NATIONAL QUALITY FORUM

+ + + + +

EMERGENCY DEPARTMENT
QUALITY OF TRANSITIONS OF CARE EXPERT PANEL

+ + + + +

TUESDAY
APRIL 25, 2017

+ + + + +

The Expert Panel met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 8:30 a.m., Stephen Cantrill and Janet Niles, Co-Chairs, presiding.

PRESENT:
STEPHEN CANTRILL, MD, FACEP, Co-Chair; Denver Health Medical Center, University of Colorado School of Medicine
JANET NILES, RN, MS, CCM, Co-Chair; President, Niles Associates, Inc.
DONNA CARDEN, MD, Professor, Emergency Medicine, University of Florida*
LISA DEAL, Pharm.D., BCPS, BSN, RN, Director of Population Health Services, Christiana Health System
JAMES DUNFORD, MD, FACEP, Professor Emeritus (Emergency Medicine) UCSD; City of San Diego EMS Medical Director, San Diego Fire-Rescue
TRICIA ELLIOTT, MBA, CPHQ, Director, Quality Measurement, The Joint Commission
SUSAN (NICKI) HASTINGS, MD, MHS, Physician and Investigator, Veteran's Administration (Durham) and Duke University
JOSEPH KARAN, Director of Advocacy and Education, National Kidney Foundation of Florida

JULIE MASSEY, MD, MBA, Medical Director, Clinical Quality Improvement, UHS, Inc.
ALEESA MOBLEY, PhD, RN, APN, Adjunct Faculty, Rowan University
ELIF OKER, MD, Executive Director for Digital Strategy and User Experience, Health Care Service Corporation
ANDREA PEARSON, MD, Pediatric Attending, Howard County General Hospital, Johns Hopkins EMS
MARC PRICE, DO, Physician Owner, Clinical Asst. Professor, Family Medicine of Malta
KARIN RHODES, MD, MS, Vice President for Care Management Design & Evaluation, Office of Population Health Management, Hofstra Northwell School of Medicine, Northwell Health
KRISTIN RISING, MD, MS, Assistant Professor & Director of Acute Care Transitions, Thomas Jefferson University*
BRENDA SCHMITTHENNER, MPA, Senior Director, Successful Aging West Health Institute
AMY STARMER, MD, MPH, Director of Primary Care Quality Improvement, Associate Medical Director of Quality, Department of Medicine, Boston Children's Hospital/Harvard Medical School
ADAM SWANSON, MPP, Senior Prevention Specialist, Suicide Prevention Resource Center
ARJUN VENKATESH, MD, MBA, MHS, Assistant Professor, Department of Emergency Medicine; Director, ED Quality and Safety Research and Strategy; Co-Director, Emergency Medicine Administration Fellowship; Scientist, Center for Outcomes Research & Evaluation, Yale University School of Medicine
SAM WEST, Business Intelligence Developer, Epic
MARGARET WESTON, MSN, RN, CPHQ, Health Care Quality Solutions Director, Western Region, Johnson and Johnson Health Systems
STEPHANIE WITWER, PhD, RN, NEA-BC, Nurse Administrator - Primary Care Division, Mayo Clinic

NQF STAFF:

SHANTANU AGRAWAL, MD, MPhil, President and CEO
KYLE COBB, MS, Senior Director, Quality Measurement
VANESSA MOY, MPH, Project Analyst
ELISA MUNTHALI, MPH, Vice President, Quality Measurement
JESSE PINES, MD, Consultant
KIRSTEN REED, Project Manager
MARCIA WILSON, PhD, MBA, Senior Vice President, Quality Measurement

ALSO PRESENT:

BRENDAN CARR, MD, Director, Emergency Care Coordination Center, Office of the Assistant Secretary for Preparedness and Response, HHS
GREGG MARGOLIS, MS, PhD, NRP, Director, Division of Health Systems and Health Policy, HHS
JESSICA OIDTMAN, MS, Policy Analyst, Emergency Care Coordination Center, Division of Healthcare System Policy, HHS

*** present by teleconference**

C-O-N-T-E-N-T-S

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

8:35 a.m.

MS. COBB: Hello, good morning everyone. Hi. We're going to get started. I think we're --- we're running a couple minutes late already and so everybody's having such a nice time catching up. I think we will start. So we're all here in person. Good morning. Hello. I am going to introduce Janet Niles and Steve Cantrill our co-chairs for this project. I'm Kyle Cobb and the rest of the project team is all assembled. We have Marcia Wilson and Kirsten Reed and Vanessa Moy and we will shortly go through introductions. But I'm going to hand it over to Steve and Janet.

CO-CHAIR CANTRILL: Thank you very much, Kyle. Could we go to the next slide, please? And that's where we are. I would like to thank you all very much for your past time, your current time and your future time in terms of working on this project. It's quite important and I'm very happy with the group we have

assembled. Lot of skill, lot of knowledge here.

So what we're going to be doing is working again on emergency department transitions of care. So we're --- the big goal was to develop a measurement framework concerning transitions of care, and one of the first steps is looking at measures that are out there either in development, testing or in use that are related to this. Then we'll try to identify some measure concepts in terms of transitions of care, looking at some gaps, setting some priorities. What we will not be doing is developing measures or endorsing measures at this point. So we're really trying to do the groundwork here in terms of future work.

CO-CHAIR NILES: Great, this is Janet. So we have some --- if we could have the next slide please? Thank you. We have some project objectives too. To develop a quality measurement framework for emergency department transitions of care. During that --- for that objective we are going to look at the evidence that is out there

and synthesize that, take in the information that you all have been working on --- the stakeholder meetings --- and focus on the patient-centered bi-directional transition communications.

The second objective is to identify and prioritize the measures and the measure concepts for improving those transitions of care from the ED, in and out of the ED and identify any gaps that there may be in those measures.

CO-CHAIR CANTRILL: Next slide, please. So the objectives for our two-day meeting are as follows. Day one we're going to look at the domains and sub-domains that have been proposed and try to see if those make sense. Are they complete? Do they need to be further refined? We will have group discussions in terms of looking at some existing measures and measure concepts and how do those relate to the different domains and sub-domains.

Day two we're going to have some discussions on measure concepts and gaps in performance related to --- to transitions of

care. And then look at maybe developing some recommendations for strengthening our transitions of care in terms of performance measurement.

CO-CHAIR NILES: Great. Next slide. We're going to have some ground rules for this meeting. For those of you in the meeting, in the room here, if you want to speak, please turn your name card up vertically so that we will recognize that you want to jump in for the discussion. Please remember to use your microphone. We have a lot of people that are participating remotely, so they can't hear you if you don't talk into your microphone.

Please --- I don't think I have to tell this group, but please share openly. We want your ideas. We need your feedback. Yes, I do not believe that's going to be an issue. And please, you know, allow others to jump in and don't --- try not to over --- overtake the conversations. So we're going to have a great day today, and I'm excited for our work here.

DR. WILSON: Okay, why don't we move

on to the next slide? Good morning, I'm Marcia Wilson. I'm senior vice president of quality measurement. Kyle has introduced the staff, Kirsten and Vanessa. We're also joined by our vice president, Elisa Munthali, and Jesse Pines who's been working on the project as a consultant. Go to the next slide.

So it's our custom here at National Quality Forum to combine introductions with a verbal disclosure of interest. When you were nominated for this committee you had to fill out a rather lengthy disclosure of interest form and so today we're going to ask you to verbally disclose anything that might be relevant to the work before the Committee.

Now, when you do your introduction, it is not necessary to summarize your entire resume because you are all --- bring a certain expertise to the table, and you have been well vetted in that respect. But we do want you to verbally disclose any activities funded or otherwise --- for example, you might sit on an expert panel ---

that you think are directly relevant to the work that we do today.

So the other thing I would say is just because you disclose it does not mean you have a conflict. We do this in the spirit of transparency and openness, which is our culture here at National Quality Forum. So what I'm going to do is I'm going to start with our co-chairs. Please introduce yourself and let us know your affiliation. I would remind you that you sit on this panel as an individual, not representing your organization. But we know you bring a certain perspective to the table.

So I'll start with the co-chairs, and then we'll go around the room and you can introduce yourself and let us know if you have anything to disclose that you think is relevant. And I will also say we have some federal partners with us today, so we will also take this opportunity to allow them to introduce themselves as well. So, Janet, if I can start with you? If you would be so kind as to introduce yourself.

And we've been joined by our CEO and president, Dr. Shantanu Agrawal. And Shantanu, we're just doing introductions and then we'll turn it over to you for a few remarks before we get started. Is that --- that okay?

DR. AGRAWAL: Absolutely.

DR. WILSON: Okay, thank you. Janet?

CO-CHAIR NILES: All right. So I'm Janet Niles. I'm a registered nurse and I live in New Orleans, Louisiana and I am representing the National Association of ACOs on this committee.

CO-CHAIR CANTRILL: Steve Cantrill, emergency physician from Denver, Colorado. I represent the American Board of Emergency Medicine. I've been involved in development of performance measures in emergency medicine for more than a decade. Time flies when you're having fun. And I've served as the chair of the American College of Emergency Physicians Quality and Patient Safety Committee for two years.

DR. WILSON: Thank you, Steve. And

Brendan, if you would introduce yourself.

DR. CARR: Hey everybody, I'm Brendan Carr. I'm director of the Emergency Care Coordination Center at HHS. I maintain an academic appointment at Thomas Jefferson, I take money from the NIH and AHRQ to do research, but don't have any other disclosures.

DR. WILSON: Thank you. Arjun?

MEMBER VENKATESH: Hi, Arjun Venkatesh. I'm an emergency physician on faculty at Yale in New Haven, Connecticut. And in terms of disclosures, I work under contract with the Centers for Medicare and Medicaid Services developing hospital outcome measures of care transitions. I lead an Emergency Quality Network funded by CMS trying to improve care transitions out of the ED. And I have a grant from AHRQ studying care transitions between hospitals.

DR. WILSON: Thank you.

MEMBER SWANSON: Hi, my name is Adam Swanson. I'm here on behalf of the Suicide Prevention Resource Center, which is operated by

the Education Development Center. We have grants from the CDC and SAMHSA to do suicide prevention research and work. I currently manage a project that helps state governments and emergency medical departments do suicide prevention within those settings. I also come with a patient perspective as a person who's experienced crisis in an emergency department setting.

MEMBER KARAN: Hi, my name is Joe Karan. I am the Director of Advocacy and Education with the National Kidney Foundation of Florida. Most of all, I'm a patient.

DR. MARGOLIS: Hi, my name is Gregg Margolis. I'm the director of the division of the Division of Healthcare Policy in the Office of the Assistant Secretary for Preparedness and Response. And other than the fact that I work for the executive branch of government, I have no conflicts to disclose.

MEMBER STARMER: Hi, I'm Amy Starmer. I'm a general pediatrician at Boston Children's Hospital where I locally oversee quality

improvement efforts and also do patient safety and quality-related research in the area of transitions of care.

I was the lead investigator of the I-PASS study which was an inpatient effort to improve transitions of care. And as a result of that, in terms of conflicts of interest, I have received funding from AHRQ, PCORI, and DHHS to support that academic work. And over the last year worked with our colleagues to co-found the I-PASS Institute, which is a company trying to assist institutions to improve their transitions of care.

MEMBER PRICE: I'm Mark Price. I'm here on behalf of the American Academy of Family Physicians. I am a physician owner of a small private practice and full-time clinical practice, so I don't have any money from anyone else.

MS. OIDTMAN: Hi everyone, I'm Jessica Oidtman. I also work for the Department of Health and Human Services for Division of Healthcare System Policy Emergency Care

Coordination Center where I'm a policy analyst.

MEMBER HASTINGS: Hello, my name is Nicki Hastings. I'm the director of the Center of Innovation and Health Services Research with the Durham VA Healthcare System. I'm also a geriatrician and researcher at Duke University. Relevant to this project, I lead funded studies from AHRQ and the VA related to ED transitions.

MEMBER WESTON: Good morning, my name is Margaret Weston. I am a healthcare quality solutions director for Johnson and Johnson Health Systems, Incorporated.

MEMBER PEARSON: Hi, I'm Andrea Pearson. I'm a pediatrician. I work for --- at a community hospital with Johns Hopkins. I take care of children in the emergency department and their inpatient unit -- we're a combined unit --- as well as doing some outpatient community pediatric clinical work. I don't have any grants or funding, I'm purely clinical.

MEMBER DUNFORD: Hi, I'm --- good morning, I'm Jim Dunford. I'm an emergency

physicians, professor emeritus at UC - San Diego Medical Center. And I'm the City of San Diego Medical Director --- EMS Medical Director. I sit on the board of an organization called the Community Information Exchange, which is a social exchange that is developing to --- in partnership with the --- with our Sand Diego Regional HIE. And I'm on the --- I am a consultant of West Health Institute, which is a foundation in San Diego that is devoted to aging well. And I'm working on projects related to aging.

MEMBER OKER: Good morning, I'm Elif Oker. When I started on this group I was the medical director at BlueCross BlueShield of Illinois. I've since taken a new role at the parent company, Health Care Service Corporation, about three weeks ago where I'm the executive director for Digital Strategy and User Experience.

MEMBER ELLIOTT: Good morning, my name is Tricia Elliott. I'm the director of quality measurement at the Joint Commission. We do have

a relationship with Mathematica, and we're a sub-contractor for measure development for CMS.

MEMBER WEST: Hi, I'm Sam West. I'm a software developer at Epic, focused on reporting and analytics for emergency departments.

MEMBER WITWER: Good morning, my name is Stephanie Witwer and I'm a nurse administrator at Mayo Clinic in Rochester. And as part of our community care umbrella of services I am the co-director of the Transitions of Care program. And I'm representing the American Academy of Ambulatory Care Nursing.

MEMBER MASSEY: Good morning, I'm Julie Massey. I'm a general pediatrician by background and training, and also a board certified clinical informaticist, former CMIO implementing electronic medical records both in the acute care setting as well as in physician office world. Currently, I'm the medical director of clinical quality improvement at Universal Health Services. Corporate

headquarters are in King of Prussia, Pennsylvania, although we have hospitals throughout the country.

MEMBER SCHMITTHENNER: Good morning, I'm Brenda Schmitthenner. I'm senior director at the Gary and Mary West Health Institute in La Jolla, California. And the West Health Institute is a non-profit medical research organization and we partner with academics and healthcare systems, as well as community-based providers to improve the quality of both healthcare and non-medical supports for seniors. Our --- all of our organizations are aligned across a single mission of successful aging and we are currently funding a number of projects that intersect with emergency care including the Geriatric Emergency Department. We are funding both the build and the establishment of a geriatric emergency department at UC - San Diego Health System.

MEMBER MOBLEY: Aleesa Mobley, adult nurse practitioner, graduate nurse faculty and computer science curriculum development for Rowan

University. I am also here representing the American Academy of Ambulatory Care Nurses, and I have nothing to disclose.

MEMBER DEAL: Hi everybody, I'm Lisa Deal. I'm the only pharmacist on this panel, I must start with. I am actually --- been in the emergency department for over 16 years as an emergency medicine clinical pharmacist. In my previous lifetime, I was an ED nurse at Johns Hopkins for seven years prior to being a pharmacist. When I started this career --- when I started with NQF I was in the ED. I have just transitioned to being a director of population health services for Christiana Health System in southern Delaware and currently hold faculty positions at Virginia Tech School of Medicine and Virginia Commonwealth University.

MEMBER RHODES: I'm Karin Rhodes. I'm an emergency room physician and health service researcher. I'm currently vice president of Care Management Design and evaluation at Northwell Health, the big health system in New York area.

And I have appointments at University of Pennsylvania as well where I recently ran a Center for Emergency Care Policy and Research with several people here on the panel.

And I have funding from PCORI around opioid abuse prevention, and from Robert Wood Johnson Foundation for measuring access to care in ten states pre-, during, and post-ACA. And I am --- have heart/nerve research funding from the West Health Institute to help enhance and scale home-based primary care. And I look at --- I work with our emergency department on transitions into the ED and out of the ED.

DR. WILSON: Thank you to everyone in the room. And I think we may have a couple of committee members on the phone. Donna Carden, are you on the phone?

MEMBER CARDEN: I am. Can you hear me?

DR. WILSON: Yes ma'am, we can. Thank you.

MEMBER CARDEN: Okay. I'm Donna

Carden. I'm an emergency physician. I'm a professor of emergency medicine at University of Florida in Gainesville, Florida. And in terms of conflicts, I've been funded by the Emergency Medicine Foundation and PCORI to specifically study the transition from ED to home in older, chronically ill patients.

DR. WILSON: Thank you, Donna. And Kristin Rising, are you on the phone?

MEMBER RISING: I am. Hi everyone, this is Kristin Rising. I'm an emergency medicine faculty at Thomas Jefferson University. For disclosures for me I have funding from the Emergency Medicine Foundation, the Emergency Nurses Association and PCORI around projects looking at --- particularly assessing patients' experience during transitions of care. And throughout healthcare settings, but especially focused on the emergency department setting.

Apologies I'm not there as well. And I will be really in and out today and tomorrow. I'm home with one-month-old twins, so they are

taking the majority of my attention and time right now.

DR. WILSON: The Committee --- thank you, Kristin, and the Committee is appropriately impressed that you have other duties right now, so please join us as you can. We appreciate your calling in.

Now is there anyone else on the phone that I did not call on?

Okay. Again, if at any time during the meeting you think you have a conflict, please speak up real time. You can approach the co-chairs or any of the NQF staff. If you think someone else might have a conflict or is acting in a biased manner, again, please bring it to our attention.

What we don't want you to do is sit here and think that there is some bias in the conversation, and months later say, you know, I was really uncomfortable with that discussion. Again, we do this in the spirit of openness and transparency. So any questions either for me or

for your colleagues? Anything that was disclosed?

Okay, great. And I think at this time, Shantanu, we can turn it over to you for a few opening remarks.

DR. AGRAWAL: Sure, thank you. Apologies to everybody for running late. If you're --- if you don't live in D.C., I can tell you that any time it rains or snows, traffic will slow down. It turns out if it's slightly misty outside, traffic also slows down. This is just the way it is here.

I wanted to thank everybody for being part of this really important work. Any time we do anything ED-related, I feel like I see a lot of familiar faces around the table. I've trained with a number of the folks that are around the table. They were actually my attendings, so I feel like I'm in residency again. So I'll be on my best behavior.

But this is extremely important work as we all know. Work like this, I think, keeps -

-- I think it helps to ensure that ED work is always patient-centered, and also part of the transition to value which I think it needs to be, sort of more explicitly part of. So I really appreciate the work. I appreciate the funding from ASPR. Thank you very much to our co-chairs, Stephen and Janet, as well. And this is just very exciting. So that's all I really wanted to say. I'm happy that you're all here and appreciate the time and dedication you're putting into this.

DR. WILSON: Thank you so much, Shantanu. And I think we're going to turn it over to Brendan at this point for a couple of slides and a --- I think if we can check the slides. Make sure we're keyed up here. Sophia Chan, are you on the phone?

(No response.)

DR. CARR: Okay.

DR. WILSON: Okay, should we ---

DR. CARR: Then I'll just say thank you. Sophia is our --- let me --- so I'm

Brendan, everybody, I'm from HHS. I direct the Emergency Care Coordination Center. Sophia, who's not on the phone, is our colleague at CMS who helps --- has helped us to sort of work on this project because they do a lot of this work. And then you heard Gregg and Jessica are the other reps from HHS here.

I mostly wanted to take two seconds to say that the Emergency Care Coordination Center is, you know, sort of a central policy home for emergency care related issues within HHS. It is located in a place that not everybody knows how to find called the Office of the Assistant Secretary for Preparedness and Response. It is there because as the ECCC was being created, ASPR was being created. ASPR is an office in the immediate office of the secretary.

And there is this --- you know, there is this connection between the healthcare system's ability to respond to large-scale events and small events. And there is this idea that if we --- if we are good in our day-to-day

operations, if we are good at transitions of care for the one patient I am seeing now, perhaps we will be good when I have a thousand patients who are worried they might have pandemic influenza, that I can transition to the outpatient setting.

So, you know, in our world there is very sort of clear connection between these. However, most folks in the policy space spend less time in the ASPR space since it's mostly around large-scale events and disasters and healthcare's response to them. And more time in more traditional places with an HHS --- CMS, CDC, Planning and Evaluation. At any rate, I --- we convene at ASPR through the ECCC. All the emergency care involved and interested folks across the federal government.

So it's a good central place to bring an emergency care issue. We can talk to, you know, everybody from VA and how they're managing emergency care within their system, to the Office of Health Affairs and Homeland Security and what we're doing about healthcare at the border. So

you know, it is --- it is a broad place where --- where we come together.

Our mission space is up on the slide here, and it is pretty broad. But you will see that, you know, some of the --- the fourth one I think we can probably spend less time thinking about in this audience. Three days when there was a big trauma meeting, we talked more about that and sort of a big-picture planning for that. I will apologize in advance that probably Gregg, Jess and maybe I will be stepping out during the day. There's a big government-wide drill, exercise happening right now that is consuming lots of time and resources, about a large-scale health-related event and how we would respond to it.

I want to point out just real quickly, you know, so central to what we're supposed to do is to take the patient voice and the --- and the community perspective, to think about the integration of healthcare into the broader healthcare system and to think about quality.

Which is why we then partner --- and you can go to the next slide --- we partner with CMS, with ASPR, with folks that control contracts like the one at National Quality Forum.

So actually this audience I don't think needs a whole lot of bullet points on the scope of emergency care. I will tell you that the central, I think, charge here is that there has for a --- you know, I --- emergency care's history has been such that it has not always been integrated fully into the way that healthcare gets delivered in the United States.

Many of the narratives that we all hear about emergency care is about how it is costly and a place to be avoided. And at the same time, we know that inpatient visits are --- or, sorry, inpatient beds are decreasing, folks are living longer with more chronic medical problems, and you know, as I sort of have joked with friends at CMS, all right I won't say emergency care any more. We'll call it acute exacerbations of chronic conditions. Right? And

if we call it that, then we can sit at the table and have a conversation.

So, you know the --- our interest here is in really, you know, Jesse at Brookings put together a panel, you know, maybe a year, year-and-a-half ago now, where Mark McClellan, the old CMS director, said how come you guys are never part of the solution? Why is the emergency department always a carve-out, doing its own thing? Why are you never part of the solution? And, you know, I couldn't agree more that we need to get to a place where we are better integrated into care delivery, whether that be in the outpatient setting, at home --- you know, the inpatient setting.

We sit at the center place of the community, the outpatient primary care office and the inpatient setting. And yet there has been more focus on smooth transitions home and coordination within a primary care medical home than there has been at this other place, you know, where people come because we don't lock the

front door and we just let them in. Right? We need to safely get them home and we need to safely get them upstairs. And we need to connect the dots in a way that makes sense for patients and for their primary care docs. That is sort of our shtick, and I've been told to not speak the rest of the day. So it's nice to meet you.

DR. WILSON: Thank you so much, Brendan. And I appreciate those remarks because it really does provide grounding for some --- a lot of our discussions the rest of today. I'm going to talk a little bit about measurement frameworks, and we teed this up on the last webinar, so a little bit is refresher and then we're going to push a little more into the details, because that's what we're going to be doing for the next couple of days. So next slide, please.

We do a lot of frameworks --- what we call framework projects --- here at National Quality Forum. And as I said on the webinar, typically these are areas where we don't have the

measures that we need and want. They are areas where there's not a huge number of measures, and we need to look at, in some kind of organized way, what measures we should have. And so what we do is create a framework, which is really an organizational structure. Within that framework we create domains and subdomains. We're going to talk a lot about those today and tomorrow.

But really this a way to provide a foundation for what should happen with measures in a particular area, in this case, as Brendan has said, for patients coming into the emergency department and leaving the emergency department and not necessarily coming and going to the same place. So next slide, please.

We have some definitions that we've shared with you --- a measurement framework. It's really a conceptual model. I don't know about you, I think conceptual models are great, but I always want to know how are you going to make this work? So we're going to take this from the conceptual down to how are we going to make

this work in the next two days. We've got some consideration for the kind of things that we should be measuring, who should be measured? We're going to talk a lot about that, especially in the area of shared accountability. What care settings? And this is particularly relevant for this type of project, where we are talking about transitions and when we should be measuring.

So again, think of this framework. It really is an organizing structure. We're going -- we're going to look at available measures. We are going to look at places where we don't have measures, like a gap, and is there a measure concept that could fill that gap? And also, we will ultimately prioritize where we should go in the future in terms of measures that need to be developed. So next slide, please.

So we have some definitions that we work with here at National Quality Forum throughout our framework projects, and the domain is kind of that high-level idea of something we want to be measuring. The subdomain makes it

concrete. The subdomain --- and when you'll see this in your breakout sessions, when you drill down to the subdomains, hopefully it makes things more real. Now let's talk a little bit about the difference between a measure and a measure concept.

At National Quality Forum where we endorse measures, we say a measure is one that has been fully tested. And one of the evaluation criteria we use is is that testing reliable and valid? We look at the scientific properties of that measure --- the evidence, the room for improvement, reliability and validity.

Measure concept is a little squishier. Measure concept is something you want to measure, but it may not have grown up to be a full-blown measure yet. Now, some measure concepts are pretty well-defined, but they maybe haven't been tested. Other measure concepts are a lot more squishy, and you're going to talk about those. And you're going to say, I really think in this area we need to be measuring X. That's going to

be great. We're going to talk about those this afternoon. And then tomorrow morning when you come back, we're going to revisit the concepts that you like and say okay, start to define them. Start to flush them out a little bit so a measure developer would have an idea of what you're trying to say needs to be measured. So we will use these definitions today and tomorrow. And then next slide.

So here's another graphic representation of the process that we're going through. So we are --- if you look at the domains on the left, and those are the domains that we currently have defined in this framework --- our framework for the emergency department transitions --- and that --- then we move into the subdomains. Again, subdomains kind of make those conceptual ideas at the domain level more real. And this morning, for example, in your first breakout session, you're going to be looking at the domains and the subdomains, and making sure those definitions are correct.

You're going to be looking at those subdomains. Do they make sense? Do we need to add one? Delete one? Combine one? Split one?

So the first breakout session is going to be spent looking at domains and refining subdomains and definitions. And then this afternoon we move into the second breakout session where we have populated our framework with measures that we found --- measures you told us about that were in the environmental scan, that were in the literature, measure concepts that you provided, that we heard from others --- our key informant interviews. So this afternoon we're going to start looking at the measures and the measure concepts within that framework.

And then the third breakout tomorrow morning is, we're going to go back and we're really going to pound on those concepts to see if we can't bring a little more definition to them. Now, I just want to make a couple overarching remarks about as we work through this framework and the measures and the concepts. First of all,

it is an iterative process. So this morning you may think you have just nailed those definitions on those subdomains, and then when you get to this afternoon you go, now that I see the measures, that's not quite working for us. So you may tweak that definition in the afternoon, or make slight changes to the subdomains. That's legal. That's perfectly okay. There is some iteration that we will go through today and tomorrow.

The second thing I will say on a framework project, we often get a question about the measures and the concepts. Do you want what we can do today? Or do you want where we want to be in five or ten years? And the answer is we want both. Measures that we could implement today we will call actionable, meaning we could implement them now and they would be a good thing to be measuring. Those are actionable measures. Aspirational is where we want to go. And what we expect at the end of two days we will have a combination of, Marcia, we could do this measure

tomorrow versus here's where we need to go in two, five, ten years to move the field forward.

So there's a tension there. There's a balancing act there. But we won't both want to be actionable so it is relevant today, but we want it to be aspirational, we don't want to set limits based on all we can do today. So that's one thing to think about.

The other thing I will say that's unique about this project is we're talking transitions. That means there is always a point A and a point B. Now in this case the point B is the emergency department. Then there's the point B and a point C because you're leaving the emergency department, going somewhere else. So we have points A, B, and C.

Think about measures that should be used perhaps in tandem. Or think of them as partner measures. And if you're measuring something in point A, is there a partner measure that should be happening in point B? And this is a little unique because we are doing transitions.

And a lot of framework projects, they just measure a single point. Always think about two points when you're thinking about measures and concepts. If we're doing this here, what should be --- we be doing there?

Then another overarching comment I would make is about measurement burden, which we hear a lot about. It can be defined a number of ways. When we talk about it here at National Quality Forum, we talk about a measure that, quite frankly, the effort is not worth what you get from the measure. That --- then we're talking burden. The object is not to find as many measures and concepts as we can. You don't get extra points if you get more than 40 measures in a domain.

So think about that balance. When you look at that domain definition, what should we be measuring? What is the best measure? Or the best measures or measure concepts for that domain? For that subdomain? And what happens is, you're going to start with a big list --- I

think we have 140 measures and concepts throughout the whole framework. That will probably go down. And then as you think about it, it will probably go back up a little bit. There's going to be some culling initially. You may look at your concepts and say, you know, these four concepts? They all hang together. What would be the best measure that would represent those concepts? That's the kind of discussion you're going to hear in your breakout.

So think about actionable versus aspirational. Think about point A to point B. What are those, maybe, partner measures that need to happen? And the third thing to think about is, is this measure worth it? Is this measure going to give us what we want? Is this going to drive better care or improvement? And I think -- - is that the end of the slides on this one, I think.

So let me pause there before we turn it over to our co-chairs for domains and subdomains, kind of where we are. Does that make

sense? Are there any questions? And again, you just flip your tent card --- your placard --- up if you want to make a comment.

The one comment I will make before I leave you is this first breakout, when we go to domains and subdomains, is still going to feel a little conceptual. It'll get real very fast this afternoon when you start matching measures and concepts. So don't worry if you walk away this morning and say that was nice, but I'm not sure that's going to get the job done. We're going to revisit it in the afternoon.

So let me turn it over to either Steve or Janet who's going to lead us through where we are with our domains and subdomains.

CO-CHAIR CANTRILL: Thank you, Marcia. Next slide, please. As part of the process that we've gone through so far, we've developed some domains and for each domain some subdomains. We started really with three: communication, engagement of broader community and achievement of outcomes. We thought very early on that we

had to split the communication into provider communication and parent and family communication.

And we've developed the subdomains as you see. Now these are probably going to require some refinement because of this --- the split that took place early on. Also in terms of looking at the bottom subdomain, the shared accountability, that may be considered an outcome and in fact might be shared with some other domains and subdomains.

We also need to think through the different domains and subdomains in terms of are some of these competing? Are they related? Are there areas of overlap? So we might have something like med reconciliation, which we can consider part of the necessary communication, but also it's a patient safety issue. So we need to kind of tease these apart as we go along. Janet?

CO-CHAIR NILES: All right. Push the right button. Okay. Next slide, please.

So let's jump in and start with domain

number one, which is provider communication. And under provider communication, we have several subdomains that have been proposed. Key information, which could include transition plans, discharge packages, risk assessments, etc. Then modality, which is verbal, in-person, telephone, electronic, written, fax, whatever might be the modality that we transmit that information.

Timeliness, which could include, you know, the specific types of patients that require more timely communication between the sender and the receiver based on the patient's condition. So that's something that we need to consider. Accuracy, which speaks for itself. Efficiency, which is the salience of the information communicated --- and I think Steve's got a lot of things to say about that.

Education as a subdomain. And then shared accountability. And as Steve was mentioning, shared accountability we need to really talk about because that may be an outcome

as opposed to a domain. And again in some of these subdomains there may be an overlap. So for example, there may be an overlap between timeliness and accuracy, efficiency from a quality-metric perspective. So we need to discuss whether those are really discrete areas of measurement, or that they could be combined so that we eliminate the overlap.

DR. CANTRILL: Next slide. Domain two --- patient and family communication. And the structure in terms of the subdomains is similar to the previous. Key information in terms of discharge packages, transition plans, contacting --- contact information for the discharging physician, then dealing with modality. Are we talking about verbal communication? Or printed communication? Or email or text messages? Timeliness in terms of the urgency of the patient's medical condition. Is it appropriate?

Accuracy, again, pretty self-evident. The efficiency, again --- the salience, and I do have very strong feelings about that. I think we

can overwhelm anyone, either the --- of the receivers -- either the physicians or the patient and family. So we need to be careful about giving them the important information. It's adequate, but it's not overwhelming.

So education, again, very important. Making sure we can communicate with the patients at their level of understanding and then again shared accountability. Now we need to refine these in terms of trying to --- to get to the essence of what we mean in terms of communication with the patient and family. Now it may be that the key information and the modality and the education --- and then the quality of the education --- or the quality of the communication are the key components. But that's something that we really look towards the small groups to --- to further refine and question.

CO-CHAIR NILES: Okay. Next slide, please. So domain number three is engagement of the broader community. And we're going to define that a little bit as the extent to which the

broader community organization services and information technology infrastructure is engaged to support and participate in systems that facilitate quality transitions of care into and out of the ED. So the community setting refers to a broad array of services and supports delivered to the patient either at home or in an integrated community setting that promotes independence, health and well-being, self-determination, and community inclusion of a person of any age and health need. I think that definition is important.

We have two subdomains proposed in this category. One is linkages in synchronization, which talks about the identification of the appropriate community services to support transitions, or bi-directional communication to facilitate the coordination. Then we have another domain of quality and availability of services. And so that moves beyond the availability and --- to support the transition of care. So that may

include equity, continuity, culturally appropriate services.

Some things to think about in this domain, again, do we have overlap here between --- in the measurement of quality and availability of services and patient family communications? So we need to look and see if those two domains are overlapping there. So for example, culturally appropriate education materials may be in domain three and not domain two under patient education. Just something to think about. And are there any other subdomains that we need to think about under domain number three?

CO-CHAIR CANTRILL: Next slide, please. Domain four, achievement of outcomes. This is one I know I always struggle with because outcomes in some ways are very difficult to measure. I think we all struggle with that. But we do have some subdomains --- healthcare utilization and cost. And I'm always reminded --- many years ago there was concern about healthcare costs, as there is now. But they were

concerned about the number of patients that were getting admitted to CCUs for rule-out MI.

And they thought --- and this was at the congressional level. They thought well maybe we just need to have better guidelines about who should be admitted. So they funded some guideline development for admission of rule-out MI patients, and the guidelines ended up an increased number of admissions. Kind of counterintuitive, but again, something that we need to be aware of that we don't want to --- we would like not to be in the position necessarily of causing a marked increase in healthcare expenditures because of --- of what we're doing. So we need to look very carefully at some of the implications of some of these measures.

Now, certainly ED visits are easy to count, but again, that can be a very superficial measure as well. Because if I can avoid an inpatient hospitalization through an ED visit, that was actually a good investment. So these are some of the complexities of what we're

dealing with.

Provider experience, certainly in terms of dealing with community supports as well. The patient experience, pretty self-explanatory. And then again the safety outcomes --- things again that bring up the medication reconciliation in terms of enhancement of patient safety. So again, are there things that we're missing here? Are there things that need to be refined? Again, that's what we're going to ask one of the small groups to address.

DR. WILSON: Okay, we --- what we'd like to do now is open it up for general discussion before you go to your small groups. In your folders, and yes, some tree gave its all for this meeting because there's --- I think there's a lot of paper there. You will find the definitions of the domains and subdomains. So sometimes that's easier to follow than flipping through the slides. It's a --- done on a landscape paper and it's just a couple of pages.

And so what we'd like to do is kind of

have a higher-level discussion of some of the domains and the definitions, reactions to some of the questions that Steve and Janet have posed. And we'll hold this discussion before we go to our breakouts. If we don't have a lot of discussion, we may go to breakouts a little bit earlier than is on the agenda, which is perfectly fine because we will be able to use that time well. So let me turn it over the Steve and Janet and they can facilitate the discussion.

CO-CHAIR NILES: All right. So I'm sure you all have some thoughts about what we've been discussing here, so we'll open this up for some folks to comment or add to what we've already been talking about. Come on, now. Yes, please.

MEMBER PRICE: One thing I don't see here anywhere is expectations. And that goes between providers, patients, outcomes, everything. And I can't tell you how often people come into my office saying well, the ER doctor told me this was going to happen. Or I

send someone to the ER, conversely, and said this is what I'd like to happen. And that doesn't happen either. So there has to be expectations on both ends --- patients, providers --- in the community as well as in the hospital and the emergency room.

CO-CHAIR NILES: Thank you. Yes, ma'am.

MEMBER SCHMITTHENNER: You know, I question under the domain and definition the term family --- with patient and family communication. Family is not necessarily the caregiver or the person that the patient would want to receive information. So is there another term that perhaps could replace family?

CO-CHAIR NILES: Good point, good point. Yes, ma'am.

MEMBER STARMER: Just to respond to that, I --- as a pediatrician I feel like often times the patient doesn't have their own voice. So we frequently use the term patient and family to refer to that person. But I do appreciate how

that might not always be the default and expanding that might be of value as well.

CO-CHAIR NILES: Yes, thank you.

MEMBER DUNFORD: Hi. One of my greatest frustrations in the emergency department is being able to verify that a well-laid plan is going to be actually executable. You know, is there a car to take you to the office? Can you get to the pharmacy to get these medicines? So somewhere in there in the communication component is some measure of validity and feasibility.

CO-CHAIR NILES: Good point. Marcia?

DR. WILSON: No, I just wanted to --- I don't want to --- I want to go to Jim's comment. But to the family --- the patient and the family, we had some discussion about who should be in the --- who should be named in the communication specifically, so we would appreciate not just at that breakout group --- the one that does the patient and family communication --- to talk about that issue. And how the breakouts will work is you'll all talk

within your domain, and then you will bring back your decisions or your questions to the larger group.

So what's perfectly legitimate to do is within your breakout, if you question, is it patient family caregiver? What is the right terminology? You all decide what you think the best recommendation is, and then that can come back when we do the report outs from the breakout groups, that comes back to the larger group so more people can weigh in. But you can explain the rationale for your decision.

So as we're talking about some of these issues, I want to be sure that we flesh them out enough that the breakout group has an idea of some of the issues you're raising, like Jim. I almost heard multi-parts there. It's not only the communication, but it would be that verification that something actually happened. So let's --- I don't --- I don't want this just to be a laundry list of things with the definition, but let's take the time to flesh out

these issues so the breakout groups know what they need to be discussing. Thanks.

CO-CHAIR NILES: Kyle?

MS. COBB: Yes, and just to follow up on the patient and family. Just --- we can run this out a little bit more. We do --- in other projects at NQF we've identified them as patient and caregivers. So we could --- and caregivers could encompass the family as well. So that's a suggestion for the panel.

CO-CHAIR NILES: Yes, ma'am.

MEMBER MASSEY: One of the questions I have after hearing the introductions, and then at the folks that are around, we haven't --- we've talked about the broader community involvement, are we also engaging in that our care managers, our ACOs, our payer community --- is that where that fits within the rest of these communications

Because we --- we've seen things change even in the duration since we all started with this and sort of broadened that expanse of

the kinds of care managers and where they come from. They're not necessarily hospital and they're not necessarily practices being able to invest. But some of those other larger clinical communities that have accountability and financial responsibility that are starting to step up from a risk perspective --- would that be the appropriate place to start engaging measures of that component?

CO-CHAIR NILES: Yes, that's a very good point. Yes, very good point. Jesse?

DR. PINES: Yes, so --- so I think that's a great point. And really what we want from the --- the sort of initial small groups is to take a really close look at those domains and --- and see where, you know, this is sort of a draft domain. So if there are other groups to include, if there are other sort of subdomains to include, we're not locked in to this particular framework. So really the first --- you know, the first small group is going to focus on, you know, did we get the definitions right? But also are

there other areas that we missed like that? So it's a great point.

CO-CHAIR NILES: Yes, Jim?

MEMBER DUNFORD: Not to hog the audience, but as a city EMS medical director, and kind of under the aspirational goals of this group, I hope we consider the fact that the paramedics and the EMTs and community paramedics in the future clearly are seeing a home environment that oftentimes is never translated back to the emergency department. So take advantage of that opportunity to think about the kinds of things they may be able to do in the future.

CO-CHAIR NILES: Absolutely. Arjun?

MEMBER VENKATESH: So as I'm looking through this and I think through a lot of other approaches to a care transitions conceptually, two terms that I don't see in our definitions of domains or subdomains are care fragmentation or integration. And so if you think of fragmentation as one of the primary obstacles or

barriers to effective care transitions, and then you think of a lot of the solutions people are trying to develop around transitions --- around these various care integration models, those are missing. I'm not sure exactly where they fit. I think they could fit within the engagement of the broader community.

The care manager example is a great example of this. Where you could have a process measure of care management and do really well, but achieve increased fragmentation or worse, integration. Like I --- I'm thinking about my shift last week. I had a patient who brought her mom and she'd had her third fall in six months. I said oh, would it help if I had our care manager come by? She said absolutely not. I have five care managers. Right? Two from the plan, one from the hospital, one from the ED, one from the primary care office.

And so I think that --- I don't know where that fits in, but I think that we have got to deal with this issue of --- we don't want to

develop things that drive increased fragmentation. And ideally we should be developing measures that reduce the fragmentation by integrating certain processes.

And shared accountability starts to get at that, right? Shared accountability starts to say that I'm going to integrate at least accountability or measurement framework or attribution for several players in the care transition. But it's --- those are terms that are missing. I would --- every group should probably think about.

CO-CHAIR NILES: Thank you. Down here on the end?

MEMBER OKER: So building on the last two comments, one of the things I think we should keep top of mind is that we are going to be digitizing a lot of these interactions. So as we come up with these measures, some of that fragmentation is going to be addressed through technology and communications between payers and hospitals and providers and even families

potentially through --- I'm using the carer word, actually, is the term I was leaning to instead of family carer --- or carer circle.

And so there are opportunities to address the fragmentation and maybe resolve it. And as you develop these measures, you might want to think about how do we fit these into a digital world?

DR. WILSON: And to that I --- that brings up another comment --- general comment that I want to make is, yes, you are correct. We want to be aspirational because it's not --- again, not just what we can do today, but what we will be able to do in the future. And the other reminder I would give you is when we had our first webinar we created a series of scenarios to help flesh out some of the elements of what makes for a quality transition, or conversely, where are we not doing it well and we need to do it better?

Keep in mind those scenarios as well because as you think of that patient coming from

any kind of setting going to any kind of setting and --- one of my colleagues this morning as I was coming up to this meeting said are you going to talk about rural? I said yes, rural will be included. But --- so think about --- we talked about it's different if the patient goes to an emergency department in an academic medical center versus a critical access --- or a more rural or more community hospital.

So as you think about these measures as well, think about the different settings in which this care needs to take place. And that's another perspective to keep in mind. Thanks.

CO-CHAIR NILES: Julie?

MEMBER MASSEY: To the question about digital, in the same alignment we talked about care management. We've done a lot of work in the digital world that I think in some ways has increased our fragmentation as opposed to the integration. The technology and its capability and I think our hope and expectations for that are not quite there completely. We're improving.

But I would think about --- in each of our groups, our paired measures as you mentioned --- what I think has driven some of the fragmentation in the electronic world has been a desire to check the box and hit the measure. So we throw care managers or we throw additional technology. And yes, we're sending that transition of care document. But we've got to look at the quality of that, see what the partner reception is on the other side so that we're cautious about not increasing the fragmentation with that technology and really improving it at the level that technology may or may not agree with us.

MEMBER OKER: Just a really brief comment, just to level set, the fragmentation around digital, it's part and parcel to the fragmentation of our health system. When you go to countries that are not fragmented in terms of healthcare, their digitization is not fragmented either. Digital is simply a tool that powers us, but it's no better than us --- we ourselves. So

that's something to just keep in mind.

CO-CHAIR NILES: Brendan?

DR. CARR: Just to piggyback on that. I think we also need to be really mindful of the --- we are talking about the emergency department, and we are talking about sort of payers and primary care are three of the big players here. But acute care is --- it's changing, right? And depending on where you live, you see this or don't see this.

But you know, care that happens inside of a CVS or inside of an urgent care center or inside of a freestanding emergency department or online --- probably, you know, we need to be nimble enough that we are having a conversation not just about the traditional two settings of care, primary or specialist office and emergency department, just --- we need to I think remember that there is going to continue to be innovation. And with that innovation comes fragmentation and --- unless we sort of are mindful of it.

CO-CHAIR NILES: Thank you. Any other

comments? Anybody on the phone have a comment? Okay, Marcia, where do we go next?

DR. WILSON: Do you want to go to break, or --- okay. So if you could go to the next slide. We're a little bit ahead of schedule, and this is not surprising because it's --- once you get into the domains and the subdomains and the measures, the conversation will get a lot more robust.

So what we're going to do is go into the first breakout session. And what I'll do is I'll give you some information about the session. I think it's on my discussion guide. All of the breakout sessions will be essentially the same. When you go to your breakout session, we're going to ask someone from the committee --- thanks so much --- to be a volunteer facilitator. You will have NQF staff in the room with you. We're going to scribe the changes, or the decisions that are made --- kind of pick up on some of the themes that emerge, questions that need to come back to the group.

But really the discussion is among the Committee members. Now we have assigned each of you to one of the main domains and this will be your assignment --- these will become your BFFs over the next two days because you'll be with them during the --- all of --- each of the breakout sessions. The first breakout session, as we said, is to look at the definitions of the domains and subdomains. And again, you should have a discussion guide document in your packet. Let me pull mine out here.

And it is labeled group discussion guide. And what we've listed here is the objective of each of the breakout sessions. And again, this first one is kind of to come to consensus on definitions of the domains and subdomains. Also do the domains make sense? And you heard a couple of questions that arose, like where is this going to find a home? Where is this kind of issue going to find a home?

So you may end up adding domains. You may end up deleting domains. You may end up ---

if you're a lumper or a splitter, you may be breaking apart domains or bringing them together. Again, not to worry too much this morning because when you start to get into the measures and concepts this afternoon, this will make a lot more sense. Let's see if I've covered all of that.

You've got some potential questions here in the discussion guide. And I think the next slide is the report backs? Yes. So when you come back, what is your job? The facilitator should bring back the changes that were made to the domains and subdomains. What NQF staff are going to be using is our laptops to do track changes, so we can bring back any changes to the group. The facilitator can talk about why changes were made, the rationale, and then if there's any unresolved issues that need to be discussed.

For example, you may be talking about something and say I think this is an issue that I don't see in the subdomains, but it may also

belong in another domain, or you may have a question for another group --- we considered this in our domain, but in this other domain did you think about this similar issue? So those are kind of like sharing issues. Again, staff will scribe on their laptops any of the changes, but we'll use the flip charts for questions that need to come back for the larger group.

When we reconvene, each small group will do a report back. We'll have the larger group discussion and our goal is by the end of this morning is to kind of be comfortable with the domains and the subdomains, and that we've considered all of the issues. Questions? Colleagues from my team, anything else that we missed?

MS. REED: Volunteers.

DR. WILSON: They can do that in the room, I think. Okay. Pardon? Location.

CO-CHAIR NILES: Location.

DR. WILSON: So the --- hang on, it's in my --- it's on my notes. So the patient

communication, because we have Donna and Kristin on the phone, you're actually going to go into a room across the hall where we have a speaker phone. And so you will actually be in a room by yourselves so that you can engage the folks on the phone. The other three teams will stay in here and we'll put provider communications back in that corner of the room.

We'll put engagement of the broader community back in that corner of the room. And behind me in that end of the room --- near the food, of course --- is achievement of outcomes. And we're small enough groups that we've done this before in this room where we have the breakouts and the groups are small enough that I don't think it will be an issue.

For our federal partners, you are more than welcome to sit in on any group that is of interest to you, which our federal partners often do. And I think Sophia Chan that Brendan mentioned from CMS is going to try and listen in by phone to the patient communication group. So

you have your marching order. Are there any questions about the purpose of the breakout groups? Clearly this group has got it. Okay.

All right. And we will reconvene --- we'll figure out the time because we are early. We're ahead of schedule. We'll figure out the time to come back. But this is actually a very good thing that we're ahead of schedule because we've found that once you get into the weeds of things, we get into some pretty robust discussions. So we can use this extra time.

We'll do a --- should we take a break after we do the breakout session? And also if --- in the meantime, if you need to just take a quick break now to step out, or you know where the restrooms are, please feel free to do so.

MS. COBB: Why don't we take five minutes to transition, and ---

DR. WILSON: Five minutes to transition. Sounds like a deal.

MS. COBB: Okay.

DR. WILSON: Thank you.

(Whereupon, the above-entitled matter went off the record at 9:36 a.m. and resumed at 11:19 a.m.)

CO-CHAIR CANTRILL: Okay. Why don't we resume. I am sure we all had way too much fun in those breakout groups. I know we certainly had a lot.

So, what we're going to do now before lunch, is have the report-outs from the different breakout groups with some discussions and unresolved issues.

So, we'll start with the first group, the Provider Communication. And if I could have the appointed reporter from that group, and you can have the floor.

Who might that be?

DR. PINES: So, I am going to report for the --

CO-CHAIR CANTRILL: Okay.

DR. PINES: -- Provider Communication group.

CO-CHAIR CANTRILL: Well, they got

away with it easy, didn't they, Jesse?

DR. PINES: Okay. So, we -- the beginning we were trying to decide whether or not we wanted to be lumpers and splitters. And we ended up doing a lot of lumping and a lot of splitting, so we decided to do both.

We ended up with four big domains, some which were -- we spend more time talking about than others. For key information elements, I think we'd love to get more group feedback on this.

The four broad subdomains that related to key information elements, specifically the transition, the plan of care and anticipated contingencies. And some of the elements of that you can see. And if you take it out of Track Changes, it might be easier to see there.

The -- some of the properties of information transfer -- so, we ended up adding to the list, including the modality, timeliness, salience, parsimony, feasibility of execution.

So, you can see all the different sort

of elements, you know, realizing the different types of transitions in and out of the ED.

Certain elements are going to be certainly more important than others, but this is sort of a laundry list of things that measure developers may want to address in their measures.

We also talked a lot about sort of shared accountability where really the, you know, any transition and care between providers is one provider sending and the other one receiving information.

And we think that it's important for -- to assign specific responsibilities for transition in terms of which -- what element -- information elements should be transmitted and what specific modality that that information should be transmitted in.

It's sort of our -- this is one of our -- sort of our more aspirational goals. It is that if we can come up with different ways to, you know, sort of long-term maybe sort of a taxonomy of transitions, you know, specific types

of transitions where specific information elements are needed in a specific modality and time frame, et cetera, that our information technology developers will develop systems that will sort of facilitate those transitions on both sides so that either coming into the emergency department or leaving the emergency department, that there could be systems built for the different types of transitions.

And then sort of our final -- this was a new domain that was important. This is around -- if you go to the next -- top of the page, it's really sort of expectations and feedback.

And one of the key elements that -- is that, you know, between providers, there's often sort of a lack of feedback after a transition in terms of what happened to that person.

And often sort of a lack of knowledge, you know, about sort of what a -- either the ED can do or what the -- a primary care physician can do after the patient goes back into that setting.

And we thought that, you know, not to, you know, that in order to sort of improve care, to make sure that everyone can actually get some feedback about sort of what happened in that transition so they can learn themselves and can actually improve care over time.

CO-CHAIR CANTRILL: Any unresolved issues, Jesse?

DR. PINES: I don't think we had specific unresolved issues. We did have a fair amount of discussion around provider education and specifically are there certain types of providers that should be -- with certain levels of education that should be doing transitions.

And ultimately, our team decided that we didn't want to be as prescriptive when it came to that, but just to ensure that sort of the right information and accurate information is transmitted. But, yeah, that was a big point of discussion.

CO-CHAIR CANTRILL: Any questions or comments for Jesse concerning this group?

I know our group did have one comment in terms of the feedback and it really hinges on appropriate feedback.

I don't want to know about every fractured ankle that I send to the orthopd, you know. I don't want the -- there are not enough hours in the day to handle all that feedback, but then how do we -- it's really the challenge how do we designate that is a case where I want feedback, and this is a case where I don't need feedback.

DR. PINES: And sort of the -- I think the concept of -- that needs to be considered is really sort of the salience and parsimony of the, you know, right information and then the -- and also the provider burden and making sure that we're not, you know, having too much information, it's got to be the right information and the information that's valuable.

CO-CHAIR CANTRILL: Yeah. I love your term parsimony. That's excellent. A great term.

Any questions?

Okay. Let's move on to the next group, Patient Communication.

MEMBER SWANSON: Okay. Great.

CO-CHAIR CANTRILL: Okay, Adam.

MEMBER SWANSON: Thank you, Steve.

So, Domain 2, Patient and Family Communication. So, we started basically this entire domain over. We changed it to Patient and Carer Communication, C-A-R-E-R, meaning that it could represent multiple, different proxies to a patient.

And thank you, Kyle, for facilitating a great session. It was a really good conversation between all of us.

This second flip chart paper over here on the wall will help guide some of our conversation, but we decided on four subdomains and a new domain definition, which Vanessa captured for us and I cannot communicate off the top -- it's on the slide already. Oh, my gosh. You're so fast.

So, the domain definition is,

bidirectional communication between patient and carer back and multi-disciplinary teams. So --

MS. COBB: It's so fast you can see -- you can see how quality the -- that's not in English, I don't think. It's missing a word or two, but --

MEMBER SWANSON: The idea being that bidirectional communication is occurring from the patient to the provider and vice versa, and really honing in on what information is.

So, for our subdomains, we had four subdomains that we identified. I will admit that we didn't get too far into several of them as we spent quite a bit of time conversing around each of these.

In terms of key information, we said there's two types of information; the patient to the healthcare provider and vice versa, like I said earlier.

More specifically, making sure that we identify the cause, the course or the plan of treatment, what's going to occur after this, what

are the symptoms I should expect, making sure that those pieces of information are defined, what do I do, where do I do it, where are those follow-up resources.

Resources in terms of not only diagnostic resources, so prescriptions, but also what community resources are out there, that was one of our main -- subdomains that we identified.

In terms of our second subdomain, it was patient needs verification. So, really asking the question, are we addressing the concerns of the patient. As the provider, are we relieving their anxiety when they leave? Are we confirming that they have the informational support that they need when leaving the ED to have a quality transition of care?

And then for our final two subdomains -- I don't know if they're on the next slide. There it is. Great. So, modality, how is this information communicated?

I think -- and making sure to our next subdomain, assessment of potential barriers, I

think those two go hand in hand, but modality, in what ways does the patient want that information and how are we communicating the most prioritized and critical information of what we're sharing.

And then in terms of potential barriers, you know, how are we addressing the transition of care, social determinants of health?

For example, are they able to get to the follow-up appointment? Are they able to fill the script that they've been prescribed? And if not, what type of resources are we providing there?

CO-CHAIR CANTRILL: Any unresolved issues that came up with your group?

MEMBER SWANSON: I don't know that unresolved issues is how I would describe it. I do think we did not get into modality and assessment of potential barriers as much as we need to and eventually will.

CO-CHAIR CANTRILL: Any questions or comments for Adam?

Yes, sir.

MEMBER PRICE: So, one thing that came up with the communication on providers -- provider communication, was the responsibility of the patients in this whole transition of care. And I was just curious if you guys touched upon that at all.

MEMBER SWANSON: We did touch on that. Actually, that exact phrase was used. What is the responsibility of the patient and, you know, any of my group members, please speak up if I am not representing your perspective, but I think the conclusion we kind of came to was depending on a patient's capacity, their ability to provide information might vary.

So, I think we kind of took the perspective that with these various subdomains, hopefully the information that is needed from the patient or the carer is being obtained by the provider.

Would that be a proper representation?

MEMBER OKER: Could I add?

So, we actually did the exercise of looking at is the patient responsible for responding back and saying, you know, I don't understand that, I don't have money for something, you know, that kind of thing. So, that's the bidirectional piece, but the caveat being is every person has a different ability to engage in that sort of discourse.

So, the burden of sorting out whether the patient can and cannot engage in a conversation really does fall on the provider.

Would that be fair?

MEMBER SWANSON: Yes.

CO-CHAIR CANTRILL: Julie.

MEMBER MASSEY: In some of our conversations, a question of consent came up. Did you address any -- I mean, when it's directly communicating between providers, but the patient's role in engagement, did that come up at all in some of your conversation about the patient giving their appropriate consent or requesting that communication?

MEMBER SWANSON: I don't know that we spoke a lot about consent in our group. I do think that's a very important issue.

I come from the Suicide Prevention Resource Center and the follow-up care that we talk about with EDs is so critical. And getting that patient consent to do the follow-up is very critical and if they're someone under the age of 18.

So, I think that's an important consideration that we can bring into our next conversation.

MEMBER MASSEY: And the patients needing to provide that conduit to some of those other -- sometimes we assume we're going to communicate to the next, but what's the patient's role in understanding that we're communicating to that next level?

MEMBER SWANSON: That is something that we did talk about as well, is how are we capturing the information and documenting the information about what is exchanged between the

patient and the provider so that when they go to that next appointment, they're not having to repeat all of the various things.

And they might not capture all of that information in their memory or in their records, so what are we capturing in the EHR or what have you.

MEMBER KARAN: Julie, just a question to make sure I'm understanding this right.

What part of consent would not be covered under the initial HIPAA? Why would there need to be an additional --

MEMBER MASSEY: I think we --

MEMBER KARAN: I'm sure there is, I just don't understand it.

MEMBER MASSEY: We talked a little bit more in some of the community resources where some of the communication may be with providers that --

MEMBER KARAN: Okay.

MEMBER MASSEY: -- otherwise don't fall under the traditional HIPAA consent, but are

--

MEMBER KARAN: Okay.

MEMBER MASSEY: -- but what is the patient's role. And to the same extent, I know in my own personal world previously, sometimes the patient actually doesn't want you to communicate with that particular caregiver even though we know it's in the best interest of the patient we think it is to communicate this element to their -- a particular caregiver, their part of the team.

MEMBER KARAN: But technically all we can do is give them the information. What they do with it is suspect at best.

MEMBER MASSEY: And I think to that end, the patient really is that conduit. They own their information and they can choose who they're sharing -- if they're bringing that to the PCP or if they're bringing that to each individual provider, but it's important to request to access those -- that information from the patient, because they're the key owner for

where that's going.

MEMBER KARAN: I got it. Thank you.

CO-CHAIR NILES: Go ahead. We have a question over here.

MEMBER SCHMITTHENNER: I think it would be important to include education of the patient as to the reason for the need for consent to communicate with the full array of providers that are across multiple care settings.

CO-CHAIR CANTRILL: Okay. Thank you.

Any other comments or questions?

Okay. Let's go on to the next group, the Engagement of Broader Community.

MEMBER DEAL: Okay. So, our group had a very good, robust discussion and really we started out by talking about what are the foundational elements, are they available, are these social determinants available.

And things that we talked about included not only case management and case coordination and navigators, but are we including things like travel expenses, expenses for

medications, including do the patients have utilities paid for, food bank services, nutrition services, employment and so much more.

So, our big thought -- our big concern was are we closing these gaps from when they leave the ED to go home? Can they implement the plan of care and how do we coordinate the communication between all of these different agencies to get that care delivered to the patient?

So, when we talked about the domain name of Engagement of the Broader Community, we changed the verbiage a little bit for the definition to include the extent to which broader community organization services and information technology infrastructures are available and engaged to support a quality transition of care into and out of the ED.

And we also changed a little bit of the terminology subsequently. The community setting refers to array of clinical and non-clinical services.

We really wanted to emphasize that there's the clinical part of the patient, but there's also this non-clinical part. And we would be remiss if we didn't say that.

So, when we look at the subdomains, the first one was Linkages and Synchronization. And we'd like to change that title to Connection and Alignment.

And by this, we decided that Connection and Alignment is better -- is going to better serve what we want to come across with this subdomain, which is identification, availability and engagement of appropriate clinical and non-clinical community services to support a transition.

And we want to be able to facilitate care coordination with leveraging existing community pathways.

And we want this to disseminate the patient-centered care plan across the care setting with all the providers.

And with this, we also want to include

the key stakeholders, which could be anything, the NCOs, the ACOs, the PCP, the medical homes, but we wanted to make sure that that was within this statement.

We decided to change the next title which was Quality and Availability of Services to Accessibility of Services.

And this would be an assessment of accessibility of services that support transitions of care.

And we feel that that would encompass everything that was in the previous statement, which would encompass the equity, the continuity and the cultural appropriateness.

We added a new subdomain to include the patient-centered care team. We really thought it was important to include everyone in these statements.

So, we -- the new subdomain is Identification, Documentation and Engagement with Patient Consent of the Patient-Centered Care Team.

So, this new subdomain is really talking about how are we communicating to the PCP? Who are these users? Who aren't we telling this information to that we need to? Who owns the patient? Who is the -- should be the care coordinator?

When Arjun was talking about a patient that had five care managers, I mean, how do we get rid of this redundancy?

So, by identifying, documenting and engaging the entire care team, we can get rid of that redundancy and get to the point where not only are we doing a better job, but the patient is going to feel less inundated with all these different care services. Because we're all trying to do a good job, it's just there's too much.

And then finally within our outcome measures, you know, all the things that -- in the subdomains that are already listed are things that we believe are accurate, but we also wanted to talk a little bit about the measurement within

the emergency department and how can we utilize repeat visits.

And it introduced care coordination that way by providing incentives to reduce those visits, get the connections made with the case managers, the care managers, can we utilize the EMS system.

We talked a little bit about, what about all those calls that the providers don't take to the hospital, the hypoglycemic patient who gets, you know, some D50 and a snack and they don't come back to the -- they don't go to the ED. How does their PCP know that that happened?

How about the grandma that fell maybe from a vasovagal event, but got up, the paramedics lifted them up and put them in, but the PCP never knew about that.

So, how can we -- how can we add that to the outcomes and measure that so that we can somehow get some of that information to the care coordinator?

And we also talked a little bit about

taking advantage of alerts. In my position, I get an alert every time someone goes to the ED. How can I utilize that information in a better way?

So, group, let me know if I didn't --

CO-CHAIR CANTRILL: Lisa, any unresolved issues?

MEMBER DEAL: Any unresolved issues? I think we did talk a little bit just about, you know, every other group kind of had the, you know, these same key domains and you kind of made us a little bit different and, you know, would that -- would there be any validity in us having the same key information, modality, timeliness.

CO-CHAIR CANTRILL: Comments.

MEMBER DUNFORD: Just as another member of the committee -- by the way, you can see we have a spectacular synthesizer in our group here.

(Laughter.)

MEMBER DUNFORD: And the point that we wanted to make about the assessment in the

communities, is because we recognize the need to risk stratify for the availability of services in the community.

And so, we feel it's important that there be some kind of community assessment of the availability and resources.

CO-CHAIR CANTRILL: Thank you. Any other questions or comments for Lisa or with this group?

Jesse.

DR. PINES: Just as a general question and, you know, and just sort of thinking about this, struggling with what -- sort of trying to operationalize the word engagement and how do you do that.

And just wanted to, you know, I guess this is a more general question for the group. How do we operationalize engagement when it comes to quality measures and how -- and specifically how things will be measured as to whether, you know, a particular, you know, care manager is or is not part of that team.

I don't know if your group had that kind of discussion there.

MEMBER DEAL: I think this might be Brenda's answer.

MEMBER SCHMITTHENNER: I think it's more about documentation of, you know, that the communication was communicated to the appropriate care managers or the appropriate hand-offs in the community whether they be clinical providers or non-clinical providers.

And perhaps even in the, you know, discharge plan, that there's documentation of that communication.

MEMBER MASSEY: One of the things we did comment is that pairing, there's the sending and the receiving, but we also acknowledged that there's really not a lot of quality measurement on the community services side yet, but aspirational we needed to figure out how do you measure the quality of the service and the quality of the engagement on the receiver end. But for now, we could start with the -- at least

documenting on the sender.

But that aspiration, you know, to have any kind of a mechanism to measure quality, when we talked about quality and availability, accessibility and -- there may be services that are not accessible, but then how do you measure the quality and level of their engagement.

MEMBER SCHMITTHENNER: And one of the barriers that we have is we really don't have interoperable communication across multiple care settings and providers. And I don't see that actually occurring any time in the near future.

MEMBER DUNFORD: As a committee member, I was gave the example of the house staff at my place who don't even know where the sobering center is, have no idea where the drug detox facility is and would not be able to make a contact, and nor would anybody else in the department, you know.

So, it's -- I agree it's this communication and basically learning about the siloed facilities that exist in the community

that do exist out there and basically developing some kind of responsibility for the emergency departments to connect to those resources rather than just giving somebody a bus pass and saying, good luck

CO-CHAIR CANTRILL: Aleesa, and then --

MEMBER RISING: Sorry.

CO-CHAIR CANTRILL: Go ahead.

MEMBER RISING: I just wanted to -- sorry. One other comment on Jesse's question of engagement.

I mean, I think it is -- it is a really challenging thing, you know. I've been talking with the scientist I work with closely and that she has dug, you know, deep and far into literature.

She's really brought up the fact that there really is no kind of established measure of engagement.

But I think from the, you know, provider to the recipient end, I do think that as

much as we can look at the recipients feeling like they were engaged is much more important than us as providers saying, yes, I engaged the person, yes, I engaged the community, you know, group, whoever it may be, because I think our perception of engagement is often quite off.

So, I think as much as we can work in the recipient end, that's important from that aspect.

CO-CHAIR CANTRILL: There's agreement there, too.

(Laughter.)

MEMBER RISING: Yes, very much.

CO-CHAIR CANTRILL: Aleesa.

MEMBER MOBLEY: Going back to the concept of engagement, not only do we need appropriate documentation, but I think the documentation to be measurable should be very specific.

We very frequently say that the nursing staff was communicated to, or we say they were connected with the appropriate facilities,

but we're not very specific in terms of documenting who we spoke to or exactly what facility; address, phone number, something that can actually be measured.

MEMBER VENKATESH: I guess a couple things.

When I saw the Engagement of the Broader Community, I thought about measurement, one topic that I always feel like we miss, because we tend to build these rooms -- we're very healthcare-centric in this room and very provider-centric within healthcare -- is that we don't think about multi-sector strategies when we think about community alignment on measurement.

And so, we talk a lot about, oh, there's these social determinants of health that impact these health outcomes, and we're trying to measure these health outcomes, and it makes it challenging for measurement of providers.

We have not gone the other way and said, well, could we measure health outcomes as outcomes of the social services?

So, should the measure on effective Area Agency on Aging or a local housing cooperative be healthcare resource utilization?

As an effective measure of outcomes for that community service, you could have shared accountability. The same measures could exist for community services as they exist for healthcare institutions.

You would then get some of this desired alignment around coordination across the sector, because the patient is moving between the healthcare sector and the non-healthcare clinical setting in this world.

The vast majority of their time is in the non-clinical setting. And I could tell you if you ask people what they want to spend their time around, how they want to spend their life and what they're thinking about, it is not the healthcare world, right?

They care about their life that is not healthcare. They do not want to think about going to the doctor, being in the hospital. They

want to do everything else in life.

And so, there's -- I think there's this multi-sector strategy on measurement that would be valuable and worthwhile to bring up within this.

And the other thing I was just going to ask is a question, if this got discussed at all, but did you guys discuss what the -- who defines the community and what the community is?

Are we going to define the community and say, oh, because I cover that life as a payer, that patient is in my community?

Or is the patient going to define the community and say what counts as being in their community or not?

And you might get very different concepts for an attribution for measurement based on what the lens is.

CO-CHAIR CANTRILL: Stephanie.

MEMBER WEST: One of the things that we talk quite a bit about is the centrality of the patient-centered plan of care that truly is

patient-centered where upstream, if possible, not in the ED, but hopefully in their previous life, those caregivers are identified and those services are identified in a manner that long-term could be shared across a continuum.

So, truly a patient-centered plan of care that could be contributed to by the Elder Network Service or whomever the patient really designates to be part of their care team.

So, who's the team of individuals or agencies or services that are amassed to support the patient going forward to support the individual? And then, that shared plan of care travels with the patient.

CO-CHAIR CANTRILL: Brenda.

MEMBER SCHMITTHENNER: You've defined an ideal state in which, indeed, the community-based, non-medical services can demonstrate the value in addressing those social determinants of health and the resulting improvements in healthcare outcomes, including reduction of healthcare cost.

The current barrier is the technology and data exchange that would allow the community-based organization to be able to capture that information.

The community-based, non-medical providers don't know if their client has been admitted to the hospital or readmitted or presented to the emergency department.

What they do know is they can identify the risk that exists within the community, within the home, but they don't have a way to then communicate that to someone who can act upon that information quickly to reduce that risk.

CO-CHAIR CANTRILL: Elif.

MEMBER OKER: I wanted to add a word that came up in our conversation that really, I think, changed a little bit about how we view things.

We keep saying patient, and a gentleman a minute ago talked about all the other places the patient wants to be when, in fact, we're talking about humans and we're needing to

design this for humans in a manner that they feel important, in a manner that they define on their terms, because they do spend the vast majority of their time being humans and not patients.

And I think if we start thinking that way, it might change our dialog around what we define moving forward.

CO-CHAIR CANTRILL: Jim.

MEMBER DUNFORD: Thank you. Yeah, we were -- to amplify what others have said, we were looking for a structural outcome measure that actually defined the community, at least the components of it, that the patient might even select from.

The other thing that we decided was that there are certain aspects of social determinants that aren't going to change, but that the emergency department ought to be in a position to actually update that, you know, the car doesn't have any gas this week, that kind of thing.

And that we also use alerting

technologies in a simplistic way. Some experiments that are, you know, already going on in the country where patient gets admitted to the hospital, Meals on Wheels is alerted, you don't have to bring meals to this patient this week.

That kind of thing is -- would be a really example of how you could actually measure an outcome.

CO-CHAIR CANTRILL: Joe.

MEMBER KARAN: When we look at community-based health, the majority of places that offer that are counties, usually not states. There are some programs within states, but it's usually county.

Which means that you may have someone who lives a mile away and not be able to get the same assistance that you're getting in the county you lived in.

So, to build a comprehensive list, which we have done, you have to actually go by county and see what overlap there is.

And it's an undertaking. But if

you're going to give the information to the patient, it's got to be broken down by where those facilities are that can help them.

So, it's not just a we-can-do-it-in-three-day kind of thing. It's going to take time to build those lists up for each facility.

CO-CHAIR CANTRILL: Yes. I can't see your sign.

MEMBER PRICE: Sorry. Marc.

CO-CHAIR CANTRILL: There you go.

MEMBER PRICE: So, just to echo what Joe just said, my practice straddles about three counties.

And we have -- I've had one of my staff members who happens to have an MPH, working for the past three weeks trying to coordinate all those different services, the shelters, food banks, places -- the Salvation Army, any possible thing outside of our care that we can provide. And it's taken her that long just for those three counties.

And depending, like Joe said, where

you live is what you qualify for. So, that's a very valid point.

CO-CHAIR CANTRILL: Any other comments or questions for this group?

Okay. Moving on to Achievement of Outcomes, Tricia.

MEMBER ELLIOTT: Yes. Thank you.

We also had a very robust discussion. We did start looking at all the domains and kind of had a nice little discussion just to make sure that we felt that the -- that it was wide enough of a landscape, and we felt that it did.

We moved on, then, to our specific domain. There was a lot of discussion on the definition.

We tossed about words such as achieved, versus improved. Also, perhaps, just using kind of a softer term of occurred.

So, we ended up, I think -- so, we ended up with occur. So, Marcia has it documented up here, kind of red lined. And we also added across systems of care to our domain

discussion.

The bulk of our time when we started talking about the subdomains was spent under the safety outcome. And then we kind of circled back to the others.

So, under the safety outcome, we had a lot of discussion on the idea of closing the loop, did the feedback occur?

Because we noticed in some of the other subdomains, particularly the provider one, there was that definition of the key information, the test and procedure results, pending tests.

We -- I think a new term was coined, orphan information. So, that was the kind of black hole of that pending, you know, the patient leaves and you still have all this information pending. So, what do you do with this orphan information?

So, we had a lot of discussion, does it fit under our domain? Is it under another domain? And we landed on the outcome being, was the appropriate action taken? So, what was done

with this lingering information or any information that was generated during this health visit.

We then -- so, we kind of redefined the safety outcome as noted on the screen here. So, the extent to which there are institutional processes to ensure appropriate follow-up after the ED visit such as pending tests, medication reconciliation, appropriate follow-up activities occurred. So, it summarizes probably 30 minutes of discussion and then we moved on to provider experience.

We just tweaked that a little bit. Took out -- we didn't feel the word unity was the right one there, so we swapped out system of care.

Patient, we had the discussion about that definition. We heard the initial comments from the group, so we were tweaking that, but we decided we would adopt whatever they -- the overall group selects for -- I heard carer in one of the presentations. So, tweaked that a little

bit.

Then we spent some time on the healthcare utilization and cost subdomain. So, some robust discussion there as well, added concepts such as admissions and readmissions and testing.

And we added the -- kind of a caveat statement to the end that utilization and cost measures should be paired with quality measures, that they couldn't stand alone, that we would want definitely that balance there, the concept of value. You don't want to lose the quality piece of that.

So, I think -- there was a lot discussed. So, I defer to some of my colleagues at the table for adding some of those commentaries.

CO-CHAIR CANTRILL: Thank you, Tricia.

We had a couple of issues that we put in the parking lot. One was in terms of follow-up.

Is that really a component of

community engagement, because it's much more than just the direct follow-up with the PCP. I mean, you have a lot of other players involved there.

Then we talked about the shared accountability that we really are talking a lot about Point B, but we have Points A and C. And is there -- there should be shared accountability in terms of all three components there, not just ours. And then the conundrum of what is appropriate care?

And especially with a performance measure that deals with appropriate care, I found that always very difficult to deal with.

Jesse, you have a question or comment?

DR. PINES: Yeah. Just a question on the safety outcomes, which I really like that -- I really like that concept, but did you all talk about any specific sort of outcome measures such as, you know, someone who may have a, you know, missed diagnosis or someone where there would be sort of the outcome of a poor transition or outcome of a good transition.

What I'm seeing here is sort of a, you know, are there, you know, sort of process and structural measures rather than outcomes?

MEMBER ELIOTT: Yes. We definitely had that discussion on the -- we focused probably more on the process piece right now.

I think what we'll flesh out as the group continues to convene over the next day or so, we'll probably get into some of those.

We kind of kept it at a high level initially on the domain and the subdomains, but you raise some excellent points and I think our discussions will evolve into that.

We didn't get into specific outcome measures just yet. Some of the -- trying to define the process and where maybe some of those outcomes would get measured, but a lot of time spent back to kind of that domain across the systems of care and really kind of making -- a lot of debate on that achievement.

We didn't want to assign a benchmark to it yet. We want to make sure that some of

these key components are actually occurring before we really assign a benchmark or an indicator to that.

CO-CHAIR CANTRILL: Brenda.

MEMBER SCHMITTHENNER: I see that there was a focus on healthcare cost.

Was there any discussion about the ability of the community to support the needs and demands? Do they have the capacity? Are those services accessible and are they funded appropriately to meet the needs of the community?

MEMBER ELLIOTT: Not as eloquently as you just put it --

(Laughter.)

MEMBER ELIOTT: -- but we did have a lot of what are some of those contextual measures and adding different components to that.

And I jotted a note that I heard across the room, too, that -- shared accountability of utilization. So, I think we can definitely add that content to our future discussions.

CO-CHAIR CANTRILL: Thank you. Comment? I can't read your name -- oh, Nicki. Sorry.

MEMBER HASTINGS: Yes. Nicki. Sorry about that.

We had a lot of discussion about just what Jesse was alluding to, which are the challenges of operationalizing performance measures at the person level for many of the concepts that we talked about.

And so, where we ended up landing was making some distinctions about what we thought could, in the current environment, be measured at the person level versus what it might be more appropriate to think about at the institution level.

So, Tricia taught me a new terms, structural standard. And I think in some ways that could be useful not only to our group, but some of the others of -- because there is so much heterogeneity among the EDs and systems that are involved here.

And so, might there be some value in us articulating what it -- we think it would be of value for an institution to have invested some of their time and resources in developing processes around.

It doesn't quite get to our aspirational goals of being able to measure particularly with the community-engagement and some of the follow-up activities where we would want to ultimately go, but maybe an interim step is asking institutions to discuss whether or not they have a process in place to exchange the information or begin to think about addressing the issues.

CO-CHAIR CANTRILL: Arjun.

MEMBER VENKATESH: Since that topic and I guess the big domain is Outcome Measures, I guess there's one kind of outcome measure that's not explicitly stated here, and those are patient-reported outcome measures. And I think of those as very distinct of the experience measures.

You can have a positive patient-reported outcome with or without a positive experience. I would -- they tend to move together, but they're not necessarily the exact same thing.

And when I think of the context of a transition out of the emergency department, that may actually be more measurable and easier to measure in many ways than a lot of these other things, which are rare events or hard things to capture or diagnostic delays or really challenging things to capture when the patient-reported measure of an effective care transition may be the recovery from what their acute care condition was or the resolution of the fear and uncertainty that initially incited that acute care episode.

And so, I wonder if that should just be kind of another outcome domain or subdomain that gets put in there, but there's a lot of work in the patient-reported outcome space as well that will be applicable.

CO-CHAIR CANTRILL: Joe.

MEMBER KARAN: When looking at community assets, one of the things I think that we tend to forget is that they're all funded and they all have budgets.

And to give you an idea, I had three this year that received their money in January. It was gone the end of January. And it was a fairly decent amount.

So, people are getting more familiar with using community-based help, but it's so free-flowing that you're always going back to fix your list. Okay. What's available for the next three months? What's available now?

It's a lot of effort and we have to make sure we don't communicate to the patient this is available, and then find out they went there and it's not.

CO-CHAIR CANTRILL: Julie.

MEMBER MASSEY: Jesse, you asked a question earlier about measurement -- about engagement.

And I think we have some of the provider experience/patient experience and maybe we can target the question a little bit about their experience and feeling engaged. And perhaps there's an opportunity to look at some of the community partners in the same way.

CO-CHAIR CANTRILL: Jim.

MEMBER DUNFORD: Thank you. Just along the idea of sort of system-based metrics, I wonder if you guys talked about things like the success rating getting the patient to the hospital that they wanted to go to, you know, which would be a clear issue of satisfaction.

A lot of times those are under the control of an emergency physician on a radio, or a nurse that's being controlled.

Another one that is plaguing us is the turnover time from when the ambulance arrives to when the patient actually gets taken over by the, you know, by the team.

And that can be in a matter of hours, which clearly is another issue of transition of

care that is oftentimes not going successfully and for which there are measures being developed.

California is trying to implement one right now that's a mandatory report for all counties to start to measure that.

So, and then the other thing, really, was does the emergency department have the responsibility to report back to the broader community?

For example, the CARES registry, currently it's not a mandatory report that a cardiac arrest that arrives in your ER, you don't have to say whether the patient survived or not.

Is that something that we have kind of a bigger responsibility to be reporting outcomes like that?

I'm just thinking, again, about the emergency department in the context of the larger healthcare system.

CO-CHAIR CANTRILL: Elif.

MEMBER OKER: Building on what Nicki said about structure, I'm actually working in an

environment where there's a lot of heterogeneity.

And one of the things that has been helpful to us is to set two red lines in the sand, if you will.

One, how is it folks want to plug and play with our standard? There's a standard way that you connect with us.

And the other piece is, what is the consistent experience? And there's a standardization there.

When you set those two parameters, it allows for everyone working in the middle to iterate based on their particular needs.

So, you can allow for heterogeneity, but you standardize the experience and you standardize the connectivity or the information exchange.

I wanted to just throw that out there in case that helps.

CO-CHAIR CANTRILL: Good. Thank you.

Any other questions or comments for this group?

Now, I would like to open the phone lines for member and public comments.

Are there any comments from those that are listening in?

THE OPERATOR: Thank you. At this time if you would like to make a public comment, please press star, then the number one.

There are no public comments at this time.

CO-CHAIR CANTRILL: Thank you.

Any other questions or comments from other guests that are present with us in the room?

Okay. We are a little ahead of schedule. And what we're going to do is before we break for lunch, Kyle is going to give us her discussion in terms of measurement -- measurement overview.

MS. COBB: Thanks, Steve.

So, yeah. I am standing between you and lunch right now. So, I recognize that. So, I will go fast.

Next slide. This is an overview of the measures that we -- but together these are not -- this is not new information.

We've reviewed this a couple of months ago, but this is the results of the scan. And we've sort of put it together by the initial domains that have slightly changed as a result of this morning, but you can see that, for the most part, the majority of the measures and concepts are all around send and receive provider communication. So, that says a couple things which I'll get into next.

But just as a reminder when you're looking at the measure compendiums today and have questions about how we categorize these measures, the relevant measures are ones that we evaluated based on their direct impact with the quality of a transition into and out of the ED.

So, it is absolutely -- these measures that are described as directly relevant are really directly relevant.

An example is the -- a measure that

looks at the percentage of patient's discharge from an ED to another setting who received transition record at the time of discharge with specified information elements.

So, this, as we can all agree, I think, informs a transition and it's part -- it's an integral part of the transition.

Potentially relevant measures have the potential to impact the quality of a transition. For example, a measure focuses on the percentage of patients discharged for whom a discharge medication list was reconciled with their current medication list.

So, it's not, per se, about the transition, but it supports the transition. And it is specific, also, to the ED.

The indirectly relevant measures may impact the quality of transition, but not directly.

So, again, similar to the med rec measures, they may impact it in some way, but they're not necessarily specific to the ED, but

we believe that, you know, they're based on transitions or an element of transition.

So, an example would be e-prescribing system or that could be in place, a structure measure to support quality transitions.

Okay. Next slide, please. So, in terms of taking a deeper dive, the provider communication -- and these are really high level looking at just the -- sort of the breakdown by domains, which may or may not have changed a little bit as I move forward, but you can see that there's a lot of emphasis around timeliness.

There's a host of measures that are around, you know, information received within 24 hours, 48 hours, 72 hours. And it's really specific to the time response, receipt of information, and also the availability of someone to answer questions. That does exist in measurement at this time.

And it would also add, and I've heard it sort of around the room in conversations, we do -- some of these measures, existing measures,

also address different settings.

So, there's some that are for SNFs and, you know, through IMPACT Act measures that are specific to skilled nursing facilities to ED or back. And we also have some specific to community position offices.

Next slide, please. So, Patient and Carer Communication domain, there were a few measures, as you can see, directly relevant. And they are really specific to did the patient get the specific information they need at discharge.

We didn't see measures that were looking at did they verify whether they understood it, or whether they could fill the prescription, but things like asthma action plans, there are measures around that. Maybe something to think about when we're looking at concepts.

Another specific key information that is being measured in existing measures is the ability to follow up after discharge. And I can't tell you right now how well they're doing,

but they do exist.

So, next slide, please. So, the results of the -- so for the Engagement of the Broader Community, we have -- and I know you have more measures now -- or subdomains now. There really -- you have a lot of work to do today and tomorrow.

The linkages, there are some meaningful use measures around, you know, electronic access -- patient electronic access to information post-discharge.

And there's also a measure around a protocol for interfacility transfers. So, looking at a structural measure to enforce consistency for a trauma system protocol.

Okay. And finally the last domain for outcomes, they're really, again, similar to the last domain, not -- two measures, but directly relevant, and they're specific to medication information reconciliation.

And there are, you know, in terms of the patient experience and I'm interested to

explore this a little more and learn more about differences between thinking about how we could incorporate PROs into this, but for -- there are some HCAHPS surveys specific to transitions, the questions that could be used, so -- that exist. So, that is everything -- next slide -- for measures.

And this seems kind of counterintuitive that we're going backwards. Now, I'm going to tell you what a measure is after I've told you how many we have and what they look like. Maybe we could have flipped this.

And I think that listening to the group, it sounds like some people are really good at measures, and maybe I should even have Trish be presenting this, because she's the real expert here, but, you know, simply put we're here to think about measures and the definition, you know, always worth repeating is that this is a standard that allows us a basis for comparison.

And so, for -- so that we can

evaluate. And in our case, we're looking -- we're evaluating performance and we're evaluating quality.

And each measure -- all measures have a numerator and denominator and -- so, this is what we consider a measure.

We will talk about measure concepts as well, and I'll get into this next, but the assumption is that most measures have been scientifically tested.

And in the case of NQF, we have endorsed measures which have a certain amount of rigor required for them to be endorsed.

So, next slide, please. So, there are types of different quality measures. And I think this is a really important slide to think about as you go into the afternoon and tomorrow when you're thinking about measure concepts, but you can measure things at different levels and in different ways.

And so, we have -- and I think, Nicki, you had mentioned the structural measures as a

way to sort of, like, adjust for heterogeneity across facilities, but you can really think about a structure measure as a way to think about how a system is operating.

And in this case, you know, we do see measures around health IT infrastructure, provider capacity systems and other supports.

There are also process measures also known as checkbox measures to many. And they go, oh, no, not another one, but these are -- and, you know, and sometimes there's checkbox measures that are like building block measures that get you somewhere.

Sometimes it's the, you know, the necessary evil, but the process measures really are looking at whether something has been done or not.

Is it complete? Was it done? Prescriptions, any type of practice, that's a process measure. Those are easy to get your head wrapped around.

Outcome measures, a little more

complicated. They take stock of the process, not the -- they take stock not of the process, rather, but of the actual results of the care or services received. So, you're looking at what happens after the process measure.

And you can look at anything from an experience of care or quality of life, well-being, ability to perform daily activities, any outcome that is valued.

So, we have different types and you could have specific health outcomes or experience outcomes.

And then there are composite measures, which combine the results of all of the above on some level, not always, but you do have -- they can -- you could look at multiple performance measures.

So, when Marcia spoke or mentioned earlier about partnering measures, they're not necessarily composites, but composites really do take together, you know, types of, you know, was somebody -- did you look to see if somebody is

smoking and then did you follow up? You could use another measure around did they get a referral and did they get treatment? And then you could throw in another measure around that around -- so, you can see where that goes.

Another example might be focused on a family caregiver intervention and could look at the percentage of caregivers that completed stress reduction training, the percentage screened for depression and the percentage received respite care. So, another example.

And then, you know, at the end, the assumption with a composite is that they're going to tell you something more comprehensive about the caregiver support in this case.

Okay. Next slide, unless there's any questions. Everybody is looking --

MEMBER PRICE: This may be a silly question, but on all your bar graphs you have a little number on the lines.

Is that multiplied by ten, individual counts, what is --

MS. COBB: It's just individual counts.

MEMBER PRICE: So, it looks like there was only like ten people surveyed?

MS. COBB: Yeah.

MEMBER PRICE: Or who responded, anyway?

MS. COBB: Oh, no, no, no. Nobody -- those are the number of measures. So, they -- for patient experience -- can we just flip back just so I can answer the question so we're clear.

Keep going. Keep going. Oh, this is -- so, in this example, so we had -- the directly relevant measures were categorized in safety outcomes.

And there were then five other measures that were indirectly relevant. And three that were potentially relevant.

For the patient experience measures, it's not respondents, it's actual measures that are measuring patient experience.

MEMBER PRICE: So, it's not -- okay.

Thank you. I understand now.

MS. COBB: Yeah. And I can see how that's a little confusing.

So, and I think this is another slide that I sort of just went through. Yeah, let's keep going to -- okay. So, we've talked about what can be measured.

And, again, important to consider when you're thinking about concepts, who can be measured in the level of analysis?

This is a -- typically we think about process measures at the individual provider level, but we can start thinking about facilities, was a facility able to do something or not, what were the outcomes of a facility.

You can look at groups, health plans and, you know, typically we look at the nation. CDC has lots of metrics around national outcomes in health, so -- but it does, I think, depending on your domain and what you're trying to improve from a quality and performance perspective, it's really important to think about the levels of

analysis.

Next slide, please. Okay. And this is my last slide before lunch. And we're going to come back and -- just as a little preview, we're going to think after lunch about the next exercise in measurement, but I think these are just a set of questions that I think are really important to consider when we're thinking about measures, but also as we're going through the concepts and really trying to determine whether there -- we should keep them or not or what we should do with them.

But you really want to ask -- these are important questions. So, what is the goal of the desired outcome for the patient? Do providers have an ability to influence what is being measured? Is there variability among providers and opportunity for improvement?

If there isn't, you're going to have a hard time measuring it. And we had that conversation in my breakout group this morning.

I think some of these areas tend to be

a little aspirational. You may not be able to measure them just yet.

And then finally, are we measuring best performance or passing the test or, you know, gaming the system or, you know, there's a bunch of other things that you could fill in there, but those are really important to think about.

So, I will end there unless anybody has questions.

CO-CHAIR CANTRILL: Any questions for Kyle?

We're almost at lunch. A couple of issues. One, how many folks will be joining us for dinner tonight?

It's a Dutch treat dinner, but we do need to have a headcount so we can let the restaurant know.

The restaurant, I believe, is just a couple blocks from here. Hopefully if it's not pouring rain, we'll be able to walk down there.

DR. WILSON: Show of hands, keep your

hands up, so we can get a reservation.

CO-CHAIR CANTRILL: Okay.

DR. WILSON: Also, for each of the breakout groups, we're trying to schedule one call after this meeting before our next webinar. And so, you should have had a sign-up sheet for your availability.

Rather than doing a doodle poll electronically, we're just doing this the old-fashioned, sign-up-on-the-sheet way.

So, each breakout group should have filled this out. And if not, we'll do that while you're at lunch just so we can schedule these calls.

And I think with that, we're ready for lunch and we will reconvene at one o'clock.

(Whereupon, the proceedings went off the record at 12:22 p.m. for a lunch recess and resumed at 1:04 p.m.)

CO-CHAIR CANTRILL: Now that we're all rejuvenated we just have to avoid the post-prandial sleep. So we're going to do that with

some excitement in terms of our second breakout.

Marcia, do you want to give us instruction?

DR. WILSON: Sure. I'd be glad to, Steve. Thank you.

Okay. Second breakout, same logistics as the first breakout. We'll do the similar format. And you'll have some resources. One, we've been revising the domains and subdomains, so we'll send those back to the NQF staff so you can work with any revisions that you made.

You also have two handouts. One of them is called a measure compendium. And this is a list of all the measures -- Are concepts in here, too, Vanessa, or just measures? -- all the measures and concepts sorted by domain and subdomain. And it's an abbreviated list. There is a longer list that was actually done in Excel. It's got a green band at the top. And that is actually more detail for all the measures and concepts within your domain and subdomains.

So those are the resources that you're

going to be using.

So, when you look at -- we've got the slide up here -- there's really two purposes to this afternoon session. This morning you worked on definitions and domains and subdomains. And so as you heard from Kyle, we took all the measures that we found, all the measure concepts that we found and that were submitted and pre-populated the framework. So we've assigned measures to your domains and subdomains.

And then the second thing that's going to happen this afternoon is that you get a chance to revisit those domains and subdomains and the definitions to kick the tires, if you will, and see if they still work. And it may be that you end up refining definitions this afternoon. That's fine. Because you may find once you start looking at measures and concepts the definition doesn't quite work the way you had it this morning.

So it's multiple part. The first thing you're going to do is look at the measures.

Are they in the right subdomains and do you like the measure? The purpose of this exercise is by the end of the afternoon when you come back to report out you will have kept some of the measures and you will have discarded some of the measures.

So the NQF staff who are working with you will keep documentation of those changes and your rationale.

When you get done looking at the measures we're going to switch to measure concepts. Now, concepts in your green-banded handout are at the very end. We did not try and assign concepts to a particular subdomain. And that's because our suggestion to you is look at the concepts as a whole. Look at your entire list of concepts. Because what we have found from other projects, what will happen when you look at a list of X number of concepts you say, You know what, these three concepts they're all talking about the same thing in a slightly different way. Maybe we need to collapse those.

So, measures have been assigned to a subdomain, which you can change. The concepts, you're going to look at those as a whole after you do the measures.

And the third thing you're going to be looking for is gaps. You've got measures. You've got measure concepts. You're going to keep some of those, start populating, further populating those subdomains. But at the end of the day you may look at a subdomain and say here's what's missing, here's a gap. And just so you can make note of that.

Now, as Kyle showed you in the presentation, not every subdomain had measures or concepts. So when you get to that point, if you've got an empty subdomain it really calls into question is this, is there a gap there that needs to be filled? Or does this subdomain not work in our framework anymore?

So when you come back to the report-back, it's very similar questions. You know, what were the changes that you made to the

measures and measure concepts? And you don't have to go line item by line item because some of you will have a lot of measures, others not so much. And if the changes were made, what was the rationale? Any unresolved issues? as you heard Steve ask.

And the other thing I would say is think about issues that you need to bring back to the larger group. So, a couple of comments from what we were hearing this morning.

There are some issues like follow-up or shared accountability that are going to go across a cross-cutting. They're not going to live in one domain. So if you're working on follow-up, think about in terms of your domain what should you be measuring. Because when we come back holistically to look at the whole framework we're going to say, Have we covered everything we want in follow-up, knowing the measures may live or concepts may live in different subdomains? If that makes sense.

So cross-cutting issues is one.

Think about, also, those paired measures or paired measure concepts. If you have a concept that you want to be measuring one thing, think about, since this is a transition, should we be measuring something else in the other setting? So, think about those paired measures.

And the last thing I will say that's something that came up this morning is again that balance between actionable and aspirational. And we heard -- and I think maybe it was Brenda, were you talking about documentation of the entire care team? And Brenda said we really want much more than that, but that's a critical first step.

So, typically in your framework projects, while we all want to go to those big outcome measures, sometimes it's necessary to have those interim, either a process measure or another measure that gets us on the path to where we want to go.

So if you have a measure that you think or a concept needs to be put into place

because it's going to advance us and get us closer to where we want to be, that's okay too.

So let me pause there and see if there's any questions.

(No response.)

DR. WILSON: Okay. I think we're going to be able to start a little bit early. So let's see when we're going to come back, Steve, to report out.

It looks like we're due back here at 3:00 o'clock for report out. So if you start to wind down before then, we'll reconvene a little bit early. But my guess is after this morning's experience with the discussion this is not a shy group, and we really got into the discussion. And I think this is going to be meatier, if you will, a little more complicated than this morning because now we're really talking about measures and measure concepts and gaps.

Yes, Brenda?

MEMBER SCHMITTHENNER: Could you possibly project the slide that has the

information about the different types of measures, the definitions?

DR. WILSON: Absolutely. The structure process outcome?

MEMBER SCHMITTHENNER: Yes.

DR. WILSON: Yeah. And then the other thing to remember, too, is the level of analysis. Are we looking -- is it -- We had that discussion in the outcomes group which is should it be, should we be measuring individuals? Should we be measuring facilities or organizations? So when you think about, as you look at your measures, it's not only the type of measure but it's also that level of analysis: who are we holding accountable for this measure, so to speak?

Any other questions?

(No response.)

DR. WILSON: Okay. We'll go to the same breakout spots that we did earlier today. Thank you.

(Whereupon, at 1:11 p.m., the panel recessed for a breakout session, and resumed at

3:24 p.m.)

CO-CHAIR CANTRILL: Okay, folks, we're on the home stretch. It's been a long day and we've done a lot of good work. Now we're going to have the report-backs from this afternoon's discussion. You see on the screen some of the discussion questions, any changes that were made to measures or measure concepts, what was the rationale if you made changes, and are there any unresolved issues that need to be discussed.

So we'll do things in the same order. The provider communication. Jesse, are you going to do that report? Or do you have --

Use your mike.

DR. PINES: I can go through some of the ideas. Arjun, do you want to?

Okay. So I was the note taker and Arjun was the facilitator.

So, so there were a number of different issues discussed. We went through several of the measures, and also took a look at some of the measure concepts. Some of the sort

of general themes are that we took the four subdomains that we had for the morning and we compressed those down to two. So, basically we have one subdomain is around key information and then the properties for that information.

And then the second one is going to be, is around shared accountability and feedback. So that actually made our job easier in terms of categorizing the measures.

There were a number of different sort of, you know, sort of feedback on a lot of the current measures out there. Some of these measures are sort of very one-sided. We thought that it was important to sort of have two-sided measures, you know, specifically around medication reconciliation, you know, and making sure that, for example, that there is bidirectional flow of information and that medication reconciliation happens not only in the emergency department or in the primary care, but that's done as sort of a shared process.

There were a number of other sort of

general comments about having -- as opposed to measuring a lot of, having a lot of process measures related to sort of provider transitions, focusing more on having the structures in place to facilitate the transitions of care that we want. And that a lot of the process measures could sort of fall into place once those structures are built.

One of the things that we discussed was coming up with sort of a taxonomy of measures, both, you know, into the emergency department and after ED care that would sort of identify, you know, key information elements in sort of big categories that would say, you know, for these certain types of very high-risk transitions, these are the elements that should be transitioned, this is the timing, this is the modality. And then, ultimately, building structures in place to facilitate both that, both on the ED side and also on the primary care side and outpatient side to build some more structural measures to make sure that happens efficiently.

Some of the other ideas that were discussed are sort of thinking about care plans and, specifically, care plans for patients who are high risk, so people who come to the emergency department over and over again. There were some existing measures around behavioral health, but to sort of expand that out in having sort of ED-based transition plans for people, for example, with sickle cell disease or with people who are coming to the emergency department frequently so that's coordinated, you know, either by primary care or between the primary care and the emergency department. And that would be implemented in the emergency department.

We also talked a little bit about sort of the types of information that emergency physicians or the emergency department should receive feedback about, and that avalanche of information, potential information that could potentially come back once you're tagged to a patient.

There was an example that Arjun had

around, you know, he had sent a patient to the neurology clinic after a seizure and was getting EEG reports eight months later on the same patient. So to figure out sort of a more, yeah, efficient way to feed information back to the physicians and to really identify those cases where the emergency physician should know about something that happened. Either, you know, something that, you know, happened that was out of the ordinary, there was a misdiagnosis, there was something unanticipated happening, some sort of expectation of the emergency physician for a test that they thought the patient should get that they didn't get. So to sort of, to sort of build that learning system and have to improve care.

There was a discussion about sort of, you know, we talked a little bit about sort of checklists and the role of checklists in general. We don't want checklists for everything. But potentially creating a checklist for very high risk transitions in care, specifically for, you

know, certain patients who fall into, you know, new diagnosis of cancer, or someone who has something very serious, we could create a checklist on the ED side. And then, also, you know, something on the primary care side that would ensure that there was a good transition of care for that high-risk individual.

There was also some discussion around ensuring sort of post-ED follow-up for patients with chronic diseases, you know, potentially as part of that checklist. You know, someone who has a very high risk condition that requires immediate follow-up. Someone with a, you know, markedly elevated blood pressure or, you know, some sort of diagnosis that actually needs follow-up to have some way to actually sort of better ensure follow-up.

But also at the same time we know that a lot of patients don't know who their primary care doctor is or may think that the primary care doctor is someone else. So making sure that that information gets to the right person. And then

also to try to create some measure that in the case where there is no primary care doctor, what can the ED do to help facilitate a high-risk transition. And to sort of, you know, because that's something that's obviously frequently encountered.

Yes, go ahead, Arjun.

MEMBER VENKATESH: I was just going to say that I think that kind of in addition to the concepts Jesse brought up, things that might be useful for the other groups were there's things that we had a lot of measure concepts that had either been brought up as ideas or measures that were from the environmental scan that we, as we discussed them, were like, Listen, this doesn't make sense, it shouldn't fit within the conceptual model. This is not what we want to advance.

I think it's helpful discussing what those are. And so there were three categories we had of things that we thought were limitations of prior measures or limitations in prior work was,

first, measures in which they are based on a fee-for-service architecture or were created because of a fee-for-service architecture.

So if we say that fee-for-service payment systems create care coordination problems and fragmentation, we shouldn't then develop measures that advance them. So, for example, there's a lot of these measures of did they have a fixed office visit within three days of ED discharge or seven days of ED discharge? These are not necessarily measures that were going to improve care coordination, but they're simply outpouring of the prior fee-for-service system. And so, we said those didn't make sense. Those didn't fit within the conceptual model of improving provider/provider communication.

Second bucket of things were there's a lot of measures out there that were, I think, developed at a time when more quality measurement was done in a manual or paper-based or chart-abstracted world. And so we kind of, I think, gravitated towards measures that would only

conceptually work and be feasible and advance in a world where you have some degree of healthcare information exchange and are based in electronic information transfer. And recognizing that means that many of the measures may be more aspirational, more concept, and you will have less things that are feasible today, but at least you're not then creating measures that create more burden and work and use systems in a way that we know doesn't transfer information.

And then the third one was that a lot of these prior measures that were looked at are things that would either have kind of arbitrary lines in them about what was or wasn't care coordination, like 60 minutes. Or to say that care coordination between two providers required a verbal conversation within two hours.

And I think that the sentiment of the group was -- and this may be me more, so I may be editorializing here -- was that getting to, like, these very prescriptive, single way of doing a single provider to provider communication was not

an effective use of measurement or process. That what we want to do is get, like Jesse was saying, to these structural measures of capabilities that you need in order to have successful provider/provider communication. Ideally have outcomes on the other side that you measure. And, hopefully, if you've got -- you're figuring out who can get the right structural capabilities and they're moving towards that and then you're measuring outcomes on the other side, people can figure out processes locally.

Some places it's going to be different people engaged in provider/provider communication. Some places it's going to be more electronic. Some places it's going to be more telephonic. But that prescribing that in a measure may actually be counterproductive rather than productive.

And then so that left us with just three gaps. I know Jesse touched on a lot of the measure concepts. We had a cross-over framework. The ones we did not come up with things for, or I

guess limitations were found were, one, is all of our discussion assumed there's two providers already in place. And we know that patients in the emergency department are uniquely more vulnerable to having access challenges and not having usual sources of care and providers. And so we didn't think about what does a transition out of the ED communication look like for a patient without an established primary care provider and an established provider for follow-up.

Second gap we had is a big concept that we brought up in our conceptual model or subdomain is provider/provider communication was accuracy of the information and communication. We didn't come up with any measure concepts in that space.

And then the last one was even when we thought about this in our model, we thought of this as a two-person communication. There are increasingly places where that communication is more than two people. Right? You want to

effectively communicate about the emergency department and visit upstream to the EMS provider or to the referring provider. And you may be communicating to multiple downstream providers.

If you're trying to accelerate a diagnostic work-up, it may be both a specialist and a primary care provider at the same time. And so we didn't get into that either.

But I think those are worth thinking about because ideally we should develop concepts in the measurement framework that supports that world, not the old world.

DR. PINES: And just a couple more comments.

The, you know, the concept of making sure that there's a transition, you know, for providers who are referring patients to the ED, making sure that there is something that happens there, you know, sort of customized for the clinical situation, I think is still important.

And that, similarly, that the ED record be completed and sent to the primary care

provider in a timely way so that they can have that information. I think, you know, those are sort of measure concepts and existing measures that we thought were actually important to have. But sort of, you know, further specifying, you know, based on the needs of the patient.

And then a couple of other concepts that Arjun mentioned, that we didn't really have a lot of concepts around accuracy. The other thing that we talked about a little bit but we couldn't really come up with a lot of ideas is trying to figure out the salience issue and how you can really, you know, we talked about all the stuff we can, you know, and should be sending, but how do we actually make that parsimonious and salient for the provider to, you know, not take a big stack of paper.

And, you know, I think that's a question for discussion. I'd like to hear what other people think about that. We didn't have a lot of great ideas.

You know, I mean sort of one way to

think about it would be to have, you know, something on the top that would identify the couple things that are most important. But we didn't really have a lot of discussion around that.

CO-CHAIR CANTRILL: Thanks.

Any questions or comments for this group? Joe.

MEMBER KARAN: Just a quick question. How does the patient who uses the ER as their primary care physician be affected by what you're doing now, the ability for the provider to report back and things like this? There's nobody to report back to.

DR. PINES: Right. And I think that, you know, we did talk a little bit about that. You know, there are patients who either don't have a primary care physician or, you know, tell you that if it's a primary care physician that it's actually someone else who is taking care of them but they don't know.

And I think thinking really sort of

carefully about transitions for those patients as even being sort of high-risk transitions and doing a checklist or, you know, something that sort of takes those specific types of transitions and looks at them carefully and says, What can we do for this patient?

MEMBER KARAN: Okay. Thank you.

CO-CHAIR CANTRILL: Any other comments or questions?

(No response.)

CO-CHAIR CANTRILL: Thank you, Jesse. Thanks, Arjun.

Moving on to patient communication. Adam, are you the man again?

MEMBER SWANSON: No. Kyle will be. Kyle will be helping us out.

CO-CHAIR CANTRILL: Okay.

MS. COBB: So, yeah, I'm sitting in the front row, I guess, and I got this great job. So, but please chime in. Donna and Kristin, who are speaking from the sky, can also keep me on track.

So, we had a couple changes to our subdomains as a result of meeting again after lunch with full bellies. And I think the major changes were that we updated the assessment of risk to a general risk assessment that would inform communication specific to transitions. But it would include both social and clinical risk assessment.

We went around and around about sort of the how from the patient perspective you get them the right information. And a key component of that decision making is really the risk assessment and understanding both the social and the clinical components.

We also talked about changing slightly the patient needs verification, which is sort of a mouthful, of a subdomain, but really thinking about how that would also incorporate shared decision making, again as a key component to support quality information. I think, you know, we did -- it was interesting to hear you say, Arjun, that being too prescriptive ends up --

ends you on a bad or dead end road.

I mean, I think what we saw with some of the existing measures that were specific to either dementia or CHF, Donna was the first to say these are the measures that are part of the dysfunction in our system that, you know, generate tomes of information needlessly. And this is not what we want to do.

So thinking about how we can describe the measures that are more sort of general but really get to what the actual key information is, and then the other levers of patient needs verification, shared decision making, risk assessment, to get those to be the right information.

We, in general we got through the measures. We did not get to the concepts. There were, in general, the measures of which there are I think four around key information, oh, also modality, really do essentially meet the needs. In general they're good. They identify key information. You know, the who, what, where, and

what you need to do. But, you know, we did, as I mentioned earlier, there are some specific conditions or diagnoses that we didn't see as being cross-cutting or useful. And those were also measures, I will add, that were not specific to the ED. But they were potentially relevant.

We also did find one measure specific to the patient needs verification that really addresses the anxiety, sort of the patient anxiety, and having a provider to follow up. So the concept of follow-up from a community doc to a patient within 72 hours after ED discharge we really liked. We thought there was a great opportunity to adopt/adapt it into some other, you know, variations. But it essentially is similar to a VA measure where each hospital discharge gets a follow-up call; 48 hours I think for behavioral health, and 72 for general. But we really, the group really liked that measure and saw great opportunity for it.

Otherwise unresolved, we do need to think about concepts a little more. And I guess

we have tomorrow for that. And in terms of gaps, we did -- there is a gap certainly in patient to healthcare provider, key information in terms of measurement. And patient to healthcare provider may be something like advanced directives. We're not really sure about that. We need to pressure test that a little more. Curious to get the panel's thoughts on how you actually measure that, and if we want to in this domain.

And then the other gap areas, risk assessment. But also curious to hear feedback on that.

And that is it, just looking at my notes.

CO-CHAIR CANTRILL: Thanks, Kyle.

Any questions or comments for Kyle for group two?

(No response.)

CO-CHAIR CANTRILL: Okay. Moving on to engagement of broader community. Lisa, are you going to report out?

MEMBER DEAL: And please, group, chime

in.

So what I've noticed between the first two groups, the provider and then the patient, there's a lot of overlapping information that our group talked about with regards to the broader community. So those overlaps would be the follow-up after the ED.

We really delved into who's responsible for that? Is it the care manager, this nebulous care manager from the payer or from whoever? Is it the ED's responsibility for that follow-up? As well as how do you share the correct information to, we talked about Meals on Wheels. They don't need all that information, they just need, you know, the diet for the patient. How do we get the right information to the right resources?

We also felt that it wasn't a bi-directional exchange like you were talking about, you know, a quadra-, you know, directional kind of thing. There's so many different places that this information needs to go.

So when we looked at our different measures and their descriptions, we really felt like within this broader community there wasn't a lot of stuff that was really pertinent to us. The biggest thing that we felt was that we really needed to look at the social determinant and have that as a screening tool that starts in the ED and getting case management involved at the ED, so that we can make sure that the care coordinator or case manager is following the patients appropriately.

We also discussed that the patient needs to own this information so that they can disseminate it to their other providers as well. And by making the patient a little bit more accountable they can, they usually can do a lot better.

A lot of the different measures we really felt belonged in the wider communication world. That included transfer of information between a trauma team looking at anesthesia communication, orthopedics. There's a lot of

stuff that, while it is important, we didn't think really talked about the community. So we felt like those are things that we would need to re-send to different areas.

Let's see. What else do we have, guys? Go ahead.

MEMBER MASSEY: We talked about a lot -- and it's overlapping -- about the need to engage in the emergency department in something that traditionally we haven't so far, risk assessments. Typically they happen in a physician office world. We have metrics that we hold for patients in a medical home. We do them in the hospital. We have some meaningful use measures around how we're doing some of these assessments. But the ED typically has been an area where we haven't done the assessment. We also haven't assessed what we can do about having the resources, even if it's just to do that referral.

So how do we shift some of that duty assessment, understand what the patient's needs

are, and then we can move on to measuring what community resources we have to address those needs. But we're not even doing the initial assessments. There's a lot of overlap with what are the needs, and then looking at how could we measure the -- what is the responsibility of the ED to collect those potential resources, to know they're community resources, and have that availability and information to meet those needs?

And is there a way we can measure that? Just has the assessment been done by the ED? Do we have the information? And then trying to look -- I think the secondary piece was understanding measures we already have around revisits or readmissions. So where can we look at and better understand potentially the failures in those connections to the community, in that we can look at revisits and how many of those actually had a referral that may or may not have happened, to leverage existing measures that we didn't actually look at in this one related to revisits?

CO-CHAIR CANTRILL: Jim.

MEMBER DUNFORD: Yeah. I think we also talked about systems of care that emergency departments can and should fit into. One of the suggested measures had to do with trauma systems. There was nothing else that actually got us to align ourselves with other processes or systems of care like STEMI, stroke, and the importance of actually developing, maybe even a little bit different than just the emergency department, but the need to actually have community metrics of performance really, the so-called accountable, you know, healthcare community with its own set of measures that the emergency department would feed data to.

Because we obviously know now that, you know, if emergency departments are on bypass for STEMIs, that Medicare patients actually have been shown to have worse care and actually can cost more. Stroke patients the same thing. So these population-based things that the emergency department effects need to be integrated into a

kind of an even higher level set of measures that is a gap at this time.

CO-CHAIR CANTRILL: Stephanie.

MEMBER WITWER: One other thing that our group talked about was the need for a common data set that would be information that would be transferred to the emergency department when a patient was referred. And then, of course, common data that would be transferred from the emergency department to any referring services that the patient would be going to.

So it would be that if the patient's coming from a referral from primary care or a nurse triage line or whatever the source might be, that there would be some common information that could or should include those social determinants when those have been assessed previously.

CO-CHAIR CANTRILL: Any other comments or questions for the third group?

(No response.)

CO-CHAIR CANTRILL: Okay. Fourth

group, achievement of outcomes. Tricia.

MEMBER ELLIOTT: Okay, thank you.

Just to kind of refresh everybody's memory that wasn't at the table with us, we had four subdomains that we talked about with measures: healthcare utilization and costs; patient experience; safety outcomes; and provider experience.

With health utilization and costs we had five measures that we looked at. A lot had to do with follow-up visits. And we felt that if some of the content could become more condition-specific that there is some opportunity there. So we coined a new term. We sent it to "conceptland." So we will revisit that tomorrow in terms of taking at least two of the measures that were in that category and seeing if we can adapt or repurpose to meet the needs of the ED transitions.

Three of the measures we just outright said they don't fit.

Patient experience, we had a very

robust discussion on the five measures that were put in front of us on the paperwork. We had a robust discussion on CTM-3 or also CTM-15, which is care transition measures. And because some of the measures that were included in our packet were HCAHPS-based. So we thought that maybe the CTM concepts were closer to what we were looking for. And we were leaning more toward the patient-reported outcome versus a patient experience per se. Although there was a little bit of debate of how do you differentiate one from the other.

We kind of took pain-related stuff and voted, voted them off the island, for the time being. So, yet, another term from the team.

The last key, sorry, second-to-last, the safety outcomes, there was ten measures there that were put in front of us. And the vast majority were related to med rec. So we sent those items off to "conceptland" as well for tomorrow because we, none of them fit just right. So, we think there's something there but we kind

of have a little bit of a homework assignment to mull all that over and really figure out the best way to make that work.

One measure we definitely took off the table because it was related to medication review and thought that that fit more with the PCP and that type of environment. So, great discussion there. But there's something with med rec, we just haven't quite put our finger on it yet.

The fourth topic, the provider experience, there were no proposed measure -- or there was only concept-only measures there, there wasn't a measure to review per se. So we had some great discussion there in terms of some opportunities of looking at, you know, where the patients are coming from when they hit the ED, whether it be from a SNF, a PCP, what we called "free range" where they just kind of show up at your door. So yet another term from the team. We're accumulating new terms here.

And then also the EMS to the ED and all those types of transitions. And potentially,

you know the experience of the provider, the provider giving input back to, or evaluating that transition from the SNF and maybe back to the SNF. So really robust, interesting discussion there as to the kind of turning it and looking at it from a provider grading that experience versus we typically talk about a patient experience.

So, I'm sure I missed a few points. So I'll call upon my team to fill in any gaps that I missed.

CO-CHAIR CANTRILL: Any comments in terms of the last report? Any questions?

(No response.)

CO-CHAIR CANTRILL: Okay, good job. I think we've covered a lot of territory today.

I think we'll now take any questions remotely. Operator, could you open the phone lines and see if we have any pending questions there.

OPERATOR: Yes, sir.

At this time if you would like to make a comment, please press star then the number one.

And there are no comments at this time.

CO-CHAIR CANTRILL: Okay, thank you.

Do we have any comments from guests that are with us today?

(No response.)

CO-CHAIR CANTRILL: Okay. Any other comments from anybody?

DR. WILSON: Do we need to tee up what's on tap for tomorrow?

CO-CHAIR CANTRILL: We can.

Tomorrow we'll be starting at 8:00 o'clock with our continental breakfast. And actually begin the meeting at 8:30 with kind of an overall review of some of the territory that we've covered today.

And then we will get into measure concept review. And then the fun part, we define some measure concepts again as our small groups.

So that's kind of where the rubber meets the road in terms of what we've been aiming for for today and tomorrow.

DR. WILSON: And, also, the other thing that staff will do tonight is that we're going to take the changes that you made either to your domains or subdomains, what measures fell out, what measures remain, and concepts or gaps that you identified, and rework probably the measure compendium Word document -- I'm confirming with my peeps here -- and so bring it back tomorrow.

Because I think what might serve us well is to look at, look across all the domains in the morning and begin hearing some of those cross-cutting issues as you're looking at measures within your subdomains and fleshing out some of those, specking out, making more specifications for some of those concepts, making sure that we're clear as to what falls in the different domains because I think there's going to be a lot of overlap.

So I think it might behoove us to start the day with just kind of a global look of where we landed before you get your marching

orders to go off to work on concepts. Because I think I can see the distinction across some of the subdomains, but in our language I want to make sure that we're all clear about that. So I think that's probably a good way to spend a few minutes in the morning, Steve.

CO-CHAIR CANTRILL: Good.

Okay, any other comments? Otherwise I guess we'll be adjourned. We will be having dinner tonight at Siroc at 5:30. That's what the reservation is for. It's in the NQF name. Again, this is going to be a Dutch treat meal.

And we'll be walking over there. I guess we could meet downstairs at 5:15 and walk over, for those that are in the vicinity.

DR. WILSON: Yes. What hotel do we have you staying at this trip?

CO-CHAIR CANTRILL: All the way up at the Hilton.

DR. WILSON: Okay, the Hilton.

CO-CHAIR CANTRILL: The Washington Hilton.

DR. WILSON: If you'd like to, like, meet in front of our building about 5:20, we can walk you over. As you walk towards K Street there's a square to your left, and it's right in that neighborhood. It's not far from our front door. So, if you want to meet.

You can find it on your own. We're fine with that. But if you'd like to meet at about 5:20 outside of our front door, we'll have somebody to walk you over. Okay.

CO-CHAIR CANTRILL: Thank you all for all your efforts today and, again, for your time and for your time tomorrow and in the future. Thanks a lot.

DR. WILSON: Thank you.

(Whereupon, at 3:57 p.m. went off the record.)

D

C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Emergency Department Quality of Transitions Expert Panel Meeting

Before: NQF

Date: 04-25-17

Place: Washington, DC

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

Neal R Gross

Court Reporter