

NATIONAL QUALITY FORUM

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EMERGENCY DEPARTMENT
QUALITY OF TRANSITIONS OF CARE EXPERT PANEL

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TUESDAY
APRIL 25, 2017

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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

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

2 8:35 a.m.

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

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

1 assembled. Lot of skill, lot of knowledge here.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6 DR. AGRAWAL: Absolutely.

7 DR. WILSON: Okay, thank you. Janet?

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

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

22 DR. WILSON: Thank you, Steve. And

1 Brendan, if you would introduce yourself.

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

8 DR. WILSON: Thank you. Arjun?

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

19 DR. WILSON: Thank you.

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

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

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

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

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

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

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

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

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

1 Coordination Center where I'm a policy analyst.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 MEMBER CARDEN: I am. Can you hear
19 me?

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

22 MEMBER CARDEN: Okay. I'm Donna

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

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

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

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

1 taking the majority of my attention and time
2 right now.

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

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

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

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

1 for your colleagues? Anything that was
2 disclosed?

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

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

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

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

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

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

18 (No response.)

19 DR. CARR: Okay.

20 DR. WILSON: Okay, should we ---

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 You're going to be looking at those subdomains.

2 Do they make sense? Do we need to add one?

3 Delete one? Combine one? Split one?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 had to split the communication into provider
2 communication and parent and family
3 communication.

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

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

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

22 So let's jump in and start with domain

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

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

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

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

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

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

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

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

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

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

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

1 include equity, continuity, culturally
2 appropriate services.

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

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

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

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

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

1 dealing with.

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

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

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

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

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

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

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

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

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

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

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

3 CO-CHAIR NILES: Yes, thank you.

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

12 CO-CHAIR NILES: Good point. Marcia?

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

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

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

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

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

3 CO-CHAIR NILES: Kyle?

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

11 CO-CHAIR NILES: Yes, ma'am.

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

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

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

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

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

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

3 CO-CHAIR NILES: Yes, Jim?

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

15 CO-CHAIR NILES: Absolutely. Arjun?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

14 CO-CHAIR NILES: Julie?

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

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

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

1 that's something to just keep in mind.

2 CO-CHAIR NILES: Brendan?

3 DR. CARR: Just to piggyback on that.

4 I think we also need to be really mindful of the
5 --- we are talking about the emergency
6 department, and we are talking about sort of
7 payers and primary care are three of the big
8 players here. But acute care is --- it's
9 changing, right? And depending on where you
10 live, you see this or don't see this.

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

22 CO-CHAIR NILES: Thank you. Any other

1 comments? Anybody on the phone have a comment?

2 Okay, Marcia, where do we go next?

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

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

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

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

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

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

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

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

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

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

17 MS. REED: Volunteers.

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

20 CO-CHAIR NILES: Location.

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

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

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

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

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

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

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

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

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

21 MS. COBB: Okay.

22 DR. WILSON: Thank you.

1 (Whereupon, the above-entitled matter
2 went off the record at 9:36 a.m. and resumed at
3 11:19 a.m.)

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

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

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

16 Who might that be?

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

19 CO-CHAIR CANTRILL: Okay.

20 DR. PINES: -- Provider Communication
21 group.

22 CO-CHAIR CANTRILL: Well, they got

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

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

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

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

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

22 So, you can see all the different sort

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

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

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

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

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

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

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

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

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

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

7 CO-CHAIR CANTRILL: Any unresolved
8 issues, Jesse?

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

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

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

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

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

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

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

22 Any questions?

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

3 MEMBER SWANSON: Okay. Great.

4 CO-CHAIR CANTRILL: Okay, Adam.

5 MEMBER SWANSON: Thank you, Steve.

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

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

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

22 So, the domain definition is,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 Yes, sir.

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

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

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

21 Would that be a proper representation?

22 MEMBER OKER: Could I add?

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

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

12 Would that be fair?

13 MEMBER SWANSON: Yes.

14 CO-CHAIR CANTRILL: Julie.

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

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

4 I come from the Suicide Prevention
5 Resource Center and the follow-up care that we
6 talk about with EDs is so critical. And getting
7 that patient consent to do the follow-up is very
8 critical and if they're someone under the age of
9 18.

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

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

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

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

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

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

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

13 MEMBER MASSEY: I think we --

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

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

20 MEMBER KARAN: Okay.

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

1 --

2 MEMBER KARAN: Okay.

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

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

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

1 where that's going.

2 MEMBER KARAN: I got it. Thank you.

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

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

10 CO-CHAIR CANTRILL: Okay. Thank you.

11 Any other comments or questions?

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

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

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

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

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

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

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

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

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

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

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

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

22 And with this, we also want to include

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

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

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

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

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

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

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

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

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

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

1 the emergency department and how can we utilize
2 repeat visits.

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

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

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

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

22 And we also talked a little bit about

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

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

6 CO-CHAIR CANTRILL: Lisa, any
7 unresolved issues?

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

15 CO-CHAIR CANTRILL: Comments.

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

20 (Laughter.)

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

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

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

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

10 Jesse.

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

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

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

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

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

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

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

1 documenting on the sender.

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

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

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

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

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

6 CO-CHAIR CANTRILL: Aleesa, and then
7 --

8 MEMBER RISING: Sorry.

9 CO-CHAIR CANTRILL: Go ahead.

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

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

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

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

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

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

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

12 (Laughter.)

13 MEMBER RISING: Yes, very much.

14 CO-CHAIR CANTRILL: Aleesa.

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

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

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

5 MEMBER VENKATESH: I guess a couple
6 things.

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

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

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

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

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

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

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

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

1 want to do everything else in life.

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

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

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

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

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

19 CO-CHAIR CANTRILL: Stephanie.

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

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

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

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

15 CO-CHAIR CANTRILL: Brenda.

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

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

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

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

14 CO-CHAIR CANTRILL: Elif.

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

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

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

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

8 CO-CHAIR CANTRILL: Jim.

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

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

22 And that we also use alerting

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

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

9 CO-CHAIR CANTRILL: Joe.

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

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

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

22 And it's an undertaking. But if

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

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

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

9 MEMBER PRICE: Sorry. Marc.

10 CO-CHAIR CANTRILL: There you go.

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

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

22 And depending, like Joe said, where

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

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

5 Okay. Moving on to Achievement of
6 Outcomes, Tricia.

7 MEMBER ELLIOTT: Yes. Thank you.

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

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

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

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

1 discussion.

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

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

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

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

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

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

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

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

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

1 bit.

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

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

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

18 CO-CHAIR CANTRILL: Thank you, Tricia.

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

22 Is that really a component of

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

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

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

14 Jesse, you have a question or comment?

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

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

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

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

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

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

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

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

4 CO-CHAIR CANTRILL: Brenda.

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

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

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

14 (Laughter.)

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

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

1 CO-CHAIR CANTRILL: Thank you.

2 Comment? I can't read your name -- oh, Nicki.

3 Sorry.

4 MEMBER HASTINGS: Yes. Nicki. Sorry
5 about that.

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

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

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

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

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

15 CO-CHAIR CANTRILL: Arjun.

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

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

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

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

1 CO-CHAIR CANTRILL: Joe.

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

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

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

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

19 CO-CHAIR CANTRILL: Julie.

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

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

7 CO-CHAIR CANTRILL: Jim.

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

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

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

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

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

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

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

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

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

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

20 CO-CHAIR CANTRILL: Elif.

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

1 environment where there's a lot of heterogeneity.

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

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

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

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

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

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

20 CO-CHAIR CANTRILL: Good. Thank you.

21 Any other questions or comments for
22 this group?

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

3 Are there any comments from those that
4 are listening in?

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

8 There are no public comments at this
9 time.

10 CO-CHAIR CANTRILL: Thank you.

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

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

19 MS. COBB: Thanks, Steve.

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

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

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

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

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

22 An example is the -- a measure that

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

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

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

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

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

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

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

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

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

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

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

1 also address different settings.

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

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

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

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

1 but they do exist.

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

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

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

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

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

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

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

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

22 And so, for -- so that we can

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

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

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

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

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

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

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

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

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

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

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

22 Outcome measures, a little more

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

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

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

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

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

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

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

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

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

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

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

1 MS. COBB: It's just individual
2 counts.

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

5 MS. COBB: Yeah.

6 MEMBER PRICE: Or who responded,
7 anyway?

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

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

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

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

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

1 Thank you. I understand now.

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

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

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

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

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

1 analysis.

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

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

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

22 I think some of these areas tend to be

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

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

9 So, I will end there unless anybody
10 has questions.

11 CO-CHAIR CANTRILL: Any questions for
12 Kyle?

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

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

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

22 DR. WILSON: Show of hands, keep your

1 hands up, so we can get a reservation.

2 CO-CHAIR CANTRILL: Okay.

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

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

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

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

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

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

1 some excitement in terms of our second breakout.

2 Marcia, do you want to give us
3 instruction?

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

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

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

22 So those are the resources that you're

1 going to be using.

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

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

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

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

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

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

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

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

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

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

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

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

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

22 So cross-cutting issues is one.

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

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

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

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

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

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

5 (No response.)

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

10 It looks like we're due back here at
11 3:00 o'clock for report out. So if you start to
12 wind down before then, we'll reconvene a little
13 bit early. But my guess is after this morning's
14 experience with the discussion this is not a shy
15 group, and we really got into the discussion.
16 And I think this is going to be meatier, if you
17 will, a little more complicated than this morning
18 because now we're really talking about measures
19 and measure concepts and gaps.

20 Yes, Brenda?

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

1 information about the different types of
2 measures, the definitions?

3 DR. WILSON: Absolutely. The
4 structure process outcome?

5 MEMBER SCHMITTHENNER: Yes.

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

16 Any other questions?

17 (No response.)

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

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

1 3:24 p.m.)

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

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

14 Use your mike.

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

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

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

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

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

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

22 There were a number of other sort of

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

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

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

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

22 There was an example that Arjun had

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

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

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

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

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

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

7 Yes, go ahead, Arjun.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 DR. PINES: And just a couple more
14 comments.

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

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

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

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

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

22 You know, I mean sort of one way to

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

6 CO-CHAIR CANTRILL: Thanks.

7 Any questions or comments for this
8 group? Joe.

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

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

22 And I think thinking really sort of

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

7 MEMBER KARAN: Okay. Thank you.

8 CO-CHAIR CANTRILL: Any other comments
9 or questions?

10 (No response.)

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

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

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

17 CO-CHAIR CANTRILL: Okay.

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

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

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

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

1 ends you on a bad or dead end road.

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

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

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

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

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

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

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

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

13 And that is it, just looking at my
14 notes.

15 CO-CHAIR CANTRILL: Thanks, Kyle.

16 Any questions or comments for Kyle for
17 group two?

18 (No response.)

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

22 MEMBER DEAL: And please, group, chime

1 in.

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

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

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

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

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

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

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

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

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

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

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

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

1 CO-CHAIR CANTRILL: Jim.

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

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

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

3 CO-CHAIR CANTRILL: Stephanie.

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

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

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

21 (No response.)

22 CO-CHAIR CANTRILL: Okay. Fourth

1 group, achievement of outcomes. Tricia.

2 MEMBER ELLIOTT: Okay, thank you.

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

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

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

22 Patient experience, we had a very

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

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

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

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

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

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

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

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

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

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

13 (No response.)

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

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

20 OPERATOR: Yes, sir.

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

1 And there are no comments at this
2 time.

3 CO-CHAIR CANTRILL: Okay, thank you.

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

6 (No response.)

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

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

11 CO-CHAIR CANTRILL: We can.

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

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

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

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

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

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

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

7 CO-CHAIR CANTRILL: Good.

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

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

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

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

20 DR. WILSON: Okay, the Hilton.

21 CO-CHAIR CANTRILL: The Washington
22 Hilton.

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

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

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

15 DR. WILSON: Thank you.

16 (Whereupon, at 3:57 p.m. went off the
17 record.)
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A			
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Before: NQF

Date: 04-25-17

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