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:

JUDD HOLLANDER, MD, Associate Dean for Strategic Health Initiatives, Vice Chair, Finance and Healthcare Enterprises, Sidney Kimmel Medical College, Department of Emergency Medicine, Thomas Jefferson University, Chair
MARCIA WARD, PhD, Director, Rural Telehealth Center, University of Iowa
DALE ALVERSON, MD, Medical Director, Center for Telehealth, University of New Mexico Health Sciences Center
ADAM DARKINS, MB, ChB, MPHM, MD, FRCS, Vice President for Innovation and Strategic Partnerships, Americas Region, Medtronic Plc, Medtronic
HENRY DEPHILLIPS, MD, Chief Medical Officer, Teladoc, Inc.
CHARLES DOARN, MBA, Professor, Family and Community Medicine, University of Cincinnati

MARYBETH FARQUHAR, PhD, MSN, RN, Vice President, Quality, Research & Measurement, URAC
ARCHIBALD (STEWART) FERGUSON, PhD, Chief Technology Officer, Alaska Native Tribal Health Consortium
DAVID FLANNERY, MD, Medical Director, American College of Medical Genetics and Genomics
PAUL GIBONEY, MD, Director of Specialty Care, Los Angeles County Department of Health Services
NATE GLADWELL, RN, MHA, Director of Telehealth and Telemedicine, University of Utah Health Care
DON GRAF, National Telehealth Director, UnitedHealthcare
JULIE HALL-BARROW, EdD, Vice President, Virtual Health and Innovation, Children's Health, Children's Medical Center Dallas
STEVEN HANDLER, MD PhD, CMD, Associate Professor, Chief Medical Informatics Officer, University of Pittsburgh Medical Center
YAEL HARRIS, PhD, MHS, Senior Health Researcher, Mathematica Policy Research
KRISTI HENDERSON, DNP, NP-C, FAAN, FAEN, Vice President, Virtual Care & Innovation, Seton Healthcare
MEGAN MEACHAM, MPH, Public Health Analyst, U.S. Department of Health and Human Services, Health Resources and Services Administration, Federal Office of Rural Health Policy
MARY LOU MOEWE, MT (ASCP), PMP, ACP, FACHE, CPHIMS, Director of e-Health Initiatives State of Tennessee, Department of Health Care Finance and Administration (HCFA) Medicaid, State of Tennessee
EVE-LYNN NELSON, PhD, Director & Professor, KU Center for Telemedicine & Telehealth, University of Kansas Medical Center

STEPHEN NORTH, MD, MPH, Regional Clinical and IT Director/Practicing Physician, Mission Medical Associates and Mission Community Primary Care
PETER RASMUSSEN, MD, Medical Director, Distance Health, Cleveland Clinic
SARAH SOSSONG, MPH, Director of Telehealth, Massachusetts General Hospital
DANIEL SPIEGEL, MD, MBA, National Director of Home Hemodialysis, DaVita, Healthcare Partners, Inc.
DENNIS TRUONG, MD, Director of Telemedicine/Mobility and Assistant Physician-in-Chief, Kaiser Permanente Mid-Atlantic States
JEAN TURCOTTE, MA, BSN, RN, Director of Tele-ICU, Adventist Health System
ANGELA WALKER, MD, FAAD, Direct Dermatology, Science 37

NQF STAFF:

TRACY LUSTIG, Senior Director

KATHRYN STREETER, Senior Project Manager

A G E N D A

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

9:04 a.m.

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

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

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

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

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

MEMBER RASMUSSEN: Hi, I'm Peter Rasmussen.

MR. GOLDWATER: Microphone, turn your microphone on.

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

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

MEMBER RASMUSSEN: Nothing relevant to telemedicine, no.

MR. GOLDWATER: Okay, great.

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

any disclosures.

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

MEMBER MOEWE: Thank you.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And in the case of e-measures, which

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

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

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

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

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

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

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

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

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

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

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

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

fail.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

process.

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

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Right.

CHAIR WARD: Is there an implication here?

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

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

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

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

CHAIR WARD: I don't know.

(Laughter.)

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

MS. WILSON: Yes.

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

MR. GOLDWATER: Right.

CHAIR WARD: And so --

MS. WILSON: Okay.

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

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

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

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

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

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

MR. GOLDWATER: Wow, see?

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

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: All right. So, me let

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER DOARN: But to say it's never

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Okay.

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

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

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

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

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

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

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

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

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

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

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

MEMBER DARKINS: So, maybe you can answer --

MR. GOLDWATER: -- just not actionable.

MEMBER DARKINS: -- in terms of what

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

MR. GOLDWATER: Not necessarily.

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

MR. GOLDWATER: Yes.

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

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

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

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

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

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

perhaps an in-person measure.

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

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

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

wasn't the most encouraging thing to say --

(Laughter.)

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: Right.

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

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: I completely agree,

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

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

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: Right.

MEMBER DARKINS: -- of quality coding for --

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

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

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

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

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

MR. GOLDWATER: Right. Okay.

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

MR. GOLDWATER: Sure.

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

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

MEMBER DOARN: Okay.

MR. GOLDWATER: -- to the --

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

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

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

MR. GOLDWATER: Okay.

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

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

MEMBER GRAF: Yes.

MR. GOLDWATER: Oh, hi, Don.

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

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

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

MEMBER HARRIS: And the MUD too?

MR. GOLDWATER: What's that?

MEMBER HARRIS: The MUD list too?

MR. GOLDWATER: Why not?

(Laughter.)

MEMBER HARRIS: I was joking, but I

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MEMBER FLANNERY: We talked about the systems --

MR. GOLDWATER: Yes.

MEMBER FLANNERY: -- system

effectiveness.

MR. GOLDWATER: Right.

MEMBER FLANNERY: And it comes under that.

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

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

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

MR. GOLDWATER: Right.

MEMBER DOARN: -- pretty much.

MR. GOLDWATER: Right.

MEMBER DOARN: Okay.

MR. GOLDWATER: Okay. David?

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

MR. GOLDWATER: Right.

MEMBER FLANNERY: Which is a quality metric.

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

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

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

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

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

MR. GOLDWATER: Right.

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

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

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

this. Those outcomes would just go under effectiveness.

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Okay. Paul?

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

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

MEMBER HANDLER: It could be this is a

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

MR. GOLDWATER: Okay.

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

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

MEMBER MOEWE: Okay.

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

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

as a separate new line item with regard to concept?

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

MEMBER HANDLER: Okay.

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

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

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Okay. Steve?

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: It's okay.

MEMBER WALKER: So, I very much think

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

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

MR. GOLDWATER: Okay. Judd?

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

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

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

MR. GOLDWATER: Okay. And, Adam?

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

So, one of the options to do in terms

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

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

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

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

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

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

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

thoughts before we move on to the dimensions? Yael, yes.

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

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

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

MEMBER HARRIS: So, if I might suggest,

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

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

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

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

MEMBER FARQUHAR: Systems effectiveness?

MR. GOLDWATER: System, right.

MEMBER FARQUHAR: Okay. I'm good.

MR. GOLDWATER: Sarah? And then Paul.

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

MR. GOLDWATER: That's correct.

MEMBER SOSSONG: Okay. That was my --

MR. GOLDWATER: Paul?

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

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

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

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

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

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

Eve-Lynn?

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

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

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

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

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

MR. GOLDWATER: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Yael?

MEMBER HARRIS: I don't want to

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

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

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

MR. GOLDWATER: Adam?

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

determinants and there are biopsychosocial pieces.

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

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

MR. GOLDWATER: Right. Okay.

MEMBER DARKINS: Yes.

MR. GOLDWATER: Daniel? Or --

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

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

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

MR. GOLDWATER: Yes. Steven?

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

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

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

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

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

MR. GOLDWATER: Okay. Paul?

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

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

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

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

MR. GOLDWATER: Okay.

MS. LUSTIG: Can I ask something?

MR. GOLDWATER: Go ahead, Tracy, sure.

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

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

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

MR. GOLDWATER: Steven? You.

MEMBER NORTH: Me? Great, thank you.

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

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

MR. GOLDWATER: Okay. Judd?

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

MR. GOLDWATER: Okay. Adam?

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

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

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

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

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

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

MR. GOLDWATER: Steven?

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

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

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

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

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

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

matrix approach, which I think is applicable here.

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

MEMBER DOARN: That includes capability?

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

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

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

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

(Laughter.)

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

(Laughter.)

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

Chuck?

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

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

MR. GOLDWATER: Yes.

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

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

MR. GOLDWATER: Correct.

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

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

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

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Right.

MEMBER DEPHILLIPS: -- is improved.

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

MR. GOLDWATER: Understood.

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

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

MEMBER MOEWE: Oh, okay.

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

MEMBER MOEWE: Is that captured in the

dimensions as far as --

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

MEMBER MOEWE: Okay.

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

MEMBER MOEWE: Okay.

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

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

And I think about that, because doing

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

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

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

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

or information gathering sufficiency.

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

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

MR. GOLDWATER: Right. Stewart?

MEMBER FERGUSON: I agree with that. I was going to jump to a slightly different topic, under technical capacity. We haven't really kind of discussed that too much, but I think the word technical is really misleading.

MR. GOLDWATER: Okay.

MEMBER FERGUSON: I think when they all

think technical, they think networks, equipment --

MR. GOLDWATER: Okay.

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

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

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

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

I want to ground the conversation and

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

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

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Understood. Paul?

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

MR. GOLDWATER: Okay.

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

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

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

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

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

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

MR. GOLDWATER: Peter?

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

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Okay. Chuck?

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

MR. GOLDWATER: Ha-ha.

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

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

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

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

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

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

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

(Laughter.)

MEMBER DEPHILLIPS: We used the term useful information --

MR. GOLDWATER: Yes.

MEMBER DEPHILLIPS: -- yesterday.

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

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

grid.

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

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

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

MEMBER HALL-BARROW: Or they leave it out.

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

MR. GOLDWATER: Adam? And then --

MEMBER DARKINS: So, a couple of

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

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

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

MR. GOLDWATER: Okay.

MEMBER DARKINS: Of behavioral health.

MR. GOLDWATER: Okay. Judd?

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

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

MR. GOLDWATER: Okay. Steven?

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

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

MR. GOLDWATER: Right.

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

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

than in the absence of information.

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

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

MEMBER HENDERSON: So, do we not --

MR. GOLDWATER: Kristi?

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

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

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

MEMBER HENDERSON: Actionable information.

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

MEMBER HENDERSON: Yes.

MR. GOLDWATER: Angela, we agree to that?

MEMBER WALKER: I still --

MR. GOLDWATER: I don't care, but --

(Laughter.)

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

MEMBER HENDERSON: We're getting closer.

MEMBER WALKER: We're getting closer.

MR. GOLDWATER: Stewart?

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

MR. GOLDWATER: You guys are ridiculous.

MEMBER FERGUSON: So, just --

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

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

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

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

MEMBER FERGUSON: Yes, you can just

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

(Laughter.)

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

MR. GOLDWATER: Thank you.

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

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

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

MR. GOLDWATER: Yes.

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

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

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

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

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

CHAIR WARD: Recap.

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

MEMBER HARRIS: She's the co-chair,

she's supposed to --

MR. GOLDWATER: Oh, that's true. Infrastructure capacity, we have appropriateness, we still have therapeutic outcome, patient outcome, and actionable information as the five dimensions. And we will -- we're good with that? Thank you all very much.

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

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

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

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

(Laughter.)

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

(Laughter.)

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

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

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

(Laughter.)

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Sure.

MEMBER GRAF: -- what you're saying.

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Okay.

CHAIR WARD: -- everything fits everywhere.

MR. GOLDWATER: Right. I know --

(Laughter.)

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

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Right.

MEMBER RASMUSSEN: And I guess --

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Okay.

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

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

MR. GOLDWATER: Okay. Sarah?

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

MR. GOLDWATER: Yes.

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

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

MEMBER SOSSONG: Okay.

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

MEMBER FERGUSON: I guess, when I think

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Right. Steve?

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

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

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

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

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

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

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

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

MR. GOLDWATER: Okay. Steve?

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

MR. GOLDWATER: Okay. Kristi?

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

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

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

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

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

MR. GOLDWATER: Okay. Sarah?

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

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

MR. GOLDWATER: Okay. Don?

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

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

MEMBER GRAF: Healthcare disparity, ethnic diversity --

MR. GOLDWATER: Oh, disparities, yes.

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

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

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

(Laughter.)

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

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

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

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

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

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

MR. GOLDWATER: Judd?

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

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

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

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

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

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

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

I mean, I understand this is sort of

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

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

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

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

MR. GOLDWATER: Okay. Don?

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

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

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

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

MR. GOLDWATER: Right. I agree.

Stewart?

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

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

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

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

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

MR. GOLDWATER: Right. Eve-Lynn?

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

MR. GOLDWATER: Okay. True. Paul?

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

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

particular service available at all?

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

MR. GOLDWATER: Kristi?

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

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

MR. GOLDWATER: Yes. Great. Stewart?

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

MR. GOLDWATER: Right. I agree.

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

sense.

MR. GOLDWATER: Angela?

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

(Laughter.)

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

MR. GOLDWATER: What do people think? Judd?

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

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

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

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

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

If there is a conceptual basis, and

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

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

MR. GOLDWATER: Right. Nate?

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

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right. Don?

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

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

MR. GOLDWATER: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Yes.

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

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

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

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

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

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

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

MEMBER NORTH: I don't think a separate

category should be created.

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Okay.

MEMBER NORTH: Yes.

MR. GOLDWATER: Adam?

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Right.

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

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

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

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

MEMBER HENDERSON: Or is it system effectiveness --

MR. GOLDWATER: Yes.

MEMBER HENDERSON: -- a piece of that maybe?

MR. GOLDWATER: Yes.

MEMBER HENDERSON: I don't know.

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

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

MR. GOLDWATER: Right.

(Laughter.)

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

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

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

MR. GOLDWATER: Right.

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

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

MEMBER FERGUSON: That's okay.

(Laughter.)

MR. GOLDWATER: I never know.

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

MR. GOLDWATER: It could be, sure.

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

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

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

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

(Laughter.)

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

MR. GOLDWATER: Okay.

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

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

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

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

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Right.

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

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

(Laughter.)

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

(Laughter.)

CHAIR HOLLANDER: And so, they saw her.

But --

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

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

MR. GOLDWATER: Right.

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

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

And there aren't -- the payers have

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

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

MR. GOLDWATER: Right. Julie?

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

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

the same. No, we don't.

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Okay. Stewart?

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

(Laughter.)

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

MR. GOLDWATER: Right.

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

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

And so, there's a whole workload

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

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

MR. GOLDWATER: Right.

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

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

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

MR. GOLDWATER: Well, not today.

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

MR. GOLDWATER: Right.

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

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

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

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

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

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

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

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

MR. GOLDWATER: Kristi?

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

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

And so, then my providers are able to

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

MR. GOLDWATER: Sure. Chuck?

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

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

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

And the licensing of the software, and

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

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

MR. GOLDWATER: Okay. Sarah?

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

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

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

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

MR. GOLDWATER: Sure. Daniel?

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

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

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

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

MR. GOLDWATER: Sure. Dale?

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

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

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

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

Same thing could go to cancer, early

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

MR. GOLDWATER: Okay. Judd?

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

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

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

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

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

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

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

Okay.

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: Right.

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

MR. GOLDWATER: Okay. And --

MEMBER HANDLER: And to the planet, perhaps.

MR. GOLDWATER: Steve Number Two.

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

MR. GOLDWATER: Okay. Dale?

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

And I don't know if that's been

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Thank you very much.

Stewart?

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

MR. GOLDWATER: Yes. Don?

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

MR. GOLDWATER: Right, yes.

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

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

MEMBER NORTH: No.

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

MEMBER DOARN: We talked about

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

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

MEMBER DOARN: Right.

MR. GOLDWATER: All right.

(Laughter.)

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

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

(Laughter.)

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

MR. GOLDWATER: Right.

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

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: Right.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Go ahead.

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

country do their own things.

Our office participates, the National Organization of State Offices of Rural Health participates, the National Rural Health Association, which is one street over, participates.

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

(Laughter.)

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

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

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

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

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

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

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

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

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

So, we wanted to use system effectiveness as one of our measure concepts. So, what elements do you think need to be included in that? And I realize it's after lunch, this is when everyone's like, ugh. All right. Yes, Steve, thank you.

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

(Laughter.)

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

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

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

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

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

effective way possible?

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

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

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

MR. GOLDWATER: Okay. Henry?

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

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

MR. GOLDWATER: Okay.

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

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

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

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

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

MR. GOLDWATER: Yes. Okay. Judd?

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

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

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

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

CHAIR HOLLANDER: Okay.

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

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

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

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

MR. GOLDWATER: Yes. Stewart?

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

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

system running whether it's redundant or not. But availability is really important, failures, I think we all know if it fails once for a doc, you actually never get a second chance.

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

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

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

MR. GOLDWATER: Right. Don?

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

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

MR. GOLDWATER: Marcia?

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

MR. GOLDWATER: Okay. Anybody else?

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

MEMBER GIBONEY: One more?

MR. GOLDWATER: Yes. Okay.

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

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

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

adoption or whatever.

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

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

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

MR. GOLDWATER: Okay. David?

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

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

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

(Laughter.)

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

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

MR. GOLDWATER: Yes.

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

MR. GOLDWATER: Absolutely. Kristi?

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

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

MR. GOLDWATER: Yes.

MEMBER HENDERSON: The right workforce? So we're not -- everyone's practicing at the top of their license.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

MR. GOLDWATER: Right, right.

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

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

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

MR. GOLDWATER: Right.

(Laughter.)

MR. GOLDWATER: Judd?

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

MR. GOLDWATER: Okay.

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

MR. GOLDWATER: Okay. Don?

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

MR. GOLDWATER: Right. Marcia?

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

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

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

MR. GOLDWATER: Okay.

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

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

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

MR. GOLDWATER: Okay. Judd?

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

MR. GOLDWATER: Right. Okay. Paul?

MEMBER GIBONEY: Yes, I mean, I think

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

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

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

also the impact on utilization of different venues.

MR. GOLDWATER: Okay. Yes. Steven?

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

MR. GOLDWATER: Nate?

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

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

MEMBER GLADWELL: Okay.

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

case that's applicable.

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

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

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

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

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

So one is convenience for the patient. Connection was one that our leadership was very interested in, what is the clinician/patient connection and how did that change over telehealth? That's something we looked at with the clinician experience also.

Specific to telehealth, their experience with the installation testing technology and service associated with that. And then, we tried to overlap it with where there were existing measures for in-person as well, so the CG CAHPS questions, we looked at all of them and thought about which were the ones that were relevant to telehealth also?

So, the ones we chose were seeing clinician within 15 minutes of appointment time, clinician explaining things in a way that was easy to understand, rating the visit, listening carefully, spending enough time. And that at least gave us something that was comparable, as opposed to just inventing metrics on our own.

MR. GOLDWATER: Wonderful, thank you. Marybeth?

MEMBER FARQUHAR: I would follow up with clinician communication, getting the needed care, getting the care in a timely manner, reliability of the service, and security/privacy.

MR. GOLDWATER: Great. Judd?

CHAIR HOLLANDER: So, this is sort of a tricky area and I think each patient comes to the table with different goals. And I think we need to basically ask a broad question, which is, were the patient's goals met? And we actually have data on that.

We're doing some student counseling, some behavioral health, students would rather sit

in their dorm room than go to the psych ward, even though it's across the street, to see somebody, it's more comfortable.

But the thing we've learned, we do net promoter scores on this, and our net promoter scores, actually for a while, we were living in the nineties. Family medicine lives at three, Amazon is in the 40 to 60 range. We're lower now and we expect regression to the mean.

But reality is, the patient goals are, I don't want to leave my house and I want to get my care. And so, even if they get disconnected three times from the video, they don't care, because their goal was, I didn't leave my house and I got my care.

And so, we're satisfying their goals. When we try and break it down line item by line item, sometimes in each line item, it's not so hot, but overall, wow, totally nailed it, it's as good as it could get.

MR. GOLDWATER: Right.

CHAIR HOLLANDER: And so, I think

having some measure of were the patient's goals met, whatever they were, is useful.

MR. GOLDWATER: Okay. Stewart?

MEMBER FERGUSON: I think this is following on what you were saying, Sarah, but we actually measure patient education. So, we actually find that telehealth, like two-thirds of our cases that the patients feel more educated about their disease state, which is much higher than the in-person.

Second one is patient compliance. We actually find they're more compliant with whatever the therapeutic regime is if we do telehealth, for some reason.

And the third one is, no-shows. We talked about that earlier, but that's a big thing, that kind of indicates the patient's interest in being involved in their care and we don't get no-shows on telehealth.

MR. GOLDWATER: Okay. Peter?

MEMBER RASMUSSEN: Expanding on the concept of convenience that Sarah started with,

it's things like time saved, they avoid travel and travel-related expenses. Because of use of technology, were they able to more easily incorporate an interested caregiver, family member in the visit as opposed to having that family member being challenged in making the in-person appointment?

And I agree with Judd, sort of that overall concept of just, how satisfied are they with the interaction, is incredibly important. We had the same experience you have.

MR. GOLDWATER: Eve-Lynn?

MEMBER NELSON: I really agree with the meeting their goals one as well. I think that aligns with patient-centered care, some of that language you were using before. In terms of connection, sometimes we talk in mental health more about relationship or therapeutic alliance, but I think it all goes back to the connection comment that was made.

And then, it was Stewart's comment, in terms of understanding the recommendations and

treatment plan, for us, I think sometimes it comes down to health literacy kinds of things. In the school-based setting, for example, it may be just even teaching, well, this is how you use the thermometer. It may be a family who's just not been socialized to the healthcare system before.

MR. GOLDWATER: Yael?

MEMBER HARRIS: I think several people mentioned this, but, basically, the form access, but not quantitative access, patient perceived access.

MR. GOLDWATER: Okay. Angela?

MEMBER WALKER: I just want to play devil's advocate for a second on patient's goals met. I can clearly identify from Yelp reviews, if I establish very early what the patient wants to accomplish during the visit and I meet those goals, I'm much more apt to get a positive review than a negative review.

However, in any setting, if a patient's goal is, I want back surgery for back

pain or I want an opioid for back pain, and that's their primary goal, if we've made that one of the outcomes, then good medicine may say, we'll never meet it.

MR. GOLDWATER: Chuck?

MEMBER DOARN: Well, I was thinking about the term perception, the patient may perceive that the medical system is on their side, because they're helping them out, they're coming to their home, and I remember down in Richmond, there's Henrico Doctors' Hospital and then there's MCV.

And Henrico had a big advertisement on Interstate 64 about, come get your gallbladder out with a robot. And I asked, because I was in the department of surgery, I said, why don't we advertise like that? He said, well, A, we're a state hospital, can't do that, and, B, the people then thought that the better technology was not at the University Hospital, but it was at this Henrico Doctors' Hospital.

So, when the patient realizes, hey,

they're really invested in me, they're coming to my home or to where I am at work, my school, with kids or whatever, so to me there's that underlying perception of the value that's added to healthcare because the system cares about them. That may not be true, but there's certainly ways of measuring that.

MR. GOLDWATER: Nate?

MEMBER GLADWELL: I would say another one to consider is patient's confidence in care. We have a lot of our rural partners that get frustrated when they feel like the care plan is going well, but the patient always says, well, just send me to the big city and they'll figure it out. And so, if we can have the big city doctor on camera say, your local doctor is doing a great job, we have confidence in him, confidence in care increases dramatically.

MR. GOLDWATER: Right. Don?

MEMBER GRAF: Pretty consistent results from 15 years of doing surveys are lost wages, time away from school, transportation costs,

shorter wait times.

MR. GOLDWATER: Great. Nate, did you have something else to add or was your -- all right. Just making sure. All right. This is terrific. Yes, Judd?

CHAIR HOLLANDER: So, I was just going to say, an interesting thing, I don't know how we capture this, but it's willingness to accept recommendations. So, particularly on the antibiotics stewardship side, you wait four hours in the ER, you are pissed if you don't get antibiotics or narcotics --

(Laughter.)

CHAIR HOLLANDER: You are just pissed. But I have yet to have a patient on telemedicine insist on antibiotics when I say it doesn't work, because they've invested six minutes of their time.

MR. GOLDWATER: Right.

CHAIR HOLLANDER: And so, I think that they can accept compliance with lack of treatment sometimes much better.

MR. GOLDWATER: It's interesting. That incident never happened to me, by the way, Chuck. I don't get pissed off. Yes, Henry?

MEMBER DEPHILLIPS: No, it's -- I'm actually -- I'm not going to argue at all, I'm just going to provide some data about our complaint rate across the board. We're a public health company, it's published, it runs at about 0.1 percent of all visits, or something like that, one in a thousand

MR. GOLDWATER: 0.1?

MEMBER DEPHILLIPS: 0.1.

MR. GOLDWATER: Wow.

MEMBER DEPHILLIPS: Yes, I mean, the satisfaction with -- to your point, we started, we look at the survey, they give us five stars and we're like, we're doing a great job. Then we start reading them, the doctor was rude, I had to wait in line, but five stars because they didn't have to leave their house to go get care. So, that's definitely the case.

(Laughter.)

MEMBER DEPHILLIPS: But that's not what I'm commenting on. Our number one complaint, we have a small number of complaints, but 50 to 70 percent every single month is, I didn't get the antibiotic that I know I need for my annual sinus infection that I've had for the last 16 hours.

And I will tell you, I'm not sure how much to tell you, but it has become an issue, because from a quality oversight standpoint, it probably represents good quality care that we're following CDC guidelines, yet patient complaints against certain providers are higher, so from a quality oversight standpoint, how do you grade that? So, I'm wrestling with that.

But interestingly, a provider satisfaction score is something that our board has us focused on, satisfaction with provider score, is something that our board has us focused on and because of our very, very diligent efforts at appropriate antibiotic prescribing, our satisfaction with provider score from the public has actually deteriorated a bit.

And people are nervous about it. So, it's not a disagreement, it's just a data point. We are in a society that expects antibiotics no matter how -- I mean, we -- to your point, four hours without an antibiotic, we have people who say, I paid $35 or whatever for this visit and you didn't give me the antibiotic, I want my money back. Like, okay.

MR. GOLDWATER: Peter?

MEMBER RASMUSSEN: I think what Henry and Judd are bringing up are interesting things to keep in mind broadly, which is if we're benchmarking ourselves against bricks-and-mortar care or current standards of care, that may not exactly be the best.

MR. GOLDWATER: Right.

MEMBER RASMUSSEN: So, clearly, what Henry's talking about here is, this isn't a failure of telemedicine, this is a failure of previous bricks-and-mortar medicine and we're just realigning things appropriately. So, it's true of a lot of the other things that we're

talking about here, is that if you're benchmarking remote patient monitoring of hypertension against standard populations, that doesn't necessarily mean we're doing the right thing or the best thing now in current practice.

MR. GOLDWATER: Right.

MEMBER RASMUSSEN: So, I think we've got to be careful of how that gets, how we benchmark to what we benchmark against.

MR. GOLDWATER: Right. I think that's an excellent point by all three of you. And before I get to Don, it's certainly something we'll have to consider as we start to fine tune these concepts.

Because I'm thinking of opioid prescriptions, given that it's an immediate public health crisis, it's well documented, it has been established everywhere. We are, NQF is taking that on, I mean, we're not taking on the opioid epidemic, but --

(Laughter.)

MR. GOLDWATER: Marcia, I didn't mean

to commit us to that. But we're working with the organizations that want to develop measures to actually target that.

But, there again, I'm sure, I'm not one of them, but I'm sure there are patients that have pain that are like, give me my freaking Percocet, like, right now, I don't care if I met with you for three minutes, I need my Percocet and I want it immediately and I need to take it and you're not making me feel better.

And if we evaluate that sort of satisfaction against a benchmark of what a patient thinks they need rather than these guidelines the CDC has released about the appropriate prescription protocols for pain managements and multi-modal therapy that doesn't necessarily involve opioids, I think Peter's point is well taken that that's something when we get into really building out these concepts to think through, because otherwise, we're going to -- is satisfaction how many Percocet or OxyContin did you prescribe, and that's dangerous to the

provider and significantly dangerous to the patient. Don?

MEMBER GRAF: I think as we're having this conversation, it's really important to take into consideration how different the conversation takes place if you have an established patient relationship versus a new patient relationship.

MR. GOLDWATER: Right.

MEMBER GRAF: And in that instance, I could have my PCP saying, this is what you need to do, but I know you and I know you're going to do A, B, and C, but not D.

MR. GOLDWATER: Right.

MEMBER GRAF: So, let's do, as opposed to, no, you don't get the antibiotic.

MR. GOLDWATER: Right. Yes. I think trying to -- that's going to be tricky when we get to that point, because personality really plays a large part in patient engagement and how they -- there's some people that grow up and if, I mean, Henry is, I've met Henry, I've known him for 48 hours, but if I had to see you, I would

trust you, you're a doctor, and Judd's another story, but if it were you, and you said, this is what you need to do, I would go do it.

But there are plenty of patients out there that, if they're having you for the first time and you say, follow this, they're going to be like, you don't know what you're talking about, you're a doctor, what would you know, you just went to medical school.

Peter, did you have anything else you wanted to add? Okay. This is great, it really is. Don, anything more? Anybody else?

I mean, it's a big -- patient experience, family experience, patient engagement, these are the big terms right now in care and particularly in the quality measurement world, where we're really trying, I mean, Marybeth can speak to this too, we're all really trying to look at measures that really have meaning and relevance to patients.

How, what -- because when quality is being measured in a way that a patient truly

cares about, then they tend to follow through with what those actions are.

And the ability now to get the data, to be able to understand what those measures are in a variety -- I could talk about this for four hours, I'm not going to, but there's so many different ways of doing this now that it's great that we're sort of able to narrow this down to really what relates specifically to telehealth.

And I think that's really going to be very, very important in how we assess patient engagement and patient satisfaction with that. Or not satisfaction, experience, sorry. Steven?

MEMBER HANDLER: Just a brief comment. Perhaps following a consult or following the use of the technology or the experience, how likely, sort of the net promoter concept, but how likely they are, not only to refer other people, but to do that again and/or do it over the other alternative approaches to care. So, just a follow-up comment.

MR. GOLDWATER: Right. Julie?

MEMBER HALL-BARROW: Yes, I just think, as we were looking at that patient experience, it's amazing. So, if we took comparativeness from waiting for your virtual visit provider to come online, less than five minutes. Comparing that to the bricks-and-mortar, you would be ecstatic if they called your name in five minutes.

I'm finding in our world, even in healthcare, so we do all 8,000 employees, five minutes, they're starting to get antsy. And we have now created a new patient expectation and experience through virtual, five minutes, you've got to be online within three minutes, how long -- we guarantee online and up within 15 minutes of a NICU baby somewhere in the state, and we thought we were doing great.

MR. GOLDWATER: Right.

MEMBER HALL-BARROW: So, it's interesting, if we're going to do comparatives to traditional or we're going to start comparing within, and I think we're going to see that time

and patient experience continue to expect more and more.

MR. GOLDWATER: I mean, it really gets back to sort of the issues that Judd and Paul and Peter were talking about on how we benchmark that and what standard do we apply? Because I bring up this example a lot, because I found this just mind-boggling, that I know a lot of us fly a lot, like Chuck probably flies every week at this point, and we all have, I'm sure, our preferences of airlines.

And I found out the airline that has the most, that's most consistent with on-time takeoff and on-time arrival is United. And yet, they're fourth in satisfaction.

Southwest, for whatever reason, has the highest satisfaction rate, even though they're like sixth in leaving on time and like ninth in arriving on time. And people are still complaining about how they board their passengers, this sort of cattle call.

I always get there early, so there's

no issue for me, because I'm just like that, but it's just amazing and when you read the comments about why are you so satisfied with Southwest, given that they rarely leave on time and they always get you there late, they're like, because it's so much fun to travel on Southwest.

Because they sing songs and they give you free water and they're goofy and the pilot will come and say, everybody give your neighbor a hug to your left and to your right, which apparently happened a couple of times, and they give free drinks on St. Patrick's Day, and it's just like it's a party in the air.

I personally have never experienced that on Southwest, I mean, I've heard all the signing, which gets a bit annoying kind of, honestly, but -- it does.

(Laughter.)

MR. GOLDWATER: No, I'm a Delta person, actually. But it's really just sort of that whole experience is what made Southwest so reliable. And Virgin America is also getting

incredibly high ratings, for very much the same reason, it's the experience.

So, if you take a standard benchmark and say, this is how we're going to evaluate, you're not necessarily getting the reflective results of what's really going on. So, it really becomes important to measure in what we think is realistic and how we think is the best way to assess.

One other brief story, I was going to Minneapolis, I think it was a couple of month ago, and it's not like I go to Minneapolis often, I don't, the last time I was there was when I was auditing Medicaid Y2K systems, so planes didn't fall out of the sky, nuclear weapons didn't go off inadvertently, and I did a Yelp search for best restaurants in Minneapolis, because I don't go there, I don't know, and Chipotle came up as, like, number four

Why would Chipotle come up as the number four restaurant in Minneapolis? And, again, it's because the consistency of

satisfaction, even with the E. coli scandal, is apparently so high that that's what keeps bring people back and back and back. If you were to use a traditional metric, they probably would be taken out.

If you used sort of the patient experience metrics that they're looking at, it rates very highly. So, Julie, did you have something else to say? Your placard is up. Dale?

MEMBER HALL-BARROW: I agree, how about that?

(Laughter.)

MR. GOLDWATER: Thank you.

MEMBER ALVERSON: And this may be just a follow-up on your metaphor with the airlines, I can tell you why I use Southwest, it's cost. I get -- and I might use American or United or whatever if I thought the fares were lower. So, when I'm having to pay it out of my own pocket, or you might even care if you're paying my way, you want to know that I got the best cost, and

they don't charge a luggage fee.

MR. GOLDWATER: No.

MEMBER ALVERSON: So, why do I -- that's my primary --

MR. GOLDWATER: Right.

MEMBER ALVERSON: It's not -- I could care less about the signing and joking and whatever, really.

MR. GOLDWATER: Right.

MEMBER ALVERSON: In fact, as far as free water and so on, that's pretty similar with every airline.

MR. GOLDWATER: Right.

MEMBER ALVERSON: But it's cost. And you could argue that that same thing is going to end up being applied to healthcare. We're going to look at, it's got to be value-based.

MR. GOLDWATER: Right.

MEMBER ALVERSON: And more of the burden of cost is going to go to patient, to the consumer. So, that's what I'm always going to look at. Now, I sort of make the assumption that

the pilots are well trained and I'll have a safe flight, right? But it really boils down to cost.

MR. GOLDWATER: Right. Okay.

MEMBER ALVERSON: So, that's why I use Southwest a lot.

MR. GOLDWATER: Right. I do too, for the same reason. Mary Lou?

MEMBER MOEWE: Well, I was going to say, anxiety with flying, I think. I get anxious, I have to be there early too.

MR. GOLDWATER: Yes.

MEMBER MOEWE: And I think there's a lot of anxiety too with physicians, when you go to see a doc, you're a little nervous, like, I don't know what's going on, help me.

MR. GOLDWATER: Right.

MEMBER MOEWE: So, I think, it's good if you have that, you establish that relationship with the doctor and you feel like he knows what I want from, what I expect from this visit. And, recently, I went to an innovation seminar and Hopkins has just done something that -- I guess,

a physician went into a physician's room, was treating him, and didn't know he was a physician, and just kind of abruptly told him, blah, blah, blah, and walked out.

And the doc that was in the bed was like, I'm really upset, because I'm a doctor, he should have talked to me differently. So, they've done something new, they have, with the patient care, they have a message board that you can type in what you want the doctor to know about you, what you want, what you expect from the physician.

And I think that's really valuable and I think that's where telemedicine could add a lot, once you've established that, you can actually, you could text or communicate first of all, like, this is what I want, this is what I'm looking for. And that way, the physician knows up-front, oh, this person is seeking opioids, or whatever.

MR. GOLDWATER: Right.

MEMBER MOEWE: And it's more direct.

I mean, there's something there, like, they're looking for painkillers. And these are things we could be more direct about and, I guess, figure out what the reason for the visit is, what their anxiety is, and maybe help alleviate that and make it better. But cost is definitely important, to me. And getting it done quickly. Like, Southwest, I think I fly Southwest flights more frequently because they're direct and I don't have to go through multiple airports.

MR. GOLDWATER: Right.

MEMBER MOEWE: So, with a physician, with care, I work all the time, I'm in my office until 6:00 or 7:00 at night, and if I get sick, I usually, I need some antibiotics or I need this or that, and I don't have time to go see my physician.

MR. GOLDWATER: Right.

MEMBER MOEWE: So, that would be great for somebody who's a workaholic, because you need to see your doctor and it's like, but I don't have time to go wait in the office for two hours

to see my doc.

MR. GOLDWATER: Right.

MEMBER MOEWE: And that's what happens, when most of us go, it's not easy to get in, it's not easy to get out, you wind up spending a lot of time and then you've got to go off and -- so, I was at Cerner yesterday, the reason I wasn't here, and they have a really cool primary care clinic right on site, right across from their main facility.

And they have no waiting, you just, you walk in, you key in the kiosk and you're in, they put you right into the room with a doc.

MR. GOLDWATER: Wow.

MEMBER MOEWE: It's amazing. It really is.

MR. GOLDWATER: Wow.

MEMBER MOEWE: And they've eliminated all that, all that excess waiting room stuff, and it's just really cool. So, I think there's a lot to be learned from innovation and what patients expect from the visit and what different cultures

expect.

Because they have -- you actually have to, as an employee there, you have to key in, I want to see the doctor at 2:00, and then you show up and you're right in. But they have, like, some of their Asian folks, like, they're used to just walking in to get care.

So, then, they go in and they don't have an appointment and they're like, oh, well, you have to schedule first, and they're very astounded at all this. So, I think there's so much innovation and technology that we could be using that we're just avoiding and I'm not really sure why, but if we do it the same way with telemedicine and you have to wait a week to get an appointment with your doctor with telemedicine, then it's silly.

MR. GOLDWATER: Right. I agree. All right. Don, then Stewart, then Chuck.

MEMBER GRAF: The concept early of substance over form or reality versus fact, I can't help thinking back to something, Chuck, you

had said earlier about marketing and packaging and to the extent that you're going to sell the idea. And whether it's real or not, is like anything, going to play out in telehealth as it is in anything. And I just heard that they're going to start charging you for bags.

MR. GOLDWATER: Southwest is? Really? Seriously?

MEMBER GRAF: Was it -- my wife told me last night. You know what, it might have been United and not Southwest.

MR. GOLDWATER: Not Southwest, no.

(Laughter.)

MR. GOLDWATER: Go ahead, Stewart.

MEMBER FERGUSON: So, I did some fact checking. It turns out, Alaska Airlines, my favorite airline, is the top ranked major carrier and has the top rated performance.

MR. GOLDWATER: Okay, so I was quoting last year's stats, Stewart.

MEMBER FERGUSON: You can't really separate them.

(Laughter.)

MEMBER FERGUSON: Just saying. But it does make me think --

MR. GOLDWATER: You and Chuck.

MEMBER FERGUSON: -- so, airlines get performance ratings, right, just based on on-time, lost bags, all those other things, but we never do that in telehealth.

MR. GOLDWATER: Right.

MEMBER FERGUSON: And I've always been curious if the performance of telehealth for, say, treating your disease is better than the performance of non-telehealth for treating your disease. And you throw a bunch of factors, you weight satisfaction, you do other things. It might be an interesting concept for a performance measure, not just these individual measures, kind of an aggregate.

MR. GOLDWATER: Okay.

MEMBER FERGUSON: That was really the reason I spoke, not because of the Alaska piece.

MR. GOLDWATER: Chuck?

MEMBER DOARN: I think, I was going to say marketing again, but I think it's the environment in which you find yourself as a consumer.

MR. GOLDWATER: Right.

MEMBER DOARN: You walk into Macy's at Christmastime, everything's crammed together. You go to Nordstrom, everything's spread out, because nobody shops at Nordstrom. No, I mean, in the sense that, when you talk about a telemedicine system, some kind of form fit, there's a lot of science that's been developed in human factors and ergonomics and how -- what's the sex appeal of the app? If it's just literally a doc in a box it's not going to be very -- you're going to kind of look at it and go, you look kind of corny.

MR. GOLDWATER: Right.

MEMBER DOARN: So, that drives some of what people are going to do or not going to do. So, in Russia, you go to a hospital in Russia in 1992, and you look at it and you go, I don't even

think this is a hospital. And then, you go through the door and it's sort of like the Wizard of Oz, you go from the cabin that's crashed on the Wicked Witch and you go in and it's this beautiful Technicolor.

And so, you go in a hospital like that and you see these beautiful operating rooms, it's the same thing here. If you walk up and down these streets and see these modern buildings integrated with these smaller buildings that maybe were here during the Civil War, they've been remodeled and they look really nice, but if you go into a really dilapidated area, you're probably not going to go into the doctor's office there, if that's where your doctor is.

Because -- and that doesn't mean the doctor's bad, it's just the environment in which you find yourself. So, I think it's very important, when we think about telemedicine and the mobile apps and so forth, telehealth, that the systems designed to work efficiently, but also to be so that the consumer actually can

interact with them and it's not difficult and it's --

MR. GOLDWATER: Right.

MEMBER DOARN: I mean, going to the doctor is not supposed to be a joyful occasion, because you've got to wait forever and look at last year's People magazine, but there's got to be some kind of -- I think one of these things that you were saying, Mary was saying -- is it Mary? No? -- about how you're actually put into the kiosk or into the pod with the doctor and it's like almost immediate, so you're not -- with telehealth, you have that.

The other part of that is, if you have these systems, and I remember when Stewart had the meeting up in Alaska, I think four years ago, I believe it was, we did a separate meeting with TATRC on tele-mental health in the Pacific Rim, and I forget the person who showed this video, which is a little bit inappropriate, but I'll use it anyway, you have the soldier, sitting there in his boxer shorts, he kind of looks like Dwayne

Johnson, like the Rock, a big, huge guy, and kids are playing.

And there's several things to learn from this video. A, the interface itself was poorly designed. The kids were using, they were downloading music on their iPads, and mom walks from this side of the room to this side of the room totally naked.

And they're like, wait a minute, time out, we're not supposed to be doing this, we're supposed to be talking to you about your condition, not seeing all these other things. So, the design of the systems have to be such that there's privacy included in that, there's the security of the data itself.

And I think a lot of times, these systems, a lot of these companies are developing things that are keeping those things in mind, but we're learning a lot of this stuff from experience. As Ron Weinstein used to say, we wear blue lab coats because they look better on camera than a white lab coat. So, I think a lot

of those human factors, ergonomic things really help with that marketing part.

MR. GOLDWATER: Right. Don, did you have something else you wanted to add? No? Judd?

CHAIR HOLLANDER: So, I think a lot of that stuff that you're talking about, Chuck, also comes back to individual patient perceptions, right? So, I've seen some videos where, one of the ones that our neurosurgeon shows, where the family got engaged behind it, little kids came over. And it was like a great experience for that patient, because now they've got a neurosurgeon joking around with the kids before they're off to school one day.

And security, we use a system where we use a secure message for a patient. You know what? The patients ask me over and over, can you just send it to my email? I don't want to log into a goddamn secure message thing, that's a pain in the butt. But yet, we don't do that, because we're so worried about security.

But if the patient doesn't care, that's not a good patient security, that's putting security ahead of a patient experience. And I don't know the data, but I know my response rate. If I send something that doesn't have patient information to them by email, I get back a thank you and I know they read it three seconds later.

If I send it through the secure message, I think they don't answer it 70 percent of the time, they don't look at it. I know I don't in my patient portal, because half the time, it's spam about remembering to do something that I don't want to do or I already did. And so --

(Laughter.)

CHAIR HOLLANDER: So, I think reality is, we have to tailor how we design systems so that individuals can use it the way they want to use it and not make it the most rigid, most secure thing in the world, but allow those people that want the level of security to have the most

security that they can have.

MEMBER MOEWE: Yes, but security, we have to be HIPAA compliant, there are all these things we have to follow through on. But I agree with you, when I'm working towards interoperability with healthcare, physician's major complaint is, I don't want to have to look yet another place for more data, I want it all to come to me, I want it to be served up to me in a way that it makes sense so I don't have to figure it out.

And it's really hard. These are very difficult things to achieve. And then with the HIPAA constraints and you have, patients can opt-out, it's difficult to share data across from hospitals to providers to rural healthcare providers to get it back to the patient.

So, they may be uncomfortable sharing with that rural healthcare physician. So, there's just so many things, hoops that you have to jump through from a IT perspective and from a HIPAA perspective.

CHAIR HOLLANDER: This is probably beyond the scope of this, but people use HIPAA as an excuse for everything. So --

MEMBER MOEWE: I totally agree with you, yes.

CHAIR HOLLANDER: So, I think we have to define, what is HIPAA compliance? So, I'll give you an ER example --

MR. GOLDWATER: Okay. Moderator interjecting here. So let's stop that discussion before -- I know where it's going.

MEMBER MOEWE: It's almost impossible --

(Laughter.)

MR. GOLDWATER: And, Judd, I completely agree with you wholeheartedly, but there's a time and a place for that --

MEMBER MOEWE: You can't fix it.

MR. GOLDWATER: -- and that's not here.

(Laughter.)

MR. GOLDWATER: Sorry. Okay. Moving on to -- yes?

MS. LUSTIG: I just wanted to make sure we were capturing, we made this about patient and family experience and I think we've touched a little bit on family, I just wanted to make sure that there wasn't anything -- I mean, I think most of the things we've discussed, we could say, and family.

MR. GOLDWATER: Right.

MS. LUSTIG: I just wanted to make sure there wasn't anything that was more specific to the family that we missed here.

MR. GOLDWATER: Julie?

MEMBER HALL-BARROW: Yes, I just want to be -- as we do more mobile health types of things, so the regulations in terms of a child sending medical data, less than 13 years old, I think we need to be sure that we're cognizant of that, because we're having families send data on behalf of their ten year old and whatever, diabetes, or for doing their mobile app for inhaler usage, where I'm getting all that data. I just want to be sure that we're inclusive of

that, that its experience is just as good on both.

MR. GOLDWATER: Okay. All right. Last one, clinician experience. So, the clinician's experience with telehealth, what are some important factors you feel need to be included there? Don?

MEMBER GRAF: Low threshold for technical glitches, especially among new providers, that you want to disengage them quickly, don't give them a good technical experience out the gate. And so, not so much for the seasoned ones, but --

MR. GOLDWATER: Got it. Others? Steven?

MEMBER HANDLER: So, I have several. So, it's physician satisfaction, burnout, which we see as a big problem, so tenure, and efficiency for physicians and themselves feeling as though they're providing good quality care -- well, and it shouldn't limit this to physicians, by the way, it's not meant to be that, but the

clinician providing care at the highest level.

Job satisfaction, creation of teamwork or new teams, new approaches, and critical thinking and/or growing skills, where they didn't have them before. And transforming -- could this be a transformative technology or solution that allows people to do things that they couldn't do before to grow their skills, which then translates back into system-level issues. A lot of this is circular, as we know. Those are some things, some thoughts.

MR. GOLDWATER: Okay. Steve?

MEMBER NORTH: I think, really, do I get warm fuzzies from this? Do I feel that I'm providing better care and that people like the fact that I'm more available? Not just my institution has said, I will now respond to emails from my patients and virtual visit consults at 10:00 p.m.

MR. GOLDWATER: Right.

MEMBER NORTH: Which they haven't, but -- yes.

MR. GOLDWATER: I'm assuming warm fuzzies is a technical term.

MEMBER NORTH: Absolutely. I think it's measure Number 537.

MR. GOLDWATER: Absolutely.

MEMBER NORTH: And it's an e-measure.

(Laughter.)

MR. GOLDWATER: Kristi?

MEMBER HENDERSON: Yes, just to emphasize the workforce development piece of that, that's been mentioned a little bit, it truly is a workforce multiplier, but it's the satisfaction to be able to continue to grow in your knowledge, but it's about co-management. So, now you don't have to be secluded, you can truly co-manage and work as a team, which is something we've just never been able to do.

MR. GOLDWATER: Okay. Marybeth?

MEMBER FARQUHAR: I want to emphasize again the team aspect and the ability to do the care coordination, but also, again, bringing up the satisfaction of the clinician, things like

the quality of the resolution and things like that, of system. That would be an issue.

MR. GOLDWATER: Okay. Peter?

MEMBER RASMUSSEN: I think something around the lines of intuitiveness of use and training requirements and maintenance of training, competency.

MR. GOLDWATER: Judd?

CHAIR HOLLANDER: I think this plays into sick days and disability and things like that for the clinicians. You may be able to not cancel the appointment of all your patient panel if you're out sick. You may be able to see the people who need to be seen while you're home. It may be better for everybody.

MR. GOLDWATER: Paul?

MEMBER GIBONEY: I think, kind of going along with what Steve said, the warm fuzzies, but to make that more concrete is closing the loop. I think sometimes a telehealth provider will provide some sort of added value and then not kind of get that back to close the loop, what was

the feedback, what was the end result with the patient, how did that end?

And then, on, I mean, you can say ease of use, but I think one of the things is, how easy and seamless is the documentation?

So, it's almost like time spent on whatever the modality is or whatever, it's kind of like the whole thing, you say, oh, when EHRs hit, we're going to save all this time and the doctors are going to be so -- and what we're finding is that doctors are actually not saving any time every day because there's so many additional things they have to do.

MR. GOLDWATER: Right.

MEMBER GIBONEY: So, telehealth is hopefully an opportunity to make that cleaner and simpler.

MR. GOLDWATER: Sure. Stewart?

MEMBER FERGUSON: So we actually ask different questions -- and we do provider-to-provider, so we really differentiate between what we ask the originating versus the receiving end

of it.

But we do talk about ease of use, especially on the originating side, but we actually also look at satisfaction with the equipment and then we try to kind of go, is their job more fun? Because, again, hiring rural providers is a real challenge.

And then we ask if they're more comfortable in delivering care to the patient, because sometimes they're uncomfortable and telehealth actually helps with comfort.

On the receiving end, we usually ask things about the quality of the data, which I think we kind of mentioned. But we also on the back end, as an e-measure, we look at the time it took them to actually do the consult, which is pretty important.

MR. GOLDWATER: Right. Don?

MEMBER GRAF: Improving operational efficiencies and expanding provider capacity that drive bottom-line, so, money talks. The other is the flexibility of providers, perhaps

transitioning to retirement, that don't want give up practice, but want to have the flexibility of doing some different things, is another aspect for them and their experience.

MR. GOLDWATER: Right. Great. Julie? No? Dale?

MEMBER ALVERSON: Thanks, Julie. One of the things, and this is parallel to patient experience, is actually clinician convenience. In other words, I can do telehealth from my home. I could do telehealth from here, with some privacy.

So, there's an element of that that I think is going to even help with some of the workforce for some physicians, maybe I'm going to retire, I'm going to have to -- because I can't go to the clinic every day, I don't want to go there anymore.

MR. GOLDWATER: Right.

MEMBER ALVERSON: Then, others say, well, we could work with you. Right, Henry?

MR. GOLDWATER: Right.

MEMBER ALVERSON: Could work with Teladoc and I could do that from home or from the beachfront, wherever. So, there's an element of that that might be measurable that's having impact, that we're keeping clinicians involved.

And that's not just docs, I mean, that's mid-levels, nurses, and so on, who might otherwise leave the workforce. So, that's something that ought to be taken into account with the clinician experience.

So, we're finding a lot people say, this makes my life better. I can tell you, after hours, when I was doing more clinical practice, I could evaluate patients without having to go into the hospital. And that meant a lot.

MR. GOLDWATER: Yes.

MEMBER ALVERSON: I could still be in my pajamas if I need to be, or a bathrobe, or whatever.

(Laughter.)

MR. GOLDWATER: We're not going there.

MEMBER ALVERSON: Anyway --

(Laughter.)

MEMBER ALVERSON: But it is an important aspect that I think is going to have an impact on how healthcare is delivered. It's better for the clinician in the long run.

MR. GOLDWATER: Right. Okay. Megan?

MEMBER MEACHAM: I think this point's been touched on kind of indirectly, but I think something that directly relates back more to the rural provider is the reduction in the feeling of isolation.

MR. GOLDWATER: Okay. Kristi?

MEMBER HENDERSON: To add to the extension of the work life, I'd add that we now can also, providers, anybody in the healthcare team that maybe becomes disabled or has some thing that causes them to not do the traditional practice of their profession, all we need is their mind and so, thinking about it from that perspective is good too.

MR. GOLDWATER: Very. Eve-Lynn?

MEMBER NELSON: I've been thinking

about the work spectrum too, some of the early professionals really like the flexibility from working from home and balancing time with family and time with work.

And then, if you do have a cancellation with telehealth, it's been appealing to our providers where you're right at your desk, you can go on with other things, you're not over in clinic where you're kind of stuck in between patients.

MR. GOLDWATER: Right. Okay. Steven?

MEMBER HANDLER: A couple of additional points. One on workforce issues, so, geriatric medicine is not a particularly sexy area to go into and we have a really hard time recruiting people, but if you can make it so that, as part of the fellowship training program, which is what we're starting to do, you incorporate telemedicine in the curriculum and there's a clear strategy to, when they're done, they have a path towards employment, you actually can create a new workforce or a sustainable workforce.

So, it's not just those that are burning out, but it's, can you have a job and a career that's rewarding, fulfilling from the beginning? The second point, as I was just reflecting a little bit also, is, the peer-to-peer consult concept.

That is, we all can get curbside consults or other ways as we need to, but how can this benefit those that need to get a consult for one of their own patients or residents, whatever, in a timely fashion and how does that affect their own clinical experience as well?

MR. GOLDWATER: Okay. Good point. Henry?

MEMBER DEPHILLIPS: So, my sense is, with this line of discussion, analogous to the patient situation, we likely are going to land on, from the physician side, sort of subjective/objective, right?

Subjective satisfaction, all the workforce issues, do I feel better, can I do it from the beach? And then, objective, is my

effectiveness at treating a broader number of patients enhanced by the use of technology? My sense is it's going to boil down to those kind of two broad categories.

MR. GOLDWATER: That's correct. Don?

MEMBER GRAF: I wanted to echo what was mentioned about isolationism. We had a number of perspective originating sites in rural communities pushing back on the introduction of telehealth, because they like when the urban provider is coming out to field clinics, because not only are they delivering care, but they're catching up on all the latest news and whatever's going on in the city. And just that alone is a big push-back.

MR. GOLDWATER: Right. Judd?

CHAIR HOLLANDER: We haven't, other than briefly yesterday, mentioned the educational benefits for this, and I think that's relevant. So, being able to supervise residents, being able to send residents to -- we can't recruit people to work in rural environments or underserved

environments, they have no experience there.

Potentially be able to send them out there and supervise them during training may make it more likely that people want to take those jobs afterwards. But I think the increased supervision and training across the board is relevant for all providers.

MR. GOLDWATER: Nate?

MEMBER GLADWELL: To get back to the disparity conversation, at risk of my previous comment, but this is in the reverse, as we send clinicians that are working to the top of their license, be that paramedics and others, into communities that don't have access or challenging access, the connection back to the provider or the clinician or the specialist using telehealth creates unique opportunities to utilize more clinicians in a broader capacity. I don't know if we've specifically mentioned that here.

MR. GOLDWATER: Megan?

MEMBER MEACHAM: This is kind of a half-baked thought, but with the clinician --

where with the patient experience and then we expanded it to the family, so with the clinician experience, is there a kind of a similar expansion to others that might be within the practice, be it the office managers, the hospital CEOs, to also think about?

MR. GOLDWATER: Okay. Steve?

MEMBER NORTH: I think this is another place to be looking at the benefit of ancillary services provided via telehealth. So, clinical pharmacology being available in my practice, how do I feel better? So, not just saying that this is a doctor, nurse, relationship that we're looking at as far as the clinician.

MR. GOLDWATER: Great. Megan, did you want to -- Judd?

CHAIR HOLLANDER: No. No, thanks.

MR. GOLDWATER: Okay. Anyone else? This is fantastic. Yes, Dale?

MEMBER ALVERSON: Just one more, because this actually just came up, where I was talking to one of our neurosurgeons, and a lot of

it is just reassurance to the primary care provider. Am I managing this patient correctly? So, there's -- nothing's changed, they just want reassurance. So, in that, in many cases, then avoided an unnecessary transfer and so on. But it was a reassurance thing for the referring physician.

MR. GOLDWATER: Great. Anything else? Okay. Quickly, while we have some time left, I said at the very beginning of this, and I'll reemphasize this again and again and again, is that the ultimate goal, besides the development of a framework, is to make sure that the framework is actionable, usable.

That you can take this or others can take it, implement it, and use it in a way that will objectively, and at times, perhaps, subjectively, measure the areas of telehealth that you all have stated here are important.

Without getting into details, because we'll spend the next meeting doing that, what are some points that you think we should be

considering as we start to develop a straw-man model, which I'm sure you're going to tear apart and I love that about all of you, I do --

(Laughter.)

MR. GOLDWATER: -- I really do, that we need to consider for implementation and to make this actionable? So, it's not a theoretical academic exercise that we can get journal publications out of, which I know is important to Chuck, and, yes, I'll send you something, but -- yes, Henry?

MEMBER DEPHILLIPS: So, particularly yesterday, I'm blown away by the talent that's in this room and I think if we kept the conversation yesterday going, we not only would solve all of telemedicine, but we would solve all of healthcare, and not even just in the U.S., but probably globally.

So, I think, getting to the point of your question, my suspicion is, very quickly it's going to become apparent, what are going to be the data sources and are they readily available?

MR. GOLDWATER: Yes.

MEMBER DEPHILLIPS: Are the data sources reliable and consistent so they can be -- I mean, there's going to be a number of logistics, all of you have more experience with this probably than I do, but the logistics of developing measures are clearly going to creep in and limit the scope of what we've talked about over the last two days so that we wind up with actionable measures. And I think the trick is going to be, for the next meeting, I guess, is to find a set of measures that are meaningful enough that those who use the measures can show impact, but that are realistic enough that there's actually data sources and reliable ways to churn the data. That'll be interesting.

MR. GOLDWATER: Okay. Steven?

MEMBER HANDLER: Well, we kept making fun of publications here, but one quick question. So --

MR. GOLDWATER: I'm not making --

MEMBER HANDLER: No, no, I know, we're

having fun.

MR. GOLDWATER: I'm just making fun of Chuck.

MEMBER HANDLER: Yes.

MR. GOLDWATER: All right.

(Laughter.)

MEMBER HANDLER: I'm not going to beat on Chuck or his Google searches or anything, but --

(Laughter.)

MEMBER HANDLER: A plug here and question actually, from the literature review that you're doing, should/could we publish what we're doing as a group or those who may want to do that? And is that a normal process as part of NQF?

Meaning, separate and distinct from a report, but a scientific publication that may summarize this, perhaps the five lefts or the five rights or whatever we're going to -- but something, or the CDC, whatever we determine might be useful that may advance the field as a

group?

MR. GOLDWATER: Right. So, it's a good thing Megan's also in the room. We're absolutely going to submit publications from this. Typically, we don't do that when it's measure development projects, because that's already transparent, it's in the open, and that's of little interest, because those are measures getting endorsed to be used in federal programs.

Something like this has extraordinary interest, because it's not measure development, it's how measures would be built. So, there will certainly be publications that will come from this. Probably the environmental scan report will be one, the measure framework, obviously a condensed version of that, because that will exceed your 4,000 word limit, Chuck, I'm sure.

I can also sort of see in some ways these concepts, as they're fleshed out into measures, also sometimes could be particular papers. I think, disparities, if we can cover that in some way, how telehealth can be used to

reduce disparities in care, is of extraordinary interest.

We'll also be presenting on these papers. I haven't talked to -- I know Judd has a conference in September, he and I have already talked about this, and I'm happy to go, because I love Philadelphia, minus the football team.

I have not talked to Jon Linkous yet, you all are welcome to do that for me, but clearly we would like to talk about this at ATA. I think he's expecting us to talk about this at ATA. Other conferences, like Academy Health, probably, even though that's very research academic focused, there are a lot of individuals there that have interest in these types of things.

Perhaps a state Medicaid conference, which I used to attend a long time ago, might be another one. I mean, it's not just going to be me, it'll be all three of us, one of the three of us. And somebody did ask me about HIMSS, whether we would present this at HIMSS, and my

inclination is to say no to that, largely because I don't know if HIMSS is really interested in this kind of thing.

MEMBER HALL-BARROW: But what about the innovation for health track that you gave before?

MR. GOLDWATER: Oh.

MEMBER HALL-BARROW: Yes, that totally fits.

MR. GOLDWATER: Okay. All right. Go ahead, Yael.

MEMBER HARRIS: But all the call for abstracts closed and they've already decided upon them.

MR. GOLDWATER: But if --

MEMBER HALL-BARROW: I just talked to them today and I got one put in. So, there's a way.

MR. GOLDWATER: But the other way --

(Simultaneous speaking.)

MR. GOLDWATER: But let me clarify, I understand, Yael's real excited about going to Orlando, but, I don't know why, but this

project's not going to be finished until the end of the summer.

So, anything from now until then, we probably -- Academy Health is probably the only one, and I'll talk to Megan about this, that we would consider, because that's in the end of June and we'll be close to getting done, there is something to talk about with that.

But the AMIA Joint Summit, which is in March, we won't be far enough along to talk about this. The year after that, perhaps. AMIA, HIMSS, maybe, ATA. Once the project is done, or is close to being completed, then I think could certainly talk about it.

Publishing papers is a different story. But there will be a lot, Steven, of publicity about this. Plus, NQF will do its own marketing.

We'll broadcast this to all of our members, we will be talking about this with all of our physician communities, we will certainly be bringing this up to the Board and to the CSAC,

and there's a lot -- Helen Darling is very, our interim CEO, is extremely invested in telehealth and really loves this topic, and I'm so sorry she's in New York and couldn't come up here to see everybody, I know she would have just loved this.

But, so, I think it will gain traction that way through wide exposure. And, like I said, I think there's a lot of different papers and presentations we can do out of this, it's not just the framework, it's also the implications of the framework as well. Chuck, and then Dale.

MEMBER DOARN: You may have addressed this before I got here yesterday morning, but I was curious, you guys have done this for other areas and when we talk about a framework, I oftentimes think of a backbone structure, metaphorically, that already exists that you can use that to build on, or is this framework like from scratch?

MR. GOLDWATER: So, it's -- we'll look at some of the things that have been done, but

more than likely, our vision of this was, it was going to be built from the ground up and it would be a backbone then to extend out.

So, what we've sort of discussed already is the framework will be built out with its concepts and its dimension and how measures can be developed, and then, again, I think based on areas where telehealth is having tremendous effect, so dermatology or mental and behavioral health, we extend those out to other projects and then really build more narrowly defined, but much more specific, measure frameworks around those areas because of the implications, and because of the policy impact that could have as well.

So, I think for publicity, I'm not shy about publicizing what NQF does, anyone that works with me, Katie knows that for sure, our value set project, which is, like, for the hardcore informaticist, I mean, those are, like, I mean, really -- Stewart, don't pretend that you're interested, because you're not.

(Laughter.)

MR. GOLDWATER: I mean, it's, like, what's the difference between one SNOMED code and another? I mean, that's how, like, seriously it -- it was just mind-boggling. And we presented that everywhere and people loved it. I cannot for the life of me, I'm not that entertaining, I'm really not, but everyone just loved it. This, I think, is going to get a significant amount of traction and exposure. So, Marybeth?

MEMBER FARQUHAR: Getting back to implementation and what's good for measure developers, please?

MR. GOLDWATER: Yes.

MEMBER FARQUHAR: We need to make sure that the concepts are crystal clear and not overlapping. And then, also a definition of what you're expecting out of measurement.

MR. GOLDWATER: Right.

MEMBER FARQUHAR: Okay.

MR. GOLDWATER: Dale?

MEMBER ALVERSON: Another important aspect, I think, which can come out of this, and

one of the other reasons I'm interested, is this unusual phenomenon of OMB, the Office of Management and Budget.

MR. GOLDWATER: Yes.

MEMBER ALVERSON: Whenever legislation goes forward that involves telehealth, they will look at the cost side and they'll mark it up. I mean, when I was president of ATA, I was always amazed and I talked to, you would talk to people at OMB and it's all kind of mysterious, but what they say is, show me the data.

So, if nothing else, if something comes out of this where we can actually now demonstrate the data and that's on there, the cost effectiveness, all those kind of things, outcomes, that's going to go a long way to facilitate adoption of telehealth across the board. And I don't know if you've dealt with OMB, but it is a very mysterious process. And they won't even talk about. They won't -- you can't -- well, I've got some data, well, it's got to be out there.

MR. GOLDWATER: Right.

MEMBER ALVERSON: So, hopefully that's going to come out of this in a very positive way.

MR. GOLDWATER: Okay. And, Yael? And then Mary Lou.

MEMBER HARRIS: I was going to add about promotion that Health Datapalooza has a call for abstracts now. I know you wouldn't have data, but I think this might be something of interest to them, because it's very policy focused.

And I think they'd be very interested in knowing that we're looking at getting the type of data that's needed to measure telehealth and would have some interesting insights that might want to be considered that could point you to more publications, et cetera.

MR. GOLDWATER: All right. So, Megan, we know what a part of our next phone call will be about. Mary Lou?

MEMBER MOEWE: Have you thought about decreasing the cost of premiums by having

patients opt-in to a telehealth model, so that they could say, 50 percent of my visits to my physician will be all telehealth, I'm good with that. And then, I will get a reduction in my monthly premium.

Because I think everything kind of revolves around, for patients, for the consumer today, is why is my premium X hundred dollars a month and how do we reduce that? And going back to the Southwest model, why I use Southwest, it's cheaper, it's faster. So, how do we -- if you operationalize something, you have to look at cheap and fast.

MR. GOLDWATER: Right.

MEMBER MOEWE: And first. So, I think that's something patients, consumers -- and I believe consumers are going to be the drivers of the marketplace in the future. And the other thing is, I told a few people I was coming to work on telehealth and they were like, is that still around? Like, isn't that from the 1970s or 1980s?

(Laughter.)

MR. GOLDWATER: Yes, I get it.

MEMBER MOEWE: A lot of people associate it with telephones and it's really, it's e-medicine, it's really electronic medicine and it's not just using your phone, it's using Skype or whatever technology is out there. And also -- so, I don't know, I think that's something you have to think about, it has to be, for the consumer to adopt it quickly. It's got to be something is like Facebook.

MR. GOLDWATER: Right. Oh, god, yes.

MEMBER MOEWE: And, I think, another thing is, there was a study done on how consumers pick their physicians and it's really by the way they look. Our consumers go on and look at the doctors' pictures and pick it, does this doctor look like someone I would want to go to see in a photo. They don't really read, where did he go to school, what did he -- but, just another thing about making it accessible for -- the normal consumer is not looking at where you were

educated or what your specialties are, they're looking at what you look like, do you look like me? So, I'm just looking at it from a consumer's perspective.

MR. GOLDWATER: Right. Great. Perfect. Stewart?

MEMBER FERGUSON: So, you were asking for thoughts around some of the -- how we might do metrics, how proscriptive would you get on metrics? And the example I'm thinking of is travel savings, for example. And the reason I ask is, a lot of telehealth programs assume every telehealth case saves travel. We don't make that assumption, we ask the providers if it saved travel and we find only about two-thirds do. The question is, where do you save travel to, it's not always to where the doctor who is talking to you, it might have been to somewhere down the street, what airfare, if they're flying, I mean, just those kinds of questions. And to compare apples-to-apples, it would be nice if we all kind of have a same kind of process for calculating

travel savings. Do you get down to that level of detail?

MR. GOLDWATER: You can, absolutely. If --

MEMBER FERGUSON: Because you almost have to.

MR. GOLDWATER: We can get down to that level, if there's a collective consensus that that is an important enough issue to be wrapped into telehealth. It gets back to what Marybeth was saying, which I couldn't agree with more, the concept has to be very, very clear, the definition has to be very, very clear.

How you're going to evaluate has to be clear, because then you don't have any ambiguity in measurement, which is what causes all these problems. So, if you think that that is going to be highly valuable to really understanding the utility of telehealth, yes, we can get into the weeds on that, not today, but we can get into the weeds later. Don?

MEMBER GRAF: So, another benefit to

having available the claims data is being able to extract on our membership information and compare the city in which the member lives and the city in which the provider is delivering the care and then create an actual cost down to per mile saved, cost per mile. So, it can get really exact.

MR. GOLDWATER: Yes. That might be good. Yes, Yael, final thoughts.

MEMBER HARRIS: So --

MR. GOLDWATER: Oh -- Yael, and then Judd.

MEMBER HARRIS: We have to close down, Judd. So, on the paper that Marcia and are waiting on Chuck to publish, we actually did do that, which is we looked at -- we calculated miles that would have had to be traveled, obviously that's judgmental in that, would they actually have traveled them, and then we looked at the form of transportation as a way of estimating cost.

So, it was an emergency and it would

have been by helicopter versus would it have been by ambulance versus would they have actually driven themselves, as a proxy to estimate how much it would be, because miles is not enough of an estimate if you're talking about an acute situation.

MR. GOLDWATER: Okay. Judd? And then Don and then someone else.

CHAIR HOLLANDER: So, I think a couple of the last comments have really focused on cost and on Dale's comment with OMB, I mean, I spent the one day of my life on the Hill, which was one day of my life, so I thought it was cool, but the resounding theme from everybody we spoke to was, we need cost data for CBO, because they're not going to pass anything unless it's cost-neutral.

So, it may be beyond the scope of this, but a lot of people had really good ideas that added onto other really good ideas with things that would need to go into an overall cost model.

And so, I wonder, if it's beyond the

scope of this or if it's not, whether we want to get together on the listserv and just develop a master list of everything we think should go into cost, like all the gazillion items, and start putting together what people would need to collect to do the perfect model.

It may or may not ever be a measure thing, it may be, it would give guidance of things that in the ideal would be measured and defined, but I think if we really want to advance telehealth, we really need to answer the cost question.

And I think the brains around this table and the experience around this table makes it the right group of people to try and at least map out all of the things we think might need to go into that calculation.

MR. GOLDWATER: So, I agree with you, Judd, and I think that's a great idea. I would caution not to do that now, I would wait until we have the concepts defined so we know what costs we're looking at and then we can start breaking

down what we need. Don?

MEMBER GRAF: Just a point of clarification on the cost, transportation cost, the studies we're doing specifically for health plan cost for, especially Medicaid contract paras who are under contract are at risk for transporting patients to their physician appointments. As opposed to patient cost.

MR. GOLDWATER: Okay. All right. Is that it? Any final thoughts? Chuck, did you find anything on Google?

MEMBER DOARN: Well --

MR. GOLDWATER: I was kidding.

MEMBER DOARN: No, I mean --

(Laughter.)

(Simultaneous speaking.)

MEMBER DOARN: The one thing I think is very important is, it's amazing to me how many people think that this is never really going to happen. I mean, I remember we were at a meeting with Deena Poskin, this goes back to 1994, and I said, we need to have a map on the World Wide

Web, clickable map, by state, click on the state, by county, who's doing what in telemedicine.

Twenty-five people in the room, 24 people had no idea what the World Wide Web was. That was 20 years ago. So, if you think that this isn't going to happen and this isn't going to become the standard of care and we're not going to do some of the things we've talked about, you're in the wrong room.

And the people on Capitol Hill, they're either going to pay for it or they're not, but industry is going to make it happen, consumers are going to use it, and the American public are going to use it.

So, this idea of somehow -- I mean, telemedicine has been the most over-studied practice of medicine, robotic surgery, laparoscopic surgery, the stethoscope, x-ray machines, they didn't go through this kind of rigor. And it's not clear to me why telemedicine and telehealth go through this rigor, but it's just a closing point.

MR. GOLDWATER: Okay. Because it will serve a higher purpose, that's why. So, amen, my brother, thank you very much. All right. Thank you all. I appreciate everything you've contributed.

We will be in touch and we will continue to keep you informed of what we're doing. We will talk to you via the web or conference call coming up. So, I -- do we want to do public comment now? Okay. So, Operator, can you open up the line for public comment, please?

OPERATOR: Yes, sir. At this time, if you would like to make a comment, please press Star and then the Number 1. And at this time, there are no public comments.

MR. GOLDWATER: Okay. All right. Well, in that case, we'll be in touch with next steps. Thank you all very much. Safe --

MEMBER DEPHILLIPS: Sorry, one other thing. I want to thank the NQF team.

MR. GOLDWATER: Yes, thank you.

(Applause.)

MR. GOLDWATER: You are very welcome. Thank you, Henry, you are now our new favorite person. All right. Everybody have a safe flight back. Happy Thanksgiving ahead of time, Merry Christmas, Happy Hanukkah, Happy Kwanzaa, whatever it may be. We will see you all soon.

(Whereupon, the above-entitled matter went off the record at 2:19 p.m.)

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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Creating a Framework to Support Measure Development for Telehealth

Before: NQF

Date: 11-17-16

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.

Neal R. Gross

Court Reporter