National Quality Forum

Moderator: Transition of Care
March 15, 2017
12:00 p.m. ET

Operator: This is Conference #: 99130131.

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

Kyle Cobb: OK. Hello. Hello, everyone. Welcome to the ED Transitions of Care Third Expert Panel webinar. Our co-chair, Steve Cantrill, will be leading the meeting today.

So, hello, Steve. I am going to hand it over to you now to provide the overview and the meeting objectives.

Stephen Cantrill: Thanks, Kyle, very much.

I am Stephen Cantrill. I welcome you all. We are joined by Marcia Wilson and Kyle Cobb, Kirsten Reed and Vanessa Moy from NQF, and Jesse Pines, who serves as consultant. We also have our expert panel. And, Kyle, do you want to take a roll call?

Kyle Cobb: Sure. Kirsten?

Kirsten Reed: This is Kirsten. I will take care of it. Hi, everyone.

Stephen Cantrill: Kirsten. Sorry, Kirsten. Yes.

Kirsten Reed: You're fine. OK. Just going to quickly go through our list here.

Billie Bell?

Billie Bell: Yes.

Kirsten Reed: (Inaudible). Donna, are you on the line?

Donna Carden: Yes. Donna Carden.

Kirsten Reed: Lisa Deal?

Tricia Elliott?

Kirsten Reed: If you are – can I ask everyone to please mute your line if you are not speaking? We have a little bit of feedback and background noise coming in.

Tricia Elliott?

Nikki Hastings?

Susan Hastings: I am here. Hello.

Male: Yes.

Kirsten Reed: Joe Karan?

Joseph Karan: Here.

Kirsten Reed: Julie Massey?

Julie Massey: Here.

Kirsten Reed: Aleesa Mobley?

Elif Oker?

Andrea Pearson?

Andrea Pearson: Here.

Kirsten Reed: Marc Price?

Marc Price: Here.

Kirsten Reed: Karin Rhodes?

Kristin Rising?

Kristin Rising: Here.

Kirsten Reed: Brenda Schmitthenner?

Amy Starmer?

Amy Starmer: Here.

Kirsten Reed: Adam Swanson?

Arjun Venkatesh?

Sam West?

Sam West: Here.

Kirsten Reed: Margaret Weston?

Margaret Weston: Here.

Kirsten Reed: Christine Wilhelm?

And Stephanie Witwer?

Stephanie Witwer: I am here.

Kirsten Reed: And did anybody else join while I was going through and didn't hear their name?

Elif Oker: This is Elif Oker. I ...

Adam Swanson: This is Adam.

Kirsten Reed: Go ahead, Adam.

Adam Swanson: I was going to say this is Adam Swanson with SPRC.

Kirsten Reed: Hi, Adam.

Elif Oker: And this is Elif Oker. I don't know if you heard me or not. I was having trouble hearing you.

Kirsten Reed: Great. Thank you.

All right. Go to the next slide.

All right. So, today's webinar, we are really going to give you a quick project update about what we have been up to and, then, go over the results from our literature review, environmental scan of measures and our key informant interviews. And, then, we are going to get into the fun stuff and go through our domains and subdomains that we have come up with, which will lead us into a larger discussion. And, then, we will just briefly talk about the upcoming in-person meeting and next steps.

All right. So, since we have last talked and since, I guess, the beginning of the project, we have been busy kind of going through a bunch of evidence, which is almost complete, which is very exciting. We have really spent a lot of our time going through the literature review, which will assist us in establishing draft measure domains and subdomains, which we have come up with and will be presenting today, as well as to aid us in identifying measures and measure concepts that are framed by the patient's perspective and related to transitions of care into and out of the ED.

We have also spoken with three different key informants and planned also to spend some time speaking to a few additional ones. So far, we have spoken to an EMT at MedStar 911 in Texas. And they are really leaders in quality improvement and identified in AHRQ Innovation Exchange. We have also spoken to – excuse me – an attending physician at MD Anderson's ED, which is really dedicated to oncology emergency patients. And then, finally, we

spoke to one of NQF's panel members on the interoperability panel. And he participated in an OMC grant as part of the impact study with a focus on transitions between the ED and SNF and the role of HIT.

As I mentioned, we also have some plans to do some additional key informant interviews and are looking at speaking with an ED nurse as well as an LTC PAC provider. And, then, the team here is also looking forward to potentially doing a site visit at the ED on a busy Friday night to really get a better perspective on what we are working on here.

So, that's what we have been up to. I am going to pass it over to Kyle now to get started.

Kyle Cobb: OK. Thanks, Kirsten.

So, let's see. One more slide over. Yes.

OK. I am going to take us through the synthesis of the lit review, the measure review and so forth. But, before we get started, I'd like to just do a quick level set and reorient ourselves before we delve into the results, specifically just to – I find that it is easy to expand our scope and vision on framework projects and, as such, let us – let us go back to one of the most essential components, quality improvement measurement, so – and review these terms, which I will be touching on in the next few slides.

So, we talked about measures, measure concepts. We talked about instruments or measurement tools. And, so, they are really three different essential points. And I am glad – I don't know if that was a "Thank you" for resetting up for that. But, I think it is important. And I – you know, we don't have to go through it too much. But, just as a reminder, we are looking at measures.

The next slide, we – you know, just another reminder that there are – we can measure in a bunch of different ways. And this is just even a short glimpse of what and how you can measure. It can go much further. But, we like to think of outcome measures where you can look at – where there really is a tangible outcome on – for example, that, you know, percentage of hypertension

patients whose blood pressure is actually under control, process – when you are looking at process improvement, sort of getting people to start trying to do new things by saying – and, you know, these may be called checkbox measures, but they do – they do help. And, you know, we also have patient experience measures where we really try to get the inclusion of the patient's voice included in the process and, finally, structure measures, which really are more specific to larger systems and looking at the broader picture. So, it is a – it is a – it is a higher level of analysis.

And it's also worth noting that measures are calculated today on a variety of different types of data sources. We have claims. We have registries, patient-reported outcomes. There is clinical, the EHR data, you know, and really ideally in the future, we are all sort of moving away from claims-based and paper measurement. So, just another sort of reminder of where we are today in 2017 in measurement.

OK. So, evidence reviewed to date. Here is the exciting stuff. So, I – the NQF team conducted a three-step approach to the synthesis of evidence and environmental scan that included – we collected information sources. We reviewed them. And, then, we also had key informant interviews. We examined different sources of information such as measure repositories, NQF QPS included, the AHRQ Measures Clearinghouse, Hospital Compare, for example. We also reviewed peer-reviewed research pubs through PubMed, Google Scholar or the Cochrane Collaboration, although I think Cochrane is now indexed in PubMed. We also went through grey literature to identify relevant white papers, technical reports and any other relevant environmental scans. So, you can see this is far-reaching. We also, through this search, collected programs and tools and/or instruments used in ED transitions of care.

Our sources were ranked according to the relevance using the criteria that we introduced to you on the first webinar around the measures. And we have "relevant," which has direct impact on the quality of transition of care; "potentially relevant," the potential impact – so, maybe it is on transitions but not specific to ED – and, then, "indirectly relevant," so it is a component of a

transition potentially but not specific to the ED but, still, we would see that information as being informative.

So, we also conducted a serious of key informant interviews, Kirsten shared with us earlier, to supplement the information found within the literature review and measure review. The results of this review are available in a bibliography and a list of relevant programs that we will post later this afternoon to SharePoint. And we will also give before we adjourn today a quick overview and reminder of how to get into SharePoint and where to find things. We can do a little live Web sharing, I think. But, the bottom line is we are really eager to get your feedback on this work and ask you to please provide feedback on what we have missed or, perhaps, given too much emphasis to. It is – you are our expert panel. We are really happy to do at least 80 percent of the work in getting us started. But, we really need the final polishing from you.

Also worth noting before we move on that, you know, as part of our result synthesis, we developed three key themes that I will share with you next, which we use to guide and inform us as we develop the draft domains and subdomains, which are, what we understand today to be the most essential and measureable domains of a quality transition of care into and out of the ED. And, again, that is – this is just my nota bene that it is important, you know, reminder for us all to think about what we are doing within the context of measurement.

So, onto key theme one. The first key theme focuses on the patient as the center of the ED episode of care. Not in the slide, but important to also consider is the role of the active patient and their family and how they – the role they can play in improving the quality of an ED transition across settings. As we know, education and communication are essential and access to community support, such as social services, health coaches, navigators, transportation have also been identified as part of the broader tent, if you will, that supports transition of care.

Key theme two is essentially specific patient's condition and how those factors guide the transition. Key information such as diagnostic uncertainty,

urgency of post-transition intervention and/or testing or social circumstances of the patient and family are particularly of note. Also, how information is communicated – is it asynchronous, not happening at the same time? You get an email, a voicemail? Or is it synchronous? How does that – how does that inform the communication? There is also essential component here of accountability, for who, where, what, when the information is communicated either at the send or receive point of communication.

And I know I am going through this pretty fast. But, what we really want to do is just introduce these to the panel and we can go back to them.

So, the third key theme and final for now – we are not going to rule any more out – and, I think, you know, as we have been discussing this and as we have been sort of reading more and this has been evolving, I'd like to sort of point out that this slide is perhaps not even as much in line with what I see as the third key theme today. And, really essentially, the third theme is focused on the capabilities and the capacity of an ED and how that informs a transition as well as a, you know, a sender or a receiver outside of the ED and their capacity and capabilities. And when I speak to capabilities and capacity, I am thinking of things such as expertise or equipment, specialists and how that really informs or initiates transition because, I think, what we have read is that – and what we have heard from people is that these things are various across settings and they are nuanced, but they will either inform, make or break a quality transition.

So, I will – I will pause there. I think those – that was the end of the three. And I will – we have questions. Well, I think the next slide says "Questions." This is not the discussion yet. But, I am happy to – I think, we can pause and so some question/Q&A and hear your impressions on these themes. We'd love to hear, you know, do they sit right with you? Are there more things that you would add? Are there – or are they just, you know, bonkers and wrong?

Adam Swanson: This is Adam Swanson from the Suicide Prevention Resource Center. From what – the work that we are doing with EDs, it is all right on target, I think, particularly around folks that come into EDs with – in mental distress or in suicidal crisis. One of those key factors is that transition of care in terms of

what information is being transferred and what is the capacity of the entity that is receiving the transfer. So, a good example would be do they have behavioral health capacity? Do they know how to do safety planning or what have you? So, I think you are right on target based on what SPRC does.

Kyle Cobb: Great. Thank you.

(Multiple Speakers)

Stephen Cantrill: Any other – any other key themes from anybody out there that springs to mind?

OK. Hearing none.

Marcia Wilson: OK. This is Marcia Wilson. And we are going to take a little time here to talk about where we are going with this project, how it is going to be structured. You've heard from Kyle about the themes and what we learned from a series of activities designed to understand the current landscape of transitions of care in and out of the ED. But, let us take a step back. And how are we going to use that information? How will we begin to put things together with the goal in front of us of at the end of the day being able to measure the quality of transitions of care in and out of the ED, in particular looking at it from the patient's perspective.

So, on this next slide, which is not too complicated for a reason – so, we call this project here at National Quality Forum a framework project. And we do a lot of these kind of projects. And, typically, they are areas where we don't have the performance measures that we need or we want. And the fact that our environmental scan for ED transitions didn't turn up with a lot of performance measures was not a surprise. We expected that.

So, framework projects are really important because they provide a critical foundation for measure development. Frameworks provide guidance as to what measures should be developed and what we can learn from those measures. So, all of our framework projects here at National Quality Forum follow a particular process. And that is what I want to explain to you.

After the initial work, we've had committee webinars. We have done an environmental scan. We have had a literature review. We have done key informant interviews. More to come. We create a framework. And a framework is really a conceptual model or structure for organizing ideas around what is important to measure.

Now, within that framework, we developed – you want to go back to the graphic. Just stay on the graphic for a while, Vanessa.

Vanessa Moy: OK.

Marcia Wilson: Thank you.

So, within that framework, we start to develop domains and subdomains. Now, a domain is a place to hold an abstract idea. That is fairly conceptual. So, for example, when Kyle walks you through the domains and subdomains that we have identified so far, the first domain is going to be Send and Receive because everything we looked at, everything we have seen, everything we have heard is that the transmission information, the sending of information and receiving of information in ubiquitous in a transition of care. So, that is like kind of the big conceptual domain. And, then, underneath that are going to be subdomains. And that subdomain takes that more conceptual idea and makes it more concrete. So, it might be a concrete activity or an event or something that is observable. So, very simplistically, that is a framework in a domain and a subdomain.

So, what we are going to do today and mainly the main conversation we are going to be having today is in just a couple of – in just a few moments, Kyle is going to walk you through our proposed domains and subdomains that we, the NQF team, have created. All of those domains have definitions and, I think, there was a separate handout, a page, that was sent out that has the definitions. I am looking at my colleagues here – yes – they are nodding yes, they did receive – that has all the domains and subdomains listed and the definitions. We are going to talk about the definitions. Do they make sense? We are going to talk about the domains and subdomains. Do they make sense?

And we are going to start working on what we put forth in refining. You may look at a domain or a subdomain and say, "That one doesn't make sense. I think it needs to be split into two subdomains," or maybe you are going to put – take two subdomains and put them together. Maybe you will say you missed a subdomain altogether, "I think (blah) should be included as a subdomain." So, this is our first pass at the framework, the domains and subdomains and building out that infrastructure, if you will.

Now, what happens after this is, for the in-person meeting, we are going to take all your edits, we are going to refine the definitions and the framework's domains and subdomains, come back with a refined model for you, and we will also take the measures that we have found and the measure concepts that we have identified and use them to populate the framework. So, under each domain and subdomain, you might see either measures that are out there that could be used for measuring quality in transitions of care or measure concepts. In some cases, we may have a subdomain that is blank. That is not unusual. We call that a gap. And, so, part of the committee's work, in addition to seeing do we have measures in the right domains and subdomains, do we need to work on the measure concepts, is identifying those gap areas and looking at what we would want to measure within that subdomain.

So, first part today, new look, a fresh look at the framework domains and subdomains, definitions, how it is organized. It is making sense to you? We refine it for the in-person meeting. And at the in-person meeting, you see that framework populated with measure and measure concepts. So, for example, one of the activities that will probably take place at the in-person meeting is we may break you up into small groups and you may look at specific measure concepts that are not well defined, a little on the squishy side, and we will say, "OK, what is the numerator? What is the denominator? What is the population? What is our data source going to be?"

And, so, you start building out the population of measures and measure concepts in the framework. And I am hoping you can see that is where we are moving towards our final product because that is what this committee is going to show. It is here is the foundational work. We want to measure quality of transitions in care in and out of the ED with a healthy dose of the patient's

perspective, what could we be measuring, what should we be measuring. And, by the way, measure developers, here is where we think the field should be going.

So, let me pause there. What I am trying to do is help you understand how we take what we have done so far, translate it into something that is actually – make it operational, that it is understandable. And this is kind of where we are going. So, let me stop there and see if anyone has any questions, if it makes sense or not.

Male: I think it makes sense.

Marcia Wilson: OK. It's making sense? OK. Good. I was – I was – I didn't want to take silence as the – yes, the implicit "Oh, that was crystal clear." So ...

Male: Marcia, can you be more elucidating about the line between a domain and a subdomain. That seems relatively arbitrary.

Marcia Wilson: Let me see. The first – the first Send and Receive – and what is an example of the subdomain that we are using in there, Kyle?

Kyle Cobb: A subdomain for Send and Receive may be the information used in Send and Receive...

Marcia Wilson: Right.

Kyle Cobb: ... and the modality of information.

Marcia Wilson: Great example. So, Send and Receive is your conceptual idea. Information – something is being sent. Something is being received. But, when we look at the quality of a transition, one is dependent – we have heard from you all, we have heard from others – it is dependent on what key elements of information needs to be – need to be transmitted, that is the mode – and that is where Kyle was talking about synchronous versus asynchronous – what is the mode of transition.

So, the subdomains are more concrete than the domain. The domain is like a conceptual holding tank. And if we want to measure Send and Receive in the

context of a transition, how are we going to do that? And, so, the subdomains are kind of those – the definitions that make something more concrete. And at the end of the day, if you talk about what information needs to be transmitted, how does it need to be transmitted – I know we have something in there, too, about the ability of the receiver to actually make the ...

Kyle Cobb: Yes.

Marcia Wilson: ... information actionable, right, looking at the subdomain's timeliness and accuracy. When we build that out and start populating it with measures, what that allows us to do ultimately is turn – go full circle back to those scenarios that we did in the first webinar, those use cases, and say, "OK, for this kind of transition, what would be the key information, the mode of transfer, the timeliness and accuracy, the level of education needed for or awareness on the part of the receiving person?"

Does that help? Better? Worse?

Male: Good. That is helpful. Thank you. Great.

Marcia Wilson: Any other questions? I'd – if it's understandable, that is great. If after thinking about it, you have a question, you can always email the team. But, trying to give you an idea of, in an operational sense, where we go next to start building out this framework so we can look at measures and concepts and identify gaps.

OK. Thank you.

Stephen Cantrill: Great.

Kyle Cobb: Yes. And this is Kyle. And I would just say there is really an art to it, as Marcia alluded to, that you really – you start with this wide (inaudible) of information and we get to these key themes. And you will see – that is why we started with the key themes as a result of the information synthesis. And, then, we go into these domains and subdomains, which become more granular. But, you could almost map these – and the goal is to map these domains and subdomains to the key themes.

So, with that, let us – let us start moving towards looking at these domains. But, before ...

Female: Before …

(Multiple Speakers)

Kyle Cobb: Yes. We have a couple of definitions.

Female: Yes.

Kyle Cobb: We can come back to this at some point. There is another definition. I think this is – let us pause on the next definitions before I go in and just – yes. Back to care coordination. We want to look at care – yes.

Donna Carden: This is – this is Donna Carden. Can I ask a question, please? I am following along on the SharePoint the definitions and the domains that you are bringing up. But, did I hear someone say that you sent these domains by email?

Marcia Wilson: Yes. This is Marcia, Donna. And you should have received in your attachments for this webinar. I am looking at people verifying ...

Female: Yes.

Marcia Wilson: ... that we sent a one-page document that listed all the domains and subdomains with their definitions. Staff, can you please confirm that?

Female: Yes.

Marcia Wilson: OK. And what …

(Multiple Speakers)

Female: It has been out end of last week.

Marcia Wilson: Yes.

Joseph Karan: I never received it. It's Joe Karan. I never received it.

Marcia Wilson: OK. Did you ...

Donna Carden: I don't think I did, either.

Female: Yes. We can – we can resend it to you.

Marcia Wilson: (Inaudible) (we will) resend it. And, also, if it helps, Kirsten, could you tell people when that email was sent? I know it always helps me if I know it came in on Friday at 5:22 p.m. We are checking. And we will – we will just resend it now. But, we can also check.

Donna Carden: OK. Thank you.

Marcia Wilson: Sure.

Kristin Rising: This is Kristin Rising. I can tell you it came in on March 9 at 4:55 p.m.

Female: Thank you.

Marcia Wilson: Thank you. But, we will go ahead and resubmit it for those of you where it's either gotten swallowed up somewhere.

Female: Yes.

Kyle Cobb: And while we are – while we are figuring this out and giving resends, let us go through some definitions that are – that are relevant to the work we are doing and important for us to keep in mind.

So, in terms of transition of care, we really do see this as a – as a subset of care coordination, which is the deliberate synchronization of activities and information to improve health simply. And within that, we have transitions of care, which really is the care coordination that is involved in the movement of patients between health care locations, providers and different levels of care. But, that is an element of care coordination.

The next two are important insofar as really our charge for this scope of work is to have it – our work be patient-centered and to think about, you know, the

transitions through the lens of the patient and understanding really from the patient's perspective what is happening through that. And this is really – I think, there is a lot – this is – this is a standard definition for a patient- and family-centered care. But, I think that the main and most important part is the second part of it, which is the respectful and responsive to individual patient's preferences needs and values.

So – and, lastly, the community services setting. I touched on this earlier, one of the key themes. But, thinking about what we have heard and what we have read is that, you know, we think about the transitions that is being part of care coordination which sort of sits under a tent that has historically been maybe a small group of organizations or delivery systems. And as we learn more and more about effective care coordination, we understand that that tent has to get bigger and that the tent really has to encompass the community and community supports. So, when we talk about the community services, we think about all of the non-clinical, non-health-specific services and supports that help patients integrate their care into their life and into their setting. And that really is that important, as we all know. I am sure I am not preaching to the choir.

So, with that, let's go to domain one. And just before I start to – for the folks that don't want to look at slides and want to have something in their email, that we get that resend.

Female: Yes.

Kyle Cobb: OK. Terrific. So, if people want to check their inboxes and they don't want to look online, they can read along with me in a Word document that we have sent out.

So, the first domain, as Marcia mentioned, is Sending and Receiving – or Send/Receive Communication. And, you know, the – we have put together – this is – and bear in mind as we go through this, this is draft. This is not final. This is not, you know, how it has to be. Our exercise today is to really take this, analyze, tear it apart, put it back together, add and subtract. I mean, this is really an interactive exercise. But, as we all know, we can't do that without

something to react to. So, we got – we got as far as we thought we could to provide a fruitful conversation.

But – so, the core of – or the – really integral to a transition of care is the Send and Receive Communication that occurs between, simply, care settings and among – so, there is the settings, there is the teams that support these transitions. And communications can involve a myriad of people. We have patients and caregivers and physicians, nurses, care managers, administrative personnel. There are EMTs and more. We will continue to identify all of those actors that take part in this. But, this is, you know, as I said, a first draft.

So, moving to the right side of the slide and we look at subdomains, these are really essential to the elements that support Send and Receive Communication. And we do have, I think, examples or definitions in the send-out. So, if you look at the – I actually don't have it in front of me – the document that we sent out to everybody, we do have definitions ...

Male: Yes.

Kyle Cobb: ... of the subdomains which, I think, will be helpful as people are looking at that. But, we do – Key Information really could cover a broad range of everything from clinical information to socioeconomic status, specific information about the patient and their – great. Somebody has just passed it to me so I can not wing it.

So – but, we did suggest as a Key Information type that it could really encompass a wide range of information, including advanced directive or preferences – care preferences, communication expectations and, then, sending – you know, sending expectations from the provider. I would say that there may be an opportunity here to expand this more. But, we may even – I would not rule out considering even breaking this up into different types of subdomains because it is so broad and it covers so many different types of Key Information that are included in a communication (that supports) the transition.

The next subdomain is Modality. And we thought about this one. We heard from you. We (saw on the) literature – we have heard all around that sort of

modality really informs transfers or it is a part of transfers. And there are pros and cons for each. And I don't know if there is an algorithm for when to use or when not to use. We have seen best practices. There is tacit expectations for some in terms of how – what types of modalities are used. But, it is variable. So, that was the second. How do I move this?

The next is Timeliness and Accuracy – Timeliness, Accuracy and Efficiency. We have added a third term, which is not reflected on the slide. But, I think, the Efficiency is sort of a follow up to timeliness and really speaks to what we have talked about over the last few months. Quite a bit – sort of touched on it, but (salience) of information communicated, how it was communicated or was it communicated in a time to allow the receiver to assume full care of the patient. I think, that is in its simplest form.

The next subdomain, Medication Safety – we saw this as the broader – mainly because med rec is an important part of what we have heard and read. But, we also understand that there is more elements to Medication Safety beyond med rec. So, proposed that there are some other practices that may be included in a transition what we would – would fall under the subdomain of Medication Safety.

Next, we have Education. And, I think, you know, I've gone a little back and forth on this one because, I think, there is – you know, there is education for the patient and the caregiver that supports it. But, there is also education for physicians, nurses, care managers as well. So, I mean, it could go the other way, too. I think, there are – there is an opportunity for education across the board and it may not specifically be – I will be curious to hear people's reactions. It may not specifically be to the level of patient and caregiver education. But, we do know that education has a huge impact on the success and quality of a transition or, at a bare minimum, patient understanding, you know, what their – what is happening, what is going on and being communicated to in a clear way that is understood.

The final domain or subdomain for Send and Receive is Accountability. And this is really – Accountability is specific to communication between providers and how they actively and effectively participate in a transition of care. We

have – we all know that there are various alignments or (malalignments) in responsibilities for transition providers and there are some measures that expect – we have seen in our review that expect – you know, there is – you provide information at some period of time after a transition. But, it is – it is still hard to understand within that context really who is accountable when sending and receiving and what those rules are. We suspect that we get into that a little more and we define it a little more, it will be – have a huge impact on quality and transitions of care.

OK. Let us move on to domain two. OK. Not my most favorite word – Utilization of the Broader Community. So, if anybody can come up with a better title, I am – I challenge you to that. But, you get the gist of it. It is really making use of the – and including the broader community. So, we are looking to the idea that the broader community organization, services – and that includes information, IT infrastructure is really engaged to support quality transition of care into and out of the ED.

This is sort of an interesting one. We did find some similarities to the NQF work of care coordination and worth at some point for the panel to take a look at. If you are interested, there is a Care Coordination Technical Report and Framework that was published in 2014 that includes three domains with multiple subdomains. And we did find that in some ways, we didn't recreate it because it is not the same. But, the utilization of the broader community – and, I think, in care coordination, they call it the health neighborhood – is, you know – is absolutely an essential part of this.

So, we do – we did use their subdomain theme of linkages and synchronization. It is worth pointing out that it is how effective the linkages and the synchronization of care and services are. It may include identification of appropriate community services to support a transition or bidirectional communication to facilitate coordination or frequent and accurate communication to solve problems. These are the essential components of how it works to include the broader community in a transition.

Female: (All right).

Kyle Cobb: (Inaudible).

Female: If you are looking through the comments about the word "utilization," you captured very well below when you talk about engagement. And, I think, in some way, engagement is the shared responsibility of the community not solely based on the provider.

Kyle Cobb: I like that.

Female: Either engagement or leveraging or ...

Kyle Cobb: Yes.

Female: ... taking advantage of that communication and engagement.

Kyle Cobb: Engagement. Yes.

Female: And you use (that later) – engage ...

Female: I agree.

Female: How to engage that broader community is a good topic.

Female: I agree. Engagement or inclusion, which is another word we used to describe this, I think, works just as well.

Kyle Cobb: Yes. Utilization just is to technical and leaves me feeling kind of, you know.

Female: It feels one-sided as well.

Kyle Cobb: Yes. It's just – it's not a – it's not a nice word.

Brenda Schmitthenner: And – this is Brenda. And another word for consideration might be "handoff" to the broader community.

Female: I like that.

Female: But, I think we are talking about handoff in both directions. I think, equality important, we have talked about this bidirectional communication. When you

have a community organization that is engaged in the communication both ways, you can measure the quality of the transition both in and out of the health care world.

Brenda Schmitthenner: And this is Brenda again. And that communication is actually more than bidirectional. It is multi-directional because there is typically not just one community support involved but many in that transition.

Kyle Cobb: Yes. Absolutely agree. And let us – let us just put a pause on that right now. I want to get through these and then come back and have exactly this feedback in the conversation. But, what I am hearing from you is that this is – this may be a little exciting that you want to start talking already. So, good.

Female: Very good …

(Multiple Speakers)

Kyle Cobb: Great feedback.

Female: Yes.

Kyle Cobb: So …

(Multiple Speakers)

Female: Just a sweet spot.

Kyle Cobb: Yes. So, just to continue with leveraging our broader community and really engaging them, I think, another essential subdomain is Quality and Availability of Service and, really, how those – the quality of those services move beyond the availability of services that support transitions of care. Examples of quality may include equity, continuity, culturally appropriateness of services.

So, OK. I move on. We will come back.

The next domain is Achievement of Outcomes. And this is really the extent to which the quality of the patient-centered ED transitions of care outcomes are

achieved. And I am sure we can see them in more ways than are outlined here and we can fine tune and work with these a little bit. But, I think, in general, we have the Healthcare Utilization OK here – the Healthcare Utilization and Cost, which is really, you know, has the – you know, the level to which the health care realization costs are decreased or increased as a result. And I – and I say it is either up or down. I don't – I don't think the outcome is not necessarily determined as being, you know, "We have saved money." We – you know, the – we – and outcomes could be is that "We have increased services." That is a good outcome. So, the – again, the Healthcare Utilization could include, you know, other things than ED visits such as medication, procedures, transportation. So, I'd just throw that out there.

The next subdomain is the Provider Experience. And in no particular order because we may – as I am walking through this one, I will start with the person. But, the provider is also a person. And their experience, their level of experience, whether it'd be positive or negative, with the quality of an interaction, I think, is absolutely an essential outcome of a transition of care. I think (enough of that). We all agree.

And, then, the final, which is Person and Family Centeredness is probably more the person's experience, patient's experience. I had – I had started a bit broader. We may want to bring it down to experience. That may be more consistent with the provider experience. But, again, this is really the extent to which care is provided to the patient and caregiver family which is respectful of and responsive to the individual patient's preferences, needs, values and ensuring that the patient's values guide all clinical decisions. So – and the outcome maybe, you know, of their experience – did that happen?

So, OK. I am done talking. Steve, I am handing it over to you.

Stephen Cantrill: Great. Thanks.

Let us go on to the next slide.

There are some questions that we want to – you want to talk about the linkage at all or we can ...

(Multiple Speakers)

Kyle Cobb: When is that – did I – yes. OK. I guess I have one more slide. I am sorry. I spoke too soon.

OK. Before we get started – OK. Just a base, everybody. In your conversation, here is an example of an existing measure relevant to the Key Information subdomain where they have – and this is in our – this is on SharePoint. It is a – it is a result of our scan that we have – this is NQF Number 0291, Emergency Transfer Communication. And it is the percentage of patients transferred to another health care facility whose medical record documentation indicated that required information was communicated and required information communicated within 60 minutes of transfer. So, one thing that would be interested to – we could look into the data on the use of this as an input potentially for the in-person to see how it is working.

Another – so, this is – and below, this is a measure concept example which, interestingly, is a measure under development through a CMS contract. It is – I adopted it to the ED setting. But, it is actually for under impact and it is specific to post-acute care. But, it is – it is – I love the spirit of this concept and, I think, it really translates very well to what we are thinking about. And it really takes the 0291 a step further where you are looking at the – you know, the transfer of information at ED admission start or resumption of care from other providers and settings. So, that really gets to the core, I think, of communication and Send and Receive and what we have been thinking about of how that information is transferred with a transition. And the – and the second part is the other way, which is the information coming out of ED. So, this is really going back to our sort of bidirectional theme.

OK. Steve, I hand it over to you now.

Stephen Cantrill: Great. Thanks.

So, let us open this up for some discussions. So, really, are these domains – are they reasonable? Are there domains or subdomains that needed to be added? Do they resonate with your experience in terms of emergency

medicine? And is it actual definition of both a domain and subdomain? So, let us open it up, and please give me your thoughts about this.

Andrea Pearson: This is Andrea Pearson. So, I primarily work in the ER, but I also do some primary care work. So, I think, I have a couple of points on both. My first one for (inaudible) for domain one, the – in the – for the – so, I was wondering if there is any way to include something along – I don't even know what the right word for it would be, like readability or ease of use for the provider who is accepting the documentation. I mean, that may fall into part of domain three, the Provider Experience. But, I think, you know, you can send over information that has all of the key information necessary and is credibly accurate but is 15 pages long. And is there any way to measure the efficiency of communication or the readability (inaudible) the ease of use for the person who is receiving it? That would be my first – my first point.

And, then, the other I – this may also fall under Provider Experience. But, just, you know, coming from the other perspective in the ER, who is often giving this information out, what is the ease of actually generating this? You know – and when you are – when, you know, you are – you have an ER with five-hour waits and you are – you are completed crushed, when you are doing these transitions, is it something that is sufficient and makes sense versus trying to get – you know, is it worth something that is going to add another 15 minutes onto that person's visit? And, I think, that would be important for the provider who is generating this document.

Stephen Cantrill: Excellent comments. And, actually, we tried to deal with the efficiency of the communication with the subgroup of Timeliness, Accuracy and Efficiency. And that is really what we were trying to address, especially with the salience of the information. I mean, too often, I have taken a transfer in and they deliver a 200-page record, which is usually unreadable and has no organization. So, that is what really what we are trying to get at as well.

And your other point – I think that is very important. And we alluded to that somewhat in terms of cost because, you know, there is no free lunch. And if you are going to end up taking more time with every patient to make sure you

get a better transition out, then you may end up – we would increase cost to the system. But, both very good points and we do hope to address those.

Any other comments?

Donna Carden: This is Donna Carden. I mean, that point that was just made about the efficiency of information that is provided either to or from another facility or provider is equally relevant to the – and I know we talked about this on the last call. It is equally relevant to the information provided to the patient. For example, it is very maybe time-efficient to generate a very lengthy set of discharge instructions for patients. But, really very similar to your example of the 200-page medical record, a lengthy document that is handed to a vulnerable population who may be using the ED is not usable actionable information. And therefore, you know, while it may seem that taking that one or two extra minutes – and the literature supports that it doesn't take that long to actually provide literacy-sensitive information to patients – may save that patient another visit to the ED and the whole ED staff and the whole system all of the time associated with the – an avoidable visits. So, I think, those comments are equally relevant to providers, other settings as well as to patients.

Marcia Wilson: And, Donna, this is Marcia. I just want to interject here that the beauty of having domains and subdomains in the framework is you may have multiple measures within a domain from different perspectives. And we have hard it now from both sides. We've talk about the efficiency of the information from the provider perspective. And, then, you are bring up another issue from the patient perspective. Now, those may be slightly different. But, there – we would fully expect that as we are done populating this framework, we will have – we could have multiple measures within a subdomain because they represent different perspectives. And I wanted to introduce that idea. Thanks.

Stephen Cantrill: Thanks, Donna.

Female: Am I – am I missing something? I'm sorry. Am I – am I missing something? Because I am looking through and I don't see Efficiency listed anywhere and maybe I am just missing it.

Stephen Cantrill: It is – it is not on the slide. It is – if you go – you also received something which is called ED QC Domains and Subdomains. It is a PDF file. It is five pages long. And that is going to be part of your homework. It is to review that in detail. We do have the Efficiency listed on that. It is on the second page.

Female: OK. Thanks.

Joseph Karan: This is Joe Karan. I am actually a patient/patient advocate. I am kind of pigeonholed into the ESRD world. But, one of the problems that we see within our dialysis clinics is the timely dissemination of medical information before the patient actually goes on a dialysis. And we are not – at this particular point, that timing is a major issue for us. And I have interviewed many of the dialysis clinics and the LDOs and we have people who were getting treatment before we have seen the results of the emergency room. And, so, that is – you know, I guess I am pigeonholed into that. But, that is a major concern for the entire dialysis community. It is – it is the speed in which we get the information.

Stephen Cantrill: Certainly a very important point. Thank you.

Arjun Venkatesh: Hey, it's Arjun here. I just – I guess, one thing I wanted to raise was as I look at these domains and subdomains, they are, to me, I think, framed in a framework that is very kind of measurable or being measured at the patient and patient level often and less of a population-based framework. And the words, I guess, I would look for in that more of population-based framework would be things like shared accountability as opposed to accountability alone or measures of care integration as measures of care transition.

And the reason I bring that up is the AHRQ did a lot of work on care coordination. They have an AHRQ Care Coordination Atlas, and they specifically used the term "shared accountability," which is different than how, I think, accountability is framed here when it is kind of specific to just the communication as opposed to both providers or both settings on either side of the care transition having accountability for that patient's transition.

And, so, the reason I bring that up is from a measurement framework, I think it is important because I think we want to set up a framework that would promote measures down the line that advance shared accountability. So, these would be measures where both, you know, the emergency clinician and the outpatient clinician would share accountability for a set denominator or patient population, and they would even potentially share a measure of the – how well that care is integrated. Those could be measures of preventable hospitalization. Those could be measures of how coordinated their acute care is. Do they have frequent touches of acute care with select numbers of providers and things along those lines?

And, so, I feel to some degree that population level of measurement is missing, and I am just wondering if kind of moving towards shared accountability as opposed to just communication accountability would get us there. I am sure how it fits in to the overall framework.

Male: Just a comment, Arjun. So, (is it) talking about shared accountability for communication transfer or sort of a specific action like for a follow-up appointment or for, you know, a stress test to be done?

Arjun Venkatesh: I think it is not about for a stress test to be done, but it is actually for the patient population. And, so, to say that you can imagine the denominator of a measure being a certain, you know, Medicare beneficiaries of a health system, well, then, their shared accountability for the care transitions of that denominator population for any clinicians or settings that touch that patient. And, so, I think that that is what I mean. It is more this idea of a care transition is more than saying, "OK, I did my job. The care transition is passing accountability from me to you and then I am done and then, now, it is the next person's job." That is a very kind of assembly line model, I think, of the care transition as opposed to one where an organization would have some accountability for the care transitions and that organization or system is inclusive of multiple providers, many of which are in ED.

Marcia Wilson: Arjun, this is Marcia. I think you are speaking to a point that we are going to get into with measurement absolutely, which is what we call at National Quality Forum as level of analysis. But, it really means where is this measure

most applicable? So, I think, that is another thing within the framework that you may have measures that are more focused on individual – interactions – transitions among individuals. But, you may also have a – or a measure where your level of analysis is a population, speaking to your point, which is we don't want this to be solely focused where the level of analysis is just at the clinician level, just at the patient level or just at the facility level.

Arjun Venkatesh: Yes.

Marcia Wilson: So, as we think about populating this framework with measures and measure concepts – it could be measure concepts. We have simply done the measure.

Arjun Venkatesh: Yes.

Marcia Wilson: With the measure concepts, that is something else for the committee to think about. It is what is the intended level of analysis.

Arjun Venkatesh: Yes.

Kyle Cobb: And it can vary.

Marcia Wilson: Yes.

Kyle Cobb: But I – Arjun, this is Kyle. I do agree that – as I was sort of drafting it and I put accountability in, it was sort of implied for – in my mind that it was shared. But, I am looking at it and interpreting it without the shared. I can see where it goes. So, that is really helpful feedback to include.

Arjun Venkatesh: Yes. And even at the item level, it might be valuable, too. Right? I think, what we don't want to think that care transition accountability for communication is I send recommendation for outpatient stress test to cardiologist from the ED. I think, it is implied there that the assumption is that there is a model in place in which there is closed-loop communication. That referral is received and feedback is provided back to the sending provider. And that could be where the ED is, the sending provider in the example I just gave. But, that is a shared accountability. And, historically, I think measures have not had that closed-loop framework to them even when it

is specific to that communication. And, so, I just wonder if adding that term to or making it clear that it is a – it is not just a – we are always thinking about this in that bidirectional matter, I think, is helpful.

Stephen Cantrill: Thanks, Arjun. Good points.

Susan Hastings: This is Nikki Hastings at Duke University. First, I just wanted to thank the team for laying this all out for us. It is really reflective of an obvious huge amount of work and really move – helps move the conversation forward in a productive way. So, definitely, thank you for that.

I am looking at the Word document and had just a few comments on that. Regarding the Communication domain and particularly identifying the actors – I know this very much in process. But, one thing I note there is the use of the term "caregiver," which applies in many cases but something more inclusive like families for our major anchor of the domain definitions might work a little bit better. Sometimes, the term "caregiver" gets applied overly narrowly to – only applied to people who require some kind of information care on an ongoing basis. And throughout the document, we talk about families a little more broadly. So, that might be something to consider.

The Timeliness, Accuracy and Efficiency item, which I think is really great, completely (a word-messing kind of) comment, but we say there that completeness, accuracy and succinctness is based on acuity and clinical complexity. And, I think, most of those apply but not accuracy. That would be something we would strive for no matter what. And, I think, it really gets to more of the volume and, definitely, the timeliness that we might want to pull Accuracy out of that. So, I think, the information, whether it is large or small – we still want it to be accurate.

The Patient Education piece, which I think is really great in terms of measurement – we might want to think about that both in terms of the key elements of information transfer for an ED transition. And, also, we could think about that in terms of measurement as far as how well patients understand the information that is provided. So, it is sort of two sides of the same coin but would have different implications certainly in terms of how we

suggest it'd be measured. And that latter one takes into account a lot of the communication barriers that exist for patients in the ED setting, which I know everybody on this call is very well versed in.

And, I guess, the last comment I would have is just picking up on what Marcia said about this domain being really big, especially compared to some of the others. And we'd love to hear feedback from others on the call about suggestions of whether it makes sense to break this domain apart and, if so, on what basis.

Stephen Cantrill: Good points. Any comments about that, especially in terms of breaking up the Send/Receive Communication domain?

Kristin Rising: I am wondering – this is Kristin Rising. Sorry. I am wondering if (inaudible) maybe Medication Safety and Education components can come out. I guess, there is a component of the Medication Safety that is going to the communication with providers. It almost seems like we could put – or we could potentially look at kind of the breakout of communication as it is pertaining with the patient and as – versus communication (inaudible) pertaining between sites of care.

Amy Starmer: Yes. And this is Amy Starmer. I was – along with the comment about the Medication Safety, one of the things I was wondering about was specific to the Outcomes domain. I was wondering – I didn't really see much there in terms of safety outcomes – so, you know, frequency of medical errors as a result of poor communication or delays in care, redundant care, you know, repeated lab draws or things like that that might have occurred as a result of problematic communication. In part, you know, maybe there is something from Medication Safety piece that would go there as well in terms of medical errors that might occur as a result of a poor transition or communication. But, the way it is written now, it is certainly more the reconciliation process, that type of thing.

Marc Price: This is Marc Price. I want to echo what one of the previous speakers mentioned about maybe breaking it up into communication with providers and the care team versus the patient and the patient's family or caregivers.

Adam Swanson: This is Adam Swanson. I would also like to see that change as well.

Joseph Karan: Yes. Joe Karan. I agree with it.

Aleesa Mobley: Aleesa Mobley. Not only do I agree, but a perfect example is the patient who is in the emergency room with high blood pressure. For whatever reason, the emergency department puts the patient on a new blood pressure medication. The patient doesn't know not to take the old blood pressure medications at home. The primary care provider may not know that the specific blood pressure medication is for blood pressure and/or heart rate and the pharmacy doesn't discontinue it if that medication is actually supposed to be a replacement.

Stephen Cantrill: All excellent points. Thank you very much.

Donna Carden: And this is Donna Carden. Just to reiterate my feelings that breaking that up into both provider and patient Send/Receive makes a lot of sense. And, also, there are strategies that providers can be informed about and encouraged to use that actually enhance patient's engagement. And those strategies can improve the transition of care. So it is not just keeping in mind the patient's educational level that is important but being sensitive to the fact that providers can be taught and encouraged to use strategies that actually make their job easier.

Stephen Cantrill: Excellent point. Thank you.

Female: Could I chime in on the Provider Education piece? (Inaudible) (that came up).

Stephen Cantrill: Sure.

Female: To the extent that many of (inaudible) (at some point) could be (couched) around fulfilling a board certification requirement like an MOC requirement I think would help adoption moving forward because you would be, you know, from a practical standpoint, killing two birds with one stone. But, also, you know, docs are busy enough if you give them an incentive that this will then cover something they have to do anyway. I think, that would be helpful.

Stephen Cantrill: That is good. Other comments, thoughts about where we are right now?

Male: Or, alternatively, if we want to go back to, you know, some of the – I know we had a brief discussion about the key themes. But, if there are – if there are other sort of thoughts on the key themes, we can – we can also have that discussion.

Well, Jesse, I think they are happy with it.

Kyle Cobb: This is Kyle. I have a question just going back to, you know, you (kind of) if you take the Send and Receive Communication and you break it up by provider and patient family and then – and I really like the concept of shared accountability that sort of transcends just the communication part of it. I am also wondering if the shared accountability could become a domain. And it seems like it is worth sort of thinking about and exploring that as it relates to what we have. Or another possibility is that the shared accountability go into engaging or leveraging the broader community and that it becomes, you know, the community being all of the different actors that have shared accountability.

Stephen Cantrill: Right. Well, certainly, as it is structured now, I have seen the first two domains having shared accountability so that – we could certainly put them in both of those.

Aleesa Mobley: This is Aleesa Mobley. Regarding domain three where we have Person and Family Centeredness. Somewhere in there, there needs to be a shared experience because just reading this as a blanket statement reminds me of all of the patients in primary care who come shopping for certain medications. And they are very upset when they don't get the antibiotic that they want for their runny nose even though there is no evidence that they have a bacterial infection.

Stephen Cantrill: Excellent point.

Kirsten Reed: Yes. This is Kirsten. I was just having that though as well, that we have – I mean, we have specifically Provider Experience as the subdomain prior. It is

not really quite clear to me that the person and family centeredness is really the (reflective net) patient experience or whether ...

Female: Right.

Kirsten Reed: You know – so, that will actually be from the patient's point of view.

Kyle Cobb: Yes. I – this is Kyle. And I agree. And, I think, I – when I went through that domain, I – it occurred to me as I was talking through it that it really is – should be more reflective of patient experience.

Stephen Cantrill: Any other – any other comments at all?

Jesse Pines: And sort of a good way to think about this, again, is – you know, I think a lot of folks have been doing this. But, sort of think about, you know, sort of examples of sort of good transitions and bad transitions that you have seen in your – on the – on the clinical side and how would those fit into these when it comes to making sure that those would sort of sit in a measurement framework and that those would be captured either, you know, in some of those domains. And, I think, some people have mentioned those. But, you know, what are the elements that we really want to make sure are, you know – are in there or not in there or, you know, eliminated in a – in a – in a good or bad transition?

Stephen Cantrill: Good. OK.

Female: Can I just add one thing about this achievement of outcomes, specifically the health care use and cost? And what Jesse said just sort of sparked my thinking. The patients involved in my research – they keep coming back to one theme. And that is even though they have access to their primary care physician after an ED visit, it is the timeliness of that visit that is sometimes problematic. So, it is not just use per se. But, that is also very sensitive to timeliness because if, in fact, you know, the transition out of the ED for a patient is a bit rocky and then the patient has fear and uncertainty, that, you know, leads them to want to make another health care visit and they don't have timely access to more continuity of care, they are likely to end up back in the ED. So, you know, something to think about as maybe subdomains of that

particular achievement of outcomes as discussed is the timeliness of that access.

Stephen Cantrill: Sure. Good point.

Stephanie Witwer: This is Stephanie Witwer. And I just wanted to make a point that with patients transitioning out of the ED, access doesn't necessarily have to be a visit initially. And as we think about the transitional care codes that Medicare has that include contacts – those are for hospitalizations – but include telephone contacts within 48 hours prior to the appointment, there might be some thought around creating measures for a contact that aren't necessarily appointment.

Female: I would agree and I would ...

Female: (Inaudible). I'm sorry. Go ahead.

Female: So, I would agree and I would think that maybe we define contact more broadly than simply telephone to include any form of digital contact because depending on the patient and their preferred (inaudible) of contact, it might not be a phone call. It could be a video chat. It could be a Skype. It could be even a message.

Female: Great point.

Female: And it's a great point. And, I think equally defining that contact like we have in the transition of care from the inpatient is a great idea. I think, the other half of this is the anticipation sometimes from the emergency (inaudible) when we talk about utilization and cost, the anticipation that it might have difficulty accessing the next layer and whether we can measure potential overutilization because of concern about timely access in the outpatient world. I think, equally in both sides, the patient experience, as well as whether we can quantify in any way and measure when things are done through emergency that could be done more electively if we had assured access.

Female: Yes.

Marcia Wilson: This is – this is Marcia.

Female: And communication.

Marcia Wilson: Something also to think about that you brought up in your discussion is what we would call balancing measures, that one of the first issues you brought up was the patient wants an antibiotic for their viral sinus infection. And is there then a balancing measure, which is appropriate use of antibiotics? And, I think, in some cases, I am hearing a tension between what different parties things should happen and then what all the parties can deliver. But, we – do keep in mind that we could think about balancing measures in some cases where we would say if you are going to measure X, you should always measure Y because it gives you a more complete picture of what is happening in the situation.

And, then, to this latter discussion, it is almost like there is a domain of accessibility that includes different elements like timeliness, like mode of access because, in part, accessibility is can the patient even get the service that he or she needs? Can they get it in a timely manner?

Stephen Cantrill: Yes.

Marcia Wilson: And the mode of access may vary. So, I think, you are on to something there that needs to be fleshed out more broadly that we can look at. But, thank you for the discussion.

Stephen Cantrill: Yes.

Stephanie Witwer: This is Stephanie Witwer again. And I am wondering about if there are concepts around active connection for patients. So, for instance, if you have patients in the emergency department who do not appear to be connected to primary care or other community resources, is there thought around a function of being actively connecting people to resources to prevent further utilization if it is that necessary?

Female: I think, that is a great point. And it is one that comes up a lot in terms of identifying if somebody has a (PCP).

Female: (Inaudible).

Female: Yes. And, then – and, then, thinking about how you actively make those connections.

Stephen Cantrill: All very good points. Any other comments at all?

OK. Shall we move on to public comment, Kirsten?

Kirsten Reed: Not quite yet. We are going to have Kyle go through a couple of more things and then we will go there. Thank you.

Kyle Cobb: OK. I am back. Let us see where are we. OK. So, we are coming – you are all coming to D.C., we hope, in April next month. We promise better weather. This week has been horrible. I don't know if we will have any trees left. But, at least it will be warmer.

So, let's go on to the next slide and let's talk a little bit about what we see the in-person being and our expectations for it, our goals for it and just what will happen between now and then.

So, the – we will ask you to do some homework between now and then to provide feedback on the domains and subdomains and continue to do that. We will take everything that we have discussed and start posting on SharePoint updates to it where we will let people either email and we can make updates to SharePoint. But, we really see the next month as being fairly interactive in terms of receiving your feedback and making updates to the domains and subdomains.

At the in-person meeting, we will continue to really polish off those domains and subdomains, develop measure concepts and, then, really looking towards the future. I mean, as part of developing measure concepts, we will be identifying gaps in measurement and highlighting what we think really works and what doesn't work.

But, I think, the most exciting part will be to think about sort of recommendations for the future and thinking about the future state of where

we want to be. And this is not where we want to be tomorrow but were we want to be in 10 years, for example, you know, understanding where technology is going, understanding where our delivery models are going and how things are happening and really making some, you know, well thought out recommendations to guide measure developers as they are, you know, going through these technical reports, to think about what measures can we develop, you know, based on what is available today, in two years, in four years, in six years. And that really is the aspirational future state that we want to get to. So, it will be fun.

So, that is really the overview of the in-person meeting goals. And we will – I don't even have the dates in my brain or on the slide. Is it on the slide? No?

Female: April (inaudible).

Kyle Cobb: Sorry.

Female: April 25 and 26.

Kyle Cobb: April 25 and April 26. We will have all of April 25, a full day. We will have – we hope people will stick and have dinner together. And then, on the 26th, we will get you out as early as you can to get home by mid-afternoon. So, this is our working agenda. It is a little more granular than that, again, but I don't have it in front of my face. So, I can't speak to it. But, that is – that is the next step. And we are really looking forward to it. And, I think, it is just – I will thank everybody once again for such a terrific session today. And all of the feedback has been tremendous and, I think, we are really getting to a point where we can sit down and get to work on this. So, thank you so much.

Female: Can you just give us a high level on what we should expect in terms of communication about travel? Should we be managing that on our own and that coming up – it seems a little far away with all the snow, but it is not that far away.

Kyle Cobb: (Inaudible) those details. Here we go.

Female: All right. (Inaudible).

Kyle Cobb: OK. (Inaudible).

Female: (Inaudible) April 25 and 26. We are currently working with our meetings department here at NQF just to kind of solidity the timing of the meeting. So, I anticipate within the next week or so you will be getting an email from the meetings department kind of letting you know how to book your travel. As a reminder, all of you travel expenses will be covered by us and you will be booking your flights through our travel website. So, please hold off on booking it separately and hold off until you receive that email.

And, then, other quick things. As Kyle already said, provide feedback to us on the domains and subdomains. Send any measure concepts that you can think of prior to the in-person. And both of those things can just be done via email to the EM Transitions inbox.

And, then, we will also be posting on the SharePoint site a list of the tools and programs and literature that we have come up with thus far. We will have you guys review it. And let us know if anything is missing or if you disagree with anything that is included – anything like that.

And, then, way down the road in the end of May, we will have another Web meeting. But, for now, we are all done with the Web meeting until after our in-person meeting.

Female: Yes.

Female: (And let's) plan to send an email out to the panel once the additional materials have been posted to SharePoint with just some instructions on how to get in. Once again, I think it is – I know it is not always intuitive.

Female: I will do that. And, then, (Nan), can you quickly just open up the lines to see if anybody has a public comment they would like to make?

Operator: Thank you.

At this time, if you would like to make a comment, please press star, one on your telephone keypad.

And there are no public comments at this time.

Female: Great.

Stephen Cantrill: Thank you. I'd just like to reiterate to everyone please review the material when it goes out on SharePoint. Very carefully read the five-page (ED2C) Domain and Subdomain Document, and please make any comment and suggestions that have not already been covered during this conference call.

Any other – any other comments?

Brenda Schmitthenner: This is Brenda Schmitthenner. And I was wondering the document that was sent out is a PDF. Would it be possible to provide that matrix with the domains and subdomains in a version that could be amended with track changes?

Female: Sure. We will add that as well.

Brenda Schmitthenner: Thank you.

Stephen Cantrill: OK. Any other comments?

If not, I'd like to thank everyone for participating in the call. I think it has been a great productive discussion. And we look forward to seeing everyone in D.C. in April. And I will give you an additional half hour back of your day. Thank you very much.

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

END