

NATIONAL QUALITY FORUM

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

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THURSDAY
NOVEMBER 17, 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:

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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

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

CHARLES DOARN, MBA, Professor, Family and Community Medicine, University of Cincinnati

MARYBETH FARQUHAR, PhD, MSN, RN, Vice President,
Quality, Research & Measurement, URAC

ARCHIBALD (STEWART) FERGUSON, PhD, Chief
Technology Officer, Alaska Native Tribal
Health Consortium

DAVID FLANNERY, MD, Medical Director, American
College of Medical Genetics and Genomics

PAUL GIBONEY, MD, Director of Specialty Care,
Los Angeles County Department of Health
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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
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Yael HARRIS, PhD, MHS, Senior Health Researcher,
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EVE-LYNN NELSON, PhD, Director & Professor, KU
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STEPHEN NORTH, MD, MPH, Regional Clinical and IT
Director/Practicing Physician, Mission
Medical Associates and Mission Community
Primary Care

PETER RASMUSSEN, MD, Medical Director, Distance
Health, Cleveland Clinic

SARAH SOSSONG, MPH, Director of Telehealth,

Massachusetts General Hospital

DANIEL SPIEGEL, MD, MBA, National Director of

Home Hemodialysis, DaVita, Healthcare

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DENNIS TRUONG, MD, Director of

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Physician-in-Chief, Kaiser Permanente Mid-

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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

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

2 9:04 a.m.

3 MR. GOLDWATER: Okay. Good morning,
4 everyone. Hope dinner was nice last night for
5 all of you that attended. Good, yes? Was she?
6 As always, yes.

7 Sorry I couldn't attend, but you'll be
8 happy to know, all my kids finished their
9 homework, studied for their quizzes, and were in
10 bed by 8:30, until my son decided to read his
11 book and stayed up until 11:00, but that will be
12 his third grade teacher's problem for today. So,
13 kidding, obviously.

14 Great to have you all back. We do
15 have two new entries to the group. So, apart
16 from missing the dinner and all of the fun,
17 snarky comments that went around yesterday, we
18 are really getting into the bulk of what we want
19 to do this morning and this afternoon, which is
20 to discuss the measure framework.

21 So, I guess, Marcia, at this point,
22 have the two introduce themselves and offer any

1 disclosures of interest, right? So, Dr.
2 Rasmussen, we'll start with you.

3 MEMBER RASMUSSEN: Hi, I'm Peter
4 Rasmussen.

5 MR. GOLDWATER: Microphone, turn your
6 microphone on.

7 MEMBER RASMUSSEN: Sorry, okay. That
8 shows I really am new to the group here. Peter
9 Rasmussen from Cleveland Clinic, trained as a
10 neurosurgeon, still practicing part time in that
11 regard, and I head up our medical directive for
12 our telemedicine or distance health program, as
13 we call it in Cleveland.

14 MR. GOLDWATER: Okay. And are there
15 any disclosures of interest you need to mention
16 to us?

17 MEMBER RASMUSSEN: Nothing relevant to
18 telemedicine, no.

19 MR. GOLDWATER: Okay, great.

20 MEMBER MOEWE: Hi. I'm Mary Moewe. I
21 work for the State of Tennessee in the Department
22 of e-Health. I'm the director. And I don't have

1 any disclosures.

2 MR. GOLDWATER: Terrific. And good
3 morning to you.

4 MEMBER MOEWE: Thank you.

5 MR. GOLDWATER: And so, there were many
6 talks about why we needed a purchaser here
7 yesterday, so thank you. Many questions I'm sure
8 will come your way to that.

9 I guess, before we begin the
10 discussion of the measure framework, Tracy talked
11 to me earlier this morning about, I think that
12 there needs to be a discussion of sort of what
13 NQF endorsement means, how a measure gets
14 endorsed, what that stamp of approval represents,
15 and how does that tie into this particular
16 project.

17 And as I said yesterday, we're not
18 here to develop measures. That is not the point.
19 We're here to develop a framework, which will be
20 a foundation for future measure development. So,
21 I think what we'll do is we'll take a few
22 minutes, let me describe sort of the process on

1 how a measure becomes endorsed, minus the
2 Schoolhouse Rock! animations and songs. And I
3 have Marcia and Katie here, so if I miss
4 something, by all means, please tell me that I'm
5 completely missing something and add in.

6 So, when NQF was founded almost 20,
7 over 20 years ago, 1999, the purpose was to sort
8 of be the neutral arbiter of examining and
9 evaluating measures against a very stringent set
10 of criteria to determine whether they were valid,
11 reliable, feasible and usable, and that, if they
12 passed that criteria, then the federal government
13 would then start to use them in their federal
14 quality reporting programs, which began in the
15 early part of the 2000s, as some of you may
16 remember, and have evolved over time where there
17 are a number of them.

18 And NQF's endorsement process, and so,
19 I'm sort of selling our organization here a
20 little bit, but it has been often thought of as
21 the gold standard for measure evaluation because
22 the criteria that is applied is so very strict.

1 And so, not every measure that comes to NQF gets
2 endorsed; there's plenty of measures that we have
3 rejected.

4 What's important to remember is that
5 NQF as an entity, it is not our decision as to
6 whether a measure is endorsed or whether a
7 measure is rejected. And I can just hear my
8 former colleague, somebody we loved and who has
9 recently passed, Reva Winkler, who would tell me,
10 make sure you're minding your own business and
11 don't get involved in things that don't involve
12 you, which she told me on a regular basis,
13 because she was in the office right next to me.

14 So, CMS will offer up clinical areas
15 in which they either, one, believe that there is
16 a gap in current quality measurement, or they
17 will continue to fund areas in which Quality
18 measures have already been developed and they
19 want to continue the cycle for additional
20 measures to be developed because science has
21 changed or there's still recognizable gaps and/or
22 because there is a need to, in this case, try to

1 transition from the way measures used to be
2 developed and collected, which is chart-
3 abstracted, into an electronic form.

4 And those clinical areas can run the
5 gamut from cardiovascular disease, which Judd sat
6 in on a panel, they can range from cancer to
7 surgery to behavioral health to care coordination
8 to a variety of areas.

9 And when those areas are released,
10 measure developers will often then either, one,
11 create measures that will then be submitted to
12 NQF, or they will take measures that have already
13 been developed, that may be chart-abstracted, and
14 converted them into an e-measure, which has been
15 happening quite frequently. Or there's a measure
16 that's already out there, that's been in use, and
17 that needs to be maintained. In other words, the
18 science has changed, perhaps, and the measure
19 needs to be modified or updated to reflect those
20 current changes in science.

21 So, many of these organizations do
22 this under contract. So, Mathematica, which Yael

1 represents, is probably, I would say, the largest
2 measure developer that works with CMS at the
3 moment. There are plenty of other organizations
4 that do work with CMS, the Lewin Group is another
5 one, I'm sure a lot of you are familiar with
6 them. Many of the specialty societies also do
7 measure development work. And they will create
8 measures and they will submit those to us by a
9 particular deadline.

10 So, the measures come to us and we
11 review them. Now, we don't review them because
12 we're looking to say, yes, they'll be endorsed,
13 or no, they won't, because, again, stay out of
14 things that don't involve you.

15 What we will do is review them to make
16 sure that the application is complete, that they
17 have filled out everything that they are supposed
18 to, that they have done the adequate amount of
19 testing necessary to indicate that they have,
20 then, a valid case to show that the measure is
21 valid, is feasible, is reliable and is usable.

22 And in the case of e-measures, which

1 we get a lot of, it's also, then, is it in the
2 right format, has it been aligned to the right
3 data model, are they using published value sets,
4 have they tested it in more than one EHR, which
5 is a requirement?

6 And we look this over and oftentimes
7 we'll have conversations with developers about
8 where there are areas in which we believe there
9 are questions that we need to be addressed.
10 Simply so that we can then make our own initial
11 assessment of, they've done everything they need
12 to do, here are our collective thoughts on what
13 we believe this is in relation to the criteria.

14 And once that's done, it then goes to
15 a standing committee. And a standing committee
16 is much like all of you: there's an open call
17 when we're starting a new committee for new
18 measures and individuals that have strong subject
19 matter knowledge in that particular clinical area
20 are invited to apply.

21 So, for cancer, for example, as I
22 mentioned yesterday, it would be very

1 distinguished, renowned hematologists,
2 oncologists, people that have significant
3 expertise in cancer care and would be able to
4 provide insight into whether the measures that
5 are in front of them would actually drive quality
6 improvement, which is really what the end goal of
7 a measure is supposed to.

8 So, we try very diligently, and
9 successfully, to have a very distinct
10 representation on these particular panels. So,
11 it's not just all doctors, it is consumer
12 advocates, it is payers, it is purchasers, it's
13 individuals that would be involved within that
14 clinical area of care.

15 The measures that are submitted will
16 then be put in front of them and individuals on
17 the committee are designated to review our
18 initial comments and then to discuss the measure
19 in front of the organization.

20 In addition to that, the actual
21 measure developer will come to the meeting and
22 describe their process of development. And the

1 measure steward, who is the one that ultimately
2 is the one that maintains the measure over time,
3 will also be present.

4 And we have a discussion about the
5 criteria of NQF as it applies to that measure and
6 the committee will vote every time we come to one
7 of those criteria points. So, they will discuss
8 the importance to measure and report and the
9 committee will vote yes or no.

10 They will vote on validity, they will
11 vote on reliability, they will vote on
12 feasibility, they will vote on usability, and
13 then they will ultimately vote whether or not
14 this should be recommended for endorsement.

15 If the measure fails on one of those
16 particular elements I mentioned above and the
17 committee says, this is not a feasible measure,
18 it doesn't go any further. Why would it? It's
19 not feasible, the committee feels it's not
20 feasible, it will not go forward for potential
21 endorsement. If they feel the measure is not
22 valid or the measure is not reliable, it will

1 fail.

2 If the measure goes through all of
3 those areas and the committee feels that it is
4 endorsed or it is potentially suitable for
5 endorsement, the process has now changed a little
6 bit, it goes just to the Executive Committee --
7 is that it at this point?

8 MS. WILSON: Yes. Once the measure is
9 reviewed by the standing committee and, as Jason
10 said, it goes through all the criteria, some of
11 which are must-pass, such as evidence,
12 reliability, validity, then the recommendation is
13 made whether to endorse this measure or not.

14 And then it goes to a separate
15 committee, it's called the CSAC, the Consensus
16 Standards Approval Committee, which is 17
17 individuals, many of whom have been on standing
18 committees and most of whom have been on the
19 standing committees and understand the
20 endorsement process.

21 And also, that committee must be
22 majority consumer purchaser, just as the NQF

1 Board must be consumer purchaser majority, it's
2 written into our bylaws. And then, they vote
3 whether to uphold the recommendations of the
4 standing committee.

5 So, as Jason said, the value of NQF
6 endorsement is, one, the rigor of the evaluation
7 criteria. It is the multi-stakeholder
8 environment in which those measures are reviewed.
9 It's also the transparency of the process,
10 because we're under the National Technology
11 Transfer and Advancement Act, so everything we do
12 is in the public domain. Anyone can come and
13 attend our meetings, anyone can make a comment on
14 the findings or the decisions of the standing
15 committee. There are multiple ways to make
16 comments. All webinars are open, all reports go
17 out on our website.

18 So, it's the rigor of the evaluation,
19 it is that it is -- measures are reviewed and can
20 be commented on by all types of stakeholders, and
21 then it is the transparency of the process. And
22 there is in statute language that says, for use,

1 as Jason said, in federal programs, the
2 preference is for an NQF-endorsed measure.

3 And if there -- if CMS or the federal
4 government wants to put a measure in a federal
5 program that is not NQF-endorsed, there must be a
6 rationale for doing so. Typically, the rationale
7 is there is no comparable NQF-endorsed measure.
8 So, that's a number of reasons why NQF
9 endorsement is held in high regard in the
10 measurement world.

11 MR. GOLDWATER: Right. And it's not
12 easy. I mean, we'll be blunt, it's a challenge,
13 there's a number of criteria that it has to meet,
14 and you're talking about a group of 25 to 30
15 individuals that have extensive knowledge and
16 expertise in this particular area, some of whom
17 are working day-to-day to provide care in that
18 particular area or those that pay or those that
19 run health plans that oversee this.

20 So, there are -- and then a lot of
21 consumer advocates that really understand where
22 the quality deficiencies lie. So, it's a very

1 rigorous process. And then -- so, when a measure
2 gets through and it's endorsed, then it's
3 acceptable for a federal reporting program.

4 And those, as you all know, and those
5 that have been around a while know that those
6 have evolved significantly over time. And that
7 now, we're in a world of value-based care, where
8 pay-for-performance, which was a demo, as
9 Marybeth may recall, we're showing our age here
10 clearly, in the early part of the 2000s, is now
11 becoming pretty much going to be the standard of,
12 reimbursement will be based upon whether quality
13 metrics have been met.

14 So, the work here now takes on even
15 added importance, apart from what it was
16 beforehand. So, what does this mean for you all?
17 Are you developing measures? No.

18 Are the measures that we are looking
19 to include in the framework that are already
20 done, are they all NQF-endorsed? No, they
21 probably will not be, largely because some of the
22 measures that we would look at that would

1 correspond to a particular area, there may not be
2 very many NQF-endorsed measures.

3 It would be the preference, our
4 preference, that that would be the first line of
5 measures that we would look at, would be NQF-
6 endorsed measures, because we would know that
7 they have gone through that criteria and have
8 been passed. But that doesn't mean that they all
9 may be.

10 And that's just something, again,
11 after we get done with the literature review and
12 we know what we're looking at, we'll have a much
13 better idea and understanding of what NQF
14 measures are around.

15 When we develop the framework and
16 there is a platform by which measures can be
17 developed, does that mean those measures will be
18 NQF-endorsed? Well, not automatically, no.

19 The framework is really done to
20 provide a foundation on how to develop a measure
21 that corresponds to telehealth and to have the
22 appropriate dimensions and elements so that it

1 reflects a telehealth modality and its use to
2 either incorporate a process or produce an
3 outcome, or in some cases, to be able to use for
4 structural purposes, which Kristi talked about
5 yesterday.

6 If that measure is going to be
7 endorsed, it would have to go through the same
8 process as any other measure.

9 So, one of the questions I'm imagining
10 is, oh, does that mean that CMS will open up a
11 telehealth project and people will submit
12 measures on just telehealth? I don't know, I
13 can't say that. My initial feeling is that that
14 probably will not be the case.

15 What would be the case is that they
16 may have a subject matter area of mental and
17 behavioral health where they want new measures to
18 be delivered and then, measures could be created
19 that incorporate telehealth that follow this
20 framework. And that those measures would then be
21 subject to the same rigorous evaluation that any
22 other measure would be.

1 And the good thing is, as we learned
2 yesterday, is that some of you have started doing
3 this work already. I mean, you have been in the
4 field, taking metrics, evaluating quality,
5 understanding the impact of telehealth on
6 specific outcomes. So, you've already done some
7 of that. And there's a lot of literature that
8 indicates that that's been done as well.

9 But my guess, and this is a guess, so
10 don't hold me to this, is that the use of
11 telehealth measures will be incorporated into
12 these clinical projects, like any other measure
13 would be: mental health, behavioral health,
14 chronic disease, cancer care, surgery.

15 And then, you have a framework to
16 build those measures, which we hope over time
17 would reduce variability, would increase the
18 appropriate attribution and would be able to be
19 linked to showing that there's strong evidence
20 base for this, because the indication is that the
21 use of a telehealth modality is leading to an
22 improvement in outcome or an improvement in our

1 process.

2 But if those measures are developed
3 and submitted, they would be subject to the same
4 rigorous evaluation that any other measure would
5 be. Did I leave anything out, Katie and Marcia?
6 Marcia?

7 CHAIR WARD: Let's see if I've learned
8 how to do this. Yes.

9 MR. GOLDWATER: Okay.

10 CHAIR WARD: So, for the framework,
11 following what you said, if the process heavily
12 goes in the direction of condition-specific
13 measures, should we be taking that into
14 consideration as we think about our framework?
15 Because we talked yesterday about the beauty of
16 all-condition measures.

17 MR. GOLDWATER: Right.

18 CHAIR WARD: Is there an implication
19 here?

20 MR. GOLDWATER: That's a good question
21 that I think we'll have to sort of see as we
22 unfold what this framework is going to look like.

1 If the measures are condition-specific, then,
2 yes, if you're going to develop measures that
3 way, then it would have to fall in that
4 particular clinical area for review.

5 If they're all-condition measures, and
6 there's an abundance of those, then we have to
7 probably talk about -- it would really indicate a
8 talk about CMS, about how they would want to
9 proceed forward on that.

10 MS. WILSON: Marcia, if I could as for
11 clarification, are you asking that question in
12 the context of thinking about getting these
13 measures endorsed? Was that the context? Or
14 just the, I don't want to say just, but the
15 framework? I was a little unclear as to your
16 question.

17 CHAIR WARD: I don't know.

18 (Laughter.)

19 CHAIR WARD: But, as I understand, what
20 we're really charged with and what we struggled
21 with yesterday --

22 MS. WILSON: Yes.

1 CHAIR WARD: -- is, what does this
2 mean, developing a framework? And --

3 MR. GOLDWATER: Right.

4 CHAIR WARD: And so --

5 MS. WILSON: Okay.

6 MR. GOLDWATER: Right. So, the other,
7 one of the other questions was, can we post a
8 framework report that we've done in the past on
9 the SharePoint site for people to observe? And,
10 yes, we're happy to do that.

11 Probably tomorrow, I'll, either Katie
12 or I will post the Health IT and Patient Safety
13 Framework on the SharePoint site along, again,
14 with all the articles that we have reviewed to
15 date, so that you all can take a look at this.

16 Again, this is going to be a little
17 different, because this is a little broader.
18 Health IT and Patient Safety was very specific,
19 because there was a very specific endpoint: does
20 this increase the safety of patients.

21 This is a little bit more widespread,
22 because, as you all have said, telehealth can

1 cover a large variety of areas and there's
2 already measures out there that cover those
3 areas, so it's really how to incorporate
4 telehealth in that appropriately. But we will
5 happily put a framework up so that you can get a
6 look at what that's like. Yes?

7 MS. LUSTIG: Actually, Katie told me
8 she's already put it up there --

9 MR. GOLDWATER: Wow, see?

10 MS. LUSTIG: -- for us. So --

11 MR. GOLDWATER: I just have an amazing
12 team, really. It's like, why do I blink? I
13 don't know. So, great. So, it's already up
14 there, so when you have a moment, please feel
15 free to look at that. That should give you some
16 idea of what we're trying to do.

17 Really, Marcia, to address your
18 question, the idea of the framework is to try to
19 identify the appropriate elements and dimensions
20 that really should be included in any telehealth
21 measure. And when we come back and convene again
22 in March, it's then -- that's all right. It's

1 probably the latest Cowboys news, so I'm fine
2 with that.

3 (Laughter.)

4 MR. GOLDWATER: So, the idea is that
5 when measures are going to be built around
6 telehealth, that those dimensions and elements
7 are incorporated, because then it will uniquely
8 distinguish a telehealth measure as opposed to
9 just a regular outcome measure that involves an
10 in-person encounter.

11 The other aspect of this is, when we
12 convene again in early March, we'll have at that
13 point hopefully come to a consensus on what those
14 elements and dimensions are and then we'll start
15 writing out what some of those concepts should
16 be, specific things that you think are very
17 important to telehealth that touch upon those
18 points and then that serves as sort of the
19 springboard for measures.

20 And you'll notice in the Health IT and
21 Patient Safety Framework, that they have those
22 dimensions. Now, those were already published,

1 so Hardeep Singh had already published his
2 sociotechnical model of patient safety and that -
3 - I mean, they had it easy, because that was just
4 like, well, that's what it's going to be.

5 And then, when we met, we had this
6 whole list of concepts that related to that. And
7 then if measures were going to be built off
8 patient safety, they would take those concepts
9 and build them into measures and it would reflect
10 the dimensions of the framework and the concepts.

11 Does that make more sense? Okay. So,
12 it's a very challenging project. I'm not sitting
13 here going, oh, this is just going to be a
14 breeze, this is not going to be easy, because
15 there's so much to cover and there's no published
16 framework available at this moment in time.

17 But what we are hoping to do is to try
18 to come to those areas where we understand that
19 there are important elements and dimensions to
20 include, that, really, telehealth should cover.
21 And we have proposed a list of things, which I'm
22 sure you all are going to tell me is okay in some

1 areas and not okay in others, and that's fine,
2 that's exactly what we want you to do, because we
3 want to get consensus amongst all of you of what
4 we need to go forward. Henry?

5 MEMBER DEPHILLIPS: Yes. I've been
6 thinking about this, yesterday's discussion and
7 you're conversation this morning. Just from kind
8 of a big-picture standpoint, I think, hopefully
9 this will be helpful, telemedicine is not a
10 different practice of medicine, there's not like
11 orthopedics, neurology and telemedicine.
12 Telemedicine is simply a tool that's used to
13 extend the current practice of all of medicine.

14 MR. GOLDWATER: Right.

15 MEMBER DEPHILLIPS: And so, I think
16 that may be a little, sort of, where part of the
17 challenge comes in. And then, when I think,
18 Marcia, about your comments yesterday and this
19 morning, I think that there are some things we
20 can look at that go across all of telemedicine.
21 And you've already got them listed from
22 yesterday, right?

1 Does it improve access to care,
2 regardless of what flavor of medicine? Does it
3 reduce the overall cost of care, regardless of
4 what flavor of medicine? And then, as far as
5 sort of -- when you get into sort of condition-
6 specific, I suppose we could look at, do
7 readmissions for asthmatics who are in a
8 telemedicine program lower than --

9 MR. GOLDWATER: Right.

10 MEMBER DEPHILLIPS: -- readmission
11 rates for asthmatics who are not? That's fine,
12 but to me, that's the distinction. I'm actually
13 even a little bit nervous that the AMA is
14 drafting separate telemedicine codes, because
15 that implies that telemedicine is a different
16 practice, whereas --

17 MR. GOLDWATER: Okay.

18 MEMBER DEPHILLIPS: -- I kind of like
19 the GT concept and the GQ concept, because it's
20 the same thing only using a different technology.
21 If that makes sense.

22 MR. GOLDWATER: All right. So, me let

1 throw in one little caveat, because I kind of
2 have to. And not a huge caveat. But I think all
3 of you know, because you've been doing this for a
4 long time, this is getting a lot of attention.
5 It's particularly getting a lot of attention on
6 Capitol Hill.

7 Regardless of the results of last
8 week, this is still an issue that has very strong
9 bipartisan support, particularly amongst
10 legislators that live in areas that have large
11 rural populations.

12 And there's a big desire to understand
13 more of the effectiveness of telehealth, because
14 as organizations like ATA continuously lobby to
15 try to remove some of the more pressing barriers
16 to widespread implementation, which, as all of
17 you know, mainly are reimbursement and the
18 certification issue, which has not gone away.

19 So, one of the reasons why this
20 project got funded, apart from, I think, HRSA's
21 vision and leadership about trying to develop a
22 way of adequately assessing this in numerous

1 communities, particularly those that are rural,
2 is also to try to advance the discussion of the
3 importance and value of telehealth so that, if
4 there are going to be legislative changes that
5 would expand telehealth, there is a body of
6 evidence to indicate that.

7 And so, that is what we have heard
8 from our folks in our police area here. When
9 I've gone to the Hill to talk to people about
10 this, that's generally the first thing that they
11 ask is, how can you demonstrate its utility and
12 effectiveness.

13 And while I could make the case and
14 say, it's just an extension of the practice of
15 medicine; it is just a different modality of
16 doing that, because of distance and access and
17 other issues, there's the desire to see concrete
18 results of, this is really helping in
19 dermatology, ophthalmology, cancer treatment,
20 whatever it may be.

21 And that, if there is enough of this
22 sort of evidence that builds, then there's the

1 greater -- it serves as a greater catalyst to
2 potentially change some of those areas that have
3 been sort of longstanding barriers.

4 So, I will say, the caveat here is,
5 that's not our directive, it's not to change the
6 law. The directive is to build a framework, but
7 part of the framework, and I think why AMA spoke
8 out about how they are going to potentially
9 modify their CPT codes to reflect telehealth
10 services, is in that vein because, again, the
11 desire to expand reimbursement and remove some of
12 these barriers. Chuck?

13 MEMBER DOARN: So, if I go to Google
14 Scholar and type in the term, framework for
15 measuring telemedicine, 27,500 things come up,
16 all of which were written before 2006. So,
17 there's a whole bunch. Just on the first page, A
18 Framework for Economic Evaluation of Telemedicine
19 --

20 MR. GOLDWATER: Right, we've look at
21 some of those, Chuck. Right.

22 MEMBER DOARN: But to say it's never

1 been done is not a true statement, it actually
2 has been done. Jay Sanders wrote some stuff,
3 Rashid Bashshur has written some stuff.

4 MR. GOLDWATER: Right.

5 MEMBER DOARN: So, I think it's
6 important to really go back, not just in the last
7 ten, 15 years, but really go back, because some
8 of that material may not be of any value, but
9 without looking at it, we don't know that for
10 sure. So --

11 MR. GOLDWATER: Okay.

12 MEMBER DOARN: -- really would caution
13 you to go back and look at --

14 MR. GOLDWATER: Right. So, as all of
15 you know, Dr. Bashshur is part of this committee.
16 He, because of health issues, couldn't be here in
17 person. So, Chuck, I did have an extensive
18 conversation with the man about the very
19 framework that he wrote.

20 And the frameworks that they were
21 developing were not necessarily about creating
22 measures of quality assessment, it was more

1 economic evaluation. It was more about cost and
2 cost-effectiveness, and several that were on
3 diagnostic accuracy, which we are looking at to
4 see how we could potentially incorporate that
5 into what we're doing.

6 So, there are, you're right, there are
7 frameworks that are being built, but there's no
8 framework at the moment that's sort of discussing
9 dimensions and elements that specifically relate
10 to quality of care that are exclusive to
11 telehealth. So, I probably needed to qualify
12 that. Adam?

13 MEMBER DARKINS: So, I get, it's very
14 helpful, what you said. The one thing I just
15 sort of ask is that it seems to me very
16 theoretical in the sense that, if you develop
17 frameworks, it's often very useful to do it
18 iteratively, with actually having the thing
19 you're doing to test against.

20 So, without considering what the
21 measures might be, it's almost as though it's one
22 step removed. So, if the function of this is to

1 provide a framework, that means it expands in the
2 way that people would like it to expand, it may
3 be totally out of kilter with the reality of what
4 then has to be implemented, if you don't actually
5 consider sort of the practicalities of the health
6 system it would go into --

7 MR. GOLDWATER: Right.

8 MEMBER DARKINS: -- and what those
9 measures might look like.

10 MR. GOLDWATER: Right.

11 MEMBER DARKINS: So, again, I don't
12 think that's a bad thing, but it would be helpful
13 to understand, is this intended to really be a
14 kind of more theoretical academic exercise to be
15 able to say, this should go into it? In which
16 case, I find it difficult to say -- the issue
17 around the measure is what you actually do and
18 some of the operational aspects then become
19 important.

20 MR. GOLDWATER: So, the answer is no,
21 this is not an academic exercise. If it were
22 almost exclusively academic, we'd be done by the

1 end of today, we wouldn't need to convene again
2 in March.

3 The reason we're going to convene
4 again in March is because, when we have the
5 framework, at least what we believe the framework
6 to be completed in terms of the dimensions
7 surrounding it, the elements that are important,
8 is then to actually get in and to develop measure
9 concepts that are very specific to telehealth,
10 ones that could be developed into measures and
11 implemented.

12 And then to also talk about, what is
13 the best way of implementing this framework so
14 measures can be developed? And that's going to
15 be the focus of the next two days that we get
16 together. I don't, and I know Tracy and Katie
17 and Marcia, we don't want this to be purely
18 academic, where it's a report that's --

19 MEMBER DARKINS: So, maybe you can
20 answer --

21 MR. GOLDWATER: -- just not actionable.

22 MEMBER DARKINS: -- in terms of what

1 that would look like. Does that mean, in the
2 next meeting, we'll hypothesize from the
3 framework that we've developed thus far what some
4 of those measures might look like? We won't
5 actually -- we might even recommend some
6 thoughts, but we won't actually -- they won't be
7 measures that will be taken forward, necessarily.
8 Because --

9 MR. GOLDWATER: Not necessarily.

10 MEMBER DARKINS: -- we'll pull back and
11 say, okay, we've kind of used this framework to
12 postulate how we might develop some measures --

13 MR. GOLDWATER: Yes.

14 MEMBER DARKINS: -- and, therefore,
15 pull back from that stage, done with it?

16 MR. GOLDWATER: That's right, that's
17 correct. The only other exception is that we
18 would hopefully at that point also include
19 measures that are already done, which we talked
20 about yesterday, and those are measures that you
21 could then go forward with as well and determine
22 how those could best be used into a telehealth

1 environment. Which is why you build a framework
2 and take what's already there and then look
3 towards the future to see what needs to be done.

4 David?

5 MEMBER FLANNERY: I'm one of several
6 dozen members of the AMA's Telehealth Services
7 Workgroup and I just want to clarify, we created
8 modifiers for codes that are appropriate to use
9 for telehealth.

10 The next thing, as Sylvia explained
11 yesterday, was to look at other codes that may be
12 used in a telehealth situation, but the
13 descriptor doesn't really include telehealth.
14 And so, then, editorial changes would be made to
15 those codes.

16 And then, there may be that third --
17 what did she call it? -- tranche, whatever a
18 tranche is, where you might say there are
19 services that are done by telehealth, but don't
20 have a code. And so, it's not going to blow up
21 the CPT system. They're trying to do it in an
22 evolutionary manner.

1 MR. GOLDWATER: David, you can watch
2 the Big Short, that'll talk to you about what
3 tranches are.

4 (Laughter.)

5 MR. GOLDWATER: It's very, very
6 educational. I actually think it's Anthony
7 Bourdain that explains that, ironically enough.
8 Yes? What's that? No, Chuck, it's not. Yes,
9 hi, Judd.

10 CHAIR HOLLANDER: So, I think what
11 makes this confusing for me and in some dinner
12 conversation last night is, when we're doing a
13 straight up telehealth measure, it seems pretty
14 straightforward and I think most of us
15 understand, particularly with your explanation
16 this morning, how the process works.

17 When we're looking at an Outcome
18 measure for a disease and telemedicine is one of
19 the things that someone may use, but not actually
20 measured, because the whole goal is just to
21 achieve that outcome, then it's a lot less clear,
22 at least to me, how we would develop a framework

1 for that or whether a framework even needs to
2 support that or whether we just need to mention
3 that if you're achieving the outcome and using
4 telehealth as one of the multiple things to
5 achieve the outcome, that's cool, we're good with
6 it.

7 But I don't know how to put a
8 framework around a bunch of in-person visits, a
9 bunch of text messages, a bunch of video visits,
10 three office visits, and meeting the 90-day goal
11 for mortality.

12 MR. GOLDWATER: So, that's the
13 challenge ahead of us, is, how do we best
14 represent that? And I hate to -- I know that's
15 sort of the typical bureaucratic answer, which
16 is, I'm dodging the question.

17 But I'm not dodging it in that the
18 idea is, again, what becomes sort of the
19 important elements in telehealth that, if we're
20 developing measures, need to be incorporated to
21 demonstrate its effectiveness and utility in
22 improving quality in a way that can be

1 demonstrated outside of this room and in a way
2 that, when measures are being developed around
3 telehealth, there is some consistency and lack of
4 variability.

5 And that concerns me, because having
6 done this for a long time, I told you yesterday,
7 the variability in measurement is significant.
8 And it has always been an inherent issue,
9 because, in the beginning, again dating myself,
10 there was a free for all for measure development.

11 There was -- we need measures in AMI,
12 we need measures in pneumonia, we need measures
13 in CABG, we need measures in COPD, and everybody
14 was developing measures, state-wide, regional-
15 wide, federal-wide. And they're all being used
16 and there's levels of variability between them.

17 What we want to do here is to take
18 what's already there, but incorporate the
19 appropriate elements and dimensions so that we
20 understand what a telehealth measure looks like.
21 So, yes, in some cases, Judd, it's not
22 necessarily going to be that much different from

1 perhaps an in-person measure.

2 And clearly, the outcome is still the
3 same, but how are we able to then link that back
4 to telehealth? Because that has a lot of effect
5 on how it would be reimbursed, whether or not
6 there needs to be adjustments to certification.
7 It goes a way in sort of removing, or at least
8 starting the discussion about, eliminating some
9 of those barriers that have been a hindrance to
10 telehealth being used much more widespread.

11 And I think those of us, including
12 yourself, that have been involved in this for a
13 long time, would probably state that one of the
14 reasons why telehealth has not been broadly used
15 nationally and consistently is the lack of some
16 objective metrics to evaluating its effect that
17 have been used on a national level.

18 So, that's what we're hoping to do.
19 And, again, emphasizing, it's not an easy task.
20 I mean, Sylvia from AMA talked to me yesterday
21 and said, you're taking on -- you're like
22 Sisyphus pushing the stone up the hill, which

1 wasn't the most encouraging thing to say --

2 (Laughter.)

3 MR. GOLDWATER: -- at that time,
4 because I know how that story ends. But I said
5 that I think that we're making a lot of progress,
6 I'm not looking to solve the issue today. And I
7 may -- I don't think we're looking maybe to solve
8 the issue in March. What we want to do is get
9 some consensus on what exactly needs to be
10 included in these measures and what concepts
11 really become important and crucial? Adam?

12 MEMBER DARKINS: One other thought,
13 just to say, comes back to coding. So, in order
14 to be able to do electronic quality assessment
15 for telehealth, one of the things you have to be
16 able to do is code the activity. So, the
17 conversation with CPT coding becomes one way to
18 do it.

19 MR. GOLDWATER: Right.

20 MEMBER DARKINS: So, it seems to me,
21 one of the things we should address is that.

22 MR. GOLDWATER: Yes.

1 MEMBER DARKINS: Because if you don't
2 systematically capture the activity that happens
3 --

4 MR. GOLDWATER: Right.

5 MEMBER DARKINS: -- the quality
6 initiative is going to end up as something that
7 really goes down the toilet.

8 MR. GOLDWATER: That's correct. And I
9 --

10 MEMBER DARKINS: So, I haven't seen
11 exactly --

12 MR. GOLDWATER: Right.

13 MEMBER DARKINS: -- how that fits into
14 our thinking. It doesn't mean we prescribe
15 whether it's -- but CPT coding does a very
16 specific thing, which doesn't necessarily fit
17 into how you end up doing quality measurement.

18 MR. GOLDWATER: Right.

19 MEMBER DARKINS: So, I don't -- if you
20 wouldn't mind just elaborating, if you have any
21 thoughts on that?

22 MR. GOLDWATER: I completely agree,

1 which is why we had that short discussion on how
2 we modify existing measures or modify frameworks
3 so we are appropriately coding the telehealth
4 activity. And we, in our research, couldn't find
5 anything that really provided us sort of a
6 schematic on how to do that, until we ran into
7 Sylvia, who said, they're thinking about
8 modifiers to the CPT.

9 Which I think is a good start to help
10 in that way. Is that the only thing to do?
11 Probably not, but I think that is certainly
12 somewhere to start to at least be able to
13 adequately reflect a telehealth encounter. Do we
14 need to possibly extend those modifications?
15 Yes, and I'm all ears as to what you suggest we
16 should be doing to incorporate that.

17 MEMBER DARKINS: So, we may not have
18 the answer. Do you expect that part of the
19 discussion documents that we have associated with
20 this would include it? The reason being, the
21 issues are, you've got multiple sites of care.
22 So a quality measurement is not on one site and

1 how you code for it. So, there is sort of, I
2 don't want to get into -- there's no point in
3 getting into the weeds.

4 MR. GOLDWATER: Right.

5 MEMBER DARKINS: But is that something
6 you want to actively do in the report?

7 MR. GOLDWATER: Yes.

8 MEMBER DARKINS: To end up saying, this
9 is an issue and discuss it?

10 MR. GOLDWATER: Yes.

11 MEMBER DARKINS: And that CPT coding
12 does this and, therefore, we may not come up with
13 a framework, but we could actually be there for a
14 reference, in terms of recommendations, so as
15 people move forward, they understand some of the
16 complexities --

17 MR. GOLDWATER: Right.

18 MEMBER DARKINS: -- of quality coding
19 for --

20 MR. GOLDWATER: That's exactly right.
21 And that goes back to sort of what Megan was
22 saying yesterday, which is, even if we don't come

1 up with the answer to that, then I would hope the
2 committee would come up with a strong
3 recommendation about what we need to be
4 considering in the future or what we need to be
5 leveraging that's existing now, or a combination
6 of the two, in the event that we are unable to
7 come up with a very structured methodology on how
8 to do this, which, Adam, you could very well be
9 right, we may not be able to come up with. And I
10 think there's an understanding that that proposes
11 some difficulty, but if we could come up with
12 recommendations about what we need to do, then I
13 think that that's perfectly satisfactory.

14 But, absolutely, that has to be part
15 of the final report. Absolutely. Because then
16 it -- coding, when it comes to Quality measures,
17 is absolutely crucial, particularly when you talk
18 about value sets and how clinical concepts are
19 represented. The delivery of care is also
20 represented, so we absolutely have to do that.

21 MEMBER DARKINS: So, I don't want to go
22 on, just one other thought, since it can be

1 captured. I think the other overlap it's worth
2 thinking with here, in terms of quality, is
3 workload credit. Because the two kind of align
4 somewhat.

5 MR. GOLDWATER: Right. Okay.

6 MEMBER DARKINS: So, if you -- just to
7 put it in the parking lot if it ever comes up in
8 the future --

9 MR. GOLDWATER: Sure.

10 MEMBER DARKINS: -- when you look at
11 your notes.

12 MR. GOLDWATER: Okay. Chuck, and then
13 we are going to have to get on --

14 MEMBER DOARN: Okay.

15 MR. GOLDWATER: -- to the --

16 MEMBER DOARN: I have Google. So,
17 Google knows everything. Framework for
18 measurement quality CPT codes for telehealth,
19 17,400 hits. I realize that that's ridiculous.

20 But there's a number of things here,
21 and again, when you're doing a literature search,
22 sometimes we may not be doing the right kind of -

1 - because right now, I don't know what kind of
2 literature search you've done, we haven't seen
3 that. So, I'm just going back and looking, even
4 in telemedicine/medicaid.gov, we talk about those
5 very same things.

6 MR. GOLDWATER: Okay.

7 MEMBER DOARN: So, there may be stuff
8 in some of these things that might be of value to
9 look at. We don't want to have a report in March
10 and say, here's the framework, and somebody comes
11 back and goes, oh, there's a framework that was
12 developed ten years ago. I'm just kidding, but
13 we want to make sure we don't leave any stone
14 unturned, even if we're pushing it uphill.

15 MR. GOLDWATER: Okay. All right. Any
16 other questions or comments?

17 MEMBER GRAF: Yes.

18 MR. GOLDWATER: Oh, hi, Don.

19 MEMBER GRAF: I just wanted to echo
20 what was said down here, and also regarding the
21 AMA's work, that it's just not the codes
22 themselves, the modifiers themselves, but the

1 rest of the information that's filled out and
2 submitted with the claim for reimbursement,
3 including things like place of service indicators
4 and other information that's used in audits that
5 can not only drive reimbursement, but also drive
6 retrospective review, all of which are around
7 quality. And so, when we have the discussion, we
8 shouldn't just limit it to the codes themselves.

9 MR. GOLDWATER: Got it. An excellent
10 point. That's a great point, Don, thanks. Any
11 other questions? Marcia or Katie, do you have
12 anything else you'd like to add to the discussion
13 on measure development? CDP process, MUC list,
14 all of the things we've grown to love? What's
15 that? Do you all know what a MUC list is? Yael,
16 explain what a MUC list is.

17 MEMBER HARRIS: And the MUD too?

18 MR. GOLDWATER: What's that?

19 MEMBER HARRIS: The MUD list too?

20 MR. GOLDWATER: Why not?

21 (Laughter.)

22 MEMBER HARRIS: I was joking, but I

1 could. So, CMS has two -- well, they have a very
2 robust process for identifying the measures that
3 they are either going to put forward to NQF for
4 endorsement or fund for further development.

5 So, the MUD list is the measures Under
6 Development. So, those are measures that CMS has
7 funded that are under development right now or
8 they plan to fund. Those measures have to go
9 through the entire CMS, which is about 5,000
10 employees now, and every single office within
11 CMS, to review and approve and agree to that
12 list.

13 That list is then released to the
14 public for public comment and then the public
15 comment is then incorporated and reviewed. So,
16 you get the final MUD list. Then, CMS decides
17 which ones are going to go on the MUC list, which
18 is the measures Under Consideration.

19 The MUC list goes through the same
20 process. So, it goes through all of CMS, then it
21 goes through public reporting, then it goes back
22 through all of CMS with all the comments. And

1 then, that is published. Those are the measures
2 that CMS can use in its programs.

3 And it is far more lengthy than the
4 measures that are in the programs, and if you
5 know all the measures in the programs, you can
6 imagine how long the MUC list is. In any case,
7 the MUC list is what CMS uses. They cannot put
8 measures in any of their programs that haven't
9 been on the MUC list, but to get to that MUC list
10 is about a year-long process.

11 MR. GOLDWATER: And thank you, Yael.
12 You explained that far better than I could have.
13 Okay. Any other -- funny, Chuck, really. Any
14 other questions? Okay. So, let's begin our
15 discussion of the measure framework. And what
16 we're going to really focus on today, this
17 afternoon, is really trying to hammer down the
18 elements, the dimensions, how they interrelate.

19 I realize, again, what we are
20 presenting is our own conceptual thoughts that we
21 came up with when we were doing the initial
22 review, as we were preparing the proposal. We

1 understand that some of these may not necessarily
2 be relevant and we may need to add.

3 Feel free to comment, make
4 suggestions, blow it up if you will, you're not
5 offending any of us. The idea is, you are the
6 subject matter experts, we are leaning to you to
7 help us shape what this is going to be. All
8 right. So, I think we can go to the third slide.
9 So, we've gone through that, we've gone through
10 this. All right.

11 So, and I realize some of these are
12 going to change, because of the comments from
13 yesterday. But, again, we look at measure
14 concepts in the way that when we start really
15 writing down particular concepts that relate to
16 telehealth, they will be reflective of these
17 areas that are on the far left.

18 Which would then include, access to
19 care, cost, I believe effectiveness is what we
20 are now going with, patient perspective and then
21 -- did we say clinician effectiveness, was that
22 one? Clinical effectiveness, right. So, those

1 are the elements that we believe measure concepts
2 should be developed around.

3 So, let me then ask -- no, no, no, not
4 quite, Katie. Thank you, though. So, sticking
5 with the measure concept part, are there any
6 other areas that we need to be focusing on? I
7 know we talked about workflow and workforce,
8 which was one -- yes, Kristi?

9 MEMBER HENDERSON: We also talked about
10 care coordination, and I don't know if that goes
11 into the cost or effectiveness. I mean, it does,
12 but we kept talking yesterday that it needed to
13 be called out separately, so I don't know if we
14 want to capture that or not.

15 MR. GOLDWATER: Do we -- is there an
16 agreement that that should be a separate measure
17 concept, should be care coordination? What's
18 that?

19 MEMBER FLANNERY: We talked about the
20 systems --

21 MR. GOLDWATER: Yes.

22 MEMBER FLANNERY: -- system

1 effectiveness.

2 MR. GOLDWATER: Right.

3 MEMBER FLANNERY: And it comes under
4 that.

5 MR. GOLDWATER: Okay. Well, so all of
6 these sort of fall under quality, they would all
7 be developed in a way to effectively assess
8 quality.

9 MEMBER DOARN: But when you think of
10 the quality of care, access to care is not about
11 quality, it's just having access to it. Whether
12 it's in the same place you live or it's somewhere
13 else.

14 The other ones seem to be more -- I
15 guess, maybe it's an underlying theme behind all
16 -- maybe it's a framework -- what am I trying to
17 say? -- it's a pillar underneath it all, holding
18 it all up. Because if you don't have good
19 patient perspective, then the quality sucked --

20 MR. GOLDWATER: Right.

21 MEMBER DOARN: -- pretty much.

22 MR. GOLDWATER: Right.

1 MEMBER DOARN: Okay.

2 MR. GOLDWATER: Okay. David?

3 MEMBER FLANNERY: When we're talking
4 about access, I thought yesterday we determined
5 to change that to the right time, right place, et
6 cetera.

7 MR. GOLDWATER: Right.

8 MEMBER FLANNERY: Which is a quality
9 metric.

10 MR. GOLDWATER: That's right. So, I
11 think what --

12 MEMBER FLANNERY: So, it's not simply
13 timeliness.

14 MR. GOLDWATER: Right. So, I think the
15 concept might be, access, but then the definition
16 of that would be, right time, right place, right?
17 So, we would have to flesh that out a little bit
18 more based on the notes from yesterday. Eve-
19 Lynn?

20 MEMBER NELSON: Yesterday, we talked
21 about the caregiver, family-centered care. So,
22 I'm not quite sure, that may fit into the patient

1 perspective, but just kind of keeping the full
2 patient family --

3 MR. GOLDWATER: Right.

4 MEMBER NELSON: -- caregiver situation
5 in mind. And then, I think, I'm not sure where
6 the technology and the reliability of the
7 technology, again, we talked about implementation
8 components, so I don't know if that would be
9 operations or I don't know the right word,
10 exactly where that fits.

11 MR. GOLDWATER: So, I looked at my
12 notes this morning and we had sort of the
13 caregiver in the patient perspective box. Is
14 that satisfactory? Do you think that needs to be
15 taken out and removed? Jean and then Paul.

16 MEMBER TURCOTTE: I'm thinking we need
17 to keep the patient and the clinician
18 perspectives separate. And so, what I heard this
19 morning in the recap was that, it became
20 clinical, clinician perspective became clinical,
21 where the effectiveness would be anything to do
22 with clinical, with that -- that's how I remember

1 this. Those outcomes would just go under
2 effectiveness.

3 But I think there's a difference
4 between the clinical outcomes and the clinician
5 perspective and I think it's important in order
6 to promote the use of telehealth that we really
7 include that clinician perspective in there. So,
8 that's just what I left yesterday --

9 MR. GOLDWATER: Okay.

10 MEMBER TURCOTTE: -- in my mind, was
11 that, we would keep patient perspective and
12 clinician perspective.

13 MR. GOLDWATER: Okay. Paul?

14 MEMBER GIBONEY: I was looking at
15 access to care related to technical capacity and
16 I actually don't think that's accurate. You can
17 have a telehealth system that is technically
18 working great, it's safe, it's accurate, and it
19 does nothing for access --

20 MR. GOLDWATER: Right.

21 MEMBER GIBONEY: -- because access is
22 driven by who's on the other end of that, what --

1 MR. GOLDWATER: Right.

2 MEMBER GIBONEY: -- principles are they
3 following, what kind of approaches are they
4 taking. So, I really like, I think we talked
5 about system effectiveness. If a system is
6 effectively working, if it's applying all of its
7 parts to the care of the patient, then access is
8 going to improve.

9 MR. GOLDWATER: Right.

10 MEMBER GIBONEY: And so, I like the
11 idea of system effectiveness and I don't think
12 access and technical capacity actually belong on
13 the same line.

14 MR. GOLDWATER: Okay. So, just as a
15 caveat, again, these -- the dimensions were just
16 sort of an initial attempt of alignment, but, in
17 all honesty, these dimensions can be interwoven
18 into many of these. Like access could cover more
19 than one. We were initially thinking that there
20 was some overlap, but, again, that's subject to
21 significant change, which we realize. Steve?

22 MEMBER HANDLER: It could be this is a

1 follow-up to that. There is the technical
2 capacity and then there's the workforce capacity
3 component to that.

4 MR. GOLDWATER: Okay.

5 MEMBER MOEWE: How are you thinking of
6 reimbursement? Is that under cost? Where are
7 you --

8 MR. GOLDWATER: Right. So, Mary Lou,
9 that would be under -- yes, we would be thinking
10 reimbursement would totally fall under cost.

11 MEMBER MOEWE: Okay.

12 MR. GOLDWATER: And in some cases, also
13 effectiveness, because we would -- as we talked
14 about yesterday, the literature was sort of
15 showing the effectiveness of telehealth by
16 providing care as opposed to in-person care or as
17 opposed to no care at all. So, there were cost
18 savings and then there was cost-effective
19 approaches. Steven?

20 MEMBER HANDLER: What did we decide
21 about the caregiver, formal/informal, with regard
22 to patient perspective? Were we considering that

1 as a separate new line item with regard to
2 concept?

3 MR. GOLDWATER: I -- so, the notes that
4 I had, indicated we were going to fold that into
5 the patient perspective.

6 MEMBER HANDLER: Okay.

7 MR. GOLDWATER: But we can certainly
8 consider breaking it out, if you think that it
9 needs to be.

10 MEMBER HANDLER: Well, the notion of
11 caregiver, formal/informal, paid/unpaid, and
12 expanding that concept certainly could be put
13 into the patient perspective. So, it could be
14 patient/family.

15 But the notion -- I think where we're
16 all heading from society is that this is going to
17 be an increasing part. Why? Many want these
18 types of services or need these types of
19 services. And the consumers in demand. We may
20 be best served by thinking about that as perhaps
21 a separate measure or concept. Just as something
22 to think about in this group.

1 MR. GOLDWATER: Okay.

2 MEMBER HANDLER: Because that is, I
3 think, going to be an important reason why many
4 will want to have telemedicine and telehealth, as
5 we've discussed.

6 MR. GOLDWATER: Okay. Steve?

7 MEMBER NORTH: I think as we begin
8 talking about caregiver, we get into a blurred
9 line about, when does someone go from being an
10 informal caregiver to becoming a clinician?
11 Because you can have, at one extreme, I can
12 present a patient to a psychiatrist, and at the
13 other, the certified nursing assistant in the
14 home can present a patient to me.

15 MR. GOLDWATER: Right.

16 MEMBER NORTH: So, we need to be
17 careful in the dimension development that we are
18 being specific around those terms, I guess. And
19 I'm not sure I can help be more specific.
20 Because they're -- yes.

21 MR. GOLDWATER: It's okay.

22 MEMBER WALKER: So, I very much think

1 that caregivers should be included on this list.
2 I think caregiver should be included on this
3 list. I think there have been some outcome
4 studies that indicate that patients that come
5 into clinic with another party, friend, relative,
6 whoever it may be, their outcomes are better than
7 if they show up in clinic appointments alone.
8 They get more information out of it, they're able
9 to take away more.

10 In the ideal setting, I'd put them
11 together, but I think as we become more remote to
12 one another and more virtual, it's entirely
13 possible that my caregiver is in another state, a
14 third location. So, in that setting, when we're
15 thinking about telehealth, I might make it its
16 own line.

17 MR. GOLDWATER: Okay. Judd?

18 CHAIR HOLLANDER: So, I was actually
19 going to argue slightly different than Angela on
20 this. So, I think we need to really bring in the
21 family and caregiver. And I was going to
22 propose, in trying to keep it simple and have

1 fewer lines rather than more lines, but yet
2 highlight the importance of it, I was going to
3 suggest that it be patient and family
4 perspective, not actually caregiver.

5 But caregiver would go in the access
6 to care component, right? Because if you have
7 somebody with you all the time, or you have a
8 caregiver with you, that is really access to
9 care. I would be equally flexible and be happy
10 to have the caregiver in the patient, family, and
11 caregiver perspective. But I think rather than
12 an additional category, just put it in the title
13 to highlight it.

14 MR. GOLDWATER: Okay. And, Adam?

15 MEMBER DARKINS: With remote
16 monitoring, it's extremely important to have the
17 caregiver involved. It seems to me that once you
18 start to do things, you're going to end up trying
19 to sort of solve the problems of the universe.
20 We can go down lots of little strands and this is
21 going to get very ragged.

22 So, one of the options to do in terms

1 of the family/caregiver and other things is to
2 think about this comes into -- whether there's an
3 element we should include in care planning? So,
4 if you're using remote care, a care plan and the
5 environment to do it, and then under the umbrella
6 of a care plan, you could cover that. As opposed
7 to saying, what are all the various options?

8 And as you know, with the CCM code,
9 one of the things which CMS has done is actually
10 brought the idea of care planning very formally
11 into the fore. So, my suggestion would be,
12 rather than get really amorphous and end up going
13 lots of strands, we perhaps think about how we
14 would formally incorporate care planning as being
15 something that comes under the umbrella of what
16 we're doing.

17 MR. GOLDWATER: Okay. Any others? Let
18 me just quickly recap. So, I think that, what
19 I've got now is, access to care, cost, system
20 effectiveness, patient/caregiver perspective, and
21 clinical effectiveness. Are there any others?
22 Did I get that correct?

1 And then, I'm sorry, patient
2 perspective, clinician perspective as well.
3 Sorry, I just remembered that. So, that's
4 basically modifying a few and adding one. Any
5 others that we need to include? Sorry, Jean, my
6 handwriting sometimes gets bad.

7 MEMBER GLADWELL: Can you say that one
8 more time? Which one did we add?

9 MR. GOLDWATER: So, we have access to
10 care, cost, system effectiveness, patient and
11 caregiver perspective, clinician perspective,
12 clinical effectiveness, are the measure concepts.
13 So, that means, just want you to understand that
14 when we start developing measures, or measure
15 concepts, they all will relate to one of those
16 areas.

17 And we will, in the report, define
18 what we mean by all of those areas, which will
19 probably require some further refinement over the
20 next couple of months. And then the dimensions
21 will be things that have to be included in those
22 measure concepts, one or more of them. Any other

1 thoughts before we move on to the dimensions?

2 Yael, yes.

3 MEMBER HARRIS: So, I just wanted to
4 verify that quality, as a concept, in other
5 words, if we're comparing, as we said, to the
6 alternative, either face-to-face or not, no care
7 at all, fits under effectiveness.

8 I just want to verify, because when
9 you are going to develop process or outcome
10 measures, we want to make sure that we can
11 compare the delivery of tele-ICU versus going to
12 an ICU, and say, we're going to compare against
13 cost, et cetera, looking at overall outcomes.

14 MR. GOLDWATER: Yes, I would definitely
15 say that quality is going to have to be baked
16 into, certainly into effectiveness and probably
17 into most of these. I agree with Paul a bit that
18 baking in quality to access might be a little
19 difficult, but I think having the right here,
20 right now, right approach, might mitigate that a
21 bit.

22 MEMBER HARRIS: So, if I might suggest,

1 almost like a diagram. So, instead of just a
2 list, like a diagram where quality interacts with
3 multiple pieces of that. Because access and
4 quality are related, but it's a different issue
5 than clinical outcomes. Stop smirking at me.

6 MR. GOLDWATER: So, Yael, that's
7 coming. I'm actually thinking way ahead of you,
8 which rarely happens. Marybeth?

9 MEMBER FARQUHAR: Quick question, where
10 does care coordination fall?

11 MR. GOLDWATER: So, that -- in
12 effectiveness.

13 MEMBER FARQUHAR: Systems
14 effectiveness?

15 MR. GOLDWATER: System, right.

16 MEMBER FARQUHAR: Okay. I'm good.

17 MR. GOLDWATER: Sarah? And then Paul.

18 MEMBER SOSSONG: Sorry, just wanted to
19 clarify. So, it's changed from access to care to
20 just plain access?

21 MR. GOLDWATER: That's correct.

22 MEMBER SOSSONG: Okay. That was my --

1 MR. GOLDWATER: Paul?

2 MEMBER GIBONEY: Access is such a huge
3 thing in telehealth. It kind of does deserve its
4 own line, but I do think that if a system is
5 being effective, if you've got an effectively
6 running system, access is going to be
7 outstanding. I mean, if you're ineffective at
8 anything, it's not going to hum.

9 And access is, I think, a derivative
10 of an effective system. But it is such a big
11 piece of this, I don't mind having it on a
12 different line, but I think others from the
13 outside who aren't aware of this conversation
14 might look at this and say, why is it called out
15 differently? Because if you've got an effective
16 system, then you're going to be getting patients
17 in at the right time, the right care, with the
18 right clinician.

19 MR. GOLDWATER: So, before I get to
20 Eve-Lynn, I'll put on my policy hat for just a
21 minute and say, I think when this is presented
22 and the way it's going to be described and how

1 measures will be collected and reported out, I
2 think the system effectiveness part is going to
3 be just how effective was the modality of
4 telehealth to provide quality care in a
5 particular area?

6 I completely agree that, obviously,
7 access is sort of solved if that's happening.
8 But I think from a policy perspective, they're
9 going to want to see access broken out.

10 I think they're going to want to say,
11 if we're going to, for example, get rid of
12 certification requirements and everybody can get
13 into compacts and then we can provide care across
14 state lines, they're going to want to say, oh,
15 well, look, if you increase access to care, as
16 these measures are showing, look what happens.
17 So, I mean, I don't want oversimplify Congress,
18 but I will, because I've been up there long
19 enough to know that's what you need to do.

20 Eve-Lynn?

21 MEMBER NELSON: Could clinical team be
22 considered, instead of just the clinician, kind

1 of to reflect the rural primary care or the
2 expert or the school nurse or whoever is touching
3 the patient?

4 MR. GOLDWATER: I think that's true,
5 yes. I think we can try to see if we can fit
6 that into the clinician perspective or perhaps
7 the patient caregiver perspective. And I think,
8 Eve-Lynn, if we see that that's not really going
9 to create a concept that would be effective to
10 what you're looking for, maybe we can break that
11 out.

12 I do want to agree with Judd a little
13 bit that we don't want to have 20 measure
14 concepts, because then it gets to be a very
15 convoluted framework, that becomes difficult to
16 develop measures. But this has been great,
17 really. Very helpful. Tracy, Katie, you want to
18 add anything?

19 MS. LUSTIG: The only thing I was going
20 to add is, and it's probably obvious, is that
21 also these categories aren't necessarily discrete
22 and distinct.

1 MR. GOLDWATER: Right.

2 MS. LUSTIG: They're all going to have
3 overlaps. And I'm already sitting here going,
4 well, does workforce go under access or is it
5 system? So, I think we kind of can't get too
6 caught up in that and just think about, these are
7 great general categories that are really a Venn
8 diagram.

9 MR. GOLDWATER: Right. Okay. So,
10 let's move on the right-hand side, which talks
11 about sort of the dimensions. And the dimensions
12 are, again, as you build measure concepts, you
13 want to include these dimensions, one or more.

14 Going back to yesterday, we had
15 technical capacity. We wanted to keep
16 therapeutic outcome, but we wanted to potentially
17 remove diagnostic impact, because the therapeutic
18 outcome and diagnostic impact were somewhat
19 redundant. That's what I have in my notes, is
20 that reflective of reality?

21 We wanted to talk about patient
22 outcome, which, Chuck, I think gets to your point

1 about that very distinctly talks about quality of
2 care. And that we wanted to keep diagnostic
3 accuracy in. We wanted to get impact out, keep
4 technical capacity, therapeutic outcome, patient
5 outcome, diagnostic accuracy in.

6 So, the initial question, is that
7 still satisfactory to the group? We also then
8 wanted to add workforce and workflow, as Kristi
9 pointed out, as another dimension. Let me make
10 sure I have that correct, yes, okay. Judd?

11 CHAIR HOLLANDER: So, I had raised
12 concerns with diagnostic accuracy, because not
13 everything needs diagnostic accuracy. And I'm
14 not sure what the right substitute phrasing
15 should be, but it's really sufficient information
16 to make the critical decisions. I'm not sure of
17 the way to capture that in two or three words.

18 MR. GOLDWATER: Okay. Adam puts his
19 sign down right as I'm about to call on him. Any
20 other suggestions for -- Paul?

21 MEMBER GIBONEY: Diagnostic
22 completeness. I'm just trying to think of --

1 you're talking about having all the information
2 that's necessary to proceed with the -- anyway,
3 I'm trying to feel what you're thinking and put
4 it into words.

5 CHAIR HOLLANDER: So, you're thinking
6 diagnostic sufficiency, maybe? Because it may not
7 be complete, but it may be sufficient to move
8 forward.

9 MEMBER MOEWE: I'm wondering how you
10 would capture something like, for instance, an e-
11 consult to a specialist? So, it wouldn't really
12 be a therapeutic type of internal medicine tool,
13 but it would be a tool to save time and money and
14 get a patient to a specialist faster via
15 telemedicine.

16 And it wouldn't really have a
17 therapeutic outcome, necessarily, or diagnostic
18 accuracy. But I'm trying to think of how you
19 would capture that kind of telemedicine that's
20 outside of a study or -- I don't know, help me.

21 MR. GOLDWATER: Yael?

22 MEMBER HARRIS: I don't want to

1 disagree with anyone, but I'm worried about this
2 whole diagnostic sufficiency issue, because we're
3 limiting ourselves when we think about other
4 applications of telehealth.

5 So, when you think about remote
6 monitoring, for example, or when you think about,
7 as we talked about, is text messaging reminders,
8 et cetera, it's not sufficient, but it's better
9 than the alternative.

10 So, I think maybe instead of
11 diagnostic completeness or diagnostic
12 sufficiency, I think it's improved diagnostic
13 information, which gets back to the impact, does
14 it impact your ability to treat more than you
15 would have had without it?

16 MR. GOLDWATER: Adam?

17 MEMBER DARKINS: So, I would say, back
18 to what I was saying about care, managed care
19 planning, before. I think if you look at that,
20 we've ended up going down a very medical model of
21 how we're doing this. And that's -- back to much
22 of this, it's around some of the social

1 determinants and there are biopsychosocial
2 pieces.

3 Diagnosis is absolutely important, but
4 take management of heart failure when someone is
5 being monitored remotely, it's comorbidities that
6 become important and it's often how you manage
7 the biopsychosocial, which is what keeps people
8 out of hospital.

9 So, I think that, accepting what
10 you've said, that this is a framework,
11 nonetheless, it will set in stone an approach.
12 So, if we start off with an approach that really
13 says, this is around trying to provide hospital-
14 based care in the community, we're going to end
15 up creating something which is going to be very,
16 very difficult to unravel.

17 MR. GOLDWATER: Right. Okay.

18 MEMBER DARKINS: Yes.

19 MR. GOLDWATER: Daniel? Or --

20 MEMBER TRUONG: So, I just want to
21 bring up that internal medicine, a lot of times
22 these days, we're trying to provide access to

1 care, we're trying to provide earlier care. So,
2 we become kind of almost a triage, right?

3 As clinicians, we become almost a
4 triage, so, we don't really diagnose, I mean, I
5 think, I agree with what Judd was saying, we
6 don't always have to diagnose, we become more
7 like -- like care appropriateness, I don't know
8 what exact word is, but just kind of want to
9 bring that up, because it sounds like we're all
10 in agreement that it's not going to always be
11 diagnostic. We may just be more of the care
12 coordination part, the extra domain that we were
13 talking about.

14 MR. GOLDWATER: Yes. Steven?

15 MEMBER HANDLER: Just following up on
16 that. So, thinking about in the medical model,
17 perhaps what we're all saying is really the
18 effectiveness, right? So, how effective is it,
19 regardless of what it is for, whether it is for a
20 diagnosis or treatment?

21 And it doesn't mean that you have to
22 necessarily be accurate or comparing it. So, it

1 could be text message, is it effective at
2 achieving the outcome that's desired?

3 So, I think, frankly, that's the term
4 that we should be driving towards, the
5 effectiveness of the intervention, whatever it
6 is, and whatever modality you're using. So, as
7 opposed to, let's say, the efficacy under
8 rigorous standards, like of a RCT or something.

9 So, I think that's really what I'm
10 hearing, is what we're trying to say. And this
11 is too precise a term and driven towards
12 something, the effectiveness is a much more --
13 it's a larger, more umbrella term, that can allow
14 us to approach it much more loosely, but it still
15 drives towards whatever the underlying technology
16 or solution or process or outcome is being
17 addressed, or trying to be addressed.

18 MR. GOLDWATER: Okay. Paul?

19 MEMBER GIBONEY: When I think about
20 what people are looking for in telemedicine, or
21 what some of these are trying to get at, maybe
22 the word capability comes to mind. Is this tool

1 capable of doing what we need it to do? Is it
2 capable of transmitting the right information to
3 the right person in the right time frame, so that
4 we can make the right diagnosis and intervene in
5 the right way?

6 So, while I like the idea of
7 effectiveness, effectiveness is so broad, it
8 seems like some of these dimensions are actually
9 trying to get a little bit more granular into,
10 what does this actually do and what are the
11 requirements? You can say anything needs to be
12 effective, but not really call out what is needed
13 to be effective.

14 And sometimes, when I look at these
15 dimensions, I think, these are some of the things
16 that are what you need to be effective, you need
17 something that has the right technical
18 attributes, you need something that facilitates
19 some of the right therapies. So, I don't know,
20 maybe diagnostic capability or clinical
21 capability or something like that might add to
22 that.

1 MR. GOLDWATER: Okay.

2 MS. LUSTIG: Can I ask something?

3 MR. GOLDWATER: Go ahead, Tracy, sure.

4 MS. LUSTIG: Hi. So my other framework
5 project here happens to be on diagnostic
6 accuracy. And one of the things I was just
7 thinking about is a big thing in that community
8 is to say, a diagnosis is not a one-time event.

9 It's not, this is what your diagnosis
10 is. They actually really prefer to talk about
11 the diagnostic process, recognizing that it's an
12 ongoing and iterative process to determine what
13 the it is.

14 So, would it maybe work a little more
15 if we turned it around and said, impact on the
16 diagnostic process rather than impact on
17 diagnosis? Because to me that seems like --
18 that's what we really are talking about in
19 telehealth, is being part of that process of
20 coming to determine what the it is.

21 MR. GOLDWATER: Steven? You.

22 MEMBER NORTH: Me? Great, thank you.

1 So, I guess, with the diagnostic and diagnosis
2 discussion, does this all really fit under
3 therapeutic outcome? All of those, are we
4 changing the trajectory of the patient's health?
5 That's what we want to know if we use telehealth.

6 And so, these words like impact,
7 effectiveness, accuracy, what we really want to
8 know is, is this patient better because
9 telehealth was used? And, therefore, can we
10 consolidate under therapeutic outcome in some
11 manner?

12 MR. GOLDWATER: Okay. Judd?

13 CHAIR HOLLANDER: I keep coming back in
14 my head that it's about sufficient information to
15 perform critical decision making. And so, I
16 think the decision making is the lynchpin of
17 this, because, what Yael talked about is,
18 whatever kind of information we get, it kind of
19 inform the decision. And then, I guess the
20 question we ask, is it sufficient to inform the
21 decision?

22 MR. GOLDWATER: Okay. Adam?

1 MEMBER DARKINS: I've been doing some
2 interesting work, and did before I joined
3 Medtronic, on end-of-life care and palliative
4 care. You've got end-of-life care measures. So,
5 the framework, as I see it, needs to include that
6 kind of perspective as well. That's a different
7 dimension, which isn't really captured here.

8 And so, this is focused very much on
9 the curative. So, I don't think it's a question
10 whether it's curative or palliative, but maybe,
11 picking up on decision making, there's something
12 about appropriateness, because otherwise various
13 value judgments come in here. And value
14 judgments are about better and otherwise. And
15 so, perhaps I could put appropriateness as a
16 suggestion.

17 MR. GOLDWATER: All right. Let me --
18 yes, Angela, I'm sorry.

19 MEMBER WALKER: So, I wonder, with the
20 different types of telehealth that exist, if this
21 is more of a matrix than a two-column
22 organization of information. So, even in the

1 dermatology spectrum, I could think of tele-
2 dermatology as a triage system, tele-dermatology
3 as a manage your illness or disease, tele-
4 dermatology as a keep you well, making sure I
5 don't see any skin cancers, even though there's
6 not one present, though I maybe wouldn't
7 recommend it for that.

8 So, if you had different types of
9 telemedicine that you wanted to practice, they
10 probably each would have some measure concept
11 that's universal to all of them, but the
12 dimensions for each of them are going to be
13 different.

14 MR. GOLDWATER: Steven?

15 MEMBER HANDLER: I actually really like
16 that concept, because even if you think about it,
17 Tracy, what you were saying, the diagnostic
18 process, sometimes what we're doing is we're
19 managing an acute change of condition or a one-
20 time and done.

21 The other could be a diagnostic
22 process or it could be tele-monitoring, where

1 you're trying to follow someone longitudinally
2 and you're trying to impact the course of their
3 disease. I could see that.

4 The problem -- the only negative, as
5 I think through that too, is we don't want to put
6 artificial constraints, because we don't know
7 what we don't know in terms of how telehealth can
8 be used, unless we want to say, we know how it's
9 being used now.

10 But to Yael's point, what she said
11 before, I don't know if we want to put something
12 out there that may constrain the future in terms
13 of applications that we don't know of how it may
14 be thought of, engineered, or done in the future.
15 That would be my only concern. But I do agree
16 with more of a matrix approach in terms of how
17 telehealth could be used or how it's being used
18 now, would, I think, make a little more sense.

19 MR. GOLDWATER: Okay. All right. So,
20 let's do this, let's go -- and, again, this was
21 the -- the two-column list was just the initial
22 thrust of what we had come up. I agree that the

1 matrix approach, which I think is applicable
2 here.

3 What I want to do is sort of go down
4 each one of the dimensions and let's just try to
5 harness our comments so that we have a clearer
6 idea of how we want to move forward with this,
7 based on, I think, everything that we've been
8 able to capture. So, technical capacity, is that
9 a dimension people agree is -- that's good?
10 We're good with that? Everybody's good with
11 that? All right.

12 MEMBER DOARN: That includes
13 capability?

14 MR. GOLDWATER: That's correct, yes.
15 Technical capacity would also include
16 capabilities, correct. Diagnostic impact, we
17 want to remove? Is that correct? Yes? No?
18 Yes? Yael, did you have something you wanted to
19 say? You don't have to raise your placard, you
20 can just pose it.

21 MEMBER HARRIS: I would just say, I
22 don't think it's necessary that you have to

1 remove it, I think you have to clarify it or
2 think of different wording.

3 MR. GOLDWATER: Okay. Do we want to
4 just then rephrase it as diagnostic
5 appropriateness or do we want to just use the
6 word appropriateness? Appropriateness as a word?
7 Okay. Therapeutic outcome? Yay? Nay? Yes?
8 We're all agreed? Okay. You guys are a lot
9 easier than I thought. I thought Chuck was going
10 to be the real rabble-rouser here, but -- good.

11 (Laughter.)

12 MR. GOLDWATER: Well, I wasn't
13 listening. So --

14 (Laughter.)

15 MR. GOLDWATER: Just kidding. Patient
16 outcome, we concur that that is another one?
17 That is the one that's probably most directly
18 related to quality. I mean, that's -- quality is
19 absolutely baked into that for sure. Diagnostic
20 accuracy, there did seem to be desire to remove
21 that and either remove it completely or to
22 replace it with diagnostic perspective. Yes,

1 Chuck?

2 MEMBER DOARN: So, I guess, one of the
3 underlying themes, I think, and I mentioned this
4 yesterday, that I think is clinically oriented,
5 but when you think about telehealth,
6 telemedicine, whatever we want to call it, there
7 are a lot of underlying themes with regard to
8 business processes, management of patients,
9 management of resources, the cost of technology
10 itself, the cost of bandwidth, and so forth, the
11 reliability and things.

12 And I just want to make sure that, so
13 I understand, as we develop these concepts and
14 the dimensions, there will be narratives that go
15 behind each one that kind of -- those underlying
16 things, like quality and things, all are part of
17 that --

18 MR. GOLDWATER: Yes.

19 MEMBER DOARN: -- they don't
20 necessarily have to be listed, but each one of
21 these has some kind of concept involving people,
22 different levels of people, and then the

1 technology and the cost of bandwidth and so
2 forth. I just want to make sure that none of
3 that gets lost and it's not just --

4 MR. GOLDWATER: Correct.

5 MEMBER DOARN: -- the clinical outcomes
6 and clinical --

7 MR. GOLDWATER: Right. I think when we
8 go back and look at our notes and then also look
9 at the transcript, it will be how we flesh all of
10 those out so that -- and I think all of your
11 comments, in one shape or form, have come out,
12 don't make this too clinically focused, it needs
13 to be much more comprehensive, somewhat more
14 holistic, much more focused on providing care,
15 access to care, types of care, and not just such
16 a -- I think Adam's quote was well stated, we're
17 not moving the hospital into telemedicine. And
18 if we do that, this will be very difficult to
19 implement. Henry?

20 MEMBER DePHILLIPS: Just a quick
21 comment. The wordsmithing is not my strength,
22 but as I think about the recipients of the report

1 and I look at the dimensions, I'm thinking,
2 what's the receiver of the report going to focus
3 on or be thinking about? And I think the first
4 is going to be patient safety, quality of care.

5 MR. GOLDWATER: Right.

6 MEMBER DEPHILLIPS: Because if it's not
7 high quality care or patient safety isn't
8 preserved, then everything else doesn't matter.
9 The second thing that I think the recipients are
10 going to focus on is access, does it improve
11 access to care? Do people who don't have access
12 to care, to Yael's point today, then have it if
13 we add this thing in?

14 And then, the third is, the overall
15 cost of care. I know, Judd, yesterday you talked
16 about, is it this person or that party? To me,
17 that's less important. If the overall cost of
18 care is impacted, then who pays for it becomes a
19 little bit less important, the most important
20 thing is that the total cost of care --

21 MR. GOLDWATER: Right.

22 MEMBER DEPHILLIPS: -- is improved.

1 So, I guess, as we change the categories and some
2 of the names, my hope is that we don't just lose
3 sight of sort of those three kind of features.

4 MR. GOLDWATER: Understood.

5 MEMBER MOEWE: Are we thinking about
6 all the transitions of care, like across, not
7 just inpatient/outpatient, but primary care,
8 long-term care, as the patient's transitioning
9 throughout and all the care coordination that has
10 to happen? Like the telemedicine focus on that
11 is, I think that's really critical for the
12 outcome, the overall outcome for the patient.

13 MR. GOLDWATER: Right. So, that was a
14 big topic yesterday --

15 MEMBER MOEWE: Oh, okay.

16 MR. GOLDWATER: -- and what I think we
17 all landed on was, that has to be a significant
18 component of what we would call system
19 effectiveness. That care transitions, care
20 coordination, are certainly an important
21 descriptor of an effective telehealth system.

22 MEMBER MOEWE: Is that captured in the

1 dimensions as far as --

2 MR. GOLDWATER: Well, in the measure
3 concepts, yes. In the dimensions, what
4 dimensions would actually go into that, would it
5 be technical capacity, would it be
6 appropriateness, would it be -- I mean, I think
7 as we start to move a little bit further into
8 this later on today --

9 MEMBER MOEWE: Okay.

10 MR. GOLDWATER: -- we can sort of
11 understand --

12 MEMBER MOEWE: Okay.

13 MR. GOLDWATER: -- what we need to
14 include into that. Dale?

15 MEMBER ALVERSON: I think Judd touched
16 on this a little bit, but on this dimension about
17 diagnostic accuracy, I can see in certain cases,
18 you're always doing this comparison, I'm
19 particularly thinking about dermatology and so
20 on, but it also gets this, is it diagnostically
21 effective?

22 And I think about that, because doing

1 this virtually isn't the same as in-person. And
2 so, but it might be -- I still can make a
3 diagnosis, I might require a third party present
4 to help me with the exam, because I can't touch
5 the patient.

6 So, somehow, I just want to -- this
7 accuracy thing, may be too precise and, Judd, you
8 had mentioned this about use sufficiency or
9 adequacy or whatever, because a lot of times in
10 telemedicine, it's not the same as in-person, but
11 it's sufficient.

12 And I don't know, Judd, what you're
13 thinking is the right term, but I just want to
14 make -- this seems like a little bit too
15 specific, diagnostic accuracy. That might be
16 part of it, but it's not always necessary.

17 CHAIR HOLLANDER: I think what I'm
18 trying to say, with multiple different words,
19 because I can't find the right two words to do it
20 is, is it enough information to make an
21 actionable, correct decision? And so, it really
22 is about, did you gather sufficient information

1 or information gathering sufficiency.

2 And then, because if you make the
3 wrong decision, but you have the right
4 information, that's not a telemedicine quality
5 issue, right? So, the issue is really, did you
6 get the right information to inform the decision?

7 And so, diagnostic accuracy assumes a
8 couple of things, one of which is you gathered
9 the right information and then you processed it
10 right. The processing of the information has
11 nothing to do with telemedicine, you're a good
12 doc, bad doc, whatever. So, it's really can -- I
13 guess, as we're talking through this, it's, can
14 you gather the information somehow?

15 MR. GOLDWATER: Right. Stewart?

16 MEMBER FERGUSON: I agree with that.

17 I was going to jump to a slightly different
18 topic, under technical capacity. We haven't
19 really kind of discussed that too much, but I
20 think the word technical is really misleading.

21 MR. GOLDWATER: Okay.

22 MEMBER FERGUSON: I think when they all

1 think technical, they think networks, equipment -
2 -

3 MR. GOLDWATER: Okay.

4 MEMBER FERGUSON: -- and I think what
5 we really mean is infrastructure, meaning human
6 resources, all the pieces that go to make a
7 telemedicine system work.

8 And I only bring that up because in
9 Alaska we're kind of working on this and we
10 actually, the whole committee was confused, we
11 started to talk about technical design and we
12 really meant infrastructure design. And I think
13 that's actually a better word for that.

14 MR. GOLDWATER: Okay. Is there a
15 concurrence on that, infrastructure capacity?
16 All right. Nate?

17 MEMBER GLADWELL: Yes. I want to go
18 back to Judd's comment, just a minute ago, around
19 just wordsmithing around diagnostic accuracy. I
20 want to ground -- I feel like we're kind of
21 getting a little into the weeds.

22 I want to ground the conversation and

1 remind myself, as I think about this, that
2 medicine -- telehealth is just healthcare with
3 something in between. And we don't want to get
4 away from that concept that -- all we're talking
5 about is the means of communication or the
6 delivery of care in a different way.

7 And as I think about that, I compare
8 it to, if you see a patient in a van down by the
9 river, can you make a good diagnostic approach as
10 if you were in a clinic that's hospital based?

11 That's sort of what we're talking
12 about, right? It's there's a patient scenario,
13 we're using something in between to assess that
14 scenario and make decisions. And so, I just
15 wanted to make sure we were grounded in that
16 concept.

17 And this isn't -- and the reason I
18 think that's important is, people that aren't
19 close to telehealth often call me and say, hey, I
20 want telehealth from the University of Utah. And
21 I'll say, what does that mean? You want an iPad
22 --

1 MR. GOLDWATER: Right.

2 MEMBER GLADWELL: -- or do you need a
3 clinical service?

4 MR. GOLDWATER: Right.

5 MEMBER GLADWELL: And then I'll ground
6 them on, if you need cardiology, let's talk about
7 that.

8 MR. GOLDWATER: Right.

9 MEMBER GLADWELL: You don't need
10 telehealth, you need what's on the end of
11 telehealth. So, just an editorial.

12 MR. GOLDWATER: Understood. Paul?

13 MEMBER GIBONEY: Yes. So, I agree with
14 everything that's been said. So, you had
15 mentioned that we might leave that one off, I
16 don't think we should leave this concept off.

17 MR. GOLDWATER: Okay.

18 MEMBER GIBONEY: It needs to be there
19 somewhere, because I think one of the big
20 questions of people with telehealth is, well,
21 it's just not enough, it's not as good, you need
22 -- there's still a huge community of people out

1 there that say, you need the face-to-face visit,
2 you need someone to lay hands on the patient to -
3 -

4 MR. GOLDWATER: Right.

5 MEMBER GIBONEY: -- be able to provide
6 the healthcare.

7 MR. GOLDWATER: Right.

8 MEMBER GIBONEY: And this is that piece
9 of all of this that helps us articulate or
10 measure, eventually, that actually, no, it is
11 sufficient, it is good. So, anyway, I want to
12 advocate for not leaving it off, I don't know
13 exactly what the right phrasing is, but this
14 concept needs to be one of our dimensions.

15 MR. GOLDWATER: Is diagnostic
16 effectiveness a better descriptor than -- no?
17 Okay. Angela, go ahead.

18 MEMBER WALKER: Yes. I agree. I think
19 these are two totally separate entities. And
20 while they may be very difficult to measure in
21 some settings, you really need to leave them both
22 there.

1 An example would be, if I see a
2 picture of a weird looking brown spot and I call
3 it an atypical mole, and I say, follow up with me
4 in six weeks, and in six weeks, I get a second
5 image and that atypical looking mole is clearly a
6 melanoma.

7 I made a wrong diagnosis at the onset,
8 but I had good management, because I had a way to
9 get the patient back, get a second image, and
10 make a new, now correct, diagnosis.

11 It may be very, very difficult to
12 collect the information with the way our health
13 system is set up and infrastructure around
14 records, but those two things are very different.
15 The management piece that got him back, that's
16 clearly good management, but the initial wrong
17 diagnosis is different -- is separate.

18 MR. GOLDWATER: Peter?

19 MEMBER RASMUSSEN: Yes. I like the two
20 I words that I've heard in the past ten minutes,
21 which is infrastructure and information, because
22 it really comes down to having an appropriate

1 infrastructure to get the clinician the
2 appropriate information to make the critical
3 decision. I think that's really the foundation
4 of it all.

5 MR. GOLDWATER: Okay.

6 MEMBER RASMUSSEN: Diagnostic, I don't
7 like that word so much.

8 MR. GOLDWATER: Okay. Chuck?

9 MEMBER DOARN: One of the things that
10 we're saying, that a lot of doctors still believe
11 that they need to be in the same room and be able
12 to -- I'm wondering, in the literature search, if
13 you go back and look at banking as an example,
14 most people in the 1940s and 1950s wanted to go
15 to the bank. In the 1920s, they didn't want to
16 go to the bank. That was supposed to be a joke,
17 a financial joke.

18 MR. GOLDWATER: Ha-ha.

19 MEMBER DOARN: Okay. But I wonder if
20 there are studies that have been done that
21 measure people's opinions on ATM machines and,
22 now, banks like Chase, you can actually deposit

1 the check by just, you don't have to put it in an
2 envelope, you just put it in the thing and it
3 takes a picture of it and so forth.

4 I wonder if there's studies that have
5 been done on consumer acceptance of that and
6 whether there are lessons to be learned from that
7 model that could also then be transitioned into
8 medicine in the sense that, if the younger
9 physicians enjoy or actually utilize this concept
10 of being able to see somebody through a video or
11 on an iChat or whatever, maybe that's something
12 that's sort of out there that we haven't even
13 thought about tapping into.

14 This sort of goes back to my concept
15 earlier about looking at things that wouldn't
16 normally be part of medicine, but the lessons
17 learned might be of value to us.

18 MR. GOLDWATER: Okay. Stewart, Dale,
19 Angela, do you -- all right, that's what I
20 thought. Henry?

21 MEMBER DEPHILLIPS: Just jumping back
22 to a term that we used yesterday, I'm looking at

1 Paul's laptop here -- don't worry, I'm not
2 looking at yours.

3 (Laughter.)

4 MEMBER DEPHILLIPS: We used the term
5 useful information --

6 MR. GOLDWATER: Yes.

7 MEMBER DEPHILLIPS: -- yesterday.

8 MR. GOLDWATER: Right.

9 MEMBER DEPHILLIPS: And I think that
10 captures what Yael was talking about, is the
11 information better than what we had?

12 MR. GOLDWATER: Right.

13 MEMBER DEPHILLIPS: Without a
14 determination of whether it's enough to get to
15 the final diagnosis, but is it useful? And that
16 also -- the notion there covers a lot of
17 concepts, right?

18 So, Fitbit, you get a list of how many
19 steps everybody did over the last 30 days, least
20 useful amount of information that I as a
21 clinician can possibly look at. So, anyway, I
22 thought that that term might help inform this

1 grid.

2 MR. GOLDWATER: So, does -- to put
3 another one out there, information accuracy,
4 instead of diagnostic accuracy. Better or still
5 not good? Better? Better? Angela?

6 MEMBER WALKER: Yes. I just think
7 about the model in which I work in the tele-
8 setting and what I would call the information is
9 information that the patient is providing to some
10 third party that's then aggregated into a
11 platform that I see.

12 So, is it correct information because
13 somebody aggregated it correctly or did the
14 patient tell us incorrect information? Because
15 sometimes they don't know all the medications and
16 medical diagnoses that they carry. So, I --

17 MEMBER HALL-BARROW: Or they leave it
18 out.

19 MEMBER WALKER: Yes. So, I just wonder
20 a little bit about that usage of the term.

21 MR. GOLDWATER: Adam? And then --

22 MEMBER DARKINS: So, a couple of

1 thoughts, one of which is, it seems to me there
2 are broad themes we haven't captured, which are
3 in health care. And I don't want to go back to
4 diagnostic accuracy, per se, but one of the
5 issues is around the medical home and moving care
6 into primary care.

7 So, if you force the issue being
8 diagnosis, you're essentially pushing an agenda
9 to drive people up the food chain, whereas the
10 trends in healthcare are really to try and say,
11 how do you end up managing people in primary
12 care? So, how do you use telehealth to support
13 primary care?

14 If you make that an agenda which is
15 explicitly around diagnosis, you're going to end
16 up really skewing where it's intended to go. So,
17 I think there's a piece around teamworking and
18 fitting into the medical home. I'm not saying --
19 but there's an element there, which, I think,
20 somehow that we're not part of in some of this
21 conversation.

22 MR. GOLDWATER: Okay.

1 MEMBER DARKINS: Of behavioral health.

2 MR. GOLDWATER: Okay. Judd?

3 CHAIR HOLLANDER: I think, so, I like
4 the information term. I think that's critical,
5 it may be the second word that goes with it. And
6 when I think about it in terms of all
7 information, using the examples that the two of
8 you just gave, with medications, I know patients
9 have no idea what medication or dose they're on,
10 but if I get that on Wi-Fi, sent to me, and nine
11 out of ten meds are right, well, now I've got
12 more information than I had from getting to the
13 patient.

14 Accuracy might not be right, because
15 I'm still wrong, right? I got nine out of ten,
16 but I had two out of ten, because they said, some
17 little white pill and something else. So, we can
18 compare it, but I think linking it to
19 information, rather than diagnosis, is, as Jason
20 said, is probably the right linkage. The second
21 word, probably we'd still finesse.

22 MR. GOLDWATER: Okay. Steven?

1 MEMBER HANDLER: So, perhaps my world
2 is unique or different, but the information
3 accuracy, I have trouble with, because we're
4 getting what we get.

5 In the nursing home, post-acute long-
6 term care environment, we get information that
7 are coming from people that may not have a lot of
8 medical training, so they may provide you with
9 vital signs, we have a cross of information
10 that's from the electronic medical record, a lot
11 of it, the information is from a paper-based
12 electronic medical record.

13 MR. GOLDWATER: Right.

14 MEMBER HANDLER: So, information
15 accuracy, for me, is, I'm going to deal with what
16 I deal with. And also, if we have family or
17 informal caregivers, or even formal caregivers,
18 once again, the information provided is the
19 information provided.

20 So, I'm not really sure how you can
21 determine information accuracy. It's just
22 information. And to the point is, it's better

1 than in the absence of information.

2 So, I guess I'm really struggling with
3 how we could ever come to terms with the accuracy
4 of information that's coming from, let's say, a
5 nurse aide, no offense, they're not really highly
6 skilled or highly paid professionals in nursing
7 homes, or from informal caregivers, we should
8 just accept it at face-value as part of
9 information.

10 Just like anything else when someone
11 comes to see me in an office or a nursing home,
12 it's part of what I'm using to make a diagnosis
13 and a treatment plan. So, I'm still a little bit
14 hung up, perhaps, on this and not sure why we're
15 -- yes, just making -- sorry.

16 MEMBER HENDERSON: So, do we not --

17 MR. GOLDWATER: Kristi?

18 MEMBER HENDERSON: -- get the accuracy
19 under therapeutic outcome and maybe information
20 is that it's actionable? Whether I got it from a
21 patient, the nurse aide, the family, whoever,
22 it's that there's enough information that I can

1 take an action. Maybe the action is no action,
2 but that, to me, captures all these different
3 scenarios.

4 MR. GOLDWATER: So, I'm sorry, Kristi,
5 repeat that for me one more time?

6 MEMBER HENDERSON: Actionable
7 information.

8 MR. GOLDWATER: Perfect. So, remove
9 diagnostic accuracy and put actionable
10 information?

11 MEMBER HENDERSON: Yes.

12 MR. GOLDWATER: Angela, we agree to
13 that?

14 MEMBER WALKER: I still --

15 MR. GOLDWATER: I don't care, but --
16 (Laughter.)

17 MEMBER WALKER: I still think there
18 might be something missing, but I accept.

19 MEMBER HENDERSON: We're getting
20 closer.

21 MEMBER WALKER: We're getting closer.

22 MR. GOLDWATER: Stewart?

1 MEMBER FERGUSON: So, I decided to do
2 what Chuck does all the time and check Google.

3 MR. GOLDWATER: You guys are
4 ridiculous.

5 MEMBER FERGUSON: So, just --

6 MR. GOLDWATER: At least it's not
7 Facebook.

8 MEMBER FERGUSON: So, I'm being Chuck
9 Jr. here. No, but it's interesting. So, I
10 googled information quality, because I think
11 that's kind of what we're talking about, and
12 there's a reference here, it says, the five
13 characteristics of high quality information are
14 accuracy, completeness, consistency, uniqueness,
15 and timeliness.

16 And it seems like that's kind of what
17 we're talking about, because we're worried about
18 accuracy, we're worried about effectiveness,
19 we're worried about sufficiency. So, I think --

20 MR. GOLDWATER: So, send me that link
21 and then that'll --

22 MEMBER FERGUSON: Yes, you can just

1 google it. It's the second one that shows. It's
2 actually authored by Chuck Doarn.

3 (Laughter.)

4 MEMBER FERGUSON: Yes, I'll send you
5 the link.

6 MR. GOLDWATER: Thank you.

7 MEMBER DOARN: When you submit the
8 report to HHS, just say, Google.

9 MR. GOLDWATER: Yes, that doesn't go
10 over very well, Chuck. Steven?

11 MEMBER HANDLER: I was just going to
12 underscore the actionable issue. In doing a lot
13 of informatics-based research, you have the
14 concept of signal-noise ratio, right?

15 MR. GOLDWATER: Yes.

16 MEMBER HANDLER: So, we have a lot of
17 generation of signal -- or sorry, rather,
18 potential noise, and what is the signal and
19 what's actionable and then, who monitors the
20 monitor and what do you do with it?

21 So, I like the concept, frankly, of
22 creating information that has some translatable

1 utility that someone then can act on. Then, it
2 translates a little bit more into, what's the
3 clinical meaningfulness of that information, and
4 that could vary across any kind of specialty and
5 that is a broad enough term and concept, I think,
6 to apply to just about anything.

7 MR. GOLDWATER: Okay. One term that we
8 did talk about yesterday, that came up
9 repeatedly, was the idea of including workforce
10 and workflow into a dimension.

11 So, let me ask, since we're changing
12 the first dimension to infrastructure capacity,
13 would workforce, workflow fit into that and not
14 become its own -- that's good? Okay, Adam shook
15 his head. Good enough for me, we're good. All
16 right. Is that it? Okay, great. Before we get
17 to the -- oh, what?

18 CHAIR WARD: Recap.

19 MR. GOLDWATER: Okay. So, what we have
20 -- Marcia, you had to make me do this? All
21 right. So, we've got -- what's that?

22 MEMBER HARRIS: She's the co-chair,

1 she's supposed to --

2 MR. GOLDWATER: Oh, that's true.

3 Infrastructure capacity, we have appropriateness,
4 we still have therapeutic outcome, patient
5 outcome, and actionable information as the five
6 dimensions. And we will -- we're good with that?
7 Thank you all very much.

8 The diagram Yael is dying to see is
9 coming up, but let's take a break for 15 minutes.
10 Thank you all very much for this. Of course, the
11 diagram now will be totally meaningless because
12 it's this, but we'll understand how things
13 intersect. So, I had a feeling this was how it
14 was going to go, but that's fine. I'll google a
15 way of doing it better, perhaps.

16 (Whereupon, the above-entitled matter
17 went off the record at 10:45 a.m. and resumed at
18 11:08 a.m.)

19 MR. GOLDWATER: Okay. So, we have
20 altered the slide per Dr. North's suggestions,
21 thank you, to reflect the now new measure
22 concepts and dimensions. So, why don't you all

1 take a look at that? It does reflect our notes,
2 we've double, triple checked it. Angela, if
3 you've got a problem with it, just don't say
4 anything.

5 (Laughter.)

6 MR. GOLDWATER: Just kidding. So, I
7 thank all of you, again, this is extremely
8 helpful. Judd was just mentioning, that's the
9 longest discussion he's ever had on trying to
10 find two words. But --

11 (Laughter.)

12 MR. GOLDWATER: Words are important, as
13 we know and have been told repeatedly over the
14 last ten days, words are important. So, it
15 really does make a strong impression on the
16 framework and I'm happy, as I know Tracy and
17 Katie are, because I think we agree that the
18 initial sort of pass at this was very clinically
19 focused, because that's what we were reading.

20 So, I think this is much more
21 holistic, for lack of a better term. And I think
22 it's more reflective of telehealth. So, let's

1 move on to the next slide. Now, so, see Yael,
2 here's a diagram, look, it's amazing, isn't it?
3 It's incredible, yes. I did it myself, be
4 impressed. So, this is going to have like no
5 relevancy now, but --

6 (Laughter.)

7 MR. GOLDWATER: So, just admire the
8 color scheme and the alignment of bullet points.
9 But what I do what to really focus on is, I want
10 to sort of just talk about the overarching
11 concepts now, because we've changed a lot and
12 it's understandable.

13 But how you align the framework by the
14 dimensions and the elements. And then, just sort
15 of talk about, given the new domains that we have
16 and the new elements, what are some, and I would
17 really stress this, very overarching concepts
18 that you think would align to these dimensions
19 that would be reflective of some of the
20 discussions that we've had?

21 I do not want to start getting into a
22 discussion of measure concepts yet, that's next

1 time we meet. We really do need the literature
2 review to know which ones are important, how we
3 want to prioritize them.

4 But I do want to just talk about --
5 and hopefully this will maybe clarify in your
6 mind what the framework's going to do. And so,
7 just to get a sense of an idea, because I think
8 that, in addition, as we compile the
9 environmental scan report, we'll break it out in
10 the different dimensions and elements.

11 So, for example, access to care, so
12 we've changed that now to access, but some of the
13 elements that we found that related to access
14 are: difference in overall utilization of
15 services, effect on the timeliness of care.

16 So, in your mind, do you think that
17 those concepts align with the access dimension?
18 Do you think we're off-base, on-base, it's too
19 vague, it's ambiguous, it's not? I guess, what
20 are your thoughts on this?

21 This is the one thing that's going to
22 keep you all quiet, really? The diagram, is it

1 the diagram? It's the colors, isn't it? All
2 right, thank you, Don. Don, thank you.

3 MEMBER GRAF: Well, I'm going to start
4 with a question, can you explain the first
5 bullet, difference in overall utilization? I'm
6 not sure I get --

7 MR. GOLDWATER: Sure.

8 MEMBER GRAF: -- what you're saying.

9 MR. GOLDWATER: So, the differences,
10 were the utilization of dermatology services, is
11 there a difference in areas? Let's take for
12 example, rural areas, is there a difference in
13 utilization of dermatology services through
14 telehealth as opposed to in-person? Marcia?

15 CHAIR WARD: I think Tracy made the
16 point that a particular measure could fit in
17 multiple --

18 MR. GOLDWATER: Right.

19 CHAIR WARD: -- and I think the effect
20 on the timeliness does make sense with access,
21 does also make sense with effectiveness. So --

22 MR. GOLDWATER: Okay.

1 CHAIR WARD: -- everything fits
2 everywhere.

3 MR. GOLDWATER: Right. I know --
4 (Laughter.)

5 MR. GOLDWATER: I know it does. Yes,
6 Peter?

7 MEMBER RASMUSSEN: I guess I get a
8 little bit worried about that first bullet point
9 and how that data might be interpreted.

10 MR. GOLDWATER: Okay.

11 MEMBER RASMUSSEN: Because I think
12 payers might be inclined to believe that
13 increased utilization is just increased expense,
14 when reality is, it might be overall better care.

15 MR. GOLDWATER: Right.

16 MEMBER RASMUSSEN: And I guess --

17 MR. GOLDWATER: Okay.

18 MEMBER RASMUSSEN: -- it makes me
19 hesitant to -- just how that gets used.

20 MR. GOLDWATER: Okay.

21 MEMBER RASMUSSEN: It could work as a
22 negative, as well as a positive. So, I don't

1 know if you could put somehow a positive spin on
2 that data point and turn it into more appropriate
3 care or more effective care, something like that,
4 would probably be a better way of measuring that.

5 MR. GOLDWATER: Okay. Sarah?

6 MEMBER SOSSONG: And just to clarify,
7 is -- we talked a lot about with the conceptual
8 areas that we discussed, that all of the
9 discussion that's being captured would ultimately
10 go into a narrative, is the idea that those
11 bullet points capture all of those narrative
12 points?

13 MR. GOLDWATER: Yes.

14 MEMBER SOSSONG: So, ultimately this
15 will be a five or six -- okay.

16 MR. GOLDWATER: Right. The diagram
17 will be much bigger.

18 MEMBER SOSSONG: Okay.

19 MR. GOLDWATER: Much more colorful,
20 probably, maybe 3D, we'll see, see what I can do.
21 All right. Stewart?

22 MEMBER FERGUSON: I guess, when I think

1 about access, I think about two things, people
2 get care faster, which is the second bullet, or
3 people get care they never got before. Is that
4 what the first bullet is, when you say -- I mean,
5 I'm just trying to make sure that's what's
6 captured. So, to me, it would be expansion of
7 services rather than difference in overall
8 utilization.

9 MR. GOLDWATER: Okay.

10 MEMBER FERGUSON: So, you offer new
11 services or you can offer them to a larger
12 population.

13 MR. GOLDWATER: Right. Steve?

14 MEMBER NORTH: What Stewart said is,
15 are you really creating new access points or just
16 different access points? And so, how does that
17 fit into this? Because in my community, having a
18 virtual dermatologist would be great, because we
19 get dermatology once a month.

20 However, if you're in the Upper East
21 Side of Manhattan and can use an app as opposed
22 to going to your dermatologist, that

1 dermatologist isn't going to be as happy, because
2 they're losing that new patient visit. So, how
3 do we look at those two things within this
4 context?

5 MR. GOLDWATER: Okay. Let me try and
6 frame the discussion this way: access is one of
7 our dimensions and we now know, I think, what --
8 actually, why don't we do this, Katie, can we go
9 back to the previous slide? Right.

10 So, access is one of the measure
11 concepts and we understand what those dimensions
12 are. So, what are some of the key elements under
13 access that we really need to be focused on that
14 incorporate one or more of these dimensions? So,
15 let's -- I'm sorry, I just did the diagram for
16 Yael's benefit, but now that we're past that,
17 what are some key elements?

18 Because I think that will, A, help
19 shape, define the access dimension and I think as
20 we get the literature and start framing it
21 underneath that concept, we'll know really what
22 literature to be focused on.

1 So, what are some of the key elements
2 that really -- or I don't want to say elements,
3 what are some of the key components of access
4 that incorporate these dimensions that we really
5 should be focused on, in your mind, that are
6 important to telehealth? Peter?

7 MEMBER RASMUSSEN: I think one of them
8 is appropriateness of access. So, it's a minor
9 complaint, it's more appropriate to be seen on an
10 online urgent care as opposed to going into
11 Judd's ED. So, I think we need to somehow
12 capture that, appropriate level of care.

13 MR. GOLDWATER: Okay. Steve?

14 MEMBER NORTH: Infrastructure capacity,
15 especially at the community level, is going to be
16 part of access. If you don't have broadband at
17 home, you can't do this.

18 MR. GOLDWATER: Okay. Kristi?

19 MEMBER HENDERSON: I think it's the
20 right care at the right place at the right time.
21 And that appropriateness captures that, but it's
22 all those things.

1 MR. GOLDWATER: Okay. Any others that
2 you think would be important for access? Adam?

3 MEMBER DARKINS: I think there's a
4 piece about who determines access. So, having
5 created programs, one of the things we always did
6 was said that, somebody could always get face-to-
7 face care if they wanted. So, I don't know how
8 people feel about that.

9 I mean, is this that the patient
10 should be able to say -- so, it's a patient
11 decision in part. The service is there to be
12 delivered virtually and then the patient can make
13 the decision. And in reality, one then finds
14 very often the patient will make that decision.

15 But is this going -- so, I think
16 there's an issue just to start, is this a patient
17 decision or is it a clinician decision? Because
18 telehealth hasn't reached the stage where it's a
19 standard of care.

20 MR. GOLDWATER: Okay. Sarah?

21 MEMBER SOSSONG: Just to build off
22 Steve's point, one thing that we think about a

1 lot is not only that bandwidth and that
2 infrastructure at the system itself, but for the
3 patient themselves. So, do they have the
4 devices? Many of our patients don't and, to
5 date, those patients haven't had access.

6 MR. GOLDWATER: Okay. Don?

7 MEMBER GRAF: It may not fit in the
8 scope, but we were just talking at the break
9 about disparity and solving for that using
10 telehealth in rural communities. And I couldn't
11 help thinking that it's conspicuously absent in
12 the discussion and I wondered if it's purposeful,
13 out of scope, or needs to be addressed?

14 MR. GOLDWATER: Okay. And, run that by
15 me again, I'm sorry? What's being left out?

16 MEMBER GRAF: Healthcare disparity,
17 ethnic diversity --

18 MR. GOLDWATER: Oh, disparities, yes.

19 MEMBER GRAF: And so, we talk about
20 appropriateness and it's more than just, in some
21 cases, making something available, the same
22 cookie-cutter approach for everybody.

1 MR. GOLDWATER: Right. So, I mean,
2 that's a big issue, just in healthcare generally.
3 What are your feelings -- let me get to Nate
4 first and then we'll bring that up. Go ahead,
5 Nate.

6 MEMBER GLADWELL: I think that's a good
7 point. One term, to back up what Peter
8 described, that we use is patient acuity
9 matching. And I don't want to introduce any
10 other terms that are undefined.

11 (Laughter.)

12 MEMBER GLADWELL: Heaven forbid. But
13 for us, that helps frame it out for non-
14 clinicians, administrators, that say, for tele-
15 ICU, as an example, in a rural community, access
16 to an intensivist greatly impacts decision making
17 down the stream, to impact costs. So, we use the
18 term patient acuity matching. And then, I had
19 another comment, but I forgot. So, I'll give
20 back the floor.

21 MR. GOLDWATER: Before we -- Dale, go
22 ahead.

1 MEMBER ALVERSON: I want to reinforce
2 some of the comments that have been made, and I
3 try to look at this alignment of your framework
4 with real life experience and I want to give an
5 example, and that has to do with ECHO and
6 hepatitis C. And that's been published in the
7 New England Journal.

8 The point was, they showed, first of
9 all, that there was more timely care and they
10 showed comparative effectiveness. They had --
11 the cure rates, sustained viral response, were
12 the same whether it was done through telehealth
13 via the ECHO model, or in-person. But the
14 important difference was, it gets to the
15 difference in overall utilization, statistically
16 significant increase in the number of minorities
17 that were treated when using the ECHO model as
18 opposed to in-person.

19 So, you were able to reach -- and that
20 gets sort of to what Don was saying. So, somehow
21 -- I mean, you're capturing it, I just want to
22 put this in the context of real life measures

1 that have been done, where they actually showed,
2 they want to show equivalency, but they also want
3 to show that there was a difference in who got
4 access to that service.

5 MR. GOLDWATER: Judd?

6 CHAIR HOLLANDER: So, we spent a little
7 bit of time yesterday talking about provider-to-
8 provider consultations without the patient in the
9 middle.

10 And with the framework you gave early
11 on and maybe being able to influence
12 reimbursement and other things, I think it would
13 be really good if we used sort of the Project
14 ECHO model or the provider-to-provider, without
15 the patient in the middle, as part of the access.
16 Maybe in the written text or the infrastructure
17 capacity.

18 Because I know 90 percent of the time
19 that I call a consult, I don't need the person to
20 come down and repeat the exam that I did. They
21 don't need to talk to them, I need a level of
22 expertise, but I could gather the actionable

1 information for them, but I need them to tell me
2 what to do in this particular situation.

3 It would be really nice if we were
4 able to assess, could we deliver care without the
5 provider coming to the bedside, or maybe even
6 interacting directly with the patient? Now,
7 maybe that's not telemedicine or telehealth, but
8 it may be worth at least a paragraph within the
9 framework document to highlight that possibility.

10 MR. GOLDWATER: Let me get back to
11 Don's point, because I think that's a good one,
12 about disparities of care. Do you think -- how
13 does -- I mean, that's, again, that's a long
14 inherent issue, NQF actually has its own standing
15 committee that is exclusively dealing with this.

16 How do you think that could be
17 incorporated into telehealth? Is there a way to
18 adequately measure that, to understand the
19 disparities and to understand whether different
20 ethnic or sub-social groups are receiving similar
21 types of care?

22 I mean, I understand this is sort of

1 a difficult and maybe perhaps impossible question
2 to answer, but I'm interested in hearing your
3 thoughts about how you think that could be done,
4 with telehealth exclusively. We didn't
5 intentionally leave it out, it was -- I'm sort of
6 interested in how that could be done. Any
7 thoughts?

8 MEMBER GRAF: How it could be measured
9 or how it could be --

10 MR. GOLDWATER: Both. I mean, how it
11 could be -- go ahead Sarah.

12 MEMBER SOSSONG: I think it's an
13 interesting question about how we can use tele to
14 improve, but I think it's also really important
15 to make sure that we have included here that
16 telemedicine won't increase disparities, because
17 I think that's a possibility also. So, having
18 that as an explicit goal could be important.

19 MR. GOLDWATER: Okay. Don?

20 MEMBER GRAF: I have the, maybe it's
21 the luxury of looking at claims data and
22 utilization of telehealth within our organization

1 across the country. And when I ping utilization
2 statistics against policy, and I'll pick on the
3 Medicaid population for now, one would think
4 you'd see a direct relationship between the
5 latitude or leniency associated with policy and
6 utilization and you don't.

7 And what comes out, starts to begin to
8 come out, is when you start looking at
9 communities in the Southeast, rural Southeast, or
10 in some instances, in the Southwest, you find
11 sort of the opposite happening.

12 And, for me, I can't help thinking
13 that maybe it's a disparity thing, maybe it's
14 we're just not approaching it the right way, but
15 clearly, instances of obesity in certain rural
16 communities, where maybe they're not eating right
17 or can't afford to eat right, are driving
18 increased need, is that disparity, I don't know.
19 But, anyway, I'm not sure I've got the answer
20 either, but it's an interesting view, when you're
21 starting to look at policy versus utilization.

22 MR. GOLDWATER: Right. I agree.

1 Stewart?

2 MEMBER FERGUSON: So, we developed a
3 national plan for the Indian Health Service to
4 deployed telehealth throughout tribal communities
5 across the U.S. And as part of that planning
6 process, we looked at the disparities, how many
7 dermatologists were we lacking, how many
8 cardiologists?

9 And there's national benchmarks for
10 how many cardiologists you need per 100,000
11 people or whatever and we were greatly lacking in
12 Indian country. And so, part of that process was
13 to estimate roughly how many encounters we needed
14 in a certain population to bring that population
15 up to the national average.

16 And that's one way that we started to
17 look at it, is, like in Alaska, we have so many
18 derm consults done by telehealth per year per
19 population and we can benchmark that against the
20 national average and that starts to tell us if
21 we're getting rid of that disparity in care.

22 So, one way to do it is, obviously, to

1 look at, have we gone from zero to 50 derm
2 consults per 10,000 people and is that getting us
3 close to the national average? So, that's one
4 way to do it.

5 MR. GOLDWATER: Right. Eve-Lynn?

6 MEMBER NELSON: With the disparity
7 topics also comes up the cultural competency in
8 more the clinician side of the coin.

9 MR. GOLDWATER: Okay. True. Paul?

10 MEMBER GIBONEY: I think, when I think
11 of disparities, perhaps even in our own inner-
12 city population in L.A., but also rural, I think
13 of two different things. I think, is the service
14 available? Like, if you've identified that tele-
15 dermatology is important, to a certain
16 population, is it even available?

17 Because, I mean, we all know, I mean,
18 when I read a lot of telemedicine literature, I
19 see, oh, well, we did these five specialties, or
20 we did this specialty in this place, but they
21 don't have access to everything else via
22 telemedicine. So, the first thing is, is a

1 particular service available at all?

2 And then, the second one, is it
3 available in such a way that it's being utilized?
4 So, if tele-derm is available, but it's only
5 available on the iPhone 7 because of some sort of
6 technological capability or requirement, well,
7 then it's not maybe going to get the uptake. And
8 so, I think if we're going to actually talk about
9 a framework or measures, we have to talk about
10 both of those things. Is it available and is it
11 used?

12 MR. GOLDWATER: Kristi?

13 MEMBER HENDERSON: So, it's
14 interesting, last week, I was here doing a
15 presentation on the use of telehealth for health
16 disparities. And so, it was an interesting
17 conversation, but around the cultural
18 competencies and my ability to now bring in
19 interpreters or anyone from anywhere to do things
20 that I couldn't do in person, it actually raises
21 the bar when you think about it. And now, the
22 geographic disparity goes away.

1 And so, I think that there are clear
2 measures that we can look at. Can we bring in
3 interpreters and now provide a culturally
4 competent workforce no matter where we are? So,
5 anyway, I think that's a great point to have
6 brought up.

7 MR. GOLDWATER: Yes. Great. Stewart?

8 MEMBER FERGUSON: We all -- we've done
9 access papers for telemedicine and we don't use
10 the standard metrics. We've looked at waiting
11 time for a patient to get served and it goes from
12 six months to two days, but the way that we
13 measure access in any normal healthcare
14 environment is we use third next available or
15 some other national benchmark like that. And I
16 wonder if it just makes sense -- I mean, that
17 would be interesting to do third next available
18 for telehealth.

19 MR. GOLDWATER: Right. I agree.

20 MEMBER FERGUSON: Right. And of course
21 you can do it by -- in the hospital, you do it by
22 specialty or department and that starts to make

1 sense.

2 MR. GOLDWATER: Angela?

3 MEMBER WALKER: After being told not to
4 change the framework --

5 (Laughter.)

6 MEMBER WALKER: Perhaps we could add an
7 additional measure concept that would be
8 equitable and equality of care.

9 MR. GOLDWATER: What do people think?
10 Judd?

11 CHAIR HOLLANDER: So, my recollection
12 is that, when I reviewed measures, there was a
13 specific thing within the measure review that
14 looked at, are there gender inequalities and does
15 this measure help to narrow that gap. Is that
16 correct across all measures or was that just some
17 specific ones?

18 MS. WILSON: No, let me clarify this.
19 In the NQF evaluation criteria, we have had a
20 clinical adjustment piece for a very long time.
21 For a number of years, we, NQF was prohibited, or
22 NQF prohibited looking at SDS, sociodemographic

1 status, or you might socioeconomic status,
2 factors and incorporating them into risk
3 adjustment.

4 We're currently in a two year period,
5 as a trial, where all measures are being
6 reviewed, not only for the clinical adjustment
7 piece, which they always have been, but for an
8 adjustment for socioeconomic or sociodemographic
9 status. That trial period started in April of
10 2015, it will conclude next spring, and at that
11 time, there will be an evaluation of the trial
12 period and the NQF Board will decide whether to
13 move it forward.

14 So, you are correct that we are now --
15 all measures that come forward, when you get into
16 the evaluation criteria, there is a criterion
17 that asks about SDS risk adjustment. And how
18 that is asked is, one, is there a conceptual
19 basis, is there something in the literature, is
20 there evidence, where a particular variable is
21 shown to influence this performance measure?

22 If there is a conceptual basis, and

1 some measures may not have a conceptual basis for
2 SDS risk adjustment, if there's a conceptual
3 basis, then the measure developer is asked to do
4 the empiric analysis and see what is found in the
5 analysis if these variables are added.

6 And from there, a decision is made as
7 to whether or not the measure should be adjusted
8 for SDS. So, on the endorsement side, that's how
9 we handle this issue, but obviously what you're
10 talking about in disparities goes beyond that.

11 MR. GOLDWATER: Right. Nate?

12 MEMBER GLADWELL: I'm having a hard
13 time linking disparities in with this
14 conversation. I certainly support reaching out
15 to underserved and disparate populations using
16 telehealth, but that seems to fit other efforts.

17 And my fear is that disparity will be
18 the new rurality clause that we faced in CMS and
19 elsewhere, that, if we create a measure around
20 disparity, CMS or other payers might say, if
21 you're not reaching a disparate population that's
22 underserved in some capacity, then we're not

1 going to fund that effort, or something to that
2 effect. So, I just wanted to raise that concern.

3 MR. GOLDWATER: Right.

4 MEMBER GLADWELL: I'm having a hard
5 time with that in my mind.

6 MR. GOLDWATER: Right. Don?

7 MEMBER GRAF: But if you're able to,
8 without perhaps even mentioning it, take
9 standards that you were talking about in
10 populations that are below what the averages are
11 and then adjust the adequacy of the care
12 availability of it to meet the need in the
13 community, then almost by definition, you're
14 addressing the issue.

15 And so, maybe there's a way of having
16 it without running the risk of it becoming the
17 new sort of forefront focus or overfocus of
18 attention. But the realities are just blatant in
19 certain communities, where instances of diabetes
20 or substance abuse, all because of social and
21 geographical and a number of issues, you can't
22 not address that.

1 MR. GOLDWATER: Right.

2 MEMBER GRAF: And for us, telehealth is
3 a huge solution. You get a lot more bang for
4 your buck.

5 MR. GOLDWATER: I mean, so, again,
6 putting the policy hat on for a second, and being
7 very mindful, Nate, of your fears, which are well
8 documented, I think there's enough evidence, and
9 Eve-Lynn can speak to this too, that the
10 disparities of care in certain areas are
11 significant, have been systemic, quite honestly,
12 and that telehealth provides a way of providing
13 care where care would not have been provided
14 before.

15 So, for example, the amount of mental
16 and behavioral health disorders amongst Native
17 Americans is significant, particularly
18 depression, anxiety disorders, substance abuse,
19 eating disorders amongst children and
20 adolescents, and the evidence from, and not just
21 federal studies, but reports from states like
22 Minnesota, Wisconsin, North Dakota, which

1 indicate the use of telehealth services made a
2 significant difference in, not necessarily
3 closing that gap, but providing services where
4 services would not have been provided, and as a
5 result, the care improved over time.

6 I'm incredibly mindful of what you're
7 saying, because we don't want to get down that
8 rabbit hole where suddenly we're providing
9 something and then CMS is like, oh, this will be
10 the sticker that every measure's got to go
11 through. Don't want to do that.

12 But I agree with Don's point, I think
13 there's a way of showing this and, mindful of
14 sort of what Stewart and Dale were talking about,
15 where we can demonstrate this without really
16 going into the type of in depth analysis where
17 CMS would start to do that.

18 And I think it's important to consider
19 for the reason that I think that is a very
20 impactful argument, from a policy perspective,
21 that if you're showing that you -- I mean,
22 especially given we don't know what's going to

1 happen in the next several months with the
2 Affordable Care Act, if we're still able to --
3 and I say that because health IT and telehealth
4 in general have very strong bipartisan support,
5 regardless of who is in the White House.

6 But given that, if we're going to --
7 if we can demonstrate that regardless of health
8 coverage policy, that if telehealth provides some
9 needed services that reduce or provide care where
10 care would not have been provided and, as a
11 result, increase access to care in these
12 populations and provide services and increase
13 quality over time, I think that's a great
14 argument as we try to move forward and expand
15 telehealth, beyond just showing some of the more
16 structured, straightforward quality metrics.

17 But, you're right, it's a very fine
18 balancing act to do this. So, I don't think I
19 want to dismiss it, I think it's worth
20 exploration. So, go ahead.

21 MEMBER GLADWELL: Just one final
22 comment, I just have to go on record in saying

1 that we would be able to do a lot more good had
2 good-minded policymakers not intervened in such a
3 way in the past.

4 MR. GOLDWATER: Right. And I hear you,
5 having been one of those policymakers a long time
6 ago. Which I don't admit openly. David?

7 MEMBER FLANNERY: I really like the
8 idea that Stewart brought up of these
9 epidemiologically-based targets --

10 MR. GOLDWATER: Yes.

11 MEMBER FLANNERY: -- for access and
12 utilization, because it goes under system
13 effectiveness, I think. And you could actually
14 have measures and you have expected number of
15 patients that should receive a type of service
16 and then, you could be measured as you're
17 delivering that. I think it's excellent.

18 MR. GOLDWATER: Right. Kristi, did you
19 have something you wanted to say, or did you --

20 MEMBER HENDERSON: He touched on it,
21 but I think that when you were talking out loud
22 around addressing Nate's point around being

1 sensitive to creating this disparity category,
2 that everything you were talking about was
3 access, and we've captured that and we don't have
4 to name it that.

5 But if we think about the cultural
6 side of it and some of those other things,
7 population health addresses those in a safe word,
8 where we don't label it as something else, but
9 put a positive spin on it. Because then you take
10 into consideration all those unique things around
11 each population that you're serving.

12 MR. GOLDWATER: Right. So, it does
13 bring up another question, to get to Angela's
14 point, regrettably, which is, do we want to
15 create another measure concept that talks about
16 equitable care?

17 Or do you think that that falls under
18 one of the concepts we already have? Does it
19 fall under patient and family experience or
20 system effectiveness, or do you think a separate
21 category should be created? Steve?

22 MEMBER NORTH: I don't think a separate

1 category should be created.

2 MR. GOLDWATER: Okay.

3 MEMBER NORTH: I think that it weaves
4 in with all of these.

5 MR. GOLDWATER: Okay.

6 MEMBER NORTH: Yes.

7 MR. GOLDWATER: Adam?

8 MEMBER DARKINS: If you start doing
9 that, you go down sort of the route of having
10 then to do health needs assessment, because
11 otherwise, what is it?

12 MR. GOLDWATER: Right.

13 MEMBER DARKINS: You said -- so, there
14 are other ways to determine access to care and
15 how that should be done by policymakers,
16 politicians, insurance, et cetera.

17 MR. GOLDWATER: Right.

18 MEMBER DARKINS: I think our role is to
19 say, if you've got targets to meet and you've got
20 standards to meet, one of the ways you could do
21 it is via telehealth. Then prescribe or attempt
22 to set some standard that says -- it's taking

1 away, really, the decision making. I think what
2 we want to do is empower people to use it --

3 MR. GOLDWATER: Right.

4 MEMBER DARKINS: -- as opposed to
5 trying to ram it down their throats.

6 MR. GOLDWATER: Right. Correct.
7 Perfect. Okay. Is that all right, Ang? Okay,
8 good. All right. Marcia?

9 CHAIR WARD: Kristi mentioned
10 population health, and is that definitely
11 embedded in here?

12 MR. GOLDWATER: I think it probably
13 could be under -- go ahead, Kristi.

14 MEMBER HENDERSON: Or is it system
15 effectiveness --

16 MR. GOLDWATER: Yes.

17 MEMBER HENDERSON: -- a piece of that
18 maybe?

19 MR. GOLDWATER: Yes.

20 MEMBER HENDERSON: I don't know.

21 MR. GOLDWATER: And access too, to some
22 extent.

1 MEMBER HENDERSON: Because then we
2 don't change the framework.

3 MR. GOLDWATER: Right.

4 (Laughter.)

5 MEMBER HENDERSON: I don't want to get
6 a reputation.

7 MR. GOLDWATER: It's okay to change,
8 it's fine. All right. Moving to cost and cost
9 effectiveness, what do you feel are some of the
10 important concepts we really need to be focused
11 on here as it relates to telehealth? Chuck?

12 MEMBER DOARN: I think the opportunity
13 costs, the costs of not doing it or the costs of
14 doing it. There are benefits to doing it and
15 there's benefits to not doing it. I think it's
16 important to look at the overall -- I mean, if
17 you talk to a business manager in a hospital,
18 they're concerned about the cost of labor, the
19 cost of equipment, they really don't concern
20 themselves about the cost to the patient to get
21 to the hospital --

22 MR. GOLDWATER: Right.

1 MEMBER DOARN: -- and the parking and
2 the driving and all that. So, there's all those
3 kinds of hidden costs that oftentimes go, I
4 wouldn't say they're unreported, but they're not
5 part of the actual return on investment
6 equations. So, I think it's important to make
7 sure that we address that, the whole cost
8 structure, not just the business part of it.

9 MR. GOLDWATER: Okay. Sure. Any
10 others? Stew? Stewart, sorry.

11 MEMBER FERGUSON: That's okay.

12 (Laughter.)

13 MR. GOLDWATER: I never know.

14 MEMBER FERGUSON: No, that's okay. Is
15 cost avoidance part of this equation?

16 MR. GOLDWATER: It could be, sure.

17 MEMBER FERGUSON: Yes. And the other
18 thing might be coding differences. Coding and
19 billing. We might be different from other folks,
20 but we find when we do stuff over the phone we're
21 not able to bill for a Level 3 or Level 4
22 consult, which we almost invariably do when the

1 person shows up in our exam room. So, there may
2 be -- you're just limited on body systems and
3 some other things that lower your coding level.

4 MR. GOLDWATER: Right. All right. Any
5 others? Judd, in your program, I mean, how do
6 you evaluate cost and cost effectiveness?

7 CHAIR HOLLANDER: We spend a lot of
8 money and have very little revenue, mostly.

9 (Laughter.)

10 CHAIR HOLLANDER: So, I think it
11 depends on how into the weeds that we want to get
12 right now, but we're doing this as a loss leader
13 for downstream revenue.

14 MR. GOLDWATER: Okay.

15 CHAIR HOLLANDER: So, we actually
16 believe that by being good to many of the young
17 people that may be using the technology that have
18 a one and done problem, means 20 years from now,
19 if they need a liver transplant, their only
20 connection will be Jefferson.

21 We find in our neck of the woods that,
22 although payers and politicians and policymakers

1 believe in the patients and family home and a
2 primary care provider, 20 and 30 year olds don't.

3 And so, we actually have real data
4 that 79 percent of the people that use our urgent
5 care center don't have a primary care provider,
6 this is not telehealth, it's the bricks-and-
7 mortar urgent care center, and 79 percent of
8 them, when offered an urgent care provider
9 appointment in the same building, so it's
10 convenient, say, no thanks.

11 And so, for us, we believe the way to
12 have the most touch points with patients is by
13 making it convenient when they want it. And
14 although we've put a lot of emphasis on care
15 coordination, that's actually not what the
16 Millennials want.

17 MR. GOLDWATER: Right.

18 CHAIR HOLLANDER: So, it's really a
19 long-term investment to do that. And then,
20 you've got to track over the years how many
21 people come to you and how much revenue do you
22 generate. So, it's really difficult.

1 One of the things we haven't tracked,
2 but Chuck reminds me in his talking, well,
3 there's a lot of technical expenses, these
4 platforms cost real dollars and everybody's happy
5 to add those to the expense side, but if you
6 attribute some fraction of the rent or bricks-
7 and-mortar portion of the building to each visit,
8 which cost accounting can do, well, they don't
9 have that and that probably more or less offsets
10 some of the technical costs.

11 MR. GOLDWATER: Right.

12 CHAIR HOLLANDER: And depending on the
13 platform and whatnot. So, I think getting into
14 detailed costs at the facility level, the
15 technical level, the society level, lost days
16 from work, being able to keep people at work is
17 huge. I'm in Philly, so there's no parking
18 spots.

19 MR. GOLDWATER: Right.

20 CHAIR HOLLANDER: And, in fact, we have
21 this unique policy, I'll say this because it's on
22 tape, where if you show up more than 15 minutes

1 late, they're not going to see you, because
2 they've made the clinical judgment they'd rather
3 not have everybody else wait and have one annoyed
4 patient rather than everybody backed up during
5 the day.

6 MR. GOLDWATER: Right.

7 CHAIR HOLLANDER: So, my wife has
8 driven there, been in and out of a parking lot,
9 because there were no spots, had to get a refund,
10 go to another lot, and showed up 16 minutes late
11 and they sent her away. So, there are ---

12 MR. GOLDWATER: I'm glad I wasn't there
13 for that.

14 (Laughter.)

15 CHAIR HOLLANDER: The next time, she
16 showed up, something similar happened despite
17 leaving earlier and she said, I think you'll see
18 me today. And they said, oh, are you that lady?
19 Because you can imagine what happened the last
20 time.

21 (Laughter.)

22 CHAIR HOLLANDER: And so, they saw her.

1 But --

2 MR. GOLDWATER: I have no experience
3 with that at all.

4 CHAIR HOLLANDER: But I guess there's
5 a lot of costs that become really hard in
6 simplistic cost models to --

7 MR. GOLDWATER: Right.

8 CHAIR HOLLANDER: -- do. And I think
9 on the other side is, there is -- we're looking
10 at the cost for our on-demand program. And so,
11 you have the option of doing something or doing
12 nothing, right, first, rather than telehealth.
13 You might go nowhere, you might go to your
14 primary, you might go to urgent care, or you
15 might go to the ER, you might do nothing.

16 You then call telehealth, but that's
17 not always one and done, we might actually send
18 some small percent to the ER or small percent to
19 urgent care, or they might elect to follow up
20 with their own doctor in the next couple of days,
21 in which case, you don't really save money.

22 And there aren't -- the payers have

1 these models and know what it is, but to the best
2 of my knowledge, there's not published data that
3 takes in the pre and the post terribly well.

4 So, I think it really would be nice to
5 have system-wide cost effectiveness and societal
6 cost effectiveness, to put some real numbers
7 around this. If we just look at how much the
8 payer may pay for a visit, we probably still win,
9 but not by as much.

10 MR. GOLDWATER: Right. Julie?

11 MEMBER HALL-BARROW: Yes, I was just
12 going to echo what Judd said. So, we've looked
13 at that separately in both our on-demand and then
14 our school-based programs. We have over 4,500
15 visits in these 97 schools and so, we took that
16 data and really looked at it.

17 So, now as we look at the payers,
18 what's the same-day self-pay rate for a school-
19 based clinic versus the same-day self-pay rate in
20 our outpatient pediatric clinic? And I will tell
21 you, we have drove our revenue management people
22 crazy, because they're like, we've got to charge

1 the same. No, we don't.

2 And so, we've actually broke some of
3 those numbers down and said, I don't have
4 registration, I don't have lab, I don't have
5 this, I don't have energy costs, I don't even
6 have the cost of the nurse, which is nice. But
7 looking at that and Medicaid, how do you pay at
8 the Medicaid rate piece, has been incredibly
9 crazy, because then, don't price it lower than --

10 MR. GOLDWATER: Right.

11 MEMBER HALL-BARROW: -- and so, it's
12 incredibly difficult. Now, on the on-demand
13 side, we've got some of that data, but I'll tell
14 you, the school nurse is a better predictor of
15 whether that child will end up going to the ER if
16 they didn't have telemedicine, we've looked at
17 some of that work as well.

18 But it's incredibly difficult, but I
19 think if we can capture some of that through some
20 of the studies, I think it would be powerfully
21 indicative of creating the measures.

22 MR. GOLDWATER: Okay. Stewart?

1 MEMBER FERGUSON: So, Judd inspired me
2 to get more complicated in my response.

3 (Laughter.)

4 MEMBER FERGUSON: No, but it's --
5 you're completely right, I mean, I think the most
6 basic cost models for telehealth miss so many of
7 the details. So, a good example is, opportunity
8 costs.

9 MR. GOLDWATER: Right.

10 MEMBER FERGUSON: So, as long as you're
11 seeing a low level patient, you're not seeing the
12 high level patient that you can do a procedure on
13 and bill for more. So, the more that you can
14 weed them out.

15 And then, the second part is, for us,
16 we've -- the decision to do telehealth sometimes
17 is more like the same reason that you actually
18 hire mid-levels, because you can do a level
19 shifting and you have people operating at the top
20 of their license rather than in the middle or the
21 bottom of their license, right?

22 And so, there's a whole workload

1 dynamic that goes along there and you have to
2 think about, now, who's doing the procedures and
3 are they spending more time doing procedures and
4 less time screening patients, because you're
5 doing that through some sort of telehealth
6 technology?

7 And then, the third thing is, most of
8 the cost models for telehealth are based around
9 fee-for-service. And with value-based
10 purchasing, we're looking at telehealth as a way
11 to jack up our MIP score and not hit the
12 penalties on Medicare reimbursement.

13 MR. GOLDWATER: Right.

14 MEMBER FERGUSON: So, you really have
15 to start to think about how you avoid your 30 day
16 readmits and how you hire quality care and in a
17 pop health model, your high acuity patients, your
18 chronically ill, you're going to keep them out of
19 your system, and that has a benefit.

20 And the healthy folks, you're trying
21 to just keep them, again, out of your system and
22 keep them healthy with a wellness program. So,

1 it's a lot more complex model, if you want to
2 dive into that.

3 MR. GOLDWATER: Well, not today.

4 MEMBER FERGUSON: No, no, but I mean,
5 I really think we should be having a cost model
6 or some measures that don't just strictly look at
7 fee-for-service.

8 MR. GOLDWATER: Right.

9 MEMBER FERGUSON: I guess, that's the
10 key thing.

11 MR. GOLDWATER: Right. I completely
12 agree with that. Steven?

13 MEMBER HANDLER: So, a couple of things
14 that we look at in particular, which are unique
15 in a way to nursing homes, but do expand to other
16 care settings, are potentially avoidable
17 hospitalizations as a concept. That's akin to
18 ambulatory-sensitive conditions.

19 And so, those are things that can be
20 costed out directly. So, you could look at
21 potentially avoidable hospitalizations, you could
22 look at ambulatory-sensitive conditions, you

1 could also look at readmission rates. All these
2 are monetized, right? You could look at failed
3 discharges, seven days, you could look at 30
4 days, you could look at 90-day horizons as the
5 alternative payment models are changing and
6 broadening. Then, the other concept that we
7 look, because we're an IDFS, we look at our
8 health plan, and this is important, because with
9 any IT-based solution, there's potential
10 unintended negative consequences and it can be
11 that you do telemedicine and then you actually
12 have additive cost.

13 Let me give a quick example. So, if
14 you see somebody for an acute change of condition
15 and you assess them, you may be putting on a
16 Band-Aid that still results in a downstream
17 transfer to the hospital two days later. So,
18 what you've done, essentially, is increase costs,
19 because you did telemedicine day one and they
20 still went out anyway on day two or three.

21 So, we have to look at not just the
22 cost savings, but how telemedicine -- we have to

1 be mindful that telemedicine, telehealth can
2 actually increase costs in certain instances as
3 well. So, I just want to make sure we're aware
4 of that so that we don't always skew this, as
5 others have said, just to the positive, but
6 there's opportunity to also look at the negatives
7 that we can introduce through the solution set.

8 MR. GOLDWATER: Kristi?

9 MEMBER HENDERSON: On the cost-
10 avoidance section, I mean, we could go on for the
11 rest of today and tomorrow talking about what all
12 that could include, and you touched on a few of
13 them, Steven, but other ones around decreasing
14 the length of stay, because I may send them home
15 on home-monitoring.

16 One that was not mentioned, that I
17 think we need to emphasize, is the no-show rate
18 for in-person clinics is very high in a lot of
19 clinics, there can be 30, and in some of ours,
20 even over 50 percent. I don't have that in
21 telemedicine.

22 And so, then my providers are able to

1 really use their time wisely. So, I'd just say
2 in the cost effectiveness piece, avoided
3 transfers, things like that are ones that we need
4 to capture in there.

5 MR. GOLDWATER: Sure. Chuck?

6 MEMBER DOARN: Well, I think when you
7 think about making people aware that telehealth
8 exists is a whole concept of marketing and
9 awareness campaigns. So, you might have people
10 come into the office and say, did you know you
11 could be seen by telehealth?

12 So, there's that face-to-face
13 interaction initially, but maybe there's --
14 oftentimes we forget about how we should budget
15 for that and effectively record that cost.

16 The other one, of course, is the
17 technology itself. You buy computer servers, you
18 buy communication bandwidth or whatever it is,
19 but that stuff has a shelf-life and sometimes
20 people forget to think about reinvesting after
21 three, four, five years.

22 And the licensing of the software, and

1 the important part of that is that if you say to
2 your patient, we're going to see you by
3 telemedicine or telehealth and we're going to
4 give you this device, it comes from your home
5 medical department, you have to have a certain
6 amount of bandwidth, you have to have a certain
7 version of this particular software.

8 And so, it's sort of both the patient
9 and the care provider. And it's almost sort of
10 like the haves and the have-nots, if you're going
11 to roll out a possibility for patients to be seen
12 by telehealth, but they don't have any bandwidth
13 in their home or they don't have any bandwidth in
14 their nursing facility, wherever it is, so a
15 couple of different items there.

16 MR. GOLDWATER: Okay. Sarah?

17 MEMBER SOSSONG: I'm not quite sure how
18 we would want to articulate this as a dimension,
19 but one of the things that we often think about
20 is the cost of the different telehealth
21 modalities. So, for example, insurers are only
22 paying for synchronous video. So, we're not

1 encouraging this, but there are phone calls that
2 could be converted to video.

3 So, there's really no incentive for us
4 to be cost effective, I think, the same thing,
5 we've been advocating to the insurers that e-
6 consults between two providers, so asynchronous,
7 should be paid for, because that would be less
8 expensive than a referral to a dermatologist.
9 But they won't pay the \$50, but they'll pay the
10 \$400 to the dermatologist.

11 Again, same thing with second
12 opinions. They wouldn't pay an \$800 second
13 opinion, but they'd pay for a \$20,000 back
14 surgery. So, how are we -- again, to Nate's
15 point, I don't want to put anything in here that
16 starts to penalize us, but something that would
17 encourage people to think thoughtfully about
18 those alternatives would be helpful.

19 MR. GOLDWATER: Sure. Daniel?

20 MEMBER TRUONG: Yes, just to kind of
21 piggyback on the point about possible increased
22 cost using telehealth and talk about redundancy

1 in the system. Locally, within our own
2 organization, we do track if someone had a
3 telehealth visit and then if they had an office
4 visit for the same thing within seven days.

5 So, that's just kind of our way of
6 showing if we're developing waste in the system
7 and increasing costs to the patient and to our
8 organization.

9 I don't know how we'd do it from a
10 system-wide perspective, where there's -- in the
11 terms of interoperability or whether it's some
12 other tracking mechanism, but I just want to kind
13 of raise that as a potential place that we should
14 kind of focus on, on decreasing waste and
15 redundancy as we build telehealth in the fee-for-
16 service world.

17 MR. GOLDWATER: Sure. Dale?

18 MEMBER ALVERSON: We touched on this
19 yesterday, but this relates to kind of where we
20 see this overlap in however you're going to
21 diagram this, with improved health outcomes and
22 cost savings.

1 And one of those that's quite evident
2 is avoiding or preventing complications and
3 subsequent more costly care. That points that we
4 talked yesterday about stroke, more timely,
5 effective treatment of a patient with stroke that
6 qualifies for treatment you've avoided need for
7 rehabilitation, speech therapy, or maybe even
8 prevented a death, but still, there's a cost
9 savings. Same thing with diabetes, with retinal
10 scanning, preventing blindness.

11 And we've looked at that, extrapolated
12 that, where 200 patients with diabetes in New
13 Mexico had a retinal scan, and of those patients,
14 ten of them had sight-threatening retinopathy
15 that got therapy and blindness prevented.

16 And we can extrapolate that and show
17 that if they'd gone blind, you could have paid
18 for the whole system by just what the cost of one
19 week of rehabilitation for blindness, let alone
20 their asset value that's been lost and so on, by
21 being blind.

22 Same thing could go to cancer, early

1 intervention, and so on. So, it's something that
2 should be factored in, but it overlaps with
3 better outcomes, but it also leads to actually
4 avoiding expensive complications and subsequent
5 more expensive care.

6 MR. GOLDWATER: Okay. Judd?

7 CHAIR HOLLANDER: One of the things is,
8 we're trying to emphasize on things that we can
9 convert to e-measures or do this by e-measures
10 and one of the comments I heard that I find a
11 little problematic in an e-measure, but not in an
12 other measure, is looking at, what's the
13 downstream visit?

14 So, one of the things that I think we
15 do best on our direct-to-consumer platform is
16 sort of down-triage people. So, if you call me
17 with a knee issue and it's 7:00 at night and you
18 would otherwise go to the ER, I send you to see
19 your orthopedist or your primary care doc,
20 depending on the exam I get.

21 So, if you're showing up, you'll have
22 a visit in the next week, but I will have

1 downgraded from an ED or urgent care visit, I
2 will have -- now you'll have one x-ray, because
3 your orthopedist is always going to repeat the x-
4 ray. And so, there's a tremendous amount of cost
5 savings, but on an e-measure, it'll look like
6 telehealth did nothing. And so, we need to
7 figure out a way to capture that.

8 MR. GOLDWATER: Right. That sort of
9 gets back to modifying the term of treatment.
10 Don?

11 MEMBER GRAF: I wanted to echo what
12 Dale was saying, with a different example of
13 reducing NICU days for complex OB patients,
14 treating comorbidities, and the calculations for
15 that are pretty simple, but when you consider the
16 extension of immature births and all of the
17 things that are avoided from the child's
18 perspective going forward and the savings there,
19 haven't even touched that, but it's real. And
20 some place, somehow, it ought to be captured.

21 MR. GOLDWATER: Good point. Steven,
22 did you have something else you wanted to add?

1 Okay.

2 MEMBER HANDLER: So, other approaches
3 that we've taken that I think are important is
4 that the concept of better using technology to
5 align with care plan goals. Meaning, as we shift
6 and understand what patient preferences are of
7 their care in terms of their intensity of care,
8 so we use telehealth for AIC program, advanced
9 illness care. So, if you could bend the curve
10 and they decided that they don't want intensive
11 care, the cost savings are incredible.

12 MR. GOLDWATER: Yes.

13 MEMBER HANDLER: So, they don't want to
14 go to the hospital anymore, they don't want to go
15 the ICU, et cetera, and then we monitor them
16 remotely. So, that's one opportunity. So,
17 better alignment of care plan goal that helps
18 with transitions of cross-cutting and there's a
19 tremendous cost savings, that's the biggest
20 outlier for our health plan per member, per month
21 issue.

22 MR. GOLDWATER: Right.

1 MEMBER HANDLER: And then, I think it
2 was mentioned also, transportation costs and some
3 people have assigned a carbon footprint, right,
4 quite literally, not only to the patient, but
5 also to the provider. So, those are huge cost
6 savings as well.

7 MR. GOLDWATER: Okay. And --

8 MEMBER HANDLER: And to the planet,
9 perhaps.

10 MR. GOLDWATER: Steve Number Two.

11 MEMBER NORTH: Thanks. One of the
12 things we spent some time yesterday discussing
13 was, does the money stay local? And so, how does
14 that fit into a cost equation? So, that TIN
15 number, where's the site of care, where's the
16 billing?

17 MR. GOLDWATER: Okay. Dale?

18 MEMBER ALVERSON: One other point, we
19 talked a little bit about various sites of care,
20 but one of the areas where that's been addressed
21 early on is in correctional facilities.

22 And I don't know if that's been

1 captured, but, again, there's a lot of health
2 outcomes that can be addressed in the prison
3 population, but there's also this avoidance of
4 transporting a prisoner for care when you could
5 do it virtually. Because that's pretty
6 significant, because it takes two correctional
7 officers usually.

8 MR. GOLDWATER: Right.

9 MEMBER ALVERSON: And so, it becomes
10 very expensive. And so, a lot of correctional
11 medicine is showing a significant decrease in
12 cost by using telemedicine. And sometimes that's
13 the foundation of a lot of programs, I know that
14 was certainly the case in West Texas, out of
15 Lubbock.

16 But somehow -- I haven't heard that
17 mentioned, but that is an issue that we have to
18 be able to address and I think there's definitely
19 a cost savings you could argue. There's probably
20 some important health outcomes as well by
21 managing those problems in a more timely manner.

22 MR. GOLDWATER: Thank you very much.

1 Stewart?

2 MEMBER FERGUSON: Did we mention days
3 lost at work and school? We did mention that? I
4 didn't hear it, okay.

5 MR. GOLDWATER: Yes. Don?

6 MEMBER GRAF: I wanted to add, when
7 we're talking about cost, extra costs of
8 delivering telehealth, it's often overlooked and
9 perhaps immaterial, but originating site
10 reimbursement.

11 MR. GOLDWATER: Right, yes.

12 MEMBER GRAF: Something that, today may
13 be a nominal amount, but as time goes on and
14 maybe if originating site from the home isn't as
15 expansive as it ought to be, it is something that
16 needs to be taken into consideration.

17 MR. GOLDWATER: Steve North, did you
18 have another comment?

19 MEMBER NORTH: No.

20 MR. GOLDWATER: Okay, good. All right.
21 So, we're at -- oh, Chuck.

22 MEMBER DOARN: We talked about

1 transportation costs and it reminded me, I
2 actually wrote a paper about federal prisons
3 about 15 years ago. When John Gotti was in
4 prison, they took him to the hospital, it took
5 them -- there were five police cars and two
6 helicopters, just to take him to the hospital for
7 a routine physical examination.

8 MR. GOLDWATER: It was John Gotti, you
9 realize?

10 MEMBER DOARN: Right.

11 MR. GOLDWATER: All right.

12 (Laughter.)

13 MEMBER DOARN: But the federal prisons
14 are -- yes.

15 MR. GOLDWATER: That would not be
16 normal protocol for me.

17 (Laughter.)

18 MEMBER DOARN: But federal prisons are
19 a little different than state prisons, and I
20 know, in Texas, obviously, there's a lot of
21 challenge with moving people around and UTMB does
22 a lot of that work.

1 MR. GOLDWATER: Right.

2 MEMBER DOARN: But also, within the
3 DoD, there's a lot military personnel that are
4 stationed around the Pacific Rim that they bring
5 them to Honolulu or to Tripler for speech
6 language issues when they're screaming to the top
7 of their lungs in the flight line.

8 So, they actually developed a
9 telemedicine system where they can actually see
10 people. And that saves the military hundreds of
11 thousands, millions of dollars, because to
12 transport one person off their duty station to
13 Tripler is in the \$100,000 to \$200,000 range,
14 just to bring them by whatever kind of plane they
15 bring. So, there's a lot of -- and the other one
16 is, Peter, you got all of these, I don't know if
17 you --

18 MR. GOLDWATER: Yes.

19 MEMBER DOARN: Again, in the
20 literature, it's done a lot of stuff on carbon
21 footprints and going green and so forth.

22 MR. GOLDWATER: Right.

1 MEMBER DOARN: So, some of those
2 papers and I think there's a couple out of Canada
3 as well.

4 MR. GOLDWATER: Yes. We talked to
5 Peter, we actually invited Peter to be part of
6 this committee, but he didn't want to be seen
7 with any of you, so -- no, I'm kidding. He's way
8 too busy and had too many academic commitments to
9 make it, which is a shame. What's that? Yes,
10 Barb's keeping him very busy, that's for sure.
11 All right. So, we're at 12:00 -- oh, I'm sorry,
12 Peter, go ahead.

13 MEMBER RASMUSSEN: Yes, just one last
14 question, I'm interested in your comment on it,
15 I'm looking at some of your other measures on
16 cost and resource use. So, for instance, the one
17 I just pulled up here is on the relative resource
18 use of people with asthma.

19 So, how are -- I mean, what are you
20 proposing would be different or expand on that?
21 I mean, if I'm thinking about a chronic
22 management program around asthma patients, it

1 would seem like what you already have would
2 really encompass that.

3 MR. GOLDWATER: So, it's a great
4 question, because it leverages, again, work we've
5 already done. And that was one of the reports
6 that we are look at actually to see it's
7 applicability to this. What's been helpful about
8 this discussion is, you all have highlighted
9 elements that need to be included within that
10 concept.

11 And so, apart from, I think, going
12 back through the literature and finding
13 literature that supports what you're saying,
14 which would help build out concepts, we'll also
15 go to what NQF has already done and start pulling
16 out some of those other measure concepts or
17 measures that relate, again, to some of these
18 elements that you've talked about.

19 And when we meet again, or I think in
20 our subsequent meetings and in our in-person,
21 that will be presented and then you can determine
22 whether or not that's relevant to include as a

1 part of the telehealth framework. It's an
2 excellent point. Okay. Before I say anything,
3 anyone else? All right.

4 So, thank you all very much. We're at
5 just after 12:00, so we'll take a half hour break
6 for lunch. When -- yes, hold on, I'm just -- I
7 know, Marcia. So, when we come back, the rest of
8 the slides, I think, are pretty useless at this
9 point. And I'm not saying that because I'm
10 criticizing myself, which I do frequently, and my
11 kids are more than happy to join in on that. But
12 I think it will lead to more confusion, because
13 it's talking about things we've just completely
14 redesigned.

15 So, what I want to do is to go back
16 over the remaining four concepts and do exactly
17 what we're doing, highlight things we need to --
18 because it's really very helpful, about how we
19 can focus in with the literature, how we can pull
20 from the NQF reports, really getting to the
21 things you all feel are incredibly important.
22 And I find that to be very, very helpful.

1 And then, I want to take a short
2 break, probably, after that, and then come back,
3 because I think we're going to have some time,
4 and to talk a little bit, maybe for half an hour
5 or so, about get your key ideas on how, from a
6 very high perspective, to make this actionable.

7 I don't want to plan, that's the next
8 time we meet, but I really want to get some
9 things for us to consider, to start to draw out
10 in the next few months, about how we actually
11 make this actionable. Megan, did you have
12 something you wanted to say? Before I get to
13 public comment?

14 MEMBER MEACHAM: I mean, if I have a
15 minute, I'll put in a shameless plug.

16 MR. GOLDWATER: Go ahead.

17 MEMBER MEACHAM: Today is National
18 Rural Health Day. So, I would just like to tell
19 you all a little bit about National Rural Health
20 Day in case you have not heard of it. It is -- I
21 think we started it in 2010 or 2011, I better
22 check my facts, but most states around the

1 country do their own things.

2 Our office participates, the National
3 Organization of State Offices of Rural Health
4 participates, the National Rural Health
5 Association, which is one street over,
6 participates.

7 So, as most of you probably know, one
8 in five Americans live in rural, about 20 percent
9 of the population. And so, it's an opportunity
10 that we picked the third Thursday in November,
11 aligns with hunting season in a lot of states, so
12 it's kind of appropriate, or not appropriate,
13 because everyone's out hunting.

14 (Laughter.)

15 MEMBER MEACHAM: But it's really just
16 the opportunity to highlight the success and the
17 challenges and celebrate the power of rural. So,
18 I just want to, again, reiterate that what you
19 all are doing through this project is really
20 going to impact rural Americans, all Americans,
21 but particularly rural given the tool that
22 telehealth can be for rural. So, thank you.

1 MR. GOLDWATER: All right. So, before
2 we break for lunch, we need to open up for public
3 comment. Operator, can you open the line for
4 public comment, please?

5 OPERATOR: Yes. At this time, if you
6 would like to make a comment, please press Star,
7 then the Number 1 on your telephone keypad. And
8 there are no public comments at this time.

9 MR. GOLDWATER: And it's just Elisa, so
10 that's good. All right. So, let's take -- I've
11 got 12:10, so 12:40, we'll convene again. So,
12 thank all you very much.

13 (Whereupon, the above-entitled matter
14 went off the record at 12:09 p.m. and resumed at
15 12:47 p.m.)

16 MR. GOLDWATER: Okay. So, we are just
17 at almost 12:50. So, let's pick up again. I
18 have all the confidence in the world we'll be
19 done by 2:30, if not earlier. All right. So,
20 thank you all very much for everything so far.

21 So, what I want to do for the next,
22 hopefully hour, maybe a little bit over, is to

1 just go through the rest of the concepts, if you
2 could all again provide some key elements of
3 things you believe we really do need to consider
4 when we look at this, when we look at the
5 literature, when we look at our reports, things
6 that we need to be focused on in order to get the
7 appropriate level of information.

8 Not simply to understand how to then
9 eventually develop the framework to build
10 measures, but also, as I was speaking to Marcia
11 afterwards, to understand where the gaps are,
12 things that we do need to be focused on as well,
13 things that don't exist.

14 So, we wanted to use system
15 effectiveness as one of our measure concepts.

16 So, what elements do you think need to be
17 included in that? And I realize it's after
18 lunch, this is when everyone's like, ugh. All
19 right. Yes, Steve, thank you.

20 MEMBER NORTH: You're welcome. I'll
21 fall asleep momentarily.

22 (Laughter.)

1 MEMBER NORTH: One of the measures of
2 effectiveness is, does the information in the
3 visit, however visit is defined, get to the
4 provider who can act on it or needs it for
5 references?

6 So, whether the virtual cardiology
7 referral ends up with the primary care physician
8 or does the remote home monitoring information
9 around pulmonary function end up at the
10 pulmonologist in a timely manner, so there's not
11 a, waiting for that fax to come in sensation.

12 MR. GOLDWATER: Okay. Wonderful.
13 Anyone else? Anyone? Yes, Paul, thank you.

14 MEMBER GIBONEY: I think also certain
15 systems, you have a limited amount of resources
16 with which to apply to a particular problem,
17 right?

18 We're the County of Los Angeles, the
19 Board of Supervisors has made it imminently
20 clear, we are getting no new money, period. And
21 so, every effort of ours is spent on, how do we
22 use the resources we know we have in the most

1 effective way possible?

2 And so, what telehealth helps us do
3 is, if I've got 15 cardiologists and I've got a
4 population of care of 650,000, how do I now say,
5 what is the expected need of my patients and what
6 resource do I have to apply to them? And so, the
7 telemedicine is one piece of how I deliver that.

8 So, when I think about how effectively
9 I'm doing that, it's not just, how quickly are
10 patients getting access to cardiology expertise,
11 it's, what are all the other things I'm asking
12 those cardiologists to do and how well are they
13 all doing it as well?

14 So, I think, system effectiveness at
15 some level is, how are you using what you have to
16 address the needs of whoever that projected
17 population of care is coming to you? I don't
18 know if that's too nebulous, but when I think
19 about that, that's something that comes to mind.

20 MR. GOLDWATER: Okay. Henry?

21 MEMBER DEPHILLIPS: That was very
22 eloquent, leave it to me to bring the

1 conversation down to the fourth grade level. The
2 most fundamental measure in the industry today
3 for system effectiveness is utilization.

4 MR. GOLDWATER: Okay.

5 MEMBER DEPHILLIPS: In other words, you
6 design it and build it and throw it out there and
7 it's brilliant, but the real question at the end
8 of the day is, does it get used? Because there
9 won't be any Outcome measures available to
10 anybody if there's no use of the actual system.

11 And, actually, when you're talking
12 about -- we talked yesterday about, this is a
13 consumer-facing thing, right? The consumer
14 experience or the patient experience is very
15 important. Utilization itself is a measure of a
16 positive patient experience, because if they use
17 it at scale, it means they like it.

18 MR. GOLDWATER: Right. Okay. That's
19 not a fourth grade level, by the way. Thanks.
20 Jean?

21 MEMBER TURCOTTE: I think we mentioned
22 this under the cost effectiveness as well, but to

1 look at redundancy under the effectiveness,
2 whether it's in the virtual office visit that
3 someone had mentioned and then within seven days,
4 they come and see their own or another physician
5 in their office, or we can apply it to the acute
6 world where, for example, in the ICU setting, you
7 really have to look at how your services work,
8 because you can have your remote team caring for
9 the patient and the onsite physician as well, you
10 really have to collaborate and coordinate who
11 will manage what aspects of the care. So, I
12 think we have to be very careful, but include the
13 redundancy of your system.

14 MR. GOLDWATER: Yes. Okay. Judd?

15 CHAIR HOLLANDER: Yes. So, although it
16 can fit several places, care coordination fits
17 here. And the other thing, although it also fits
18 on cost and cost effectiveness, and Peter threw
19 these words out before lunch, the relative
20 resource use would be nice here, because if we're
21 coordinating enough and dialing down total
22 resource use, that's fine.

1 And then, I'm going to ask a question
2 and confuse this a little bit. Do we mean the
3 system by the health system or the telehealth
4 system? And then, the word system, now as I
5 think more about it, pigeonholes us so in my neck
6 of the woods, we mean Jefferson, but I want to
7 coordinate their care even if they go to Penn or
8 Hahnemann or Drexel.

9 And so, does system -- do we want to
10 define it as the care system for the patient, but
11 not the healthcare system? Do we want to make it
12 broader rather than narrower? Because I think
13 that's more patient-focused.

14 MR. GOLDWATER: I don't think it refers
15 to the healthcare system, I think that's a bit
16 out of scope.

17 CHAIR HOLLANDER: Okay.

18 MR. GOLDWATER: But the system of care
19 for the patient as it pertains to telehealth,
20 yes. Dale?

21 MEMBER ALVERSON: Sort of to add to
22 that, and we've mentioned this again yesterday,

1 but this gets into transitions of care. And
2 that's where you may be crossing over to a
3 totally different system or you're going from
4 hospital to rehab to skilled nursing facility or
5 even home.

6 So, that concept of transitions of
7 care seems to fit into that systems
8 effectiveness. And that's going to be a really
9 important thing. That then leads to other
10 issues, the decrease in errors through better
11 communication, better transitions of care. And
12 then, that also leads to unnecessary duplications
13 of testing and procedures and inappropriate
14 treatments. So, anyway, just so that, I make
15 sure that gets captured as well.

16 MR. GOLDWATER: Yes. Stewart?

17 MEMBER FERGUSON: So, just a friendly
18 amendment to what Jean said. So, you were
19 talking about redundancy, I guess I would call it
20 availability.

21 Redundancy suggests that you got a
22 backup; availability means that you keep the

1 system running whether it's redundant or not.

2 But availability is really important, failures, I
3 think we all know if it fails once for a doc, you
4 actually never get a second chance.

5 And then, the second thing I'd say is,
6 response times. And I don't know if that belongs
7 in one of your other dimensions, but the ability
8 for a doctor to have a timely response is huge,
9 actually, in terms of the system being effective.

10 And then, in terms of growth, I really
11 like what Henry said. We actually track, do
12 doctors keep using it more each year and we
13 actually find that most of them keep adding about
14 ten percent more cases per year, which really
15 tells us a lot.

16 But I think the other thing for system
17 effectiveness, it makes no sense to build out a
18 system, but only do one service. So, you really
19 have to look at the range of services you offer
20 for the entire system to be effective. You can't
21 just do mental health and stop.

22 MR. GOLDWATER: Right. Don?

1 MEMBER GRAF: Yes. I wanted to mention
2 two examples under continuity of care, kind of
3 overview. One was, physicians who are extending
4 their service models for their patients who are
5 snowbirds. So, as I am going this way for the
6 winter or that way for the summer, I'm able to
7 extend my reach and continue, rather than having
8 one doctor for six months of the year.

9 And in one instance, I actually ran
10 into a physician who themselves was a snowbird
11 and was connecting back to their own clinic
12 virtually to be present virtually when their
13 extenders were continuing to treat patients. So,
14 wanted to throw that out as, from a continuity
15 of care, or wherever it may fit.

16 MR. GOLDWATER: Marcia?

17 CHAIR WARD: I think yesterday when we
18 talked about this, somebody mentioned recruitment
19 or retention, and for rural healthcare. I think
20 we talked about it fitting within this category,
21 workforce.

22 MR. GOLDWATER: Okay. Anybody else?

1 Does that cover generally the larger range of
2 system effectiveness issues that we really should
3 be covering? Paul?

4 MEMBER GIBONEY: One more?

5 MR. GOLDWATER: Yes. Okay.

6 MEMBER GIBONEY: I think, and maybe I
7 referred to this a little bit yesterday, but
8 whenever you're working in a telehealth space,
9 you're constantly bringing new users of your
10 telehealth implementation or your tools onto the
11 system.

12 And sometimes it requires them to
13 think about the world differently, right? It
14 requires a specialist to realize, yes, I can
15 actually deliver high value care to a patient and
16 not actually have them in front of me, in my
17 clinic with my hands on them.

18 And so, if an organization or if an
19 implementation is going to be successful, they
20 have to have some sort of way of onboarding
21 people to the use of the tool and then measuring
22 the effectiveness of their use of the tool, the

1 adoption or whatever.

2 But it kind of -- I don't know if
3 there's like a training piece or an
4 implementation piece or an onboarding piece that
5 goes into that, related to that as the concept of
6 building people's professional capacity.

7 I mentioned this to Jason over the
8 break, one of the cost spending curves, but
9 another thing that goes on with this as well is,
10 say a primary care doctor is communicating with a
11 specialist, they're learning from that. And so,
12 their, actually, their expertise and their
13 capacity goes up over time.

14 If they're communicating with Angela
15 about a rash, next time they see that rash, they
16 actually don't even have to communicate with her
17 anymore, they just treat it. And so, I don't
18 know -- but I think a healthy high performing
19 system is going to measure somehow how they are
20 doing with adapting to new technologies and
21 bringing their team on to that.

22 MR. GOLDWATER: Okay. David?

1 MEMBER FLANNERY: I think we also
2 mentioned, keeping the patient in their medical
3 home as part of the system.

4 MR. GOLDWATER: Okay. Anybody else?
5 Chuck, nothing? Nothing on Google?

6 MEMBER DOARN: I'm checking to see
7 what's --

8 (Laughter.)

9 MR. GOLDWATER: Oh, okay. Dallas
10 doesn't play until Sunday. Anyway. All right.
11 Let's move on to -- yes, sir?

12 MEMBER RASMUSSEN: I guess, going back
13 to the concept that Kristi had about right care,
14 right place, right time, is there a way to
15 measure, let's say, decreased transfer across the
16 system from secondary to tertiary care --

17 MR. GOLDWATER: Yes.

18 MEMBER RASMUSSEN: -- some better
19 utilization of system resources or something?

20 MR. GOLDWATER: Absolutely. Kristi?

21 MEMBER HENDERSON: So, better
22 utilization of systems, but also personnel, did

1 we -- is this where we're going to pull that in?

2 MR. GOLDWATER: Yes.

3 MEMBER HENDERSON: The right workforce?

4 So we're not -- everyone's practicing at the top
5 of their license.

6 MR. GOLDWATER: Okay. All right.

7 Let's move on to clinical effectiveness. As
8 everyone sighs, like, ugh. Sorry. So, clearly
9 there's a lot of -- a lot of the literature,
10 certainly what we've gone over, a lot of it does
11 talk about the very clinical nature of what
12 telehealth can do and in some studies that have
13 been RCTs or case-controlled or quasi-
14 experimental have really gotten into that aspect.

15 But what I'm interested in, and I
16 think what would be of tremendous help to three
17 of us, is, rather than just looking at simply the
18 intersection of telehealth on an outcome, which
19 we're going to report on, what are some of the
20 elements of telehealth providing effectiveness in
21 the clinical setting? Or in a clinical
22 encounter, whether it be virtual -- for a

1 clinical virtual encounter through a number of
2 modalities? Yes, Don?

3 MEMBER GRAF: Just a point of
4 clarification, when we're talking about clinical,
5 we're talking about sort of practice management,
6 clinic, as opposed to outpatient or hospital or
7 are we talking about medical effectiveness?

8 MR. GOLDWATER: So, it would be -- I'm
9 presuming where the telehealth encounter would
10 take place, correct? Or the point of the
11 encounter? Or -- no? How would you define that
12 then? It's a good question.

13 MEMBER GRAF: Because the patient could
14 be in an ER, the patient could be presenting from
15 a hospital bed, a --

16 MR. GOLDWATER: Okay. So, let's start
17 with that. How do we want to define clinical?
18 I'm not a physician and I don't play one on TV, I
19 don't have -- my medical training is whatever I
20 pick up from the doctors that I interact with,
21 which is little. Sorry, Judd. All right.
22 Henry, go ahead.

1 MEMBER DEPHILLIPS: I actually am a
2 doctor, I am. So, when I listen to the
3 discussion over the last two days and I think of
4 clinical effectiveness, two things come to mind.
5 Don, I think that you started going down this
6 road, personally, I think about telemedicine as
7 extending the knowledge from where it is to where
8 it needs to be, right?

9 Using technology to extend medical
10 knowledge elsewhere. That's how I just
11 conceptually think about telemedicine. So, from
12 that standpoint, there's two parts to clinical
13 effectiveness that in my mind emerge from an
14 outcomes measurement standpoint.

15 Number one is, do the patients who are
16 receiving care using that modality have better
17 outcomes? Do asthmatics have fewer admissions, I
18 mean, there's all kinds of measures that we could
19 measure there.

20 And the second thing is, does the
21 provider of care become more efficient and
22 effective at treating successfully or caring for

1 successfully a broader range of patients? Those
2 are the two -- so, clinical outcomes and clinical
3 efficiency are the two things that I think of in
4 that dimension.

5 MR. GOLDWATER: So, in that regard, is
6 it clinician efficiency? Kristi, we'll start
7 with you.

8 MEMBER HENDERSON: Doesn't that go
9 under the system effectiveness, where we were
10 talking about the workforce utilization?

11 MR. GOLDWATER: Right, right.

12 MEMBER HENDERSON: I think it does.
13 So, we then can keep this, maybe, as clinical
14 effectiveness and not the efficiency, leave it in
15 the system, maybe.

16 MR. GOLDWATER: Sure. Steven, and then
17 Judd.

18 MEMBER NORTH: When I think of clinical
19 effectiveness, I think, did the treatment that I
20 prescribed or recommended work? And so, that --
21 expanding the access to the knowledge that I have
22 or that I have via Google, to multiple patients.

1 MR. GOLDWATER: Right.

2 (Laughter.)

3 MR. GOLDWATER: Judd?

4 CHAIR HOLLANDER: I think this one
5 could actually be relatively narrowly defined,
6 because we've defined everything else broadly
7 around it.

8 MR. GOLDWATER: Okay.

9 CHAIR HOLLANDER: So, I just come --
10 so, it's really the patient outcome and did we
11 get enough actionable information to make a
12 decision from the encounter. I think I just want
13 to come back to comments that several of us made
14 yesterday with respect to the outcome, it doesn't
15 need to be better, it could be the same, but more
16 efficient.

17 MR. GOLDWATER: Okay. Don?

18 MEMBER GRAF: And I just wanted to be
19 careful that there's a lot of people in the
20 audience that would see clinical and really
21 narrowly define it as, my doctor's office.

22 MR. GOLDWATER: Right. Marcia?

1 CHAIR WARD: And I want to --
2 telemedicine gets used by the nursing profession,
3 nursing effectiveness, so I want to make sure
4 that our language is inclusive.

5 MR. GOLDWATER: All right. So, let --
6 I mean, I'm sort of stuck on Steven's point,
7 where it is, and Judd's as well, it's the
8 providing of information that helps make a
9 decision about a patient's care. That's a narrow
10 scope for this, or a narrow definition for this
11 term. But, specifically, I'm understanding what
12 we need to avoid, but what do we need to include
13 in that definition? Or as concepts? Jean?

14 MEMBER TURCOTTE: For the clinical, and
15 I'm bringing it back to probably a nursing view,
16 is to really look at the clinical outcome. We've
17 covered system processes, we've covered a lot,
18 but I think this is where it really does focus
19 on, where do the clinical outcomes come in?

20 MR. GOLDWATER: Okay.

21 MEMBER TURCOTTE: And acute care
22 setting is different than community or rural. A

1 great example would be, I think, a measure or
2 something we really need to look at is
3 compliance. We use post-discharge telehealth,
4 what are the compliance rates?

5 Just because we've set somebody up,
6 are they actually following through? Are we more
7 effective getting follow-up appointments with
8 patients through telehealth than just having them
9 come either to the physician office for a follow-
10 up visit?

11 MR. GOLDWATER: Okay. Judd?

12 CHAIR HOLLANDER: So, I think it's
13 important that it's not necessarily a medical
14 outcome, right? So, we do a lot of pre-admission
15 testing. If I save someone the trouble of coming
16 downtown and I'm able to complete and get all the
17 information I need to go forward with surgery,
18 that's a really valuable outcome. So, in this
19 particular case, I think we'd have to be broad in
20 the term outcome.

21 MR. GOLDWATER: Right. Okay. Paul?

22 MEMBER GIBONEY: Yes, I mean, I think

1 when people are going to be looking at this
2 framework and they're going to be trying to put
3 measures into it or things, I mean, this is the
4 place where they're going to be looking at some
5 very disease specific situations. Are people's
6 hemoglobin A1cs improving because there's some
7 sort of home-monitoring and feedback technology
8 with them?

9 But they're also going to be looking
10 at outcomes on a population. Because of
11 telehealth is there, are there fewer ER visits?
12 I mean, that is a -- I don't think that's a
13 system effectiveness, I think that's actually a -
14 - it might be a clinical outcome, I don't know.
15 Maybe it is a system effectiveness outcome.

16 But I think there are disease-specific
17 outcomes and then I think they're going to be
18 looking at, did this patient or is there --
19 because they got earlier care, they catch a
20 cancer at a lower stage, or something like that?
21 And so, I'm kind of thinking about this in two
22 different ways, the actual disease process, but

1 also the impact on utilization of different
2 venues.

3 MR. GOLDWATER: Okay. Yes. Steven?

4 MEMBER NORTH: I see venue utilization
5 as really fitting into system effectiveness and
6 what Kristi had said earlier about the right
7 place.

8 MR. GOLDWATER: Nate?

9 MEMBER GLADWELL: It seems to me that
10 this would be the area that provider associations
11 and groups would be most active. And so, I
12 wonder if we're just trying to put guidelines or
13 points of emphasis as they're creating their
14 individual measures. Is that correct? Would you
15 say that's a correct --

16 MR. GOLDWATER: That's a correct
17 assumption, yes.

18 MEMBER GLADWELL: Okay.

19 MR. GOLDWATER: Okay. Anything else?
20 This is helpful, largely because I'm -- and I'm
21 always an advocate for broader at times is
22 better, I agree with Judd, I don't think in this

1 case that's applicable.

2 This needs to be, I think, somewhat
3 narrow and in a way, it really does have sort of
4 a direct line to outcome and I think that's sort
5 of what the focus of at least this particular
6 concept needs to be. Let's turn our attention,
7 then, to patient and family experience, which is
8 broad. And patient experience can include free
9 drinks on your round-trip flight.

10 I mean, I'm kidding, but it can
11 include a whole host of things, so rather than, I
12 think, sort of explode this into everything that
13 could fit under patient experience of care or
14 patient engagement or patient self-management, I
15 would like to really try to focus on concepts or
16 ideas that relate to patient and family
17 experiences as they apply to telehealth, to the
18 best of your ability.

19 I understand that some of them, some
20 overarching concepts that apply across healthcare
21 we could tie into this rather easily, and I think
22 we'll do that, but I'd like to just get your

1 thoughts while you all are here about what you
2 think it could do in relation just to telehealth.
3 Sarah?

4 MEMBER SOSSONG: I'm sure everyone in
5 this room has done a lot of thinking around
6 patient experience surveys and just need to share
7 some of the concepts that we have included in our
8 patient experience surveys.

9 So one is convenience for the patient.
10 Connection was one that our leadership was very
11 interested in, what is the clinician/patient
12 connection and how did that change over
13 telehealth? That's something we looked at with
14 the clinician experience also.

15 Specific to telehealth, their
16 experience with the installation testing
17 technology and service associated with that. And
18 then, we tried to overlap it with where there
19 were existing measures for in-person as well, so
20 the CG CAHPS questions, we looked at all of them
21 and thought about which were the ones that were
22 relevant to telehealth also?

1 So, the ones we chose were seeing
2 clinician within 15 minutes of appointment time,
3 clinician explaining things in a way that was
4 easy to understand, rating the visit, listening
5 carefully, spending enough time. And that at
6 least gave us something that was comparable, as
7 opposed to just inventing metrics on our own.

8 MR. GOLDWATER: Wonderful, thank you.
9 Marybeth?

10 MEMBER FARQUHAR: I would follow up
11 with clinician communication, getting the needed
12 care, getting the care in a timely manner,
13 reliability of the service, and security/privacy.

14 MR. GOLDWATER: Great. Judd?

15 CHAIR HOLLANDER: So, this is sort of
16 a tricky area and I think each patient comes to
17 the table with different goals. And I think we
18 need to basically ask a broad question, which is,
19 were the patient's goals met? And we actually
20 have data on that.

21 We're doing some student counseling,
22 some behavioral health, students would rather sit

1 in their dorm room than go to the psych ward,
2 even though it's across the street, to see
3 somebody, it's more comfortable.

4 But the thing we've learned, we do net
5 promoter scores on this, and our net promoter
6 scores, actually for a while, we were living in
7 the nineties. Family medicine lives at three,
8 Amazon is in the 40 to 60 range. We're lower now
9 and we expect regression to the mean.

10 But reality is, the patient goals are,
11 I don't want to leave my house and I want to get
12 my care. And so, even if they get disconnected
13 three times from the video, they don't care,
14 because their goal was, I didn't leave my house
15 and I got my care.

16 And so, we're satisfying their goals.
17 When we try and break it down line item by line
18 item, sometimes in each line item, it's not so
19 hot, but overall, wow, totally nailed it, it's as
20 good as it could get.

21 MR. GOLDWATER: Right.

22 CHAIR HOLLANDER: And so, I think

1 having some measure of were the patient's goals
2 met, whatever they were, is useful.

3 MR. GOLDWATER: Okay. Stewart?

4 MEMBER FERGUSON: I think this is
5 following on what you were saying, Sarah, but we
6 actually measure patient education. So, we
7 actually find that telehealth, like two-thirds of
8 our cases that the patients feel more educated
9 about their disease state, which is much higher
10 than the in-person.

11 Second one is patient compliance. We
12 actually find they're more compliant with
13 whatever the therapeutic regime is if we do
14 telehealth, for some reason.

15 And the third one is, no-shows. We
16 talked about that earlier, but that's a big
17 thing, that kind of indicates the patient's
18 interest in being involved in their care and we
19 don't get no-shows on telehealth.

20 MR. GOLDWATER: Okay. Peter?

21 MEMBER RASMUSSEN: Expanding on the
22 concept of convenience that Sarah started with,

1 it's things like time saved, they avoid travel
2 and travel-related expenses. Because of use of
3 technology, were they able to more easily
4 incorporate an interested caregiver, family
5 member in the visit as opposed to having that
6 family member being challenged in making the in-
7 person appointment?

8 And I agree with Judd, sort of that
9 overall concept of just, how satisfied are they
10 with the interaction, is incredibly important.
11 We had the same experience you have.

12 MR. GOLDWATER: Eve-Lynn?

13 MEMBER NELSON: I really agree with the
14 meeting their goals one as well. I think that
15 aligns with patient-centered care, some of that
16 language you were using before. In terms of
17 connection, sometimes we talk in mental health
18 more about relationship or therapeutic alliance,
19 but I think it all goes back to the connection
20 comment that was made.

21 And then, it was Stewart's comment, in
22 terms of understanding the recommendations and

1 treatment plan, for us, I think sometimes it
2 comes down to health literacy kinds of things.
3 In the school-based setting, for example, it may
4 be just even teaching, well, this is how you use
5 the thermometer. It may be a family who's just
6 not been socialized to the healthcare system
7 before.

8 MR. GOLDWATER: Yael?

9 MEMBER HARRIS: I think several people
10 mentioned this, but, basically, the form access,
11 but not quantitative access, patient perceived
12 access.

13 MR. GOLDWATER: Okay. Angela?

14 MEMBER WALKER: I just want to play
15 devil's advocate for a second on patient's goals
16 met. I can clearly identify from Yelp reviews,
17 if I establish very early what the patient wants
18 to accomplish during the visit and I meet those
19 goals, I'm much more apt to get a positive review
20 than a negative review.

21 However, in any setting, if a
22 patient's goal is, I want back surgery for back

1 pain or I want an opioid for back pain, and
2 that's their primary goal, if we've made that one
3 of the outcomes, then good medicine may say,
4 we'll never meet it.

5 MR. GOLDWATER: Chuck?

6 MEMBER DOARN: Well, I was thinking
7 about the term perception, the patient may
8 perceive that the medical system is on their
9 side, because they're helping them out, they're
10 coming to their home, and I remember down in
11 Richmond, there's Henrico Doctors' Hospital and
12 then there's MCV.

13 And Henrico had a big advertisement on
14 Interstate 64 about, come get your gallbladder
15 out with a robot. And I asked, because I was in
16 the department of surgery, I said, why don't we
17 advertise like that? He said, well, A, we're a
18 state hospital, can't do that, and, B, the people
19 then thought that the better technology was not
20 at the University Hospital, but it was at this
21 Henrico Doctors' Hospital.

22 So, when the patient realizes, hey,

1 they're really invested in me, they're coming to
2 my home or to where I am at work, my school, with
3 kids or whatever, so to me there's that
4 underlying perception of the value that's added
5 to healthcare because the system cares about
6 them. That may not be true, but there's
7 certainly ways of measuring that.

8 MR. GOLDWATER: Nate?

9 MEMBER GLADWELL: I would say another
10 one to consider is patient's confidence in care.
11 We have a lot of our rural partners that get
12 frustrated when they feel like the care plan is
13 going well, but the patient always says, well,
14 just send me to the big city and they'll figure
15 it out. And so, if we can have the big city
16 doctor on camera say, your local doctor is doing
17 a great job, we have confidence in him,
18 confidence in care increases dramatically.

19 MR. GOLDWATER: Right. Don?

20 MEMBER GRAF: Pretty consistent results
21 from 15 years of doing surveys are lost wages,
22 time away from school, transportation costs,

1 shorter wait times.

2 MR. GOLDWATER: Great. Nate, did you
3 have something else to add or was your -- all
4 right. Just making sure. All right. This is
5 terrific. Yes, Judd?

6 CHAIR HOLLANDER: So, I was just going
7 to say, an interesting thing, I don't know how we
8 capture this, but it's willingness to accept
9 recommendations. So, particularly on the
10 antibiotics stewardship side, you wait four hours
11 in the ER, you are pissed if you don't get
12 antibiotics or narcotics --

13 (Laughter.)

14 CHAIR HOLLANDER: You are just pissed.
15 But I have yet to have a patient on telemedicine
16 insist on antibiotics when I say it doesn't work,
17 because they've invested six minutes of their
18 time.

19 MR. GOLDWATER: Right.

20 CHAIR HOLLANDER: And so, I think that
21 they can accept compliance with lack of treatment
22 sometimes much better.

1 MR. GOLDWATER: It's interesting. That
2 incident never happened to me, by the way, Chuck.
3 I don't get pissed off. Yes, Henry?

4 MEMBER DEPHILLIPS: No, it's -- I'm
5 actually -- I'm not going to argue at all, I'm
6 just going to provide some data about our
7 complaint rate across the board. We're a public
8 health company, it's published, it runs at about
9 0.1 percent of all visits, or something like
10 that, one in a thousand

11 MR. GOLDWATER: 0.1?

12 MEMBER DEPHILLIPS: 0.1.

13 MR. GOLDWATER: Wow.

14 MEMBER DEPHILLIPS: Yes, I mean, the
15 satisfaction with -- to your point, we started,
16 we look at the survey, they give us five stars
17 and we're like, we're doing a great job. Then we
18 start reading them, the doctor was rude, I had to
19 wait in line, but five stars because they didn't
20 have to leave their house to go get care. So,
21 that's definitely the case.

22 (Laughter.)

1 MEMBER DEPHILLIPS: But that's not what
2 I'm commenting on. Our number one complaint, we
3 have a small number of complaints, but 50 to 70
4 percent every single month is, I didn't get the
5 antibiotic that I know I need for my annual sinus
6 infection that I've had for the last 16 hours.

7 And I will tell you, I'm not sure how
8 much to tell you, but it has become an issue,
9 because from a quality oversight standpoint, it
10 probably represents good quality care that we're
11 following CDC guidelines, yet patient complaints
12 against certain providers are higher, so from a
13 quality oversight standpoint, how do you grade
14 that? So, I'm wrestling with that.

15 But interestingly, a provider
16 satisfaction score is something that our board
17 has us focused on, satisfaction with provider
18 score, is something that our board has us focused
19 on and because of our very, very diligent efforts
20 at appropriate antibiotic prescribing, our
21 satisfaction with provider score from the public
22 has actually deteriorated a bit.

1 And people are nervous about it. So,
2 it's not a disagreement, it's just a data point.
3 We are in a society that expects antibiotics no
4 matter how -- I mean, we -- to your point, four
5 hours without an antibiotic, we have people who
6 say, I paid \$35 or whatever for this visit and
7 you didn't give me the antibiotic, I want my
8 money back. Like, okay.

9 MR. GOLDWATER: Peter?

10 MEMBER RASMUSSEN: I think what Henry
11 and Judd are bringing up are interesting things
12 to keep in mind broadly, which is if we're
13 benchmarking ourselves against bricks-and-mortar
14 care or current standards of care, that may not
15 exactly be the best.

16 MR. GOLDWATER: Right.

17 MEMBER RASMUSSEN: So, clearly, what
18 Henry's talking about here is, this isn't a
19 failure of telemedicine, this is a failure of
20 previous bricks-and-mortar medicine and we're
21 just realigning things appropriately. So, it's
22 true of a lot of the other things that we're

1 talking about here, is that if you're
2 benchmarking remote patient monitoring of
3 hypertension against standard populations, that
4 doesn't necessarily mean we're doing the right
5 thing or the best thing now in current practice.

6 MR. GOLDWATER: Right.

7 MEMBER RASMUSSEN: So, I think we've
8 got to be careful of how that gets, how we
9 benchmark to what we benchmark against.

10 MR. GOLDWATER: Right. I think that's
11 an excellent point by all three of you. And
12 before I get to Don, it's certainly something
13 we'll have to consider as we start to fine tune
14 these concepts.

15 Because I'm thinking of opioid
16 prescriptions, given that it's an immediate
17 public health crisis, it's well documented, it
18 has been established everywhere. We are, NQF is
19 taking that on, I mean, we're not taking on the
20 opioid epidemic, but --

21 (Laughter.)

22 MR. GOLDWATER: Marcia, I didn't mean

1 to commit us to that. But we're working with the
2 organizations that want to develop measures to
3 actually target that.

4 But, there again, I'm sure, I'm not
5 one of them, but I'm sure there are patients that
6 have pain that are like, give me my freaking
7 Percocet, like, right now, I don't care if I met
8 with you for three minutes, I need my Percocet
9 and I want it immediately and I need to take it
10 and you're not making me feel better.

11 And if we evaluate that sort of
12 satisfaction against a benchmark of what a
13 patient thinks they need rather than these
14 guidelines the CDC has released about the
15 appropriate prescription protocols for pain
16 managements and multi-modal therapy that doesn't
17 necessarily involve opioids, I think Peter's
18 point is well taken that that's something when we
19 get into really building out these concepts to
20 think through, because otherwise, we're going to
21 -- is satisfaction how many Percocet or OxyContin
22 did you prescribe, and that's dangerous to the

1 provider and significantly dangerous to the
2 patient. Don?

3 MEMBER GRAF: I think as we're having
4 this conversation, it's really important to take
5 into consideration how different the conversation
6 takes place if you have an established patient
7 relationship versus a new patient relationship.

8 MR. GOLDWATER: Right.

9 MEMBER GRAF: And in that instance, I
10 could have my PCP saying, this is what you need
11 to do, but I know you and I know you're going to
12 do A, B, and C, but not D.

13 MR. GOLDWATER: Right.

14 MEMBER GRAF: So, let's do, as opposed
15 to, no, you don't get the antibiotic.

16 MR. GOLDWATER: Right. Yes. I think
17 trying to -- that's going to be tricky when we
18 get to that point, because personality really
19 plays a large part in patient engagement and how
20 they -- there's some people that grow up and if,
21 I mean, Henry is, I've met Henry, I've known him
22 for 48 hours, but if I had to see you, I would

1 trust you, you're a doctor, and Judd's another
2 story, but if it were you, and you said, this is
3 what you need to do, I would go do it.

4 But there are plenty of patients out
5 there that, if they're having you for the first
6 time and you say, follow this, they're going to
7 be like, you don't know what you're talking
8 about, you're a doctor, what would you know, you
9 just went to medical school.

10 Peter, did you have anything else you
11 wanted to add? Okay. This is great, it really
12 is. Don, anything more? Anybody else?

13 I mean, it's a big -- patient
14 experience, family experience, patient
15 engagement, these are the big terms right now in
16 care and particularly in the quality measurement
17 world, where we're really trying, I mean,
18 Marybeth can speak to this too, we're all really
19 trying to look at measures that really have
20 meaning and relevance to patients.

21 How, what -- because when quality is
22 being measured in a way that a patient truly

1 cares about, then they tend to follow through
2 with what those actions are.

3 And the ability now to get the data,
4 to be able to understand what those measures are
5 in a variety -- I could talk about this for four
6 hours, I'm not going to, but there's so many
7 different ways of doing this now that it's great
8 that we're sort of able to narrow this down to
9 really what relates specifically to telehealth.

10 And I think that's really going to be
11 very, very important in how we assess patient
12 engagement and patient satisfaction with that.
13 Or not satisfaction, experience, sorry. Steven?

14 MEMBER HANDLER: Just a brief comment.
15 Perhaps following a consult or following the use
16 of the technology or the experience, how likely,
17 sort of the net promoter concept, but how likely
18 they are, not only to refer other people, but to
19 do that again and/or do it over the other
20 alternative approaches to care. So, just a
21 follow-up comment.

22 MR. GOLDWATER: Right. Julie?

1 MEMBER HALL-BARROW: Yes, I just think,
2 as we were looking at that patient experience,
3 it's amazing. So, if we took comparativeness
4 from waiting for your virtual visit provider to
5 come online, less than five minutes. Comparing
6 that to the bricks-and-mortar, you would be
7 ecstatic if they called your name in five
8 minutes.

9 I'm finding in our world, even in
10 healthcare, so we do all 8,000 employees, five
11 minutes, they're starting to get antsy. And we
12 have now created a new patient expectation and
13 experience through virtual, five minutes, you've
14 got to be online within three minutes, how long -
15 - we guarantee online and up within 15 minutes of
16 a NICU baby somewhere in the state, and we
17 thought we were doing great.

18 MR. GOLDWATER: Right.

19 MEMBER HALL-BARROW: So, it's
20 interesting, if we're going to do comparatives to
21 traditional or we're going to start comparing
22 within, and I think we're going to see that time

1 and patient experience continue to expect more
2 and more.

3 MR. GOLDWATER: I mean, it really gets
4 back to sort of the issues that Judd and Paul and
5 Peter were talking about on how we benchmark that
6 and what standard do we apply? Because I bring
7 up this example a lot, because I found this just
8 mind-boggling, that I know a lot of us fly a lot,
9 like Chuck probably flies every week at this
10 point, and we all have, I'm sure, our preferences
11 of airlines.

12 And I found out the airline that has
13 the most, that's most consistent with on-time
14 takeoff and on-time arrival is United. And yet,
15 they're fourth in satisfaction.

16 Southwest, for whatever reason, has
17 the highest satisfaction rate, even though
18 they're like sixth in leaving on time and like
19 ninth in arriving on time. And people are still
20 complaining about how they board their
21 passengers, this sort of cattle call.

22 I always get there early, so there's

1 no issue for me, because I'm just like that, but
2 it's just amazing and when you read the comments
3 about why are you so satisfied with Southwest,
4 given that they rarely leave on time and they
5 always get you there late, they're like, because
6 it's so much fun to travel on Southwest.

7 Because they sing songs and they give
8 you free water and they're goofy and the pilot
9 will come and say, everybody give your neighbor a
10 hug to your left and to your right, which
11 apparently happened a couple of times, and they
12 give free drinks on St. Patrick's Day, and it's
13 just like it's a party in the air.

14 I personally have never experienced
15 that on Southwest, I mean, I've heard all the
16 signing, which gets a bit annoying kind of,
17 honestly, but -- it does.

18 (Laughter.)

19 MR. GOLDWATER: No, I'm a Delta person,
20 actually. But it's really just sort of that
21 whole experience is what made Southwest so
22 reliable. And Virgin America is also getting

1 incredibly high ratings, for very much the same
2 reason, it's the experience.

3 So, if you take a standard benchmark
4 and say, this is how we're going to evaluate,
5 you're not necessarily getting the reflective
6 results of what's really going on. So, it really
7 becomes important to measure in what we think is
8 realistic and how we think is the best way to
9 assess.

10 One other brief story, I was going to
11 Minneapolis, I think it was a couple of month
12 ago, and it's not like I go to Minneapolis often,
13 I don't, the last time I was there was when I was
14 auditing Medicaid Y2K systems, so planes didn't
15 fall out of the sky, nuclear weapons didn't go
16 off inadvertently, and I did a Yelp search for
17 best restaurants in Minneapolis, because I don't
18 go there, I don't know, and Chipotle came up as,
19 like, number four

20 Why would Chipotle come up as the
21 number four restaurant in Minneapolis? And,
22 again, it's because the consistency of

1 satisfaction, even with the E. coli scandal, is
2 apparently so high that that's what keeps bring
3 people back and back and back. If you were to
4 use a traditional metric, they probably would be
5 taken out.

6 If you used sort of the patient
7 experience metrics that they're looking at, it
8 rates very highly. So, Julie, did you have
9 something else to say? Your placard is up.
10 Dale?

11 MEMBER HALL-BARROW: I agree, how about
12 that?

13 (Laughter.)

14 MR. GOLDWATER: Thank you.

15 MEMBER ALVERSON: And this may be just
16 a follow-up on your metaphor with the airlines, I
17 can tell you why I use Southwest, it's cost. I
18 get -- and I might use American or United or
19 whatever if I thought the fares were lower. So,
20 when I'm having to pay it out of my own pocket,
21 or you might even care if you're paying my way,
22 you want to know that I got the best cost, and

1 they don't charge a luggage fee.

2 MR. GOLDWATER: No.

3 MEMBER ALVERSON: So, why do I --
4 that's my primary --

5 MR. GOLDWATER: Right.

6 MEMBER ALVERSON: It's not -- I could
7 care less about the signing and joking and
8 whatever, really.

9 MR. GOLDWATER: Right.

10 MEMBER ALVERSON: In fact, as far as
11 free water and so on, that's pretty similar with
12 every airline.

13 MR. GOLDWATER: Right.

14 MEMBER ALVERSON: But it's cost. And
15 you could argue that that same thing is going to
16 end up being applied to healthcare. We're going
17 to look at, it's got to be value-based.

18 MR. GOLDWATER: Right.

19 MEMBER ALVERSON: And more of the
20 burden of cost is going to go to patient, to the
21 consumer. So, that's what I'm always going to
22 look at. Now, I sort of make the assumption that

1 the pilots are well trained and I'll have a safe
2 flight, right? But it really boils down to cost.

3 MR. GOLDWATER: Right. Okay.

4 MEMBER ALVERSON: So, that's why I use
5 Southwest a lot.

6 MR. GOLDWATER: Right. I do too, for
7 the same reason. Mary Lou?

8 MEMBER MOEWE: Well, I was going to
9 say, anxiety with flying, I think. I get
10 anxious, I have to be there early too.

11 MR. GOLDWATER: Yes.

12 MEMBER MOEWE: And I think there's a
13 lot of anxiety too with physicians, when you go
14 to see a doc, you're a little nervous, like, I
15 don't know what's going on, help me.

16 MR. GOLDWATER: Right.

17 MEMBER MOEWE: So, I think, it's good
18 if you have that, you establish that relationship
19 with the doctor and you feel like he knows what I
20 want from, what I expect from this visit. And,
21 recently, I went to an innovation seminar and
22 Hopkins has just done something that -- I guess,

1 a physician went into a physician's room, was
2 treating him, and didn't know he was a physician,
3 and just kind of abruptly told him, blah, blah,
4 blah, and walked out.

5 And the doc that was in the bed was
6 like, I'm really upset, because I'm a doctor, he
7 should have talked to me differently. So,
8 they've done something new, they have, with the
9 patient care, they have a message board that you
10 can type in what you want the doctor to know
11 about you, what you want, what you expect from
12 the physician.

13 And I think that's really valuable and
14 I think that's where telemedicine could add a
15 lot, once you've established that, you can
16 actually, you could text or communicate first of
17 all, like, this is what I want, this is what I'm
18 looking for. And that way, the physician knows
19 up-front, oh, this person is seeking opioids, or
20 whatever.

21 MR. GOLDWATER: Right.

22 MEMBER MOEWE: And it's more direct.

1 I mean, there's something there, like, they're
2 looking for painkillers. And these are things we
3 could be more direct about and, I guess, figure
4 out what the reason for the visit is, what their
5 anxiety is, and maybe help alleviate that and
6 make it better. But cost is definitely
7 important, to me. And getting it done quickly.
8 Like, Southwest, I think I fly Southwest flights
9 more frequently because they're direct and I
10 don't have to go through multiple airports.

11 MR. GOLDWATER: Right.

12 MEMBER MOEWE: So, with a physician,
13 with care, I work all the time, I'm in my office
14 until 6:00 or 7:00 at night, and if I get sick, I
15 usually, I need some antibiotics or I need this
16 or that, and I don't have time to go see my
17 physician.

18 MR. GOLDWATER: Right.

19 MEMBER MOEWE: So, that would be great
20 for somebody who's a workaholic, because you need
21 to see your doctor and it's like, but I don't
22 have time to go wait in the office for two hours

1 to see my doc.

2 MR. GOLDWATER: Right.

3 MEMBER MOEWE: And that's what happens,
4 when most of us go, it's not easy to get in, it's
5 not easy to get out, you wind up spending a lot
6 of time and then you've got to go off and -- so,
7 I was at Cerner yesterday, the reason I wasn't
8 here, and they have a really cool primary care
9 clinic right on site, right across from their
10 main facility.

11 And they have no waiting, you just,
12 you walk in, you key in the kiosk and you're in,
13 they put you right into the room with a doc.

14 MR. GOLDWATER: Wow.

15 MEMBER MOEWE: It's amazing. It really
16 is.

17 MR. GOLDWATER: Wow.

18 MEMBER MOEWE: And they've eliminated
19 all that, all that excess waiting room stuff, and
20 it's just really cool. So, I think there's a lot
21 to be learned from innovation and what patients
22 expect from the visit and what different cultures

1 expect.

2 Because they have -- you actually have
3 to, as an employee there, you have to key in, I
4 want to see the doctor at 2:00, and then you show
5 up and you're right in. But they have, like,
6 some of their Asian folks, like, they're used to
7 just walking in to get care.

8 So, then, they go in and they don't
9 have an appointment and they're like, oh, well,
10 you have to schedule first, and they're very
11 astounded at all this. So, I think there's so
12 much innovation and technology that we could be
13 using that we're just avoiding and I'm not really
14 sure why, but if we do it the same way with
15 telemedicine and you have to wait a week to get
16 an appointment with your doctor with
17 telemedicine, then it's silly.

18 MR. GOLDWATER: Right. I agree. All
19 right. Don, then Stewart, then Chuck.

20 MEMBER GRAF: The concept early of
21 substance over form or reality versus fact, I
22 can't help thinking back to something, Chuck, you

1 had said earlier about marketing and packaging
2 and to the extent that you're going to sell the
3 idea. And whether it's real or not, is like
4 anything, going to play out in telehealth as it
5 is in anything. And I just heard that they're
6 going to start charging you for bags.

7 MR. GOLDWATER: Southwest is? Really?
8 Seriously?

9 MEMBER GRAF: Was it -- my wife told me
10 last night. You know what, it might have been
11 United and not Southwest.

12 MR. GOLDWATER: Not Southwest, no.

13 (Laughter.)

14 MR. GOLDWATER: Go ahead, Stewart.

15 MEMBER FERGUSON: So, I did some fact
16 checking. It turns out, Alaska Airlines, my
17 favorite airline, is the top ranked major carrier
18 and has the top rated performance.

19 MR. GOLDWATER: Okay, so I was quoting
20 last year's stats, Stewart.

21 MEMBER FERGUSON: You can't really
22 separate them.

1 (Laughter.)

2 MEMBER FERGUSON: Just saying. But it
3 does make me think --

4 MR. GOLDWATER: You and Chuck.

5 MEMBER FERGUSON: -- so, airlines get
6 performance ratings, right, just based on on-
7 time, lost bags, all those other things, but we
8 never do that in telehealth.

9 MR. GOLDWATER: Right.

10 MEMBER FERGUSON: And I've always been
11 curious if the performance of telehealth for,
12 say, treating your disease is better than the
13 performance of non-telehealth for treating your
14 disease. And you throw a bunch of factors, you
15 weight satisfaction, you do other things. It
16 might be an interesting concept for a performance
17 measure, not just these individual measures, kind
18 of an aggregate.

19 MR. GOLDWATER: Okay.

20 MEMBER FERGUSON: That was really the
21 reason I spoke, not because of the Alaska piece.

22 MR. GOLDWATER: Chuck?

1 MEMBER DOARN: I think, I was going to
2 say marketing again, but I think it's the
3 environment in which you find yourself as a
4 consumer.

5 MR. GOLDWATER: Right.

6 MEMBER DOARN: You walk into Macy's at
7 Christmastime, everything's crammed together.
8 You go to Nordstrom, everything's spread out,
9 because nobody shops at Nordstrom. No, I mean,
10 in the sense that, when you talk about a
11 telemedicine system, some kind of form fit,
12 there's a lot of science that's been developed in
13 human factors and ergonomics and how -- what's
14 the sex appeal of the app? If it's just
15 literally a doc in a box it's not going to be
16 very -- you're going to kind of look at it and
17 go, you look kind of corny.

18 MR. GOLDWATER: Right.

19 MEMBER DOARN: So, that drives some of
20 what people are going to do or not going to do.
21 So, in Russia, you go to a hospital in Russia in
22 1992, and you look at it and you go, I don't even

1 think this is a hospital. And then, you go
2 through the door and it's sort of like the Wizard
3 of Oz, you go from the cabin that's crashed on
4 the Wicked Witch and you go in and it's this
5 beautiful Technicolor.

6 And so, you go in a hospital like that
7 and you see these beautiful operating rooms, it's
8 the same thing here. If you walk up and down
9 these streets and see these modern buildings
10 integrated with these smaller buildings that
11 maybe were here during the Civil War, they've
12 been remodeled and they look really nice, but if
13 you go into a really dilapidated area, you're
14 probably not going to go into the doctor's office
15 there, if that's where your doctor is.

16 Because -- and that doesn't mean the
17 doctor's bad, it's just the environment in which
18 you find yourself. So, I think it's very
19 important, when we think about telemedicine and
20 the mobile apps and so forth, telehealth, that
21 the systems designed to work efficiently, but
22 also to be so that the consumer actually can

1 interact with them and it's not difficult and
2 it's --

3 MR. GOLDWATER: Right.

4 MEMBER DOARN: I mean, going to the
5 doctor is not supposed to be a joyful occasion,
6 because you've got to wait forever and look at
7 last year's People magazine, but there's got to
8 be some kind of -- I think one of these things
9 that you were saying, Mary was saying -- is it
10 Mary? No? -- about how you're actually put into
11 the kiosk or into the pod with the doctor and
12 it's like almost immediate, so you're not -- with
13 telehealth, you have that.

14 The other part of that is, if you have
15 these systems, and I remember when Stewart had
16 the meeting up in Alaska, I think four years ago,
17 I believe it was, we did a separate meeting with
18 TATRC on tele-mental health in the Pacific Rim,
19 and I forget the person who showed this video,
20 which is a little bit inappropriate, but I'll use
21 it anyway, you have the soldier, sitting there in
22 his boxer shorts, he kind of looks like Dwayne

1 Johnson, like the Rock, a big, huge guy, and kids
2 are playing.

3 And there's several things to learn
4 from this video. A, the interface itself was
5 poorly designed. The kids were using, they were
6 downloading music on their iPads, and mom walks
7 from this side of the room to this side of the
8 room totally naked.

9 And they're like, wait a minute, time
10 out, we're not supposed to be doing this, we're
11 supposed to be talking to you about your
12 condition, not seeing all these other things.
13 So, the design of the systems have to be such
14 that there's privacy included in that, there's
15 the security of the data itself.

16 And I think a lot of times, these
17 systems, a lot of these companies are developing
18 things that are keeping those things in mind, but
19 we're learning a lot of this stuff from
20 experience. As Ron Weinstein used to say, we
21 wear blue lab coats because they look better on
22 camera than a white lab coat. So, I think a lot

1 of those human factors, ergonomic things really
2 help with that marketing part.

3 MR. GOLDWATER: Right. Don, did you
4 have something else you wanted to add? No?
5 Judd?

6 CHAIR HOLLANDER: So, I think a lot of
7 that stuff that you're talking about, Chuck, also
8 comes back to individual patient perceptions,
9 right? So, I've seen some videos where, one of
10 the ones that our neurosurgeon shows, where the
11 family got engaged behind it, little kids came
12 over. And it was like a great experience for
13 that patient, because now they've got a
14 neurosurgeon joking around with the kids before
15 they're off to school one day.

16 And security, we use a system where we
17 use a secure message for a patient. You know
18 what? The patients ask me over and over, can you
19 just send it to my email? I don't want to log
20 into a goddamn secure message thing, that's a
21 pain in the butt. But yet, we don't do that,
22 because we're so worried about security.

1 But if the patient doesn't care,
2 that's not a good patient security, that's
3 putting security ahead of a patient experience.
4 And I don't know the data, but I know my response
5 rate. If I send something that doesn't have
6 patient information to them by email, I get back
7 a thank you and I know they read it three seconds
8 later.

9 If I send it through the secure
10 message, I think they don't answer it 70 percent
11 of the time, they don't look at it. I know I
12 don't in my patient portal, because half the
13 time, it's spam about remembering to do something
14 that I don't want to do or I already did. And so
15 --

16 (Laughter.)

17 CHAIR HOLLANDER: So, I think reality
18 is, we have to tailor how we design systems so
19 that individuals can use it the way they want to
20 use it and not make it the most rigid, most
21 secure thing in the world, but allow those people
22 that want the level of security to have the most

1 security that they can have.

2 MEMBER MOEWE: Yes, but security, we
3 have to be HIPAA compliant, there are all these
4 things we have to follow through on. But I agree
5 with you, when I'm working towards
6 interoperability with healthcare, physician's
7 major complaint is, I don't want to have to look
8 yet another place for more data, I want it all to
9 come to me, I want it to be served up to me in a
10 way that it makes sense so I don't have to figure
11 it out.

12 And it's really hard. These are very
13 difficult things to achieve. And then with the
14 HIPAA constraints and you have, patients can opt-
15 out, it's difficult to share data across from
16 hospitals to providers to rural healthcare
17 providers to get it back to the patient.

18 So, they may be uncomfortable sharing
19 with that rural healthcare physician. So,
20 there's just so many things, hoops that you have
21 to jump through from a IT perspective and from a
22 HIPAA perspective.

1 CHAIR HOLLANDER: This is probably
2 beyond the scope of this, but people use HIPAA as
3 an excuse for everything. So --

4 MEMBER MOEWE: I totally agree with
5 you, yes.

6 CHAIR HOLLANDER: So, I think we have
7 to define, what is HIPAA compliance? So, I'll
8 give you an ER example --

9 MR. GOLDWATER: Okay. Moderator
10 interjecting here. So let's stop that discussion
11 before -- I know where it's going.

12 MEMBER MOEWE: It's almost impossible
13 --

14 (Laughter.)

15 MR. GOLDWATER: And, Judd, I completely
16 agree with you wholeheartedly, but there's a time
17 and a place for that --

18 MEMBER MOEWE: You can't fix it.

19 MR. GOLDWATER: -- and that's not here.

20 (Laughter.)

21 MR. GOLDWATER: Sorry. Okay. Moving
22 on to -- yes?

1 MS. LUSTIG: I just wanted to make sure
2 we were capturing, we made this about patient and
3 family experience and I think we've touched a
4 little bit on family, I just wanted to make sure
5 that there wasn't anything -- I mean, I think
6 most of the things we've discussed, we could say,
7 and family.

8 MR. GOLDWATER: Right.

9 MS. LUSTIG: I just wanted to make
10 sure there wasn't anything that was more specific
11 to the family that we missed here.

12 MR. GOLDWATER: Julie?

13 MEMBER HALL-BARROW: Yes, I just want
14 to be -- as we do more mobile health types of
15 things, so the regulations in terms of a child
16 sending medical data, less than 13 years old, I
17 think we need to be sure that we're cognizant of
18 that, because we're having families send data on
19 behalf of their ten year old and whatever,
20 diabetes, or for doing their mobile app for
21 inhaler usage, where I'm getting all that data.
22 I just want to be sure that we're inclusive of

1 that, that its experience is just as good on
2 both.

3 MR. GOLDWATER: Okay. All right. Last
4 one, clinician experience. So, the clinician's
5 experience with telehealth, what are some
6 important factors you feel need to be included
7 there? Don?

8 MEMBER GRAF: Low threshold for
9 technical glitches, especially among new
10 providers, that you want to disengage them
11 quickly, don't give them a good technical
12 experience out the gate. And so, not so much for
13 the seasoned ones, but --

14 MR. GOLDWATER: Got it. Others?
15 Steven?

16 MEMBER HANDLER: So, I have several.
17 So, it's physician satisfaction, burnout, which
18 we see as a big problem, so tenure, and
19 efficiency for physicians and themselves feeling
20 as though they're providing good quality care --
21 well, and it shouldn't limit this to physicians,
22 by the way, it's not meant to be that, but the

1 clinician providing care at the highest level.

2 Job satisfaction, creation of teamwork
3 or new teams, new approaches, and critical
4 thinking and/or growing skills, where they didn't
5 have them before. And transforming -- could this
6 be a transformative technology or solution that
7 allows people to do things that they couldn't do
8 before to grow their skills, which then
9 translates back into system-level issues. A lot
10 of this is circular, as we know. Those are some
11 things, some thoughts.

12 MR. GOLDWATER: Okay. Steve?

13 MEMBER NORTH: I think, really, do I
14 get warm fuzzies from this? Do I feel that I'm
15 providing better care and that people like the
16 fact that I'm more available? Not just my
17 institution has said, I will now respond to
18 emails from my patients and virtual visit
19 consults at 10:00 p.m.

20 MR. GOLDWATER: Right.

21 MEMBER NORTH: Which they haven't, but
22 -- yes.

1 MR. GOLDWATER: I'm assuming warm
2 fuzzies is a technical term.

3 MEMBER NORTH: Absolutely. I think
4 it's measure Number 537.

5 MR. GOLDWATER: Absolutely.

6 MEMBER NORTH: And it's an e-measure.

7 (Laughter.)

8 MR. GOLDWATER: Kristi?

9 MEMBER HENDERSON: Yes, just to
10 emphasize the workforce development piece of
11 that, that's been mentioned a little bit, it
12 truly is a workforce multiplier, but it's the
13 satisfaction to be able to continue to grow in
14 your knowledge, but it's about co-management.
15 So, now you don't have to be secluded, you can
16 truly co-manage and work as a team, which is
17 something we've just never been able to do.

18 MR. GOLDWATER: Okay. Marybeth?

19 MEMBER FARQUHAR: I want to emphasize
20 again the team aspect and the ability to do the
21 care coordination, but also, again, bringing up
22 the satisfaction of the clinician, things like

1 the quality of the resolution and things like
2 that, of system. That would be an issue.

3 MR. GOLDWATER: Okay. Peter?

4 MEMBER RASMUSSEN: I think something
5 around the lines of intuitiveness of use and
6 training requirements and maintenance of
7 training, competency.

8 MR. GOLDWATER: Judd?

9 CHAIR HOLLANDER: I think this plays
10 into sick days and disability and things like
11 that for the clinicians. You may be able to not
12 cancel the appointment of all your patient panel
13 if you're out sick. You may be able to see the
14 people who need to be seen while you're home. It
15 may be better for everybody.

16 MR. GOLDWATER: Paul?

17 MEMBER GIBONEY: I think, kind of going
18 along with what Steve said, the warm fuzzies, but
19 to make that more concrete is closing the loop.
20 I think sometimes a telehealth provider will
21 provide some sort of added value and then not
22 kind of get that back to close the loop, what was

1 the feedback, what was the end result with the
2 patient, how did that end?

3 And then, on, I mean, you can say ease
4 of use, but I think one of the things is, how
5 easy and seamless is the documentation?

6 So, it's almost like time spent on
7 whatever the modality is or whatever, it's kind
8 of like the whole thing, you say, oh, when EHRs
9 hit, we're going to save all this time and the
10 doctors are going to be so -- and what we're
11 finding is that doctors are actually not saving
12 any time every day because there's so many
13 additional things they have to do.

14 MR. GOLDWATER: Right.

15 MEMBER GIBONEY: So, telehealth is
16 hopefully an opportunity to make that cleaner and
17 simpler.

18 MR. GOLDWATER: Sure. Stewart?

19 MEMBER FERGUSON: So we actually ask
20 different questions -- and we do provider-to-
21 provider, so we really differentiate between what
22 we ask the originating versus the receiving end

1 of it.

2 But we do talk about ease of use,
3 especially on the originating side, but we
4 actually also look at satisfaction with the
5 equipment and then we try to kind of go, is their
6 job more fun? Because, again, hiring rural
7 providers is a real challenge.

8 And then we ask if they're more
9 comfortable in delivering care to the patient,
10 because sometimes they're uncomfortable and
11 telehealth actually helps with comfort.

12 On the receiving end, we usually ask
13 things about the quality of the data, which I
14 think we kind of mentioned. But we also on the
15 back end, as an e-measure, we look at the time it
16 took them to actually do the consult, which is
17 pretty important.

18 MR. GOLDWATER: Right. Don?

19 MEMBER GRAF: Improving operational
20 efficiencies and expanding provider capacity that
21 drive bottom-line, so, money talks. The other is
22 the flexibility of providers, perhaps

1 transitioning to retirement, that don't want give
2 up practice, but want to have the flexibility of
3 doing some different things, is another aspect
4 for them and their experience.

5 MR. GOLDWATER: Right. Great. Julie?
6 No? Dale?

7 MEMBER ALVERSON: Thanks, Julie. One
8 of the things, and this is parallel to patient
9 experience, is actually clinician convenience.
10 In other words, I can do telehealth from my home.
11 I could do telehealth from here, with some
12 privacy.

13 So, there's an element of that that I
14 think is going to even help with some of the
15 workforce for some physicians, maybe I'm going to
16 retire, I'm going to have to -- because I can't
17 go to the clinic every day, I don't want to go
18 there anymore.

19 MR. GOLDWATER: Right.

20 MEMBER ALVERSON: Then, others say,
21 well, we could work with you. Right, Henry?

22 MR. GOLDWATER: Right.

1 MEMBER ALVERSON: Could work with
2 Teladoc and I could do that from home or from the
3 beachfront, wherever. So, there's an element of
4 that that might be measurable that's having
5 impact, that we're keeping clinicians involved.

6 And that's not just docs, I mean,
7 that's mid-levels, nurses, and so on, who might
8 otherwise leave the workforce. So, that's
9 something that ought to be taken into account
10 with the clinician experience.

11 So, we're finding a lot people say,
12 this makes my life better. I can tell you, after
13 hours, when I was doing more clinical practice, I
14 could evaluate patients without having to go into
15 the hospital. And that meant a lot.

16 MR. GOLDWATER: Yes.

17 MEMBER ALVERSON: I could still be in
18 my pajamas if I need to be, or a bathrobe, or
19 whatever.

20 (Laughter.)

21 MR. GOLDWATER: We're not going there.

22 MEMBER ALVERSON: Anyway --

1 (Laughter.)

2 MEMBER ALVERSON: But it is an
3 important aspect that I think is going to have an
4 impact on how healthcare is delivered. It's
5 better for the clinician in the long run.

6 MR. GOLDWATER: Right. Okay. Megan?

7 MEMBER MEACHAM: I think this point's
8 been touched on kind of indirectly, but I think
9 something that directly relates back more to the
10 rural provider is the reduction in the feeling of
11 isolation.

12 MR. GOLDWATER: Okay. Kristi?

13 MEMBER HENDERSON: To add to the
14 extension of the work life, I'd add that we now
15 can also, providers, anybody in the healthcare
16 team that maybe becomes disabled or has some
17 thing that causes them to not do the traditional
18 practice of their profession, all we need is
19 their mind and so, thinking about it from that
20 perspective is good too.

21 MR. GOLDWATER: Very. Eve-Lynn?

22 MEMBER NELSON: I've been thinking

1 about the work spectrum too, some of the early
2 professionals really like the flexibility from
3 working from home and balancing time with family
4 and time with work.

5 And then, if you do have a
6 cancellation with telehealth, it's been appealing
7 to our providers where you're right at your desk,
8 you can go on with other things, you're not over
9 in clinic where you're kind of stuck in between
10 patients.

11 MR. GOLDWATER: Right. Okay. Steven?

12 MEMBER HANDLER: A couple of additional
13 points. One on workforce issues, so, geriatric
14 medicine is not a particularly sexy area to go
15 into and we have a really hard time recruiting
16 people, but if you can make it so that, as part
17 of the fellowship training program, which is what
18 we're starting to do, you incorporate
19 telemedicine in the curriculum and there's a
20 clear strategy to, when they're done, they have a
21 path towards employment, you actually can create
22 a new workforce or a sustainable workforce.

1 So, it's not just those that are
2 burning out, but it's, can you have a job and a
3 career that's rewarding, fulfilling from the
4 beginning? The second point, as I was just
5 reflecting a little bit also, is, the peer-to-
6 peer consult concept.

7 That is, we all can get curbside
8 consults or other ways as we need to, but how can
9 this benefit those that need to get a consult for
10 one of their own patients or residents, whatever,
11 in a timely fashion and how does that affect
12 their own clinical experience as well?

13 MR. GOLDWATER: Okay. Good point.

14 Henry?

15 MEMBER DEPHILLIPS: So, my sense is,
16 with this line of discussion, analogous to the
17 patient situation, we likely are going to land
18 on, from the physician side, sort of
19 subjective/objective, right?

20 Subjective satisfaction, all the
21 workforce issues, do I feel better, can I do it
22 from the beach? And then, objective, is my

1 effectiveness at treating a broader number of
2 patients enhanced by the use of technology? My
3 sense is it's going to boil down to those kind of
4 two broad categories.

5 MR. GOLDWATER: That's correct. Don?

6 MEMBER GRAF: I wanted to echo what was
7 mentioned about isolationism. We had a number of
8 perspective originating sites in rural
9 communities pushing back on the introduction of
10 telehealth, because they like when the urban
11 provider is coming out to field clinics, because
12 not only are they delivering care, but they're
13 catching up on all the latest news and whatever's
14 going on in the city. And just that alone is a
15 big push-back.

16 MR. GOLDWATER: Right. Judd?

17 CHAIR HOLLANDER: We haven't, other
18 than briefly yesterday, mentioned the educational
19 benefits for this, and I think that's relevant.
20 So, being able to supervise residents, being able
21 to send residents to -- we can't recruit people
22 to work in rural environments or underserved

1 environments, they have no experience there.

2 Potentially be able to send them out
3 there and supervise them during training may make
4 it more likely that people want to take those
5 jobs afterwards. But I think the increased
6 supervision and training across the board is
7 relevant for all providers.

8 MR. GOLDWATER: Nate?

9 MEMBER GLADWELL: To get back to the
10 disparity conversation, at risk of my previous
11 comment, but this is in the reverse, as we send
12 clinicians that are working to the top of their
13 license, be that paramedics and others, into
14 communities that don't have access or challenging
15 access, the connection back to the provider or
16 the clinician or the specialist using telehealth
17 creates unique opportunities to utilize more
18 clinicians in a broader capacity. I don't know
19 if we've specifically mentioned that here.

20 MR. GOLDWATER: Megan?

21 MEMBER MEACHAM: This is kind of a
22 half-baked thought, but with the clinician --

1 where with the patient experience and then we
2 expanded it to the family, so with the clinician
3 experience, is there a kind of a similar
4 expansion to others that might be within the
5 practice, be it the office managers, the hospital
6 CEOs, to also think about?

7 MR. GOLDWATER: Okay. Steve?

8 MEMBER NORTH: I think this is another
9 place to be looking at the benefit of ancillary
10 services provided via telehealth. So, clinical
11 pharmacology being available in my practice, how
12 do I feel better? So, not just saying that this
13 is a doctor, nurse, relationship that we're
14 looking at as far as the clinician.

15 MR. GOLDWATER: Great. Megan, did you
16 want to -- Judd?

17 CHAIR HOLLANDER: No. No, thanks.

18 MR. GOLDWATER: Okay. Anyone else?
19 This is fantastic. Yes, Dale?

20 MEMBER ALVERSON: Just one more,
21 because this actually just came up, where I was
22 talking to one of our neurosurgeons, and a lot of

1 it is just reassurance to the primary care
2 provider. Am I managing this patient correctly?
3 So, there's -- nothing's changed, they just want
4 reassurance. So, in that, in many cases, then
5 avoided an unnecessary transfer and so on. But
6 it was a reassurance thing for the referring
7 physician.

8 MR. GOLDWATER: Great. Anything else?
9 Okay. Quickly, while we have some time left, I
10 said at the very beginning of this, and I'll
11 reemphasize this again and again and again, is
12 that the ultimate goal, besides the development
13 of a framework, is to make sure that the
14 framework is actionable, usable.

15 That you can take this or others can
16 take it, implement it, and use it in a way that
17 will objectively, and at times, perhaps,
18 subjectively, measure the areas of telehealth
19 that you all have stated here are important.

20 Without getting into details, because
21 we'll spend the next meeting doing that, what are
22 some points that you think we should be

1 considering as we start to develop a straw-man
2 model, which I'm sure you're going to tear apart
3 and I love that about all of you, I do --

4 (Laughter.)

5 MR. GOLDWATER: -- I really do, that we
6 need to consider for implementation and to make
7 this actionable? So, it's not a theoretical
8 academic exercise that we can get journal
9 publications out of, which I know is important to
10 Chuck, and, yes, I'll send you something, but --
11 yes, Henry?

12 MEMBER DEPHILLIPS: So, particularly
13 yesterday, I'm blown away by the talent that's in
14 this room and I think if we kept the conversation
15 yesterday going, we not only would solve all of
16 telemedicine, but we would solve all of
17 healthcare, and not even just in the U.S., but
18 probably globally.

19 So, I think, getting to the point of
20 your question, my suspicion is, very quickly it's
21 going to become apparent, what are going to be
22 the data sources and are they readily available?

1 MR. GOLDWATER: Yes.

2 MEMBER DEPHILLIPS: Are the data
3 sources reliable and consistent so they can be --
4 I mean, there's going to be a number of
5 logistics, all of you have more experience with
6 this probably than I do, but the logistics of
7 developing measures are clearly going to creep in
8 and limit the scope of what we've talked about
9 over the last two days so that we wind up with
10 actionable measures. And I think the trick is
11 going to be, for the next meeting, I guess, is to
12 find a set of measures that are meaningful enough
13 that those who use the measures can show impact,
14 but that are realistic enough that there's
15 actually data sources and reliable ways to churn
16 the data. That'll be interesting.

17 MR. GOLDWATER: Okay. Steven?

18 MEMBER HANDLER: Well, we kept making
19 fun of publications here, but one quick question.
20 So --

21 MR. GOLDWATER: I'm not making --

22 MEMBER HANDLER: No, no, I know, we're

1 having fun.

2 MR. GOLDWATER: I'm just making fun of
3 Chuck.

4 MEMBER HANDLER: Yes.

5 MR. GOLDWATER: All right.

6 (Laughter.)

7 MEMBER HANDLER: I'm not going to beat
8 on Chuck or his Google searches or anything, but
9 --

10 (Laughter.)

11 MEMBER HANDLER: A plug here and
12 question actually, from the literature review
13 that you're doing, should/could we publish what
14 we're doing as a group or those who may want to
15 do that? And is that a normal process as part of
16 NQF?

17 Meaning, separate and distinct from a
18 report, but a scientific publication that may
19 summarize this, perhaps the five lefts or the
20 five rights or whatever we're going to -- but
21 something, or the CDC, whatever we determine
22 might be useful that may advance the field as a

1 group?

2 MR. GOLDWATER: Right. So, it's a good
3 thing Megan's also in the room. We're absolutely
4 going to submit publications from this.
5 Typically, we don't do that when it's measure
6 development projects, because that's already
7 transparent, it's in the open, and that's of
8 little interest, because those are measures
9 getting endorsed to be used in federal programs.

10 Something like this has extraordinary
11 interest, because it's not measure development,
12 it's how measures would be built. So, there will
13 certainly be publications that will come from
14 this. Probably the environmental scan report
15 will be one, the measure framework, obviously a
16 condensed version of that, because that will
17 exceed your 4,000 word limit, Chuck, I'm sure.

18 I can also sort of see in some ways
19 these concepts, as they're fleshed out into
20 measures, also sometimes could be particular
21 papers. I think, disparities, if we can cover
22 that in some way, how telehealth can be used to

1 reduce disparities in care, is of extraordinary
2 interest.

3 We'll also be presenting on these
4 papers. I haven't talked to -- I know Judd has a
5 conference in September, he and I have already
6 talked about this, and I'm happy to go, because I
7 love Philadelphia, minus the football team.

8 I have not talked to Jon Linkous yet,
9 you all are welcome to do that for me, but
10 clearly we would like to talk about this at ATA.
11 I think he's expecting us to talk about this at
12 ATA. Other conferences, like Academy Health,
13 probably, even though that's very research
14 academic focused, there are a lot of individuals
15 there that have interest in these types of
16 things.

17 Perhaps a state Medicaid conference,
18 which I used to attend a long time ago, might be
19 another one. I mean, it's not just going to be
20 me, it'll be all three of us, one of the three of
21 us. And somebody did ask me about HIMSS, whether
22 we would present this at HIMSS, and my

1 inclination is to say no to that, largely because
2 I don't know if HIMSS is really interested in
3 this kind of thing.

4 MEMBER HALL-BARROW: But what about the
5 innovation for health track that you gave before?

6 MR. GOLDWATER: Oh.

7 MEMBER HALL-BARROW: Yes, that totally
8 fits.

9 MR. GOLDWATER: Okay. All right. Go
10 ahead, Yael.

11 MEMBER HARRIS: But all the call for
12 abstracts closed and they've already decided upon
13 them.

14 MR. GOLDWATER: But if --

15 MEMBER HALL-BARROW: I just talked to
16 them today and I got one put in. So, there's a
17 way.

18 MR. GOLDWATER: But the other way --

19 (Simultaneous speaking.)

20 MR. GOLDWATER: But let me clarify, I
21 understand, Yael's real excited about going to
22 Orlando, but, I don't know why, but this

1 project's not going to be finished until the end
2 of the summer.

3 So, anything from now until then, we
4 probably -- Academy Health is probably the only
5 one, and I'll talk to Megan about this, that we
6 would consider, because that's in the end of June
7 and we'll be close to getting done, there is
8 something to talk about with that.

9 But the AMIA Joint Summit, which is in
10 March, we won't be far enough along to talk about
11 this. The year after that, perhaps. AMIA,
12 HIMSS, maybe, ATA. Once the project is done, or
13 is close to being completed, then I think could
14 certainly talk about it.

15 Publishing papers is a different
16 story. But there will be a lot, Steven, of
17 publicity about this. Plus, NQF will do its own
18 marketing.

19 We'll broadcast this to all of our
20 members, we will be talking about this with all
21 of our physician communities, we will certainly
22 be bringing this up to the Board and to the CSAC,

1 and there's a lot -- Helen Darling is very, our
2 interim CEO, is extremely invested in telehealth
3 and really loves this topic, and I'm so sorry
4 she's in New York and couldn't come up here to
5 see everybody, I know she would have just loved
6 this.

7 But, so, I think it will gain traction
8 that way through wide exposure. And, like I
9 said, I think there's a lot of different papers
10 and presentations we can do out of this, it's not
11 just the framework, it's also the implications of
12 the framework as well. Chuck, and then Dale.

13 MEMBER DOARN: You may have addressed
14 this before I got here yesterday morning, but I
15 was curious, you guys have done this for other
16 areas and when we talk about a framework, I
17 oftentimes think of a backbone structure,
18 metaphorically, that already exists that you can
19 use that to build on, or is this framework like
20 from scratch?

21 MR. GOLDWATER: So, it's -- we'll look
22 at some of the things that have been done, but

1 more than likely, our vision of this was, it was
2 going to be built from the ground up and it would
3 be a backbone then to extend out.

4 So, what we've sort of discussed
5 already is the framework will be built out with
6 its concepts and its dimension and how measures
7 can be developed, and then, again, I think based
8 on areas where telehealth is having tremendous
9 effect, so dermatology or mental and behavioral
10 health, we extend those out to other projects and
11 then really build more narrowly defined, but much
12 more specific, measure frameworks around those
13 areas because of the implications, and because of
14 the policy impact that could have as well.

15 So, I think for publicity, I'm not shy
16 about publicizing what NQF does, anyone that
17 works with me, Katie knows that for sure, our
18 value set project, which is, like, for the
19 hardcore informaticist, I mean, those are, like,
20 I mean, really -- Stewart, don't pretend that
21 you're interested, because you're not.

22 (Laughter.)

1 MR. GOLDWATER: I mean, it's, like,
2 what's the difference between one SNOMED code and
3 another? I mean, that's how, like, seriously it
4 -- it was just mind-boggling. And we presented
5 that everywhere and people loved it. I cannot
6 for the life of me, I'm not that entertaining,
7 I'm really not, but everyone just loved it.
8 This, I think, is going to get a significant
9 amount of traction and exposure. So, Marybeth?

10 MEMBER FARQUHAR: Getting back to
11 implementation and what's good for measure
12 developers, please?

13 MR. GOLDWATER: Yes.

14 MEMBER FARQUHAR: We need to make sure
15 that the concepts are crystal clear and not
16 overlapping. And then, also a definition of what
17 you're expecting out of measurement.

18 MR. GOLDWATER: Right.

19 MEMBER FARQUHAR: Okay.

20 MR. GOLDWATER: Dale?

21 MEMBER ALVERSON: Another important
22 aspect, I think, which can come out of this, and

1 one of the other reasons I'm interested, is this
2 unusual phenomenon of OMB, the Office of
3 Management and Budget.

4 MR. GOLDWATER: Yes.

5 MEMBER ALVERSON: Whenever legislation
6 goes forward that involves telehealth, they will
7 look at the cost side and they'll mark it up. I
8 mean, when I was president of ATA, I was always
9 amazed and I talked to, you would talk to people
10 at OMB and it's all kind of mysterious, but what
11 they say is, show me the data.

12 So, if nothing else, if something
13 comes out of this where we can actually now
14 demonstrate the data and that's on there, the
15 cost effectiveness, all those kind of things,
16 outcomes, that's going to go a long way to
17 facilitate adoption of telehealth across the
18 board. And I don't know if you've dealt with
19 OMB, but it is a very mysterious process. And
20 they won't even talk about. They won't -- you
21 can't -- well, I've got some data, well, it's got
22 to be out there.

1 MR. GOLDWATER: Right.

2 MEMBER ALVERSON: So, hopefully that's
3 going to come out of this in a very positive way.

4 MR. GOLDWATER: Okay. And, Yael? And
5 then Mary Lou.

6 MEMBER HARRIS: I was going to add
7 about promotion that Health Datapalooza has a
8 call for abstracts now. I know you wouldn't have
9 data, but I think this might be something of
10 interest to them, because it's very policy
11 focused.

12 And I think they'd be very interested
13 in knowing that we're looking at getting the type
14 of data that's needed to measure telehealth and
15 would have some interesting insights that might
16 want to be considered that could point you to
17 more publications, et cetera.

18 MR. GOLDWATER: All right. So, Megan,
19 we know what a part of our next phone call will
20 be about. Mary Lou?

21 MEMBER MOEWE: Have you thought about
22 decreasing the cost of premiums by having

1 patients opt-in to a telehealth model, so that
2 they could say, 50 percent of my visits to my
3 physician will be all telehealth, I'm good with
4 that. And then, I will get a reduction in my
5 monthly premium.

6 Because I think everything kind of
7 revolves around, for patients, for the consumer
8 today, is why is my premium X hundred dollars a
9 month and how do we reduce that? And going back
10 to the Southwest model, why I use Southwest, it's
11 cheaper, it's faster. So, how do we -- if you
12 operationalize something, you have to look at
13 cheap and fast.

14 MR. GOLDWATER: Right.

15 MEMBER MOEWE: And first. So, I think
16 that's something patients, consumers -- and I
17 believe consumers are going to be the drivers of
18 the marketplace in the future. And the other
19 thing is, I told a few people I was coming to
20 work on telehealth and they were like, is that
21 still around? Like, isn't that from the 1970s or
22 1980s?

1 (Laughter.)

2 MR. GOLDWATER: Yes, I get it.

3 MEMBER MOEWE: A lot of people
4 associate it with telephones and it's really,
5 it's e-medicine, it's really electronic medicine
6 and it's not just using your phone, it's using
7 Skype or whatever technology is out there. And
8 also -- so, I don't know, I think that's
9 something you have to think about, it has to be,
10 for the consumer to adopt it quickly. It's got
11 to be something is like Facebook.

12 MR. GOLDWATER: Right. Oh, god, yes.

13 MEMBER MOEWE: And, I think, another
14 thing is, there was a study done on how consumers
15 pick their physicians and it's really by the way
16 they look. Our consumers go on and look at the
17 doctors' pictures and pick it, does this doctor
18 look like someone I would want to go to see in a
19 photo. They don't really read, where did he go
20 to school, what did he -- but, just another thing
21 about making it accessible for -- the normal
22 consumer is not looking at where you were

1 educated or what your specialties are, they're
2 looking at what you look like, do you look like
3 me? So, I'm just looking at it from a consumer's
4 perspective.

5 MR. GOLDWATER: Right. Great.

6 Perfect. Stewart?

7 MEMBER FERGUSON: So, you were asking
8 for thoughts around some of the -- how we might
9 do metrics, how proscriptive would you get on
10 metrics? And the example I'm thinking of is
11 travel savings, for example. And the reason I
12 ask is, a lot of telehealth programs assume every
13 telehealth case saves travel. We don't make that
14 assumption, we ask the providers if it saved
15 travel and we find only about two-thirds do. The
16 question is, where do you save travel to, it's
17 not always to where the doctor who is talking to
18 you, it might have been to somewhere down the
19 street, what airfare, if they're flying, I mean,
20 just those kinds of questions. And to compare
21 apples-to-apples, it would be nice if we all kind
22 of have a same kind of process for calculating

1 travel savings. Do you get down to that level of
2 detail?

3 MR. GOLDWATER: You can, absolutely.

4 If --

5 MEMBER FERGUSON: Because you almost
6 have to.

7 MR. GOLDWATER: We can get down to that
8 level, if there's a collective consensus that
9 that is an important enough issue to be wrapped
10 into telehealth. It gets back to what Marybeth
11 was saying, which I couldn't agree with more, the
12 concept has to be very, very clear, the
13 definition has to be very, very clear.

14 How you're going to evaluate has to be
15 clear, because then you don't have any ambiguity
16 in measurement, which is what causes all these
17 problems. So, if you think that that is going to
18 be highly valuable to really understanding the
19 utility of telehealth, yes, we can get into the
20 weeds on that, not today, but we can get into the
21 weeds later. Don?

22 MEMBER GRAF: So, another benefit to

1 having available the claims data is being able to
2 extract on our membership information and compare
3 the city in which the member lives and the city
4 in which the provider is delivering the care and
5 then create an actual cost down to per mile
6 saved, cost per mile. So, it can get really
7 exact.

8 MR. GOLDWATER: Yes. That might be
9 good. Yes, Yael, final thoughts.

10 MEMBER HARRIS: So --

11 MR. GOLDWATER: Oh -- Yael, and then
12 Judd.

13 MEMBER HARRIS: We have to close down,
14 Judd. So, on the paper that Marcia and are
15 waiting on Chuck to publish, we actually did do
16 that, which is we looked at -- we calculated
17 miles that would have had to be traveled,
18 obviously that's judgmental in that, would they
19 actually have traveled them, and then we looked
20 at the form of transportation as a way of
21 estimating cost.

22 So, it was an emergency and it would

1 have been by helicopter versus would it have been
2 by ambulance versus would they have actually
3 driven themselves, as a proxy to estimate how
4 much it would be, because miles is not enough of
5 an estimate if you're talking about an acute
6 situation.

7 MR. GOLDWATER: Okay. Judd? And then
8 Don and then someone else.

9 CHAIR HOLLANDER: So, I think a couple
10 of the last comments have really focused on cost
11 and on Dale's comment with OMB, I mean, I spent
12 the one day of my life on the Hill, which was one
13 day of my life, so I thought it was cool, but the
14 resounding theme from everybody we spoke to was,
15 we need cost data for CBO, because they're not
16 going to pass anything unless it's cost-neutral.

17 So, it may be beyond the scope of
18 this, but a lot of people had really good ideas
19 that added onto other really good ideas with
20 things that would need to go into an overall cost
21 model.

22 And so, I wonder, if it's beyond the

1 scope of this or if it's not, whether we want to
2 get together on the listserv and just develop a
3 master list of everything we think should go into
4 cost, like all the gazillion items, and start
5 putting together what people would need to
6 collect to do the perfect model.

7 It may or may not ever be a measure
8 thing, it may be, it would give guidance of
9 things that in the ideal would be measured and
10 defined, but I think if we really want to advance
11 telehealth, we really need to answer the cost
12 question.

13 And I think the brains around this
14 table and the experience around this table makes
15 it the right group of people to try and at least
16 map out all of the things we think might need to
17 go into that calculation.

18 MR. GOLDWATER: So, I agree with you,
19 Judd, and I think that's a great idea. I would
20 caution not to do that now, I would wait until we
21 have the concepts defined so we know what costs
22 we're looking at and then we can start breaking

1 down what we need. Don?

2 MEMBER GRAF: Just a point of
3 clarification on the cost, transportation cost,
4 the studies we're doing specifically for health
5 plan cost for, especially Medicaid contract paras
6 who are under contract are at risk for
7 transporting patients to their physician
8 appointments. As opposed to patient cost.

9 MR. GOLDWATER: Okay. All right. Is
10 that it? Any final thoughts? Chuck, did you
11 find anything on Google?

12 MEMBER DOARN: Well --

13 MR. GOLDWATER: I was kidding.

14 MEMBER DOARN: No, I mean --

15 (Laughter.)

16 (Simultaneous speaking.)

17 MEMBER DOARN: The one thing I think is
18 very important is, it's amazing to me how many
19 people think that this is never really going to
20 happen. I mean, I remember we were at a meeting
21 with Deena Poskin, this goes back to 1994, and I
22 said, we need to have a map on the World Wide

1 Web, clickable map, by state, click on the state,
2 by county, who's doing what in telemedicine.

3 Twenty-five people in the room, 24
4 people had no idea what the World Wide Web was.
5 That was 20 years ago. So, if you think that
6 this isn't going to happen and this isn't going
7 to become the standard of care and we're not
8 going to do some of the things we've talked
9 about, you're in the wrong room.

10 And the people on Capitol Hill,
11 they're either going to pay for it or they're
12 not, but industry is going to make it happen,
13 consumers are going to use it, and the American
14 public are going to use it.

15 So, this idea of somehow -- I mean,
16 telemedicine has been the most over-studied
17 practice of medicine, robotic surgery,
18 laparoscopic surgery, the stethoscope, x-ray
19 machines, they didn't go through this kind of
20 rigor. And it's not clear to me why telemedicine
21 and telehealth go through this rigor, but it's
22 just a closing point.

1 MR. GOLDWATER: Okay. Because it will
2 serve a higher purpose, that's why. So, amen, my
3 brother, thank you very much. All right. Thank
4 you all. I appreciate everything you've
5 contributed.

6 We will be in touch and we will
7 continue to keep you informed of what we're
8 doing. We will talk to you via the web or
9 conference call coming up. So, I -- do we want
10 to do public comment now? Okay. So, Operator,
11 can you open up the line for public comment,
12 please?

13 OPERATOR: Yes, sir. At this time, if
14 you would like to make a comment, please press
15 Star and then the Number 1. And at this time,
16 there are no public comments.

17 MR. GOLDWATER: Okay. All right.
18 Well, in that case, we'll be in touch with next
19 steps. Thank you all very much. Safe --

20 MEMBER DEPHILLIPS: Sorry, one other
21 thing. I want to thank the NQF team.

22 MR. GOLDWATER: Yes, thank you.

1 (Applause.)

2 MR. GOLDWATER: You are very welcome.

3 Thank you, Henry, you are now our new favorite
4 person. All right. Everybody have a safe flight
5 back. Happy Thanksgiving ahead of time, Merry
6 Christmas, Happy Hanukkah, Happy Kwanzaa,
7 whatever it may be. We will see you all soon.

8 (Whereupon, the above-entitled matter
9 went off the record at 2:19 p.m.)

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9:00 1:9**9:04** 5:2**90** 125:18**90-day** 40:10 156:4**97** 151:15**9th** 1:9

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: 11-17-16

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.



Court Reporter

NEAL R. GROSS

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