it or nobody thinks it's of value. And I think a lot of times in telemedicine, you know, even though you train people on how to use the equipment, the turnover is great. And we saw this several times over the last 25 or 30 years where you have the systems aren't, they're not maintainable.

Because the people who are supposed to maintain them don't have any idea, you know. And we learned this the hard way many times when the equipment was a lot more expensive. So I think, when you look at the technical capacity, to think about, not only the equipment itself, the software and hardware part, and how you maintain that with software licenses and so forth, but the people who are actually using it.

Whether it's an IT guy or gal or it's a physician, whether it's a nurse. Whoever is

using it, their level of competency, it becomes very critical I think in maintaining it. The systems are getting easier to use, but nevertheless there's still that concern.

MR. GOLDWATER: Okay. Daniel?

MEMBER SPIEGEL: Could you explain a little bit more what you mean by diagnostic impact? I guess in my mind adding more useful information to the diagnosis is supposed to reorient the differential. And then, ultimately, get you to a more accurate diagnosis. So what is, what's the difference there?

MR. GOLDWATER: So diagnostic -- and so I'm going to use the literature as the reference point here. So the way it was described was diagnostic accuracy really is, through the use of whatever modality of Telehealth you are using and wherever you are using it, is the provider. Whether it's a dermatologist, ophthalmologist, general practitioner, whoever it may be, are they able to make a correct diagnosis of the base of the

information they're receiving through the Telehealth application.

Can they get that and say, okay I know what this is? So again, we've looked at -- we have started to look like at a number of dermatology studies. I'm not focusing that because Angela's, like, right there. But I mentioned because, you know, it's very prominent in that literature, that they're taking a lot of high quality images and sending them to dermatologists. Who are commenting that the image quality is as high as if they would have taken it in their own office.

And from that, then they are able to make a correct diagnose off of what they see. The impact is, is what they are receiving useful enough? Is it something that is providing enough basis for which they are then able to make a diagnosis and then provide the appropriate care that comes with that? And where we've seen that in the literature has, to date, this is not everything, but to date, has been in the areas of

mental and behavioral health.

Where the information that is being sent to appropriate mental health therapists, particularly in areas where they're using the modality, like cognitive behavioral therapy. That they're getting information about a situation where somebody is suffering from generalized anxiety disorder or major depressive disorder, and understand from that then that they can then employ CBT as an appropriate therapeutic protocol.

So the impact of that information is they're able -- it's useful enough for them to then follow forward with what they need to do. If you think we're conflating those two terms and maybe one of them is maybe not necessary, that's perfectly fine. I'm just, again, pointing out what we found when we were reviewing the literature initially.

MEMBER SPIEGEL: Yes, I guess I just don't know if diagnostic accuracy and therapeutic impact cover it and if you need that additional

-- sorry, yes. I don't know if you need that additional diagnostic impact component, if those two other surrounding pieces are there.

MR. GOLDWATER: Okay.

MEMBER SOSSONG: My thought around that, maybe going to the process question, but when we think about the second opinions work we're doing, we're often -- it's not -- e-consults for derm are a great example, right?

Yes, you can compare an image side by side on the photo and on the skin. But with second opinions for example, we're looking at how often is there a change in diagnosis or a change in treatment plan or avoided surgery. So perhaps there's a broader term that would capture those types of things and examine all the e-consults. Are you avoiding a referral, avoiding surgery?

MR. GOLDWATER: Okay, Marcia? Mic?

CHAIR WARD: I'll learn eventually. Diagnostic accuracy, diagnostic impact and therapeutic impact into care decisions?

MR. GOLDWATER: Okay, so let me ask

this. What would your recommendation be? We take out diagnostic impact and leave the others, and then add, you know, economic impact would be, probably would replace diagnostic impact with the cost and return being the subset under that. Okay, Chuck?

MEMBER DOARN: I got picked first. I think diagnostic impact -- if you use telemedicine or Telehealth and the person is in their home and you're monitoring them remotely, the useful information that's coming out of that -- I'm not sure that's the right term. But I think that's different than accuracy, you know, you've been diagnosed with a disease.

There's a treatment protocol, you send the patient home, they take their medication, and then you're going to monitor them. You're going to continue to have an impact on managing their healthcare, so to me they're actually two separate things. And maybe they could be combined in some way, but I wouldn't delete them.

MR. GOLDWATER: Okay, Judd?

CHAIR HOLLANDER: I was going to echo very similar to what Chuck just said. I mean, if I was getting rid of one of them I'd get rid of accuracy and keep the impact. Because if you've got the impact right you've probably got the accuracy right, but I mean maybe it could be one, diagnostic accuracy and/or impact, so it depends on the specific disease, you choose one. But I would hate to eliminate impact because I think that's more important than accuracy.

MR. GOLDWATER: Okay. Henry?

MEMBER DEPHILLIPS: I care a little bit less about whether you collapse or keep the -- how you name everything. But, and I'll use our world as an example, all three of those have important elements in them that I think need to be preserved. So I would just be concerned about losing sight. So diagnostic accuracy, you know, in our world the number one diagnosis is sinusitis.

And the question everybody asks is how do you -- how does the diagnostic accuracy in

person compare with the diagnostic accuracy remote? So correct diagnosis is clearly on the radar of those who purchase the service, diagnostic impact is also important. So, you know, at the moment about 4% of the folks that use our service get referred on because they need something else that we don't offer. Like a lab test or an x-ray or, you know, whatever.

And so useful information is important because as more and more ubiquitous, inexpensive information gathering tools, like devices, the useful information will go up and your diagnostic impact is going to expand. You're going to be able to diagnose more using telemedicine then you would without the additional information. And then of course therapeutic impact and, Sarah, I think your example is a good one, even on the second opinion thing. Because if you are able to successfully avoid surgery, as an example, that is a therapeutic impact.

I mean, that patient got probably higher quality care because they didn't undergo a

procedure that they didn't need. So anyway, I would just advocate for all three of those -- the thought process around the three categories to be preserved even if you collapse them.

MR. GOLDWATER: Right, understood. Okay, Stewart?

MEMBER FERGUSON: I would actually keep therapeutic and collapse the other two, diagnostic. I don't like the phrase useful information, a lot of information is useful, we always use the phrase necessary and sufficient. And that's one of the things that happens a lot of times, is a very condensed model of information the physician gets. You have to make sure it's good quality images, but sometimes there has to be more with it.

So you need the necessary, minimally necessary and sufficient. But therapeutic, you know, planning treatment and doing those other things, are really separate from diagnosis. And so, I do echo what you were just saying, that we need to keep therapeutic on there as a separate

topic.

MR. GOLDWATER: Okay, Judd? Oh, Marcia? Mic?

CHAIR WARD: We talked about a whole bunch of other things, other concepts and I'm not seeing them on the list. And so, if this is a framework that's going to encompass everything, do we need to go back and revisit the workforce? And the things that aren't quite so clinical?

MR. GOLDWATER: I think when we get to tomorrow and we start looking at the elements, which we're going to map to the domains of the literature review. And we sort of understand how those intersect, that's at what point we can decide how you want to expand that. You know, how do you want to expand the elements? Do you want to expand the dimensions? Can some of those elements that you're talking about fit into one of those dimensions? Do we need to create a new dimension and new elements?

I mean, that's why we're ending at 4:00 and we'll talk about this tomorrow, because

that's a big talk. Because, again, this is so crucial to finishing this work is understanding the dimensions and the elements. And keep in mind something, when we finish the framework -- and this becomes the basis for measure development -- you don't have to put all of these in to every measure that you do. The measure's got to touch one or more, in that we have this -- because in every Telehealth measure that we look at we'll have one or more of these, and then we all know those are Telehealth measures.

When you reduce variability, you have, you encompass all of the elements, you hopefully have appropriate attribution. We sort of remove ourselves from some of the inherent problems of quality measurement that have sort of plagued the enterprise for quite a while. Do you have anything else to add, Henry? No? Well, Chuck did. Yes, Chuck, go ahead.

MEMBER DOARN: I'd like, you know, as I was thinking about earlier today, somebody made a comment about it being too clinically oriented.

And if you look at these five items, they're all clinical except the very first one. And there's nothing wrong with that, but maybe it becomes a six-legged table. And you have personnel or management or organization or, you know, some kind of term that's an actual management component of managing healthcare, managing personnel, managing the technology. Where -- because telemedicine and Telehealth aren't just necessarily about providing the best care.

I mean, that's the underlying theme, but part of doing it is -- you're doing it for a variety of reasons, there's the shortage of physicians, the shortage of allied health workers. The distance between point A and B is, you know, a million miles or whatever it is. So you -- I think that maybe there's room for that sixth category.

MR. GOLDWATER: I agree.

MEMBER DOARN: You know, and again we can talk more about it tomorrow.

MR. GOLDWATER: Yes, I think that's

something we've learned, which I'm grateful for, truly, that the three of us have gathered. Because a lot of what we've looked at from the literature, you know, is very clinically focused. It's about a particular clinical area of care and a study that's been done, and how they've utilized Telehealth regarding that. Whether it be ICU or stoke or dermatology or ophthalmology or whatever it may be.

So I'm very appreciative of really leveraging this expertise on the non-clinical elements of this. And I think those are found, you know, foundational elements for a framework. How we're going to incorporate those, you know whether they become dimensions or whether they become elements or what they may become, you know, that'll be tomorrow's discussion. But I think we'll really come out.

I'm very confident -- because I'm not letting any of you go home -- that by tomorrow, you know, we'll have a very solid list of elements and dimensions that we can then really

work from for the existing measures. And then, you know, how we come up with measure concepts when we meet in March. So I feel great about that, which is -- this is how I wanted to feel when I left, so thank you all. No thanks to you.

MEMBER DOARN: No, no it's -- but I think in that venue though, and again I was thinking of one of my graduate students, they're trying to look at one area of a particular thing that we're studying.

And I'm like, you know, go into this series of manuscripts and these journals and look for something different, right? This is all about developing apps and the struggle with people who are trying to do that. And so, in this venue there's a number of articles and health affairs that relate. I don't have any idea which journals you looked at.

MR. GOLDWATER: All of them.

MEMBER DOARN: But there may be -- there are several journals out there, maybe they're IT journals, maybe they're management,

maybe they're nursing journals, that are addressing some of these issues that are not even on the radar. Because we didn't think about that, I mean, I think using some of these new -- this new terminology, maybe, that we start pointing in that direction.

MR. GOLDWATER: No, I can certainly see after this we'll probably add on to the lit review -- I'm sorry to say that Katie -- for some terms. We -- the breadth of the literature that we have is fair in the sense that we've covered from Health Affairs to AJMC to New England Journal of Medicine to results from aim year conferences to ICS conferences to, you know, the things you go to, Chuck, that no one else goes to.

But a lot of these journals, computing journals, I mean a large variety of them -- and then your journal, Chuck, has been, you know, great. Right. So, but I think we'll probably -- it's almost needed that we'll have to go back, refine the search a little bit more to pull up

some of these non-clinical elements. But I think that'll be real helpful, and again I think I'm really appreciative. I know we all are very appreciative of just the added dimensions of this because it makes for a very robust framework. And will make for a great way to develop measures, so.

MEMBER DOARN: Is it possible for you to send us a list of the journals that you have looked at?

MR. GOLDWATER: So actually, by tomorrow we will post all of the articles that we've pulled to date. And we'll have it on the share point site that's accessible to all of you, so you can look at it whenever you want. And then as we get more we will post more on there. You'll see, I mean, you're going to see yourselves in some of them. So you're welcome ahead of time, right? Okay. All right, well I think that's going to end if for today. So, operator, if you could open up the line for public comment, please?

OPERATOR: If you would like to ask a question or make a comment please press Star 1. And we have no comments at this time.

MR. GOLDWATER: Okay and do we have any comments from the back? We do, Ann. Ann has comments, so.

MS. TRUJILLO: It s actually an offer and an observation. So in the description that you all developed, it was helpful and I was thinking about a pathway forward. And the complexity is staggering, but we will just offer this shared experience -- which I reached out to Jason and some of you already are on the CBT Telehealth services workgroup. That a parallel and complimentary process, to the one that you're engaged in, involved a decision by the CBT editorial panel to look at the CBT code set to -- which is a code set that describes services and procedures.

It does not describe outcomes. There are some codes, that's a latent set of codes around quality, but it's latent and it's only

CMS. So just a clarification, I'm talking about the codes that describe services and procedures. And so, a decision was made to update the code set to reflect new digital medicine, service and procedures. And the approach was to create three tranches.

The first tranche was those codes that the participants were aware that were being offered. And that the code as it exists today -- the description of the service and procedure today could serve as a descriptor for both in person and virtual. That was tranche number one. And based on an environmental scan, there is a new appendix to the code set for those codes that have an appendix that will -- I'm sorry, a modifier that will tell you whether or not the service is provided virtually or in person.

It will not tell you outcome and it will not tell you a quality measure, but it will tell you I provided the service. It doesn't tell you by what method, but it will tell you if it was in person or virtual. Right, it's technology

neutral.

The second tranche is a process that's ongoing, which are existing codes that may need modification. That the service can be provided both virtually and in person, and the current descriptor may intimate or explicitly provide that it is person. When, in fact, it can be offered both virtually and in person.

And the last tranche are those services and procedures that may not be described in any existing code. And may, in fact, may be a new service and procedure that has emerged as a result of these new technologies and services. The work remains ongoing, but in fact this effort can be both complementary and we can learn from this process.

And, perhaps, you all may be able to utilize our process. I address at least one aspect of what I heard a lot of folks talking about in here, how do we differentiate between whether the service went in person or virtual? And you may want to consider that in a

development of some of the measures, or use of existing measures.

There is, potentially, a way to know whether it was virtual or in person without altering the existing description of the quality measure. So it could reduce significantly at least the initial tranche of quality measures, that you may want to say yes these are quality measures as described that can be used both virtually and in person.

And we will be able to tell if there's an associated service that also is described as either virtual or in person. And have the benefit of growing the evidence base too, so that we will know over time whether or not there are differences between the in person and virtual as well. So we are happy to keep you updated.

MR. GOLDWATER: Please so.

MS. TRUJILLO: And we are happy to share with you all information about which services and procedures. We'll, as of January 1, 2017, be eligible for that modifier. And these

are for synchronous services, asynchronous is present some interesting issues that we think you're going to run into as well. So I think that'll be opportunities for us to talk. Thank you.

MR. GOLDWATER: Great, terrific, any other comments? All right, thank you all so much. Enjoy dinner at Siroc, it's amazing, and do not believe a word Tracy and Katie say about me at all. Thank you.

(Whereupon, the above-entitled matter went off the record at 4:12 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Creating a Framework to Support Measure Development for Telehealth

Before: NQF

Date: 11-16-16

Place: Washington, DC

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

Neal R. Gross

Court Reporter