NATIONAL QUALITY FORUM

Moderator: Transition of Care
February 1, 2017
1:00 p.m. ET

OPERATOR: This is Conference #: 99115785

Female: Hi, Steve. Go ahead.

Steve Cantrill: I'd like to welcome everyone to the National Quality Forum Emergency Department Quality of Transitions of Care. This is a webcast, you can dial in at 844-649-7790 if you'd like to. And also join us on the web as well.

I'm Steve Cantrill, I'm an emergency physician. I've been asked to co-chair this panel with Janet Niles and we have quite an expert panel that's involved in this.

Vanessa, next slide, please.

This is going to be our agenda. Have welcome introductions then we'll – a little bit about the project overview and update. And then the bulk of the call will be dedicated to discussion of quality transitions in the emergency department. And then we'll have some next steps.

Next slide.

And the – we have a project staff from the National Quality Forum. And you see them on the webcast now, Marcia Wilson, Kyle Cob, Kirsten Reed, Vanessa Moy and Jesse Pines, who's also an emergency physician and consultant. And this is our expert panel. On the website associated with this project, you can see, if you're interested, some of the bios of all of us. And we're going to just take a quick roll call to see who's here.

Kirsten, you're going to do the roll call for us?

Kirsten Reed: Yes, thanks, Steve. So we know that Steve and Janet are here. Billie Bell?

Billie Bell: Yes, hi.

Kirsten Reed: Billie. Donna Carden?

Donna Carden: Present.

Kirsten Reed: Lisa Deal? James Dunford?

James Dunford: Jim Dunford here in San Diego.

Kirsten Reed: Thanks. Tricia Elliott? Nikki Hastings? Joseph Karan?

Joseph Karan: Here.

Kirsten Reed: Julie Massey?

Julie Massey: Yes, I'm here.

Kirsten Reed: Aleesa Mobley?

Aleesa Mobley: Here.

Kirsten Reed: Elif Oker? Andrea Pearson?

Andrea Pearson: I'm here.

Kirsten Reed: Marc Price – oh, great, thank you. Marc Price?

Marc Price: Marc Price is here. I'm here.

Kirsten Reed: Karin Rhodes?

Karin Rhodes: I'm here.

Kirsten Reed: Kristin Rising? Brenda Schmitthenner?

Brenda Schmitthenner: Here.

Kirsten Reed: And Amy Starmer? If you guys aren't speaking, can you please make sure you mute your lines to avoid the feedback?

Adam Swanson? Arjun Venkatesh? Sam West?

Sam West: I'm here.

Kirsten Reed: Margaret Weston?

Margaret Weston: I'm here.

Kirsten Reed: Christine Wilhelm? And Stephanie Witwer?

Stephanie Witwer: I'm here.

Kirsten Reed: Great, thank you. And as you know, we've also invited a number of other committee members to join us today. So if any other committee members are on the line, can you please say your name and what committee you're with?

Kristin Rising: I just want to let you know, this is Kristin Rising, I'm here. I was having a problem with my microphone, sorry about that.

Kirsten Reed: Great, thank you.

Nikki Hastings: Nikki Hastings, I'm also on the line.

Kirsten Reed: Great, thanks, Nikki.

John Shaw: John Shaw from the Medicaid Accelerator Project.

Kirsten Reed: Great, thanks, welcome.

Christine Hawkins: Christine Hawkins from Medicaid Accelerator Project …

Kirsten Reed: All right, Christine, can you repeat that?

Christine Hawkins: It's Christine Hawkins.

Kirsten Reed: Oh, great. And which committee are you with?

Christine Hawkins: Medicaid Accelerator Project.

Kirsten Reed: Great, thank you.

Sheila Roman: Sheila Roman with …

Dave Moskovitz: Go ahead.

Sheila Roman: Sheila Roman with the Rural Health Quality of Care Measures.

Kirsten Reed: Hi, Sheila.

Sheila Roman: Hi.

Dave Moskovitz: Dave Moskovitz, Medicaid Accelerator.

Kirsten Reed: Hi, Dave. Do we have anybody else on the line from other NQF committees or panels?

Ryan Mutter: Hi, this is Ryan Mutter from SAMHSA.

Kirsten Reed: Hi, Ryan.

Steve Cantrill: Hey, Ryan.

Kirsten Reed: All right. Well, welcome everyone and thank you so much for joining us today. I'm going to pass it back over to Steve to continue.

Steve Cantrill: Thanks, Kirsten.

These are our stated project goals. Again, we're going to try to develop some – a quality measurement framework based on evidence (so that briefly) we can get some through stakeholder meetings and research that will try to define and identify examples of care quality for transitions into and out of the emergency department.

The goal, again, is to improve patient-centered care, the value and cost efficiency while improving the management of E.D. transitions. So, this meeting, our goal was to solicit multi-stakeholder feedback and have a general discussion with the expert panel, focusing on trying to identify some common elements across transitions of care and emergency medicine as a basis for our framework.

This is our second conference call, we had an initial conference call and organizations call on January 4th. And Kirsten, do you want to go over kind of our timeline of where we are in the project and where we're going?

Kirsten Reed: Yes, sure. So, following today's webinar, we will continue kind of going forward with our lit review and kind of putting that into where we've already been with our measure scan.

We are also in a process now of scheduling and doing key informant interviews which we also will hope that will help us kind of learn more about what's going on in this area. Then we will be doing a preliminary environmental scan review webinar where we will be sharing what we have found thus far. Followed by our in-person meeting at the end of April.

Then we'll do some in-person follow up, anything we may have missed during the in-person, if there are prior follow ups. And then we will be busy drafting our measurement framework which will …

(Off-Mic)

Kirsten Reed: … put out to the public for any commenting. And this is also a great chance for all of you, that our committee members, if you have any thoughts on what we've come up with and you have any ideas, please share it during that time with us.

And then finally, we will hold our post-comment call while we will go over any comments received and kind of, you know, determine best ways moving forward and answering those comments.

And then finally, our final report will be due and submitted by the end of September.

Steve Cantrill: So, a pretty aggressive timeline certainly. And now, what we've tried to do is to outline some potential scenarios, Vanessa, next slide, in terms of transitions.

When we look at some of the key elements when we have a transition of care, obviously, the patient is – there we go, that's what I wanted to look at. You have the emergency department in the middle and we've got incoming and we've got outgoing.

And we have all types of combinations and permutations. So we did get pretty extensive and it's quite heterogeneous which I think is going to be part of the problem in terms of trying to define where we need to go in terms of our framework.

Vanessa, go back to the previous slide if you could, please.

There you go. In terms of looking at the transition of care, these are the key elements that we've identified. You got the patient in the center. Certainly, their clinical status is extremely important. And then we worry also about their socioeconomic status and their sociodemographic status on what the patient preferences are, and then cultural aspects that we'll also enter into this.

So, when we think about all those, we need to think about what data or information is going to be shared, how is it going to be shared, is there a standard of information sharing based on the nature of the transition, and then who are the participants going to be. And all of this is loosely described at the system of care, although some would maintain that is not a system of care, it's a spectacle of fragments of intention, unfortunately. And our goal is to try to make it a more cohesive system of care.

So as we go – next slide, Vanessa. As we go through that, there will be several questions we want to discuss.

So, for each of the transitions, what are the essential data that we need to have that's going to be transmitted to support the transition, what mode of information transfer will be involved, are there preferential modes in terms of the nature of the transition, is there a standardized process for the sharing of the transition information, who are the key participants, are there patient attributes that should be included. And then, in terms of the patient themselves, how much information should be shared with the patient. And how did that differed by some of the patient attributes.

So, again, quite an extensive and aggressive nature of things that we need to discuss.

Now, we have a lot of folks on the call. So just as a reminder, if you're not speaking, if you could make sure your line is muted. And when you do speak, if you could please introduce yourself, so we know who is talking.

So, now, we're going to start and go through some scenarios. Janet has the first one. And for those of you – no, go back. Vanessa, no, no. There you go. Yes.

For those of you that aren't familiar with emergency medicines, the way we can keep emergency departments open 24/7, 365 is we have people who work shifts. So if you're going to have a patient that's going to be there for a long period of time either because of the nature of their problem or because of the complexity of their workup, very often, more than one group of care providers will be involved.

And that means that the information about the patient needs to be handed off from one team to the next team. So the outgoing team will hand it off to the incoming team. So we have an example of this. And Janet, do you want to take it from there?

Janet Niles: Sure, thank you. So, our first scenario, we actually (put) first because we see this happens quite frequently and since we have such experts on the panel, I'm sure that you have seen this happen before in your own practice. So our first scenario is an 86-year-old female with mild dementia, brought in from a nursing home for confusion and is seen by a practitioner at the end of her shift.

The nursing home, as not unusual, has not finished chart or documentation of the code status for this patient. She's going to – she is sent for a CAT scan as the head during shift sign out and returned just after the first practitioner has left. Her C.T. shows a large stroke and she's rapidly becomes obtunded. So the new practitioner is called to determine if she should be intubated emergently.

So, we'd like for you all to think about discussing this scenario in light of the elements that are listed here on this slide, the data, the information, modes of information, process, participants, patient attribution, information for the patient as to what we could put in for some standards or some quality measures on these things.

So, I will turn it over to you all to begin the discussion. Steve, maybe you want to start.

Steve Cantrill: Sure. Yes, and I think that one of the issues here is the wide variation of patients that we have to deal with. Some are very simple and don't require a lot of information transfer. And some are very complex and I think it's – at least in my experience, the older people are, the more problems they have, the more complex they become. Most systems do have standards currently of information that should have come in nursing home patients, most of them do have forms. They are filled out with a varying degree of diligence and sometimes, certainly in the end, through the emergency situations, you may not get the form at all.

I have always maintained that I can go a long way. If I've got the patients' problem list and the list of medications that – especially for a complicated nursing home patient, I'm about 80 percent home.

And the normal mode of information transferred here is on paper, although often, nursing homes will call and just to give the emergency department a heads up, that's just – that's proper manners.

Jesse Pines: And this is Jesse here. So just to also clarify this, so this is sort of primarily focusing at least for this case just on the E.D. shift change, and also, you know, just to sort of get a brief reminder of a, you know, a group that was, I guess about seven or eight years ago, looked at this and sort of the upshot of – you know, this is sort of, I think, again, probably one of our hardest task here is to say, you know, how do we balance completeness with salience when you have sort of, you know, time limited – you know, you don't have extensive time to communicate all of the various things you may need. So this is – you know, again, this is just sort of one scenario here that, you know, I think probably a lot of us have seen, what are those sort of rapid decompensation where there may be incomplete information there.

But sort of, you know, generally, maybe we can just sort of open it up and sort of think about, you know, when it comes to shift change transfers, what are some of the things that are useful and, you know, how do we sort of balance salience and, you know, completeness in a way that is, you know, to be useful for quality measurement.

James Dunford: Jesse, this is Jim Dunford. I'd say, you know, the first thing in a case like this for me is, is there a (pulse) document or is there some other declaration in some place that someone can retrieve quickly to define what this patient would have wanted. Nothing came with here, but is there a document in some place, and so that's essential data to me in deciding if she just gets bagged or whether she gets intubated.

Donna Carden: And this is Donna Carden. Certainly, I think we've all been in this situation from the provider point of view. But I will have to say that over the past year, I've been on the other side on the family member side of very similar case. And I would just advocate not just for looking for the written documentation of what the patient would have wanted, but someone should certainly look for a family or health care surrogate if there is one. Because I think that really can direct the degree of aggressiveness that one pursues, and certainly, quality and satisfaction with an outcome.

Arjun Venkatesh: It's Arjun here. I think – I agree. I think one of the things that's unique in this case as you presented is, you have a patient being transferred to an emergency department who already has dementia, and I'm assuming kind of, and I think of this patient as there often, degree of cognitive impairment where they are not making health care decisions.

And so I think that part of the challenges here is recognizing that you can identify several populations ahead of time in which you're going to have unique or distinct care transition or information failures, right? So, this problem does not come up with a patient that does not have cognitive impairment in the same way because you can have that conversation with them.

And so, I think that, to me, is a patient attribute but I think changes how much depth you wanted the information. The other thing when I see modes of information transfer here, we've been doing some work here trying to distinguish between information that needs to be communicated, synchronous versus asynchronously. And this, to me, is information that needs to be certainly synchronous to the E.D. visit but not in person and not necessarily in a personal conversation because of the shift change risk.

And so this would be the kind of information that you would want, I think, ideally to have the ability to have electronic transfer of information from the nursing home to the emergency department, or that it'd be in structured documents between the nursing home and emergency department. And then that also leaves it in a place so that's available to any emergency department provider and it's not subject to a phone call or something that would have happened between the E.D. and the nursing home.

Kristina Cordasco: Hi, this is Kristina Cordasco from the Veterans' Health Administration, V.A. Greater Los Angeles.

There seems to be two transitions here. There's the transition from the nursing – in the scenario, there's the transition from the nursing home to the emergency department, and the transition between one provider and the next within the emergency department. And I think that the information needs and, although similar, are somewhat different. And so, I think that some of the discussion here is talking about both transitions.

(Crosstalk)

Steve Cantrill: Yes. If I can just say clarify, we’ve put this scenario forward to really talk about the transition within the E.D. We have a nursing home scenario coming up later. So I think if we could just concentrate on the basically the handoff of information between care providers in the emergency department.

Joseph Karan: Hi, this is Joe Karan. One of the problems we're having here in Florida is that more and more large medical facilities because of viruses and different ways to get the information really are very difficult to send the information into.

And most of the hospitals we have down here, it's very difficult for us to send information unless we use a USB stick and that stick stays with the patient's file and travels with them when they go to an emergency room or any transfer information.

Kristina Cordasco: So this is Kristina Cordasco again. I just want to concentrate on the E.D. shift change part of this. So, I – this case brings to mind either the obvious retrospect – you know, retrospective scope of it, obvious that in this specific transition, what should have been signed out someone provided to the next is what to do if the patient deteriorated.

And it brings – and those things like that are always more obvious in retrospect. But it seems that what this brings to mind is the need for a structured kind of sign out in provider – to provider and that element like what to do if the patient deteriorates. That's not said as eloquently as I think others might say it.

But, what to do if the patient deteriorates might be part of that structure. But there probably are other elements, but I know there are other elements that would be applicable to other cases. So, the importance of structured information exchange at sign out from one provider to the next.

James Dunford: This is Jim Dunford again. Oh, excuse me.

Kristin Rising: Sorry, this is Kristin Rising. Just kind of adding onto that for a bit, thinking about the structure, I think, you know, there's talk in different transitions of looking at, you know, kind of some of what needs to be relayed is outstanding test. But I think something in here is perhaps kind of key test results or other patient data information and for, you know, patients such as this and whether this is just something that's generally included in there to be all inclusive or someone determine is not applicable thinking about having code status as part of that documentation and then key outstanding testing or other information pieces, right?

Because it seems like the first provider certainly in here may not have had the time or ability yet to determine the code status and yet it should have been something that would be flagged to the next to say, "This is a key piece of information that still needs to be collected", much like these are key outstanding test results and that maybe this could be kind of clumped together and thought of as one.

Janet Niles: So, this is Janet. So, are you really kind of saying that should be part of a standardized process?

Kristin Rising: I think it could be something that we could think about putting together that certainly, you know, I think those discussions as I experienced don’t often happen in sign out and that that key moment happens of, A, (given though) the code status, and if not, if there's – is there a plan for determining that and I think it is something that would be reasonable for us to think about whether we could incorporate that in.

Jesse Pines: And …

Male: This is …

Jesse Pines: This is Jesse here. Just another consideration, (at least) another discussion that sort of have been kind of around these (EDDE) transitions is – that is the context, you know, whether in small emergency departments where you may be handing off what's a, you know, four patients or where the expectation would be to sort of wrap things up before you go home versus big academic E.D. where you may be taking sign out on, you know, 40 patients.

The, you know, the information elements may be different and sort of the former, there was a program called Safer Sign Out that was developed by Drew Fuller, where the sign out would happen in sort of a templated way for that E.D. shift change actually at the patient's bedside with the patient being involved. You know, and that, you know, it's been deployed in, I think, in EMA, some EMA sites in Maryland. But, you know, the broader question is, you know, would that work in your, you know, big (app), you know, your big inner-city emergency department where there's so many transitions.

Nikki Hastings: This is Nikki Hastings. And I'm a geriatrician so it's hard for me not to comment on the first transition that Kristina pointed out, nursing home, the E.D., although I know we're going to get to that.

From the shift change perspective, I think the things to keep in mind for a patient like this, many people have already touched on. But what – the comment that was just made made me think about the importance that the information that's transferred between E.D. providers be very clear about the person's mental state at the time care is handed over. Because I think a hallmark of older patients like this with mild dementia is that they can often change and there is a relatively high risk of a cognitive bias in nursing home patients of thinking that someone who's altered or obtunded may have come to you that way, can come to us that way.

So I think that is a really important clinical piece of information to keep at the floor and we need to talk about doing the information change at bedside, obviously, that would be addressed.

Because of the changes that can occur, I think the idea of really focusing on the surrogate decision maker as a key piece of information so that that could be accessed if needed really makes a lot of sense to me.

And the other one would just be the E.D. course, because someone made the comment earlier about the complexity of these patients. So, definitely they often have time sensitive medications that they need that may not even be related to what they came in for, insulin comes to mind and making sure that there are not any errors in handover transitions because we don't understand what's already happened or assumed incorrectly, I think have or haven't been given.

David Newman-Toker: This is David Newman-Toker at Johns Hopkins. Can you guys hear me?

Steve Cantrill: Yes, we can. Thanks.

David Newman-Toker: I'm with the Diagnostic Safety and Quality Committee. I'm a neurologist, does research on emergency department diagnosis, and particularly in neurologic conditions.

And I just – when I heard the issue of sort of what tests are outstanding or not, just thinking from the diagnostic perspective, obviously, this case is really more about what management to institute or not. When we think about E.D., the E.D. provider transitions around diagnostic issues, the issue of diagnostic uncertainty is sort of a general theme, where there may or may not be the appropriate amount of information transferred from provider A to provider B. And sometimes then, if somebody gets labeled prematurely, we get a premature closure and a diagnosis that was sort of a suspected diagnosis becomes a probable or final diagnosis without much further thought, and despite evolving clinical circumstances.

Kristina Cordasco: This is Kristina Cordasco. I just want to add one more thing and this is probably obvious. But there's been quite a bit of literature in the last five years about transitions in care from provider to provider in the internal medicine hospital literature, which there are obvious differences between the emergency department and the hospital patients. But there are probably some similarities and that literature probably applies here.

Stephanie Witwer: This is …

James Dunford: This is Jim Dunford, oh.

Stephanie Witwer: Oh, sorry.

James Dunford: Go ahead.

Stephanie Witwer: Oh, this is Stephanie Witwer, Mayo Clinic. And I think we need to also recall that the – there's a larger team involved in this transition and nurses often need much of the same information that the other providers do on the team. And sometimes represent the continuity that carries from one shift to the next shift.

So, very important that we consider the whole team as we think about transfers. And …

(Crosstalk)

James Dunford: This is Jim again from San Diego. I was just going to say for the bucket list, when it comes to information technology, basically, the concept of actually ultimately having regional plans for care like this should really be sought out as everybody knows in (org) on their registries now that can be web-based, that can be searched to be able to identify information. Because what I see in this case is uncertainty on the part of the first physician who's going to pass that to the second physician is really not ultimately going to be helpful, unless there was a plan of care to go find out if definitively, there was a family member or there is a document.

A lot of times, you know, the care transition isn't going to affect anything if the first physician didn't have the right information to pass to the second one.

Donna Carden: I agree, this is Donna Carden again. I agree. And many – and I think, you know, in emergency medicine, it wouldn't be necessarily the first provider not passing that information off to the second provider, it would be more likely that there was still that uncertainty.

And so I've seen in the literature, even something that seems so common sense as checking the prior records, just to see what the status was before and this goes beyond just, you know, living wills or health care surrogates and that sort of thing. But documentation of what status was before.

And so many times I see in our M&M, you know, that common sense (rule) step is not done. So, I just agree wholeheartedly with checking whatever documentation is available, and at least having as a priority searching for more.

Aleesa Mobley: This is Aleesa Mobley. Regarding the transition of care from provider to provider in the emergency room, again, it sounds like there should be ample room for a multidisciplinary communication as you go from one shift to the next. And it also sounds like the SBAR template can be somewhat modified to cover all of those immediate and most important elements of the patient's actual situation to be transferred over to the next team.

Just the elements of documentation that you have to get from the nursing home, or the (pulse) sheet are all important. But for that immediate transition of care for that emergency situation, using some sort of a template that can be completed in a multidisciplinary manner sounds like something that would increase the quality of that communication.

Steve Cantrill: Steve Cantrill. One of the issues, of course, is what evidence do we have. I know the review that, Jesse, you referred to which came out of the American Oncology (Inaudible) (Physician) section on quality improvement and patient safety that was lead author was (Steve Chang). They found 24 different unique handoff mnemonics at that time in the literature. But the problem was there wasn't data that said which one is good, and which one isn't good. So I think that's still going to be a challenge.

Now, our environmental scan is still underway and hopefully we'll find some literature that's going to support one over the other. So, that's kind of where we are right now.

Jesse Pines: And this is Jesse. Just to comment on that, I mean, there was a lot of discussion when we did that paper years ago about the, you know – coming up with some sort of a templated way to do it and really came down to sort of a balance between completeness and salience and, you know, if you're signing out 40 patients and you're going through, you know, 200 different data elements, some of which maybe, you know, or obviously, you know, unnecessary and some of which are obviously more necessary.

I mean, sort of, you know, like Dr. Newman-Toker said around the, you know, an older person at high risk of, you know, something serious going on where there is – there may be diagnostic uncertainty because she hasn't gone to the head P.T. that, you know, maybe sort of focusing on patients where they are higher risk and you're, you know, you're signing up the ankle sprain with the, you know, just pending an X-ray on a 20-year-old. You may have less, but to sort of think, you know, and to try to distinguish, you know, perhaps by risk.

Kristin Rising: It's interesting. I wonder – Jesse, this is Kristin Rising. I wonder if by risk or if by, you know, the inherent risk here is talking about if there are actually certain kind of protocols for the sign out of patients who, you know, for instance, have dementia, so kind of speak to their own and the same that others can, you know, dementia or altered mental status patients needing a certain kind of list for sign up that others don't potentially need in the same way.

Jesse Pines: And then, another point of discussion at least historically was the sort of the anticipate the worst scenario, you know, with the worst – you know, there's really not a whole lot that's going to happen to 20-year-old with the ankle sprain, but for a patient like this who's much higher risk to sort of think through, you know, what would happen if this person were to be compensated and actually have that discussion, or sort of intentionally focus the sign out on the highest risk patient. You know, and I think people do this organically, you know, they say, "This is the – take this patient in the emergency department", and they really sort of go into a lot of more detail for certain patients.

Arjun Venkatesh: Jesse, it's Arjun here. When you say that, I think, to me, is actually is I make it a point, I know – and we try to teach this here at – when we do within shift rounds is we ask no matter what – whichever unit is to at least identify who the most sick patient is, but you – it's a strong level, right? I think a lot of people use that in the handoff process. And so if you could open around by saying, you know, these are the two or three patients that I think are at highest risk of a care transition failure in these rounds, and so you label them upfront and you transition them first.

There's probably some importance in utility to that, I was looking up an old study we did on communication of vital signs at handoff. And the two things I remember that stuck out to me is, one, the duration of a patient handoff, meaning the amount of time spent on that handoff reduces as you get through the rounds. So you actually spend more time handing off the first few patients that you handoff than later patients. And the second was that 7 percent of handoffs had another patient care related item that caused an interruption to the handoffs.

So you have to have a process in place be at any of these mnemonic devices that is resilient to the numerous interruptions that happened in the workflow in the emergency department.

Steve Cantrill: And this is Steve Cantrill. Again, I think one of the challenges is the heterogeneity of different EDs across the country and it's – unfortunately, it may be – it's not going to be a one size fits all. I think that's really the challenge for us here.

OK. Any other comments, if not, we can – we'll move onto our next scenario.

And this is a – Vanessa, why don't you move us on, there we go. So this is, again, another very common situation, take care of a patient and send them home. But you've got an ongoing chronic problem, this is a 7-year-old asthmatic who presents – brought in by her parents. She's wheezing and speaking in short sentences, she gets a neb, she get some steroids, she improves, she goes home with a script for her oral steroids and instructions to follow up with her pediatrician.

So, again, how much obviously follow up is required here? So, how much information and what type are we going to convey to the pediatrician who's going to follow up for this – on this patient.

Any thoughts on this?

Andrea Pearson: This is Andrea Pearson. I work in a (peds) emergency department and do some primary care work.

I think that – this is – this in terms of (peds) is a pretty simple case, I don't think it warrants necessarily phone call or things like that. But I think that there should be some documentation of that since, you know one of the things that I'm sure anyone in primary care knows, this is a – the paper workload is absolutely crashing.

And one of the challenges that I have in primary care is that when we get something like this with a child with a relatively simple straightforward typical E.R. visit, you end up with – you can end up with a 10-page long documentation where 90 percent of it is to help the billers and coders and only 10 percent of it is really relevant and can spend five minutes going through – just to try and figure out why medication for others …

(Crosstalk)

Andrea Pearson: … discharge on and other things, what was done in the E.R. And I think that having a streamline documentation process, number one, is extremely important. And two, in just making sure that that documentation actually gets to the pediatrician. Family usually forget to bring in that documentation so I don't think that can be something that you give them in hand and assume that it's going to go over that there should be something, a fax sort of electronically transmitted or something for these more simple straightforward kids.

Jesse Pines: And I guess one of the (items) that comes up on the receiving side here is that, you know, that in this case, the – in the transition, there may be, you know, nothing that is specifically requested from the E.D. physician to their pediatrician, you know, the – you know, that patient may just need some short-term steroids and – but if for example, if, you know, a guy saw her last night who was not well controlled and that the asthma was there. Sort of in and out of the E.D., and had really, you know, was not on the right medicine for her to help prevent asthma flares, that may be a case. And how do we think about identifying, you know, cases where there's, you know, something that the primary care physician or the pediatrician should do rather than FYI, you know, the patient was in E.D.

Marc Price: This is Marc Price. In New York, we have something, Upstate, New York (Inaudible) health information exchange in New York which gives us a notification that the patient was in the emergency room. And then, I'll echo what the previous, I can't remember the woman's name, I'm sorry, the pediatrician, mentioned about getting excessive amount of paperwork.

I'll get two or three notifications from them just saying she was there, the patient was there for shortness of breath, and then I'll get documents of pages of documentation where the end result is they went home with steroids.

The problem is not just that as a simple problem and a simple solution and it was taken care of relatively easily. The problem is if the patient is going to one – or a different E.R., or they're receiving it from urgent care, or different facilities and it indicates they do need the higher level of care and they need a control of medication, or they need some other treatment, possibly a referral, possibly other testing, then maybe the diagnosis is reassessed, that information is lost to us because it's a one-time thing, and it's – we mostly get the information where the patient is in follow up as they're instructed.

So, I don't – I think that there needs to be a succinct way of telling what the problem was, the follow up and also with the procedures without getting 20 pages versus getting just the diagnosis of what they've come in for just to complain. And that assumes that the hospital is participating with that information exchange, not all hospitals participate with it.

So, sometimes the patients aren't reliable sources. And I think that's part of the information we needed, the diagnosis, what was done, and even if it's just to notify us, even if we don't need to follow up just so we can see if someone's been seen for an ear infection, you know, three times in the past three months, well, they should be – they need something more. And if we're not aware they've been seen, then we can't help assist with that care.

Stephanie Witwer: This is Stephanie Witwer. And one of the issues that we have in our primary care practice is that often times, people are discharged from the emergency department with instructions to follow up that are not specific. So they call the primary care practice and they say, "I was instructed to follow up." And our appointment coordinators and our nursing staff do not know what follow up is for that particular patient.

And the patient doesn't know what follow up is. So I really think it would be helpful to have specific follow-up instructions.

Margaret Weston: This is Margaret Weston from Johnson & Johnson. And I have been doing work looking at readmissions to the emergency room for patients just like this that walked away without really clear instructions. So I like to build on that idea.

I think part of what we need to look at is, what are we actually providing to the patient as they walk out that door, especially in these pediatric cases where the parents are very stressed especially if it's a first episode, they are worried more about their child than they are about what else is going on or the instructions that they're getting. And they get home and they realized that they don't really understand what medication should be provided, what is the next dose that should be provided and when they should be following up. So, that ends up on the back end either another admission because the child deteriorates or multiple calls to the primary care provider trying to figure out really what are they supposed to do to (care) for that child.

(Crosstalk)

Janet Niles: Yes. This is Janet. One of the things that I was thinking about on this is that this seems to be a perfect scenario for a follow up with a case manager either one that's from the E.D., maybe one from the payer, one from the primary care physician. But, possibly, this child and her parents need – you know, they need an asthma action plan. They need to understand the triggers. They need to understand a lot of things and maybe that was cut down on the paperwork that has to go to the pediatrician. And also might actually be the key to getting that appointment schedule and getting the patient in appropriately.

Kristina Cordasco: This is Kristina Cordasco. I wanted to follow up on that. From a V.A. standpoint, we have the advantage of being an integrated health system with the integrated medical record system. But we have worked with a system for delivering a message from the emergency department providers to nurse care managers in the primary care side about specific or urgent follow-up needs.

And then the nurse works with the primary care team to triage those needs appropriately. We are finding that from the emergency department side, they don't know enough about the primary care structure to know what the – who and the most appropriate follow up is for that patient, whether that's phone or that's in person, and just because – because they don't work in that environment.

And so that care manager is the person who knows the primary care resources and a team and availability. And that is what we're hoping does is keep the message from going to the patient that they need an in-person follow up in two days because that's not always the case.

But again, we do have the advantage of an integrated medical record system so the primary care team can see what happened in the emergency department.

Elif Oker: So this is Dr. Oker from Blue Cross. I ask that maybe we should …

(Off-Mic)

Elif Oker: … a little time and define what we think the right follow-up instruction should look like because I think as emergency physicians to know exactly how one primary care practice or operates versus another who's asking a little bit too much. That there's too much diversity there. But if we could define specifically what those instructions should contain at minimum, that might be helpful.

Donna Carden: This is Donna Carden. This is, I think, an overarching theme that doesn't relate just to pediatrics, but we'll probably see it come up in these other cases. But, two things, patients frequently go home. And they don't know what follow up means.

Obviously, as emergency physicians, we don't know what follow up means to some of the primary care practices. And then, it sounds to me like a lot of practices don't know what that means when they have a request for follow up. But that's a very big cause for concern and repeat E.D. visits on the part of patients. They go home and this is based on our in-depth interviews with patients that were enrolled in our studies. And they frequently go home and they get confused, they don't know if the provider is supposed to call them or they're supposed to call the provider like the primary care providers, they go home with a tome of papers that is very difficult to find the essential elements.

And so, when you look at the health literacy literature and (Shara Den) did a systematic review in 2001, it's a wonderful source for actually pinpointing what kind of specific targeted information is needed. And I think it may be helpful to both physicians and patients. I mean, it's succinct, I heard that word before, but it's succinct and it consists of the essential information first or as a standalone – as a standalone message. And then other limited messages thereafter.

So, this seems to be a common problem, not only what follow up means and it should be as specific as possible for the patient's point of view and also the type of written information that a patient goes home with. Some of the primary care providers that we did our interviews with, they mirrored some of the comments here, they didn't know that the patients have been in the emergency department. There's evidence in the literature that internet communication within a single health care system or systems that communicate with each other actually does help a primary care provider. But they often have to rely on the patient who comes with a piece of paper and says, "I was in the emergency department."

So again, the quality of that written information that goes home with the patient that is not a tome of, you know, billing and coding or whatever, or legal leave could in fact help not only the patient to be clear on what they're supposed to do and (arrange) …

(Off-Mic)

Donna Carden: … but they can also help both providers.

(Crosstalk)

James Dunford: This is Jim Dunford.

(Crosstalk)

James Dunford: I would just say that the other side of it is the telephone call follow up or some means of verifying that the patient actually followed through. The best written instructions, you know, without somebody going to pick up those oral steroids aren't really that meaningful.

So, you know, there's a lot of value in developing some process that for certain kind of patients that next day follow up by the emergency department or somebody will improve the compliance and overall, you know, ability to execute the care plan.

Jesse Pines: This is Jesse here. Just as a comment that, you know, just an anecdote. When – I was actually discussing a very similar case and the way that the Kaiser system does it. There was a friend of mine who works in the Kaiser Mid-Atlantic office here and, you know, he was seeing actually a very similar patient in the emergency department where he wanted to connect with the primary care physician about, you know, similar to transition and care and was able to actually sort of message the primary care physician in the system, then about the issues that were going on. And then the primary care physician actually called him back and say, "You know, why did you message me in the system?" You know, he said, "Because I think I – you know, somebody's got to call this patient back." And the response from the primary care physician is, "We call everyone back after they're seen in the emergency department."

So, also sort of thinking about, you know, at these transitions, who sort of take the ultimate responsibility to make the – make sure that the transition happens and the patients get what they need.

Karin Rhodes: So, this is Karin Rhodes. And I want to call attention to some of the work that's been done by Maggie Samuels-Kalow. She's at the MGH. She's a (med PCM). And she's one of my former mentees at Penn. And the thing – and we did a lot of qualitative interviewing both on the pediatric parent side and on the adult side with asthma in specific, and trying to identify what a successful discharge was.

And I think that we need to put – so first of all, in terms of essential data and information for this visit is right off the bat, does this child have a primary care physician, and when was the last time they saw them, are they on, you know, medication from a regular basis as the seasonal. I mean, all of that sort of stuff.

But, on the way out, I think an equal amount of time needs to be spent with parents especially in the pediatric side, but even on the adult side with education and we're finding like read back, teach back, actually seeing the parent administer the nebs and going overall of it is very helpful, particularly with low literacy but not just with low literacy with everybody.

And then I think it works better to actually arrange follow up. If you've got some standard systems, you can make that follow-up appointment. We found that many of our asthmatics who – they feel like the emergency department really took care of them and they see no reasons for follow up after the acute incident.

And so, I think that knowing how often they've been in the E.D., that's essential information that ought to be there. And then as they leave, how do they take their meds, watching them take their meds, especially with, you know, if they're using, you know, inhalers, are they doing it accurately. And telling – going over the difference between, you know, controller versus acute meds and then what symptoms should prompt the return to the E.D.

So – and in terms of case management, I think that there – it's all over the place, when it's by the payer, some places have the payer reaches out, they have the primary care medical home reaches out. And then, should the E.D. really be involved with that follow up, unless it's actually coordinated. There are some situations where there's a lot of confusion and people feel like they get different information from different places, and don't know quite how to interpret it in terms of follow up.

I think a system – you know, a standardized process that makes that appointment that has that person, you know, that documents that we get the asthma plan, et cetera, et cetera, would be pretty critical. But, I think – take a look at some of the work Maggie is doing around a successful discharge for asthma. And …

Male: This is …

Karin Rhodes: … how parent defined it, how patients defined it and how providers defined that was very different.

Aleesa Mobley: This is Aleesa Mobley speaking. Over the past year, I spent a lot of time in primary care and family practice. One of the problems with follow up is the patient may come back to you in 10 days, then they come back to you in four months. And they're still talking about the same last emergency room visit follow up.

Sometimes when the emergency room sends that paperwork, it will request a follow up but it won't provide a timeframe. So, that decision then gets left up to the patient.

One of the problems with that is, we don't know the education level of our patients. For all adults, they're all talking to us, they're all taking directions, they're all doing what we think they're supposed to do. And then we find out later, they read on a fifth grade level, or they don't read at all, they just remember what you tell them and what they can't remember gets lost.

In terms of making that follow-up call, in ambulatory care surgical centers, it's a standard at least in New Jersey, where the nurses will call the next day to make sure the patient's all right, has any problems of taking their pain medication, or if they need to intervene to make sure they have another follow up with their surgeon or provider or whomever.

Regarding case management, motor vehicle accidents are probably the best ones of making sure there's a care manager involved in the process to make sure the patient keeps their follow-up visits, keeps on time, and that money is not wasted and the care is much more efficiently delivered.

But in terms of trying to do all of that patient teaching following the emergency room visit, literally, what was descried was the perfect primary care visit that should be the follow up after the emergency room visit. That's not the kind of thing that's going to be able to take place in our emergency rooms if we're actually using those forms of care appropriately.

David Newman-Toker:This is David Newman-Toker from Johns Hopkins. Just in keeping with the theme of diagnostic uncertainty. Obviously, that's not just an issue from E.D. to E.D. providers, it's also an issue from E.D. to primary care and then issue from E.D to patient.

So, in the sort of vein of what was mentioned about, you know, what should prompt you to come back to the emergency department. In cases where there are diagnostic concerns, you know, obviously, this is one where the presumptive diagnosis is presumed to be correct. But for a large fraction of E.D. patients that leave and gets send home with follow up to their primary care doctor, there's substantial residual diagnostic uncertainty.

And again, being effective about telling the patient what they need to watch out for in terms of serious symptoms that should prompt them to come back and sort of what to do, what level of urgency, whether they call 911 to call – to come back to the emergency department to call their primary care doctor urgently, I think, are critical pieces of expressing that diagnostic uncertainty in that transition out of the E.D. and back to home, and also communicating that same information to their standard care providers.

Nikki Hastings: This is Nikki Hastings at Duke. And adding to that, one of the things that we saw on patients don't understand well when they leave the emergency department as the expected course of their illness or symptoms in terms of duration and in terms of how thing should get better overtime. And that those who did not understand the expected course of their illness were more likely to come back.

So, in terms of thinking of best practices, sometimes we don't know exactly what the problem is, but we can give some explanation around how we anticipate things will go for the patient and that's very much inline with all the things you talked about of red flags, et cetera.

It makes me think about (Eric Coleman's) work on transitions of course where he think – talks about the pillars of a good transition being red flags, medications, which we have touched on a little bit here, but we'll get into more deeply with adults or older adults, I imagine, follow up and then self-care, what the patients need to do and know to help themselves on their recovery path.

(Crosstalk)

James Dunford: This is Jim Dunford. I just want – my previous experience on NQF committees is that we also have to be thinking as we're mentioning all the wonderful important things that we have to have in transitions is how do we measure them. Because really the focus of NQF at the end of the day is to create bucket list of good ideas that we don't have measures for and then also to identify existing measures that we can capture, because ultimately, in order for payment reform and in driving quality and value, we have to be able to measure these things. So I think we should also keep in mind how would we measure all these important things that we think need to be part of the documentation in a discharge plan.

Jesse Pines: And I think we're going to be getting there in future discussions, that's a great point, Jim.

The other thing we haven't really talked a lot about is mode of transfer and whether, you know, suddenly certain patients, you know, a phone call may be more appropriate, you know, a new diagnosis of malignancy or, you know, where something is, you know, pretty serious and absolutely needs very close follow up versus, you know, in this case, where there may be sort of less urgency and, you know, we want to see our folks think about, you know, sort of dividing lines between the various mode of transfer.

Karin Rhodes: So I'd say the – this is Karin Rhodes. I mean, the best is sort of multi-modal, the patient has access to the information on discharge whether that's on their own literal USB or an internet place they can go to or written in paper is also transferred in the same way to – and identify the primary care provider in a timely way.

So electronically and setting up standardized processes to make that transfer and I think, you know, I feel pretty strongly, arrange the follow-up appointment for the patient if it's needed and don't rely on them. They have to make the call, have it set, somebody can call and confirm the next day.

Sheila Roman: This is Sheila Roman from the Rural Quality Health Committee, and I just wanted to put the rural aspect into this case.

I think a lot of the things with that have been reviewed from the perspective of follow through and follow up are on the, you know, are really on the mark. But I think when you're dealing with the situation where the patient and parents as in a pediatric case have come in from a long distance, and their PCP may be as far away as the emergency room is from them. You know, I think it has to be very clear in those instances that they're ready to go home, that the parents are – do understand and have the ability to deal with what maybe new treatment that have been given to the child and when to return.

I also think it's very important in the rural situation for a phone call to be placed to make sure that a follow up has been arranged.

Jesse Pines: Good. I think that's actually a great transition to our next scenario which is rural E.D. to home.

Steve Cantrill: Right. I was just going to mention that, Jesse.

Janet Niles: Yes.

Steve Cantrill: Janet ...

(Crosstalk)

Janet Niles: Thanks. So, if we're ready to move on to that, we can move to that next scenario, which is a transition of rural E.D. to home.

We have a 57-year-old male with congestive heart failure. And COPD and diabetes. He presents with dyspnea to the E.D. He's noted several pounds of weight gain. The chest X-ray is consistent with mild pulmonary edema. He received Lasix in the E.D. and he has systematic improvement. And then he refuses admission stating he needs to get home to take care of his wife who is ill. And he lives nearly an hour away. So this definitely fits into the rural issue that we were just talking about.

Did somebody like to kick this one off?

Marc Price: This is Marc Price, and I'm sitting here because I'm a family doctor.

There's a lot of what we said in the last scenario which actually plays true into this as well. I don't think it's necessarily age specific. I did like the last few comments, when someone mentioned about making follow ups for patients where they felt need it and this may be one of those situations. And patients in my office, when they need to see a specialist for some reason, I usually have my staff or myself even, make that appointment to make sure that they're reducing the likelihood the patient will miss the appointment or have problems getting an appointment or to emphasize the severity of what needs to be done.

So for this patient, in particular, where there are some definitely some issues that needed to be worked out, I think this is something that that transition would be including. Maybe a little more effort from the E.D. to their primary care specialist who would help then coordinate the rest of the care that's needed.

Steve Cantrill: Well, this might be an ideal case to get the visiting nurse involved as well, especially over short term. If you've got a patient that you wanted to admit who declined admission, so you know he's not the most stable individual in terms of his current health care.

Dave Moskovitz: This is Dave Moskovitz ...

(Crosstalk)

Dave Moskovitz: Sorry.

Brenda Schmitthenner: Sorry, this is Brenda Schmitthenner from the West Health Institute. And certainly, I think there would need to be some consideration for perhaps addressing the social issue, which is the reason he's declining admission. And that is, is there some sort of support or communication with community-based support to help the wife so that he can then be admitted and treated for the incident.

Dave Moskovitz: This is Dave Moskovitz.

(Crosstalk)

Marc Price: I agree 100 percent, this is Marc Price again. I agree 100 percent with that. And I've dealt with that many times in my office as is. I need to hospitalize a gentleman and I had to put his wife in the hospital as well because there's no one to care for her. So that does remain a big issue.

And I think that making sure – and I agree the visiting nurse would not be an appropriate person either, but at the same time, most E.R. doctors around here anyway don't want to sign the orders. They expect that primary care doctors to sign the orders without having that communication first. I think there just needs to be more communication, and that's what we're trying to accomplish and that's what we're trying to figure out, how the best way to go about doing that.

Kristina Cordasco: Hi, this is Kristina Cordasco. This is – this brings to mind and perhaps this was part of the conversation before as well, but it just brings to mind the ability to distinguish between people – and perhaps distinguish in our processes between people who need follow up within 24 hours, like this gentleman versus those who may need it a little later or may just need someone to check in on them.

And that this gentleman – communication about this gentleman to his primary care team has to be treated like a critical lab value, you know, like of a high potassium or something like that.

And then, as well as a close communication loop so that the communication is not just sent but is also confirmed that the baton has been successfully passed. And they acknowledge receipt and they're either going to take care of it or – within whatever system they have, whether that's visiting or sort of whatever that particular health care system or, you know, give instructions to the patient about returning to the emergency department, you know, because this might be a case where that is most appropriate depending, again, on the patient's system of care.

Sheila Roman: I think it is also extremely important and certainly a rural transition scenario but also in the previous scenario as well is identifying with the patient that they do have a primary care physician or somebody that they can follow up with, because in large segments of our population, they come to the emergency room because that's their primary mode of care. They don't have that primary care physician to follow up with. And identifying that is certainly something that's crucial to consistency of care.

Dave Moskovitz: This patient strikes me as someone who may be on the radar of their insurance plan with a care management program. But often times, I've seen that those programs poorly coordinate with the patient's primary care provider. This is an opportunity, I think, to ensure that patients who may be enrolled in numerous different care management or disease management programs are really connecting up with the one that most – that they're more apt to utilize.

Aleesa Mobley: This is Aleesa Mobley. I'm looking at this scenario from an emergency room perspective that screams a medical legal risk. I don't know if it's possible, depending on the state that you're in. But the concept of getting skilled nursing involved if the patient's definitely going to leave the emergency room makes a lot of sense. If the emergency room physician is allowed to just order the skilled nursing assessment and then if the information is available regarding the primary care provider, the skilled nursing assessment once that done – once that is done would contact the primary care provider for actual follow-up orders.

Karin Rhodes: So, this is Karin Rhodes. I want to say that I'm also – I think Marc Price suggested that – or someone suggested early on that, you know, the social needs here transportation (then) our way. And if this guy is the caretaker, I'd like to see how sick his wife is. So I'm concerned as, you know, just sort of a health system like what are we doing for the family that is far away, and thinking in terms of enrolling them in possibly home-based primary care, linking in community payer medicine if it's available, but some clear transfer of care.

This patient, I would be very concern that they go home without a clear follow up. And somebody who's going to continue to tweak their Lasix and, you know, their COPD meds, et cetera, et cetera. So, high risk.

Female: We also haven't mentioned some of the other technology potential solutions related, it's often odd to think of enrolling patients into a telemedicine support. But here, you have somebody who may benefit from some of the monitoring devices and remote monitoring if you have a connectivity with either a home nursing or with a specific primary care that would be able to help monitor that together.

Stephanie Witwer: This is Stephanie Witwer. And wondering if this doesn't point out the need as a standardized process in an emergency department to have access to social services that can really help plan this discharge so that the E.D. staff can identify what the patients home going needs are and they can have the assistance of social services to actually arrange for those.

Kristin Rising: This is Kristin Rising. I feel like this takes us back to something we talked about a little bit on the first call, which is trying to figure out how we can incorporate in the patient's perceptions of their transitions, right? So like, we can't possibly plan to have measures for all the different types of patients and anticipate their various needs. But having some sort of process where we've gone through and, you know, there's an assessment with the patient of, do you have the types of things that you need at home, do you need help with follow up?

You know, there are maybe patients who say, "I don't want you to make appointments, I want to go home. I can do that easily." And some who do say, it may be, "Do you need help with transportation, or do you need home care assistance for yourself or for loved ones, do you need?" But, I think having a process side which we ascertain from patients if their actual perception was that there are various needs were at least asked about and know that needed to be addressed is something that feels a little bit more comprehensive and able to be tailored to individual patients.

Steve Cantrill: Any other comments about this scenario? If not, we can move onto our next scenario.

And now, we get into nursing home. Vanessa, if you can just go on to the next slide for us.

OK, a 35-year-old male with advanced Parkinson's is transferred to an E.D. from a skilled nursing facility for a possible hip fracture from a fall. The hip fracture is in fact diagnosed by X-ray. He's seen by an orthopod and it happens often in private sectors admitted to a hospitalist for planned surgery in the morning.

So here, we have the question that came up with the first one, too, in terms of transfer from a long-term care facility, what information do I need? And then we have, on the other side, the outgoing side, we have the interface between the E.D. physician, the emergency physician and hospitalist, and the emergency physician and the orthopod, slightly different needs on each case. But, how are we going to deal with that?

Certainly, coming from the nursing home, as I've said before, that if I have a complete problem list and a list of meds, that gets a long way in terms of taking care of those patients.

Any other thoughts from the group on that?

Female: I just have a clarification as to scope. It is within the scope of what this group would do to think about quality measures for the incoming transition?

Steve Cantrill: And outgoing.

Female: And outgoing, so …

(Crosstalk)

Steve Cantrill: We're good. It's the whole ball of wax, and that's what makes it so complex and the heterogeneity of all these different transitions adds to the difficulty, certainly.

Karin Rhodes: So, this is Karin. I think the same issue as the first case that we heard about, that who's – you know, who's the surrogate, what are the goals of care for these patients. You know, the orthopods are going to – are planning for surgery but nobody's talked to the primary care provider for that patient.

And a lot of times, it's very confusing if someone comes from a nursing home, like who is the primary care doctor, is it a nursing home doc. And – but being able to have access to standardized processes when somebody is admitted to a nursing home and then transfer those so, who to reach out to on the – for the patient's family is pretty critical and what the goals of care are because maybe that's ought to be managed in a different way.

Aleesa Mobley: This Aleesa Mobley. You had asked about the nursing home and who is the patient's primary care. It actually depends on the facility. Some nursing homes, private physicians will come in, do rounds on their patients. The current one that I am in, which is a sub-acute rehab center, we have our own hospitalist within the building. So, as long as they're internal to our facility, we are the primary care providers.

Either way, the emergency room is probably going to benefit with having the last documented encounter on that patient as well as any recent diagnostic test that may have been ordered during that skilled nursing (facility's).

Brenda Schmitthenner: Hi. This is Brenda Schmitthenner from West Health. And there has to be consideration for communication back to the skilled nursing facility about the fact that this patient is going to be admitted for surgery. Because there's implications for holding the bed that this – that bed may be that patient's home. And if there is a jeopardizing his placement, that needs to be communicated both to the nursing facility and to the family or caregiver.

Female: Great point.

Steve Cantrill: Any thoughts about the transition of care from the E.D. to the inpatient service to the hospitalist and the orthopod. I know there's been some work, there's a nice paper by (Kristich) concerning interfacing with the hospitalist. And they actually even have put together some best practice recommendations that are seven different points, which I think is a good starting point.

Now, would that apply to both, or we can have different information subsets based on the specialty of the individual.

Nikki Hastings: This is Nikki …

Steve Cantrill: And certainly, your (side is worried) about the bones.

Nikki Hastings: Right, this is Nikki Hastings. I think, that, you know, we – you're going to hear any kind of a doctor or older adults bring up medications over and over and over, but that's one thing that I should think we have to highlight here in terms of both the information that we have to have from the nursing home and the information that has to make it through the E.D. to the hospitalist.

Because definitely, sometimes, we will see patients arrive with a fairly complete packet of records and then somehow that's lost at the time that they, you know, need – somebody else needs to be seeing it because when it's paper records, there's, you know, always that risk of happening. So, making sure the information follows all the way through is an important piece. And the medications is really where I see a lot of misadventures turned into harm, if we get inadvertent therapeutic duplications because didn't realize the patient had something recently, et cetera.

Jesse Pines: I think one of the issues that also comes up is the diagnostic uncertainty issues. So this is a, you know, if someone falls down and has, you know, a clear hip fracture, there’s less diagnostic uncertainty that if someone, let's say, has, you know, delirium or, you know, a behavioral issue, where there may be, you know, more information that would need to be transferred about the patient's baseline in prior, you know, sort of prior episodes.

And I think that's where the, you know, lot of times, the information breaks down because it's – you know, as emergency physicians, we see the patient for the first time and not knowing them and this is – you know, this is sort of a simple case where, you know, we know exactly what to do here. But in the case where a, you know, maybe a phone conversation with the referring primary care physician who's sending that patient to the emergency department might be helpful.

David Newman-Toker: David Newman-Toker, just to follow up one nuance on that point, which I think is an excellent one, is the idea that sometimes things are not what they appear. So, sometimes a fall is a secondary effect, obviously, of something like dizziness or vertigo, whatever, which may be a symptom of something else. And especially in a patient who may be in a nursing home or not have the full mental state, so we have to really articulate that. There may be an extra need for sort of understanding the circumstances under which the event happened in the first place.

Nikki Hastings: And I would also add that the nursing home physician, because there are a lot of models but a medical director with – is often the person who has the ultimate medical authority over patients in a particular facility, may not have the most up-to-date information about a patient who's being referred in. Because once the patient is in the facility then if they're under Medicare, they will be seen by a doctor every 30 days, potentially even only every 90 if they're under a different payment model.

So it's really the nurses in the nursing facility, if you need information about the status of a person right before they came in or around the event that are going to be much more likely to have it in the supervising physician.

Aleesa Mobley: Aleesa Mobley speaking. Regarding taking the simple scenario and turn it into something more complex, when you refer to uncertainty, I think back on that medication list, it's not only important to have an accurate up-to-date list, but we need to know the last time the medication was provided. Because just as you mentioned, someone could also have dizziness, they can have a cardiac arrhythmia and it may be due to a dosage of something either just being given or something that was withheld for whatever reason.

(Crosstalk)

(Karin Rhodes): Some sort of communication about the patient's code status and baseline memo status, if this 75-year-old develops delirium, you know, what we have to worry about in addition to meds.

So, I think the – whoever made the point about the information package, I think when it's hard copy, getting that to the right people especially if there's multiple providers, hospitalist involved, I think we have to go with electronic ways of communicating and making information available on admitted patients that everyone can go to or have the patient sort of carry it with them.

James Dunford: This is James Dunford. I think – I agree with everybody. I think what we're already getting at is reconciliation of the patient's past record medications and all the other component parts of the past history that should – that there should be an expectation that information will accompany the patient on a transfer from a skilled nursing home.

(Karen Rhodes): And again, this is an acute incident. There's no mention of the family. And so, I think that somewhere in the standardized processes, who's the surrogate, are there family members that need to be notified and that that's checked off whether it's done by, you know, the registration clerk, or nursing, or the physician, somebody needs to be checking off that the information is passed on to the relevant people who need to know.

Nikki Hastings: There is one more sort of handoff inherent in a case like this when a patient comes in with a hip fracture in most cases, and that's in EMS group of provider. So just to the extent, we – you know, keep in my mind, they do have some role in making sure that the information conveys properly from point A to point B.

(Karen Rhodes): Right. And if it's not long-term nursing, if it was from home, that sort of the state of the home, something about – like if you found out there were throw rugs or there was beer cans all over, that sort of stuff gets lost somewhere in between the EMS and the E.D. providers, and the hospitalists, and the surgical consults and then getting back to the primary provider, whoever it is, so. And social services.

Steve Cantrill: And in terms of EMS, I would make a plea for currency of information. I know on our systems, very often, we don't get the trips (up) until two days later and by that time, it's completely useless.

(Karen Rhodes): Yes.

Steve Cantrill: And often may contain very important information that was not conveyed in the verbal report.

(Karen Rhodes): Right. Like the vital signs in the field.

Steve Cantrill: Yes.

(Karen Rhodes): That he was bradycardic or whatever, yes.

Steve Cantrill: OK. Any other comments about this scenario? If not, we can move onto the next one. Janet?

Janet Niles: OK, yes, yes. So the next one is, again, common that has some complications both ingoing and – incoming and outgoing. So we have a 64-year-old female presenting to a community hospital, E.D., with cough, fever, and dyspnea. Her chest X-ray shows dense consolidation in the right lower lobe. She becomes hypertensive and started on pressors, and she's deemed too sick for the hospital small ICU and a transfer is requested to a local teaching hospital.

The accepting intensivist requests that she'd be intubated for safe transfer and that imaging accompany her on C.D. She arrives at the academic hospital intubated, sedated and without (family). So I think, you know, we need to think about lots of different things here, but definitely, the outgoing transfer is going to be critical on this one.

(Crosstalk)

Janet Niles: And this pays into, I think, a rural scenario also.

Steve Cantrill: Yes. And one of the issues that I can relate to here is the information overload, the transferring institution will just give you a huge data dump so you end up with an inch of paper that you can't sort through to figure out what the devil actually happened with the patient.

So again, the need for – I hate to say it, but maybe a templated summary of the information is really what you need.

(Karen Rhodes): And this is even worse if the patient's been admitted any period of time, like was in that hospital's ICU and is basically crashing, and that's when they want to transfer her.

Steve Cantrill: Right.

(Karen Rhodes): It's impossible to sort of sort out a thick realm of paper as you're trying to stabilize her and figure out what's happened. So I would be in favor of a very templated, standardized amount of information that should be transferred with any such patient.

Female: And as mentioned earlier, being able to leverage work that's done in the hospitalist-to-hospitalist world looking for those templates that work, this is similar, you're moving from one hospital to another level of care, but it happens to have another physical location in between. But to be able to look in that environmental scan that is being worked on that what is out there related to hospital, that templated standardized handoff highlighting the most important things so they get buried.

(Crosstalk)

Kristina Cordasco: This is Kristina Cordasco. So, inherent in all these discussions, but this one really brought it to mind is, I can imagine the E.D. provider, of course, in a very busy E.D. be perhaps – this is even a sicker patient than they've – are used to seeing at that E.D., just not having the time and bandwidth to put together that package and summary, et cetera, and of course – and then the support staff helping them make this not kind of – does not have the medical knowledge to synthesize in the back end, and that's, of course, why we get the tomes of information because the E.D. provider can't go through and pick out what's important for the transfer and then the clerk will just print everything.

And so it brings to mind the need for both – like I.T. tools to help with this to make it more – so make the work most efficient for the people doing it, as well as the personnel support, and that that personnel support be at a high enough level to have enough clinical knowledge to assist in that transition.

And that just remind on the E.D. provider, you know, the provider-to-provider transmission in itself and their labor and time is not sufficient.

Steve Cantrill: Yes. I hate to be a cynic, but I think at least at this point in time, I.T. has exacerbated this problem rather than helped it. But I think …

(Crosstalk)

Arjun Venkatesh: So it's Arjun here. Some ideas that might help along those lines are – we are doing a project. We have AHRQ funding for a care transitions learning laboratory here, and these are the patients that we are particularly focused on. We're developing an improved care transition model for patients with atraumatic ICH from a variety of small hospitals, most the withdrawal outside of our health system into the system.

And one of the things that we've learned in terms of making that care transition safer and making it both easier for the sending hospital and for the receiving hospital is that our current processes are heavily siloed. And so, one of the things that we have actually tried to do is create a single source of information transfer from the other hospital in.

And so in this case, there are many systems where when this transfer happens, the sending doctor has to communicate both with an intensivist and accepting specialist or something like at the receiving hospital and then they separately communicate with a clinician in the E.D.

What we found was that the average lag time between the initiation of a transfer for critically ill patient, from a smaller hospital until their actual emergency department arrival at our center is on average of about four hours. And something on the order of less than 10 percent of patients were carried for on arrival by the physician that took – that was available to take communication, the call initially.

And so what this resulted in is the change in thinking about how and when you communicate this information. So there's an initial communication between sending hospitals and the receiving hospital. You then have to think about developing some sort of interface for information transfer that can live either with the patient or can even live at the receiving center. And so we use an Epic EHR and essentially the same call-in information that we would use, a template for that that we would use for a private doctor sending their patients to E.D. is used by the accepting doctor to now template out what the status of the patient is and what key contact information is.

And then the thing we did on the information transfer, which actually I think is better than we think. I think sometimes because of our silos, we don't talk to the people that work on the back end of radiology as much or these other sites. Virtually, all of the major vendors of radiology image management systems have a cloud-based platform. And so our old one had it. We're transitioning the new one that has it. And what it creates is a world where virtually any hospital can, via the cloud, send the images prior to arrival.

And so we have tried to transition away from any CDs at all. And the cloud client is web-based accessible at any hospital no matter what they are, where they are. So they don't have to install a software, they have to learn a very basic upload process. But it allows for the transition of images, securely and previous to the patient even leaving. It also makes the transition safer when they get there. There's no uploading of the C.D., all of that.

And so I think that, you know, there's – systems like that, they can be built, the model that probably does this the best is the telestroke community, does this really well. And so, there are ways to think about how they've organized care transitions in the telestroke world where patients may be getting (tPA), a lot of critical interventions and then being sent to another hospital. And we're essentially mirroring what happens in the telestroke world across other critical care populations. But I think that that's a model where I.T. works and people have been fairly successful.

Steve Cantrill: Thank you.

Sheila Roman: This is Sheila Roman from the Rural Health Quality Measures Panel. And I just wanted to make the point here that there is another handoff here, and that is the handoff to whoever transfers and in a rural setting, that could be helicopter transfer, that could be a very long ambulance transfer, so that you have other providers who are in the middle here who may actually be spending a fair amount of time with the patient.

And you know, I think there needs to be some standards for communication, perhaps even during transfer and how the communication at the end of transfer will be made to the accepting hospital and care team.

Karin Rhodes: This is Karin. I think you bring up an excellent point. As long as we're using sort of this cloud-based ideal, you know, communication platform, perhaps the people en route could have the ability to add to it if there's a deterioration or change in circumstances, and to sort of complete a few measures that would remain available about the transfer situations, vital signs en route, et cetera.

James Dunford: This is Jim Dunford. Hi. And I'd echo both of those last two comments. There is the new national EMS information system. It's the standard platform to exchange information between three hospital providers, and HL7 hospital-based information systems. And I think we should be encouraging that, whether it's CCT or any EMS provider that they are operating to the highest standard which is currently 3.4.

I agree with that idea that the – whether this person was coming from another hospital or coming from home, the pre-hospital record or the out-of-hospital record is really an important element to integrate.

Steve Cantrill: OK. Any other comments about this scenario?

(Crosstalk)

Karin Rhodes: Just for transfers, I think that for people just thinking of deterioration en route, like who's the online medical control during the transfer and what sort of support does EMS have during that process, especially if it's along transport.

Steve Cantrill: Well, the transferring physician has the responsibility until the patient arrives at the receiving institution. That doesn't answer your questions, but it's really – the burden is on the transferring side.

Karin Rhodes: I'm not sure that's always true. Like if you're a major – like center and you – some of them send out people …

(Crosstalk)

Steve Cantrill: Yes, if I send it, I'm responsible for it.

Karin Rhodes: Yes.

Steve Cantrill: But if it's – at least in our system, a vast majority come in via other system – other services, in which case, they have the responsibility.

Karin Rhodes: There just needs to be a way of transferring information if there's a change en route and getting some backup or support for the EMS. And it seems like it's reasonable that that'd be defined whether it's the place they're going and taking the patient, that's going to see this patient, that's may – may have had to change or the place that sent the patient. It needs to be clearly defined what that – who's available to the EMS folks for online medical control.

Male: And in fact, if it's a critical care transport and it's nurses that are doing it, they're maybe entirely out of the EMS system all together.

Karin Rhodes: Right. That's frequently when they're sending people, you know, like we used to send the helicopter, go get someone, pick them up there, transfer them, and then we had – we knew who we were reporting to. But, you know, in rural areas where they put someone in the ambulance, that's not always – you know, if they're not critically ill at the time but then they deteriorate, that's problematic.

Steve Cantrill: OK. Let's move onto the next scenario. Vanessa, can you give us the next slide?

This is pretty straightforward. This is a 52-year-old female who has bipolar disease and presents to E.D. for a med refill, and she's ran out. So, who will we going to transmit information to, and how much? And is it necessary at all?

Any thoughts about this?

Adam Swanson: Hi, this is Adam Swanson from the Suicide Prevention Resource Center. I think this relates to a lot of the scenarios that we see when working with state government. When it comes to persons with mental illness and persons experiencing suicidal ideation, we often find through our work that the hospitals don't have to systems in place for these patients, particularly if they're not working with an integrated setting, where they might have a connection with the behavioral health specialist to do some type of handoff with.

And when it comes to suicidal ideation, we often see that medical records don't allow physicians in the E.R. to even indicate that suicidal ideation is a risk factor for the patient. So then, when developing a handoff or a transfer to either a psych E.D. or a community-based provider, there's often very little information transferred in that transfer.

So I would say that there's a lot of critical information that does need to be exchanged in the handoff here. And I think part of it, and perhaps the measure, could also work with, you know, encouraging emergency departments to make sure that those connection points actually (to this) in the first place.

Janet Niles: Yes. And this is Janet. I think there is definitely handoff back to whoever her care provider is that's been prescribing her meds because she's obviously not following up or something is going on there. So again, I make the case-for-case management and coordination back with the behavioral health practitioner.

James Dunford: And Jim Dunford. Let's just imagine that this patient is brought in on a voluntary hold by the police, because she had raising thoughts and somebody called them and they felt that she was a danger.

I think one of the important things that we really should be capturing is the time that it takes from law enforcement to release in an emergency department at the time that the emergency department actually can't accept their history, I was just at a three-day conference in San Antonio this week, where the whole intercept between law enforcement and mental illness and emergency departments (in holds) was a very major topic of discussion and would be very useful to have some metric that we could develop that would record how long it took for a law enforcement to have such patients to be able to turn them over to responsible emergency departments, so that they can get back into service.

It's just like different on a theme of transition but I think it's equally important from a suicidal point of view.

Aleesa Mobley: This is Aleesa Mobley speaking. Just to follow up on that timeframe, we also have to give considerations before trying to transition this patient as to not only what medication she was on, but how long it will take them to reach a therapeutic blood level.

Karin Rhodes: So, I don't know if Jesse and Kirsten have had experience. I've found that Philadelphia did very well because they had sort of ongoing community mental health and actually with the psych E.D., where you could send this person, and they had access to what medicine they were supposed to be on and what their histories were. A lot of times, mental health histories are totally hidden. You can't access them as part of the medical record.

So having someone who can break that glass and, you know, is pretty critical to expediting their care and making sure that they get appropriate care and linked back in to whatever source of care they were on before was appropriate, you know, addressing of the non-compliance, whether that's a flare of her disease or other use of substances, et cetera, et cetera.

Female: Or socioeconomic situations where she couldn't afford it and just ran out and this is your only recourse.

Karin Rhodes: Exactly. So this needs a system of care. Bottom line is, mental health, we need a full system of care that can support the emergency department and law enforcement and assure that these patients who are pretty high-risk of recidivism get the kind of care they need.

Sheila Roman: This is Sheila Roman again. From a rural perspective, just to make the point that this person may not have psychiatric access if they're coming in from a rural setting, and may actually utilize the hospital E.D. for access to psychiatric meds.

Female: Good point.

Karin Rhodes: Yes. Yes.

Kyle Cob: Hi, this is Kyle Cob from NQF, and I'm going to suggest that we, you know, give people a little of bit time back. It's been a fabulous conversation and we have really got so much information from the panel and our guest today. So thank you.

But I'd like to move us a little along. And Steve and Janet, I apologize for hijacking the meeting at this point.

Steve Cantrill: Actually, I thought I was just going to turn it over to you anyway.

Kyle Cob: There you go.

Janet Niles: I was going to make the same suggestion, so we're all in the same page.

Kyle Cob: OK. Good. Good, I'm glad we've all been communicating, you know.

Janet Niles: Psychically.

Kyle Cob: Psychically. So, let's open it up to public comments.

John Shaw: Hi, this is John Shaw from Next Wave. And I wanted to first say that I really enjoyed seeing the case study scenarios used to trigger the discussions. I think that went very well and it resonated with me.

Wanted to just highlight a few things that resonated from the perspective of the Medicaid Accelerator. First is the recognition that you really need a full system that because of the wide variation and complexity, the reality is, there is no single or simple solution and really need to focus on all the different nuances that were discussed today. And particularly, I wanted to look through the lens of the Medicaid and uninsured populations, it’s a few people but much cost and much variability in care.

And so, the biggest issue that resonated was the whole concept of patient centeredness, looking at the patient's capacity and health literacy, particularly Doctors Carden and Rhodes and several others. We really need to have enough understanding to bring it to the people that are in charge of much of their care most of the time.

And one thing that suggested itself based on the discussions is a process measure to say, is there a designated provider or stakeholder, that's actually going to do the teach back, read back, observe medications, that type of thing. Because somehow the transition to the patient or their support system is critical to keeping them healthy and keeping them from coming back to the E.D. like many of them end up doing.

And so – but that was a big potential area. I don't know if there's any measures out there but maybe there should be.

Second one was, it seemed everyone was in favor of having the E.D. arranged follow up. And that could be another process measure, was it done, who did it.

And the third area is looking at if there's discussion of synchronous versus asynchronous feedback, and the need to differentiate what's critical now that needs asynchronous communication versus the asynchronous follow up that could be done at a later date and distinguishing those throughout may be useful.

And I thank you, great job.

Steve Cantrill: Thanks for the comment. Any other comments at all?

David Newman-Toker: This is David Newman-Toker, Johns Hopkins. I don't know whether I will be invited to give further comment at subsequent meetings since I’m on one of the other committees.

But, I just wanted to make a (meta) point that the case, the cases that were used were mostly cases of where there was no diagnostic uncertainty and where this sort of – the disease was known and the treatment was an issue. There's a common theme that we see, this sort of diagnostic part of things, often gets forgotten. And I would just encourage the group to make sure that that remains a piece of the puzzle even though there are obviously many important therapeutic issues that the diagnostic issues are also often important. Thanks.

Steve Cantrill: Actually, diagnostic uncertainty is brought out especially in terms of the communication between the physician and the hospitalist, the emergency physician and the hospitalist, so that – it's very much on our radar and it certainly is a problem especially in terms of even with premature closure as you mentioned.

Kirsten, do you want to talk about next steps?

Kyle Cob: Sure.

Kirsten Reed: Kyle's got it.

Kyle Cob: OK.

Kirsten Reed: Thanks.

Kyle Cob: So, thank you, everyone. We will – our next steps are, we'll have a webinar on March 15th and we will review essentially today's discussion where we have thought about common elements and variations of them. But, the next step is really to think about measurements from the perspective of accountability, which has just come up and also what quality is from different perspective.

So, that, we will synthesize and organize all of the information that you shared with us today into some type of a format that we can dive into it, I think, you know, in, you know, pieces as we did today to really think about how to measure these elements, so.

And in anticipation of that meeting, you will receive materials as usual a day in advance. And I encourage the panel members to visit the SharePoint site for information and as we find more information and get further along in our lit review, that information will be available. So I encourage you to take a peek if you have some spare time.

Steve Cantrill: Thank you. I just like to thank our expert panel, our NQF project staff and certainly all the other participants as well. I think this has been a very fruitful discussion. And we appreciate all the participation and I think we're off to a pretty good start.

Kyle Cob: Thank you.

Steve Cantrill: So with that, I think we're done. I will give – we'll give you 10 minutes back.

Kyle Cob: Yes, and just one last point for the public that joined us today. We do have our project page that's open to the public on the NQF website. And so we encourage everybody to visit our project page as well. Thanks.

Male: OK, thanks, everyone.

Female: Thank you.

Steve Cantrill: Thank you, everyone. Thanks.

Female: Thank you, bye-bye.

Male: Bye-bye.

Male: Bye-bye.

Female: Thanks, bye.

Female: Bye-bye.

END