NATIONAL QUALITY FORUM

Moderator: Kyle Cobb
January 4, 2017
11:30 p.m. ET

Operator: This is Conference #99103478.

Operator: Welcome, everyone. The Webcast is about to begin. Please note today's call is being recorded. Please stand by.

You may begin.

Kyle Cobb: Hello. This is Kyle Cobb from NQF. Welcome to your first panel expert panel orientation meeting for our Emergency Department Quality of Transitions of Care project.

Today, we have the NQF project team with us including myself, Kyle Cobb; Marcia Wilson, our senior vice president of quality measurement; Kirsten Reed, project manager for this project; and Vanessa Moy, our support project analyst; as well as Jesse Pines, who is our MD ED consultant. So, I will now -- and, also, to mention as well on the team are our project sponsors from Assistant Secretary for Preparedness and Response, also known as ASPR, who include Brendan Carr, (Jessica Oitman) and (Sophia Chen). And we may have (Matthew Cudgedel) on the line as well. I am not sure. But, he is our contracting officer. So, welcome.

I will now hand it over to you, Kirsten, to introduce the panel.

Kirsten Reed: Great. Thanks, Kyle.

Welcome, everybody.

So, as you all know, NQF did a call for nominations recently to seat this panel. And you were all the lucky winners, and we are very excited to be working with you throughout the next few months. But, I am going to ask everyone -- I am going to kind of go through this list here and have everyone briefly introduce themselves. Because time is tight, we are just going to ask that you please say your name, organization and the primary -- and your primary expertise most relevant to this panel.

So, we are going to start with Stephen Cantrill.

Stephen Cantrill: Steve Cantrill. I am an emergency physician from Denver Health Medical Center. I have been a medical director for 18 years of a large urban (MD) and have been involved in developing performance measures in emergency medicine for about 10 years now.

Kirsten Reed: Great. Thank you.

Janet Niles?

Janet Niles: Hi. I am -- excuse me. I am Janet Niles, and I am a registered nurse. I have been working in this space for about 30 years, which I hate to say, mostly concentrating on transitions of care, catastrophic and complex case management, disease management and utilization management, more recently the total population health space when I was at Ochsner Health System as the vice president of the accountable care organization.

Kirsten Reed: Great. Thank you.

Billie Bell?

Billie Bell: Hi. This is Billie. And I am the vice president of operations for Medina Healthcare System. I have been an RN for years and have a quality and operations backgrounds. And my area of expertise for this panel is in rural health care.

Kirsten Reed: Wonderful. Thank you.

Donna Carden?

Donna Carden: Hi. My name is Donna Carden. I am professor of emergency medicine at University of Florida. I am trained in emergency and internal medicine and, for the past 10 years or so, have been working in health services research, specifically on ED-to-home transitions for older patients who are chronically ill.

Kirsten Reed: Great. Thank you.

Lisa Deal? Lisa, are you on the call?

All right. James Dunford?

James Dunford: Hi. This is Jim Dunford. I am the City of San Diego EMS medical director, and I have been an emergency physician at UC San Diego for 35 years. My interest in this stems from my five years experience at the National Quality Forum. I served as the emergency medicine expert on the Dual Eligibles MAP committee and enjoyed the opportunity to get involved in selecting measures.

Kirsten Reed: Tricia Elliott?

Tricia Elliott: Hi. Good afternoon. This is Tricia Elliott. I am the director of quality measurement at The Joint Commission. Prior to that, I have held director roles in acute care settings managing quality and patient safety departments. My interest in participation in this panel is related to potential, you know, development of measures related to the ED transitions of care. Thank you.

Kirsten Reed: Thank you.

Nikki Hastings?

Joseph Karan?

Joseph Karan: Hi. My name is Joe Karan. I am a dialysis -- was a dialysis patient and have had my transplant for the last three and a half years. I am the director of advocacy and education for the National Kidney Foundation of Florida.

Kirsten Reed: You are welcome.

Julie Massey?

Julie Massey: Hi. This is Julie Massey. I am the medical director of clinical quality improvement at UHS, a pediatrician by training. Thank you.

Kirsten Reed: Aleesa Mobley?

Aleesa Mobley: Hello. Aleesa Mobley speaking, graduate nurse faculty at Rowan University in New Jersey, representative for the American Association of Ambulatory Care Nursing and 20-year practicing nurse practitioner.

Kirsten Reed: (OK). Elif Oker?

Elif Oker: Hello. I am Elif Oker. I am an emergency physician. I started out in academics. Currently, I am the medical director of Blue Cross Blue Shield of Illinois, which is a division of Health Care Service Corporation. I work in population health analytics, cost of care initiatives here on our health care delivery team. I am also plugged into the entrepreneurial digital health community here in Chicago. My interest here is with respect to our quality program. And I look forward to working with all of you.

Kirsten Reed: Great. Thank you.

Andrea Pearson?

Andrea Pearson: Hi. I am -- this is Andrea Pearson. I am a pediatrician. I work for the Johns Hopkins Emergency Medical Services, and I am (a staff) of Howard County General Hospital, which is one of their community hospitals. I take care of patients in the emergency department and the inpatient unit. We are a combined unit. And I also have (several) years of additional experience in outpatient management in pediatrics. So, I have seen transitions from all different (sides).

Kirsten Reed: (OK). Marc Price?

Marc Price: Hi. My name is Marc Price. I am a family physician. I have been in private practice in my own (wholly-owned) practice for the past 11 years, up until recently solo, now it's a group practice. You are welcome to look at my biography that was sent out. The only thing that is not correct in there is I am not part of an ACO. Everything else is correct. Other than that, my interest in this is I am a practicing family doctor every day and need to have a better way to transition patients from the ER and urgent cares to my office so I can get the information and provide better care.

Kirsten Reed: Great. Welcome.

Karin Rhodes?

Karin Rhodes: Hi. I am Karin Rhodes. I am an emergency physician and have been for about 35 years. And I am a health services researcher who has studied the quality of emergency provider patient communication, including the quality of discharge instructions. I have done a lot of work around screening for social determinants and linkage to outpatient resources and studying access to primary and specialty care. I led a transition-in-care initiative at University of Pennsylvania where I recently moved from last year.

Kirsten Reed: Great. Thank you.

Kristin Rising?

Kristin Rising: Hi. I am Kristin Rising. I am faculty of the Department of Emergency Medicine at Thomas Jefferson University. I work as a clinician and a research and really have focused my research on looking at patient transitions into and out of the emergency department and how those can be more effective and (efficient). So excited to work on this, which directly fits into the research that I have been doing.

Kirsten Reed: Great.

Brenda Schmitthenner?

Brenda Schmitthenner: Hi. Brenda Schmitthenner, senior director at the West Health Institute for Successful Aging as well as a program officer for the Gary and Mary West Foundation. Prior to joining West Health nine months, I was the aging program administrator for the County of San Diego's Aging and Independent Services, where I implemented a number of care transitions program in partnership with the Social Services Agency and hospitals, including the largest community-based care transition program in the country that partnered a community-based service organization with 13 hospitals served over 60,000 high-risk fee-for-service Medicare beneficiaries and reduced the readmission rate for those participating in the program by over 70 percent. So, care transitions is a focus and passion of mine.

Kirsten Reed: Wonderful. Thank you.

Amy Starmer?

Amy Starmer: Yes. Hi. This is Amy Starmer. I am a general pediatrician out of Boston Children's Hospital, where I work clinically as a primary care provider predominantly but spend the majority of my time locally overseeing quality improvement activities within the hospital here and then also in research-related activities, which is my biggest area of relevant focus for this group. I was the lead investigator of the I-PASS handoff study, which was a study -- multicenter trial investigating the impact of bundle intervention to improve handoffs of care within the inpatient settings. That was shown to be associated with a significant reduction rates of medical errors as well as improved communication processes.

And more recently, our team has started to expand efforts and apply similar interventions and look at measures across different settings of care including transitions into the emergency room and in and out of the hospital. So, looking forward to participating.

Kirsten Reed: Great. Thank you.

Adam Swanson?

Adam Swanson: Hi. I am a suicide prevention specialist at the Suicide Prevention Resource Center, which provides training and technical assistance to states, tribes and universities throughout the U.S. looking to implement suicide prevention protocols and policies. I am also a person with PTSD who has experienced the sometimes disjointed care transitions that occur in ED settings. And I also manage SPRC's ED collaborations programming.

Kirsten Reed: Great. Thank you.

Arjun Venkatesh?

Arjun Venkatesh: Hi. Arjun Venkatesh here. I am a faculty in emergency medicine at Yale University in New Haven, Connecticut. I have a lot of experience in quality measure development. I work under contract with CMS through the Yale Center for Outcomes Research and Evaluation in the development of the hospital outcome and efficiency measures and the star rating system. I am also -- have been involved with (ASEP) for many years in quality measure development for the new registry as well as co-lead of the Emergency Quality Network. And I have served on several NQF committees in the past, CMS technical expert panels and AHRQ panels on quality measures.

Kirsten Reed: Great. Thank you.

Sam West?

Sam West: Hi. I am Sam West. I am software developer at Epic in Verona, Wisconsin. I (perform) development efforts towards reporting and analytics for EDs and I am exciting to participate in discussions with the panel.

Kirsten Reed: (OK). Margaret Weston?

Margaret Weston: Hi. I am Margaret Weston. I have been a nurse for over 30 years. I currently work Johnson & Johnson in their Healthcare Quality Solutions department. And I have spent the better part of last year working with large integrated networks exploring the implementation of transitions of care across a variety of therapeutic areas. Prior to that, I was the chief quality officer for the VA

(and Vision 20) in the Pacific Northwest Network and did a lot of work specific to system redesign in the emergency room.

Kirsten Reed: Thank you.

Christine Wilhelm?

Christine Wilhelm: I am the chief operating officer at a critical access hospital in northern Michigan, on the committee representing the 36 critical access hospitals in Michigan. And we are especially interested in quality measurement in the rural health care setting.

Kirsten Reed: Great.

Stephanie Witwer?

Stephanie Witwer: Hi. This is Stephanie Witwer, and I am a nurse administrator that works at the Mayo Clinic Rochester site. And I am working primarily with the primary care practices and have been doing that for about the past 10 years. We do have a certified health care (hub) and so have dome many initiatives around transitions from primary care to hospital and hospital to home or to nursing home. I also work with our enterprise population health initiative primarily with the care coordination programs and care transition programs. And in addition, I am representing the American Academy of Ambulatory Care Nurses.

Kirsten Reed: Great. Welcome.

I am going to circle back to see if Lisa Deal has dialed in.

OK. Well, thank you, everybody. Welcome again. You are certainly an impressive bunch of people. (I going to be beginning to) step up my game (to get on your level). So, I will start planning.

So, I am going to turn it back over to Kyle at this point.

Kyle Cobb: Yes. Well, hi. And also incredibly varied. I think, you know, one of our real challenges today will be to give everybody the right amount of information so

that you will have what you need to really interact on this project effectively. Our goal with the agenda is to provide you with enough background on the project as well as information to get oriented and informed.

And we will start to that end with some opening remarks from Brendan Carr and (Jessica Oitman) from ASPR to really ground us and understand what sort of the genesis of this project was and, then, move over to Marcia Wilson, who will provider really an overview of the NQF and what we do and how this project fits into the NQF portfolio. We will then come back to Kirsten, who will dive into the role of the expert panel, the co-chairs and staff and really the mechanics on how this project will work.

And, then, we will go into the -- and also included in that are the ever-important milestone timelines and objectives. We will come back towards the end of our time today to myself and Jesse, who will talk about the environmental scan methodology, what we have done so far, what we thought about.

And, then, we will go open it up for an open discussion and talk about some of the next steps. I did forget one thing. I am looking across the room at Vanessa Moy, who will also be most probably the most important part, walking you through how to access information on our SharePoint site and some of the really important details of how we communicate on these types of projects.

So, Brendan and (Jessica), I will hand it over to you.

Brendan Carr: Thanks so much. I promised (Jessica) that she only had to speak if my (man code) actually put me on my back. But, she is here and is the brains of the operations. So, thanks, (Jessica), for everything.

And I don't know if our partners from CMS and from (ASPI) are on, but I just want to thank them, too. They have been -- (Sophia) and (Anne) have been amazing in helping us to understand how to navigate better the contract process to work with NQF.

So, I am Brendan Carr, everyone. I know -- I think I know, you know, a chunk, a quarter or half of that -- of that list on the phone. And it is nice to meet the rest of you and to have the opportunity to work with those of you who I already know. I am an emergency physician I am a policy researcher. And I have had the privilege of spending the last couple of years running the Emergency Care Coordination Center, which is the emergency care policy home within Health and Human Services.

We are based, as you heard in the introductions, in ASPR, which is the Office of the Assistant Secretary for Preparedness and Response. And that has been, at times, really empowering for us and, at times, a little bit tricky for us because we are -- at ASPR, everybody assumes that we do disasters and we only do disasters. And the truth is that we have worked really hard to make clear that that isn't true. We are the -- we are the bridge into the disaster world from the health care world in a lot of ways. We think that the emergency care system that functions well in the day to day really does have the ability to surge and to help us to respond better when we have larger-scale events.

So, we -- my office convenes all of the folks across the federal government that have any dog in the emergency care fight through a council called the Council on Emergency Medicare Care. And the CEMC really allows us to sort of work hand in hand with folks that think pretty differently. When you put OMC in the same room as Department of Defense along with the Homeland Security folks and CMS, it becomes really hard for them to understand how they are all engaged. And when you add the mental health folks and, then, like the emergency management folks and the minority health folks, it becomes -- it becomes, you know, even more of a challenge.

We are trying hard to make sure that we meet the four key domains which you see on the slide in front of you, which are the mission space that we have been given. You know, I said on the slide in front of you, but it turns out I am not looking at the slides. Hopefully, they are on the slide. They are indeed.

So, those are the four key pieces of our mission space. We are support to lead the government's efforts to, you know, coordinate emergency care activities

and to make a system that is, part one here, patient- and community-centered. We have spent some time working with (PCORY) and thinking about the patient (standardized) portfolio. It is nice to hear (Dawn) and (Christine) on the call. They are two, you know, (fun emergency-minded) folks through (PCORY).

Integrated into the broader health care system is probably the largest piece of what we have done over the last year or a couple of years. We had a nice seat at the table for all the delivery system reform tasks. It has been a pleasure to work with so many folks from CMS and CMMI and the Office of the Secretary on sort of making sure that we start to see emergency care as a piece of the solution, as a piece of the puzzle, not just as this terrible, expensive, unnecessary, inappropriate place that patients go when they are scared.

The third piece here is, you know -- I think the second piece sort of touches on this initiative, but so does the third. Obviously, the health care system needs to be high quality. And the quality measurement structures in emergency medicine are not as well developed, not as robust as they are in some other domains. And we've had great opportunity to work with, as I said, CMS and (ASPI) to work in this space.

And, then, the last one really is where I started, which is if we have an emergency care system that is strong in the day to day, well, when the system gets pushed just a little bit further then it is used to going, we hope that we have -- we can learn some lessons and leverage what we do in our day to day to make our response strong.

So, bullet point two there -- there are a lot of emergency department visits. And we have accepted on some level this idea, this narrative that we could avoid most of them, that they are so costly that we should just figure out another way. It is tricky for us. you know, from my vantage point -- and I spend a lot of time interacting with folks who very much believe that we are going to dramatically, dramatically reduce these numbers. From my vantage point, we are moving to a largely outpatient system with lots and lots of sick folks who are getting, you know, care in a lot of different ways with community paramedics and home nurses and skilled nursing facilities. And,

surely, that is -- and day program and patients out of medical homes -- that stuff is going to be enormously helpful. But, I find a -- I have a hard time getting to a place where I believe that this sick older population functioning as outpatients are not going to, at times, have an exacerbation of their chronic conditions that require someone to decide whether they need to be admitted to an inpatient setting or whether or not they need some management that is going to allow them to sort of safely move back into their usual source of care.

Sorry I continue to struggle to breath here. So, this narrative has a little bit painted us in a -- in a tricky -- in a tricky light. I was asked -- you know, Jesse put together a panel with Brookings a while back and, you know, I was asked why the emergency care community was never at the table solving these problems rather than just sort of generating a bill when patients walk into the emergency department. And, you know, it's a -- it's a -- it's a solid question. I guess I will say that, in part, I think it is because we are not considered part of the solution.

We don't have -- in general, the primary care community and the emergency care community have not come to this understanding that much of the acute care and acute exacerbations of chronic conditions will happen in the emergency department. Chronic disease management and preventative efforts will happen in the -- in the scheduled environment and we will communicate really well with each other to make sure that both skillsets and both specialties are working in concert to get to the same goal.

So, sort of towards that end, you know, I think the goal here is for us to continue to think about -- I love that there was a patient representative -- actually a couple -- on the phone because your voice is going to be extremely valuable as we start to really understand what it feels like to transition into an acute care setting to get some diagnostics and told whether or not you need to be admitted or make some decisions collaboratively but whether or not you need to be admitted to the hospital or to coordinate activities that might allow you to be stabilized without being admitted to the hospital. But, in order for that to happen, we really need to get to a place where we just aren't. Some integrated delivery systems sure are. But, most of us function in competitive marketplaces where the primary care community and the emergency care

community or the hospital-based community just don't communicate nearly as effectively as we could.

So, you know, that sort of is our lens of it. And our goal moving forward is that we use the perspective of the patient to help us to understand what information needs to be available to me when someone walks into the front door and what information I need to then make available to whoever I am going to transition this person back to. So, we have written all over the scope of work that we really see this as a bidirectional thing. Much of the work that has been done has been about safe transitions out of the emergency department.

And, surely, that is an enormously important piece. But, to be clear, that is a piece that is driven by an interest by payers to reduce cost by reducing inpatient admissions. We want a little bit of a different perspective. I believe when someone comes in in distress or terrified that I should be allowed to have some insights, some information into what has come before so that I can be the best advocate for them. And I fully believe that I have a lot of responsibility to then safely bridge that person -- to bridge that person back into their usual source of care after I have done my piece and to communicate what I have done.

I am going to be -- I will be on the call the entire time. I am really, really grateful that you guys have -- are willing to spend your time with us today and to -- and to do the work of this -- of this -- of this committee. I am happy to take questions (with an outcome -- I can cough a little bit).

Kyle Cobb: Thank you, Brendan. And we have -- well, before you start coughing too much, Brendan, we had -- and I think you went through that on our second slide of the project goals. But, we really did have -- there was just -- the next slide talks about really

(Multiple Speakers)

Kyle Cobb: …(Jessica), if you would like to speak about…

Brendan Carr: I won't make her -- I won't make her rescue me yet. I am happy to be…

(Multiple Speakers)

…I think -- well, this piece is, I think, the piece that you knew that you were signing up for. Whether or not you fully understood the lens on this, we were asking you to see it through -- I don't know. So, this is now for you, guys. And maybe I will just read the bolded piece because I think it is really important.

This first piece is to -- is to synthesize evidence through stakeholder meetings and research to determine the viability of bidirectional transition of care quality measurement framework. So, we are talking, again, this transitions into the ED and out of the ED. And we are talking -- and this is -- this is language that NQF has been kind enough to teach me over the last couple of months. We are talking about a framework by which to measure this. We are not talking about quality measures just yet. That maybe is a down-the-road thing.

But, the idea here is that you guys are the big thinkers in this space. There will need to be sort of some in-the-weeds work done down the road to develop quality measures. That is a totally separate animal. This animal is the -- I think, the fun part is the conceptual framework around how we might start to think about how to measure this.

I commented already on stakeholders and the critical importance of having folks from different walks of life. I actually -- I actually didn't hear that we had our rehab or skilled nursing facility nursing home community on the phone. If I missed it, I am sorry. And I know that we try to get it. But, I am glad that we have pretty everybody from pediatricians and hospitals and family docs and certainly, obviously, the emergency care community. And, then, last and, of course, not least are the patient representatives that are really going to be helpful for us to understand whether or not we are talking on to getting this right.

And then, you know, at the end of the day, the goal is, I think, crystal clear that this is about improving person-centered care. There is a value piece, for

sure. There is a cost effectiveness piece at all time. But, I actually think the great news is that there are lined up here. Most people, if they have a safe, warm place to go to would like to go to that place if we could help them with some services in that place. So, you know, the challenge is for us to coordinate that in real time so that at 11 o'clock at night, I can know that at 6 a.m., somebody is going to show up at somebody's house to give them their next dose of X, Y or Z or to visit them or to check on them or whatever it might be.

Thanks very much, guys. Hopefully, there are no more slides.

Kyle Cobb: There not none. Thanks, Brendan.

I will hand it over to you now, Marcia.

Marcia Wilson: OK. Thank you so much.

This is Marcia Wilson. And my job today is to give you an overview of NQF, who we are, what we do and how this all fits in. So, those of you who don't know, is we were formed in 1999 as a nonprofit, nonpartisan membership-based organization. And this is just about the time that performance measurement was really taking off in health care. You can see our mission statement at the top of the slide here. Everything we do is about improving quality through measurement.

And there's three things I want you to know about us.

First is we are multi-stakeholder. We have, I think, over 400 -- probably close to 430 -- organizational members. And they represent all the leaders in the various stakeholder groups. We have consumers and patients, providers, purchasers, health plans, the supplier industry, pharmaceutical company. And we have hundreds of volunteers that sit on our committees representing the different stakeholders just like this expert panel.

The second thing is we are a consensus-based entity, which means we have to reach consensus in all of our decisions. Now, consensus does not mean unanimity. But, it does mean that every voice is considered and heard. And

when you are trying to reach decisions in a multi-stakeholder environment, let us just say we have some very interesting discussions here at National Quality Forum, and I expect that this expert panel will also be having some very interesting discussions given the varying perspectives.

The third thing I would want you to know about NQF is we have to be transparent in all our activities. We are under something called the National Technology Transfer and Advancement Act of 1995. That does not exactly roll off the tongue. But, what it means is that everything we do has to be transparent.

So, for example, all of our meetings and Webinars, including this one today, are open to the public. All of our reports, our issued briefs, any document goes out on our Web site and is publicly available. And at any time, anyone can make a comment at a meeting, in a Webinar on one of the measures that we are looking or in writing. So, we have to be transparent.

So, what is it that we do here at National Quality Forum? Here is a nice graphic that explains our core activities all focused on this mission of improving health and health care through measurement. So, you may not be familiar with all these activities. So, let me give you a little more detail on the next slide.

We are going to start with performance measurement endorsement, which is one of our longstanding activities. What this means is we convene committees with the appropriate expertise to evaluate measures based on certain criteria. Those criteria include evidence, whether there is room for improvement in the measure, whether the measure is reliable and valid. And if the committee determines that the measure meets the criteria, that measure is recommended for NQF endorsement. Now, NQF endorsement is valued, one, because it is a very rigorous evaluation and, two, it is conducted by a multi-stakeholder committee. Again, all those perspectives are at the table.

The second main activity that we do is measure applications partnership or the MAP. And for the last six years, we had a contract with the U.S. Department of Health and Human Services to review measures that they are considering

for federal programs. Now, as you know, primary, CMS has more than 25 -- I think it is close to 30 -- federal programs that cover a broad swath of providers and settings. And these programs are required reporting typically for public reporting or pay for performance.

And every year, CMS and HHS convene measures under consideration that they are thinking about putting into rulemaking and adding to these program. We convene committees of experts. They review the measures, and they recommend to CMS and HHS whether those measures should be included in the program. We are currently in what we call MAP season. You may have just been through a holiday season. We are currently going through our MAP season. And we will be sending reports on the recommendations from these workgroups to CMS in February and then a large report a little bit later on.

A third bucket of activities is something we call measurement science. And this covers a lot of different types of projects. One is what we would call cross-cutting issues and measurement. For example, we are just now completing a project on attribution. Given the shift in payment mechanism where providers, either individuals or organization, are now being held accountable and are being assigned certain patients, how is this attribution done? There's a number of different methodologies. So, this committee has been looking at what are the different methods, what are the pros and the cons. And what they have come up with is a checklist of consideration when you are going to be attributing or assigning patients to groups for accountability purposes. So, that is an example of a cross-cutting project.

The other thing we do, which is what we are going to do with you all through this project, is the development of frameworks. Now, we have done a number of framework projects. And they are typically in areas where we don't have the measures -- performance measures that we need or want. So, what we do is create a framework, which is really a way of organizing what we want to measure. Think about it as putting measures into clusters or domain. And I am using that term "measures" futuristically. As Brendan said, we are really all about developing the framework but with an eye towards where we want to go in measurement.

So, for example, we just recently finished last fall a two-year project where we convened a very large group of home- and community-based services, experts, patients who use the services and people who provide the services. And they developed a framework for what they wanted to be measuring to determine there was quality of care being provided based on the individual's preferences in the world of home- and community-based services. And, then, they look at what all the different states were looking -- were measuring or what they wanted to measure and look at where some of those measure concepts -- and you will hear more about a measure concept later on -- would fit into that framework. So, you are going to be doing a very similar project.

Now, in the next slide, we have another different kind of activity -- a couple of other activities here at NQF. One is called the measure incubator. And this is actually one of our newer endeavors. We have been at this now about a year or a year and a half. NQF does not develop measures.

However, we know a lot of people who do. And the idea behind this incubator is could we connect those people who have measures ideas, funding for measure, data that you need to develop measures and the technical expertise to actually do the measure development. Could be play matchmaker, in a sense, and bring those people together and accelerate the development of measures that we need and want?

This is just getting off the ground. We think that this is -- got a lot of potential. And interestingly enough, I will say in our initial projects, both the ones that are currently active and the ones where we are in the, say, contracting part of the decision-making, the biggest area of interest is patient-reported outcomes, those measures based on what the patient has to say about his or her care. And that has almost been across the board in all the ideas that have come forward that have been brought to the incubator.

The last thing I will mention is our national quality partners. And this is where we really bring together our member organizations around specific topics to talk about action. OK. We've got measures. There is a national issue. How can we accelerate the use of measures and the implementation of measures to drive change?

So, I will mention, for example, one of our recent efforts was the Antibiotics Stewardship Playbook where we brought together a diverse set of our members that actually developed a playbook in antibiotic stewardship. Obviously, that has been in the new quite a bit in the last year and a half. And this playbook is very practical, and it is really for hospitals and health systems to strengthen either their existing antibiotic programs in their institutions or actually to develop one. Again, remember that transparency thing. This antibiotic stewardship playbook is on our Web site. It is free. Anyone can download and use it. And I heard a factoid recently about how many times it had been downloaded and, literally, it was thousands of times. And I can -- tens of thousands of times. So, that is an example of an action item. So, I will tell you that I personally work in health care in one way or the other my entire career. And I have never seen the scope or the pace of change that we have seen in the last five or six years. It has really been phenomenal.

NQF has to change, too, because health care is changing and that is where we live. So, we have developed a strategic plan you see that you see the graphic on the slide for to cover a three-year period, 2016 to 2019. And it is moving NQF from a more reactive positive because, historically, quite frankly, NQF sat back and waited for somebody to develop a measure and then bring it to us for endorsement. That is historically what we had done. So, a much more proactive role of taking -- of leading and prioritizing and collaborating to drive measurement the can result in better and safer and more affordable care.

So, as you look at around this graphic at the strategic initiatives, they really build on and expand our core competencies. For example, we are looking at measure gap, those areas where we need measures and don't have them, and existing measures. NQF is creating criteria by which gaps and measures can be prioritized hopefully providing guidance to measure developers for what needs to be done. And in part, this project is going to contribute to that effort with the framework. It is to help us think about where (it needs) for measures.

And endorsing and selecting measures -- talked about that through our endorsement process and the measure applications partnership. But,

hopefully, can we also reduce the number of measures that are in use to address burden and also help align measures?

Over in the left-hand side, you've got something that says "Facilitate Feedback." Well, we learn a lot of about measures through the endorsement process. But, we need to know more about what happens when measures are in use. Implementation challenges, problems, issues with the data, the good and the bad changes that may result when these measures are put into play. So, we currently have a feedback initiative under way where we are going to be actively soliciting better and more complete information so we can get that into the hands of decision makers when they are considering measures, whether it is for federal programs, whether it is for endorsement or a number of other uses. So, really, we are trying to create more of a learning system in measurement that gives those decisions makers access to better information.

All right. You have just had the (whirlwind for us in) NQF, what we do, who we are and some -- and, hopefully, understanding how your work really ties into a much broader portfolio of work at NQF. So, before I turn it over to the next speaker, let me pause there and see if there's any questions, anything that was unclear or if I made some outrageous statement that needs to be addressed.

Any questions?

And I think, Kirsten, if I am not incorrect, all of our committee members are unmuted.

Kirsten Reed: Yes.

Marcia Wilson: So, all you have to do is even just to say your name and we will be glad to address your question.

Marc Price: This is Marc Price. I have a quick question.

Kirsten Reed: Yes?

Marc Price: Is all this information on SharePoint? Because I am still not -- I am having trouble logging in. So, I have been -- I am using the handouts that were sent via e-mail. Is all those information you are talking about in the slides on SharePoint so when I do have access, I can look at them there?

Kirsten Reed: The slides themselves are not yet up, but they will be following the Webinar.

Marc Price: OK.

Marcia Wilson: Did you e-mail the slides to everyone?

Kirsten Reed: No.

Marcia Wilson: Could we do that?

Kirsten Reed: Yes.

Marcia Wilson: Yes. Hi. This is Marcia. Just having a -- sorry -- a sidebar conversation. I did not realize that you did not have these that we are presenting. Is it -- that we are presenting. Is it possible -- I am looking at staff to e-mail those as we speak, do a blast e-mail to the committee and just attach those. I apologize. I thought you had access to these slides already.

I tell you what, Marc, we are going to work on that and see if we can get that to you. But, I don't want to hold up the meeting in the meantime. But, thank you for bringing that to our attention.

Marc Price: Thank you.

Marcia Wilson: OK. And I think I am turning it back over to Kirsten.

Kirsten Reed: Yes. All right. Thanks, Marcia.

So, now, I am going to go over some not-so-exciting stuff and, then, turn it over to Kyle and Jesse to get into the really exciting stuff.

Next slide, please.

So, as we have already kind of talked about the goals of the project, you know, what are we hoping to accomplish throughout the next few months? And, really, the goal is to establish (a prioritized measure concept list) to guide the development of performance measures in support of enhancing the quality of ED transitions of care. We will do this by developing a framework that addresses the current landscape of quality measures to inform future development focus and ensuring that the patient perspective is incorporated along the way. We will also assess the potential of translating existing measures to support the overall goal. We will assess this piece a little bit later on in the Webinar.

Next slide.

All right. So, on this slide, you can kind of see the, I guess, timeline of deliverables moving forward. So, we have made it to the first deliverable. So, we can check that one off. Well, not yet. Almost. But, soon enough. So, following today's Webinar, we will be continuing our work here on our side on the environmental scan and also begin doing some outreach to potential key (informants), who will also tell you a little bit more about how that is going to work later on in the Webinar.

Our second Webinar, which will be happening on February 1, is our multi-stakeholder input Webinar. Because this topic encompasses so many different areas, we really want to make sure that we solicit information from a variety of experts. We are not saying that you guys aren't enough. But, we know that you can't beat -- you know, 20 people is not enough to kind of cover the topic area.

So, we have done some outreach to various NQF project teams, asking them to invite their panels and committees to attend this Webinar, during which we will be providing a project briefing to a broader community in order to incorporate their feedback. Some of the panels that we have included in our outreach is care and coordination, person- and family-centered care, Medicaid innovation, telehealth, patient safety and rural health. We also expect that all of you attend this Webinar as information gained during it will really help to

guide future work and allow us to work against silos to ensure there is no redundancy and that we are harmonizing across all domains of measurement.

So, our third Webinar will be a preliminary environment scan review. During this Webinar, we will be discussing our draft environmental scan results with you and obtain your feedback and recommendation. The scan that we are presenting will have two parts. First, the scan of existing measures and measure concept that relate to this topics area. Again, that is something you will be hearing about when I am finished.

And second is a literature scan of articles, findings, evidence, guidance and all that kind of stuff, which will all be based on your expert feedback to really support which elements should be incorporated when conceptualizing potential measures. You will all receive the preliminary scan prior to this Webinar to ensure that you have enough time to review.

So, following that Webinar, we will have our two-day in-person meeting on April 25 and 26. This will give us the opportunity to all come together and meet face to face to discuss a number of items including the opportunity to leverage the measures found during our scan, provide guidance on important aspects of ED transition that may introduce (strings or various barriers) for measure concept and review potential transitions of care between the ED and other sources of care in order to identify key elements of ED care that could benefit from quality improvement. We promise that this meeting will be fun and interactive and really kind of we will use your time appropriate, we promise.

All travel to this meeting will be covered by NQF. So, our meetings department will reach out to you prior to the meeting with information on booking your hotels and flights and all that stuff.

So, after that meeting, we will come together again on May 24 to do a quick little debrief and review and discuss the recommendations from the meeting, as well as to discuss priorities for the framework, consider experiences, best practices and challenges shared by stakeholders.

Excuse me. Following that meeting, the project team will be busy working on drafting the measurement framework using all the information we received up until that point to prepare for our public commenting period set to begin on May 24 -- I'm sorry -- 26. At this time, we will post our draft framework for a 30-day public commenting period. So, the date on the slide is incorrect. And, so, we will update that. It will go more towards the end of June. And we will allow the public to make any comments on it.

So, our fifth and final Webinar will be our post-comment one. And that is on July 12. This will be used to discuss and review any of the public comments we receive and then prepare our responses. And, then, following that Webinar, the team will incorporate all suggested (edits) and comments and everything we have gathered from this point on and prepare the final report, which I will discuss in more detail on the next slide.

All right. So, all of these work will lead us to our final report, which will illustrate the definition of quality transitions of care for the emergency department, discuss the current measure landscape, identify gaps in measurement and key concepts for quality transitions of care, establish a framework and include a framework (time list) of measure concepts to show the opportunities, barriers, and challenges as well as what, if any, special considerations will need to be made.

The final product will be something that everyone across the health care spectrum can use in a number of ways. Developers can look at the gaps noted and potentially develop measure. Providers can see what measures and best practices are out there that they can implement. And policymakers can see the need and value for quality transitions of care.

All right. Now, I am just going to quickly talk about everyone's roles and responsibilities. So, as we mentioned earlier, you have all been selected to be part of this panel due to your wealth of knowledge and expertise, that we know that you will assist us in achieving the goals of the project and engage (in discussions) while providing valuable feedback which will guide the development of this work.

We have also selected two co-chairs, Steve Cantrill and Janet Niles, who will assist the project staff at facilitating meetings and ensuring that we all reach consensus on decisions, keep us on track during meetings without hindering critical discussion and input, and assist us in identifying any additional information that may be useful to share with each of you.

All right. So, what is NQF's roles in all of these? We will be responsible for organizing all meetings and calls, help you and make sure that we are guiding you in the right direction, ensure that communication and collaboration among everyone is happening, be here to answer any and all of your questions and ensure that we are meeting project deliverables and milestones.

And, then, as Marcia mentioned earlier, we are all about multi-stakeholder approaches. So, we also have our members and the public engaging in this project. So, for this project, they will be asked to review the draft reports and provide feedback through the public commenting period and, of course, are welcome to join all of our Webinars and meetings.

We have also invited five federal representatives to join each of our Webinars and meetings as an opportunity for them to learn from the work that we are doing. They include representatives from SAMHSA-HRSA and (ARC).

All right. I will pause if there's going to be questions and, then, I will turn it over to Kyle and Jesse.

Kyle Cobb: OK. No questions.

Jesse Pines: Great.

Kyle Cobb: I guess silence is acceptance. You understand your role and we will -- we will move on to some of the information that we have uncovered so far and some of the -- a little more into the weeds in terms of our process. But, as Marcia mentioned earlier in her overview of NQF, NQF is really in an absolutely unique position to understand measurement, what has worked, what hasn't, where there are gaps and, also, things like the feedback (loop) that Marcia mentioned are really important inputs into what we do when we consider framework.

So, as we start to develop these frameworks, we have an environmental scan. And before I even touch sort of the details of the scan, I think it is important to maybe even have a level set around what a measure is and measurement. I never assume that everybody speaks the same language around measures. Some people refer to measures as tools. Some people refer to measures as performance measures.

So, you know, for the purposes of, you know, having good definitions, what we are talking about are measures which are standards that provide a basis for comparison. So, they, you know, can also be seen as a reference point against for which other things can be evaluated to -- you know, to bring comparison and produce a standard.

Performance measures essentially, as we all know, provide us with a means to assess healthcare against recognized standards. And that is not just my definition. I think that is somewhere from the NQF Web site. But, again, as -- you know, in the beginning when we went through our NQF overview with Marcia, NQF has been endorsing measures since 1999. But, there's also other measures which may be specific to health care systems or specialty societies to support their organizations in achieving high stands of care. There are also different ways of measuring.

Some examples include process, an example for which maybe, you know, percentage of women who have had a cervical cancer screening. That could be a process measure. Or an outcome measure -- the rate of deaths from any cause within a 30 -- within 30 days after hospitalization for a heart attack. Or there's measures that -- think about patient experience or patient-reported outcomes. So, patience experience with care surveys such as the (CAP surveys). And, then, there is structural that reflects conditions in which providers are providing care for patients. So, the number of productive hours worked by nursing staff with direct patient care responsibilities per patient day. So, that would be specific to the place where the care is being provided.

And then, finally, there are these fun things called composites which makes some people start trembling. But, they are essentially a combination of

multiple performance measures where you can provide a more comprehensive picture of the quality of care.

So, that said, those are -- and for us, when we talk about measures and endorsed measures, the idea is that they have gone through the rigor of NQF endorsement. They have a numerator and denominator. They may have exclusions. And they have been tested. And, so, they have gone through that rigor.

So, a measure concept -- and I am moving away from what a measure is to me -- a concept may be identified through guidelines or evidence-based practices. But may not have exact specifications for how to measure. So, it wouldn't have a numerator or denominator or have gone through testing.

An example of a measure may be the percentage of people that were -- that were discharged from an ED with a transition record but we wouldn't have any other information. So, if we turn that concept into a measure, we would have to compare it against something. So, we would have the percentage of patients who receive transition record over the patients discharged from within a determined timeframe, which may or may not also include exclusions. There may be people for which a transition record may not be appropriate to get out. And I will leave that to the experts to decide. But, that is really an example of the difference between a measure and a measure concept for what we are thinking about here.

So, on to the environment scan. And when we start a scan, we really think about, you know, the measures. We have our usual sources. And, then, we move on. So, existing measures are straightforward. And we include a series of directed searches from a standard set of sources.

But, for concepts, priorities, gaps, they all really go into what we are talking about in terms of framework. Think of a framework as an established relevant universe for what we are thinking about. It could even be a taxonomy. I mean, it is -- but, it is just something to describe what this area of (work) that we are thinking about and a way to better define it.

So, you know, for the concepts and gaps, they are a little harder and they -- and it is sort of an iterative process where we think about the framework. We develop the framework through literature reviews, input from you, our expert panel, from key informant interviews. And it is built as we determine what is relevant, what isn't, where -- how we form this universe. So, the measures and the existing measures are a small part of it and, then, we move on to the other.

The next slide looks at -- so, the measure review -- we have gone through a series of -- and you will, once you have access to SharePoint, be able to see our measure inventory related to this project. And Jesse will take you through some of the measures that we have look at and some additional criteria for deciding what is relevant and not.

But, our measure review is we go to the usual sources starting with our NQF QPS system and move on to (ARC), the National Quality Measure Clearinghouse and guidelines. We look at the health indicators warehouse, of course, CMS and their measure inventory. We also have their measures under consideration that come up every year as part of the MAP process that Marcia explained earlier. And, then, we have other NQF projects that are currently identifying areas of prioritization or gaps and, finally, The Joint Commission.

So, in terms of what we found as we put together our review of measures, yes, we -- and I am -- and, then, we will hand it over to Jesse in terms of our criteria and how we came on to these sort of buckets. But, we sort of divided between directly relevant, potentially relevant, indirectly relevant and not. But, the search did include transition ED. And we looked at other areas that could be adopted or amenable to use in the ED.

So, you know -- so, this is just as an overview of -- and you can see there is -- there is quite a few. But, you know, in terms of really the relevant ones, there is not as many as one would hope, just a few if you look at some of the top row.

Anyway, I will and it over to Jesse to walk us through.

Jesse Pines: Great. Thank you.

And I'm very excited to be working on this project. I think I know probably about half of you. Similar to Brendan, I have worked with you in a -- in a variety of arenas and I am -- very nice to meet the remainder of you. And we are also -- you know, we've got a really fantastic stuff of this project just, you know, sort of hearing and being reminded of everyone's bios. It is just amazing -- the breadth of experience we have at the -- at the table here in terms of experience with emergency care, with multiple sides of the transition between the emergency department, within the emergency department and other settings and also certainly the patient representatives, which will give us some great insight about their perspectives.

I think this was already mentioned. But, there are a lot of different transitions that occur between the emergency department and other settings, some of which we have clear representatives here and some which we -- you know, we don't have some representatives. So -- but, you know, I think a lot of us will have experience with some of those other types of transitions such as the emergency department to EMS, transition of care such nursing home transitions. I think that people have all had those experiences.

So, you know, I think the first question is, you know, what do -- what do we mean by transition in care and what is really relevant to us? In our -- in our scan, we found a lot of different measures out there. And you can certainly after the call be able to log in to SharePoint and see there is an Excel file where we have a lot of details from the environmental scan and where the measures have been categorized into just some broad buckets. And this was sort of a first pass at me looking at these measures and here with the staff to focus them.

So, you sort of think about how to measure quality of care for a transition in care from the emergency department. So, we are -- you know, when it comes to what we are talking about, we are talking about transitions between the emergency department and other settings. And there are a variety of other settings that, as we know, the emergency department interacts with the -- from the emergency department to other settings outside the hospital to within the emergency department to within the emergency department to the hospital.

And, also, there are a variety of measures that look at the quality of programs outside the emergency department that actually may impact transitions in the emergency department. So, for example, there may be a variety of interventions, for example, that may happen in the medical home -- so, something that would be not directly -- you know, that would happen inside the ED but would certainly impact transitions of care into the emergency department. So, really, the -- you know, there are a lot of measures out there. You know, the environmental scan uncovered a lot of measures that I hadn't seen before.

Just to give you a sense of what some of the measures are, sort of think about either the quality of a -- of a transition. So, what we don't have is a lot of measures that really look at the quality of a -- of a transition itself, specifically whether, for example, the -- you know, the -- you know, the right information was transitioned in a way that was useful to both -- to both providers. So, really, there is really not many measures that look at the quality of the transition, although there are several measures. And this is one of the directly relevant ones that we (found) on the next slide here which is -- which is the presence of specific elements within the transition measure.

So, there are -- you know, when we are transitioning information between sites, there are certain things such whether, you know, which procedures were done in the emergency department, what the diagnosis was, what some of the test results were, what the follow-up plan of care is. But, again, there's really very few measures related to the specific quality of that -- of that information. So, there were, again, several directly relevant measures that look at elements related to transitions.

For potentially relevant measures, the next one, this is just an example. Medication reconciliation after discharge -- so, this is a -- you know, a process that is related to the -- related to transitions in care where if done better, it may impact the quality of a transition. So, when it came -- when it came to an indirectly relevant measure, this is a structural measure.

On the next slide is, for example, the adoption of medication e-prescribing. So, this is sort of a structural measure that looks at, you know, patient encounters and whether or not a process is in place that may -- that may impact transitions a little more indirectly.

And there are -- there are also a variety of measures that are -- that are directly relevant to other settings to other transitions in care, you know, specific elements that may be transitioned between providers that could actually be adapted to the emergency department, specifically transition measures between the hospital and home. There are a lot of -- a lot of measures there that could be potentially adapted to the emergency department.

And, also, when it comes to the care quality measures -- and you will in the environmental scan we did have several measures in there in the initial scan that looked at the quality of specific care processed in the ED, for example, related to chief complaints. You know, for example, you know, are we doing EKGs in syncope patients and, you know, are we doing EKGs in chest pain patients? That actually is sort of out of scope at this point and those were marked as not relevant.

So, just a couple of comments about sort of your role. And I have been involved with NQF since -- I guess, 2009 was the first -- I was a member of a committee back in 2009. And, you know, from my perspective, I have learned a tremendous amount being involved in these (committees). You know, really, your role is not to help us write the report. The committee will be responsible for really sort of writing the report and gathering all the information. Your role is to really -- to really participate and really give us your feedback and react.

And, again, what we wanted your feedback on things that were missing, the -- you know, in terms of the various projects I have been involved in, the ones that involve conceptual frameworks I found the most interesting. And, really, the ask here is for you to sit with us and, as a committee, try to think -- try to think about ways that the measurement community can measure a lot of the concepts that may be not measures at this point. So, for example, thinking

about the quality of a transition in a scenario where there is really not a whole lot in that area. That may be a point for discussion.

And, also, really help us think about what are the ways to prioritize transitions measurement in ways that can be sort of either immediately used, you know, sort of immediately taken on by a measure developer. So, thinking about the audience for the report, the measure developer might look at the -- might look at the measure concepts list. That, you know -- that could be handed to another -- one of the processes here in NQF with the measure incubator whether we could be -- take one of those concepts and further develop it. It could -- it could potentially be handed off to, you know, (RGEN), (ASEP). You know, (ASEP) is taking more of an active role in quality measure development.

So, really, sort of thinking about our overall goal here. The overall goal is to write a report. And your role is to participate and give us your feedback as we develop that. And, again, the -- you know, really differentiate -- the overall goal is to, you know, come up with the framework and then come up with some -- a prioritized list of measure concepts that would really be useful for measure developers and also for folks who are interested in learning -- in learning more about the topic.

So, at this point, we have been talking for the last 70 minutes. What we want to do is hear from you all and get -- you know, get some of your feedback on either questions, you know, areas that we should look into in the -- you know, in the near future, things that we are missing. We are also going to be sharing some of the names of folks. We are going to be doing some key informant interviews with and want to get your feedback on other folks we should potentially talk to. But -- and, so, for this call, I am going to be sort of -- Kyle and I are going to be leading and moderating this session. For future calls, we are going to be asking Steve and Janet to moderate the calls.

But -- so, at this point, let us go ahead and open it up for questions or comments.

Kyle Cobb: OK. Yes. And I just -- as you mentioned, before we get to that point, there's just a couple few more slides. And I know we've had a huge information push for which you will be able to read at your leisure in SharePoint.

But, I think, some key takeaways from what Jesse just mentioned are that we will do the heavy lifting. We will do the literature review. You will direct us in our work. We have the usual sources that we will go through. We will also have supplemental experts by -- you know, we see you as the experts and you are the expert panel. But, we will have a series of key informant interviews, including the likes of (Eric Coleman) and (Jay Shure), who were unable to be on the panel but we do need their feedback.

And then, finally -- and I am flipping slides really quickly to get to the fun part of our conversation today. But, we will -- I am not onto -- keep going, Vanessa. We are into the literature review. So, here we are. And, I think, this is really where we want to start getting some interaction.

We see the definition of this project -- the definition that we will adopt for this project is here for -- in terms of transition of care. If you have -- please review the -- and if you have feedback on this content or any words missing that you would like to share with us, please share with us after our meeting today. We are not going to discuss this now. I think we have more important things to move on to. But, this is something we really ask you to review, look at, think about and get back to us on.

The next slide.

And here, we get into our expert panel discussion. And, I think, we said this in a bunch of different ways over the last hour and 15 minutes. But, really, the goal is to -- of this project is to just scope out our universe. And we want to develop a large enough framework to accommodate different situations and populations. But, we also need to recognize the project parameters -- it's 12 months -- and that we are not going to be able to turn over every rock and pebble to that. And we, you know -- our goal is for this framework to be foundational, to inform future work and to act as a guide for prioritizing gaps and existing measures.

So, with that, I think here are -- I will hand it over to you, Jesse, to really think about what are most important areas of ED transition that we should focus on.

Jesse Pines: Yes. So, really, we want to hear from you at this point. Again, any questions about the process or (open) -- or also any comments about where we should focus.

Stephen Cantrill: Jesse, Steve Cantrill. I have about the literature review process. Do you have a tool or do you employ methodologists to actually grade the literature? I have seen too many measures that have been developed really on poor data but there is citation in the literature. But, it is a crap piece of literature. So, are you guys -- in terms of the existing measures, is there an attempt to judge the quality of -- upon -- the literature upon which the measure is based?

Jesse Pines: Yes. We -- so, the only thing we really know at this point from looking at them is whether or not there is NQF endorsement. If there -- if there is NQF endorsement, there is a very rigorous process that those measure go through that look at -- you know, that look at the literature, whether or not there is literature supporting a measure, whether or not that -- you know, how measurable something is, whether it is usable, whether it is feasible.

So, for NQF-endorsed measures, there is a very rigorous process that happens. For the purposes of our literature review, we did not specifically grade the literature. This is more of a -- you know, more of a conceptual project at this point. So, you know -- so, really, our literature review was very expansive.

Stephen Cantrill: OK. I am just concerned that, you know -- that we promulgate stuff that really is not purely evidence-based.

Jesse Pines: Yes.

Stephen Cantrill: And I am -- I am very concerned about that, especially looking over the universal literature -- and there is a lot. But, even though a small amount that I have looked at, the results are highly variable in terms of whether we are doing any good or not.

Jesse Pines: Yes. Right. And then, you know, at the end of the day, what we want is a series of measure concepts that we think that, you know, might have a chance to get through the NQF process, which would be a rigorous process to look at the literature and to be -- just to be specified. So, you know, measurability and the -- you know, whether or not something is important to, you know, report and that there is good literature behind it is going to be certainly one of our criteria.

Kyle Cobb: Yes. And I think it's important. And feasibility.

Jesse Pines: Yes.

Kyle Cobb: It would be your two main factors for evaluating those.

Stephen Cantrill: OK.

Jesse Pines: Other questions?

So, maybe what we could do is just take a quick look at some of the questions on this slide. So, you know, when you think of ED transitions, is there anything that we -- that we haven't, you know, talked about already? So, thinking about the various transitions between the ED and other settings, are there -- are there -- you know, are there transitions that are more measurable or less measurable?

Should we be thinking about transitions -- quality of transitions in different ways within the emergency department, between the emergency department and other settings et cetera?

Joseph Karan: Jesse, this is Joe Karan, the patient. I am curious as to the scope of the transition of care and how it reaches every corner of a patient. As I do with patients with end-stage renal disease, they have multiple comorbidities, multiple specialists. It is -- when looking at it on a single-patient premise, it seems like it is even a very difficult thing for a patient.

(We just want to) make sure the information from the patient is there to the emergency room when they get in and to make sure all the information that

has been (done in the) emergency room gets back to all the physicians, all the specialists, the dialysis clinics and other health facilities for the patient. It looks like it would be a major accomplishment to be able to meet them. And I am assuming we are not using electronic medical records.

Jesse Pines: Yes. I think, certainly, you know, electronic medical records are on the table. I mean, they are present in most emergency departments these days with -- this -- you know, over the last five years, there has been a major shift to electronic medical records. So, that -- so, that would certainly be on the table. It would be, you know, measuring transition in care that would involve electronic medical records.

And, also, I think you brought up a really good point for us to think about. It's high-risk populations. You know, there are certain patients who are going to need more focus when it comes to transitions in care, certainly for dialysis patients or older adult. People with more complex health care needs are going to be a greater focus. So, again, we want to have discussions about specific measures for those populations or whether or not we should think about measurement differently for those high-risk populations.

Marcia Wilson: You know -- and, Joe.

Female: (Inaudible).

Marcia Wilson: I was just going to add on. Sorry. Joe, this is Marcia. And you raised a really good point, which is how do we set the boundaries in this project. The scope of this project is quite broad. And we have been talking about that internally, and we will certainly be using guidance from the expert panel on this. We want this framework to be foundational and to be somewhat multipurpose in terms of settings and patients. But, we also realize that there are going to be certain populations of patients -- and you brought one in end-stage renal disease patients with multiple comorbidities -- seeing a wide range of different providers and different settings. It may be that we cannot address every single type of patient and every type of setting. But, can we create a framework that, then, in the future could be used to drill down to certain subpopulations and still be a viable framework that could be used in a more (natural) sense?

So, that will be one of our challenges going forward. We cannot boil the ocean in 12 months as much as we would love to. But, can we create a framework that can be used for multiple different purposes with our work in this 12 months demonstrating the utility of that framework, if you will?

And I apologize. There is another committee member who just spoke, and I didn't mean to cut you off.

Julie Massey: Yes. Hi. It's Julie Massey. I didn't mention -- I'm also -- in my background as a former chief medical information officer. Very focused. And I glad that you mentioned the electronic medical record. Just recognizing the context that we are in where there has been some other -- a number of other initiatives with Meaningful Use and other things around the electronic exchange, regional and local health information exchanges where we are working within, there has been some frameworks set up and measurements out there that we can at least leverage and look at where organizations' practices are already looking at some of at least the actual exchange of the information -- that we have an opportunity to look at that content and the quality of it as well, understanding what has come before and then working within a context to help define what is most useful in that setting.

Jesse Pines: And, Julie, just a clarification -- thanks for participating here. Great to have you on the panel. When you -- when you say quality, we didn't really come across a lot of measures that (throughout looked) at quality -- (they do) -- how is that being measured or how was people thinking about that?

Julie Massey: I think, going back to -- the framework we are talking about establishing is what is the information that we are looking to convey? What are the key pieces of information that we want to convey and make sure that gets conveyed accurately, whether -- it is not just simply the ability for us to send or receive a document electronically. But, is it the relevant information that is needed?

Jesse Pines: So, it is specific information elements, not just the structure and (price in place).

Julie Massey: Right. And, again, leveraging the work that, perhaps, has already been done that we have been pushed to do for other initiatives where some of that metric and ability to measure is already in place, but to look at that and see if it can fit within our framework so that it will make it easier to actually measure.

Jesse Pines: OK.

Arjun Venkatesh: Hey, it's Arjun here. Jesse, you know, as I look at the questions you have on the slide and in some of this discussion, I guess, some initial response in places where it might contribute to the scope of this work are you've got a question here around do the project include internal ED provider handoffs? And my gut reaction when I saw that was no, thinking back and reflecting on what Brendan had said earlier on about our goal, about thinking about this at the population level, viewing the emergency department often as a, you know, front door or front porch to a hospital-based case system.

I will say, though, here, I am a project (PI in Art Grant) where we have a learning laboratory around hospital care transitions in, through and out of the hospital. And one of the interesting things we found is as we have tried to improve safety of care transitions into the hospital, one of the primary drivers that we have identified as a safety risk to care transitions into the hospital has been hospital capacity issues (around crowding and boarding), which is a place that ASPR has done a lot of work.

And, so, I think, even though my gut initially said "No," I do think to some degree, we have to think about how the hospital ecosystem impacts care transitions in terms of its readiness, ability to handle surge and a variety of things like that. And there are measures that we could think about in that space.

The other thought I had was that when you have this question around measures of ED visits have an outcome or other ED transitions, I think that one of the concepts that would be great for this group to deal with is actually this issue of ED visit as an outcome of quality measures. And to get beyond the usual -- the usual party line on this is one of two ways it goes. Either, A, it goes that it is from traditionally in a lot of, you know, circles and federal

policymakers that (look at ED visits as bad outcome, it's costly), expensive, inefficient. Or there is this other side of this which is a variety of folks that you've heard on this -- within this group.

Before, I talked about how it is the primary place for acute (unscheduled) care. It serves as an acute diagnostic center. And, I think, we have to get past this kind of ED visit as an outcome of the measure good, bad. I think, what it is is it is about context. There are times when including ED visits as an outcome in a quality measure does make it an important measure of care transition. And maybe that is one we are measuring at the population level or we are measuring it at a system level of things like that.

And there are probably times when it doesn't make sense. And if, I think, this group could give guidance to future measure developers on when it does make sense and doesn't make sense to have the ED visit as an outcome using existing measures as frame of reference, that would be valuable.

And, I think, it also would allow us to think about proposing measures around the role of the ED in acute unscheduled care. And, so, I think that, you know, there is this idea where we keep (focus on SPs in the New England Journal perspective) piece around acute care fragmentation. There is a world in which you could think about measures of acute care fragmentation or acute care coordination being converses of each other. And we may want to measure not just ED visits but health system. I think, one of the challenges we have is we've got a health care system where there is increasing consolidation, there is increasing relationships between hospitals, emergency departments, ED groups -- you name it.

And what we haven't done is develop measures to see whether or not that consolidation is complementary with coordination of care, which is the general premise by which it runs when we use the word "system" for these health systems. But, having some measures around that to see if it is coordinating acute are would be valuable.

Stephen Cantrill: Arjun, Steve Cantrill. I agree with you very much. Especially in terms of the internal handoff, we may want to partition it into high-risk patients and lesser-

risk patients, such as the board of patients I always consider high risk. And in terms of the ED visit always being a negative, I think that is -- we could do a great service to all of medicine if we look critically at that and we are able to partition those. Sometimes, it is and sometimes it isn't. Good comments.

Marc Price: This is Marc Price. I'd like to add to that. As a -- as a practicing physician 100 percent of the time, one of the biggest frustrations I have is when someone comes back not just from the (ER or hospital) in general with orders or with advice or with some type of information of what to do or what the follow up or the fact there is need for follow-up care with visiting nursing or physical therapy where they have medicine changes and I am not aware of any of it.

And it's a simple -- I mean, I think it was a simple communication, you know, with a phone call. But, it actually throws a wrench into it and it actually casts doubt on the patient's mind -- (at least I would assume it casts doubt on the patient's mind) about the ED or the (hospitals do) the right thing or is the primary care up to date with what is going on.

So, there needs to be more communication, whether that'd be through (it with ability) with (EMRs), whether that would be with phone calls, with templates, with discharge planning or something. But, you know, it is something that -- it is a -- it is a chronic source of frustration and it makes -- I think it makes the whole system looks disjointed.

Male: Yes. And just another comment that came to mind. You know, I think, another issue that we may want to discuss is sort of the level of measurement. You know, we sort of think about at NQF there are a number of different measures -- ways that measures can be deployed in terms of at the provider level, at the ED level, at the health system. When we think about transitions measures, this is really about a -- transition is about a (dial). It is about -- it is about one group sending information and the other one receiving information.

So, I think -- I think -- I think it will also be important to think about sort of who is responsible and who is responsible for making sure that the

information is transmitted and also received and then used for during the next visit.

Donna Carden: Jesse, this is Donna Carden. Wonderful comments here. And I am not sure I can tell you the order of what we should focus on. But, I want to bring up the patient's perspective at least from my research and the ED-to-home transition. And in terms of patients, what they have told us -- our patient stakeholders told us, it is not necessarily a deterioration specifically in a chronic disease that leads to go to the emergency department. It is -- it is their anxiety, their lack of informational support. And, so, you can have all of the greatest transition record available and that can be transmitted between providers.

But, I would suggest that there is another key ingredient there that impacts the quality of the transition. And that is what does the patient know? What does the patient understand in terms of what they are supposed to do as a next step when they transition from the emergency department back to home? Who are they supposed to follow up with? What is the quality of what they understand? Because, clearly, the emergency department visit -- what we have found is that both the patient engagement and their quality of life is highest at the time of that ED visit because, a lot of times, their fears, their anxieties and the informational gaps that they suffer are satisfied during that visit and they reform in the days after the ED visit.

That leads to a poor quality transition for them and it may, in fact, lead to another ED visit because they don't know what to do and the quality of information that they are provided was, in fact, very poor. So, it is more than just providers. The patients are a critical ingredient in that whole mix.

Jesse Pines: Great point.

Kristin Rising: Yes. This is Kristin Rising. I just wanted to dovetail on that. First, I think we should (really be doing) research together (because -- so much have been found -- what I have been doing and finding). But, in talking with patients about (nursing home), I would agree the feeling of the unknown and, I think, the feeling of kind of know where to go and lack of ownership for a lot of people after they leave an ED encounter, I think, the really challenging aspect

for patients, and many patients have really identified this as the primary that they seek recurrent care in the emergency department. I think, it is -- it is incredibly challenging for us to look at kind of how to capture that in a systematic way.

But, I think, at least for my work, there is even a portion of patients -- a large number of patients, really -- who are going home with that feeling of fear and uncertainly related to like "I still don't know what is going on with me. Right? You ruled out -- you said all these dangerous things are happening. But, I still don't know what is going on. Therefore, you can't give me a clear plan. Therefore, I don't even know where to go next." And, I think, some of that can actually be captured at the time of -- and, I think, thinking about how we can capture that patient experience in the post-discharge period is really important.

(Multiple Speakers)

Jesse Pines: …patient-reported measures, Kristin?

Kristin Rising: Sorry.

Jesse Pines: Were you thinking patient-reported measures?

Kristin Rising: So, I think it would be some sort of patient-reported measure. I mean, I don't think yet. I don't think any of the existing kind (PROs) existing. But, I do think that we getting some patient report on some of their experiences is a really important element of this.

Jesse Pines: Great. OK. Great point.

Joseph Karan: This is Joe. Just one thing. Are we -- are we counting every type of visits to the emergency room here, even the ED rooms that are used as primary care facilities for those without insurance?

Jesse Pines: Yes. I think, we do want to look at sort of a broad group of ED visits. So, you know, one for (low-acuity reasons and for all reasons). Yes.

Joseph Karan: OK. Thank you.

Aleesa Mobley: This is Aleesa Mobley. Regarding ED visits of a broad nature, I believe that there are still well over 80 percent of what goes into the emergency room that can be considered a primary care visit. So, in terms of outcome measures, we might want to look at exactly the reason why someone goes to the emergency room. Obviously, the person thinks it is an emergency. But, is it because they were unable to get an office visit? Is it because it was something that was truly acute and different in terms of their health status? Or was it simply an unmanaged chronic condition that they weren't well at managing in the first place?

In terms of the information that goes back home or goes to the emergency room back to the subacute care center or the skilled nursing facility, a lot of times, the emergency room provides the correct paperwork and the correct information. It simply never gets all the way to the provider. Is there a way for emergency rooms to give the discharge planning to the patient as well as make sure it gets electronically sent directly to the facility where the patient is going, whether it is a skilled nursing facility and assisted living facility or a primary care office?

Jesse Pines: And for the first -- for the first comment there -- and I think others will probably have comments about, you know, the use of an emergency department for primary care. I think -- I think that could sort of dovetail in the -- in the discussion of what Arjun had mentioned of sort of the role of the emergency department in the -- in the acute care system and sort of how we think about ED visits as a measure.

I was -- I was involved in another group about seven or eight years ago where we looked at developing some sort of community measures looking at the emergency department as an outcome of sort of community health interventions and sort of thinking about different types of emergency department visits as a measure of, you know, access in the community. I think that we can certainly have that discussion.

Elif Oker: You know -- this is Elif Oker. I'd like to add, just overall, one of the things I'd like to suggest that we be cognizant of as we develop this framework is the

end user experience in all of this. It would be great to have a framework. But, if it becomes something that is onerous or not relevant to the end user, whether that end user be the provider who is getting emergency care or the primary care physician or the patient or, frankly, the patient's family and the context (with what) people experience the whole ED visit, I think it would be doomed to fail.

So, one of the things I'd like to see talked about is, OK, there is a measure here that we think is relevant, but how is that measure being experienced as we ask someone to pay attention to it or to register or to communicate it?

Jesse Pines: OK. Other...

James Dunford: This is Jim Dunford from San Diego. One of the things that is valuable, I think, in addressing patients, particularly chronic users of emergency services and those people that really (cost very most) is the ability to alert the primary care physician of the patient's arrival in the emergency department or at least to notify them if they have been admitted. The use of ADT, the Admit Discharge Transfer electronic alerting systems, I think, have been really until now underutilized and, I think, it is a measure gap.

The idea that a patient is arriving in an emergency department and the opportunity to tell the primary care team of that patient, particularly high-risk patients, really would afford a tremendous opportunity because a lot of times, as an ER doc, we really don't know why the patient arrived and we don't know what the care plan is. And if that electronic care plan can't be pushed electronically, at least alerting systems that can notify somebody on call for a large group that one of their patients has arrived in an emergency department is -- would be a tremendous value added. And the ability to measure that -- it may not -- it may just be in its infancy, but I think that that is something that we have to keep our eye on.

Jesse Pines: OK. That is right. Yes. Great point. And, again, try to -- try to think about the various types of measures we want to come up with. There are going to be certain measures that already exist in our -- in our environmental scan, specific transition elements that should transition from the emergency

department to other providers. And, then, there are going to be a lot of these more sort of broader conceptual ideas that we definitely want to have those discussions and think about how to -- how can we fit, you know, patient-reported outcomes and, you know, the concept of notifying the providers when they come into the ED (into) the measurement framework are great points.

Male: What other idea...

Stephanie Witwer: This is Stephanie -- sorry.

Male: Go ahead.

Stephanie Witwer: This is Stephanie Witwer with a comment regarding kind of the upstream systems around patients coming to the ED. One group of stakeholders that I haven't heard mentioned yet that you may want to consider are triage centers -- nursing triage centers. I know we have a large triage center here in Rochester, about 180,000 phase calls a year and send around 5 percent of the patients to the emergency department or even through ambulance to the emergency department.

And, you know, we have very little communication directly with the emergency department regarding effectiveness of that triage and the communication that we send, whether it is helpful to the emergency providers or not.

Jesse Pines: Other comments?

Arjun Venkatesh: It's Arjun. One other idea I had -- I just -- I don't know if it fits under this category best at all. But, it is kind of this idea of transition measurement and elements of a transition measure. I don't know where you want to put things such as level of measurement or use of measurement. But, one of the things that I know is challenging in previous work at NQF that was done under the Care Transitions Steering Committee -- I did some work with them some years back -- was that, often, our measures focus on one actor in the health care system. So, they are, you know, a measure of a primary care doctor's quality of care of a measure of an emergency physician's quality of care or a

measure of a hospital's quality of care or a measure of a nursing home quality of care. And what we really want in care transition measures is to measure the in between. That is where the breakdowns happen. That is where the challenges are. That is where the uncertainty and information gaps that patients face are.

And, so, one of the potential solutions of that is since you can't measure the in between, is can we develop measures where the identical measure is used on both ends of that? And, so, in the same way that a hospital and a nursing home may have 30-day readmission measures that are aligned, does the same framework apply to measures around acute care transitions where the same measures would exist in the mental health -- for mental health care providers as in the emergency department or for a primary care organization in the hospital-based emergency department so that you would actually start getting aligned incentives? And you would assume that if you mention them both in the same measure, you would start driving people to solving that in-between space.

Jesse Pines: I think really, really good point.

So, I will just let you know we have a couple of other question we put up here in the last few minutes here that talk about some elements of, you know, good, bad, adequate transition and thinking about some of ways. And we have had, you know, some of this discussion already, but thinking about how can this be measured, you know, a certain way, you know, when there is -- you know, there may be a transition between two settings such as a nursing home and an emergency department where there -- you know, there may be an absence of a transition, there may be no phone call, you know, no transition of information and really no ability to sort of call back someone and figure out why they were sent in.

Or, also, there may be the quality of a -- of a transition that exists on a regular basis such as the ED -- (the hospital list) transition where, you know, there may be certain information elements that, you know, should always be discussed. I mean, you know, the -- or, alternatively, you know, something about understanding whether the right information was transitioned.

And then -- and also thinking about -- we had some discussion of the sort of ED-to-ED transitions. And I was at a group several years ago that sort of looked at this when emergency physicians are handing up to one another in the -- at sign out sort of the balancing completeness versus (salience), I think, which is a really, really big issue. You know, I took sign out yesterday at 3 o'clock and there were, you know, 30 different patients who I was hearing about and, you know, certainly, the question is should I be hearing five different elements for every single patient? It might be sort of too much and sort of how do we balance that.

So, just for, you know, the last few minutes, I just want to open it up for discussion about -- thinking about sort of specific elements or how do we -- how do we think about measurement in this area for things we haven't discussed yet.

Joseph Karan: This is Joe again. I am sorry for talking so much, but it is hitting a lot of my -- a lot of my buttons. We -- it is -- I refer back to the computer industry -- garbage in, garbage out. And if that information we are getting from the patient at that most critical time in ED can either not be found or it takes too long to get it or the patient doesn't have anything like a thumb drive, which we are pushing for -- in Florida, for every patient, I have a thumb drive -- and also for physicians to use the portals that that the patient may have entered their hospitals that will list everything for them, their last labs and their overall condition and what problems they have -- I don't see a lot of that being done. And I (am only seeing patients) many times a week. And I don't see any of that being done.

So, there is a -- there is a wait there between when the ED doctor or nurse can actually start doing anything other than your basic lifesaving things because they are trying to spend the time digging up all the information that their life would be easier if they had it -- (hand it to) -- or had a way to go to it.

And I think that one of the frustrating things for our patients is when you have a particular disease, you don't have a good memory. You don't have -- if your (toxins) are high, sometimes you don't -- you can't even think. If there

is no family member with your or just one, they may or might not have the information. So, to me, separate gateways of ways to get the information on the patient in the quickest form, I think, would benefit the visit from the beginning.

Jesse Pines: Yes. I think that is a great point. I am thinking about timing of when -- you know, when should that information be transitioned just to, you know -- what -- you know, an example of a transition where -- I used to work -- EMS transition -- there was -- there was a requirement to have the transition record in the chart within 24 hours of the ED visit, which was, obviously, you know, certainly, in a lot of ways, too late to actually use that information during the visit. So, I think that is a really, really good point about the timing and content.

Marc Price: Well, this is Marc Price again. Just another comment about that. Like I mentioned earlier, the communication is the best part. I don't -- and I didn't mean to think -- to sound like it was just a matter of getting information from ER to the primary care on follow up. I think there is -- it is a two-way street. I think the primary care has to be able to get the information to the ER. Without interoperability of EMRs, I mean, obviously, some medical Intranet would be the (opposite best) option where the EMRs are (plug and play) (anytime) (soon).

But, it is a two-way street. The information has to go both ways to make -- to facilitate the ER seeing the patient but also to communicate back to ED (so they have time of care) about what transpire so that there is (no break in care) and there is - it is more (continuity).

Stephen Cantrill: This is Steve Cantrill. And, again, it is not just access. It is having access to a data construct which facilitates the transition. I mean -- and people talk about the data dump. I mean, I can bury you in data and you will be wondering forever. So, we've got to be able to -- and, I think, Jesse already talked about it -- being succinct, you know, or being complete. And that is -- it is always a yin and a yang. And it might be different for different patients as well. But, I mean, that is something we need to consider.

Female: You know, building on that, the term in the digital community is smart data. So, perhaps, one of the activities could be to come up with the idea of what basic elements of information are needed to make that transition useful. And I think there are some variation on that theme. But what would be the basic elements that emergency physicians would expect from primary care physicians and the same in reverse?

Male: Well, I have always maintained give me a problem list and (list all their meds) and I am 80-percent home.

Female: I agree with you.

Kristin Rising: You know, that is certainly true. This is Kristin. And, I think, some of those discussions also just (apply in this area). You know, I served on the (Clinical Champion Committee) for our regional health care exchange platform. And these are very much discussions they are having there. So, I think, some of that can be leveraged off of some of the health care exchanges that are currently undergoing a lot of other structuring questions, you know, what needs to be (going to be) primary and what needs to come to the ED when patients present. So, some of that work is happening and (stuff we can leverage).

Male: Yes.

Elif Oker: Yes. And -- I'm sorry. Go ahead.

Male: Yes. Go ahead.

Elif Oker: This is Elif again. The reason I raised it -- I think one of the articles we were asked to look at always talked about the cultural differences between the types of providers and types of physicians. So, what -- I as an ED physician might say it is perfectly acceptable amount of information, it might seem (woefully) insufficient by my -- by my non-ED colleagues.

Jesse Pines: Yes. And also just a general point for the committee that, you know, Kristin, have you come across other groups that are working on similar projects where that is sharable -- you know, where you can share the information? Please do

send that to the committee. All of that -- we want all of that as early as possible or as that becomes available. So, please do send that.

Kristin Rising: Absolutely. (Will do).

James Dunford: Jesse, this is Jim Dunford one last time. As everybody knows, I mean, social determinants have held there are probably major drivers of the use of emergency departments and they are traditionally not even captured in the electronic record. That is at its infancy here with the Institute of Medicine. And the National Academy is starting to define what these are going to be. But, I think, it is an important gap right now to identify and -- because emergency departments -- while people are sitting in waiting rooms, there is an awful lot of time to find out whether people are fundamentally in the emergency room because they are -- because of food insecurity or a whole host of other social variables.

So, a lot of the so-called blame that I see being assigned to emergency room really has to do with the underlying determinants of these people and why they choose to access the EDs. And, I think, that is going to be important measure for these transitions of care. People who fall down, for example, at or over the age of 65 shouldn't get discharged home with a follow up in three days. I mean, there is fundamentally that matter with that entire construct that -- and we are really not capturing that kind of information today.

Adam Swanson: This is Adam -- this is Adam Swanson. I would second that. I think when you are talking about persons with significant mental health conditions, oftentimes, the go to for those folks are emergency departments, particular folks that fall onto the Medicaid bracket. And, then, when they transition out of the systems, very rarely are they connected with community-based providers and other mental health entities. So, I do think that the -- looking at the social determinants of health in some capacity would definitely be important.

Janet Niles: Yes. This is Janet. And I 100 percent with both of your comments. And, I think, the other thing we should make sure that we include in there is some kind of look at caregivers, especially when we are talking about people with

dementia or people that have fallen because a lot of times, they are there because the caregiver is burnt out, not because the patient needs to be there.

Male: Great point.

Elif Oker: This is Elif Oker. I'd like to ask a question. And I don't know where this would quite fit. But, I wanted to raise it in terms of patients who have health insurance of some sort, whether it'd be a government plan or a private insurance, and those who don't. For those who do have some means of payment, they might also have resources available through their various payers, whether it is Medicare, Medicaid or private insurers in terms of care coordination and care management, access to information about that patient through an assigned case manager. Is there a role for connecting those two environments in this project? I am not entirely sure, but I thought I would raise it.

Janet Niles: This is Janet. Hi. I think there absolute is because too many times, there is such a silo between the providers and the payers that, I think, there should be a bridge there and, maybe, there is a way we could measure that.

Male: Yes.

Aleesa Mobley: This is Aleesa Mobley. From what I am hearing, that sounds like a perfect bridge for a subacute care. Unfortunately, unless you have an eligible hospital stay, your insurance won't cover it. But, if that can somehow be reorganized or managed, emergency rooms could have qualifying eligibility for a subacute stay even if it is only 48 hours in order to arrange for those social services, that follow up, those other resources that the patient may need.

Female: Let me clarify my comment. I wasn't referencing reimbursement. What I was referencing was that there are people who through their insurance plan -- if it is employer-based, for example -- have access to nurse case managers, disease management, social work, behavioral health specialists and also a variety of things that are already paid for as part of their benefit but they don't access that because they don't know how to access that and, oftentimes, their providers don't know that they have access to that.

Aleesa Mobley: And to add to some of that, in addition, there is often redundancy because you may have multiple -- eligibility for multiple different programs, depending on whether it is through the insurance or through other support that you have. And they can be challenging to access.

Female: Right.

Jesse Pines: Well, just for time reasons -- and this has really been a fantastic conversation giving us a lot of -- a lot of good ideas. And, again, if there are -- if there's material that you come across, please do send that to the staff here and to the -- send things around to the committee. And we will also be posting things on what is called SharePoint, which we will be hearing about from -- Vanessa will be telling us about how to access SharePoint and how to get in.

Female: (Inaudible) (the most important part of our conversation).

Jesse Pines: Yes.

Female: How to access information.

Jesse Pines: Right.

Vanessa Moy: Thank you, everyone, for your comments and feedback. They are very helpful and meaningful. And as Jesse said, we are going to talk a little bit -- it's a quick overview of the SharePoint.

So, you should be getting an e-mail login from (Connie Ball) with information on how to log in to SharePoint. There is a Web site. If you (note on it), it should say "share.something." And Kirsten will talk more about it. On this slide -- the slide right now is showing the committee homepage of transitions of care. This is where you will see all the postings of the meetings, the agenda, the PowerPoints, the measures inventory that we have done initial pass on.

On the next slide, you will see the meetings timeline for it such as the orientation, the stakeholder input, the in-person follow up. (That is where you view) the calendar of the committee meetings and in-person meetings.

And the next slide -- you will also see -- if you are interested to know the committee's information such as their e-mail or how to contact one another, it is also located on the SharePoint. And also, lastly, on this slide, there will be also contact information for us staff. Also, we will also include Jesse's information. If you want to contact each one of us, there is our e-mail address and our name.

And I will give it to Kirsten.

Kirsten Reed: And as Vanessa mentioned, I know a lot of you have some trouble accessing the SharePoint site. The way it works is we also have a staff site at SharePoint, but our link is different than your link to access it. So, it is -- sometimes, when we send an e-mail, that link that we send out -- even though we said share.nqf.com, it just goes to staff automatically. So, if you are having trouble, the first thing is to just double check and make sure that it is actually saying "share" and not "staff."

And we will be adding this -- I did send around the slides to everybody. So, you should have those. We will be adding that to the SharePoint site as well as the list of all of the measures that we have come across thus far.

Kyle Cobb: Yes. And never get too frustrated with SharePoint because it is not a perfect system. So, if there is any information that you need, just e-mail us and we can always send you whatever you need.

Kirsten Reed: And I tried to e-mail it to everybody in addition to having it on SharePoint because I know for some people it doesn't work. And I am one of those people. So, I totally get it.

All right. So, now, as we do in every Webinar, we are going to open it up for public comment. So, operator, if you could please open the phone lines for any member or general public who would like to make a comment?

Operator: Thank you. At this time, if you would like to make a comment, please press star, then the number one on your telephone keypad. We will pause for just a moment.

And there are no public comments at this time.

Kirsten Reed: Great. Thank you.

All right. Any other general questions from the panel before we wrap things up?

Karin Rhodes: This is Karin Rhodes. I didn't chime in earlier. But, I was curious if identifying barriers to good transition is part of what we will be doing.

Male: Yes.

Female: Once we establish what quality is.

Marcia Wilson: Yes. This is Marcia. I think, the goal is to go to what we really want and, in that process, identify what barriers would need to be overcome. So, the focus is where do we want to go while recognizing there are some barriers to overcome? So ...

Karin Rhodes: Good.

Kirsten Reed: All right. And, then, on the screen now, you will just see the project contact information. The best way to get a hold of us is by using our project inbox, which is emtransitions@qualityforum.org. The public project page is listed there and, then, the SharePoint site, which is specific to each of you on the panel you will see there. And that is the correct link with that "share" beginning.

So, is there are no more questions or comments, I think we can go ahead and call it a wrap on our first Webinar. And we will be looking forward to talking to you in less than a month for our second Webinar. But, of course, we will be in touch before then to give you guys all the information you need. So, thanks again for your time, and we look forward to working with you.

Male: Great. Thanks, everyone.

Female: Thanks so much.

Female: Goodbye.

Female: Thank you.

Male: Thanks.

Male: Thank you.

Male: Thank you.

Male: Goodbye.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END