NATIONAL QUALITY FORUM
REGIONALIZED EMERGENCY MEDICAL CARE SERVICES STEERING COMMITTEE
TUESDAY
MAY 24, 2011

The Steering Committee met in the Monticello Room in the Marriott Crystal City, 1999 Jefferson Davis Highway, Arlington, Virginia, at 8:30 a.m., Andrew Roszak, Co-Chair, presiding.

PRESENT:

ANDREW ROSZAK, JD, MPA, EMT-P, Steering Committee Co-Chair, Health Resources and Services Administration

BRENDAN CARR, MD, MA, MS, University of Pennsylvania School of Medicine

ARTHUR COOPER, MD, MS, Columbia School of Medicine

JOHN FILDES, MD, FACS, FCCM, UNLV Medical Center

HOWARD A. KIRKWOOD, JR., MS, JD, EMPT-P, EFO, National EMS Management Association

JOHN A. KUSSKE, MD, University of California-Irvine School of Medicine

THOMAS LOYACONO, MPA, NREM T-P, CMO, Chief EMS Operations Officer, City of Baton Rouge and Parish of East Baton Rouge

RONALD V. MAIER, MD, FACS, Harborview Medical Center

RICARDO MARTINEZ, MD, FACEP, Emory University School of Medicine

NICK G. NUDELL, BS, NREMT-P, FirstWatch Solutions, Inc.
JESSE M. PINES, MD, MBA, MSCE, The George Washington University Medical Center
KATHY J. RINNERT, MD, MPH, FACEP, University of Texas Southwestern Medical Center
MICHAEL R. SAYRE, MD, The Ohio State University
GARY WINGROVE, Mayo Clinic Medical Transport
RICHARD ZANE, MD, FAAEM, Brigham Women's Hospital

NQF STAFF:

ERIC COLCHAMIRO, MPA
LAURA RICHIE
SALLY TURBYVILLE, MA, MS

ALSO PRESENT:

CHARLES CAIRNS, MD, FACEP, UNC-Chapel Hill
CYNTHIA HANSEN, Office of the Assistant Secretary for Preparedness and Response
GREGG MARGOLIS, Office of the Assistant Secretary for Preparedness and Response
JOE MORRIS, DHS-Office of Health Affairs
MIKE RAPP, Centers for Medicare and Medicaid Services
TINA TURGEL, RN, Health Resources and Services Administration
JEFF WILLIAMS, MD, UNC-Chapel Hill
C-O-N-T-E-N-T-S

Opening Comments  4
  Mr. Roszak and Ms. Turbyville

Working Group Gap Analysis and Review  31
  of Domains and Subdomains
  Dr. Cairns, Dr. Williams & Committee

Working Group Discussions  93
  (Off the record)

Finalize Domains and Subdomains  93

Recap: Committee Priorities for  167
  the Second Draft
  Mr. Roszak and the Committee

NQF Member and Public Comment  182

Summary and Next Steps  191
  Ms. Turbyville, Mr. Colchamiro
  and committee

Adjournment  195
CO-CHAIR ROSZAK: Good morning, everybody. Thank you all for coming back for another fun filled day, and hello to everybody listening on the phone.

We are going to kind of juggle the schedule a little bit today. We do have some things to get to, but I think we've got a little bit of time built in. So we should be pretty good to go.

I just wanted to kind of recap the day yesterday and see if anybody had any thoughts or comments. I know we had a chance to reflect a little bit on the activities last night.

So how is everybody feeling today about the work that was done yesterday? Any comments? Any outstanding issues we need to address? Rick, you got something? We kept the UNC folks working hard last night, and we are going to get to some of their revisions
and such in a moment here.

Anything else that's outstanding issues? Rick?

DR. MARTINEZ: Yes, two things. I thought you all did a great job yesterday. I thought the panel did a great job.

I wanted to do one clarification, and then make a little comment back on part of our conversation yesterday.

You know, I realize that sometimes when I engage in hyperbole about how much I hate patient satisfaction, maybe you get the wrong impression. I actually think it is quite, quite important -- quite important, and it is a good indicator of our doctor-patient relationship. But I want to tell you, to clarify my comments, because it goes back to our comments yesterday, I actually believe it has created, a lot like Art said, too much focus on the wrong thing, because it is a trailing indicator.

So the best people can't do well
in a bad system. So if your system is the problem and what you do is you tell the staff, don't forget to be nice, make some nice comments, you know, give a cookie, then you are really not fixing the problem.

So it goes back to this discussion about patient centered outcomes versus patient centered processes. A system is nothing more than a collection of processes and, if those processes are not patient centered -- and I think, you know, trauma is a good example where the resources are delivered to meet the needs of the patient; STEMI is a good example where the resources have been redesigned to meet the needs -- then we are not going to have -- we are not doing the right thing.

So I would actually urge we go back and put in not just patient centered outcomes, but patient centered systems or processes, because those processes are what is driving the outcomes we want.

CO-CHAIR ROSZAK: Would that be a
guiding principle, do you think?

DR. MARTINEZ: Under the guiding principles, yes, I would like us to go back and make a point of that is really the issue. I mean, I got to sit there. I get a lot of -- I had 100-some hospitals. They come in. someone has got bad patient satisfaction. You go in there, and what you realize is the waiting room times are an hour and a half or three hours or five hours, and then what they are doing is they are focusing on what are they going to do to make the doctors and nurses, make the patients happier.

Well, the process is wrong. So I just want to make sure we understand there is a difference there.

CO-CHAIR ROSZAK: That is a very good point. I was looking back last night over the guiding principles, and I just wanted to make sure that the group felt comfortable.

Kind of building off of what you were saying, Rick, I know we talked a great
deal at the IOM and then out in Phoenix about, you know, regionalization is not centralization.

I think we have captured that point very well in the guiding principles, but also this concept that Christie kind of alluded to yesterday where, you know, it is not necessarily always moving the patient. We can move the knowledge. We can move the resources. We can move the expertise through a lot of these innovative mechanisms that are out there now.

Kind of looking back through our guiding principles, I don't know that that is really expressed as much as maybe it should be, and welcome your comments on that, but I think it kind of goes to the point that you were making.

DR. MARTINEZ: I agree with you. You quoted it well, that it is about getting the resources to the patient in the right place at the right time.
I have never transferred a patient to poison control, but I call them, and they follow the patient, and there is limited knowledge to the bedside with a plain old phone, and I don't think people -- That is why I told you earlier, I am not a big fan of the word regionalization, not because it is not a good issue, but because in our mind we threw it into the old model. So sometimes we got to find a way to show that new model. So maybe we need to be explicit.

CO-CHAIR ROSZAK: Any other thoughts or comments on the discussion yesterday, guiding principles, anything you would like to add or omit? Okay, very good.

So just kind of an overview of what we are going to do today: As we talked about yesterday, we are going to break into small groups, and we will do that for approximately an hour, and like I said, these times are a little bit kind of loose this morning, but around 9:00 or 9:30, somewhere in
that time frame, we will break into the small
groups. Eric will fill us in more on the
details of that.

So we will talk in small groups
for about an hour, and then we will reconvene
as a whole group and kind of put some stuff up
on the screen, and we've got easels in the
room for the small groups to utilize, to
really look at the buckets, the domains and
then some of the items that actually go into
those buckets to help look at a whole picture
of a regionalized emergency care system.

So that should take us almost
until Noon. We will do the lunch break. We
will come back around one o'clock and recap
the priorities for the second draft. There
was a little confusion yesterday. So I just
want to make sure we are all clear.

The charge from the committee back
to UNC will be the second draft of the
framework. The environmental scan is done,
and it is a background document. It is a
resource for us to use, but we won't be making any substantial edits to that document. We will be looking to redraft the framework with all the hard work that we have done in the last two days.

So we will go through that and give the charge to UNC. Then we will do the member and public comments, and then we will just briefly discuss the summary and next steps. So like yesterday, the timeline is pretty tight. So we just review that to make sure everybody is on the same page. Yes, sir?

DR. COOPER: Andy, forgive me for not bringing this up two minutes earlier, but I was still sort of forming my thoughts.

I think one thing that we have not touched on, and one huge elephant in the room in terms of emergency services, is the obvious fact that emergency care, and particularly resuscitation, really begins in the field with a workforce that is widely varied in terms of its skill level, preparation, and source of
compensation; that is to say, a huge number of
volunteers who are large on heart, but not
necessarily always perfect in terms of
execution.

We all know that the first few
moments of care in the emergency care system
are largely what make the difference. We can
have a tertiary quaternary level ICU care all
we want, but if we haven't begun the
resuscitation in an effective and timely
manner and transported the patient to
definitive care, whether that care begins in
a community level hospital or in an academic
center, the outcomes are not going to be good.

As we think through the issues of
quality standards, I think that a huge -- a
huge opportunity for improvement really exists
in the pre-hospital realm where quality
improvement efforts, as you know, have been
hit or miss, despite the valiant efforts of
huge number of people -- you know, Tommy
Loyacono among them -- and I am not exactly
sure how a group like the NQF could begin to
influence the development of true quality
improvement in the field, but I think it is a
nut that has to be cracked, if we are going to
make significant progress in terms of
improving the quality of emergency care
nationwide.

CO-CHAIR ROSZAK: I think that is
a great point, Art. You know, hopefully,
this framework -- when we are setting it up,
we can take some of those issues into account,
look at standardized curriculum and training
and some of the issues that Nick kind of
alluded to yesterday. But I completely agree
with you.

Being a field provider myself, it
is very hit or miss, and looking back from
where we were in the 1960s all the way to
today, it is a little bit amazing we are not
kind of further down the path. Skip?

MR. KIRKWOOD: I think, when we
look at the out of hospital component of the
emergency care system, the discussion
frequently goes toward exactly where Dr. Cooper went, and talks about the large amount
of the land mass of the United States that is served by volunteers. But I don't think we should let that serve as an obstacle, because if you look at it differently and look at who the majority of out of hospital patients are, you would probably find, if anybody ever did the study which, like so much of out of hospital stuff, is not adequately studied, that most of the patients are actually touched by full time career personnel of some sort or other, because they are in major metropolitan and heavily populated areas.

Two areas where this group might make some contribution to pushing the pre-hospital care world along is in the use of technology and getting the out of hospital care system from the very beginning linked into the health care information system that is going to grow over the next many years.
While we ought always to try and focus on outcome measures, those are impossible if you don't have intelligent processes built. So we may want to look at some process measures in the out of hospital world to look at intermediate steps of performance of the EMS systems in communities.

We can't get to a good outcome at the end of the hospital stay without a good EMS system, but we don't quite know scientifically what that means yet, and some process measures could help push it there.

CO-CHAIR ROSZAK: Those are all good points, and I certainly think there is room in our domain for our Care coordination to really look at those issues about is the pre-hospital medical record actually integrated into the in-hospital medical record and, if so, great; if not, why not?

I kind of agree with you in some degrees about the standard of care, and I know we struggled with this at the National Fire
Protection Association when we did the 1910
and 1920 and all those standards.

So I think this group does have to
do a little reflection and, really at the end
of the day, is a paramedic in Chicago the same
as a paramedic in rural Montana? Should you
be provided the same level of care?

Like it or not, there is great
variation across this nation, and I don't know
that we are going to fix that in this room
today, but are we at a point now where a nurse
should be a nurse, a doctor should be a
doctor, and a paramedic should be a paramedic?

I think in the pre-hospital
environment, as we have seen across all the
states, it is not necessarily comparing apples
to apples all the time. I think there might
be some opportunities here to at least address
that. Tom?

MR. LOYACONO: To follow what Skip
is saying, too, when we talk about record
linkage, you think about the pre-hospital
record; but in a lot of systems, the pre-

hospital component is not a single entity as

well.

I know in my own system we have

fairly good linkage between the EMS component

where the paramedics are and the hospital, and

being able to get those records together. But

there is no reflection of the first response

system at all. The fire department goes out

first. Are they part of the system? They are

getting there first. They are getting someone

an EMT on the scene before anybody else is.

Largely, what they are doing and what they are

accomplishing is not recorded at all, because

they are handing it off to my system, who --

that is where the record begins. I think we

are missing a huge amount of data there.

CO-CHAIR ROSZAK: And, Tim, as you

know, a lot of times those first responders

don't get paid. So that even furthers the

problem of, well, why are we documenting this

if we are not going to get reimbursed. We
could spend a whole three-day session on that, I am sure.

MR. LOYACONO: Well, yes, and when you bring that up, the system that requires transport for pay -- and I know we have all heard this in many, many meetings over the years -- and when we talk about bringing technology into the field and telemedicine and those things, there are many things that the pre-hospital system can do to move patients more efficiently, in some cases past the emergency room directly to a cath lab, something like that.

A lot of times, there is an opportunity to fix a problem and bypass the hospital entirely by putting them into the primary care arena, take care of their problem on site and refer them to somewhere other than an emergency room. But all these things are going to take the technology and the connections, and there is going to have to be a funding mechanism so that I can be paid for
providing the service. The physician or intermediate provider on the other end is able to be compensated and protected for their role in it.

You are right. We could talk about that all day.

CO-CHAIR ROSZAK: Nick?

MR. NUDELL: I would like to add to my distinct colleagues -- distinguished colleagues, excuse me.

The pre-hospital care record begins before they see EMS. It begins with the EMD dispatch call triage steps, and there is quite a lot of data that is collected at that point in time and stored and recorded. But by and large, it is not used for outcomes or patient evaluations or tying back in initial presentation over the phone to the care that was received in the pathway.

So I think it would be -- We would be well served to bring that link as early into the chain as possible.
My second comment was about Dr. Cooper's comments. I appreciate what he had to say about the pre-hospital arena. There are many areas of the country, geographically large, where the ambulance services have no quality assurance, no quality improvement activities taking place, and their main focus in quality is just making sure an ambulance responds.

So they are at such rudimentary levels of quality improvement or quality management that a lot of this will be right over their heads, because it is not where their planning and thinking is.

So I think that we would be well served to make sure that the draft speaks to their needs and provides some mechanism to help bring them into it.

CO-CHAIR ROSZAK: Those are really, really good points, and before I came here, I actually graduated high school in a small rural town with 24 other kids. So I
have lived the rural life and could definitely appreciate just trying to get the ambulance out the door at three in the morning. A very good point, very well taken.

Nick and Gary and Tom, you know, and a few of our other folks with rural experience to make sure that we are not going too off track in that. Mike?

DR. SAYRE: I just want to provide a little slightly different view. To me, the whole genius of this approach and why we are here today is it has got the opportunity to kind of turn that system around. So what I am hearing a lot is a sort of top-down approach: We need to improve training.

Really, what we are talking about is more of a bottom-up approach here, to actually measure stuff, and you get different people engaged then who then start to pay attention.

So in the local community, if the pre-hospital care is bad, then the hospital's
quality measures aren't going to look very
good in that regionalized system, and they are
going to get interested in wanting to make it
better. That is going to really, I think,
make a huge difference, and different
communities are going to solve that problem in
different ways.

Some places may choose, say, not
to have paramedics at all, because it just
isn't a good way to use their resources. I
think that we would be wise to not be too
prescriptive about that and rather to let
various communities figure that problem out
for themselves. There is plenty of resources
about how to do that.

CO-CHAIR ROSZAK: Good point, good
point. Dr. Cooper?

DR. COOPER: Very briefly, I
raised the issue, because I fundamentally
agree with Mike. I think the question for us
here is how can a group like the NQF
creatively address this problem through
creation of a benchmark that -- or suggestion of a benchmark, a creation of a platform for a benchmark, so to speak, that will begin to address some of these issues and give some of those local communities a direction in which to go to help figure out what the next steps are.

It is a tall order, given the disparate nature of that system, but as Mike has said, every community will solve it in a different way, but some direction in terms of a benchmark toward which -- or benchmarks toward which the initial critical component of emergency care can go will be very helpful.

CO-CHAIR ROSZAK: Thank you very much. I did want to just compliment everybody on your engagement yesterday. I did find it very fascinating that everyone around the room actually spoke up. I know we are not a shy group. So it wasn't that much of a shock, but I do appreciate your feedback. Ron?

DR. MAIER: I will just add to
what Art was saying, though. I think, if it is going to work which as we heard, it has been a long time -- you know, the late Sixties, 50 years, and we haven't made much of a dent in this problem.

In addition to benchmarks, because I think it should go from the ground up, is just to provide and ensure the joint accountability that we were talking about yesterday. That is something that has really been missing from the program, is that the hospitals have been able to disassociate themselves from having to work with the pre-hospital providers, because that joint account has never been in the system before. I think, without that component, it is still going to be very difficult to get the changes that we need to have made.

CO-CHAIR ROSZAK: Good point.

Skip?

MR. KIRKWOOD: I would like to explore this, do it from the ground up, and
let every community find its own way just a little bit, because that seems quite different from the way the rest of health care is approached.

When we hit the hospital door, we start dealing with National Consensus Standards. We start dealing with strong centralized regulation and requirements from CMS, and I am wondering why our colleagues think that the pre-hospital community should be held to standards that are homegrown or not at all or something.

DR. SAYRE: Good point. I think the issue isn't -- those of us who work in hospitals maybe do not agree, but I think most of them would -- that this top down approach of imposing standards doesn't really actually result in improved quality, which is sort of why the National Quality Forum exists, because we went for many, many years with saying, well, if you just had this and that and the other thing, then patients are going to get
great care, and it is not about that.

It is about actually holding
people accountable for the kind of care that
they deliver, and when -- As Dr. Martinez
pointed out yesterday, I, too, remember making
many phone calls trying to get some
cardiologist interested in taking care of a
STEMI patient, and it was like, oh, no, you
know, got a golf date, whatever, can't do
that; and suddenly, within one month, the idea
that the hospital was going to look bad in the
local paper because their door to balloon time
wasn't good -- problem solved.

Just making them accountable for
the actual outcomes for the patients where a
process measure that was tightly linked to
outcomes --

MR. KIRKWOOD: I am not
disagreeing with that, but --

DR. SAYRE: But they didn't tell
us how to solve that problem. They didn't
say, well, you need to have pre-hospital 12
lead, and you need to have this, and you need to have that.

MR. KIRKWOOD: But they told you that the problem needed to be solved.

DR. SAYRE: Right.

MR. KIRKWOOD: You know, I think I watched the same changes in behavior that you did, and it came right after the announcement came out that CMS or somebody else was going to publish exactly that performance, and that was -- From my view, that was an externally imposed top down performance standard, you will do this. It wasn't something that somebody invented locally and decided this was a great way to do it.

DR. SAYRE: Sure, but they didn't tell us like how many interventional cardiologists we had to have.

MR. KIRKWOOD: No.

CO-CHAIR ROSZAK: I think there is kind of a fine line there between identifying the issue and bringing attention to it versus
being so prescriptive that you have to have 12
ambulances staffed by three paramedics or
whatever. So we have to be mindful of those
as we proceed today, but I think both sides
kind of have merit there.

Any other comment as we begin to
g et into our small groups? I am going to turn
it over to Sally for some introductory
remarks, and then we are going to talk about
the domains again with UNC.

MS. TURBYVILLE: First off, I
apologize. I think I have been late for three
meetings, but I don't know what happens in
this area when it starts to rain, but people
lose their minds. So I have gotten stuck
trying to get here, took much longer. It is
usually only a 10-minute trip for me. So I
apologize to all of you.

I did hear a lot of comments
yesterday and some real important common
themes, at least I thought. I wanted to
bounce them off of all of you and give you an
opportunity to react to some of the notes that I jotted down.

I heard a call for us to make sure we are explicitly incorporating the concept of population health. I think all of you understand that it is there, but making sure, as we reach out to a broader audience, that we are being very explicit about that.

Acknowledging that emergency care is part of the entire health care system and that we can't necessarily make huge strides in making it effective and efficient if the rest of the health care system is not as well. So I don't think there was a call for us to change any of our approaches, but to make sure that we are acknowledging that that is true.

A call for leadership, a need for national and local leadership to keep these types of improvements moving.

I also heard an interesting discussion about looking at the model and that, with emergency care, that we think about
that Phase 3 in the episode of care and loop back into the community or the population health. I thought that was a very important and interesting concept that came out of this group.

Then I think the more blunt comment was the call for us to add a new domain. It has been called the sixth domain, but actually, I think it is the new first domain around access and capacity.

So I think we walked away yesterday with a lot of really important changes to our approach and the document, and really appreciate the thoughtfulness. We are very excited that we have gotten this far in just one day, and we are really looking forward today to kicking around the domains that we have and improving them and making sure that we have the domains and subdomains as they should be.

So again, to echo Andy's comments, yesterday was fantastic. I really heard a lot
of important contributions and updates that we need to make, and we are really looking forward to doing that, and I know that Jeff and Chuck have already been working on revising some of the definitions and updating the guiding principles, but I think we came to a really good point yesterday with a lot of agreement of what we still need to do with the framework.

CO-CHAIR ROSZAK: So if we are ready, we can begin the roast of Chuck, Day 2. Poor guy went up and soaked in the bathtub -- we beat him up so bad yesterday.

As you know, Chuck, none of this is personal. You know that. We are all having fun. So I believe you guys have revised some definitions, and then we will talk about some of the domains, and provide a little recap of yesterday from your perspective. So I will turn it over to you guys.

DR. CAIRNS: So, thank you all
again. No, actually, we found the session very productive yesterday. It reflected a little bit of the evolution that we hadn't thought as we have been interacting with NQF and understanding the development of measures. Frankly, I thought it was really extraordinary kind of insights into how both emergency care is perceived, how it can be measured, and how we think of it as a system, especially in this regionalized context. So I thought it was very valuable.

So two charges this morning: The first one was to go over some revised definitions, and I thank Jeff yet again for extraordinary work on this. The second one is to introduce this new domain. So let's start with the definitions.

So in this case, we've got regionalization and regionalization of emergency care services, and taking Dr. Maier's suggestions and comments, we are really just going to collapse them.
So the first comment is we are going to look at regionalization, and then we are going to look at this key definition of regionalized emergency medical care services as an inclusive term, and then I guess the question is what should be key? What should be key definitions? What should be glossary terms?

The idea here is that in most of the NQF frameworks, there are key definitions as a component to the report, but we heard the valuable suggestion yesterday to include a glossary of terms. Clearly, I think that units of service, centralization -- there were a number of other medical specific terms, ED overcrowding, Kathy, that I heard, boarding.

DR. RINNERT: Boarding, crowding, offloading.

DR. CAIRNS: I think that anything that is specialty specific or kind of used in a jargon or this kind of vernacular really needs to be defined. Sir?
DR. MARTINEZ: What happens to systems of care? Did we decide? I mean, Kelly is not here. So we can do what we want today.

DR. CAIRNS: That is fair enough. So, Rick, we put them altogether. If you think there would be value in keeping it separate as a system of care, we certainly could.

DR. MARTINEZ: I thought yesterday it was a separate issue, only because it went into greater detail of what it is. It is a collection of processes, blah, blah, blah, and I thought it built it out. But I don't care. I just didn't see it disappearing yesterday. That's all.

DR. CAIRNS: How about this, Rick? We put up the proposed key definition of regionalized emergency medical care services and see the complements or opportunities for extension to a systems of care definition?

DR. MARTINEZ: I just -- The
committee can correct me on that. I don't recall us getting rid of that. We've rolled some things up. Was that the issue, was to roll all that into one definition? Is that it? Is that the proposal?

DR. CAIRNS: That was certainly the post-meeting discussion that we had with our colleagues.

CO-CHAIR ROSZAK: Yes. I don't think that we ever actually fully resolved the issue. I know some were leaning toward eliminating it, and some were kind of leaning toward keeping it in. So I think they have done a good job at revamping and reworking some of these.

So maybe we should just see what we have here before we get too far.

DR. MAIER: Well, before you go too far, though, I agree. I thought we were going to -- Since the verbiage of regionalization and system are virtually the same, I thought you were just going to
collapse them, but you changed it to services from system.

DR. CAIRNS: Ron, I think we would like to just see what these definitions are, and then we can go back and clarify the moniker after we see the definition. Is that fair enough?

CO-CHAIR ROSZAK: Skip?

MR. KIRKWOOD: While we are painfully wordsmithing, I think it is wise to keep the system or whatever we are talking about in the plural, because if you go -- if you move to the singular, then you are talking about at least the flavor of centralization or central authority or something, which I think we are trying not to do.

DR. CAIRNS: Great point, Skip. You know, we played around with system versus systems in multiple aspects of the document, and I think that is why it would be valuable to at least go over these definitions and see where we are and where find intersection with
yesterday's and where we will bring them back.

MR. KIRKWOOD: I know in greater Raleigh this week, the fight is over whether there will be one system or two systems. So very timely as the SCUDs fly back and forth between Chapel Hill and Raleigh.

DR. CAIRNS: Well, one thing, though, is that, clearly, you can have an overriding system on a modeling perspective, and you could have a system of systems as part of that technical model.

DR. RINNERT: Chuck, one of the other things that we talked about yesterday that I don't know if it was properly captured, and it didn't have to do with terms and definitions, but it had to do with more of a concept of sort of describing the milieu in which health care would be occurring.

John did that quite -- I think it was John that brought up the idea of the horizontal elements and the vertical elements in a system or set of systems that overlap.
Along the horizontal axis is sort of the baseline regional kinds of concepts that you would have, with everyone having at least a certain minimum level of care that is provided or competence, and then going toward the thought of the vertical elements allowing more subspecialized and very beefy tertiary kinds of care, and how the patient would work through the system, both on a horizontal and in a vertical sense.

Sally sort of talked about it, saying that we would want to have arms where we were more beefy in exactly what the patient would be getting, and then arms that maybe are a little more rudimentary in describing what would be the basics that everyone would need to provide. Depending on the level of expertise that the patient needs, they would move both horizontally and vertically within the system.

I think it was John's concepts, if I am not mistaken, but I think as an
overarching sort of planning principle or a concept for how patients would move horizontally and vertically within the system depended upon what their individual needs would be and whether they would be cared for in the regional or in a horizontal basis or have to seek a more higher level of care within the vertical axis would be something you could grid out.

DR. CAIRNS: Thank you, Kathy. In fact, I think that one of the ways we talked about illustrating that would be to have a generic episode of care for regionalized emergency medical services and incorporate the Phase 1 components that are basic to all regionalized medical care services, the Phase 2 components, the Phase 3.

Frankly, I like the split to a Phase 4. So a phase 3 would be in hospital. A phase 4 would be outside. I think that was Dr. Carr. I think that having that across the various generic episode of care for
regionalized emergency medical services, I think, would be the way to illustrate that concept.

That would then allow for conditions specific, whether that is symptom based or whether that is disease based episodes, to then be generated for more directed conditions.

DR. RINNERT: Right, because obviously, the fidelity of what resources are brought to bear on that patient are dependent upon the expertise that is looking at that. So you would have, you know, symptoms or chief complaints along sort of the basic level, and then as you get more and more information about that patient, whether it is through testing or more sophisticated examiners looking at this patient, you then would be getting a beefier sort of snapshot of what is going on with them, and what are the exact treatments that need to be brought to bear on that patient.
So even this level of sophistication of the people that are interacting with that particular patient would be very variable, dependent upon what information you had at hand. Sometimes it is just the dispatcher asking a bystander, is the patient breathing. Those are sort of very basic kinds of interactions that allow you to gain some data, and then move the patient further down the continuum.

DR. CAIRNS: So one thing that we could think about, Sally, and this would just be a question maybe on the episode of care model, is: You have a Phase 1. Phase 2 is where the episode begins. Phase 2 could either have different units of service, like pre-hospital which could even be split into community response versus EMS response; then emergency department response.

In our model, Phase 2 also could include acute care areas of hospitals, and then a Phase 3 would be in-hospital specialty
care or to transfer to a definitive care facility if the patient were transferred.

Then Phase 4 would be post-hospital care, potentially interventions or prevention and rehabilitation and things.

Is it better, you think, to continue the phases out and say, okay, Phase 1 is pre-episodic care. The first phase is literally kind of in the sequence, so community response and EMS, emergency department, hospital, post-hospital; or are we getting too many phases?

MS. TURBYVILLE: I think that it is definitely intriguing. The other question, though, is at what point do they go get integrated back into Phase 1. So I wonder if this idea of Phase 4 isn't the component that puts them back into Phase 1, which is the population at risk, which is pretty much the community, because anyone at a given time has the potential to require emergency care, if I am thinking about this right.
So I think it is important to capture this piece. I am not so convinced that it needs to be a Phase 4 versus part of Phase 1, but clearly, all of you have that contribution.

So I don't think -- We don't want to limit the thinking of the group to this episode based model. It is meant to be something to spur you into how the model will work. So I think we should play around with it.

DR. CAIRNS: So just one quick response. I see John's. I see a number of cards going up. So I would modify it based on that comment, that maybe Phase 1 -- Phase 1 is going to have a loop to a Phase 4.

Number 2, Phase 2 could be -- A potential Phase 2 would be the out of hospital component. Phase 3 would be the in hospital component, and Phase 4 would be the post-hospital care.

MS. TURBYVILLE: Phase 2 in the
traditional part of it is where the condition is identified. Right?

DR. CAIRNS: Fair enough. So we should collapse still the units of service of out of hospital and emergency department care still in Phase 2. Phase 3 could be this hospital based, and then the question is, is it a Phase 4 or is it a stratified Phase 4/Phase 1?

MS. TURBYVILLE: And I wonder if it is really not trajectories that are coming out of the phases, whether or not we need a Phase 4 or not, because do all emergency situations end up going into the acuity -- into an acute hospital setting or can some not be resolved in the emergency department.

So I think the phases are -- when we have the potential for it to be resolved in different ways, maybe those are trajectories off of the model versus the actual Phase 3 that someone may or may not. But I think we can play around with it.
DR. CAIRNS: No, I hear your point. I like that.

MS. TURBYVILLE: And I am not saying no. I just think that we are right to think about how this model applies.

DR. CAIRNS: So just for the benefit of the group: So what we are talking about, it is in one of the model episode of care frameworks, severity will determine a trajectory out of Phase 2. If I hear you correctly, this would be an opportunity.

So one of the trajectories would lead to acute hospitalization or transfer or some other event. Another part of the trajectory could be to -- well, yes, but then, unfortunately, you don't have to worry about the episode of care.

MS. TURBYVILLE: Or it is Phase 3. I mean, I just want to push it a little bit. I think we should kick it around. I don't know -- It is kind of hard to --

DR. CAIRNS: Fair enough. Well,
we could put together this graphic based on these concepts, Kathy, to incorporate the discussion that various units of service are going to have different levels of information and different levels of interventions that would be important, but that the overall theme of integration across those services, including communication, including disposition, including integrating the care that is available across those different units for an episode of care will be important components of any generic episode of care.

DR. RINNERT: We always want to remember, and we don't have the little picture up there, but at any point in the system, whether the patient is in Phase 1, 2 or 3, if someone dies or if someone gets better or there was a misdiagnosis and the patient got sent home, whether that was right or wrong, those are sentinel -- in my opinion, sentinel events, and those are ones where you learn the most about the system, and you learn the most
about your sophistication of care.

So we sort of dispense with them and go, well, we really want to know about the people that go all the way through, because we think we learn the most. I would caution us to make sure we have measures to look at the people who fall out of that or don't ever -- maybe even the people that don't ever get included from the outset.

DR. CAIRNS: Well, I think one of the key components that illustrates that concept is if we were to go to conditions like symptom based care, and Jesse was bring that up yesterday, that clearly not all people who have chest pain are going to have acute myocardial infarctions. In fact, the vast majority won't.

So understanding that interaction across an episode of care will be very important, specifically if the performance measures are linked to AMI and not to chest pain. So understanding that dynamic will be
very important, because clearly, there would be resource utilization issues, cost, capacity of the system and a lot of other components that will come into play.

CO-CHAIR ROSZAK: Let's just go around and knock off some of the comments, and we will just work our way this way. Go ahead, John.

DR. FILDES: Just a couple of comments. One is that what Sally is articulating very well, in fact, is the Public Health model for the system of care for time sensitive injury and illness. That is really a drive-home message in the HRSA document of 2005, and these phases of care do match up with this.

We talk about trauma systems, but honestly, it is just a disease based system of care for a time sensitive condition, and you can just plug in any diagnosis you want on top of it. But the requirements when we go out and look at a system of care that deals with
injury as a time sensitive condition is that
you have to actually define the public health
and the population. You have to define the
epidemiology of the condition, in this case in
jury in the population.

You have to actually educate the
community about it. You have to have primary
and secondary prevention in position. You
have to have access to care through 911 and
dispatch of ground to air units. You have to
have a plan of where they are going to go, and
all that stuff really gets into Phase 1.

Then when the first provider
reaches them, then you actually begin Phase 2,
and that includes a variety of out of hospital
emergency medical personnel, and they
eventually get to a receiving area, which
could be a burn unit, an obstetrical unit, an
emergency department or whatever that happens
to be. Then they get maybe an operation, and
they might go to an ICU, and then you follow
them into the convalescent phase, which might
actually cross over to a Phase 3.

Then some of them go to rehab, and
some of them go to LTAC, and some of them go
home. At the end, there has to be a data
system to record their outcomes and to link
them back to --

DR. COOPER: The structure
response in Phase 1.

DR. FILDES: -- to Phase 1 to
mitigate that activity, going forward, and
modify the risks. That is really what the
discipline of the disease specific system of
care for injury has been doing since 1966, and
in a certain sense, I am trying to let this
unfold, because this is a creative process,
but you are recreating a wheel here. I hate
to say that, but you are recreating a wheel.

A lot of this terminology has
already been nailed down, and it is not just
in publication, but it is actually in
Congressional law and other sorts of things.

They call things systems. They don't call
them services.

So I'll stop there, and I have emailed some important documents to important people in the room, and I will come back around and say some more things later.

DR. COOPER: I think John's comments, of course, are right on the mark. I agree with him completely. I will just add two thoughts here.

I think, as we think about the episode of care model, you know, Sally's comments about how different patients may follow different trajectories through the model is absolutely correct. But when we are talking about an individual patient, when we are talking about individual health as opposed to population health, we may be thinking about a linear model. Okay? But when we are talking about population health, we are really talking about a cyclic model, in the sense that Ron Maier just mentioned.

In other words, the data that we
gather or the aggregate data that we gather from the experiences of several patients that are going through that episode of care model feeds back from the last phase to the first phase, whatever number you are talking about.

In terms of performance improvement, it is a big performance improvement cycle. It is a PDCA cycle, you know, if you want to think of it that way, because the data is just going around and around. So we are -- I mean, this is really the chain of survival, only the aggregate data from the chain of survival links back -- It doesn't go out to infinity. It actually links back on itself to the beginning, so that you have the kind of feedback in terms of the system and the risk modification that Ron Maier was just talking about.

So I think, as we think about episodes of care, we have to understand that it is the aggregate experience of populations who are obtaining those episodes of care that
MR. KIRKWOOD: At the risk of repeating myself, not every episode of care that begins with a contact to a 911 center needs to end up with the patient in a hospital, but there are a number of other trajectories, and I really -- I like the term, but they don't all end one further step up the health care system.

DR. MARTINEZ: Just a little different, but build on the idea of making sure that what we do builds on the past and kind of strengthens it.

The one thing you mentioned earlier, I am not sure we have incorporated too much, but as we go to maybe the next steps we are going to do is I think we need to be mindful of the aims of quality, so that we put things in those terms, in a way. A lot of these measures we are talking about are efficiency measures. They are measures on timeliness, effectiveness, patient
centeredness, that sort of thing.

It is funny because, you know,
even things like equitable are going to come
out in the cost issue, winners and losers
within the system.

DR. CARR: The other piece that I
think we didn't make sure that we keep on the
radar is that we could draw this -- you know,
whether it is the HRSA trauma injury system
circle or the episodes of care, they are
pretty analogous, I think, in many ways.

I strongly think that we shouldn't
be drawing, as Sally mentioned yesterday, 14
of them for each of the domains of each
emergency care condition that we are willing
to regionalize.

I don't know how we get around
that. I mean, this is one of the pieces that
-- you know, trauma has got a long track
record of doing this, and we have now seen the
American Heart Association put out a call for
proposals for regionalized STEMI systems,
regionalized cardiac arrest systems,
regionalized stroke systems.

It is an interesting thing. It is
a parade of disease conditions, and I don't
want us to be stuck in this model where we
don't recognize the synergy that can happen
from learning from each other and building
pieces together.

MR. NUDELL: I put my flag up four
commenters ago. Where we were in the
discussion at that point in time was comparing
the Phase 3 and Phase 1 and how you
transition.

My thought at the time was that
doesn't really work for the community
paramedic model where the community paramedic
isn't serving the Phase 1 purpose. They are
serving the Phase 3 purpose where the episode
-- it is hard to define when the episode is
ending and when it is continuing or
restarting.

So I would just encourage us to be
mindful of that. Some of the work that the community paramedics are doing is still evolving, and it is still -- they are still finding their way, but many of the things that they are doing are preventing people from coming back into Phase 1.

So having an allowance for that would be good.

MR. LOYACONO: I wanted to expand on Kathy's comment a little while ago. As we look in communities, I think it is essential that we be able to seek a way to find these people that fall out of the system. I know an EMS service, you know, you send a name on some call, and for whatever reason the patient stays home, and an hour later you are going back out there, and they have had another event.

They don't always go to the same hospital either, and when you are making a second run on a patient who has already been in and out of a hospital and they've got some
event, and now I am not going there anymore, don't take me there, there needs to be a way to connect those people so that you can find where the system failed and fix it. That is a moving target, but I think it is terribly important.

CO-CHAIR ROSZAK: These are all great comments. In the interest of time, I would like to get back to the definitions and get that done. We are about 9:35 now. So, Chuck, why don't we run through the definitions. We will refresh on the domains, and then we do need to get into our small groups to keep on the schedule for today.

DR. CAIRNS: Very good, Andy. So if you could just go to the next slide. So here is regionalization. The key change is the last line, "to a defined population of patients."

So regionalization: The concept of an established network of resources that delivers specific care -- for example,
protocols, definitive procedures, higher care
levels or care pathways -- that is not
universally available in the out-of-hospital
setting -- for example, a physicians' office --
or in some acute care hospitals to a defined
population of patients.

This is really per Art Kellerman's
suggeston yesterday, again keeping this
concept that regionalized care does not equal
centralized care.

This is now this kind of
amalgamation of definitions for regionalized
emergency medical care services. This is
going to just focus in on the services: A
deliberate and planned system of both in- and
out-of-hospital resources that delivers care
to a defined population of patients who have
conditions for which rapid diagnosis and early
intervention for acute illness or injury
improves patient outcomes.

A key change here, other than the
amalgamation, is the incorporation of Dr.
Carr's emergency conditions language.

A regionalized system of care may exist to serve a particular geographic area, patient population or disease condition. The out-of-hospital component of regionalized emergency medical care services may be represented by the pre-hospital (i.e., field EMS), recognition of a time sensitive condition, an initiation of the system of care, or could also be represented by the transfer of a patient for specialty care within a regionalized network.

This is new language now. "When unscheduled episodic care of varying levels of acuity is provided in both in-hospital and out-of-hospital settings of regionalized emergency medical care services, the focus of this project is on measuring systems of care for time critical, life threatening clinical conditions. Nonetheless, the effectiveness and capacity of regionalized emergency medical care services systems is determined, at least
in part, by the system's ability to deliver emergency care, while non-emergency care is also provided to other patients."

So the key concepts addition there were just these ideas of non-emergent care, the fact that it will affect the performance of emergency care, and to provide a context of the system of care in which regional emergency medical services are provided.

DR. PINES: The one comment I have is a potential -- an amendment that we would -- where we say life threatening, to put in some language about potentially life threatening. That would include chest pain and acute myocardial infarction as what we are trying to tackle. So we could focus also on diagnostic centers to re-stratify along with the patients who actually have AMI.

DR. CARR: I don't know what Art said yesterday, but the language from the very first definition of regionalization ends with the word "patient." I don't know that that is
true. I think it is to a defined population. I mean, they are potential patients until something happens to them, and I think that is important. I mean, to the population, they think we are weird, because we call everybody patients.

Then the second thing I wanted to say is that in the emergency care sensitive condition piece, that emergency care sensitive condition isn't my language. That came from my partners at AHRQ, because they were mirroring something that already exists, which is the ambulatory care sensitive conditions that is recognized.

So if want to -- I am not wedded to it, and clearly the committee should decide, but if we want to draw the parallel to ambulatory care sensitive conditions, we should call them emergency care sensitive conditions, not time sensitive, not emergency care conditions. That is sort of the variants that are mixed in here.
CO-CHAIR ROSZAK: Fair enough. I guess we are trying to synthesize it into this approach, though, for regionalization.

MR. LOYACONO: I hate wordsmithing, but on the definition -- I think it is the next one -- disease condition -- I mean, you know, the care system is for a geographic area or a patient population who may have a specific disease condition. To me, we are providing a system that treats people, not disease.

DR. MAIER: To that specific point, I think somebody brought the analogy of like you got one hand surgeon. He defines his population, because he is the only show in town, and so it is totally disease driven.

DR. FILDES: My point was that it was resource driven. So if you only have one person around who can deliver a baby, then that drives it to the resource.

MR. LOYACONO: Isn't it still the person with the cut-off hand that we are
seeking to serve?

DR. PINES: My other comment, just in general about a lot of this stuff, is I think we all understand what this is, but I can imagine showing this to someone who doesn't really think a bit in this area, and this language is, I think, very complex and is very jargony.

I know we were talking about having a glossary, but it may be helpful to show some of this to someone who hasn't thought about this and make sure that this is understandable to them, because just on the surface, it seems pretty complicated.

MS. TURBYVILLE: Thank you for that comment, and not only will we try and avoid jargon as much as possible, but the document will be posted for public and member comment. So I will encourage all of you. We certainly do a lot of outreach to make sure that folks are taking a look at it and providing us comments, including such as it is
too -- filled too much with jargon. So that is a very important point that we should keep in mind.

DR. MARTINEZ: I worry sometimes that we focus too much on the STEMI and that sort of stuff, and the system -- to me, the capacity of the system really shows its underbelly with the patients who don't fall into that category.

If you look at CDC data, they will show you only about 8 to 12 percent of the patients shouldn't be in the ER. They actually are so minor, they shouldn't be there. In other words, this idea of what is an emergency versus not is more than those life threatening right in front of you.

The lack of access to time creates the emergency. A good example I see all the time is an asthma patient. An asthma patient can be a little short of breath because they don't have their medications and they have an episode. The longer they wait, the worse they
get, and you can get to the life threatening aspect of it.

So the capacity of the system really reflects sensibility to deliver the resources to that patient.

We have actually built a very bizarre system now. We have two things. We have a fast track, and we have the rest of the ER, and if you have nothing wrong with you, we have a place for you right away and, if you are really sick, we have a place for you. if you are a level 3, headache, abdominal pain or shortness of breath, you wait in that waiting room until you call CNN eventually, and they show the videos, but that is what happens.

So I worry a little bit about us making sure that we identify that they are time sensitive and could become, as opposed to, you know, they emergent and then we should still be able to take care of the nonemergent, because I don't consider them nonemergent, those other patients. I consider them needing
acute care, and it is a real dilemma. How do you frame that?

I just worry about that, because if you look at screening out programs, the most they can do is eight to 10 percent, because that is what happens. So we are talking a real small minority being nonemergency.

CO-CHAIR ROSZAK: Kind of back to our comments on that first paragraph on the screen, it seems that a lot of that was captured maybe on the slide before, and I wonder if it is going to confuse the issue and everything like that, do we even need that paragraph? The one on the next slide that talked about the disease conditions.

It is kind of repetitive. We have said a lot of that in the definitions before. Do we really even need that paragraph in there? I'm not sure what the value added is and if it is going to create the bait and potentially confuse people, maybe we should
just eliminate it. I don't know. Ron votes yes. Thoughts on that?

DR. MAIER: In the attempt to capture everything, it is becoming a bit rambling, and again it is very difficult, I agree, to -- you know, what we just heard from Rick, the challenges are there, and they need to be addressed. The question is how much do you put in the short definition.

CO-CHAIR ROSZAK: Right, and there are, certainly, numerous other documents other people can look at, and this isn't the be-all, end-all of regionalization, and we try to, I think, point that out by referencing a lot of the great documents that have come before and, I am sure, many that will come after.

So I just wanted, for the sake of brevity -- and if people want to learn more on regionalization, perhaps there's other venues they can do that in, and this may not be appropriate. I don't know. Thoughts on that? John?
DR. FILDES: I have to agree with you. In synthesizing documents like this, the goal should be to deliver it at the sixth grade literacy level, like USA Today does. So if you can't actually explain this to a sixth grader in the elevator going to the third floor, then you missed it.

DR. CAIRNS: Obviously, these are slides, and so the words aren't up there the way they appear in print, and it is really more of the concepts. But I hear what you are saying, John. I mean, clearly, it has got to be language that is understandable. Clearly, it has got to minimize jargon, and clearly, it has got to be consistent with the language that we have discussed within the rest of the framework.

DR. FILDES: And I would say that it has to be consistent with the historical path that this discipline of thought has taken, too.

DR. CAIRNS: Well, it certainly
has to recognize it.

CO-CHAIR ROSZAK: All right. I would like us to move on, if we could, just to the domains, so we can get into the small groups. Ron, you got one burning issue?

DR. MAIER: Let's go back to that first little slide, number 2. We really are talking about regionalized system. You can make it systems, if you want. It is not services.

DR. CAIRNS: Ron, did you like the Systems of Care slides from yesterday?

DR. MAIER: The Systems of Care? I don't know which one you are talking about.

DR. CAIRNS: Is it possible to pull that one up?

DR. MAIER: All I am saying is, is yesterday we had regionalized care, and then we had systems of care.

DR. CAIRNS: Right.

DR. MAIER: And they seemed to be saying exactly the same thing with different
words. But I think the concept that we are going after is regionalized care systems, not regionalized care services, which is what you changed it to. That is all I am pointing out.

DR. CAIRNS: Thank you, sir. We need to add the word systems. We will.

DR. MAIER: That is all I am saying, is --

DR. CAIRNS: I got you. Remember, the way that the project was entitled for the RFP was Regionalized Emergency Medical Care Services Systems, and we are going to add the word systems. Then we will refer to it after we get past that title aspect and initial line to regionalized emergency care systems. Is that fair enough?

DR. MAIER: Yes.

DR. CAIRNS: In the document, so we meet both mandates.

DR. MAIER: Yes.

DR. CAIRNS: No, I heard you, Ron. Thanks.
DR. MAIER: Because I realize that you go on to define those services on both sides as systems.

DR. FILDES: Right.

DR. CAIRNS: Hence, you can see the reconciliation between the two charges.

CO-CHAIR ROSZAK: EMSS.

DR. CAIRNS: And in the rest of the language, we will -- we use the word systems, if that is acceptable to -- at least in the next draft for review by our partners.

MS. TURBYVILLE: We will figure it out. Thank you.

DR. CAIRNS: So the next charge was to look at a review of the domains. You will see, we added a new domain. Its current proposed title is Capability, Capacity, and Access. We kept the rest of the domains as we discussed. Next slide.

So here is the new domain one: Capability, Capacity, Access. There is a need to understand the capability, workforce, and
resources of a regionalized emergency medical
care services within a region to provide
emergency care.

Again, forgive some of the
language here. We will get the document in
place to make it more close -- closer to
English, acceptable English, and I like the
sixth grade level guise.

Second: Capacity -- Excuse me.
go back to second paragraph: Capacity can
change rapidly. Therefore, the measurement of
a real time capacity of this system to provide
timely emergency care is important.

The third: Regions can vary
widely in the access to care, either for a
defined population or within the defined
geography.

So that would be kind of the
outline and, again, forgive the language --
the outline for this capability, capacity,
access. So the distinguishing features are:
There's got to be a capability, but that
doesn't mean that the capacity is necessarily there. It is a dynamic and, clearly, how that capacity is then accessible to the population is another important component.

Domain 2 remained essentially the same.

Domain 3: We kept the first one the same for resource utilization, recognizing, though, that a lot of the resources for infrastructure, for capability, capacity are going to now be captured in Domain 1, we decided to refine the second paragraph.

So: include structural and process components at regionalized emergency medical care that catalog facility, specialty consultants and advanced service resources. So this was the idea that we were discussing yesterday on specialty. Frankly, it came up again this morning about specialty availability, capacity, and advanced care availability.
Page 74

1             Domain 4: Remained the same.

2             Domain 5: Remained the same.

3             Domain 6: We kept it the same,

4             Rick, recognizing that for the principles that
5             patient oriented processes now comes --
6             appears to be very important language to
7             include. Since this domain is entitled
8             Outcomes, we kept patient oriented outcomes,
9             but played around with the idea of adding
10            processes and outcomes to that first sentence,
11            or we could just keep it in the guiding
12            principle.

13            In the guiding principles, we
14            talked about how there should be patient
15            oriented outcomes as a key component. There
16            was a lot of discussion both yesterday and
17            today to capture patient oriented processes
18            and outcomes as a guiding principle. So that
19            is the language that we have been changing for
20            the guiding principle for the next draft.

21            This is a discussion now of the
22            domain of the outcomes, and the question is
whether or not to include patient oriented processes and outcomes as a key component to the domain.

Now one may argue, and I think effectively, that patient oriented outcomes are clearly going to be linked to processes, and so these things are not -- It is going to encompass processes. The question is whether or not we want to emphasize it in the language of the domain. Is that fair enough? Now we are at outcomes. I just want everyone to -- at least the thought behind this -- Again, this is just for your draft consideration, is that we really wanted to be sure we focused in on what is important.

DR. MARTINEZ: Can I ask? Can you just go back to where you have the processes. Multiple times people have said, the way you get things to happen is you have a goal, and the goal is not people should live; the goal is like we are going to get them to the operating room in such and such a period of
time. That is our goal. Right? That is our process goal, STEMI, our time with EMS, all those things.

So I think it is going to be the thing that we are going to measure to see differences rather than outcomes. Outcomes are sometimes really hard to see. So where is it in here? Back?

DR. CAIRNS: I think the idea is just linking those processes to outcomes. So the component of this domain is to recognize what are the important outcomes we are trying to achieve.

DR. MARTINEZ: So this is the output side.

DR. CAIRNS: Yes. Clearly understanding that the actual measures may involve processes linked to those outcomes, and clearly recognizing that this whole system is going to be geared toward outcomes. At least, it is evaluation.

So the focus of the domain was
really on outcomes.

DR. RINNERT: Just a couple of comments. I would remind us to put things like capability and capacity in a glossary of some sort, so people can understand the differences between those things.

I guess the other thing I am not seeing in our domains, and maybe I am just still not awake yet this morning, but I don't see an allusion to feedback process improvement where the system is learning from itself.

Every patient encounter or all of the things we are devising are intended to, hopefully, make our next patient encounter better, more efficient, more effective, and I don't know which domain that should fall in. Maybe it is the outcomes one, but I think there needs to be a strongly worded comment somewhere in there that talks about we are trying to do better each time, and the way we do that is because we are informed about what
we did the last time or the last 20 times, or
maybe the last patient that didn't do so well,
maybe the last patient that should have come
to the tertiary center but didn't, those ones
that fall out, the sentinel events, and how we
are sort of learning from ourselves, I don't
know that that is captured quite yet.

DR. CAIRNS: I think it is an
important process, you know, kind of the
quality management construct. Again, there
are four different ways that we evaluate
measures, and included in that will be a
quality construct, as has been alluded to.

So I think quality will be an
important goal. I think the management piece
will be -- we could put in suggested processes
or put it into that framework.

you know, frankly, when you talk
about units of service in an episode of care,
you are into a quality management construct.

CO-CHAIR ROSZAK: I think it could
probably go in all of these, but I think it
definitely needs to be addressed throughout this whole process. So I think that is a very valid point. I want to make sure we get that incorporated.

Let's wrap up with some comments, and then we will get into the small groups. So we've got Rich. We've got Gary. Art, I'm sorry, I didn't see you over there.

DR. ZANE: Just a brief comment.
I think this is a pretty remarkable endeavor, and the work that has been done has been really good, good work out of, really, what is a void.

One of the questions I have is about the juxtaposition of access and capacity and how you would define those with a unit of measurement or not, because they are so interrelated, and they can be perceived so differently.

DR. CAIRNS: So I think one of the concepts that was discussed yesterday -- It's okay if I briefly respond? I think one of
the concepts that we are trying to synthesize with that is that a capability of the system can vary widely, but is an important kind of key structure.

If you don't have a specialist or if you don't have an EMS system or if you don't have a destination hospital, that is really important, and understanding the parameters around those could be valuable.

A second piece is that the capacity of that capability can rapidly change. Demand would be one thing, for example. Infrastructure compromise would be another component that could influence that, or a lack of availability of providers could alter what the capacity of a capable system is.

Then the third component of access is how the patients actually are able to access such a system. You may have a system that is capable, that has the capacity, but if patients can't intersect -- for example, 911
doesn't direct or they don't have access to 911 or they are a vulnerable population without that first initial communication link -- then, clearly, there would be a compromise in access to a capable system with capacity.

That was the initial thoughts on how we might put those things together, because we heard so many -- we heard a lot of discussion yesterday about the key components to access. We talked about the challenge of capacity, but we also heard and recognize the wide variation in capability, say rural versus urban system, rich versus poor, and we have already talked about specialty distribution, heterogeneity.

Those are the thoughts.

MR. WINGROVE: Could you go back to domain 3? Is that one intended to only include hospital components?

DR. CAIRNS: No.

MR. WINGROVE: That is what it does, I think.
DR. CAIRNS: I think we could certainly add -- You want to catalogue services? But again, remember that the language for the slides is different than the language in the text, but we absorb your comments that we need to be sure we have the out-of-hospital components, although in the new Domain 1, just to be sure, a lot of the Phase 1 -- some of the Phase 1 things regarding EMS are going to be captured in the new Domain 1 under capability. Is that okay? This is more about resource matching.

DR. COOPER: Going back to our new Domain 1 -- this may be, not wordsmithing, but perhaps concept-smithing -- I think that your last sort of response got at the notion that the underlying principle here is access, and that access is limited both by entry into the system and by the ability of the system to respond to that need.

So I would begin -- I think we
really want to begin with access rather than
begin with capability.

Second, as the terms, capability
and capacity have evolved over the last
several years, particularly in the disaster
medicine world, as all of us know, generally
speaking, capacity refers to the stuff and
space, and capability refers to staff -- you
know, the capability to actually operate that
stuff and space to the benefit of the patient.

So I think we need to be very
careful with those terms, because they may be
misconstrued, and I think we should probably
try to congruent to the extent that we can
with the way they are being used in the larger
world.

So I would talk about this set of
concepts in terms of access first and capacity
second, and then last, capability to actually
operate that system to the benefit of the
patient.

So in other words, this is -- If
you want to think of it this way, the Access, Capacity, Capability is another way of thinking about input, throughput and output in different words. That is why I am glad Sally suggested this earlier, that it is such an overarching first domain rather than a last domain.

DR. CAIRNS: Well put.

CO-CHAIR ROSZAK: All right. I am going to turn it over to Sally, who is going to talk about the group activities. We are going to break into small groups of 10-15, and we will do that for an hour. Then we will reconvene in the big group.

So Eric and Sally will give us some guidance and some direction on how we are going to proceed.

MS. TURBYVILLE: Thanks, Andy. So this is the opportunity to really kick around these domains. We want you to go to your groups, and I think we will do Group 1 here. Group 2 can stay in the middle, and Group 3 at
that table over there.

There are some broad questions that we are asking you to think about. It includes the now six domains, making sure that the group discusses whether or not the proposed domains still make sense, based on all the conversations that have taken place, if there are any other missing domains.

Then also take a little bit of time to think about the overlap among domains, and I am sure there are some, but whether there is an opportunity to collapse or combine any of those. We are fine with six domains, but spend a little time thinking about that.

Then depending on which group you are in, we have a set of questions that Chuck and Jeff helped us sketch out that we want you to really take a critical view of.

So we are going to spend about -- how much time in the groups, Eric? -- one hour. Then come back. Ask one of your from your group to discuss what you guys decided
upon in that hour with the rest, and get the committee's reaction.

A goal here is really for us to walk away with a good final set of domains and subdomains, and if you think about these subdomains and the domains, they certainly touch all parts of the episode of care that we have been talking about.

The reason why they are so helpful is it really informs the measure developers and users and implementers. It provides them a context to think about these measures. So you will see some of them -- for example, coordination of care, certainly, is probably a bar underneath that episode. Others may focus on certain parts of the episode more than that one. But it does provide a lot of context for measuring.

So the goal is, as Helen alluded to yesterday, you can almost think of it as a tree, and we are providing the branches. then our hope is to populate these branches with
important assessments, measures of the quality of care that is being provided, if that is helpful. Yes?

DR. RINNERT: The domains we are going to be working with this morning are the ones we just evolved and are different from what we were provided. So I want to make us as efficient and sort of targeted as we can be.

Are we going to be given the newly defined domains with sort of their different elements, so we can be succinct or are we working off of what we were given yesterday, because it is not as --- We have sort of added some things, and I don't want it to get lost because we are working off of information that we had or the domains as we defined them previously.

MS. TURBYVILLE: Thank you, Kathy. I think, from what I heard from the changes in the domains, there is general consensus on that. Unfortunately, this was printed out
yesterday. So my request is exactly that, Kathy, that you think about the domains as they have been revised by the Steering Committee in the past day and a half.

I think the questions should still apply, but if you have other questions, they are really just to help you get going. We are not trying to restrict the conversation at all. We just wanted to do some of the pre-work for you and think about the questions, but as you get together with your group, if you think our questions are way off base, add your own. That would be fine.

DR. PINES: Just a question. So in these current groups -- so Group 1 is going to do detection and identification -- Should Group 1 do the capability, access and capacity domain or should we -- each group do that separately?

MS. TURBYVILLE: Our thought was -- Great question, Jesse. Thank you -- that we would have Chuck and Jeff work on that,
because we felt that, with a lack of preparation and time for it, it may be difficult. But to the extent that the individual groups want to think about that, if you finish early, you are more than welcome to do that. But we are going to continue working on that particular domain. We have even gotten input this morning on how to better contextualize it, and that will be something you will see in the next draft.

So we will get your feedback not necessarily on the subdomains in this meeting, but we will certainly get your feedback through email and conference calls.

DR. PINES: And just in terms of what these -- how these groups should be run, should we focus on the specific questions as an outline for the group or should we focus on some of the language or have a philosophical discussion? I am just trying to figure out what we are going to deliver back in an hour.

MR. COLCHAMIRO: I think it is
really a concrete set of recommendations,
looking at the specific questions and really
trying to provide any additional key points.
Really, it is more of a deep dive, giving each
group a chance to focus on each specific
domain, and again printed yesterday, so
recognizing that there have been some
revisions made already, but diving deep in,
coming up with some concrete recommendations
and supplementing some of the work done so
that we can look at it from maybe a different
perspective.

MS. TURBYVILLE: So, thank you,
Eric. So one of our biggest concerns is that
we are missing a domain, that we miss a
subdomain or that one of them is not quite
right.

We have talked about the domains
quite a bit as a group. So I think we have
come up with the six, but we want to walk away
today with what is pretty close to a final
set.
As far as wordsmithing, I think that can become very difficult in a group dynamic, but concept-smithing, as Art put it, is absolutely what we need. We need enough input to walk away today with the final bunch of domains and subdomains that will then provide this platform for measure developers, people who are building the data platform, what can we do now and do we need to do in order to do what we want in the future.

So it is both the here and now and the forward thinking. If you think about a domain -- for example, we might -- I do a lot of work in resource use measurement. So there could be a clinical domain of resource use measurement as one way to think about it, and within that there may be subdomains that are targeting very specific areas of resource utilization.

So we are still getting the big picture of what is going on with cardiac heart resources, but then within that there may be
clusters of AMI resource utilization versus CHF resource utilization that provide more concrete comparisons within, but clearly, we are still interested in the domain as a whole as well. So I don't know if that helps.

So it is an important task to get you guys' input on these domains, and so we do want some concrete recommendations back so that Chuck and Jeff can walk away with their charging orders to wrap up the next iteration of the draft of this report.

DR. RINNERT: I hate to say it again, but I think we need a copy of the most recent determination on how the domains -- what the domains currently are, because we are working off of something that is, while not antiquated, it is not quite as well defined as we had from this morning.

So I think, for our groups to be most efficient and to give you the best input we can, think we ought to have a copy of the new domains, because I just made little
scratchy notes on here. I just want to make
sure we are giving you our best effort.

MS. TURBYVILLE: We can put the
slide deck on the flash drives and hand those
out. Great. Thanks.

So as I said, Group 1 will meet
over here at this table. Group 2 can go ahead
and get together at this larger table, and if
Group 3 could go over there, we can go ahead
and get started.

Eric and I will come around with
thumb drives, so if someone could take a
computer with them to each of the tables, that
would be great.

(Whereupon, the foregoing matter
went off the record at 12:12 a.m. and resumed
at 11:48 p.m.)

CO-CHAIR ROSZAK: All right.

Welcome back, everybody. Sounds like we had
some pretty good discussion in the small
groups. So looking forward to hearing
everything you guys talked about.
So just to kind of give you an update of where we are at, it is 11:50 now. We are going to talk about the different groups. We have three groups that met. So we are going to have a report out from each of the groups, and then have a group discussion.

We are going to be serving lunch around 12:15-ish. If it is okay with you, we would like to make that a working lunch. So we will do a working lunch and, hopefully, finalize most of these issues, and then we will move on to the rest of the agenda as it was scheduled.

So for the first group, which dealt with detection and identification and also resource utilization, I believe someone was going to do the report out from Group 1. Who is the lucky person? All right. Nick, I will give you the floor. Do we have slides for these things or -- not really?

MS. TURBYVILLE: No.

CO-CHAIR ROSZAK: No, no, no, you
don't have to do slides. I wasn't sure.  

Someone is going to capture the notes and  

everything, I'm sure.  

MR. COLCHAMIRO: Yes. I will be  
capturing the notes here on the screen as you  
are going along.  

MR. NUDELL: Yes, I am the lucky  
one here. To start off with, we changed the  
name of the first one, Detection and  
Identification. We changed it to Recognition  
and diagnosis, and that is basically going to  
capture the first contact with help, whether  
that is a 911 call or an OnStar call or some  
kind of a call for help. It is the first  
contact. It would be a point of measure.  

So the next one, Research  
Utilization, was also one of ours, but we did  
not change the name of that one.  

So the general questions: We  
generally agreed with the proposed domains,  
although we had a suggestion for changing the  
medical care coordination to include --
MS. TURBYVILLE: Nick, I think this was where there was a discussion about the disease-specific care coordination and disease-specific resource utilization actually becoming subdomains in Medical Care.

MR. NUDELL: There we go, yes.

MS. TURBYVILLE: So in thinking about the domains of Care Coordination and Resource Utilization, those were fine except there was a desire of some of the group to parse out disease-specific care coordination and disease-specific resource utilization, and put those as subdomains under Medical Care. Did I get that right?

MR. NUDELL: Yes, rather than being separate. Right.

CO-CHAIR ROSZAK: Why don't you go ahead and give a readout of your discussion. Then we will open it up to the group. Probably makes the most sense, I suppose.

MR. NUDELL: So the next one, no domains missing, and overlapping domains --
yes, we feel there are some that overlap and
that that is a good thing.

Now the things specific to our
domains: We were asked to talk about when
does the episode of care begin, and I kind of
mentioned it already, but basically we feel
the episode actually starts when the symptoms
begin, but the actual measurement point is not
going to be reliably determined until somebody
makes contact.

So in the typical 911 world, that
is when the phone rings at the 911 dispatch
center. There is a time stamp associated with
that. So that could be measured.

The system components that would
contribute to it: We feel very strongly that
there is a lot of opportunity for things to
happen prior to that 911 call or prior to the
episode actually beginning that may prevent an
episode. So we feel that there needs to be a
lot of attention paid to what happens before
somebody enters the recognition phase.
So that puts a lot of overlap between the different phases, but we didn't spend a lot of time trying to solve that part, because that wasn't really part of our domain.

Next we were asked to talk about the system level measures that would impact this. So we left it pretty simple, that system level measures have to do with communications and being able to provide information to many different people who are trying to provide resources, whether that is the dispatch center trying to make sure the right kinds of resources go to a scene or the transporting crews trying to make the determination as to where they should take the patient, in the hospital trying to make sure the right resources within the hospital are used, and then afterwards post-hospital care, the right resources.

So there is a lot of different interchanges of information that all surround communication and being able to provide that.
So the system level measure is related to being able to provide that information.

The last question was patient centered episodes of care: Does that apply to this domain? We felt yes.

MS. TURBYVILLE: And I think, Nick, this is where earlier you were talking about the overlap of Phase 1 and Phase 2 and that these -- that for Detection and Identification potentially resides in both. Am I remembering correctly? Then Resource Utilization spans the entire patient centric episode and, in fact, the system as a whole?

MR. NUDELL: Yes, in capabilities and capacities and access, access could follow through throughout the whole episode, because it could be to special pieces to various things along the way. So that domain goes across the phases. Am I missing something?

DR. RINNERT: I think that one of the other thoughts that we had when you looked at our episode of care, there is that big
population circle, and then there is the interface between the population circle and Phase 1, kind of that gray area which is where identification traditionally would sit.

Certainly, there are population measures that -- There's things that are occurring in the population before an actual event is identified. We need to ferret that out a little better, and there is a huge gap in there for being able to sort of -- the pre-sentinel event.

The sentinel events are things that are happening before there is actually an emergency that someone recognizes and then reports. That is sort of where that gray area or overlap of Phase 1 and Phase 2 occurs. So there are opportunities to think about how do we have measures going on within our population so we might better predict and intervene before there is a need for emergency services.

Then, certainly, in Phase 2 and
Phase 3, there are episode measures that will inform what are the particular specific needs of that individual patient? Will they need an LTAC? Will they need other interventions within the hospital phase or follow-on care? Those are more episodic measures related to a specific disease or a specific management of a patient, which may be different than the population measures, and all of those will inform the system about what sorts of capability and capacity is needed versus what is already available, because there may be a disconnect between what is available and what is needed.

DR. MAIER: So I think, as an extension of what you were just going through, that we can educate the public or somehow intervene to shorten the phase of the time needed to make the recognition of the symptom, for example.

Did you folks think that that should become a part of the pre-hospital --
yes, thank you -- mission -- good word -- so that the paramedics, EMTs, that pre-hospital consortium. Is it part of that mission to actually provide that education to reduce the risk and shorten the recognition time?

DR. RINNERT: We didn't talk about what were the workforce needs to be able to address that. Certainly, a community paramedic or home health nurse or community patrolling by EMS providers or some sort of advanced care person would be able to more or less troll the population that they are responsible for and maybe intervene earlier, prevent the people from running out of medication so they don't dip over and have their CHF exacerbation and don't need to call 911.

That is all sort of in that population Phase 1 before you hit that gray area where Phase 1 and Phase 2 overlap, because when you hit that gray area, someone has made a recognition that something is not
right: I need to call 911.

That is a pretty reliable time stamp. I mean, that call is a pretty reliable and measurable kind of thing, but what we were interested in was measuring what was going on in the intervening days, weeks or months that brought them to that point where something finally happened.

So there are a lot of different workers who can --

DR. MAIER: But just as we have CPR training and so forth, could we expand those concepts to make it an even, as you say, entry into the recognition and entry into the system earlier to prevent them it from being a severe and acute episode or whatever, and minimize the emergency needs of the disease?

DR. RINNERT: Sure. I mean, how many times do I take care of the drunk driver in the ED who fell asleep in their car and didn't have an accident, and then further down the road that patient actually runs headlong
into another car, and now I have a bunch of people I am taking care of from a traumatic injury standpoint, when if I had intervened with the person who has the alcohol problem to begin with, there is a lot of prevention that -- just an example. So, yes, you are right.

MR. KIRKWOOD: I guess, to make sure that the question you asked got answered, was I hearing you ask that whether interventions in that symptoms to reporting time should be part of EMS's responsibility?

DR. MAIER: Yes, just as it is to teach CPR and so forth. Yes.

MR. KIRKWOOD: Well, I guess my answer would be EMS certainly plays a role in that, but at least as the world exists today, that is an optional component of what most EMS agencies do, because it is not funded by anyone, and the domain of people who should intervene in that is much larger. It is a public health issue.

CO-CHAIR ROSZAK: So it kind of
sounds like maybe one of the subdomains of your Recognition and Diagnosis category may be some form of public education or public awareness or something like that. Is that kind of safe to say? No?

MR. NUDELL: That is not really the direction. At least the way I was thinking about it while we were discussing it was it could potentially in many cases be the responsibility of the care providers who sent the patient home to start off with, and maybe there is follow-up from the staff, a CHF nurse or just various other people who might prevent it from happening.

CO-CHAIR ROSZAK: Mike?

DR. SAYRE: I think, not to get too down in the weeds here, but I think the issue is definitely one of trying to figure out the strategies to shorten symptom onset to actually taking action, and our group certainly doesn't have the solution to that problem. This is way bigger than just the
public education issue, and it is certainly
not clear to me who should be responsible for
that, but there needs to be a measure that
somehow -- and that has to be part of that
emergency, that system of care.

CO-CHAIR ROSZAK: I certainly
think, kind of comparing this to our fire side
colleagues -- I mean, everyone knows "stop,
drop and roll." Everyone knows smoke
detectors, all this stuff. There has been a
tremendous effort, public education campaign.
I don't know if this is the proper forum, but
there may be some stuff that we could draw
some similarities. Rick?

DR. MARTINEZ: Not to belabor, I
think the point has been made. Basically, the
issue here really, for us, I think, is to help
make sure there's measures, because now that
you know what you do and who does it and what
you have to do, all depends on what the issue
is and what is an effective countermeasure.

Could be anything.
CO-CHAIR ROSZAK: Skip, are you still up or are you done?

MR. KIRKWOOD: I'm done.

CO-CHAIR ROSZAK: Okay. So kind of getting back, I didn't really hear anybody articulate. Was there subdomains in Domain 1 or Domain 2 that we had kind of identified? I know you kind of got interrupted mid-stream. So I didn't mean to throw you off your pattern there.

DR. RINNERT: Do you mean Domain 2 and Domain 3?

CO-CHAIR ROSZAK: Yes, the now renumbered Domain 2. So the Recognition and Diagnosis domain and then the Resource Utilization domain.

MS. TURBYVILLE: I don't think the group really identified subdomains. There was discussion about out of hospital and in hospital, but because there needed to be integration, the sense that I got from the group was to not create these subdomains. Is
that right?

CO-CHAIR ROSZAK: I think, kind of in the same line of thinking that you guys were talking about, you know, recognition and diagnosis, I'm not sure what all that bucket would capture. Does that include things such as does this region have access to 911? Is it enhanced 911? Okay, so stuff like that would be in that domain? Okay.

DR. RINNERT: Yes, the right response to the right place to the right services. That had to do with whether or not, when you called 911, did they have the capability for EMD. So did you have an informed dispatcher who was engaging with the caller, whether it was a bystander or patient, in determining what level of what level of response to send. Is it going to be a BOS ambulance or ALS? Do I even have that in my bag of things to send? Am I going to send the lights and siren or not? All those sort of determinations about the level of response and
making that determination -- those were all
sort of subdomains of -- I think it was
Recognition -- or Response?

CO-CHAIR ROSZAK: And then on the
resource domain, was there discussion about,
is this an appropriate domain to place things,
like wait times, boarding, diversion? Are
these the kind of resource issues that you
guys dove into or do you see that fitting
somewhere else, in maybe a different domain,
maybe on call coverage, stuff like that?

MR. NUDELL: Those were part of
all of those pieces of information that would
need to be communicated to somebody. So we
didn't go into the details of all of the
different kinds. We just assumed that we know
that there are lots of different kinds of
resource availability kinds of information
that need to be shared.

MS. TURBYVILLE: And I also heard
from the group that, for matching resources,
that there is a real lack of infrastructure
that needs to be brought out in the paper, because of the -- yes, and communication being one of those, to provide the ability to appropriately allocate people to the right resource. There is such a lack of infrastructure there that would allow it to be at a regionalized system, that that should be a very big focus in the paper of what needs to happen.

CO-CHAIR ROSZAK: Go ahead, Ron.

DR. MAIER: I want to support what you are saying, but as an extension of that it also gives the opportunity to standardize that infrastructure also, which is another major part of the lack of infrastructure, is that everybody has their own wave lengths, their own communication equipment. It would be a very nice way to standardize as you provide that infrastructure, so that it can be interchangeable and intercommunicative among the various regions and states and everything.

DR. COOPER: Two issues that I
didn't hear mentioned that perhaps could be discussed at greater length are, first, the penetrance of professional level emergency medical dispatch systems.

A lot of people are not using Clawson inter-APCO. You know, they are using some home grown system which may not get patients to the right place at the right time quickly enough.

The other piece that I did not hear mentioned that may deserve some additional thought is the increasing availability of electronic systems for detection. Probably the prototype of that is the Advanced Automatic Crash Notification System.

I am sure that, as time goes by, we are going to see other similar kinds of systems through other types of disease develop. I mean, just as sort of a really way out thought, one could imagine that somebody is internal, implanted defibrillator could
have a chip in it that says I am starting to fail, you know, and let the pre-hospital system know about that ahead of time. But that kind of thing, I think, is something we have to think about for the future.

CO-CHAIR ROSZAK: Anytime you think about resource utilization, especially around this context, I always think of helicopter EMS, and I am surprised no one has brought up any kind of helicopter EMS issues yet. Skip, I'm kind of looking at you or Gary or somebody in that corner to maybe talk about it or at least address it, if appropriate.

MR. KIRKWOOD: Just a couple of thoughts. One is that it has always interested me that in other public response disciplines like law enforcement and fire, we have built multiple redundant systems. In law enforcement, you have a city police agency, a county sheriff, a state police and a national response capability in a variety of Federal law enforcement agencies.
Same thing in the fire service.

EMS is unique in that it is pretty much one deep everywhere until we get to something really, really bad, and when we bring things like the National Disaster Medical System to bear.

You know, it may be that, if somebody takes a more systems approach and the funding model becomes more rational, that you could very well use a helicopter as a first responder in an area that is 200 miles from the nearest ambulance station and four hours from the hospital, which would be far more appropriate than what we do today, which is fly people around over the top of large urban cities, and crash occasionally.

MR. NUDELL: Thank you for raising the EMD issue. I think we agree with you completely with that, and we did mention the electronic system detection concept. There are actually medical devices that do that also, like STEMI detectors and things like
that. So we are aware of that.

The issue becomes how do you have a standardized measurement across lots of systems, and the most reliable one at this point in time, we feel, is the first phone call or the first kind of notification into the system, wherever that comes from. That could come from one of those devices or somebody actually making a call.

CO-CHAIR ROSZAK: Other comments or thoughts about the group. I see Jesse, Skip, Nick, Kathy and Mike were all on the panel. Comments from the group? I think they have captured the flavor of the conversations well. Other thoughts about what may or may not be included in this domain? Any subdomains that you would like to see? Anything that might be missing? No? Good job.

All right. Maybe what we will do is we will take a break here and get some food between this first group and the second group.
Yes, let's grab the food, and we will take a
five to 10 minute break to grab some food.
Then we will come back, and we will do the
next two groups.

(Whereupon, the foregoing matter went off the record at 12:12 p.m. and resumed
at 12:27 p.m.)
A-F-T-E-R-N-O-O-N  S-E-S-S-I-O-N

12:27 p.m.

CO-CHAIR ROSZAK: Let's try to keep on task, and we will move the group, too. I think, Eric, you had a couple of brief announcements, just administrative-wise.

MR. COLCHAMIRO: Just as far as getting to the airport, I know folks have flights at different times. We checked with Sheila and our staff here.

There is a shuttle that goes to the airport every 15 minutes or so, and then as well there are taxis, apparently, lined up in front. So no need to reserve ahead. You can just walk out there. There is a bellhop who will flag one down, and it should be within minutes.

CO-CHAIR ROSZAK: Super. So, let's see, Group 2. They dealt with medical care, which includes the out of hospital care, the emergency department care, and inpatient care. Let's see, I've got Dr. Carr, Dr.
Cooper. Who else was on here? Dr. Zane --
oh, everybody, a lot of actors on this one.

Who is the spokesperson for Group 2?

DR. CARR: I am going to take the
first swing, and then I am sure the team will
pitch in.

CO-CHAIR ROSZAK: Sounds good.

DR. CARR: So going in order with
the questions specific to domain 4 -- now 4:

When does the emergency episode of care begin?

This one is the only one we had
consensus on, and we greed that it should
begin with symptom onset begins, not at first
contact with medical care. There is plenty of
dialogue to be had on the others. This one,
do you want to stop, pause, for each one for
people to feed back?

CO-CHAIR ROSZAK: I think each
group was asked that question. So we can
probably just move on.

DR. CARR: Very good, very good.

So what determines whether a patient receives
medical care that met accepted standards?

So now things became muddy for us promptly. So we started with the structure that, I think, is pretty common in this, which is to look at outcomes, processes and structures.

We decided that for outcomes, you know, hard outcomes are obviously the best, and the ability to meet accepted benchmarks for disease-specific, risk adjusted, morbidity/mortality rates is important. We think that that needs to happen at the population level, and what that means in terms of region or catchment is, obviously, something that needs to probably be better articulated, and a primary problem here is that these outcome metrics don't exist, which is why we very often rely upon the structure process proxies.

So we think that a key component here is to think about the data systems that exist and to think about how we grow those
data systems and what those endpoints would be if we grew those data systems.

So the second tier here is the processes. As I think this crowd certainly knows, the processes are all measured so that you can proxy an outcome that you can't measure or can't measure very well. So with the idea that processes are -- the aim of the process is to achieve an outcome, we thought that the gold standard here -- this is a -- well, I guess it is a silver standard, because it is not the outcome, but the standard for a process is whether or not the patient received evidence based interventions; as a second tier, when no evidence based interventions exist, we thought it was consensus based interventions.

Then key within this process is that systems level metrics be met that are not condition specific, and we will sort of circle back around on those again, but this is where we start to think about not measuring
hospitals, not measuring providers, but measuring systems.

With respect to the last one, the structure piece, which is -- So structures exist, obviously, to drive processes, all in hopes of driving outcomes. This is, I think, where we are stuck, because the processes that we describe above are very dependent upon the structure.

So we think that, just as in the first part we thought that there needs to be a strong push toward improving data collection systems for outcomes, here we think that there needs to be a strong push for driving some sort of systems collection inventory for resources and capabilities.

We couldn't get ourselves outside of the pickle that you can't decide what processes are the appropriate process for your system to meet until you have any clue what that system can or can't do.

So in the absence of understanding
whether or not a system has providers, resources, fixed structures, you can't decide what the metric to hold them to. An obvious and, I think, straightforward example is, you know, you could choose -- We have been using STEMI a lot here, and holding a hospital accountable to a time to cath lab metric in a hospital that doesn't have a cath lab just doesn't make sense. That is a nice clearcut one. There are lots that are much less clearcut, but without describing on the front end what your hospital can and can't do, it is hard to know then what standard they should be held to.

I have a couple of other things to say on this one, but I sort of, I think, maybe want to pause, because I am sure my team, who had plenty of opinions, might want to chime in.

DR. FILDES: We all agreed pretty much that the emergency episode begins when the patient recognizes something is wrong, and
the education of the public and the primary
and secondary prevention measures deployed in
the general population affect how quickly
people access care -- gain access to care,
understand the gravity of their illnesses.

That is really, actually, part of
a system of care. The participants in the
system of care are responsible to help educate
and prevent the public. The problem with that
is that it has got an uncertain time stamp,
but in the hierarchy of that, you put about
things being optimal but perhaps unmeasurable.

We thought it was important to
advance that as an issue.

The next one, what determines
whether a patient receives medical care that
met an acceptable standard: Again, we backed
into that generically. Obviously, outcomes --
the crude ones are lived or died, functional
status at the end of hospitalization, things
that have published metrics, easy to define.

Then you back down to processes of
care, and did they get their antibiotic
timely, did they get their medication timely,
were they seen timely. All of those kinds of
things are the next level of surrogates.

Then finally, the structural ones:
Did the health care provider or did the
location where health care was provided -- was
it adequately staffed? Did it have the
equipment and things to do what they were
supposed to do? Obviously, if you take
somebody who is in labor to a sports medicine
clinic, you are not going to get a very good
outcome.

The next one is how is emergency
care integrated across settings? We actually
had a lot of discussion trying to define what
that means, but if you go to the public health
documents from HRSA and so forth, integration
of emergency care across the system includes
essential services such as mental health,
social service, child protective, public
safety, prevention, community partnerships,
community health, and those sorts of things.

Now I am not sure that is what you were driving at. I would just pause for a moment and see.

So in order to integrate all of the kinds of things or even just to integrate with other medical services. Let's say, you integrate with out-of-hospital medical providers or integrate with post-discharge medical care and rehab or LTAC or integrate with the data frame that you are collecting. You actually need a system plan with governance and authority, critical elements of the infrastructure piece that you heard earlier.

CO-CHAIR ROSZAK: Our group took a similar approach. I was not the author of the question. So I don't know who was, but --

DR. CARR: You know, I would push back on that. I think we had a rich conversation in our group about whether or not this governance authority I was referring to
is a top down piece to build the system is important or if you change the incentive, which again is vaguely top down, and then allow people to innovate to get to that incentive, which is richer.

The example, the concrete examples, that we talked about was the trauma system is a relatively top down approach where you are credentialed by whatever your credentialing agency is as being a Level 1 or a Level 2 or not, and Mission Lifeline sort of went the other way and allowed facilities to declare themselves to be a STEMI receiving hospital or not, and then offered to help to identify existing networks based on who was referring to who, who was doing cath, who wasn't doing cath, and then it allowed the community to sort of build that up themselves.

At the end of the day now, if the metric becomes time to transfer if you are a non-cath lab hospital or time to cath lab if you are a cath lab hospital, the system still

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needs to all work together. I have more to
say about that, but I see Dr. Maier's hand is
up.

DR. FILDES: To finish up, though, if you have a system with a lot of elements in
it, and you've got an element of out-of-
hospital medical personnel and in-hospital
medical personnel, and you've got disease-
specific programs and you've got an
information frame running, there has to be a
way for them to relate to one another in an
organized fashion, for them to integrate all
the things that they do.

In general, that is going to
require oversight by someone in authority,
leadership by the personnel in the system,
finances as an underpinning, and an
information framework in the background. That
is directly from HRSA's public health
document.

So the other things, I would just
say that required elements for a system of
care, really, to do this are legislative
authority, lead agency, and sufficient
financial underpinnings to carry it forward
and to be transparent in the public realm with
regard to the care provided. That is how I
would just see that.

Then the last thing I am just
going to talk about is what system level
measures are important in assessing the
quality of emergency medical care.

You can only measure things that
you can answer yes or no to, you can count, or
that have units of measurements associated
with them, such as time, weight, volume.

So in terms of doing that, we got
down deep in the weeds about some of the
disease specific things, but you can back up
from that and just talk about general response
time, seen times, transport times, time to
seen in ED, all the standard measures that are
already in place for many other things.

I don't think there are any new
and imaginative measures that haven't already been tried out. That's all I have to say.

DR. MAIER: Well, I guess, sort of just, I think, to reinforce what you have heard, and that is whether you use the top down or the bottom up approach, and I think both have to be used.

If you are looking at structure processes or outcomes, it seems what works is having data and making it transparent. We use the examples of the New York CABG outcome studies. The reason why it improved dramatically was they collected the data, and they shared it with the public, and all of a sudden cardiac surgery became much safer in New York state, and it is pure data and transparency.

I think you can use that to utilize again the infrastructure, the processes that you happen to pick or the outcomes, but you have to collect the data, and you have to share it, and it has to be
transparent and used.

    I think the second part is, if you
take it that way, it makes it somewhat
simplistic, because with data you can make the
system move the direction you want, because
everybody sees it, and everybody wants to do
well.

    The second is just to reinforce.
I think you have to have an oversight
structure which is global, and we have never
had that. So if you want various silos to
work together, you need to put them underneath
the same oversight structure and not under
different ones, because then we all play those
games at every level in our lives, in
business. Everything plays that system
against itself, and you get nowhere.

    So I think, if we are really going
to move this system forward, this system needs
to be under one leader or one leadership model
and not left in a bunch of different silos
under different leadership so that it can be
continued without moving it forward as a common system.

So I would just push those two concepts as major goals that we need to do to move the overall system forward.

DR. CARR: To add onto that, the question -- On some level running through all of this is how much of this can NQF can do? How much is our mission versus how much is a legislative mission?

So as I was trying to think concretely about this, I offered something that I had offered to the group. I offered it internally, and we had a dialogue about it.

That is, how much should there be shared risk, shared reimbursement, shared accountability for unplanned critical illness? The very specific examples that we were using was, I think we talked about cardiac arrest and we talked about whether or not EMS's reimbursement should be tied to the ultimate gold standard, patient outcomes, even though
they are very, very proximal, and even though they may do perfectly on their process measures, because there is no gold standard for them. They are not the end of the chain of survival. The end likely happens as an inpatient or upon hospital discharge.

If we think the gold standard is the patient's outcome, should we be advising CMS, should we be advising the metrics makers to be thoughtful about how they can make both the hospital -- or the multiple hospitals in the region and the EMS system all have skin in the game. So they are all dependent -- their dollar reimbursement is all dependent upon the overall outcome, no matter what their part in that game is.

You know, there is conversation about this, and not everybody felt like that was a fair thing to do. I look forward to the group's conversation.

DR. COOPER: It isn't that all of us didn't think that was a -- that there
needed to be shared accountability, but that
the system of penalties and rewards needed to
be aligned appropriately with the degree of
collection to a particular outcome.

By definition, every component of
the system can really only be measured, in and
of itself, by its intermediate outcome, for
what it can do that particular phase of care;
whereas, the system as a whole can be measured
from start to finish. Very hard to hold any
individual component to that standard.

In America, we are in some ways
the victim of our history and our politics,
and we were so afraid, when the Republic was
founded, of tyranny that we divided --
separated and divided power so completely that
at times everyone is at odds with one another,
but to look at the disaster realm for a
minute, one of the things I like to say is who
is charge? Well, everybody is in charge of
what they are in charge of.

I think that is the kind of model
that we need to adapt here, to follow on both
Ron's and John's and Brendan's points. In
circumstances where this has been achieved,
where some measure of joint accountability has
been achieved, it has always been in the
context of a public/private partnership, that,
if you will, as we in New York like to refer
to them, the heads of the five families kind
of get together around a table with an
appropriate official from public health or
government, and they work together to come up
with a common public health oriented solution
that works to improve the system as a whole.
It is not unlike a unified command kind of
concept in terms of disaster management. But
in effect, that is what we are talking about,
 isn't it?

When I am speaking to disaster
oriented people, I sometimes refer to our
emergency care system as an individual
casualty incident as opposed to a mass
casualty incident, but the systems of care
that are required are not unlike one another in that the patient is like a baton in a relay race, and it requires every runner to sort of do his or her thing to make sure that the baton doesn't get dropped. But there's got to be a coach, and there's got to be somebody overlooking the whole thing.

Again, it usually works best in the context of a public/private partnership. Why? Because the public has the authority, and the private has the expertise. If we can bring those together and find a metric that, in effect, guarantees that warm and fuzzy togetherness, we will be a long way down the road, a long way farther down the road than we are right now.

DR. SAYRE: I just wanted to agree with Brendan and echo that I think that implementing this shared accountability model is critical for really making these regionalized systems work, and that the genius of this group, again, is that we are kind of
thinking that through, and we don't necessarily have all the answers right now, but I think this has really got to happen.

It may be that EMS, for example, in cardiac arrest is held financially accountable for what happens in the hospital, to some extent, because they control what hospital a patient goes to. If the hospital isn't participating and engaged in the appropriate way, then maybe they shouldn't be taking patients there.

MR. KIRKWOOD: I guess, building on what Dr. Carr said, I will go back to my point about a system capability index, because depending on the environment, EMS could do everything just fine, and the hospital could do everything just fine, and because the patient was so unfortunate as to experience their cardiac arrest 150 miles from the hospital, the outcome could be suboptimal.

So if we are going to reward either system components or systems as a whole
financially based on outcome measures, then we have to put those within the realm of the possible, which is, to come degree, varies every place.

DR. CARR: That is a really important point, and I apologize if we weren't more explicit about it. So the CABG reporting stuff is an important thing, too, because you know in whatever report injury outcomes or any outcomes in health services research literature without appropriate mixing and adjusting, and part of the case mix adjustment in unplanned critical illness, I think, is geography or is access to the right resources.

It just sort of echoes back to the fact -- As part of Number 2, I was saying, you almost need a separate set of processes for each set of structures, and one of these structures is whether there is a cath lab at the hospital, whether you are 200 miles away from the hospital, all of these pieces.

This is the piece where I think
where we are the most stuck, is if we don't
know -- It is hard, without having the lay of
the land, to know what processes people should
be held to. I don't know how we get around
that. Maybe it is to hit -- But here you
don't mean outcomes data. Here you mean some
basic logistics about or some descriptives
about what the hospitals can provide 24/7/365.

DR. FILDES: What I am hearing is
a discussion of why no one of these elements
on its own is enough, but why there needs to
be multiple elements joined together to really
oversee the medical care portion of this.

So it starts with the authority to
create a system plan and to monitor what
happens within the system, and it is laced
with financial incentive and disincentive and
perhaps even legal or regulatory incentive and
disincentive, and gap analysis that leads to
improvement through data framework.

We have heard all those things,
but I think that is how the puzzle pieces come
DR. RINNERT: It occurs to me, and I am surprised it hasn't come up in my mind before this, but as Brendan was talking, it occurred to me that we haven't really talked about taking the population's needs and marrying them to what the system provides.

So in other words, we need to look at the populations that we serve, which may be different in one area of the United States versus another or in another country, and you look at their disease burden, and you look at their risks.

Some of those risks may be age or comorbidities or the geographic location where they are at or the activities that they do.

You take the population needs, and you could, in fact, predict what resource -- what injuries or diseases they might get, and then you could then say, well, based on that, we then have these -- this is the kind of health care system that needs to surround this
particular population.

You would -- It is almost like the old fashioned certificate of need thing. When we were first looking at building hospitals in this country, you had to submit a CON, and it had to name who is this particular population that you are serving, and why do you think you need three hospitals or two hospitals, whatever.

So it occurs to me that -- and maybe this discussion has already gone on in other forums that you all have engaged in, but it just occurs to me, we haven't really mentioned that, and thinking about what is the population that is being serviced and their disease burden and their risks. Then you develop a system that will address what those needs are.

So you would have population measures that would help you understand what the needs are, and then you would have system measures based on what those needs are that
you need to meet. Then you would have disease measures.

I don't know that we have necessarily thought about systems development in that way, but as Brendan was talking, that was kind of what was occurring to me. Since they are the ones that are talking about data collection, and we don't have data to say how many -- or what the performance needs to be, it just tumbled to me that we haven't necessarily included -- We can build a lot of things, and we can measure a lot of things, but are we really meeting the needs of a community or the population we say we are serving?

I don't know that we have that information as part of informing the system.

DR. MAIER: But that is why we have put such emphasis on the data component. Just based on that -- you know, whether it is the structure, the processes, the outcome, whatever level of the process you want to look
at, we need more data, and we need good data so that we can validate both need -- you know, how many cath labs do you need, where?

    That is how you build the system with any logic. Then you monitor the system with, again, data on the outcomes, and make sure that your plan fits the needs of the disease and the population.

    As John just said, then you look at the gaps based on the data, and you fill the gaps in. But again, the one thing that it really requires for it to work is somebody has to be in charge. I sort of personally agree with the public/private mix.

    I think that those are the kind of systems that worked well in the past, and I think that is what we are evolving to. But we have no consistent oversight. Whether CMS wants to take it, or whomever -- I mean I am not going to say which entity should do it, but somebody needs to or we will never get these disparate processes on the same page as
far as a system goes.

DR. COOPER: You know, part of the reason that that kind of planning process has come unstuck is because the health care costs continue to rise, despite that kind of planning process, and in and around the late Eighties, mid- to late Eighties, early Nineties, people said, well, this planning process has failed; we really need to go to a market solution whereby we individually negotiate rates with hospitals, providers, etcetera, etcetera, to drive the costs down that way.

That having been said, I think there is a perfect example of the fact what you are saying, Kathy, should work and can work does work, and that is, for all of its faults, the VA system.

They function in terms of their resource allocation just in exactly that way.

It is a mutual planning process that involves the entire system, but the system has
governance, and every hospital has to make its
case for the number of providers and the
amount of resource that it needs, based upon
the population that it served.

With the advent of quality
measures within the VA, from which the NISQIP
system that the College of Surgeons uses, as
you all know, was born, that, I think, in many
ways is the proof of the pudding.

To me, while America being
America, we are never going to be in a
situation -- maybe not never, but certainly
for the foreseeable future, not in a situation
where we are going to see individual hospitals
collaborating, sharing data to improve best
outcomes and so on, I think a strong argument
can be made that emergency care is a public
good and that the public has an absolute right
to do that for emergency care, because there
is no caveat emptor involved.

You know, the public can't choose.
The public has got to go where the system
takes them or nearest trauma center, nearest
STEMI center, nearest stroke center, what have
you, when they are in the kind of mental state
where they can't make an informed decision.
So the public has to make that decision for
them.

Under those circumstances where
the public has to decide on behalf of the
individual citizen, because he or she cannot
do so on his or her own, I think a very strong
argument can be made that the public good
model applies, and that, therefore, it is
absolutely necessary to have some kind of
robust system of governance in place that
links the health care system with the public
health system with appropriate authority to do
planning and rational distribution of
resources.

CO-CHAIR ROSZAK: I definitely
agree, and I like -- Kathy, I like your
suggestion. I like your observation. I think
there is definitely a need for more public
health-like integration into these systems, and based on local community need or regional need, it makes all the sense in the world. It is something that we, honestly, have lacked.

DR. RINNERT: And I think it is interesting, if you look at bullet point four, which I think was trying to capture what I was saying, I think it is worded the opposite; because what we are saying is we are taking -- What the system provides, we will try to make sure it -- We need to define the needs of the population, and then you build a system that addresses them, not the other way around.

DR. MAIER: I like what I am hearing, of course, but I think this is a different meeting. Ours is about the measures, and this is like how and what people should do.

I will tell you, I think it will change over time how you use the data, and also it depends on how you are paid to do things. I have been in a very capitated
environment, and you are stopping people from
going in the hospital, and instead of becoming
a colleague, I became a cost -- right? -- in
the ED.

So those things change. So I
think all you need to do is make sure that we
have a way to look at the population you
serve, what the problems are there, and then
what the system should do and how it does
everything else, I think we need to leave
open-ended for a change, an innovation, as
things go down the road.

CO-CHAIR ROSZAK: I realize we are
still up against the time clock here a little
bit. So I want to keep things moving along.

I did want to bring up, just
because I know it came up in a couple of
groups, especially about this medical care
domain. We have heard a little bit about the
time stamps and door-to-doctor and 911 to
arrival and all this kind of stuff.

I just wanted to know if you guys
had any discussion. I know a lot of areas in the country are kind of moving away from lights and sirens to every 911 call now, triaging it along with emergency medical dispatch.

I just would hate to see us set a vision or a future out there where we are still responding lights and sirens to every little minor thing, a stubbed toe. It is a great liability. It is a lot of risk. It puts the public at risk as well as our providers.

Was there any discussion of that in the group about how we can kind of move away from those time stamps?

DR. RINNERT: I think our group addressed that, in a way, because we were sort of thinking about how do you determine -- We think it would be ideal if every call for help was addressed and provided with the services that were matched for what the need was.

That is done through a scripted
interview between the dispatcher and the caller, whether it is a bystander or the patient, to determine the level of need and then responding in like fashion, whether that is with BLS only. Maybe it is ALS or --- and also then whether it is lights and siren or it is a cold response.

So we sort of addressed that and said that we thought that there was opportunities, and there are examples out there where that is what is done every day.

MR. LOYACONO: We certainly talked about that issue. You know, about the only response time standard, if you will, that is out there is -- and you should get a name, though -- first responder is here in four to six minutes, and ALS there in about nine minutes.

A lot of places adhere to that, but it is based on cardiac arrest survival. If the public has any knowledge of that, they go, oh, you know, all the ambulances are
supposed to be there within nine minutes. But most of what emergency ambulances run on in this country, 80 percent-plus, I would say, is really non-critical emergent situations.

To perpetuate that metric, many, many systems still run lights and siren to everything. It is in their policy; this is what we do. There is plenty of evidence to suggest that that is dangerous and not the smartest thing in the world to do, and I think we clearly don't want to do anything that would perpetuate that.

Rather, I think it would be good to start someone down the path of defining what is an appropriate response, and when is it appropriate to respond hot or cold and, as Kathy is saying, many systems don't have the tiers that APCO is based on, that Clawson is based on.

In my own system, we have nothing but paramedic-level ambulances. So it is kind of pointless to have a BLS response, because
we don't have one to send. Likewise, you will find places that don't have anything but a BLS system as well.

I think it is a very important point that needs to be pushed forward, if we get the opportunity.

DR. CARR: But in the absence of -- I appreciate that we don't have evidence, and I am very glad, Andy, that you brought this up. But in the absence of having evidence, what we do is we come up with consensus, and this room right now could tell you that probably running lights and sound for every non-urgent call is a bad idea.

So doesn't the metric then -- Doesn't this just get concretely boiled down to the metric of you must have guidelines in place that are consistent with the consensus opinion, and I am sure that the National Association of EMS Physicians and the other organizations that I am too ignorant to know about could provide that, if it was an
important thing to provide that, and that at the county and the state level or the local level, wherever the rulebook is made, if it were a metric that you had on the books, something that was consensus bound, that would happen. Right? So that is metric one.

Can't metric two then be for the EMS system, their compliance with their rules? You could know when they run lights and sirens above and beyond when they are supposed to, and you can know when they don't, when they are supposed to.

So a proportion of runs that are consistent with policy -- seems to me, that those are two very low hanging fruit -- well, the first one, not so much; the second one, a relatively low hanging fruit metric.

Those data -- I apologize that I don't -- I am way outside of my domain. So I don't know that data, and I am ready for the beating, but I don't know if that data exists, when you ran lights and sirens, when you
didn't, and I don't know if there is really consensus about what proportion of the time for each condition it should be.

MR. KIRKWOOD: There is probably not evidence, but there is strong consensus, and those are simple mandatory data elements of the existing National EMS Information System. So it is there. But I think we got to make sure that we don't throw the baby out with the wash water.

Using red lights does not necessarily equate to trying to drive real fast. Probably the most useful time you can use red lights on an ambulance is when you are going 12 miles an hour in a snowstorm, so people see you and don't hit you, for example.

So I think we have to carefully tailor, but whether you have -- My system is like Tommy's. We have all paramedic ambulances, but we still use the Clawson classification system, because not only does it separate ALS from BLS, but it separates
resuscitative, urgent and emergent things and others pretty well.

So it is out there. It is a matter of, again, providing incentives for that to be used, which don't exist, and this is another place where we got to reach outside the health care; because I'll bet in half the land mass of the United States that 911 and emergency radio communication system is fully controlled by someone who is not in any way, shape or form part of the health care system. That is the county Sheriff, who owns that and who decides whether the dispatchers will provide EMD or not.

So if there was a buck attached to it someplace, he would at least have a conversation.

MR. NUDELL: I just wanted to address the data side of that question. When it comes time to actually documenting these, I think we need to be very explicit in what exactly we think we mean when we say -- I am
not saying that we would use response type,
but using that as the old example, there are
five different starting time stamps for
response time and another five ending time
stamps.

So we need to be able to -- So there is no standardization. So to just say
response time is not well defined. So when we get to identifying things, we need to be very
specific, down to naming the field in the data base that is used or the function that it serves. Otherwise, there won't be any standardization.

DR. RINNERT: I was just going to support the fact that there needs to be a
standardized definition and a standardized way so that, when you are measuring systems and comparing them, maybe two neighboring systems, that there is parity in the way things are being compared, so that it is -- you know, they are measuring it differently so they look better than me.
I am just pointing up a generic area over there, not any one individual.

MR. WINGROVE: We also need to be mindful of the fact that some of these decisions and discussions about EMS at the local level get made in a political and patient sensitive -- or a patient satisfaction oriented environment.

Having once been forcibly dragged out of an ambulance, because I responded without my lights and siren to what the bystanders perceived to be something real emergent, like a -- I don't know, a gunshot wound to the finger, evidence is fine. Safety is fine, but again people who are not part of our world get to have a vote in some of this, and we have to be mindful of the impact of that.

CO-CHAIR ROSZAK: All right. We would like to move on to Group 3. I think Tommy has the great fortune to report out to the group. So I will turn it over to him.
MR. LOYACONO: Well, we had a robust discussion, and we have a lot of agreement with what I have already heard here from the other two groups. What we didn't have is consensus on who was going to report. So I would like to call on the other members of the group to fill in the gaps, since I am working off of two sets of notes here.

With regard to the general questions, we do believe that the six domains that have been identified are just fine. We don't think any are missing. We didn't really find any overlap among those domains.

We did recommend making a change to the name of the third domain. In the second bullet, we think you should put a period after the word care, so that it would say "include structural and process components of regionalized emergency medical care."

With regard to the specific questions, we believe that the emergency episode of care begins at the point in time
that anyone recognizes that a potential need
for emergency care exists. So not just the
patient, but the bystander who walks by and
sees the guy laying on the side of the road.

    We recognize that it is hard to
capture the data on that, but oftentimes it is
available, especially with the advent of
cellphones where 911 is concerned. A lot of
times there is a bystander there, and in the
course of asking the questions you say, you
know, when did this first happen? So we
believe that the attempt ought to be made.

    What system components are
necessary to coordinate care across the
settings? I guess I should slow down, in case
there are any -- Okay.

    Rick provided us with some nice,
neat packages: data, communications, clinical
pathways and protocols, handoffs which we call
interfaces, and feedback mechanisms.

    Some of the specifics that we
talked about was the availability of an
electronic health care record throughout the continuum of care, so that there is data sharing and data integration, and everybody within the system is able to get outcome data, understand where the patient went, what happened to him, that sort of thing.

We talked a good bit as well about shared governance and accountability. How patients are being routed within a system: In my own system, I am accountable to no one outside of my organization for what I do, for the most part, other than license my people. It is just not appropriate.

There has to be some governing entity that controls the whole system, if we are going to get good data sharing, if we are going to get people working on the same path, and it is done at a local level in a lot of places, but as we think about a regional system, that we really have to think about a governing authority of some sort.

What system level measures are
important to the system? The coordination of appropriate care across the geographic and populations. Packages: Again, cost, morbidity, mortality, unscheduled returns, unscheduled admits or readmits, rather, absence or presence of the structured protocol to guide the system -- goes back to governance.

Are there patient centered, efficient, time sensitive, and appropriate cost efficient matrices that are based on acuity? This got into the discussion that we just had about lights and siren to everything. But basically, level of acuity should have something to do with what -- just how fast you are moving, not only in the pre-hospital setting but otherwise.

Then what outcomes are important to EMS systems? Let me look on the other page over here and make sure I didn't miss anything. Final outcomes communicated to all the units of service; transfers to the
emergency department and transfers to higher
depth of care, with and without admissions;
readmits, both to the ER, to the hospital,
within some period of time to be defined by
somebody besides us; unscheduled returns; time
to mortality in some number of days; being
able to capture patients that return somewhere
else.

I think it is a moving target, but
somebody comes into your system, goes out and
shows up somewhere else in a short period of
time. The system needs to be able to identify
that as a fallout.

I think that is what I have.

CO-CHAIR ROSZAK: Yes, I think the
buckets or the subdomains, the data, the
communications, the clinical pathways,
protocols, the handoff and transfers -- we had
a lot of great, kind of neat discussion of
what exactly those meant.

Even data like you just alluded to
-- do we know that this patient has been at
three of the four hospitals in the region over
the last week? You know, is there some kind
of a public health surveillance component here
that, hey, all of a sudden, X, Y and Z is
becoming a real problem in our region; maybe
there is something going on.

Communications: We talked a lot
about online and offline medical direction for
EMS providers, and where is that headed, and
where has it been or where is it heading? Is
there a single point of contact for the
ambulance? Could I call from the ambulance
and say here I come with this patient, and get
a response on what hospital is open, which one
can accommodate me, where I should go.

Clinical pathways and protocols:
A lot about do they exist? Do we have them?
Are they standardized throughout the region or
at least very similar? Is there some kind of
a standard EMS drug box, which amazes me that,
depending on what county I am in, I have to
lock up certain drugs and get all other drugs.
Then also in the handoff and the transfer section, not only handing off between pre-hospital to the emergency department, but then that whole piece of inter-hospital transport, and then also a piece that is usually overlooked, the 911 call to the EMS, the handoff.

So is there data there that is being captured, and it goes back to a lot of what you guys were saying in your group. Then the unscheduled returns, including repeat use of 911, repeat use of emergency medical services, all that kind of stuff?

I think, Rick, anything else?

DR. MARTINEZ: I think you have got most of it. I was going to say, the issue of governance. I don't know if you mentioned it, but we looked at it. We started looking at communication and feedback to the system, and realized that is a big problem in terms of capability, is the loss of the patient, no feedback.
So we talked about making it a learning system and use that as an overarching concept of being a learning system. So you are constantly giving feedback between the various players within the system, so that you are always constantly growing.

Then the thing I was going to say, we looked at it at interfaces and having a structured way for interfaces to occur. That is going into the hospital -- within the hospital, and then within hospitals. Right? So we see those as places where the -- and you can frame these things in terms of patient safety and efficiency, all these things.

The other thing I would throw up is just one in terms of the last part. Tom, I think we talked about cost or finances as being there in terms of outcome measures. I don't know if we had mentioned that or not. Did you? Okay, that's fine.

Then the other thing I would throw up is that 3 and 4 are really ones that you
could do a matrix that had at least input, throughput, output, going back to Tom's point or Art's point, and then compare that against the IOM attributes. Right? So you could have those things, and input, throughout, output in transition. That may be a starting point for a matrix.

CO-CHAIR ROSZAK: And I guess one more thing as we think about care coordination and particularly the governance part. Looking at the training, the certifications in that region, do people all have the same level?

DR. MARTINEZ: You know, we didn't put workforce, and we should have.

CO-CHAIR ROSZAK: Right, and looking at even equipment, how many times do you go to a hospital, and I got to start this kind of IV, because they carry this brand, and this kind of IV because they carry that brand, and some are needleless, and some aren't, and all this kind of stuff. So that is a very important part of the governance structure as
well.

Comments from the group?

MR. WILLIAMS: I just wanted a quick clarification. I apologize. Could you guys repeat your title change and where that specifically was?

DR. MAIER: I think it was under Interface. Was it five? What is the one with the second --

MR. LOYACONO: It is Domain Number 3 of the new domains.

DR. MARTINEZ: It was the second paragraph in one of the domains, and we just thought you could stop it earlier. Keep going. Right there. You see where it says "includes structure and process components of regionalized emergency care" -- period, is what the suggestion was, because it may be limiting.

DR. FILDES: I just want to bring up a comment from our group that didn't carry forward, but I thought this group might just
want to consider.

Under Medical Care, there's three subdomains. So if one of the domains was out of hospital care, logically the other domain would be in-hospital care, and then under each of those would be additional branch points or subdomains. Just from a logical point of view, that was a comment I made.

CO-CHAIR ROSZAK: Any other comments about the domains or the work we have done on the groups today? Pretty exhaustive list.

All right. Well, at this point we are going to switch over then, and be assured we are going to put the timeline back up here in a few minutes, and I want to make sure that you all know that you will have additional opportunity for input and comment on all this stuff, and our great folks at UNC are going to put this all into a nice document that we will be able to see and look at and examine together.
So I guess that kind of leads us into our next section here, which is the committee priorities for the second draft. So I would kind of like to take just a little bit of time and maybe just go around the table just so we capture everybody's thoughts.

You know, as we have spoken about, UNC is going to be redrafting this framework based largely on everything that we have talked about in the last two days. So I guess I will start with Jesse. Is there any kind of take-home message of the last two days' discussion? What is of the utmost importance that you want to make sure is reflected in the document? I know it is hard to pick just one or two things, but is there any direction or any charge that you specifically would like to give to the UNC folks?

DR. PINES: Sure. This is something that I have said before, but just make sure that we consider symptoms versus diagnosis, and that that is factored in.
Also, just adding into especially a lot of the definitions and wording wherever we say life threatening to say potentially life threatening, which I think would encompass a large group of patients, and also that patients with sudden symptoms would also benefit from regionalization, even if they don't have the true life threatening disease.

DR. MAIER: I think we are woefully short on data, which is amazing at this point in time, and I think we need to provide the infrastructure and the mandate that data be collected on whatever topic you want to name, and use that data, make it transparent, and utilize that data in an overarching shared authority, shared accountability ruling model so that we have somebody who we know is in charge, give them the mandate, share it with the caregivers to develop a combination accountability to move the process forward.

DR. FILDES: I would just say that
the work here is very good. The sets of care
and the domains and everything really mesh
well. I would say that the measures are out
there. They are commonly in use. They may
not have peer review substantiation, which I
know you seek, but response times are long.
That is usually bad, and if response times are
short, that is usually good. But I think some
of those things are never going to be tested
out.

So I would make a plea that we
consider using some of those things that we
know are valid but that may not have met
scrutiny at the level of peer review
publication.

I would also echo what others have
said, that we were asked to come here to talk
about measures, and what we have spent a lot
of time talking about is how to construct a
system that can measure itself.

DR. COOPER: I think that, as Ron
has said, that data is really at the core of
what we are all doing here; and as John has said, without a congruent system to collect that data, trying to develop quality measures is extremely difficult.

I think that there are two things that a document like this could do that could really help us move in those directions. The first is to make a strong case that emergency care is a public good and, therefore, requires a level of system oversight that the rest of the health care system doesn't necessarily enjoy.

Second, as the nation's health care information systems continue to be refined, that are hospital discharge data abstracts that explicitly address emergency conditions include at least an initial set of vital signs so we can get some sense of the physiologic derangement that results from the time sensitivity of these conditions. I think that would go a huge long way toward helping develop a rudimentary set of measures that
could help us achieve our collective goals.

MR. KIRKWOOD: I agree with my colleagues to my right, and I probably agree with my colleagues to my left.

DR. MARTINEZ: I think there is a lot of opportunity here. A lot of us around this table -- it's funny. We have been dealing with systems issues for years, and yet health care still hasn't figured it out.

You know, Walmart can track a pallet of sand around the world within 15 seconds. We lose them in the waiting room. There is an issue there. But with the changes going down the road, the financial survival of a lot of these health care hospitals and stuff will be dependent on our ability to work with others, I think.

So this is a great opportunity kind of created into a model. So my -- I am very impressed with what I have heard, but I do think we need to make sure that we just don't have a document with a bunch of metrics,
but there is a model there that people can see. But I think in the end they have to see it as flexible and adaptive, because my experience in California with -- They kept changing the way they paid every like 22 months, is that you kept trying to change, and the problem with something that is too restrictive is you block innovation and change, and so people don't adopt it.

So I think a lot of the measures and things like that here will change over time in how you address things, but I think we just want to make sure we are flexible, and it drives patient focused outcomes. That will be the best of all worlds, in my view.

DR. ZANE: I just want to reiterate what a great process this has been and what a great product so far has come out of this.

I think I would encourage as we look at pre-hospital care and out of hospital care that we require that practice is evidence
based, just as we are requiring it in the rest of health care, which has been very late to the table for pre-hospital care, and that as we look to processes we don't overcomplicate the issues and focus on blocking and tackling, and look at simple evidence based metrics.

DR. CARR: A couple of people have commented on data. I would like to add one piece to that data element. Often when we talk about data, we talk about outcomes data, and I think that we -- in our group it became very, very clear that it is very hard to come up with processes of care that are not dependent upon structure.

So I think we need some fundamental structure data of what the system looks like, so that we can appropriately come up with tiered processes, because otherwise I think we know what they will be. They will be the lowest common denominator processes, and we will all be unhappy with them. So that is sort of my first point.
My second point is that I strongly, strongly believe that, when you do incentivized "coopitition," if we are not running -- The patient being the baton and us running in a relay is a great analogy, except right now each of us gets a different color medal at the end of the relay race, instead of all of us either getting a gold or not.

So if we don't force ourselves to compete and cooperate at the same time, I think we miss an opportunity here.

DR. RINNERT: Of course, I agree with Ron and a lot of the others around the room that talk about the -- It flabbergasts me that we are trying to build systems and perform care without really knowing what the numbers are. So the data dearth is just astounding.

I would encourage us to get information about the populations that we seek to serve. That is why we are here. So I think population measures, while hard to get,
are things we need to seek so that we build
systems that meet their needs.

Then along the lines of, as we
provide care, having each step, whether it is
Phase 1, Phase 2, Phase 3, Phase 4, having
quality measures within each one of those and
have them feed back and inform not only the
populations that we serve, so they know what
they are getting, but it also informs the
system to go forward and improve.

MR. NUDELL: I also agree with
most of the comments that have been made. The
issue -- I am concerned about the issue of
data standards and that that is a process that
could take many years to work through.

There are a lot of activities that
are already going on data standards, and have
been going on. If we wait to start building
the measures until after those standards have
been put into place, that could take a long
time. So it would be nice to start with some
of the low hanging fruit, some things that we
can do without having that deep of a requirement.

One that popped into my mind is something that is fairly simple process-wise, but most -- well, not most. Many EMS providers can tell you which hospitals will share patient information with them and which ones won't. If you deliver a STEMI patient to a hospital, you may or may not learn if it was a patient that ended up going to the cath lab. Did they triage him out with an EKG in the ER? Did they refer him for follow-up?

Something as common and as simple as that, there is no feedback loop, and that is something that could be addressed without technology.

Otherwise, the only other thing I wanted to mention is it would be nice if we could mention some of the current examples of best practices that are being used in various places. There are some people using technology now to share information or to do
different things, and they probably would appreciate getting that kind of attention, because they have invested the time, energy and money into doing that. So recognition for them or using that as a learning point, what can we learn from what they have done?

DR. KUSSKE: First of all, let me say I have learned a great deal at this meeting, and I appreciate being here.

I would like to say that one of the things that I consider to be most important is determining how we will know what the outcomes are of this entire EMS system, and what results we are actually getting. That, I think, can be done with better data collection at the hospital end, but that is one thing I would like to see come out of this.

I also think that the interface that was talked about is very important, the interface between all the providers at various levels, because I have seen situations where
there has been things that have been dropped because of the interface, and that has caused some serious problems down the road, not only between the EMS system and the hospital emergency room, but between the emergency room and the providers in the hospital, and even between the providers in the hospital and the eventual destination of the patient after they leave the hospital.

So I think that all those things are part of the system and need to be worked on and, hopefully, discussed in this publication.

The other thing I would like to say which hasn't been talked about here very much is that, when this is written, it should be -- the attempt should be made to make it consistent and congruent with the EMTALA laws, because there's a lot of things that have been discussing here, various issues, which are covered by the regulations, by the state guidelines, and by a number of things, which
if not dealt with, will possibly cause problems down the road.

So I would hope that, at least as this is being done, that there are some considerations given to that statute, which is an overriding feature in all this. Thank you.

MR. LOYACONO: I, too, really enjoyed participating in this process. Three comments.

You know, EMS has been called the intersection of public safety and public health, and I don't think I have ever heard it put quite like Dr. Cooper did earlier, but emergency services is just different, in a way, and it is much more public interest than other aspects of health care, because you don't have a lot of choices when you are in a crisis situation. I think this regulation piece that we have talked about so much is just extremely important.

We keep talking about pre-hospital care and other emergency care. We need to
start thinking about pre-hospital care as the pre-hospital component of emergency care. When we stop thinking about it as a different animal than the rest of health care, then we will start seeing it studied and researched and funded like other special interest areas are. Well, special interests might not be the right word.

Finally, I, too -- I think that the solutions are not going to all look alike. When regions develop very well defined regionalized systems of care, they are going to be very different because of many factors, and we need to look at identifying centers of excellence that we can put forward as good examples that others can pick and choose pieces of that will work in their systems, and share their successes as well. Thank you.

DR. SAYRE: I agree.

CO-CHAIR ROSZAK: All right, Chuck. What do you think?

DR. CAIRNS: First of all, great
session. Thank you all for participating.

Thank you for accepting an extraordinary percentage of the draft framework, and for your really useful comments and hard work today.

I think those concepts that you have discussed are important. I think the challenge is trying to put them into a framework that will be understood by those who do performance measurement, and that is what I look forward to working with our colleagues from NQF to do.

I think your comments on the need for leadership and structure and potential policies should be something we will continue a dialogue with our Federal partners on, and thank you all again. It has really been an honor and a pleasure to be here, and look forward to your comments on the next draft.

CO-CHAIR ROSZAK: All right. At this point, we open the public comment session for those in the room or those who are joining
us by telephone. So anyone in the room who
would like to say a few words? Cynthia?

MS. HANSEN: So I will come out
from behind the post here. Thank you all very
much for the opportunity to have been able to
observe such impressive conversation and
expertise for the last day and a half.

As I mentioned yesterday, I am
Cynthia Hansen, and I work at ASPR. I had a
couple of comments that I wanted to put forth
for the committee's consideration.

Being with the Assistant Secretary
for preparedness and Response, the concept of
surge is quite critical and, while it is
essential that day to day operations be
successful, and I know that is the necessary
focus of this group's work, the idea of a
regionalized surge capacity in the event of a
catastrophic event is something I would put
forward for your consideration as an
additional element.

Secondly, with all the robust
conversations that happened, I would also like to put forth to you as you describe the domains to be sure and include psychiatric, behavioral health examples, and to balance out the Med-Surg focus. That is an easier conversation sometimes to have, and also that health care in this country is also delivered through tribal health, either through 638 compacts or Indian Health Service.

I would hope that the intersection and linkages with those emergency medical services would also be considered as you look at measurements.

I was really struck by -- I think it was one of you guys who were talking about the link with non-health care entities such as sheriff's departments, and that those linkages are in some ways part of the challenge of a regionalized emergency care services, and I know this is a tremendous challenge.

I would just bring forth these particular issues for the group's
consideration. Thank you.

MR. MARGOLIS: To build on the ASPR theme. My name is Greg Margolis, and I work for the Office of the Assistant Secretary for Preparedness and Response, and I would like to also take an opportunity to thank each and every one of you for participating.

As you probably know, this is a project jointly sponsored by ASPR and ASPE, the Assistant Secretary for Planning and Evaluation, and based on where I work, I can at least extend my appreciation on behalf of Dr. Nicole Laurie, the ASPR, for your participation.

It has been an interesting experience. I have known many of you for a long time, and this is a little bit of a new role for me, being in the back of the -- in the peanut gallery, if you will, as opposed to around the table, but it has been a very rewarding experience, and I applaud the progress of the group.
Obviously, ASPR's interest in this particular project really does focus on emergency preparedness, and it does recognize the fact that emergency preparedness is built on an efficient and effective emergency care system every day.

I am very encouraged at the amount of conversation that has gone on over the last two days that make sure that we measure and report and come up with metrics to look at variables such as emergency preparedness, ED crowding, boarding and diversion, which Dr. Laurie views as true preparedness issues.

The other thing is that I am impressed as the group has gone around. I would like to tell you how important a work this will be.

Skip had a question early in the dialogue of how is this going to be used. I think it is going to be used in a lot of different ways, but in particular, there has been a fair amount of conversation about,
well, who is in charge, and how do we put everybody -- make everybody responsible.

There is a variety of policy levers that exist, and certainly centralization and authority and responsibility from the top down perspective is one way that we can look at the emergency care system, and may work in certain cases. But doing that in a private sector health care system is very challenging when the majority of the system works in a very different way.

So in particular, I see this project as really starting us down the path of public reporting, and I would hope that you all realize the incredible power in a private sector world that public reporting can have, and we are really starting to talk about for the first time a way that we can, on a website such as hospitalcompare or whatever, we can actually allow elected officials, policy makers and other people that have responsibility for various sectors of the
population to be able to evaluate the quality of their emergency care system, and to compare it to other systems of similar challenges, and hopefully then, to make resource allocations and community decisions about what they are willing to accept and how they want to start to fix some of their challenges.

So there is incredible power in the work that is being done here, and it really has a tremendous opportunity to improve emergency care in this country.

Then finally, it also has the opportunity, maybe for the first time, for us to start looking at aligning incentives to start encouraging the type of behavior that we want this private sector health care system to deliver.

So again I thank you all for your participation, and I will turn it over to my colleague.

MR. MORRIS: Thank you. I just want to thank you all for the opportunity
allowing me to sit here in the peanut gallery
and listen to great comments.

As I was taking notes, trying to
figure out what I would say, you have already
said it all. So I concur with a lot; a few
disagreements, but it is going to come out,
and I really look forward to looking at the
second draft and seeing, because right now
there are so many notes, I don't know what is
-- I'm versioned out.

In the Office of Health Affairs in
Homeland Security, we work with EMS, Public
Health, and disaster preparedness, kind of in
that triangle. So I am going to approach my
viewpoints from that standpoint. But if there
is anything we can do in our office to help or
any questions, please feel free to call us.

I will be working with Greg and
the other colleagues here to help make this
the best document we can.

CO-CHAIR ROSZAK: Operator, this
is Andy Roszak. Is there anyone on the phone
that would like to comment?

OPERATOR: If you would like to comment over the phone, please press Star-One.

Sir, your line is open.

MR. KNIPPER: This is Ken Knipper.

CO-CHAIR ROSZAK: How are you doing? Go ahead, Ken.

MR. KNIPPER: This is Ken Knipper, National Volunteer Fire Council. I have caught most of it the last two days, and find it very, very interesting.

I would have to comment on the fact that somebody made a comment -- A number of times, a comment has been made to how important the cooperation of the fire chiefs and the EMS chiefs will be, and as the Chair of the National Volunteer Fire Council, EMSR Section, I would be interested in getting the copies of the draft and being kept in the loop on this.

MS. TURBYVILLE: Thank you, and you can go to the NQF website which will have
the timeline of when the next draft will be posted for public comment, and we certainly would welcome your comments on that draft, and we do take a look at them, and the Steering Committee considers all of those.

So it is going to be posted for public comment, as of now, sometime in July, but the website will keep everyone updated, if there are any changes. So that is the National Quality Forum's website. You can just put in NQF and Google it, and you will find it pretty quickly.

MR. KNIPPER: Yes, I have already been on it.

MS. TURBYVILLE: Oh, fantastic. So, great.

MR. KNIPPER: Thank you.

CO-CHAIR ROSZAK: Thank you, Ken. Operator, do we have anymore comments?

OPERATOR: Not at this time.

CO-CHAIR ROSZAK: We will close
the public comment period, and we will move to
the last portion of the agenda for today,
which is the summary and next steps, and I
will turn the mic over to Sally here.

MS. TURBYVILLE: So I would like
to say I agree with all the -- Thanks to all
of you for taking time to participate. I
think your contribution has certainly enriched
the draft that we have. We have got a lot of
ideas about what to change now and how to
continue to drive the system to be improved.

I would like to thank my team at
NQF as well, Eric and Laura for keeping us on
target and preparing for this meeting.

That said, to go over some of the
next steps and, Eric, feel free to jump in if
I forget any, we will be synthesizing the
meeting notes. We will send those out for you
all to review. Those are eventually posted
for the public, as well as transcripts which
are being taken, and a recording, if you
wanted to listen to two days of conversation.
Again, we would certainly make that available to you.

On the meeting summaries and working with Chuck and Jeff at UNC and their team -- and also thanks to you all very much for all the hard work that you have done so far -- we will revise the draft, and it is a quick turnaround.

So we will be -- If we have specific questions, we may contact a few of you based on some of the concepts that have been tossed around, so that we can more quickly get that draft updated, but we will then send the draft back out to all of you in June.

We will convene on the telephone a Steering Committee conference call after you have had a chance to review the draft, get any final inputs, make sure that you all agree that it is ready to go out for public comment for a posting, and then we provide 30 days for that public and member comment.
After we get the comments back, we put them into an Excel spreadsheet, and we provide them to all of you so that you can take a look, and make any suggestions if we need to adjust the framework at all.

In the end, what we will be looking for all of you is a recommendation that this framework move forward as an endorsed framework for this particular area, which means it goes to the CSAC, which is an oversight committee. They oversee all the Steering Committee work. Then if they agree with the recommendation, then it goes to the Board of Directors.

So those are some of the details, but stay tuned for meeting minutes -- summary, not minutes. The minutes will be the transcripts, but so making sure that we have captured key concepts we will be working directly with our UNC colleagues to keep this framework moving along. Then stay tuned for a draft in about three weeks, I'm thinking, of
actually -- yes, about three weeks.

Any questions about that?

DR. RINNERT: Are we doing the conference call on the 21st?

MR. COLCHAMIRO: All of the dates there are ballpark. So there is the little thing next to August 10th. I forget that word for it, but these are estimates of the dates. It should be around that time.

I will send out, similar to what I did for the orientation call, a little link, and we will pick a day and a time around there that works for the majority of the Committee members.

DR. RINNERT: We are looking at the August date.

MR. COLCHAMIRO: Right. The June date is for the final -- is for the webinar, and then we will have another one in August.

MS. TURBYVILLE: So that means two more webinars from the Steering Committee, at least, one to look at the second draft, and
then one to give us any guidance and reaction
to our solicited public and member comment.

This week you can expect an email
where we will nail these down or solicit your
input on availability, and we will get those
nailed down in stone really quickly.

CO-CHAIR ROSZAK: All right.

Well, I greatly appreciate again your
attendance, your effort, your contributions.
It was a great pleasure working with you, and
thank you again. I hope you all have safe
c Travels, and we will be talking soon.

I officially adjourn this meeting.

(Whereupon, the foregoing matter
grew off the record at 1:49 p.m.)
branches 86:21,22
brand 164:18,19
break 9:18 10:1,14
84:12 114:21
115:2
breath 64:20 65:13
breathing 41:7
Brendan 1:15
134:18 138:4
140:5
Brendan's 133:2
brevity 67:18
brief 79:9 116:5
briefly 11:9 22:18
79:22
Brigham 2:5
bring 18:4 19:21
20:18 37:1 47:13
113:4 134:12
146:16 165:20
183:21
bringing 11:14
18:7 27:22
broad 85:2
broader 29:7
brought 37:20
40:11,21 62:13
103:7 110:1
112:10 150:9
BS 1:25
buck 153:15
bucket 108:5
buckets 10:9,11
160:16
build 53:11 125:1
125:18 140:11
141:4 145:12
174:15 175:1
184:2
building 7:21 55:7
91:8 135:12 139:4
175:18
builds 53:12
built 4:10 15:4
34:14 65:6 112:18
185:4
bullet 145:6 156:16
bunch 91:5 104:1
129:21 171:22
burden 138:12
139:16
burn 49:18
burning 69:5
business 129:16
bypass 18:15
bystander 41:6
108:16 148:2
157:3,9
bystanders 155:12
C
CABG 128:11
136:7
Cairns 2:12 3:5
31:22 33:19 34:5
34:17 55:6 36:3
36:17 37:7 39:10
41:11 43:12 44:3
45:1,6,22 47:10
57:15 68:8,22
69:11,15,20 70:5
70:9,18,21 71:5,8
71:14 76:9,16
78:8 79:20 81:20
82:1 84:8 180:22
California 1:19
172:4
call 9:2 19:13 29:3
29:14,17 30:7
50:22,22 54:21
56:15 61:5,19
65:14 95:13,13,14
97:18 102:16
103:1,3 109:11
114:6,9 147:3,19
150:14 156:6
157:19 161:12
162:6 188:17
192:17 194:4,11
called 30:8 108:13
179:10
caller 108:16 148:2
calls 26:6 89:14
campaign 106:11
capabilities 99:14
120:16
capability 71:17,21
71:22 72:20,22
73:10 77:4 80:2
80:11 81:12 82:11
83:2,3,8,9,19 84:2
88:17 101:11
108:14 112:21
135:14 162:21
capable 80:16,21
81:5
capacities 99:15
capacity 30:10 48:3
59:21 64:7 65:3
71:17,21 72:9,10
72:12,20 73:1,3
73:11,21 77:4
79:15 80:11,16,21
81:5,11 83:4,7,18
84:2 88:17 101:11
182:18
capitated 145:22
capture 43:2 67:4
74:17 95:2,12
160:7 167:6
captured 8:4 37:14
66:12 73:11 78:7
82:10 114:14
162:9 193:19
capturing 95:5
car 103:20 104:1
123:6,7,15,19
124:10 127:1,5,10
132:8 133:20,22
137:13 138:22
142:4 143:17,19
144:15 146:18
153:7,11 156:17
156:19,22 157:2
157:14 158:1,2
159:2 160:2 164:9
165:17 166:2,4,5
169:1 170:9,11,14
171:9,15 172:21
172:22 173:2,3,13
174:16 175:4
179:16 22:2
180:1,2,4,12
183:7,16,19 185:5
186:8 187:2,11
187:16
cared 39:5
career 14:13
careful 83:12
carefully 152:17
caregivers 168:19
Carr 1:15 39:21
54:6 60:19 116:22
117:4,8,21 124:19
130:6 135:13
136:5 150:7 173:7
carry 127:3 164:18
164:19 165:21
Carr's 59:1
case 32:18 49:4
136:12 143:2
157:15 170:8
cases 18:11 105:9
186:8
casualty 133:21,22
catalog 73:16
catalogue 82:2
catastrophic 182:19
catchment 118:14
category 64:9
105:2
cath 18:12 121:7,8
125:16,17,21,22
136:19 141:3
176:10
caught 189:10
cause 179:1
caued 178:2
caution 47:5
caveat 143:20
CDC 64:10
cellphones 157:8
center 1:18,23 2:1
2:2 12:14 53:4
78:4 97:13 98:12
144:1,2,2
Neal R. Gross & Co., Inc.
202-234-4433
CERTIFICATE

This is to certify that the foregoing transcript

In the matter of: Regionalized Emergency Medical Care Services Steering Committee

Before: NQF

Date: 05-24-11

Place: Arlington, VA

was duly recorded and accurately transcribed under my direction; further, that said transcript is a true and accurate record of the proceedings.

[Signature]
Court Reporter